ULHT Quality Account

2018/19

2021
A different Lincolnshire
A great ULHT

Excellence in rural healthcare

GLOSSARY OF ABBREVIATIONS

A&E	Accident & Emergency
AAA	Aortic Abdominal Aneurysm
AoMRC	Academy of Medical Royal Colleges
BAF	Board Assurance Framework
CABG	Coronary Artery Bypass Graft
CAUTI	Catheter Associated Urinary Tract Infection
CAS	Central Alerting System
CCG	Clinical Commissioning Group(s)
C. Diff	Clostridium Difficile
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CP-IS	Child Protection Information Sharing
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRN	Clinical Research Network
CT	Computerised Tomography
CYPAU	Childrens & Young People Assessment Unit
DATIX	Incident Reporting System
DH	Department of Health
DoC	Duty of Candour
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DSR	Data Security & Protection
DVT	Deep Vein Thrombosis
ED	Emergency Department
eDD	Electronic Discharge Document
EFN	Estates and Facilities Notifications
EFA	Estates and Facilities Alerts
EMAS	East Midlands Ambulance Service
ENT	Ear, Nose & Throat
FFAP	Falls and Frailty Audit Programme
FFT	Friends & Family Test
GDH	Grantham District Hospital
GIRFIT	Get It Right First Time
GP	General Practitioner
HES	Hospital Episode Statistics
HQIP	Health Quality Improvement Partnership
HSMR	Hospital Standardised Mortality Ratio
IAC	Integrated Assessment Unit
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care National Audit & Research Network
ICU	Intensive Care Unit
IDVA	Independent Domestic Abuse Advisor
IG	Information Governance
IP&C	Infection Prevention & Control
IPR	Integrated Performance Report
IV	Intravenous

IVAB	Intravenous Antibiotics
KPI	Key Performance Indicator
LCH	Lincoln County Hospital
LCRF	Lincoln Clinical Research Facility
LeDeR	Learning Disability Mortality Review Programme
LUCADA	Lung Cancer Audit (National)
MAPPA	Multi-Agency Public Protection Arrangements
MBRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MCA	Mental Capacity Act
MDA	Medical Devices Alerts
MDSG	Medical Devices Support Group
MDT	Multi-Disciplinary Team
MHRA	Medicines and Healthcare Products Regulatory Agency
MI	Myocardial Infarction
MINAP	Myocardial Infarction National Audit Programme
MOCH	Medicines Optimisation in Care Homes
MoRAG	Mortality Review Assurance Group
MorALS	Mortality Assurance & Learning Group
MRI	Magnet Resonance Imaging
N/A	Not Applicable
NBCA	National Bowel Cancer Audit
NCEPOD	National Confidential Enquiry into Patient Outcomes and Death
NG	Naso Gastric
NHS	National Health Service
NHSBT	National Health Service Blood & Transplant
NHSi	National Health Service Improvement
NHSLA	National Health Service Litigation Authority
NHSPSA	NHS England Patient Safety Agency
NICE	National Institute for Health and Care Excellence
NICOR	National Institute for Cardiovascular Outcomes Research
NIV	Non Invasive Ventilation
NJR	National Joint Registry
NMC	Nursing & Midwifery Council
NNAP	National Neonatal Audit Programme
NPCA	National Prostate Cancer Audit
NIHR	National Institute for Health Research
NRLS	National Reporting Learning System
NVD	National Vascular Database
OD	Organisational Development
PAS	Patient Administration System
PbR	Payment by Results
PDSA	Plan Do Study Act
PHB	Pilgrim Hospital
PHSO	Parliamentary and Health Service Ombudsman
PICANet	Paediatric Intensive Care Audit Network
PPID	Positive Patient Identified
PROMs	Performance Reported Outcome Measures
QGC	Quality Governance Committee
QSOG	Quality & Safety Oversight Group
RAT	Rapid Assessment

RCEM	Royal College of Emergency Medicine
RCP	Royal College of Physicians
RCT	Randomised Control Trials
ReSPECT	Recommended Summary Plan for Emergency Treatment
RTT	Referral to treatment
SBAR	Situation, Background, Assessment, Recommendation
SHMI	Standardised Hospital- Level Mortality Indicator
SHOT	Serious Hazards of Transfusion
SHRBP	Senior HR Business Partners
SI	Serious Incident
SOP	Standard Operating Procedure
SQD	Safety Quality Dashboard
SSNAP	Sentinel Stroke National Audit Programme
ST	Safety Thermometer
STP	Sustainability & Transformation Programme
TARN	Trauma Audit Research Network
TOM	Trust Operating Model
ULHT	United Lincolnshire Hospitals NHS Trust
VTE	Venous Thromboembolism
WTE	Whole Time Equivalent
7DS	7 Day Services

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PART 1

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CHIEF EXECUTIVES STATEMENT

Welcome to the Quality Account for United Lincolnshire Hospitals NHS Trust for 2018/19. This document provides an overview of all of the activity that has been taking place within our hospitals on the quality agenda over the past year.

During the year, we continued to monitor and improve the quality of care that we provide, whilst we remained in quality special measures. I believe we have seen significant improvements in the quality of care that we provide in many areas of the Trust.

The most notable success for us around quality during the year has, of course, been our move from an 'inadequate' to a 'requires improvement' rating by the CQC, following an inspection in March 2018, with reports released in July 2018.

We are immensely proud of the commitment and perseverance shown by staff over the past year, and feel this improvement reflects the hard work that has taken place.

One of the ways in which we have transformed our approach to quality is the introduction of our quality matrons and our ward accreditation programme. This is a scheme aimed at engaging staff and empowering leaders to improve standards and quality on adult in-patient wards, by monitoring them against a series of standards. The programme has now seen 21 of the Trust's 40 adult inpatient wards achieve a green rating.

However, we know that we still have many challenges to face in order to make our services safer and more sustainable, and repeat CQC inspections to the emergency department at Pilgrim Hospital, Boston later in the year reflected the work that is still to do.

During the year we have also faced other challenges. We remain in a significant financial deficit, and we have failed to meet national targets such as the maximum four hour wait in accident and emergency, some of the cancer targets and some key quality measures. We are working hard to address these challenges and we are encouraged by signs of improvement in different areas of the Trust.

Staffing challenges have also continued to be a real issue during the year, and we continue to work innovatively on how to meet these challenges to ensure our services remain safe and sustainable. We were pleased that our new nurse associates came into post as part of our transformation programme.

As well as reported challenges, we are also proud of many developments. We've made good progress with taking forward the future of our services with the development of our 2021 strategy, clinical strategy and the beginning of the Lincolnshire NHS Healthy Conversation 2019.

We also invested in the future of many services, including significant investment in fire safety upgrades, the Pilgrim ‘Big change’ piece of work reconfiguring our services at the site, redesigning our operating model to be centred more around clinical service areas and patients, transforming our outpatient services and trialling a new approach to delivering trauma and orthopaedic care.

Looking forward, I believe that 2019/20 will be a further year of significant improvement for the Trust, with continuing development of our 2021 strategy, which is focused on enhancing our quality and safety.

We hope that you find this report informative and that it demonstrates our commitment to providing safe, quality care for our patients.

On the basis of the processes the Trust has in place for the production of the Quality Account, I can confirm that to the best of my knowledge the information contained within this report is accurate.

Jan Sobieraj
Chief Executive Officer

PART 2

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PRIORITIES FOR IMPROVEMENT IN 2019/20

Deciding our quality priorities for 2019/20

In order to determine our priorities we have consulted with a number of stakeholders including our Trust Quality Governance Committee (QGC), clinical boards and our commissioners. The QGC on behalf of the board approved the priorities and there will be regular reports on progress to QGC throughout the year.

We have ensured that our quality priorities are aligned with this year's Trust Quality Strategy and to the Lincolnshire wide system quality priorities . We have taken into account our progress throughout the year against last year's priorities to help decide which priorities need an ongoing focus within this year's quality account. The priorities also reflect the key areas that were raised in the CQC report published in July 2018. We have also reviewed our clinical incidents, complaints, feedback to ensure these are the priorities that matter most to our patients, carers and families.

The following improvement priorities for the Trust have been identified for particular focus in 2019/20. These priorities will be extended over the coming years to ensure they are fully embedded within our organisation. The overarching principle for all these work streams is their importance for patient experience: they have been grouped under the CQC domains below for the purpose of this quality account document.

CARING	• Patient and Carer Experience
CARING	• I would recommend my organisation as a place to work/If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation
EFFECTIVE	• Ensuring effective systems for reviewing mortality
WELL LED	• Ensuring people are being cared for in the right place at the right time - Respiratory Patients

PRIORITY 1 – PATIENT AND CARER EXPERIENCE

Why have we selected this Priority?

There is a need to review, launch and deliver the ULHT Patient and Carer Experience Plan. Over the past two or three years, the organisation has begun to see increased recognition of the importance of understanding patient's experiences. We need to strengthen connections, with issues around performance and quality/safety, so that patient experience is seen in its broadest sense and with staff experience, as evidence demonstrates the link between the two is strong.

We need at a corporate level to be more systematic in using data to identify issues and drive improvement. Themes from patient feedback have consistently related to communication, attitudes, behaviours and transactional factors such as, waiting times and appointments.

Alongside this, local level ownership and accountability must be in place. Patient experience must be seen as an issue for all staff, rather than being in the domain of nursing and therapies only.

We need through the governance and performance management processes, to establish systematic ways of using the variety of data we have available, to fully understand the issues and identify actions that will have a positive impact. Our revised plan must ensure that the organisation fully embraces the concept of 'patient-centred' care.

The patient experience team have largely been seen as responsible and accountable for the quality of patient experiences to date. We need to use the implementation of the new Trust Operating Model and the Performance Review meeting format to truly put the patient at the heart of what we do.

Our current status

With the current Patient Experience Strategy due for review in 2019 this is an excellent opportunity to draw in the new Trust Operating Model, revised governance frameworks and the refreshed 2021 Strategy and objectives.

Our data from the Friends and Family test (FFT), National Surveys, Complaints and PALS and social media feedback such as Care Opinion tells us our focus has to be on:

Patients recommending us as a place to receive care and treatment; our recommendation rates are below the national averages.

Patients and their families and carers being involved in decisions about their care and helping to design services; our national inpatient survey shows this has declined.

Communication; feedback tells us that patients do not always feel staff work together as a team and that they at times receive conflicting information.

Compassion and empathy; surveys have shown us that patients have not always been able to find someone to talk to about their worries or fears and whilst this may be related in some way to staff time to talk our complaints and PALS enquiries show that it also relates to staff perhaps not being curious enough or asking outright if someone is worried or afraid.

Keeping patients informed and up to date on their care and treatment; we know that with bed pressures our patients are too frequently moved to different wards and this can cause concern and delay discussions and decisions about care. We also know from our national surveys that doctors and nurses in some cases talk over patients as if they weren't there.

Valuing patients time; our patients spend a lot of time waiting – this may be for appointments or procedures but also for reports or decisions or for discharge as well as for day to day care on the wards. We know from feedback that many discharges are delayed for a range of reasons such as waiting for a doctor decision or medications. We also know that only 30% of patients are seen on time or within 15 minutes of their outpatient appointments.

Information and advice; a large number of PALS enquiries relate to the need for information or advice or clarifying such; our national surveys tells us that adequate information at discharge needs to improve such as written information, what danger signals to look for and how to manage medications.

What will success look like?

- Our FFT and national in-patient scores will align with national averages.
- We will see improvements in valuing patients time with more people seen on time or within 15 minutes of their outpatient appointment and reduced waiting for information and discharge.
- Our new SUPERB patient feedback dashboard will be used across the Trust to provide meaningful and useful patient feedback intelligence to enable patient centred improvement actions and initiatives.
- We will introduce a process to align patient experience with staff experience at team and service level. This will incorporate how we are engaging clinical staff.
- We will review our complaints process to ensure patients receive high quality and timely responses.
- All our services will have identified FAB Experience Champions who will drive local level improvements in patient experience supported by the Patient Experience Team.
- Co-design of services will be systematic and our leaders will be skilled in engaging with service users

How will we assess our progress?

A work plan drawn from our strategy will be monitored through Patient Experience Group.

Further development of the SUPERB dashboard will enable us to analyse and use our data and to triangulate across data sources.

Patient Experience metrics will be included within Integrated Board reports and Performance Reviews.

Real Time Surveying will give contemporary intelligence and enable focused and remedial support to be provided.

Divisional reports and progress will be reported through Patient Experience Group.

PRIORITY 2 – I WOULD RECOMMEND MY ORGANISATION AS A PLACE TO WORK / IF A FRIEND OR RELATIVE NEEDED TREATMENT I WOULD BE HAPPY WITH THE STANDARD OF CARE PROVIDED BY THIS ORGANISATION

Why have we selected this Priority?

The connectedness between staff recommending ULHT as a place to work and a place they would recommend to receive treatment reflects the morale within the organisation and the extent to which our staff are engaged with the vision and values of the Trust.

We fundamentally believe if we can improve staff experience at work and their connectedness with ULHT, our staff will be able to deliver the highest standards of care. As a consequence, they will be more inclined to recommend ULHT as a place to receive care.

We hope to create a united sense of purpose through 2021 and emphasise that the patient lies at the centre of everything that we do. At present, not all our staff believe that ULHT is creating the conditions in which they can provide the best care.

We want to ensure that all our staff believe that the Trust can get to a better place, and that each of them feels they have a part to play in that success.

The Trust has stated its ambition to be known as a learning organisation and potentially to become a “teaching trust”. This aligns with the employment brand we have been promoting (as a means to recruit and retain). We know we must do more to put education at the core of our business, improve the training experience and ensure access to learning for all our staff.

We acknowledge that there is a link between the sense of engagement and the staffing position and certainly the narrative around the staffing positon, which impacts significantly on overall levels of morale.

Our current status

The Trust scores for key engagement and morale measures in the National Staff Survey 2018 have dropped significantly since the Trust went into quality and financial special measures.

Our Staff Friends and Family test scores are:

Recommend as place to work:
ULHT: 41.4%
Average: 62.6%

Happy with standard of care provided:
ULHT: 47.4%
Average: 71.I3%

What the evidence shows from the KPIs is that the vacancy rates for medical and nursing have increased substantially since the Autumn of 2017. We have seen an improvement in AHP vacancy rate in the last couple of months, which demonstrates that that where we do have a focus, improvement can be made. We need the same focus now in other areas.

Turnover in nursing is a significant issue. The profile of the workforce means that there is the potential for turnover to increase and we need a strong focus on flexibility in employment practice, the encouragement of talent and the provision of development opportunities for all, if we are to sustain engagement and support retention.

Sickness rates have stayed fairly stable, which given the pressures in the organisation, is an achievement and supports the focus in the strategy on getting the basics of workforce management right as a building block to sustained improvement.

What will success look like?

All our responses to the staff survey are embedded within our overarching People Strategy. The majority are focussed on improving the workplace experience for our staff because we believe by doing that, this will in turn lead to an improvement in staff recommending ULHT as a place to receive care.

We are:

- Relaunching 2021 with a clear focus that patients really are our number one priority
- Supporting the development of the new triumvirates
- Ensuring that all Divisions are holding staff charter workshops for all staff
- Creating a refreshed approach to leadership
- Developing and embedding a coaching culture within ULHT and working with partners in the system to enhance our coaching capacity and capability.
- Adopting a consistent and robust approach to values based recruitment and selection for all senior posts building on the TOM Assessment Centre model.

How will we assess our progress?

Alongside our corporate response, we are working with Divisional triumvirates and Senior HR Business Partners (SHRBPs) to create local responses to specific concerns and listening to staff in focus groups.

We will undertake mini pulse checks incorporating these two Staff Friends and Family Test questions alongside all the other metrics in the People Strategy

Reports will be presented to Workforce and Organisational Development Committee.

PRIORITY 3 – ENSURING EFFECTIVE SYSTEMS FOR REVIEWING MORTALITY

Why have we selected this Priority?

The Care Quality Commission (CQC) report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare. When mistakes happen, providers working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

Reforms to death certification, when implemented in England, will result in all deaths being either scrutinised by a Medical Examiner or investigated by the coroner in certain circumstances. Additionally, Medical Examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to coroner any death appearing to involve serious lapses in care.

Our current status

From February 2018 – January 2019 the Trust had 2121 deaths of which 1266 were reviewed. It is the responsibility of each Speciality to review their deaths.

The Trust had 29 deaths grade 2 / 3 which equates to 2.8% from February 2018 – January 2019.

The Trust has implemented the Medical Examiner albeit on a limited scale. Currently there are 9.5 WTE Medical Examiners covering Lincoln and Pilgrim sites. The Trust is also in the process of appointing a Medical Examiner's Assistant to cover the shortfall at Pilgrim site.

The role of the Medical Examiner is to ensure a screening of the patients notes is completed within 7 days of a patients death.

The Medical Examiner will seek to answer three questions:

1) What did the person die from? (ensuring accuracy of death on the medial certificate)

2) Does this case need to be reported to the coroner? (ensuring timely, accurate referral)

3) Are there any clinical governance concerns? (ensuring investigations are completed)

They will do this by following these steps:

- Proportionate review of medical records
- Interaction with the attending doctor(s)
- Interaction with those who have been bereaved

Each of these steps is important but the interaction with people who have been bereaved is especially so. For cases not reported to the coroner, contact with bereaved people is made by telephone as soon as possible after the medical certificate is completed. This will be done sensitively and is an opportunity to ask them if they have any concerns about the care given and if they do to consider the need for further investigation.

The Medial Examiner does not investigate; their role is to detect and pass on to the appropriate team to investigate. Any review completed by the Medical Examiner that has any issues identified will be forwarded to the Speciality for a further in-depth review.

More complete information on Medical Certificate of Cause of Death (MCCDs), including contributory conditions and factors leading to cause of death and spotting of unusual trends in deaths will improve the quality of cause of death, help the Trust to learn and save more lives in the future.

What will success look like?

- There will be Medical Examiners available in the Bereavement Centre to complete the initial review and be a point of contact for junior doctors.
- Increase in the number of deaths screened by the Medical Examiners
- Specialities will review the cases referred by the Medical Examiners within a timely period
- Bereaved families will have had contact the Medical Examiner / Medical Examiner Assistant
- A strategic learning group will be implemented – Mortality Assurance Learning Strategy (MorALS) Group
- Widespread sharing of lessons learnt promulgated throughout the Trust
- A reduction in SHMI to within expected limits (band 2)
- Yearly updates to the 2019 – 2021 Mortality Reduction Strategy

How will we assess our progress?

A monthly report will be presented at the Patient Safety Group

The Quality Governance Committee will receive monthly narrative on Learning from Deaths

The Trust Board Committee will receive monthly narrative on Learning from Deaths

PRIORITY 4 – ENSURING PEOPLE ARE BEING CARED FOR IN THE RIGHT PLACE AT THE RIGHT TIME – RESPIRATORY PATIENTS

Why have we selected this Priority?

Community Acquired Pneumonia (CAP), Hospital Acquired Pneumonia (HAP) and Chronic obstructive pulmonary disease (COPD) are common and deadly conditions that puts huge pressure on the NHS in winter. CAP is contracted outside of hospital and is caused by a bacterial infection which inflames the tissue in one or both lungs which fill up with fluid. HAP is an acute lower respiratory tract infection that is by definition acquired after at least 48 hours of admission to hospital and is not incubating at the time of admission. The term COPD is used for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease These can cause severe breathing problems and are the causes of thousands of deaths across the NHS every year.

Acute exacerbation of chronic obstructive pulmonary disease (COPD) is a common reason for admission to hospital. Non-invasive ventilation using positive airway pressure has an important role in the management of acute hypercapnic (type 2) respiratory failure.

The key to better health outcomes is fast diagnosis, correct disease severity assessment and rapid and tailored treatment.

Acute NIV reduces mortality by 50% and shortens hospital length of stay when used to treat COPD exacerbations complicated by acute hypercapnic respiratory failure (AHRF).

At a national level pneumonia and flu caused 269,313 emergency hospital admissions in the UK in 2016/17 which cost the NHS an estimated £1 billion.

Our current status

For the period from February 2018 to January 2019 there were 1,566 patients admitted with COPD and 2,148 admitted with pneumonia.

The Trust is not alerting in Hospital Standardised Mortality Ratio (HSMR) for pneumonia, however, it is alerting within our Summary-level Hospital Mortality Index (SHMI). Pneumonia is accountable for 14% and COPD is accountable for 4% of our in-hospital deaths which includes deaths within 30 days of discharge between October 2017- September 2018.

An internal audit was conducted on the compliance of the CAP bundle and the COPD bundle at ULHT which demonstrated the following results:

- CAP bundle in notes = 16%
- CAP bundle fully completed = 8%
- COPD bundle in notes = 55%
- COPD bundle fully completed = 5%

What will success look like?

The following interventions are required to ensure best practice is adopted for chronic obstructive pulmonary disease (COPD) and Pneumonia patients :

- Completion of key interventions within 4 hours for chronic obstructive pulmonary disease (COPD) and community acquired pneumonia (CAP) bundles
- Rapid confirmation by chest x-ray
- Rapid scoring of disease severity
- Guided antibiotic therapy

- Improvements in uptake of bundle for COPD and CAP patients
- Improvements in completion of bundle for COPD and CAP patients
- Development of a training programme and competencies for A&E staff / Resuscitation Staff
- Development of a Standard Operating Procedure for prompt delivery of NIV
- Patients who meet evidence-based criteria for acute NIV should start NIV within 60 minutes of the blood gas result associated with the clinical decision to provide NIV and within 120 minutes of hospital arrival for patients who present acutely
- Participation in the national British Thoracic Society audits to enable national comparison

How will we assess our progress?

The audits will be performed 6 monthly on the following;

- CAP bundle
- COPD bundle
- NIV pathway

Reports will be submitted to the NIV working group and the pneumonia group

Quarterly reports will be presented at the Patient Safety Group

LOOKING BACK: PROGRESS MADE SINCE PUBLICATION OF 2017/18 QUALITY ACCOUNT

This section of the Quality Account presents in summary the Trust's progress since the publication of last year's account against the identified improvement priorities.

In 2018/19 these were:-

1. PROMOTING A POSITIVE PATIENT EXPERIENCE TO DELIVER WHAT MATTERS MOST TO OUR PATIENTS, CARERS AND FAMILIES
2. LEARNING OUR LESSONS WHERE OUR CARE SHOULD HAVE BEEN BETTER AND BEING OPEN AND HONEST SO WE PUT IT RIGHT NEXT TIME
3. ELMINATING AVOIDABLE PATIENT HARM (FALLS)
4. ELIMINATING AVOIDABLE PATIENT HARM (CATEGORY 3 / 4 PRESSURE ULCERS)
5. GENERATING HEALTHCARE FOR THE FUTURE THAT ARE CREATIVE AND FORWARD
6. ERADICATING PREVENTABLE DEATHS (SEPSIS)
7. PROVIDING SERVICES BY STAFF WHO DEMONSTRATE OUR VALUES AND BEHAVIOURS

Introduction

The Quality Account for 2017/18 outlined the Trust's proposed quality improvements for the year ahead (2018/19). These priorities were identified following engagement with patients, the public, staff, governors and external stakeholders. During the year 2018/19 we have been monitoring our progress against these priority ambitions through our governance framework. The priorities that we have not carried forward will become 'business as usual' and have defined work streams to enable the Trust to deliver on the improvements not achieved in 2018/19.

The Trust has not fully achieved all its priority ambitions however there is evidential progress in a number of areas with sustained patient safety improvements. We set ourselves ambitious targets and have achieved 74% of the individual elements. Improving our Governance arrangements we aim to improve our 2019/20 priorities by holding the identified leads to account on the delivery of their priorities through the Quality & Safety Oversight Group (QSOG). The priorities have also been aligned to the Lincolnshire quality priorities.

Trust performance

This section provides detail on how the Trust has performed against the 7 priority ambitions of 2018/19. Results relate to the period 1st April 2017 – 31st March 2018 or the nearest period available. Mechanisms of measurement vary by priority and by the availability of national benchmark.

PRIORITY 1 2018/19 - PROMOTING A POSITIVE PATIENT EXPERIENCE TO DELIVER WHAT MATTERS MOST TO OUR PATIENTS, CARERS AND FAMILIES

WE SAID WE WOULD:	
Success Measure	**Result**
A data analyst will be employed to interrogate and understand our quantitative and qualitative data, develop a structure and process for utilising and triangulating this and develop a system to provide baskets of data sets and reports for services **(Clinical Effectiveness)**	ACHIEVED
From the new data process we will identify hot spots and include within reports and performance processes to provide early intervention **(Safe)**	ACHIEVED
The 'Academy of FAB NHS Stuff' principles and concept of celebrating improvement and innovation and sharing and learning from others will be mainstreamed under the hashtag #UltimateULHT **(Patient Experience)**	ACHIEVED
A FAB campaign will run through the year seeking out and sharing examples each month **(Patient Experience)**	ACHIEVED
FAB experience champions will be identified across directorates and come together 4 times a year to share and learn **(Patient Experience)**	ACHIEVED
Patient experience metrics will be introduced into the Performance Review framework and directorates held to account **(Patient Experience)**	ACHIEVED
We will see an improvement on FFT percentage recommends and national survey scores – target is to meet the national average across all streams **(Patient Experience)**	NOT ACHIEVED

Data Source

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. The FFT asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. The FFT target set for ULHT was an internal aspiration utilising our 2017/18 data and setting a percentage improvement against each department collecting FFT data.

WHAT MORE DO WE NEED TO DO TO ACHIEVE OUR SUCCESS MEASURES?

FFT

We are now aware that the poor inpatient response rate for FFT was due to a factor within the data extract sent to our FFT surveyors and has been resolved in year with a subsequent 5% improvement.

There was clearly an error in setting the target for 2018/19 for Outpatients FFT as the national average response rate is 7% yet we set a target of 14% which is unreasonable. The national average is 7% and ULHT achieved 7%.

FFT percentage recommends remains a continuing challenge to improve. The development of FAB Experience Champions alongside the launch of SUPERB and the changes to performance and accountability will enable a greater grip on supporting services in their improvement actions.

% Recommend Scores 2017/18 – 2018/19. The results are monitored through the patient experience group.

Stream	ULHT	Target	ULHT	Variance from 2017/18

	2017/18	2018/19	2018/19	
Emergency care	81%	87%	83%	Improved by 2%
Inpatients	93%	97%	93%	No change
Outpatients	92%	94%	93%	Improved by 1%
Maternity antenatal	97%	97%	99%	Improved by 2%
Maternity birth	95%	97%	99%	Improved by 4%
Maternity postnatal ward	91%	95%	99%	Improved by 8%
Maternity postnatal community	97%	98%	99%	Improved by 2%

PRIORITY 2 2018/19 - LEARNING OUR LESSONS WHERE OUR CARE SHOULD HAVE BEEN BETTER AND BEING OPEN AND HONEST SO WE PUT IT RIGHT NEXT TIME

WE SAID WE WOULD:	
Success Measure	**Result**
Continued use of Patient Safety Briefings to disseminate key safety messages and lessons learned **(Safe)**	ACHIEVED
An increase in low and no harm incident reporting which is recognised nationally as a measure of improved safety culture. In 2018/19 there were 13580 low / no harms incidents reported compared to 11886 in 2017/18 **(Safe)**	ACHIEVED
A reduction in Serious Incidents. In 2018/19 there were 226 declared compared to 379 in 2017/18 **(Safe)**	ACHIEVED
Avoidance of Never Events **(Safe)**	NOT ACHIEVED
Establishment of Learning Lessons Forum **(Safe)**	SUPERSEDED
100% compliance with the statutory requirement to fulfil Duty of Candour. In comparison from March 2018 the Trust achieved 46% whereas in February 2019 the Trust achieved 100% **(Safe)**	ACHIEVED
All prospective Serious Incidents to have 72 hour report completed within 72 hours of request by Trust Risk Team **(Safe)**	NOT ACHIEVED
All Serious incident (SI) reports to be completed within 40 working days and forwarded to the Trust Risk Team for quality assurance unless an extension has been agreed, and should be forwarded to the CCG within 60 working days for approval and closure. In March 2018 there were 165 overdue SI's compared to 0 in March 2019 **(Safe)**	ACHIEVED
Comparative reporting data from the National Reporting and Learning System (NRLS) will show a decrease in the number of moderate and severe harms to be in line with national reporting rates. In 2018/19 there were 339 moderate / severe harms reported compared to 608 in 2017/18 **(Safe)**	ACHIEVED

Data Source

Utilising Datix (the Trusts internal incident reporting system) which is the repository for all incidents reported by the Trust. The data is compared with 2017/18 performance.
The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports where all Trusts submit their incident data which is also used to benchmark Trusts.

WHAT WE NEED TO DO TO ACHIEVE OUR SUCCESS MEASURES?

Never Events

The Trust declared 6 Never Events in 2018/19 compared to 4 in 2017/18. This includes 3 wrong site surgery incidents' 2 mis-selection of high-strength midazolam incidents; and 1 wrong prosthesis incident. Each has been subjected to a comprehensive SI investigation and improvement actions are all monitored through Datix.

Learning Forum
A learning forum has been concluded as not to be the most appropriate way to disseminate shared learning. A staff survey exercise took place during March 2019 to improve our understanding of possible barriers to effective learning and sharing of lessons from incidents; complaints; claims and inquests. A new policy is also being developed.

Serious Incidents
Between August and December 2018 the Trust completed 56% of 72 hour reports on time. This data was not collated previously. A new Incident Management Policy is currently being consulted upon, which includes proposed changes to the existing process to support more timely decision-making.
The Patient Safety Group receives a report on SIs and Never Events. This is upwardly reported to Trust Board.

PRIORITY 3 2018/19 - ELMINATING AVOIDABLE PATIENT HARM (FALLS)

WE SAID WE WOULD:	
Success Measure	**Result**
Reduction of falls with harm by 10% which will equate to 5 a month with a total of 60 for 2018/19 compared to 120 in 2017/18. The target set is an internal target utilising data on Datix and comparing 2017/18 data with 2018/19 data. (The data in the 2017/18 quality account is different due to the data including all falls including staff and patients, whereas the data for 2018/19 is only patient falls). **(Safe)**	ACHIEVED
Consistent achievement of 90% against all Safety Quality Dashboard (SQD) metrics. **(Safe)**	NOT ACHIEVED
Establish site falls meetings with ward representation from falls ambassadors **(Safe)**	ACHIEVED
Dissemination of lessons learned through Serious Incidents through Newsletter **(Safe)**	ACHIEVED
Demonstrable momentum for Ward Accreditation domain – reduced number of wards with overall red domain status. **(Safe)**	ACHIEVED

Data Source

Using Datix (the Trusts internal incident reporting system) compares all of our internal patient falls data and a 10% reduction was set utilising the 2017/18 falls data. The 10% reduction was an internal aspirational target.

WHAT MORE DO WE NEED TO DO TO ACHIEVE OUR SUCCESS MEASURES?

90% Safety Quality Dashboard metrics

Work is ongoing with the Falls ambassadors to target and focus on key performance indicators from the SQD dashboard. Ambassadors are currently working on action plans for ward areas to improve compliance. 7 of the 9 metrics achieved the 90% standard required.

The Patient Safety Group receives a report on falls. This is upwardly reported to Trust Board.

PRIORITY 4 2018/19 - ELIMINATING AVOIDABLE PATIENT HARM (CATEGORY 3 / 4 PRESSURE ULCERS)

WE SAID WE WOULD:	
Success Measure	**Result**
Reduction of 30% in number of avoidable category 3 and category 4 pressure ulcers. There were 55 avoidable category 3 & 4 pressure ulcers for 2017/18 which will be a trajectory of 40 for 2018/19, however there were 77 avoidable category 3 / 4 pressure ulcers. This is an internal target utilising the Trusts data from 2017/18 on Datix. **(Safe)**	NOT ACHIEVED
Consistent achievement of 90% against all Safety Quality Dashboard metrics. This is a Trust developed dashboard and target set is an internal aspiration. **(Safe)**	ACHIEVED
Dissemination of lessons learned through Serious Incidents through Newsletter and Lessons Learned Forum. **(Safe)**	ACHIEVED
Collaborative working with community partners inclusive of mirror categorisation tool **(Safe)**	ACHIEVED
Development of Harm Free Care Assurance Group with Ward Ambassadors supported and developed through link ambassador programme **(Safe)**	ACHIEVED
A corporate action plan to be developed to address specific challenges that have been identified as either important areas of work though national evidence base or are specific issues that have been identified through RCA investigations **(Safe)**	ACHIEVED
Data Source Using Datix (the Trusts internal incident reporting system) which compares all of our internal pressure ulcer data and a 30% reduction was set utilising the 2017/18 pressure ulcer data. The 30% was an internal aspirational target.	
WHAT MORE DO WE NEED TO DO TO ACHIEVE OUR SUCCESS MEASURES?	
30% reduction of category 3 / 4 pressure ulcers The Trust has adopted the NHSi recommendations regarding pressure ulcer categorisation and measurement from December 2018, aligning the Trust with national practice and reporting. During quarter 4 the Trust has reduced Category 3 & 4 pressure ulcers with no category 4 pressure ulcers for January and February 2019. The Patient Safety Group receives a report pressure ulcers. This is upwardly reported to Trust Board.	

PRIORITY 5 2018/19 - GENERATING HEALTHCARE FOR THE FUTURE THAT ARE CREATIVE AND FORWARD

WE SAID WE WOULD:	
Success Measure	**Result**
All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission **(Clinical Effectiveness)**	NOT ACHIEVED
Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: **(Clinical Effectiveness)** a. Within 1 hour for critical patients b. Within 12 hours for urgent patients c. Within 24 hours for non-urgent patients	NOT ACHIEVED
Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols **(Clinical Effectiveness)**	ACHIEVED
Patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, 7 days a week, unless it has been determined that this would not affect the patient's care pathway. 100% Spring 2018. **(Clinical Effectiveness)**	ACHIEVED
Recruitment of consultants with reference to 7 Day Services working in job plans **(Clinical Effectiveness)**	ACHIEVED
Continued momentum within 2021 programmes to redesign services clinical services **(Clinical Effectiveness)**	ACHIEVED
Data Source Utilising the Seven day Services audit which is conducted twice yearly across all NHS funded services. A 90% target is set nationally for all standards.	

WHAT MORE DO WE NEED TO DO TO ACHIEVE OUR SUCCESS MEASURES?

Emergency admissions seen within 14 hours

The Spring 2018 survey reported the overall proportion of patients seen and assessed by a suitable consultant within 14 hours of admission was 79% against a target of 90% compared to 70% in September 2017. The Trust is repeating the audit in April 2019 and will focus on the specialities who did not achieve 90% or greater. The audit did demonstrate that 90% of patients did have a consultant review within 17 hours.

Seven day access to diagnostic services

The Trust does not provide Echocardiography and Ultrasound at the weekends, however they do provide portable scans during this timeframe. The Clinical Strategy will identify improvements with access at weekends. The Clinical Effectiveness Group receives the biannual report and is upwardly reported to Trust Board.

PRIORITY 6 2018/19 - ERADICATING PREVENTABLE DEATHS (SEPSIS)

WE SAID WE WOULD:	
Success Measure	**Result**
All patients will receive a full set of vital signs observations on arrival and repeated at minimum 12 hourly frequency in accordance with Trust Observations Policy **(Safe)**	ACHIEVED
All inpatient areas will use electronic screening tool for early Sepsis identification and treatment **(Safe)**	ACHIEVED
90% of staff will have undertaken Sepsis e-learning training. In March 2018 the Trust achieved 80% compliance compared to 90% March 2019 **(Safe)**	ACHIEVED
90% of patients will receive Sepsis Screen within 60 minutes of NEWs 5≥. **(Safe)**	NOT ACHIEVED
90% of patients with identified red flag Sepsis will receive IV antibiotics within 60 minutes of diagnosis **(Safe)**	NOT ACHIEVED
Where there is evidence of deterioration patient records will demonstrate use of Situation, Background, Assessment, Recommendation (SBAR) tool to escalate **(Safe)**	ACHIEVED
All inpatient and assessment areas will have a Sepsis box or trolley **(Safe)**	ACHIEVED
100% of patients that are not screened or treated within 60 minutes will be reviewed through appropriate harm scrutiny process **(Safe)**	NOT ACHIEVED
EMAS to provide updates to the sepsis committee on the outcomes of administering IVAB by the paramedic crew is having on patients **(Safe)**	ACHIEVED

Data Source

Utilising the national CQUIN data which set the target of 90% achievement for sepsis screening and administration of IVAB within 1 hour.

WHAT WE NEED TO DO TO ACHIEVE OUR SUCCESS MEASURES?

Sepsis screening

The Trust has not achieved the expected 90% for screening. The Trust sepsis meeting is being invigorated by the Deputy Chief Nurse. The Sepsis Practitioners are attending the speciality governance meetings to discuss their compliance and address any issues. For 2017/18 A&E's compliance was 85.59% and inpatients 68.71% compared to 80% for A&E, 78% for inpatients and 55% for paediatrics in March 2019. The Trust commenced collating paediatrics sepsis data in 2018/19.

IVAB within 1 hour

The Trust were consistently achieving 90% or greater until October 2018. There are Sepsis boxes or trolley's in all adult inpatient/admission areas to ensure the treatment is administered within 1 hour. All ward managers complete a non-compliance review template for all patients who did not receive their treatment within the hour. For 2017/18 A&E's compliance was 95.01% and inpatients was 91.65% compared to 100% for A&E, 80.9% for inpatients and 0% (2 pts) for paediatrics in March 2019. The Trust commenced collating paediatrics sepsis data in 2018/19.

Harm Reviews

This objective is being incorporated within our 2019/20 quality priorities

The Patient Safety Group receives a sepsis report and is upwardly reported to Trust Board.

PRIORITY 7 2018/19 - PROVIDING SERVICES BY STAFF WHO DEMONSTRATE OUR VALUES AND BEHAVIOURS

WE SAID WE WOULD:	
Success Measure	**Result**
Implement the 2021 staff engagement programme **(Clinical Effectiveness)**	ACHIEVED
Deliver the 2018/19 leadership programme and establish a talent management strategy **(Clinical Effectiveness)**	ACHIEVED
Collaborate with clinical directorates to determine the future workforce requirements through workforce capacity reviews ensuring right size against activity rate using model hospital data **(Clinical Effectiveness)**	ACHIEVED
Reduce reliance on agency workforce (medical & nursing) through improved retention and bank strategies **(Clinical Effectiveness)**	NOT ACHIEVED
Increase in positive responses to 49.5% for "Would you recommend ULHT as a place to work" and "Would you recommend the care at ULHT" **(Clinical Effectiveness)**	NOT ACHIEVED
Implement new approach to individual appraisal & performance management with more systematic links to values and behaviours **(Clinical Effectiveness)**	ACHIEVED
Reduction in perceived bullying from staff as measured by national staff survey **(Clinical Effectiveness)**	NOT ACHIEVED
Data Source Using the national staff survey data where over 497,000 staff responded to the 2018 survey, the Trust set internal improvement targets from the 2017 staff survey responses received by the Trust.	

WHAT WE NEED TO DO TO ACHIEVE OUR SUCCESS MEASURES?

Agency Workforce

Agency spend has continued to grow in 2018/19 and is likely to total around £35m, against a target of £20m. The growth is largely in medical agency spend and is a consequence of decisions taken (in Pilgrim ED) on quality and safety grounds to increase establishments and the increase in the vacancy rate for both medical and registered nursing staff.

The Trust has not achieved the switch from agency to bank fill that we hoped for. The incentivisation of the nursing bank as an example did not increase fill rates by bank staff.

Key to reducing agency spend is recruiting to substantive posts and there is significant activity to support recruitment at greater pace and volume being put in place, as well as a centralised bank and agency team who will extend the bank offer for non-nursing staff.

Staff survey – positive responses

Scores for staff recommending ULHT as a place to work declined to 41.4% in the 2018 survey compared to 44.1% in 2017 and as a place for care from 50.6% to 47.4% in 2017. It is evident that morale has not improved in the last year. Whilst we are pleased by the response rate to the survey (in line with the national average) and that scores associated with patient safety have improved, overall scores have declined once more.

We will review the data and the free text comments and will identify the actions we can take, as part of our People Strategy, to reverse the decline in morale evident since the Trust went into double special measures.

Staff survey – perceived bullying

Unfortunately those reporting bullying, harassment or abuse from managers increased from 15.9% in 2017 to 19.7% in 2018 and by staff, from 20.2% in 2017 to 24% in 2018. After last year's results we ran a zero tolerance to bullying campaign, but this does not appear to have had an impact. We also initiated work to understand what lay behind the perception that people were being bullied. This work is coming to a conclusion and our view is that we need to do more work to:

1). Improve the consistent quality of line management

2). Provide vehicles through which people can safely talk about their experience of bullying

3). Target certain vulnerable groups, such as newly-qualified nurses and junior doctors

The information is discussed at workforce Group and upwardly reported to Trust Board.

STATEMENT OF ASSURANCE

Review of services

During 2018/19, the United Lincolnshire Hospitals NHS Trust (ULHT) provided and/or subcontracted 98 relevant health services.

The ULHT has reviewed all the data available to them on the quality of care in 98 of these relevant health services.

The income generated by the NHS services reviewed in 2018/19 represents 92.4% of the total income generated from the provision of NHS services by the ULHT for 2018/19.

PARTICIPATION IN CLINICAL AUDITS

During 2018/19 40 national clinical audits and 6 national confidential enquiries covered relevant health services that ULHT provides.

During that period ULHT participated in 95.2% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that ULHT was eligible to participate in during 2018/19 are as follows: (see tables below). Audits not achieving fully have an action plan developed to enable the Trust to achieve full compliance.

The national clinical audits and national confidential enquiries that ULHT participated in during 2018/19 are as follows: (see tables below)

The national clinical audits and national confidential enquiries that ULHT participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage 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 Surveillance (MBRRACE-UK) Saving Lives Improving Mothers Care (MBRRACE-UK)	Yes	January – December 2016 2014-2016	No case ascertainment reported No case ascertainment reported
Neonatal Intensive and Special care (NNAP)	Yes	1st January – 31st December 2017	1060 cases submitted (PHB 383, LCH 677) Case ascertainment is not reported
Children			
Paediatric Intensive Care (PICANet)	N/A	This audit is 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
Paediatric Asthma (British Thoracic Society)	Registered	Audit not yet commenced due to start June 2019	N/A
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	1st April 2016 – 30th November 2017 (report published August 2018)	259 cases submitted. (case ascertainment is not reported)

National Audits	ULHT Participation	Reporting Period	Number and % required
Acute Care			
Emergency Laparotomy	Yes	1st December 2016 – 30th November 2017	Cases submitted PHB 97 (87.4%), LCH 169 (100%), National (82.7%)
Cardiac Arrest (National Cardiac Arrest Audit) ICNARC	Yes	1st April 2018- 31st December 2018	Case ascertainment is not reported
Feverish Child (RCEM)	Yes	1st August 2018- 31st January 2019 Report awaited	Not available
Vital Signs in Adults (RCEM)	Yes	1st August 2018- 31st January 2019 Report awaited	Not available
VTE Risk in Lower Limb (RCEM)	Yes	1st August 2018- 31st January 2019 Report awaited	Not available
Chronic Obstructive Pulmonary Disease (COPD) Royal College Physicians	Yes	1st January 2018 – December 2018	Case ascertainment is not reported
BTS Community Acquired Pneumonia	Yes	Data submission in progress	Not yet available
BTS Non Invasive Ventilation	Registered	Data to be submitted by June 2019	Not yet available
Adult Critical Care (Case Mix Programme) ICNARC	Yes	1st April 2017 - 31st March 2018	1274 cases submitted LCH 736 PHB 538 Case ascertainment is not reported
Long Term Conditions			
Diabetes (National Adult Diabetes Audit)	Yes	1st January 2016 – 31st March 2017	Case ascertainment is not reported (data is linked to local CCG)
Diabetes (National Adult Diabetes Inpatient /Survey/ Audit HARMs)	Yes	Ongoing data collection until end of May 2019	Case ascertainment not yet available
Diabetes National Audit Foot Care	Yes	2014 - 2017	Case ascertainment is not reported
National Pregnancy in Diabetes Audit	Yes	2014-2016	76, LCH 44, PH 32 Case ascertainment is not reported
National IBD Registry Ulcerative Colitis & Crohn's Disease (National IBD Audit) biologics Audit	Yes	2018	No case ascertainment available
National Parkinson's Audit	Yes	2017 Report published 2018 Registration for the next audit is open	116 Case ascertainment is not reported
National End of Life Audit	Yes	2018	Case ascertainment is not reported

National Audits	ULHT Participation	Reporting Period	Number and % required
National Audit Dementia	Yes	Data submitted data validation completed report awaited	Case ascertainment not yet available
Elective Procedures			
BAUS Urology Nephrectomy	Yes	1st January 2014 – 31st December 2016	151 (89%)
BAUS Urology Percutaneous Nephrolithotomy	Yes	1st January 2014 – 31st December 2016	33 Case ascertainment is not reported
BAUS Urology Female Stress Urinary Incontinence	Yes	1st January 2014 – 31st December 2016	9/17 (52.94%)
BAUS Urology Urethroplasty	N/A	Applicable to specialist centres only	N/A
Cardiac Arrhythmia (NICOR)	Yes	April 2015 – March 2016 Report published February 2017 Latest report not yet published	413 (case ascertainment is not reported)
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Yes	January 2015-December 2015 Report published September 2017 2018 Report awaited	1153 (100%) eligible cases 1178 cases submitted 2018
National Vascular Registry including NVD -Carotid Interventions Audit)	Yes	2018 Report (2017 data) 2015-2017	29 (121%) cases Infra-renal AAA , 38 (102%) cases Carotid Endarterectomy 22 cases Emergency Repair AAA 195 cases Lower Limb Bypass,152 cases Major Limb Amputation
Rheumatoid and Early Inflammatory Arthritis	No	Unable to commence audit until April 2019	N/A
Hip, Knee, Ankle and Shoulder Replacements (National Joint Registry)	Yes	2018 Report	1411 (90.36%)
National Elective Surgery Patient Reported Outcome Measures (National PROMs Programme) Overall patient participation rate Participation by each PROM (varicose vein and groin hernia have been discontinued and are not reported) 1.Hip Replacement 2.Knee Replacement	Yes	PROMs April 2016 – March 2017 Finalised report PROMs April 2017 – March 2018 – Finalised report Patients who completed a pre-	1244/1942 (64.1%) 846/1183 (71.5%) 16/17 1 - 437, 76.3%,

		operative questionnaire	2 - 606, 79.6.%, 17/18 1 - 390, 70.8% 2 - 456, 72.2%
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
Ophthalmology Cataract Audit	Yes	September 2015 – August 2016	1796 (47%)
Cardiovascular Disease			
Stroke Care (National Sentinel Audit of Stroke) SSNAP	Yes	April 2018 – December 2018	809/814 (99.3%) (72 hours), 803/814 (98.6%) (to discharge)
Acute Myocardial Infarction & Other Acute Coronary Syndrome (MINAP)	Yes	1st April 2016 – 31st March 2017. Report published November 2018	1214/985 (123.25%)
Heart Failure	Yes	April 2016- March 2017 Report published November 2018 April 2017 – March 2018 Report not yet published	1057/1003 (105%) GDH 154 LCH 490 PHB 406
Cancer			
Prostate Cancer (NPCA) (ULHT is part of the Specialist MDT East Midlands)	Yes	1st April 2016 – 31st March 2017	1035 (89.6%)
National Audit of Breast Cancer in Older Patients	Yes	January 2014-December 2016	No case ascertainment is reported
Lung Cancer (LUCADA)	Yes	Patients diagnosed with lung cancer first seen between 1st January 2016 and 31st December 2016	424 cases submitted No case ascertainment is reported
Bowel Cancer (NBCA)	Yes	Patients diagnosed between 1st April 2016 and 31st March 2017	LCH + GDH 90/249 (36%) PHB 108/108 (100%)
Oesophago-Gastric Cancer (National O-G Cancer Audit)	Yes	Patients diagnosed between 1st April 2015 and 31st March 2017 tumour records submitted	120 (<50%) case ascertainment
Trauma			
Hip Fracture (National Hip Fracture Database)	Yes	1st January 2017 – 31st December 2017	833 cases submitted, PHB 399 (119.1%) LCH 360 (102.3%) GDH 74 (94.9%%)

Includes National Falls & Fragility Fractures Audit (FFFAP)	Yes	2018	Case ascertainment not reported
Trauma Audit Research Network (TARN) Trauma	Yes	April 2016 – July 2018	654 (100+%) PHB 307 (100+%) LCH 347 (100+%)
National Audits	**ULHT Participation**	**Reporting Period**	**Number and % required**
Blood Transfusion			
Blood Transfusion Audits	Yes	Awaiting update	Not available
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	2018	Case ascertainment is not reported

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

During 2018/19 hospitals were eligible to enter data in up to 6 NCEPOD studies. Below is a summary of those studies in which ULHT participated. Studies for which ULHT were exempt are not listed. Action plans are developed for any areas not achieving the recommended standards.

National	ULHT Participation	Reporting Period	Number and % required
Confidential Enquiries			
Chronic Neurodisibility	Yes	2017/2018 Clinical questionnaire Case note Lead clinician questionnaire completed	 7/7 (100%) 7/7 (100%) 5/5 (100%)
Young People's Mental Health	Yes	2017/2018 Clinical questionnaire Case note Organisational questionnaire completed	 8/8 (100%) 8/8 (100%)* 2/2 (100%)
Cancer in Children, Teens and Young Adults	Yes	2017/2018 ICU Cases SACT Cases Organisational questionnaire completed	 No eligible cases No eligible cases 3/3 (100%)
Acute Heart Failure	Yes	2017/2018 Clinical questionnaire Case note	 9/9 (100%) 9/9 (100%)
Perioperative Diabetes (*please note the figures are not yet final)*	Yes	2017/2018 Surgical Clinical questionnaire Anaesthetic Clinical questionnaire Organisational questionnaire completed	 8/8 (100%) 0 4/4 (100%)

* For 2017/18 Quality Account the data stated 8/8 (0%) this was a typographical mistake

Pulmonary Embolism	Yes	2018/2019 Clinical questionnaire Organisational questionnaire	 17/17 (100%) 3/3 (100%)

Please note the following:
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 2018/19 the data period covered may cover previous years.

The reports of 34 national clinical audits were reviewed by the provider in 2018/19 and ULHT intends to take the following actions to improve the quality of healthcare provided (see tables below).

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 year on year. Local reporting of latest results as national reporting is still behind schedule • Procedure to open up blocked heart vessels quickly to restore coronary blood flow 97.2% of patients met the door to balloon time of 90 minutes compared to the national average of 90% • Collaborative work with EMAS is continuing to ensure eligible patients are taken directly to the Heart Attack Centre. The last report towards the end of 2018, showed 83.8% average time during the year of 70.1% of patients met the time of call for help to balloon time of 150 minutes compared to the national average of 71% there has been a change to how calls are being assessed • Prescribing preventative medications above the national average at for all eligible patients ULHT has been sustained at 100%, above the national average • Patients requiring angiography within 72 hours met best practice tariff 7/11 months
TARN (Trauma)	• Trauma meetings held at Lincoln and Pilgrim to discuss findings and share learning continue • Transfer to Trauma Centre continues to be reviewed with the Trauma Network to ensure eligible patients are transferred for specialist care ongoing • There is a robust data collection process across the Trust with good data submission which is maintained by the TARN project officer with 100+% data submissions recognised by the Trauma network

	• On-going work to review and improve compliance with standards with updated reports and dashboards
Hip Fracture	• Sharing best practice across the trust to improve the patient pathway data is available via site dashboards which records data live • Monthly governance meeting to review data and discuss improvements where needed
Stroke	• Improving compliance with NICE standards strategy in place to improve areas requiring improvement • Results are shared at the speciality Governance meetings • Scoring A-E used for stroke units with A being the highest score to achieve latest published report shows Pilgrim as a B and Lincoln as a B • Strategy to improve data submissions is working well with case ascertainment of a high standard
Cardiac Arrest	• Education and training around deteriorating patient is on-going • Results are presented to the Patient Safety Committee and discussed with staff
Bowel cancer data	• Review of outcomes completed and reported • Process for submitting data reviewed to improve case ascertainment from latest report LCH 36%, PH 100% • Data quality reviewed action data from the MDT will be recorded and submitted at the time of the MDT
PROMs	• Ongoing recruiting of patients for Hip and knee replacement surgery via pre-assessment clinics to complete the questionnaire before surgery 71.5% of patients completed a pre-operative PROM during 2017/2018 • NHS England review of PROMs, the varicose vein surgery and the groin hernia surgery has been discontinued nationally • Data is reported every four months to monitor progress with participation rates and outcome measures
Hip, Knee and Ankle Replacements (National Joint Registry NJR)	• On-going review of NJR process to improve quality of data submission to the national database annual data quality audit taking place • Consultants have access to Clinician feedback to review their own practice
Falls Audit	• Improvement work is ongoing with the Falls Group
Heart Failure	• Data submission is reported as 100+%

	• Heart Failure Nurses have Improved the service to deliver care to patients • Locally achieving Best Practice Tariff each month with 70% data submission and 60% specialist review
Chronic Obstructive Airways Disease (COPD)	• Data validation process in place • Best practice tariff achieved for two quarters of the year • Care bundle in place in line with British Thoracic Society (BTS) best practice standards • Compliance with the best practice standards discussed at the Speciality Governance meeting
National Vascular Registry	• Aortic Abdominal Aneurysms mortality rate within expected • Carotid Endarterectomy time from symptoms to surgery 13 days better than the national average at 14 days • Lower limb angioplasty data submissions to improve plan in place with lead Interventional Radiologist

Local Clinical Audit

The reports of 93 local clinical audits were reviewed by the provider in 2018/9 and ULHT intends to take the following actions to improve the quality of healthcare provided: (see tables below).

The local audit plan is linked to National Institute for Health and Clinical Excellence (NICE), CQC, Best practice and key priorities for the Trust.

Examples of actions taken locally:

Local Audit	Actions - Improvements
Re-audit of VTE Risk Assessment	The results showed: • Improved compliance with VTE risk assessment • Prescribing of stockings or medication to prevent clots improved and compliance was good • Ensure all junior doctors are updated at Induction that the VTE risk assessment must be reviewed at the next senior review
Audit of NG Tube	• Improved compliance data now collected by the Safety Quality Dashboard
Planned Caesarean Section	• 100% had a VTE risk assessment completed

	• 100% consent procedure followed • 97% Consultant invovlement in the decision for a Caesarean Section (CS) • Vaginal birth after a previous CS to improve discussions that take place in the Antenatal Clinic • Improve the utilisation of the birth choice clinic
Paediatric Circumcision Audit	• Compliant with national best practice • Dedicated paediatirc clinic in place
Cataract Audit (annual)	• Compliant or better than the national benchmark • 97.3% of patients reported they were satisifed with the outcome of their cataract surgery

PARTICIPATION IN CLINICAL RESEARCH

Clinical research is an essential part of maintaining a vibrant culture of improvement. Our research and innovation department has a strong record in recruiting patients and collaborative working with other organisations and the NIHR East Midlands Clinical Research Network to ensure that high quality research is a part of the culture at ULHT.

The number of patients receiving relevant health services provided or sub-contracted by ULHT in 2018/19, that were recruited during that period to participate in research approved by a research ethics committee (National Health Research Authority) was 1161. Total number of patients/participants recruited for portfolio and non-portfolio studies were over 1300. 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 delivering trials within a wide variety of specialities and recruited from 21 disease areas in current financial year. In particular, the Trust is delivering more commercial studies for the National Institute for Health Research (NIHR) as compared to last few years. This increasing level of participation in clinical research demonstrates ULHT'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. Research evidence shows that hospitals that participate in clinical trials have been shown to improve patient care and outcomes.

Due to the increased number of commercial and non-commercial trials, Lincolnshire patients are benefitting and receiving latest drugs/treatment, majority of which are 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 savings.

The Trust is involved in conducting about 180 clinical research studies including studies in follow up. By the end of February 2019, for cardiovascular area recruited 64 patients. In case of cancer Randomised Controlled Trials (RCT), the Trust recruited 189 patients and in the case of Cancer non-RCT, we recruited 293 patients. Since the establishment of the NIHR, the Trust has been using the national system for approving all studies (portfolio and non-portfolio) and carry out risk assessments. In 2018/19 financial year the Trust has approved 28 portfolio studies.

In the last three years, over 35 publications have resulted from our involvement in clinical research, helping to improve patient outcomes and experience across the NHS.

The Lincoln Clinical Research Facility (LCRF) and the Research and Innovation Department is committed and will continue to play an important role in the following areas:

1. To promote research and innovation
2. To promote and support rural health research projects
3. To develop a culture in which research is seen as integral to clinical practice
4. To support Clinical Business Units in developing specialist clinical services
5. To support all healthcare staff undertaking research
6. 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
7. To increase the number of staff within the Trust with skills in research
8. To work closely with Research & Innovation Departments within the other Lincolnshire health providers to incrementally increase patients recruitment over the next five year period

USE OF THE COMMISSIONING FOR QUALITY & INNOVATION (CQUIN) FRAMEWORK

A proportion of ULHT's income in 2018/19 was conditional upon achieving quality improvement and innovation goals agreed between ULHT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2018/19 and for the following 12 month period are discussed below.

Link to the national CQUINs:
https://www.england.nhs.uk/publication/commissioning-for-quality-and-innovation-cquin-guidance-for-2017-2019/

NHS England published a two year scheme which potentially provides greater certainty and stability on the CQUIN goals for the Trust to focus on implementing the initiatives. Local CQUINs were not developed as it was mandated to use the national CQUIN schemes. The CQUIN scheme is intended to deliver clinical quality improvements and drive transformational change. The scheme is designed to support the ambitions of the Five Year Forward View and directly link to the NHS Mandate and it now focuses on two areas:

1. Clinical quality and transformational indicators

3 indicators have been defined which aim to improve quality and outcomes for patients including reducing health inequalities, encourage collaboration across different providers and improve the working lives of NHS staff.

2. Supporting local areas:

- Sustainability and Transformation Plans (STPs) – reinforcing the critical role providers have in developing and implementing local STPs.
- Local financial sustainability – encouraging providers and commissioners to work together to achieve financial balance and to complement the introduction of system control totals at STP level. To achieve the ambitions both individual provider contributions and cross community collaborations have a part to play. By doing so the NHS will deliver better quality standards for patients, improve the working environment for staff, and deliver financial balance.

At the time of writing this Quality Account ULHT is still awaiting the outcome of quarter 4 achievements however we have depicted what we think ULHT will achieve. A summary of the achievements of the CQUIN milestones for 2018/19 are demonstrated below.

National CQUIN schemes

	CQUIN	Q1	Q2	Q3	Q4 (expect)	Value	Value Received
1a	Improving Staff Health and Wellbeing					£243,316	£0
1b	Healthy food for NHS staff, visitors and patients					£243,316	£243,316
1c	Improving the uptake of flu vaccinations					£243,316	£243,316
2a	Timely identification for sepsis					£182,487	£59,308
2b	Timely treatment for sepsis					£182,487	£ 159,676
2c	Empiric review of antibiotic prescriptions					£182,487	£182,487
2d	Reduction in antibiotic consumption					£182,487	£ 60,829
4	Improving services for people with mental health needs who present to A&E					£729,984	£ 729,984
6	A&G services for non-urgent GP referrals					£729,984	£ 419,720
9	Preventing ill health by risky behaviours – alcohol and tobacco					£729,984	£628,060
	STP Engagement					£3,649,742	£3,649,742
				Total		£7,299,590	£6,376,438

Specialised CQUIN schemes

	CQUIN	Q1	Q2	Q3	Q4 (expect)	Financial	Received
B12	Severe Haemophilia Haemtrack Patient Home Reporting					£38,314	£38,314
GE3	Hospital Medicines Optimisation					£230,755	£230,755
GE3	Block					£283,803	£283,803
AF1	Embedding the Armed Forces Covenant					£27,608	£27,608
1	NHS Dental Services					£114,291	£114,291
	Public Health					£144,831	£144,831
				Total		£839,602	£839,602

Green	Fully achieved
Red	Not achieved
Amber	Partially achieved
Grey	N/A

For 2018/19, £8,139,192 of ULHT's contracted income was conditional on the achievement of these CQUIN indicators (£8.05m in 2017/18).The Trust has predicated to receive 88.65% of the total CQUIN value for 2018/19.

The national and specialised CQUINs were 2 year CQUINs which ceased in 2018/19.

The Trust will not be participating in the national CQUINs for 2019/20 as the Trust will be aligning our quality priorities across the Lincolnshire system. As Lincolnshire moves towards an Integrated Care System, the vision for Quality is focused on developing a single framework for system wide quality assurance, with a shared commitment to the

development of a culture of quality improvement. This would focus on ensuring the delivery of effective care, the assurance of the safety of the services that are offered to patients and supporting people to have a positive experience of care.

In 2019/20 the focus will be on ensuring that quality improvement is embedded into everyone's business, and to support the delivery of consistently high quality care. In moving towards this vision and ambition for Lincolnshire, it is recognised that it is necessary to develop an integrated and collaborative approach to quality governance and assurance across Lincolnshire, that minimises duplication, reduces variation and delivers improved outcomes for the people of Lincolnshire

The strategic approach to assurance and improvement includes the following:

- Development of a single system quality steering group to provide strategic leadership, direction and oversight for quality across Lincolnshire
- Development of a shared definition, vision and understanding of quality to establish a single view of quality across the health system, this work will encompass both the local authority as well as the wider health and social care sectors
- Redesign of the quality governance and assurance mechanisms across the system which will reduce duplication and focus on quality improvement
- Review of the quality resource and information flows across the system to reduce duplication and maximise the use of our collective resources
- The new system approach to quality improvement will be tested through an integrated pathway approach to quality improvement aligned to our and system priorities, supported by a system wide serious incident review and learning process where incidents cross organisations

The following quality priorities have been selected by the Trust for 2019/20 with a view to extending them for 2 years:

- Recommending ULHT as a place to work and if a friend or relative required treatment I would be happy with the standard of care provided
- Embedding and further developing our approach to monitoring and managing patients with sepsis
- Ensuring effective systems for reviewing mortality in all care settings
- Ensuring people are being cared for in the right place at the right time
    - Respiratory Patients

CARE QUALITY COMMISSION (CQC) STATEMENTS

The Care Quality Commission (CQC) are the regulators of quality standards within all NHS Trusts. They monitor our standard of care through inspections, patient feedback and other external sources of information. The CQC publishes which Trusts are compliant with all the essential standards of care they monitor and which organisations have 'conditions' against their services which require improvements to be made.

ULHT is required to register with the Care Quality Commission (CQC) and its current registration status is registered. ULHT has the following conditions on registration: the Trust was given regulatory action on section 31 on 20/02/2018. The CQC has taken enforcement action against ULHT during 2018/19.

ULHT has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Between 15 February and 8 March 2018, CQC inspected a total of five core services provided by the Trust across four locations. They inspected urgent and emergency care, medical care, surgery and outpatients at Lincoln County and Pilgrim Hospital. They also inspected children and young people's services at Pilgrim Hospital. Medical care and surgery were inspected at Grantham and District Hospital and surgery inspected at County Hospital, Louth. There was also a review of the well-led domain at Trust level.

The CQC rate the Trust on the following domains:

Safe

Are people protected from abuse and avoidable harm?

Effective

Does peoples care and treatment achieve good outcomes and promote, a good quality of life, and is it evidence-based where possible?

Caring

Do staff involve and treat people with compassion, kindness, dignity and respect?

Responsive

Are services organised so that they meet people's needs?

Well-led

Does the leadership, management and governance of the organisation assure the delivery of high quality patient centred care, support learning and innovation and promote and open and fair culture?

The Trust received its final report in July 2018 which rated the Trust as 'Requires Improvement' overall, however to remain in 'Special Measures' so the Trust can receive the support required to make further improvements.

The Trust's ratings for whether its services are safe and well-led have changed from 'Inadequate' to 'Requires Improvement'. Meanwhile, the Trust remains rated 'Requires Improvement' for whether its services are effective and responsive and 'Good' for whether its services are caring.

The CQC found staff were caring and committed to helping patients, but were disappointed to find that insufficient improvement had been made at Pilgrim Hospital in Boston since their last inspection in October 2016, and an overall rating of the hospital remains Inadequate.

The CQC made an unannounced visit to the Pilgrim A&E on the 18th December 2018 which was to follow up actions the Trust had taken following the CQC focused inspection on 30 November 2018. The report was published on the 30th January 2019. The CQC made a further unannounced visit on the 25th February 2019, which was to follow up actions the Trust had taken following the focused inspections on 30th November and 18th December 2018. The report was published on the 3rd April 2019 and the A&E remains as inadequate.

The key findings from the unannounced visit at Pilgrim A&E were:

- Unreliable and inconsistent system in place to identify critically ill patients who may present to the department
- Patients did not always have an early warning score calculated at triage
- Patients arriving by ambulance remained on ambulances for significant amounts of time
- Patients at risk of deteriorating consciousness levels were not monitored effectively
- The Rapid Assessment and Treatment (RAT) process was ineffective at reducing ambulance handover times
- Children in the department were placed at risk of harm as they were not cared for by nursing staff with the necessary competencies to provide safe and effective care
- The layout of A&E was not suitable for the number of admissions the service received. During our inspection we saw significant overcrowding in the department. Throughout our inspection we saw patients being cared for on trolleys in the central area of the department and in the ambulance corridor as there were no free cubicles to use.

However the CQC did acknowledge there were improvements since their previous visit:

- The Trust had implemented a process for transferring patients to wards and other clinical areas, which did not impact on nurse staff to patient ratios
- There was good co-ordination between the doctor and nurse in charge
- Two hourly safety huddles had been introduced

- Nurse and medical staffing levels and skill mix were sufficient to meet the needs of patients
- The Trust had taken some action to ensure the 'fit to sit' room was not overcrowded and patients were not cared for along a thoroughfare corridor in the department.
- The Trust had implemented a dedicated frailty team based in the ED, which provided immediate review and care for patients who attended from care homes or where they needed input from older people specialists.
- There had been improvements in the provision of nursing staff for children at this inspection. Between 10am and 10pm there was at least one registered children's nurse present in the department responsible for the care and treatment of children.

The Trust developed a programme of work that was identified from the CQC visit between 15 February and 8 March 2018. Each project had to develop an action plan on the key actions required to address the concerns raised by the CQC.

ULHT has made the following progress by 31 March 2019 in taking such action: (see table below)

Project Name	Achievements in 2018/19
Safety Culture	• Analysing and Learning from Patient Safety Incidents, Complaints, Claims and Coroners Inquests Policy drafted and circulated • An in-house Quality Improvement Programme is developed and delivered within the Trust
Governance	• Redesigned the Trust risk management framework and rebuilt corporate and operational risk registers, linking them to the Board Assurance Framework and new divisional structure • Developed and introduced a mandatory e-learning training package on Duty of Candour for all patient-facing and clinical governance staff • Introduced regular induction training in risk and incident management for all new nursing and medical staff • Redesigned the structure of the clinical governance department and committed to substantial investment in additional resources • Reviewed governance and performance arrangements and aligned them to a new divisional operating model and management structure
Deteriorating Patient	• Standardised, Background, Assessment, Recommendation (SBAR) forms updated and rolled out to wards • Sepsis policies updated • Face to face sepsis training on all wards • Fluid balance policy updated • eLearning for fluid balance developed • Roll out of ReSPECT across the Trust
Pilgrim A&E	• Implementation of a Pre-Hospital Practitioner and additional triage streams has supported identification of acutely ill patients being prioritised. • Oversight of patients pre-and post-triage has improved by creating additional triage streams and by the 2 hourly huddles. • GP streaming has successfully been implemented with on average 25% of patients per day being seen through this stream.

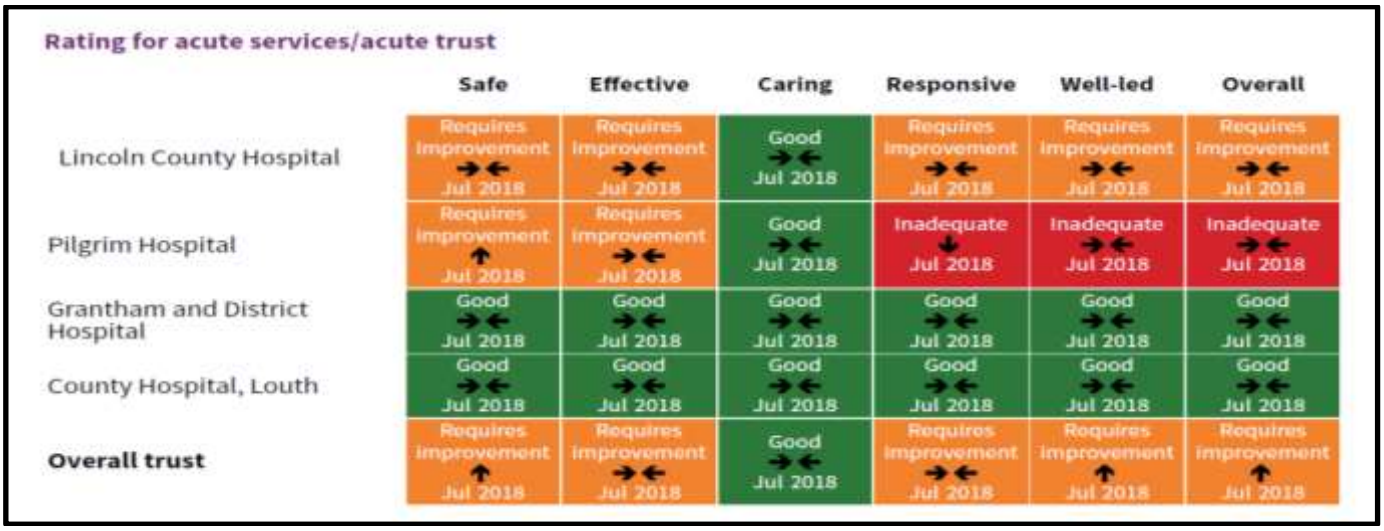
	• A Full Capacity Protocol has been approved to support with crowding in ED. • There is always either a registered nurse with paediatric competencies on duty or a paediatric trained member of staff. A dedicated paediatric cubicle has also been implemented. • Leadership in the department has improved with the introduction of an Emergency Physician in Charge and Nurse in Charge. They have overall oversight of the department and lead 2 hourly safety huddles. • Medical and Nursing staffing templates have been uplifted and the majority of the posts have been recruited to. To manage timely ambulance handovers the role of the Pre-Hospital Practitioner has been introduced. A rapid assessment and treatment process has also been established.
Paediatric Services	• 6 month Paediatric review of Pilgrim Model assured a safer winter 18/19 compared to 17/18, Royal College of Physicians (RCOP) recommendations reviewed and ongoing with continued focus on stabilising workforce. • Creation of a Paediatric Programme in March 2019 which will support service improvement for children in Lincolnshire, linking in with system partners. • Recruitment of Lead Nurse to support 'Hidden Child' work • Recruitment of Childrens Nurse to support ED pathways
Safe Care	Naso gastric (NG) management • Naso gastric policy re-written • Naso gastric competencies created • Naso gastric bundle developed • elearning created and initiated Safety Huddles • Huddle template developed , piloted and reviewed • Guideline and Standardised Operating Policy (SOP) developed Intentional rounding • Guideline and Standardised Operating Policy (SOP) developed • Intentional Rounding Form designed, piloted and reviewed with staff input Accountability handover • Guideline and Standardised Operating Policy (SOP) developed • Rollout confirmed for Spring Positive Patient Identified (PPID) • Guideline and Standardised Operating Policy (SOP) developed • Policy updated • Rollout planned for spring Pot it dot it (administration of medication) • Guideline and Standardised Operating Policy (SOP) developed • Sticker for drug trollies designed, approved and printed • Rollout video compiled • Rollout planned for spring
Safeguarding	• CP-IS (Child protection Information Sharing) system implemented helping health and social care staff to share information securely to better protect society's most vulnerable children. • Working with Womens & Childrens in relation to under 16yrs old being cared for in in-adult areas. • Introduction of Hospital IDVA, (Independent Domestic Violence Advisor) • Mental Capacity Act (MCA) packs rolled out trust wide to support improved MCA knowledge and completion of paperwork. • Multi-Agency Public Protection Arrangements (MAPPA) Process agreed to commence 1st April

	• Introduction of a DASH risk assessment. This is a tool to assist practitioners assess the potential safety risk to a person who is experiencing domestic abuse. A post DASH checklist has been introduced to help guide staff through what actions to take to ensure that people receive the right information and support.
Medicines Management	• The Trusts incident recording system (Datix) reporting fields have been improved to give more detail and clarity around medication related incidents • Use of Summary care Record (SCR) to confirm patients medication is used routinely as a source of information • Clinical Pharmacy Technicians integrated on to wards to facilitate medicines reconciliation and drug administration • Speciality pharmacists allocated to a speciality to provide detailed reporting and action around incidents in that area • Pilot of pharmacist role in ED at Pilgrim • Medicines Optimisation in Care Homes (MOCH) pharmacists • Development of Get it Right First Time (GIRFT) Medicines Optimisation frailty pathway
Mortality	• Medical Examiners in post at Lincoln and Pilgrim sites • Business case for Medical Examiner Assistant approved • Coding Masterclasses implemented for clinicians to understand the importance of documentation • The Saving Babies Lives Care Bundle has been implemented • Discharge based criteria for Non Invasive Ventilation (NIV) developed for patients discharged with NIV • Hospital Standardised Mortality Ratio (HSMR) is below expected.
Data Quality	• Kite mark approach for ULHT agreed and applied to formal committee reports and Integrated Performance Report (IPR). • Key Performance Indicators (KPI's) for committees agreed • Information owner and data guardians identified • Single source of truth and process for collation of data agreed
Hospital @ Night	• Task and Finish Group Created in February 2019, created vision for 24/7 Hospital. With focus on 'Safe Night'. • Business cases to support out of hours for weekends and bolster nights to support staff and improve patient experience completed. • Reports created via NerveCentre now available to wards to review and manage their out of hours work. • Hospital At Night Dashboard created and in use to review incidents and drive continuous improvement
Medical Devices	• Medical Devices Safety Group (MDSG) has been reconstituted in January 2019 • Completed an awareness programme on the existence of the Trust's Medical Devices Policy through our Communications Team • Agreement on using a centralised medical equipment management database, Clinical Engineering's MEMS software platform. Work in progress on delivery of the full project as multidisciplinary engagement has already started. • The delivery of a centralised user-training database project is in its scoping stage and it has been identified that a Trust template on training needs analysis exists on the intranet since 2010, here: http://mems-l1/competency/homepage.htm

The CQC domains were reported as:-

SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED
REQUIRES IMPROVEMENT	REQUIRES IMPROVEMENT	GOOD	REQUIRES IMPROVEMENT	REQUIRES IMPROVEMENT

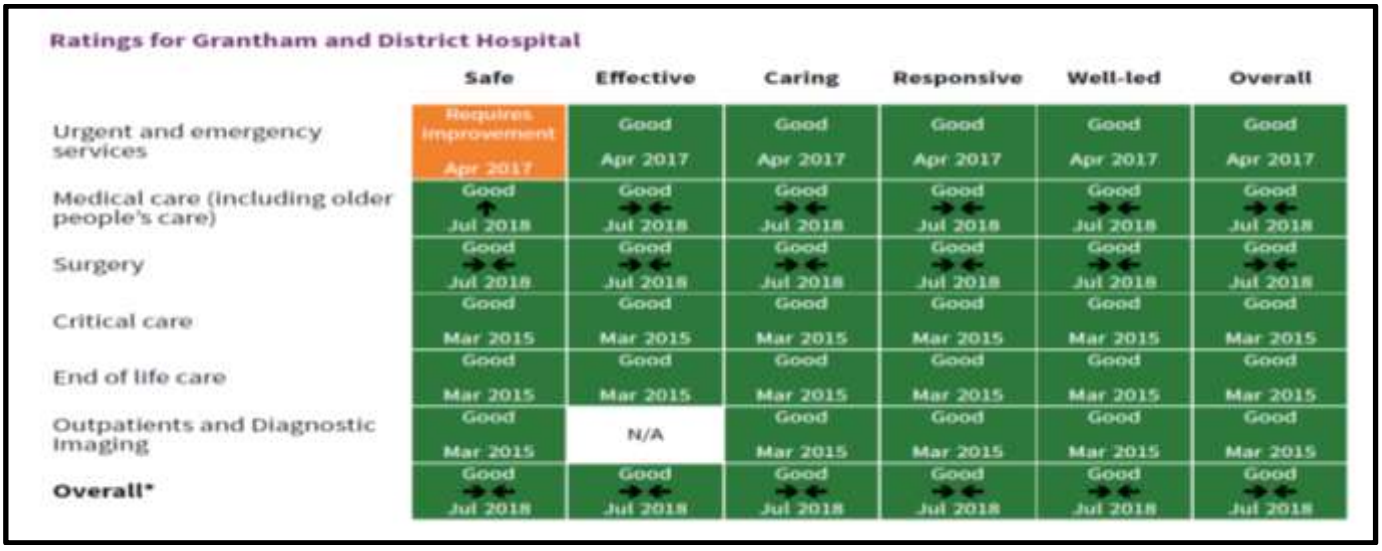
Ratings for United Lincolnshire Hospitals NHS Trust compared to previous CQC visit



→← same as previous inspection
↑Up one rating from previous inspection
↓ Down one rating from previous inspection
↓↓ Down two ratings from previous inspection
↑↑Up two ratings from previous inspection

Ratings for Lincoln County Hospital compared to previous CQC visit

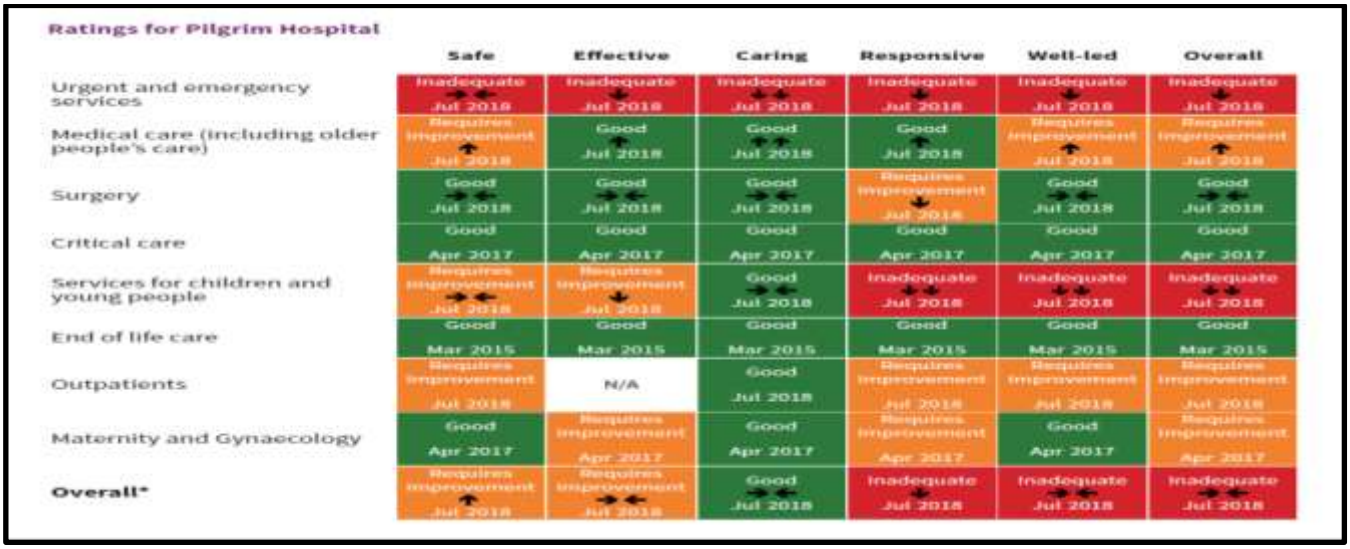
Ratings for Grantham and District Hospital compared to previous CQC visit



Ratings for Grantham and District Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Medical care (including older people's care)	Good ↑ Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018
Surgery	Good →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018
Critical care	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
End of life care	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Outpatients and Diagnostic Imaging	Good Mar 2015	N/A	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Overall*	Good →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018

Ratings for Pilgrim Hospital compared to previous CQC visit



Ratings for Pilgrim Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate →← Jul 2018	Inadequate ↓ Jul 2018	Inadequate →← Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018
Medical care (including older people's care)	Requires Improvement ↑ Jul 2018	Good ↑ Jul 2018	Good ↑↑ Jul 2018	Good ↑ Jul 2018	Requires Improvement ↑ Jul 2018	Requires Improvement ↑ Jul 2018
Surgery	Good →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Requires Improvement ↓ Jul 2018	Good →← Jul 2018	Good →← Jul 2018
Critical care	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Services for children and young people	Requires Improvement →← Jul 2018	Requires Improvement ↓ Jul 2018	Good →← Jul 2018	Inadequate ↓↓ Jul 2018	Inadequate ↓↓ Jul 2018	Inadequate ↓↓ Jul 2018
End of life care	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015
Outpatients	Requires Improvement Jul 2018	N/A	Good Jul 2018	Requires Improvement Jul 2018	Requires Improvement Jul 2018	Requires Improvement Jul 2018
Maternity and Gynaecology	Good Apr 2017	Requires Improvement Apr 2017	Good Apr 2017	Requires Improvement Apr 2017	Good Apr 2017	Requires Improvement Apr 2017
Overall*	Requires Improvement ↑ Jul 2018	Requires Improvement →← Jul 2018	Good →← Jul 2018	Inadequate ↓ Jul 2018	Inadequate →← Jul 2018	Inadequate →← Jul 2018

DATA QUALITY

NHS Number and General Medical Practice Code validity

ULHT submitted records during April 2018 to January 2019 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:

- 99.8% for admitted patient care (National performance 99.4%)
- 99.9% for outpatient care (National 99.6%)
- 98.8% for accident and emergency care (National 97.6%)

which included the patient's valid General Medical Practice Code was:

- 100.0% for admitted patient care (National performance 99.9%)
- 100.0% for outpatient care (National 99.8%)
- 100.0% for accident and emergency care (National 99.3%)

Information Governance Toolkit attainment levels

ULHT Information Governance Assessment report is no longer available and the system has been replaced by the "Data Security & Protection Toolkit (DSP Toolkit)".

The new toolkit demonstrates that the Trust is working towards the 10 National Data Guardian's data security standards as set out in the Data Security and Protection Standards for health and care.

There are no longer attainment levels, instead the toolkit works on either 'standards met' or 'standards not met'. All organisations are expected to achieve 'Standards Met' on the DSP Toolkit. With this being the first year of the DSP Toolkit Standard, NHS Trusts have been allowed to publish a DSP Toolkit if they are approaching a level of 'Standards Met' in all but a few areas.

ULHT's toolkit publication for 2018/19 was 'standards not met'. Due to this we were required to provide an Improvement plan of how we are going to bridge the gap between our current position and meeting the DSP Toolkit 'Standards Met'. This has been submitted to NHS Digital who will review and agree the plan. Once the Improvement plan is agreed with NHS Digital our publication will be displayed as 'Standards not fully met (Plan Agreed)'.

Clinical coding

ULHT was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. The Trust, however commissioned a Payment by Results Clinical Coding audit by CHKS in November 2017. Based on the results of this audit, there were a number of recommendations made to improve the capture of information from clinical notes into Medway PAS for onward use in financial and quality measures. The audit specifically focussed on poor performing areas based on CHKS internal benchmarking using a number of different data quality metrics available from HES data (via NHS Digital). The recommendations ranged from improvements to the content and filing of clinical notes, through to wider engagement with Clinical teams to support Clinical Coding. A review of the Clinical Coding structure took place and was approved by the Trust Board in 2018. Following writing of new job descriptions and a robust consultation process, the Trust started to implement changes to the structure in January 2019. The Trust has also engaged with IQVIA who review Clinical Coding activity and make recommendations for areas to review internally.

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. In addition to this, Clinical Coding Masterclasses have been held with Clinicians, led by the Clinical Coding Manager. This has reinforced the importance of the clinical notes being accurate and complete, as well as improving the Coding/Clinician relationships.

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.

Data quality

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

- Work undertaken to review the main Key Performance Indicators (KPIs) that are reported to the Trust Board and Board Committees. This involved understanding the metric itself, how it was calculated and assurance around underlying robustness of the metric and data source.
- This has led to the introduction of a Data Quality Kite Mark assigned to individual KPIs alerting the end user to 4 indicators: Timeliness, Completeness, Validation and Process
- Further embedding and exploitation of Medway (Patient Administration System) following the implementation mid-2014 and subsequent upgrade to v4.8 in October

2017, process maps and standard operating procedures continue to be 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

- Work is ongoing to test upgrades to the latest version of Medway
- Continuation of implementing actions identified by the 2017 CHKS Audit on Payment by Results (PbR) income (mainly around Clinical Coding) – this has led to a restructure of the Clinical Coding department increasing head count from 28.6 Whole Time Equivalent (WTE) to 41WTE, which will lead to improved Coding, internal audit and training and improved engagement with Clinical Divisions
- Review of structure of Data Quality function and wider Information Services structure to ensure the team supports the needs of the Trust.
- Further development of the data warehouse and front end visualisation tools that will enable more timely reporting of information and assist with data quality reporting throughout the Divisions in the Trust

LEARNING FROM DEATHS

United Lincolnshire Hospitals NHS Trust have been reviewing deaths of patients and disseminating learning. Our process over the years has expanded and become more robust when the Keogh Review identified ULHT as one of the 14 Trusts as an outlier for mortality. Our processes have been developed further since the release of the National Quality Board Learning from Deaths published in March 2017.
The measures below are outlined by the NHS Quality Account legislation 27 for the year 2018/19

Measure	QTR 1 Apr 18 – Jun 18	QTR 2 Jul 18 – Sep 18	QTR 3 Oct 18 – Dec 18	QTR 4 Jan 19 – Mar 19	Comments
Number of patients that have died within ULHT.	483	448	510	650	During 2018/19, 2091 of ULHT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
Number of deaths that have had a case record review/Investigation. For 2018/19 the reviews and investigations are conducted as one however this will change in the future	363	285	206	101	By March 2019, 955 case record reviews and investigations have been carried out in relation to 2091 of deaths included above . In 955 of cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was :
Number/percentage of deaths that escalated with problems in care. In relation to each quarter, this consisted of: 17 representing 4.7% for the first quarter 25 representing 8.8% for the second quarter 6representing 2.9% for the third quarter 9 representing 6.8% for the fourth quarter	17/4.7%	25/8.8%	6/2.9%	9/8.9%	57 representing 6% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using the grading system that highlights potential areas of concern in care. All cases that are graded 2&3 automatically get escalated to our Mortality Surveillance Group (MoRAG) for further review. A selection of reviews graded 1 or below are also referred for a more indepth analysis.

Summary of what ULHT has learnt from case record reviews and investigations conducted in relation to deaths.

ULHT have learnt from case note reviews and from completing in-depth reviews on Diagnosis Alerts. We have disseminated learning on a number of thematic lessons using a modality of communication systems:

- Hyperkalaemia Management
- Appropriate referrals from Community to Acute Care
- Oxygen Prescribing and Toxicity
- Safe Discharges- Electronic Discharge Document (eDD)
- Breaking bad news to Patients and Families
- Consequence of poor documentation in clinical records
- Chronic Obstructive Pulmonary Disease Management
- Community Acquired Pneumonia Management
- Dangers of failure to secure venous access in acutely unwell patients
- Timely administration of adrenaline
- Use of wrong size Nasogastric and Ryles tubes
- Catheter Associated Urinary Tract Infection (CAUTI) management
- Early recognition of end of life patients and appropriate care planning
- In-depth Diagnosis Alert reviews undertaken: Other perinatal conditions, AAA, Liver Disease, Acute Myocardial Infarction, Stroke, Sepsis, Fluid and electrolytes, Biliary Tract Disease, NIV and Pneumonia

Description of actions that ULHT have taken in 2018/19, and proposes to take forward in consequence of what the ULHT has learnt.

ULHT have taken actions in relation to all learnings and have disseminated Trust wide:

- Patient Safety Briefings in relation to thematic reviews from investigations
- Clinical Coding Masterclass held Tri-annually- The importance of accurate documentation
- Redesign eDD to ensure compliance of sent within 24 hours of discharge to the GP
- Development in line within the new Trust Operating Model a new Mortality Assurance Learning Strategy Group (MorALS Group)- this group will monitor Trust Mortality Report, Divisional Reporting, Trust Mortality Action plan and link with Specialty Governance Leads
- Implementation of the Medical Examiner role within the Trust to screen deaths and escalate to concerns to the appropriate Specialty or Trust wide learning
- Audit compliance in care bundles used and re-launching care bundles, designing awareness posters and engaging with Clinical Staff
- Mortality is embedded within the Specialty Governance reporting and discussions
- In-depth reviews undertaken for alerting diagnoses and learnings disseminated to the appropriate forums and assurance given to Patient Safety Committee
- Developing Frailty Service on sites within A&E to assess patients
- Thematic review of care home admissions to acute care

Assessment of the impact of actions which were taken by ULHT during 2018/19

From actions taken ULHT have appreciated and recognised the impact of:

- All patient safety briefings are disseminated to the Trust via communications; discussed at Specialty Governance and relevant forums
- Increased engagement in understanding mortality and importance of accurate documentation
- The Trusts HSMR is below expected limits
- The Trusts SHMI is showing a downward trajectory
- Crude mortality has decreased
- County wide audits resulted in the need for end of life training within the community engaging GP's and Care Homes-to ensure ReSPECT is embedded in practice for advance care planning
- Increase in palliative care engagement within the hospital
- Compliance against care bundles used by the Trust
- eDD compliance monitored
- Mortality is part of the Trust's Quality and Safety Improvement programme
- Reduction of unsuitable admissions to Acute Care

Measure	QTR 1 Apr 18 – Jun 18	QTR 2 Jul 18 – Sep 18	QTR 3 Oct 18 – Dec 18	QTR 4 Jan 19 – Mar 19	Comments
Number of reviews / investigations completed which took place before the start of the reporting period.	394	99	48	8	549 case record reviews and investigations completed after 31st March 2018 which related to deaths which took place before the start of the reporting period.
Number/Percent of deaths that are judged likely not to be problems in care	373/95%	91/92%	40/92%	7/87%	511 representing 93% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the grading system below.

United Lincolnshire Hospitals NHS Trust have been using a grading of avoidability since January 2016. The review grading is outlined below:

- Grade 0- Unavoidable Death, No Suboptimal Care.
- Grade 1- Unavoidable Death, Suboptimal care, but different management would not have made a difference to the outcome.
- Grade 2- Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)
- Grade 3- Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death).

Measure	QTR 1 Apr 18 – Jun 18	QTR 2 Jul 18 – Sep 18	QTR 3 Oct 18 – Dec 18	QTR 4 Jan 19 – Mar 19	Comments
A revised estimate of Number/Percent of deaths that are judged likely not to be problems in care	-	-	-	-	0 representing 0% of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient. All are included in the table above.

NHS DIGITAL INDICATORS

The following data relating to national reporting requirements in the Quality Account are provided by NHS Digital. NHS digital provide data for 15 mandatory indicators, based upon the recommendations by the National Quality Board. The last two previous reporting periods available on NHS Digital for ULHT are to be reported within the Quality Account.

Domain	Measure	Description	Jul 17 – Jun 18	Oct 17 – Sep 18	*ULHT
Domain 1	Preventing people from dying prematurely	The data made available to the trust by NHS Digital with regard to - **The value and banding of the Summary Hospital-level Mortality Indicator (SHMI) for the Trust for the reporting period** • ULHT SHMI/Band • National Average • Best/Worse National Performance	115.29/1 100.35 69.82/125.75	114.05/1 100.34 69.17/126.81	114.05/1 100.34 69.17/126.81
Domain 1	Preventing people from dying prematurely	The data made available to the trust by NHS Digital with regard to - **The percentage of patient deaths with palliative care coded at either diagnoses or speciality level for the trust for the reporting period** • ULHT • National Average • Best/Worse National Performance	25.3 33.1 58.7/13.4	25.7 33.6 59.5/14.3	25.7 33.6 59.5/14.3

ULHT considers that this data is as described for the following reasons:
Our patient data is submitted to Secondary User Services which is validated.
ULHT intends to take the following actions to improve this mortality rate and so the quality of its services, by monitoring the impact of the frailty service in A&E to ensure acute care admissions are appropriate. Use of the ReSPECT and SPICT toolkit to recognise end of life and increase in referrals to palliative care where appropriate. Working with the Community to ensure appropriate pathways are in place for the county's patients. The embedding of the Medical Examiner to ensure deaths are screened within 7 days and timely escalation to Specialties for cases of concern.

** This is the latest data ULHT has available internally*

Domain	Measure	Description	2016/17	2017/18	*ULHT

Domain 3

Helping people to recover from episodes of ill health or following injury

The data made available by NHS Digital with regard to the Trust's patient reported outcome measures scores for -

Total/Primary Hip replacement surgery & Knee replacement surgery-EQ:5D Index

- ULHT EQ:5D index Hip Replacement surgery
- National Avg EQ:5D index Hip Replacement surgery
- ULHT EQ:5D index Knee Replacement surgery
- National Avg EQ:5D index Knee Replacement

2016/17	2017/18	2018/19
0.40(L)/0.41(H)	0.46(L)/0.46(H)	89.5%
0.44(L)/0.44(H)	0.46(L)/0.47(H)	N/Av
0.32(L)/0.33(H)	0.33(L)/0.33(H)	71.4%
0.32(L)/0.33(H)	0.33(L)/0.34(H)	N/Av

Domain 3

Helping people to recover from episodes of ill health or following injury

The data made available by NHS Digital with regard to the Trust's patient reported outcome measures scores for -

Total/Primary Hip replacement surgery & Knee replacement surgery-VAS Index

- ULHT VAS index Hip Replacement surgery
- National Avg VAS index Hip Replacement surgery
- ULHT VAS index Knee Replacement surgery
- National Avg VAS index Knee Replacement surgery

2016/17	2017/18	2018/19
11.92(L)/12.58(H)	12.63(L)/12.69(H)	55.6%
13.18(L)/13.53(H)	13.83(L)/14.17(H)	N/Av
5.32(L)/5.80(H)	7.11(L)/7.62(H)	62.5%
6.86(L)/7.02(H)	8.17(L)/8.31(H)	N/Av

Domain 3

Helping people to recover from episodes of ill health or following injury

The data made available by NHS Digital with regard to the Trust's patient reported outcome measures scores for -

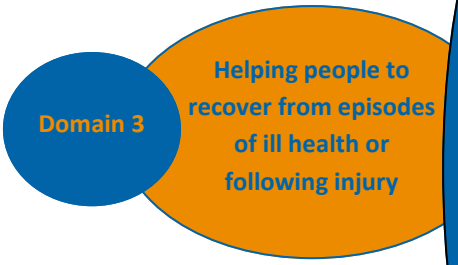
Total/Primary Hip replacement surgery & Knee replacement surgery-Oxford Score

- ULHT Oxford hip surgery Score
- National Avg Oxford Hip surgery score
- ULHT Oxford Knee surgery Score
- National Avg Oxford Knee surgery score

2016/17	2017/18	2018/19
19.93(L)/20.58(H)	21.63(L)/22.29(H)	100%
21.29(L)/21.73(H)	22.09(L)/22.56(H)	N/Av
15.81(L)/15.94(H)	16.80(L)/16.91(H)	100%
16.32(L)/16.47(H)	16.96(L)/17.10(H)	N/Av

ULHT considers that this data is as described for the following reasons:
The data is taken from NHS Digital PROMs data set.
ULHT intends to take the following actions to improve PROMS outcomes and so the quality of its services by improving patient participation and providing patients with information leaflets at their pre assessment visit. The Trust is continuing to look at the issues for hips and knee outcome scores in greater detail in particular those patients who have had a negative outcome.
** The latest data ULHT is from a provisional data set from PROMs for 18/19. Data available is the percentage improved not the index figure and is only for primary not revisions.*
Therefore National performance is not available. ***(L)=Lowest (H)=highest***

Domain	Measure	Description	2010/11	2011/12	*ULHT



The data made available to the trust by NHS Digital 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 (emergency readmissions).**

- ULHT readmitted within 28 days: 0-15/16+
- National Average: 0-15/16+
- Best-Worse National Performance: 0-15/16+

2010/11	2011/12	2018/19
8.37%/10.16%	7.97%/10.49%	11.2%/27.6%
N/Av	N/Av	N/Av
6.43%-14.11%/ 9.78%-13.02%	6.40%-16.9%/ 9.43%-13.8%	N/Av

ULHT considers that this data is as described for the following reasons:
The data is taken from the Trust's Patient Administration System.
ULHT intends to take the following actions to improve this indicator and so the quality of its services by working with our wider Health and Social Care Community to ensure care planning for our patients are appropriate and support within the Community when discharged from acute care. Investigations are undertaken where concerns or harm to a patient is made and outcomes actioned and changes made where appropriate. The Trust is adopting the SAFER standards in relation to patient discharge planning. Readmission rates performance is monitored within the Trust Mortality Report
** This is the latest data ULHT has available internally.*

Domain	Measure	Description	2016/17	2017/18	*ULHT

The data made available by NHS Digital with regard to the Trust's

Responsiveness to the personal needs of its patients during the reporting period

- ULHT
- National Average
- Best/Worse National Performance

2016/17	2017/18	2018/19
65.7	66.8	N/Av
68.1	68.6	N/Av
86.2/58.9**	85.0/60.5	N/Av

ULHT considers that this data is as described for the following reasons:
The data is provided by the national survey contractor.
ULHT intends to take the following actions to improve this indicator and so the quality of its services by reviewing, launching and delivering the ULHT Patient and Carer Experience Strategy.
**ULHT and National Performance data is not available at this time*
***For 2017/18 Quality Account the data was inserted as worse / best and not best/worse*

Domain	Measure	Description	Dec 2018	Jan 2019	*ULHT

The data made available by NHS Digital with regard to 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 to family & friends

- ULHT Strongly agree/Agreed
- National Average Strongly agree/Agreed
- Best/Worse National Performance Strongly agree/Agreed

2017	2018	2019
9/42	17/53	N/Av
21/48	21/52	N/Av
0/70	0/77	N/Av

ULHT considers that this data is as described for the following reasons:
The data has been sources from NHS Digital and compared to published survey results.
ULHT intends to take the following actions to improve this indicator and so the quality of its services by relaunching the 2021 strategy with a clear focus that patients are our number one priority and adopting a consistent and robust approach to values based recruitment and selection for all senior posts
**ULHT and National Performance data is not available at this time*

Domain	Measure	Description	Dec 2018	Jan 2019	*ULHT

Domain 4

Ensuring people have a positive experience of care

The data made available to the trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2).

Patients who would recommend the Trust to Family and friends: % recommended

- ULHT A&E/National Avg/ Best-Worst
- ULHT Inpatients/National Avg/ Best-Worst
- ULHT Maternity /National Avg/ Best-Worst

Dec 2018	Jan 2019	Feb 2019
83/86/100-43	83/86/100-60	81/N/Av
93/95/100-81	92/95/100-76	89/N/Av
100/97/100-78	97/97/100-77	100/N/Av

ULHT considers that this data is as described for the following reasons:
The data has been sources from NHS Digital and compared to published survey results.
ULHT intends to take the following actions to improve this indicator and so the quality of its services by improving our communication and keeping our patients informed and updated on their care and treatment.
** This is the latest data ULHT has available internally therefore National performance is not available*

Domain	Measure	Description	Oct 17-Dec 17	Jan 18-Mar 18	*ULHT

Domain 5

Treating and caring for people in a safe environment and protecting from avoidable harm

The data made available to the Trust by NHS Digital with regard to the

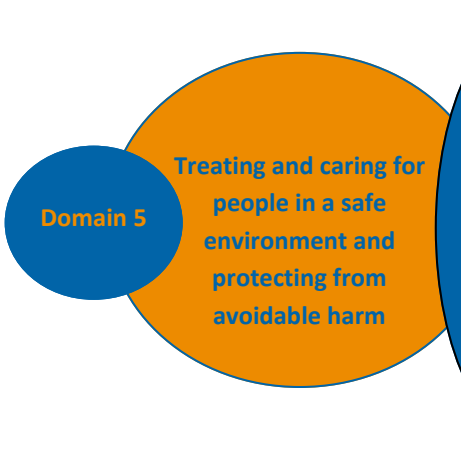
percentage of Patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

- ULHT %
- National Avg %
- Best-Worst National Performance %

QTR3 Oct 17-Dec 17	QTR4 Jan 18-Mar 18	Jan 2019
97.17	97.66	96.61
95.36	95.21	N/Av
100-76.08	100-67.04	N/Av

ULHT considers that this data is as described for the following reasons:
The data has been sourced from NHS Digital and compared to internal data.
ULHT intends to take the following actions to improve this indicator and so the quality of its services by continuing to be above the national average. The Trust will continue to complete detailed analysis on all hospital acquired thrombosis and share learning.
** This is the latest data ULHT has available internally therefore National performance is not available*

Domain	Measure	Description	2016-17	2017-18	*ULHT



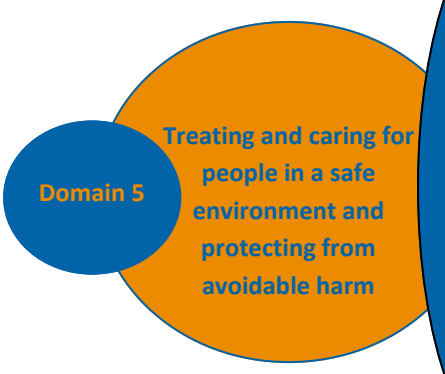
The data made available to the trust by NHS Digital with regard to the **rate per 100,000 bed days of cases of Cdifficile infection reported within the trust amongst patients aged 2 or over during the reported period**

- ULHT %
- National Avg %
- Best-Worst National Performance %

2016/17	2017/18	Jan 2019
15.3	18.2	12.4
13.2	13.2	N/Av
0-82.7	0-91	N/Av

ULHT considers that this data is as described for the following reasons:
The data has been sourced from NHS Digital and compared to internal data.
ULHT intends to take the following actions to improve this indicator and so the quality of its services by reviewing each case and share learning.
** This is the latest data ULHT has available internally therefore National performance is not available*

Domain	Measure	Description	Oct 16-Mar 17	Oct 17-Mar 18	*ULHT



The data made available to the trust by NHS Digital 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**

- ULHT %
- National Avg %
- ULHT Total No incidents/Severe-Death

Oct 16-Mar 17	Oct 17-Mar 18	Oct 18-Mar 19
1.45	1.55	0.8
N/A	N/A	N/A
5917/86	6399/99	14731/118

ULHT considers that this data is as described for the following reasons:
The data has been sourced from NHS Digital and compared to internal data.
ULHT intends to take the following actions to improve this indicator and so the quality of its services by updating their reporting system and encouraging staff to report. The Trust has also updated and streamlined their serious incident process.
** This is the latest data ULHT has available internally therefore National Average is not available*

Explanatory Notes

All data published as descripted and provided from NHS Digital website correct at time of reporting for the periods available.
https://digital.nhs.uk/data-and-information/indicators/indicator-portal-collection/quality-accounts

Summary Hospital-level Mortality Indicator SHMI

This is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by NHS Digital with the first publication in October 2011. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. SHMI is reported every 6 months and has a 6 month time lapse and in hospital death rate should mirror HSMR therefore HSMR can be a predictor for this. NHS Digital does not retrospectively refresh data from the previous reporting period.

Patient Reported Outcome Measures (PROMS)

PROMS is an optional questionnaire that is filled out in pre-operative surgery and a follow up questionnaire is sent post-surgery. The measures required for the Quality Account is to report on the Adjusted Average Health Gain for Hip Replacement Primary, Total Hip Replacement, Knee Replacement Primary and Total Knee Replacement, rounded to two decimal places. The data does not include Knee or Hip replacement revisions.

NHS England undertook a consultation on the national PROMs programme in 2016. As a result of the findings of that consultation, NHS England has taken the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections. As a result of the NHS England consultation, the Trust has not participated in the collection of the varicose vein and groin hernia surgery due to the low number of patients that would be available for this cohort which would not allow for sufficient modelled records to equate for an adjusted health gain.

Readmission within 28 days of discharge

The most recent period for this is 2011/12- there is no further information available past this date on NHS digital. This is a measure of readmissions within 28 days of a patients discharge, there are two metrics required to be reported 0-15 years and 16+ years, the indicator measure taken for the last two periods is the “Indirectly age, sex, method of admission, diagnosis, procedure standardised percent.”

Responsiveness to inpatients personal needs

The indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals.

Staff Survey

This data has been taken from the Staff Survey Question 21d results that have been published upon NHS Staff Survey website.

Friends and Family Test

This data has been taken from the Friends and Family responses received for the Trust as published on NHS Digital for the last two reporting periods. The National Average for England is excluding independent sector providers. Maternity data has been taken from Trust Question 2- asked in birth setting. This is relevant to Pilgrim and Lincoln sites only.

Clostridium Difficile Infection

The data is taken from table 8b of the NHS Digital published annual table for the last two reporting periods and the metric is the infection rate per 100,000 bed days.

Clostridium Difficile also known as C. Difficile or C. Diff is a gram positive bacteria that causes diarrhoea and other intestinal disease when competing bacteria in a patient or person's gut are wiped out by antibiotics. C. Difficile infection can range in severity from asymptomatic to severe and life threatening, especially among the elderly. People are most often nosocomially infected in hospitals, nursing homes, or other institutions, although C. Difficile infection in the community and outpatient setting is increasing.
The description is the rate of C. Difficile infections per 100,000 bed days for patients aged two or more on the date the specimen was taken during the reporting period.
The data definition is described as:

- Numerator: The number of C. Difficile identified within a trust during the reporting period.
- Denominator: The number of bed days (divided by 100,000) reported by a trust during the reporting period.

The scope of the indicator includes all cases where the patient shows clinical symptoms of clostridium difficile infection, and has a positive laboratory test result for C. Diff recognised as a case according to the trust's diagnostic algorithm. A C. Difficile episode lasts for 28 days, with day one being the date the first positive specimen was collected. A second positive result for the same patient, if collected more than 28 days after the first positive specimen, should be reported as a separate case, irrespective of the number of specimens taken in the intervening period, or where they were taken. Specimens taken from deceased patients are to be included.
The following cases are excluded from the indicator:

- people under the age of two at the date the sample of taken; and
- where the sample was taken before the fourth day of an admission to the trust (where the day of admission is day one).

Venous Thromboembolism (VTE) Risk Assessment

Venous Thromboembolism (VTE) is a term that covers both deep vein thrombosis (DVT) and its possible consequence: pulmonary embolism (PE). A DVT is a blood clot that develops in the deep veins of the leg. If the blood clot becomes mobile in the blood stream it can travel to the lungs and cause a blockage (PE). The risk of hospital-acquired VTE can be greatly reduced by risk assessing patients on admission to hospital and taking appropriate action to prevent a VTE from occurring. Where clots happen the assessment, prescription and administration of appropriate medication is assessed to see if this has all been done correctly.

NICE guidance has given advice on the scope of who to include within the cohort - surgical inpatients, inpatients with acute medical illness, trauma inpatients, patients admitted to Intensive Care Unit, cancer inpatients, patients undergoing long term rehabilitation, patients admitted to a hospital bed for day-case or surgical procedure and private patients attending NHS hospital.

The patients out of scope are patients under 18 years (however in March 2018 NICE updated their guidelines and have lowered the age to 16 years and above from 18 years), people attending outpatients and people attending A&E who are not admitted. The Trust signed up to the Midland and East Cohort agreement. The National target is for at least 95% of patients to be risk assessed for VTE within 24 hours of admission. The results are collated through an electronic system known as Medway. For the 2017/18 compliance the external Auditors identified issues with the data source and the 2017/18 may not be a true reflection.
Compliance with VTE assessment:
2017/18 = 97.48%
2018/19 = 96.66%

Patient Safety Incidents

This metric is the number and where available, rate of patient safety incidents that occurred within the trust during the reporting period, and the percentage of such patient safety incidents that resulted in severe harm or death as published in the Patient Safety Indicators latest file on NHS Digital. The national Average is not available as the England reporting is not within the same time frames.

OMITTED NOTE the following Domains and metrics were not applicable for ULHT reporting:

Domain 1

- Patients on Care Programme Approach (CPA) followed up within 7 days of discharge from psychiatric inpatient stay-**Mental Health Community**
- Category A telephone calls (Red 1 and Red 2 calls) ; emergency response within 8 minutes-**Ambulance**
- Category A telephone calls; ambulance response within 19 minutes**-Ambulance**
- Patients with suspected ST elevation myocardial infarction who received an appropriate care bundle (Domain 1 and 3)**-Ambulance**
- Patients with suspected stroke assessed face to face who received an appropriate care bundle (Domain 1 and 3)**-Ambulance**

Domain 2

- Admissions to acute wards where the Crisis Resolution Home Treatment Team were gate keepers**-Mental Health Community**

Domain 4

- Patient experience of community mental health services**-Mental Health Community**

PART 3

2021
A different Lincolnshire
A great ULHT

Excellence in rural healthcare

REVIEW OF QUALITY PERFORMANCE

PATIENT SAFETY

The safety of our patients is central to everything we want to achieve as a provider of healthcare. We are committed to continuously improving the safety of our services, and will focus on avoiding and preventing harm to patients from the care, treatment and support that is intended to help them. We will do this by successfully implementing proactive patient safety improvement programmes and by working to better understand and improve our safety culture. We will also continue to conduct thorough investigations and analyses when things go wrong, identifying and sharing learning, and making improvements to prevent or reduce the risk of a recurrence. We will be open and honest with patients and their families when they have been subject to a patient safety incident, and will strive to eliminate avoidable harm as a consequence of care we have provided.

Patient Safety Alerts

The Trust complies with CQC Regulation 12: Safe Care and Treatment "Providers must comply with relevant Patient Safety Alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS)".

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

The Department of Health uses Central Alerting System (CAS) to distribute and monitor Trust actions for notices published by:

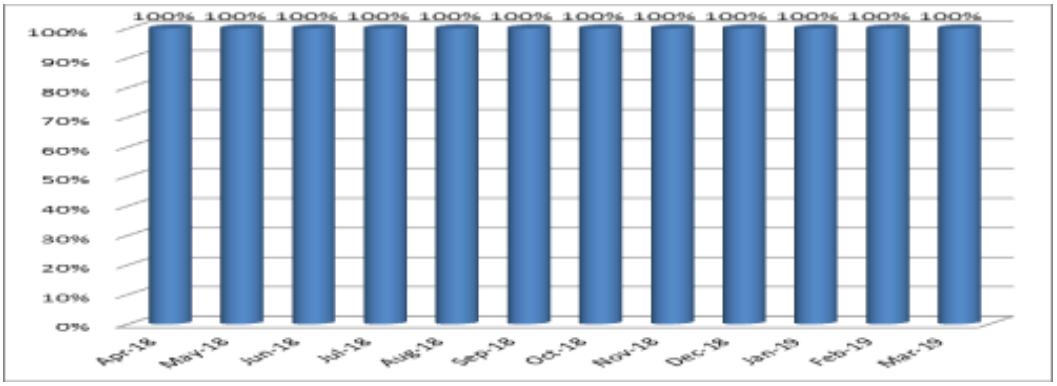
- Department of Health and Social Care (DH)
- Medicines and Healthcare Products Regulator Agency (MHRA)
- Medical Device Alerts (MDA)
- NHS England Patient Safety Agency (NHSPSA)
- Estates and Facilities Notification (EFN)
- Estates and Facilities Alerts (EFA)

CAS is also used to send out emergency alerts (important public health messages – 'CMO messaging' and MHRA Drug Alerts and Dear Doctor Letters). These alerts are also emailed

directly to senior NHS staff, including Trust Chief Executives and Medical Directors for onward cascade depending on locally agreed processes.
When a new alert is issued, the CAS officer is notified by email. The alerts must be acknowledged by the Trust within 2 working days. The Trust must then determine whether the alert is relevant to the organisation. Alerts are cascaded to relevant groups within the Trust for information/action. The Trust must then respond to the alert within a specified timescale. A local database is maintained of all alerts received and an audit trail is preserved for each alert to ensure the required actions have been implemented. Monthly compliance reports are produced and discussed at the Patient Safety Group meeting. A proportion of CAS Alerts are included in the Trust Audit Programme to ensure ongoing compliance.

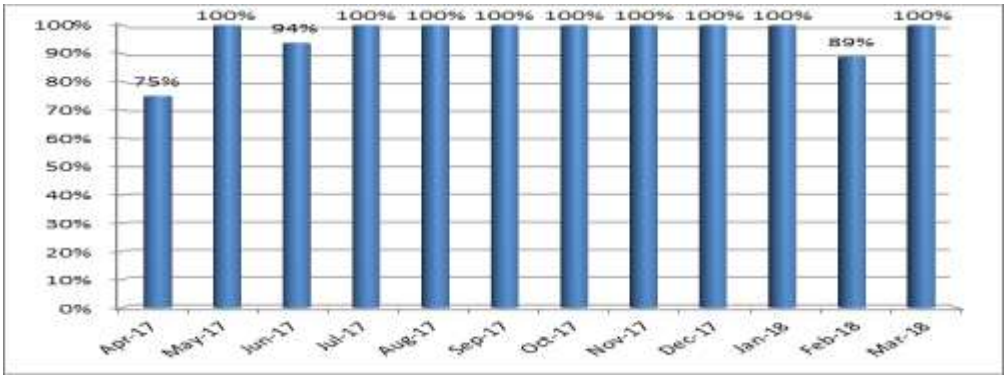
71 CAS Alerts have been received between 01/04/2018 and 31/03/2019 – ALL of these (100%) were completed within deadline. 25 required action and 46 did not require action (please note: one is still open from 2017/18 and awaiting completion). Nationally,18542 Alerts were received by NHS Trusts. 16801 were completed within deadline (90.6%). Our Trust in-month compliance is illustrated below:

Compliance with completion of safety alerts within the required timescale 2018/19



101 CAS Alerts were received between 01/04/2017 and 31/03/2018 – 98 of these (97%) were completed within deadline. 26 required action, 74 did not require action and one is still open and awaiting completion. Nationally, 26639 Alerts were received by NHS Trusts. 24497 were completed within deadline (92%). Our Trust in-month compliance is illustrated below:

Compliance with completion of safety alerts within the required timescale 2017/18



Safety Thermometer

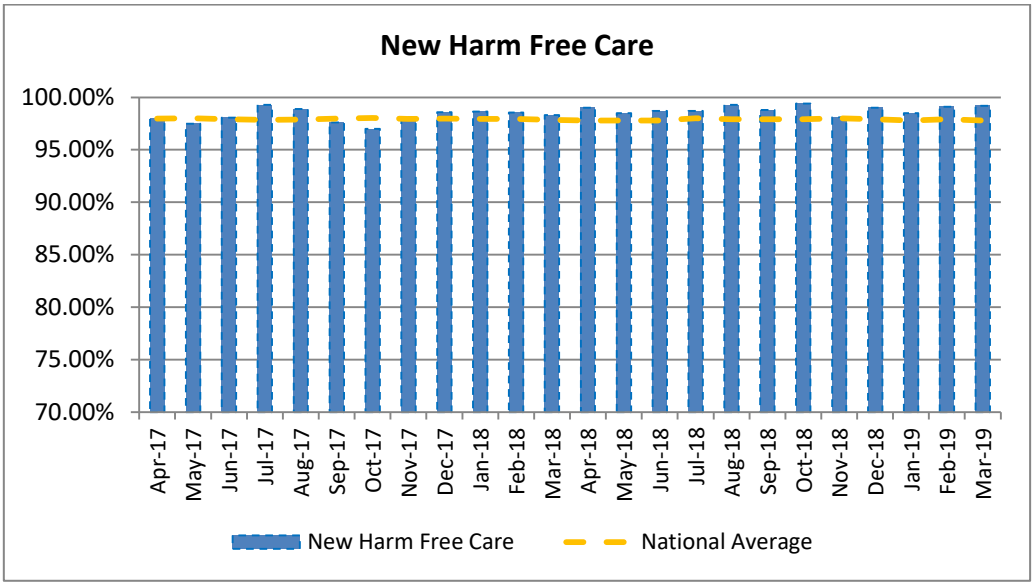
We have contributed to the national data collection via the NHS Safety Thermometer throughout the past year. The Safety Thermometer is a point prevalence tool which allows nursing teams to measure four specific harms and the proportion of their patients that are free from all of these harms on one specific day each month. The NHS Safety Thermometer acts as a “temperature check” and can be used in conjunction with other indicators such as incident reporting, staffing levels and patient feedback to indicate where a problem may occur in a clinical area.

Safety Thermometer is a national tool on one set day each month all patients are included in the national data collection to which our data contributes to give a snapshot of care in the country on that day. The four harms measured are:

- Falls
- Urinary Catheter Associated Infections
- Venous Thromboembolism
- Pressure Ulcers

The following chart shows the percentage of “Trust new harm free” scores which relates to the percentage of patients in our care that did not develop one of the four harms whilst in our service. The national average for new harm free care is 97.88% whereas the Trust has had a 98.8% average. We will continue to work hard to make sure all our patients are kept free from harm in our care.

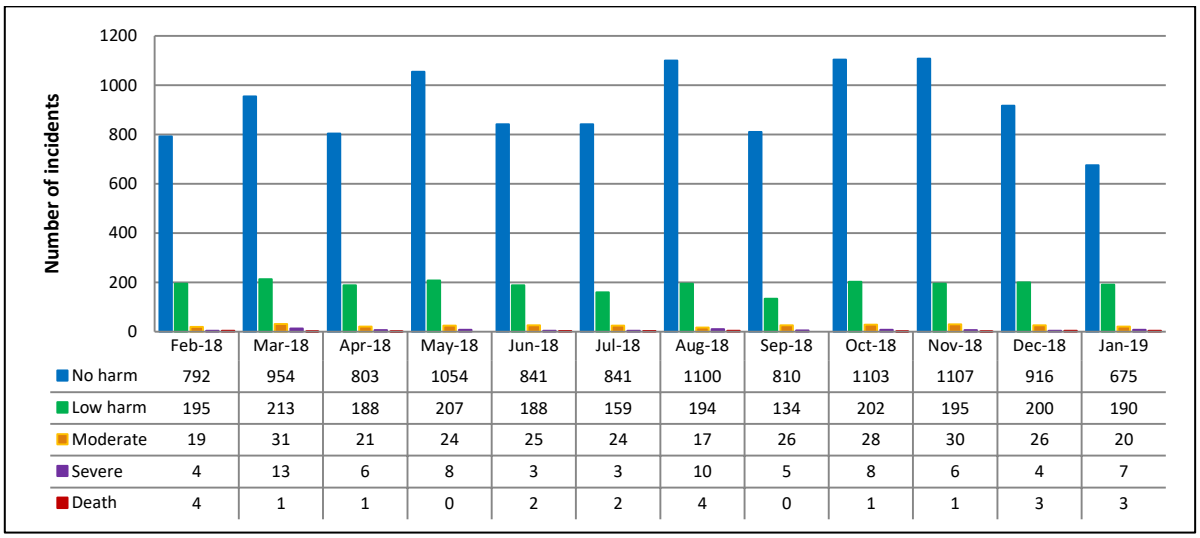
New harm free care from 2017/19



Patient Safety Incidents

The chart below provided by NRLS shows the number of incidents reported within ULHT each month, by degree of harm caused:

Patient safety incidents on NRLS February 2018 – January 2019



	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
No harm	792	954	803	1054	841	841	1100	810	1103	1107	916	675
Low harm	195	213	188	207	188	159	194	134	202	195	200	190
Moderate	19	31	21	24	25	24	17	26	28	30	26	20
Severe	4	13	6	8	3	3	10	5	8	6	4	7
Death	4	1	1	0	2	2	4	0	1	1	3	3

Overall incident reporting rates have increased steadily in each of the past 3 years, which can be seen as a positive indicator of an improving culture of patient safety awareness and staff confidence in the Trust's incident management processes. In 207/18 there were 1246 incidents reported compared to 2018/19 there were 1345 safety incidents reported. Comparison with other acute trusts, provided by NHS Improvement, shows that there is no evidence of under-reporting at ULHT. The Trust is also reporting significantly fewer incidents resulting in severe harm or death than it was a year ago.

Serious Incidents

The purpose of identifying and investigating serious incidents, as with all incidents, is to understand what happened, learn and share lessons, and take action to reduce the risk of a recurrence. The decision that an event should be categorised as a serious incident is made by an executive director.

The Trust declares an average of around 18 SIs each month. The largest proportion of these SIs (around 40% of the total) is made up of hospital acquired pressure ulcer incidents, which are all investigated thoroughly and reviewed by a dedicated Scrutiny Panel in order to identify potential learning and support the delivery of a Trust-wide improvement plan.

At the start of the 2018/19 year there were 151 open investigations,104 of which were overdue. By the 31st March 2019 there were 37 current investigations and only 1 that were overdue. The Trust has invested in a dedicated support team for Serious Incident investigations, which has led

to an improvement not only in the timeliness but also the consistent quality of investigations and the learning gained from them to support improvement planning.

Duty of Candour

In 2018/19, we further developed our communications and systems for being open for patients and families who use our adult services. In particular, we have changed our policy to make it clearer how patients and families can be involved in an investigatory process if they want to be.

In accordance with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 all reported patient safety incidents that result in Moderate harm, Severe harm or Death require the Trust to provide a notification in person to the patient or their representative (as soon as possible after the incident is identified and within 10 working days) which must include a summary of the incident; an apology; and details of further enquiries to take place. This must then be followed up with a notification in writing. A record must be kept of compliance with these steps.

The Trust uses the Datix incident record for this purpose, to enable compliance to be monitored and reported on.

The Datix system has now been updated to provide clearer guidance to users when recording compliance with Duty of Candour requirements, and regular information continues to be provided to divisional management as well as to the Trust Board and its Quality Governance Committee along with the Patient safety Group to support improved compliance.

From January 2019 a mandatory e-learning module on Duty of Candour has been introduced for all patient-facing and clinical governance support staff. The Trust has also commissioned an animated educational video, which has been published on our YouTube channel.

CLINICAL EFFECTIVENESS

We will ensure that each patient receives the right care, according to scientific knowledge and evidence-based assessment, at the right time in the right place, with the best outcome.

Understanding, measuring and reducing patient mortality

Over the last year, the Trust has continued to monitor the number of patients who die in hospital and those who die within 30 days of discharge. This is done using the two main tools available to the NHS to compare mortality rates between different hospitals and trusts: Summary Hospital Mortality Indicator (SHMI) produced by NHS Digital (formerly the Health and Social Care Information Centre) and the Hospital Standardised Mortality Ratio (HSMR) produced by Dr Foster.

The Trust has developed a 2018-2021 Mortality Reduction strategy, to ensure there is an effective mortality review programme in place that identifies areas for improvement, and an effective governance structure that monitors delivery of improvements. In turn and together with a focus on complete and accurate clinical documentation and coding, and high quality care being delivered this should reduce the Trust standardised mortality rates.

The mortality programme will ensure:

- All cases where patients have died are reviewed by the Medical Examiner and if there is concerns the cases are escalated for an in-depth review or investigation
- An independent case note review or an investigation will be completed if identified at the initial screening by the Medical Examiner there were failings in the care to provide additional assurances and ensured the Trust is compliant with national guidelines
- Mortality rates are monitored to identify trends and areas of emerging concern
- Findings from all mortality reviews are shared for learning at the appropriate level to ensure risks are identified and acted on
- Where mortality reviews have shown that care falls short of the agreed standard, focused actions are identified to improve care and service delivery
- Processes are in place to support accurate and thorough clinical documentation and coding
- The Trust is working to deliver and implement 7 day services
- Staff are adhering to the completion of care bundles for specific conditions
- There is appropriate escalation and rescue of the deteriorating patient

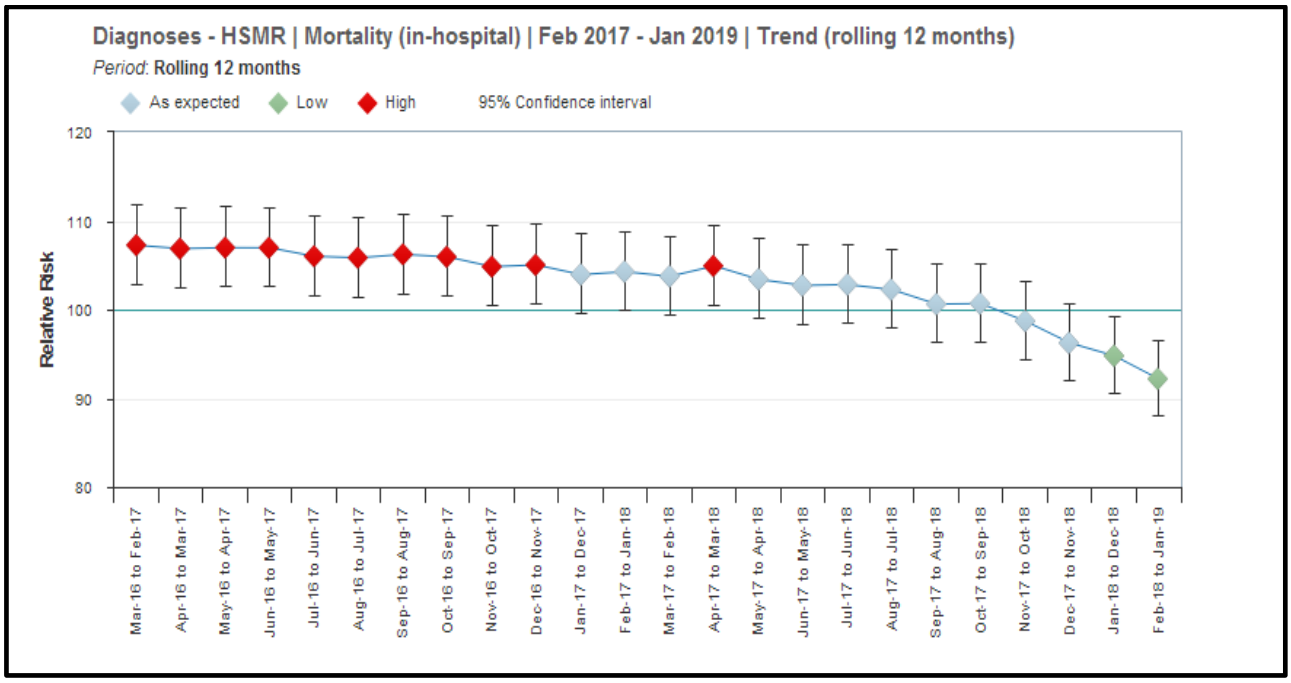
HSMR compares an organisation’s actual number of deaths with their expected number of deaths. The prediction calculation takes into consideration the following criteria:

  - Age of the patient
  - Gender
  - Primary Diagnosis
  - Mode and method of admission
  - Admission for the previous 12 month period
  - Palliative Care

- Co – Morbidities

Standardisation of the ratio allows valid comparison between different hospitals.

HSMR February 2017 – January 2019



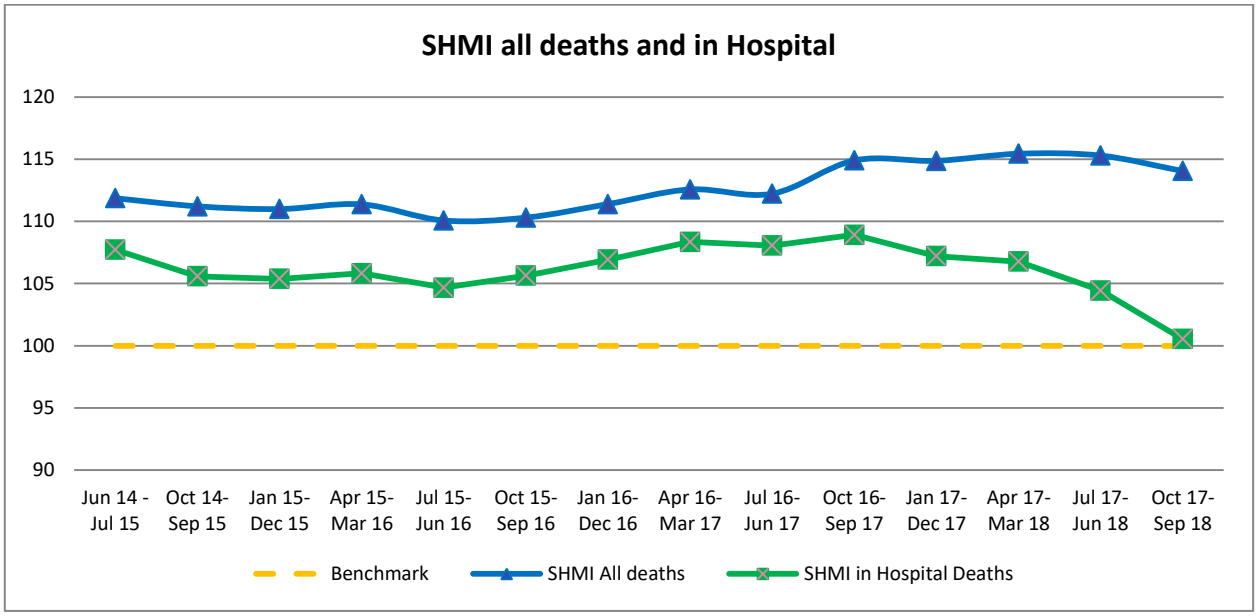
From April 2018 the Trust has been consistently below the national standard of 100. The data is published with a 3 month time delay.

SHMI reports on the number of deaths and covers all deaths reported of patients who were admitted to non-specialist acute Trust in England and either die while in hospital or within 30 days of discharge. The data can be separated into in-hospital and out of hospital (within 30 days) to enable detailed analysis of the Trust.

The expected number of deaths is calculated from a risk adjusted model developed for each diagnosis group that accounts for the following:

- Age
- Gender
- Primary Diagnosis
- Method of admission
- Co-Morbidities

SHMI Jun 14 – Sep 18



The Trust is demonstrating a reduction in SHMI and due to the six month time delay with the data the forecast is for the SHMI is to continue in line with the HSMR data. The SHMI for in-hospital deaths has reduced to being within the national average, however the SHMI for 30 days of discharge is above expected. The Trust is working with the community teams to ensure patients are not being admitted inappropriately and they have appropriate care planning in the community setting.

Seven Day Services

ULHT is committed to delivering high quality services that ensure equity of access for all patients 24 hours a day, seven days a week. The Trust participated in the April 2018 national audit for seven day hospital services against the four clinical priority standards:

- Standard 2 - All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.
- Standard 5 - Access to Consultant-directed Diagnostics within one hour if critical, 12 hours if urgent and 24 hours for non-urgent patients
- Standard 6 - Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.
- Standard 8 - Patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours.

The process for submitting the data on seven day services has changed from February 2019. The Trust had to submit a Board Assurance Framework (BAF) detailing their compliance with the four clinical priority standards from the audit completed in April 2018. The submission of the BAF will be the expected process going forward. The BAF will be presented at Quality Governance Committee and upwardly reported to Trust Board prior to being submitted nationally.

The Trust has made improvements since commencing the audits, however, the Trust is not achieving the 90% standard for clinical standard 2 - senior review within 14 hours of admission. The Trust achieved 79% and for the audits to be conducted in April 2019 the Trust will focus on the specialties not achieving the 90% standard.

The following are also being adopted to improve our time to senior review (Clinical standard 2):

- Consultant job planning to be conducted yearly
- Implementation of Getting It Right First Time (GIRFT) across the Trust to reduce variation
- Implementation of the Clinical Services Review and adoption of the Clinical Strategy

For clinical standard 5 the Trust is non-compliant for ultrasound and echocardiography at the weekend. For all other diagnostic services the Trust have them available on all sites. The implementation of the Clinical Services Review and adoption of the Clinical will resolve this.

For clinical standard 6 the Trust has achieved 24 hour access to the required services

For clinical standard 8 the Trust achieved 89% for twice daily reviews compared to the 90% standard. The non-achievement is due to the weekend compliance. The Trust to ensure stable patients on a clear pathway have detailed clear plans established on Friday by the parental team.

The Trust currently has multiple work streams dedicated to the delivery of improved patient flow through the organisation. Whilst many services are delivered on a seven-day basis, in other services there remains a differential between week days and weekends. There is however clear clinical commitment to move towards seven-day services within our Divisions.

Trust Operating Model (TOM)

The Trust is beginning to transform how we work, with our staff and patients at the centre of all that we do. Over the coming years we have the opportunity to really develop, through the implementation of our 2021 strategy, supported by the Lincolnshire Sustainability and Transformation Partnership (STP).

We believe that to successfully achieve all we want to for our patients, we need to radically rethink how we are organised. The TOM will be a new way of working, which will set out how we are organised and who does and is responsible for what. This will enable decisions to be made more closely to the clinical teams and to be consistent across the organisation.

It will involve a shift in the way we work and are managed as we will merge our specialty teams to one ULHT team per specialty. This is an opportunity to reduce variation in managerial and clinical processes between our sites and services, for the benefit of our patients and staff.

The Trust went live with TOM on the 1st April 2019.

Clinical Services Review

The Clinical Service Review Programme is a programme of work that looks in depth at how our clinical services are performing from the perspective of; Access, Quality, Deliverability and Finance

The Service Review Programme currently underway within ULHT has completed full reviews of the following services:

- Trauma & Orthopaedics
- General Surgery
- Review of peripheral sites:
- Respiratory Medicine
- Ophthalmology
- Urology

The service review process focusses on access, quality, deliverability and finance, and the reviews completed to date have produced exciting ‘blue prints’ for the services that will see changes in workforce skill mix to address some of the challenges in clinical recruitments, new clinical pathways being implemented to eliminate variation and improve the patient experience, changes to service delivery models to embrace new activity and financial savings.

Getting it Right First Time (GIRFT) Programme

Getting It Right First Time is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between Trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

Importantly, GIRFT is led by frontline clinicians who are expert in the areas they are reviewing. This means the data that underpins the GIRFT methodology is being reviewed by people who understand those disciplines and manage those services on a daily basis. The GIRFT team visit every Trust carrying out the specialties they are reviewing, investigating the data with their peers and discussing the individual challenges they face.

The national GIRFT team have already reviewed Radiology on 16/11/18 and Hospital Dentistry on 22/11/18 with resulting action plans being agreed with the Clinical and Divisional Management Teams.

Clinical specialities to receive a GIRFT review will include:

- Endocrinology is having a GIRFT review in July 2019
- Cardiology, ULHT has received an invitation to participate in the review, dates are being arranged at the current time
- Critical & Intensive Care – Deep dives have started, and we are awaiting an invitation for a review
- Anaesthetics – Sending out deep dive invites, and we are awaiting an invitation
- Pathology Services – Sending out deep dive invites, and we are awaiting an invitation.

The GIRFT programme is extending beyond clinical services to cross-cutting areas including:

- Clinical Coding
- Procurement
- Litigation
- Patient Safety
- Strategic Clinical Changes
- Medicines Optimisation
- Frailty

Our 2021 strategy

At ULHT we want to be excellent in all that we do, providing the most effective, safe and personal care for every one of our patients.

Our 2021 strategy sets out our intention to provide consistently high quality patient-centred care. We want to build a reputation for being a learning organisation, supported by Centres of Excellence. We want to encourage our staff and patients to develop ideas for improving the way we deliver our services, ensuring that we are valuing our patient's time.

We have been developing our vision and ambitions with our staff, volunteers, patients, carers and stakeholders, with the original launch at the end of 2017. This has been further supported by the development of our objectives, strategic and tactical priorities.

Our purpose:
We are here to deliver the most effective, safe and personal care to every patient through our team of safe, skilled, compassionate, dedicated and valued staff.

Our vision:
We will provide excellent specialist care to the people of Lincolnshire, and collaborate with our local partners to prevent or reduce the need for people to be dependent upon our services.

We want to be a learning organisation proving high quality care. We are proud of our vision for the future, and we want to build on all our wonderful achievements, to strive for and organisation that we can all be proud of.

As a Trust, we want to be known and recognised for providing consistently safe high quality care for our patients. Underpinning our vision are our values, where we want to demonstrate behaviours outlined in our Staff Charter and Personal Responsibility Framework. Our values are;

- Patient-centred
- Safety
- Excellence
- Compassion
- Respect

We have set our ambitions, which will deliver our vision through setting clear outcomes, objectives, strategic and tactical priorities, which are outlined below:

Our Patients			
Outcome:	**Objectives:**	**Strategic priorities for 2021:**	**Tactical priorities for 2019/20:**
Providing consistently safe, responsive, high quality care	o Harm Free Care o Valuing Patient Time	Learning and Safety Culture	o Learning from Experience o Patient Experience
Our Services			
Outcome:	**Objectives:**	**Strategic priorities for 2021:**	**Tactical priorities for 2019/20:**
Providing efficient, effective and financially sustainable services	o Zero Waiting o Sustainable Services	o Estates o Financial Recovery o Digitisation	o GIRFT o Theatres o Urgent & Emergency Care o 62 Day Cancer o Data Quality o Immediate Fragile Services Fixes
Our People			
Outcome:	**Objectives:**	**Strategic priorities for 2021:**	**Tactical priorities for 2019/20:**
Providing services by staff who demonstrate our values and behaviours	o Modern and Progressive Workforce o One Team	o Future Workforce o One Team o Quality Improvement Programme	o TOM o Recruitment
Our System/Partners			
Outcome:	**Objectives:**	**Strategic priorities for 2021:**	**Tactical priorities for 2019/20:**
Providing seamless integrated care with our partners	Service Integration	Partnership Working – Governance and strategy definition in line with STP	Pathway Redesign (3 STP and 6 Community commitments)

We need to make sure that every activity we undertake, every decision made and every minute spent has our patients at the heart of it.

We have been making progress with our Transformational changes through our 2021 Improvement Programmes. Each of these programmes are led by an Executive Team member, which contributes to delivering the 2021 Strategy.

And our five improvement programmes:

- Improving quality and safety
- Saving money and improving our environment
- Redesigning our clinical services
- Delivering productive services
- Developing the workforce to meet future needs

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Our ambitions

Our Patients

Providing consistently safe, responsive, high quality care

We will do this by:

- providing harm free care to our patients
- valuing our patients' time

Our Services

Providing efficient and financially sustainable services

We will do this by:

- promising zero waiting for our patients
- providing sustainable services

Our People

Providing services by staff who demonstrate our values and behaviours

We will do this by:

- developing a modern and progressive workforce
- working as one team

Our System Partners

Providing seamless integrated care with our partners

We will do this by:

- working with our partners to provide integrated services

2021
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A great ULHT

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Our values

Patient-centred

Putting patients at the heart of everything we do, listening and responding to their needs and wishes

Respect

Behaving and using language that demonstrates respect and courtesy to others. Zero tolerance to bullying, inequality, prejudice and discrimination

Excellence

Striving to be the best that we can be. Innovating and learning from others

Safety

Following ULHT and professional guidelines. Speaking up to make sure patients and staff are safe from harm

Compassion

Caring for patients and their loved ones in ways we'd want for our friends and family

2021
A different Lincolnshire
A great ULHT

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Ward Accreditation

Ward accreditation is a way of the organisation promoting standardisation and reducing unwarranted variation, whilst recognising the diversity and differences between staff and patient groups and localities. The continuing accreditation process provides assurance to the Trust of the current situation in the adult inpatient and emergency areas within ULHT, also offering the assurance that as these accreditations and the associated work promotes and develops the embedding of evidence based practices and culture.

The Trust launched the Emergency Departments (ED) accreditation tool in October 2018. Since the rollout the Quality Matrons in conjunction with the Childrens' improvement lead nurse and colleagues from infection prevention and control (IPC) team, have visited Pilgrim ED monthly, including a night-time visit. During November and December there was a quality matron in the ED most weekdays undertaking check and challenge, supporting interview processes, assisting staff with departmental organisation and cleanliness, also ensuring all members of the Quality Matron team became familiar friendly contacts for the ED staff.

On the 1st January 2019 the Trust launched the revised ward accreditation metrics. The revised metrics have seen changes in some details within the accreditation standards and some of the processes by which the information is obtained.

The ward accreditation system now involves greater observational assessment, making the process more robust. The assessing team now ensure they witness practice and collate visual evidence to support the information that ward teams and pre-visit datasets are telling them.

The assessments are undertaken by the Quality Matrons who are a team of senior nurses with extensive nursing experience, from a variety of backgrounds and localities. The team support staff within the Trust to provide safe, effective care and the best possible experience for our patients' through consistently demonstrating and delivering excellent standards".

The current RAG status of the wards - March 2019.

Current position	Grantham	Lincoln	Pilgrim	Total
Green rated Wards	5	12	6	23
Amber rated wards	0	8	5	13
Red rated wards	0	0	2	2
	5	20	13	38

The current RAG status of the Emergency Departments - March 2019.

Current position	Grantham	Lincoln	Pilgrim
	Amber	RED	RED

Scoring criteria:

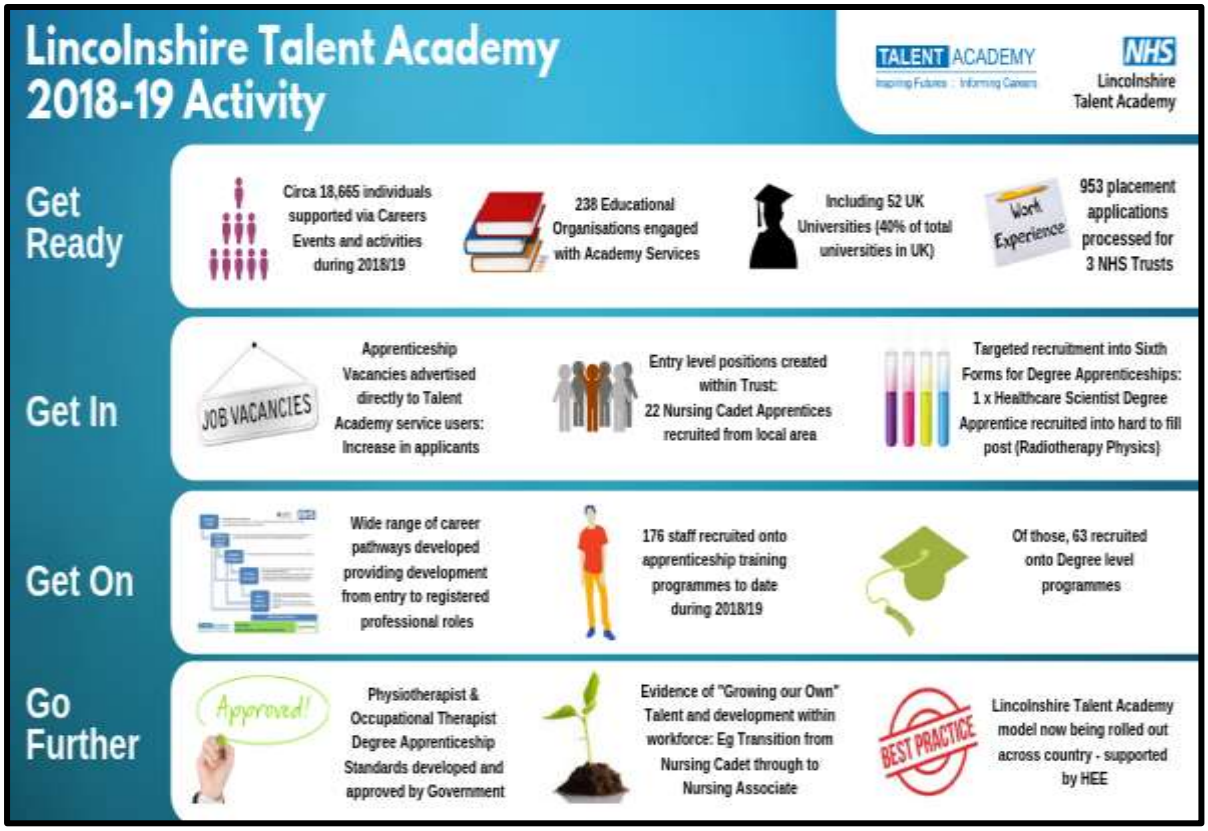
Overall Ward Score			
Red	**IP&C Red or 5 red standards or more in total**	**Level 0**	Reassess at 2 months
Amber	**3-4 red standards and/or less than 7 green standards in total**	**Level 1**	Reassess at 4 months
Green	**1-2 red standards and a minimum of 7 green standards in total**	**Level 2**	Reassess at 9 months
Blue	**3 consecutive green WHAM assessments**	**Level 3**	Reassess in 12 months

Lincolnshire Talent Academy

Lincolnshire Talent Academy, initiated by ULHT, provides a central interface for staff and general public to engage with a wide range of careers and education services. The Academy works on behalf of the Lincolnshire Health and Care system, of which ULHT is now the main stakeholder, and has been recognised as best practice by Health Education England resulting in the model being cascaded nationally.

The service delivers activities across 4 strands, representing the Talent for Care Framework – Get Ready; Get In; Get On; Go Further:

Details of ULHT activities can be seen on the infographic below:



Each strand has specific services delivered under them, all of which are delivered in context for ULHT, whilst also being replicated across the wider Lincolnshire health and care system in order to support our system-wide working and integration.

The centralised Work Experience Service developed by the Trust and currently supporting the Lincolnshire Health and Care system is to be expanded to provide national service. The Academy, which to date has delivered in excess of 2,300 placements over the last 3 years, is currently working with other Trusts as we start to incorporate them into the system. The system is currently used by students and the general public looking for experience, or exposure to the range of careers in order to inform future career choice, and to support their onward education or employment. This service is critical for ensuring the Trust, and wider healthcare system, remains at the forefront of individuals minds for their career.

The use of Apprenticeships within ULHT continues to increase as a result of targeted Career Pathway development, supporting the Trust to grow its own skills aligned to future workforce needs. The apprenticeship programme is now embedded within the organisation and provides development across all levels, from entry level through to professional registration.

For National Apprenticeship Week, the Academy launched its #NHS100Challenge – challenging the 3 Lincolnshire NHS Trusts to recruit 100 apprentices in 100 days. The challenge, which is due to conclude on the 11th June 2019, is supported by a marketing and media campaign which is still underway. To date, the campaign has resulted in a significant increase in enquiries from within the organisation as we seek to widen the opportunities for education and training across the Trust, with a focus upon areas of skills shortage.

The Talent Academy and Trust have been successful in the development and approval of the National Physiotherapist and Occupational Therapist Degree Apprenticeship. As a result, the programme is now available from April 2019 nationally and has been included within ULHT's workforce plans. The first apprentices are due to commence this new national programme from April 2019.

The Trust currently has in excess of 170 staff on apprenticeship programmes, the majority being within clinical roles – Healthcare Support Workers and Trainee Nursing Associates due to workforce demand. Additional planned apprenticeship posts scheduled for the next 6 months include: Registered Nurse, Physiotherapist, Occupational Therapist, Operating Department Practitioner, Midwife. In addition, we shall be commencing a range of Leadership and Management Apprentices in May and June.

In addition, the Talent Academy continues to develop and support entry level apprenticeship posts as part of our "Grow our Own" pathway. Roles include Nursing Cadets and Administrative Apprentices. Each post has been designed to provide the foundation training and education for individuals with no prior experience. To date, all of our entry level apprentices have progressed into established roles, thereby reducing the term of recruitment whilst allowing us the opportunity to develop the skills required for each area.

Paediatric Services

The interim model for children's & young person's services was introduced on the 6th August 2018 due to safety concerns arising from a culmination of factors over several years which led to a high number of medical vacancies at middle level. Combined with difficulties in recruiting consultants, and children's nursing vacancies which exacerbated this problem.

The model implemented in August 2018 at Pilgrim is a 12 hour length of stay model. Children admitted to the unit would be assessed, hospital treated, stabilised and discharged. Children requiring care beyond 12 hours are transferred to the Lincoln Hospital or to another acute trust. A full and complete standard operating policy is in place.

The Trust deployed a dedicated ambulance service to ensure that patients reaching the 12 hour standard or requiring urgent emergency care could be transferred quickly and safely. Since the introduction of the dedicated ambulance service there have been no instances where an ambulance has not been available to meet the needs of the service. The maximum number of children transferred to Lincoln on any single day has been three.

Since the introduction of the Children and Young Person's Assessment Unit (CYPAU) in August 2018 at the Pilgrim hospital there has been a significant improvement in throughput coupled with an improving patient experience. During the first twenty six weeks of operation of the new service model, 1,869 patients have been assessed and treated in the CYPAU with 203 patients

transferred to other units. This suggests that, while there is not a requirement for an inpatient ward at Pilgrim, there is a requirement for a CYPAU due to rurality and distance between sites.

The Trust has invested in designing new and dynamic ways to recruit. The team have reviewed adverts to ensure they are not only fit for purpose but enticing. The HR department have more recently employed a subject matter expert on recruitment, the service are working closely with HR in order to capture a wider market.

The Trust has appointed an interim children's lead. There is now support, via NHSI, from a lead children's nurse who is supporting work for the Hidden child. More recently a Childrens lead nurse has been on secondment to work with the team. A new Trust operating model has been designed and this will go live on the 1st April 2019. Recruitment for a substantive lead paediatric nurse is ongoing.

Since the introduction of the interim model, the Trust and service have carried out extensive staff and public engagement. This helps to understand people's experiences of using the service, concerns, and helps to mitigate any concerns where possible, whilst using the findings to inform future service design.

A survey has been completed which attracted 805 responses, and since August 2018 the Trust and service have facilitated five public engagement events at Pilgrim hospital, attracting over 100 attendees in total. The service has undertaken face to face engagement at 24 different groups in the Boston and Skegness areas, including parents and toddler groups and children's centres.

Findings and opinion on the provision of services vary widely according to geography, age and demographics of the patients. The general consensus has been that parents want assurance that emergency children's services will remain as close to home as possible, but acknowledge that they may sometimes have to travel for specialist/ outpatient services.

As a result of the findings from public engagement, the service leads and team have worked with our partners, staff and patients to look at specific issues including: open access families, transport for transfer of patients, clarity around service specifics including length of stay on the CYPAU and additional support for families whose children are transferred.

Grantham A&E

Due to our staffing difficulties a number of our services remain fragile. The services this affects include urgent care, paediatrics and breast services. The A&E department unfortunately remains closed at Grantham overnight (6.30pm to 8am) due to a shortage of staff. Significant efforts have been made to recruit additional staff, but despite this sufficient staff have not been recruited to populate three rotas. Work remains in progress with partners to secure the long-term model for urgent care across Lincolnshire.

PATIENT EXPERIENCE

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning to improve patient experience.

The plan is created through conversations between a person and their health professionals. The plan is recorded on a form and includes their personal priorities for care and agreed clinical recommendations about care and treatment that could help to achieve the outcome that they would want, that would not help, or that they would not want.

ReSPECT can be for anyone, but will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons.

A regional task and finish group was created and Lincolnshire introduced ReSPECT in February 2019. Training started in 2018 and has continued beyond the launch. Patient and public engagement have been delivered in collaboration with different organisations. The CCG and ULHT communications department have worked together for the launch.

Patient Complaints

The Trust values the contributions patients and their carers have made to its patient surveys, complaints and compliments. The table below provides a summary of the key complaints performance indicators monitored within the trust:

Measure	Target	2018/19	2017/18
New complaints received	N/A	739	744
Acknowledged all complaints within 3 days	95%	95%	95%

Where a breach of the agreed completion date has occurred, Heads of Service and Clinical Directors are informed so they can support and reinforce the importance of staff completing the investigations within the timescales agreed.

The total number of new complaints received in 2018/19 is 739 which represents a slight decrease of 5 from the total received in the previous year. The main themes resulting from complaints are detailed in Table below:

Themes	Action Taken
Clinical Treatment	Development of specific pathways to ensure evidenced based care aligned to NICE and best practice
Communication	Bespoke in house training programme developed
Values & Behaviours	Staff charter developed
Patient Care	The Trust has developed the Ward Accreditation programme to ensure patient care is meeting the required standards. This has now been rolled out to all inpatient wards and A&E.
Admissions & Discharge	The Quality matrons are reviewing the discharge processes. The Electronic Discharge Document (eDD) has been streamlined and relaunched.

The Trust recognises that in the majority of instances it is best to resolve issues as soon as possible. The Trust uses a variety of ways to encourage concerns to be raised immediately with the person in charge of the patient's care, such as complaints patient information leaflets and complaints posters. Alternatively contact details are provided for the PALS service and the the Complaints Team.

During 2018/19, the Parliamentary and Health Service Ombudsman (PHSO) notified the Trust of its intention to investigate 19 complaints. Of these, 9 were rejected, 6 currently being investigated, 3 are awaiting a decision to investigate and 1 investigation has been fully completed and closed.

The Trust is in the process of redesigning the complaints process to ensure the complainants receive a timely and quality response to their complaint and lessons are triangulated and promulgated throughout the Trust.

FAB Champions

We are really excited to launch our FAB Experience Champions network across the Trust. This is about building and strengthening our Patient Experience Ambassadors (PEAs) work from last year and supporting all our teams and services to identify / seek / volunteer someone to be their FAB Experience Champion (see the handy poster overleaf). Current PEAs will be 'morphed' into our new champions

Our aim is for every service to have a FAB Experience Champion; they may share with another team but ultimately the patient experience team have a link, a go to person, someone with a passion and interest who we can work with, liaise with and train to even greater FABulousness.

Our patients experiences are a critical factor in our quality improvements and service developments and our 2021 plan puts patient centred care at the heart of all that we do. The patient experience team is small and we want to be able to hone in and support where it's needed and wanted and help with initiatives and events and training and information. We can do that best if we have a named person to go to and for your FAB Experience Champion they then have, on behalf of your team and service, someone they can go to as well.

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Do you want to make a real difference to patients, their families and their carers?

Are you passionate about patient and carer experience?

fab Experience Champions

Do you have any ideas to improve patient experience?

Interested in the Academy of Fabulous Stuff and how it works?

If you've answered "Yes" to any of these questions, you could be a FAB Experience Champion for your area!

We see our FAB Experience Champions (there for our patients, their families or carers) being champions as well as empowering staff to drive forward positive patient experiences by listening, learning, responding to feedback and helping others to do the same.

FAB Experience Champions will:

- champion all patient experience data received into the trust for their specific ward/department
- establish a staff resource folder
- keep team members aware of current patient experience trends locally and nationally
- ensure ward/department's patient experience data is shared with all staff and patients
- promote the use of patient and carer feedback to make positive changes to the experiences of patients, families and carers
- support and actively promote the Academy of FAB Stuff
- ensure the needs of carers are identified and supported. Updating carers on the Caring for Carers badge and to the external support available from Carers First.
- be the liaison with the patient experience team.

Who can be a Champion?

A FAB Experience Champion needs to be someone with a passion and an energy for getting involved with and promoting and supporting the patient experience agenda.

It can be anyone of any role; it can be a clinician or administrator – the essence is being outgoing and approachable and being recognised within the directorate as the champion for patient experience.

What are the advantages to being a FAB Experience Champion?

- Personal and professional development in terms of understanding and appreciating the significant patient experience agenda.
- Opportunity for 1:1 and group training from the patient experience team on national, regional and local patient experience data and initiatives.
- The ability to network and provide and receive support from other champions across the Trust.
- Regular FAB Experience Champion meetings (bimonthly), newsletters and What's App group
- Resource folder
- Ward accreditation metric
- Training framework
- Protected time!

Where can I find out more?

Please contact: Sharon Kidd, Patient Experience Manager,
Email: patient.experience@ulh.nhs.uk Telephone: 01476 464560/07799 968206

Single Unified Patient Experience Reporting Board

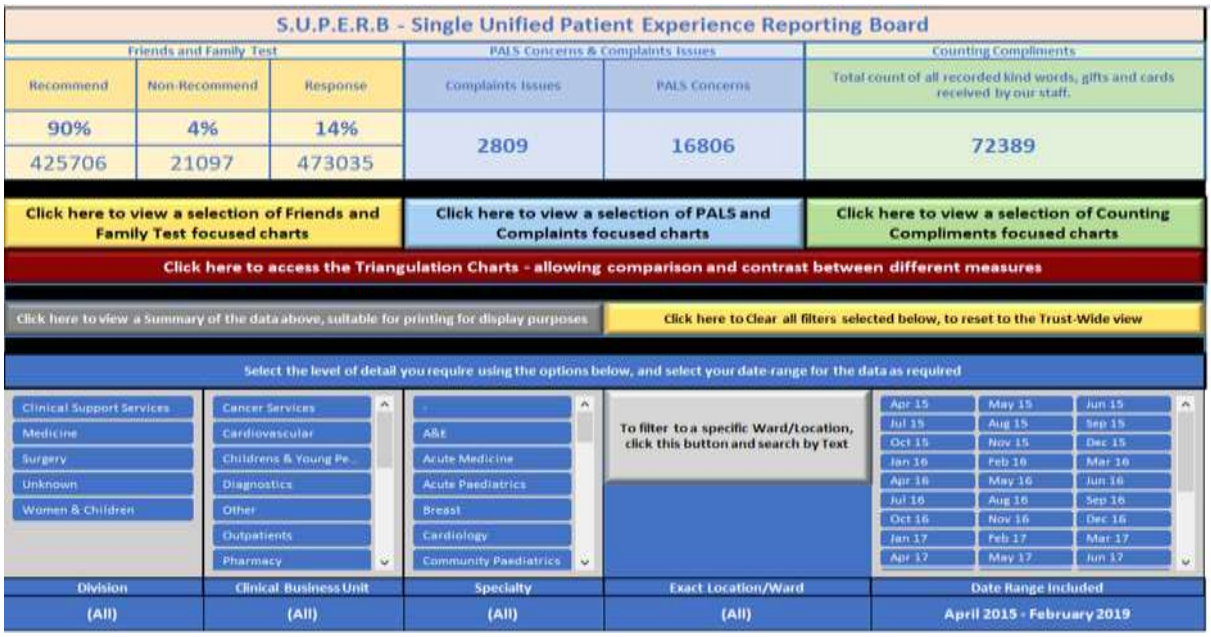
Single Unified Patient Experience Reporting Board (SUPERB) is a dashboard to allow for interactive visualisation of various different Patient Experience metrics. This tool allows everyone from individual staff up to the Chief Executive to be able to easily see a much fuller picture of 'their world' from the Patient Experience perspective, and not only see a fixed snapshot of the state of play but be able to track changes occurring over time.

Prior to the development of the dashboard there were a large number of subtly different reports generated on a monthly basis and manually distributed to various different teams across the Trust. These reports were static and as such there was emphasis placed on a score 'now' being good or being bad, but drawing any longer term trends around improved or declining Patient Experience behaviours was nigh on impossible.

Rather than just focussing on a single element of Patient Experience data, this brings together (currently) FFT, PALS & Complaints and Compliments from all across the Trust and gives the opportunity for comparisons and contrasts to be drawn between them all. No single measure should ever be the 'be all and end all' and this tool therefore allows for easier presentation and interpretation as to the 'bigger picture'. As well as this, rather than being a static 'scorecard' individuals can set the dashboard to only show data relevant to them and their field of interest, therefore removing any unnecessary data that may hide a key learning point from becoming apparent.

Through the introduction of this dashboard there is an aspiration that greater ownership of Patient Feedback will be taken across the organisation.

SUPERB dashboard



National Cancer Patient Experience Survey

The NHS England National Cancer Patient Experience Survey was published in Sep 2018 (2017 results) for ULHT.

The average rating given by respondents when asked to rate their care on a scale of zero (very poor) to 10 (very good), for non-tumour specific questions, was 8.6, against a national average of 8.8.

The average rating given by respondents when asked to rate their care on a scale as above, for tumour specific scores, was 8.7, against a national average of 8.8.

In 2017, the Living With Cancer and Beyond Strategy for Lincolnshire was developed, for 2017-2019, which set out it's aims to change and improve the experience of people living with cancer in the county, to transform and move towards an holistic person centred approach that is well co-ordinated and integrated. ULHT is working in partnership with the Living with Cancer Team, which has been developing over the last 18months, to build system wide relationships, to support delivery of the programme.

The Living With Cancer Strategy for Lincolnshire 2019-2021 has recently been completed, and this builds on the foundations which have now been set, continuing a collaborative systems working approach, setting out the delivery plans for the next 2 years.

We have secured considerable funding from Macmillan and the East Midlands Cancer Alliance to help us meet our objectives. The funding means that we can carry on our work until May 2021 which gives us more opportunity to transform support for people living with cancer.

A workforce and service review of the Information and support centres on each site will be taking place, to look at how we might improve the access to this service, as well as the offer and completion of HNA's within the centres.

The results from the 2018 survey are expected to be published the end of August/September.

Staff charter

NHS
United Lincolnshire Hospitals
NHS Trust

Safety

What we expect to see from you	What you can expect from us
You raise concerns of risk, safety and quality of patient care as quickly as possible in accordance with Trust policies	We will keep you safe at work and listen when you raise concerns of risk, safety and quality of patient care. We will take action and feedback
You keep you and your colleagues' working environment safe, clean and tidy	We are committed to creating safe, clean and tidy working environments
You are professionally inquisitive, seeking to learn from experiences and improve what you do	We are committed to learning and development, so that the Trust can improve what it does and you can develop as individuals

Compassion

What we expect to see from you	What you can expect from us
You meet our patients' personal daily needs sensitively and compassionately	We will support you in putting the needs of patients and families first
You are thoughtful of others' feelings when giving bad news or negative feedback	We will support you when giving bad news or negative feedback to others
You will help and support those when needing assistance or guidance	We will help and support you when you need assistance and guidance, both at work and in your personal life
You take responsibility for your own health, wellbeing and personal needs	We will support you in taking responsibility for your health and wellbeing, listening to you when you need us and providing support when you are unwell, helping you return to work

Patient-centred

What we expect to see from you	What you can expect from us
You give your full commitment to provide high quality, safe patient care and support their families and carers when our patients wish or need them to be involved	We are committed to creating the environment, and providing support and the resources required to provide excellent, safe care to our patients, families and carers
You keep patients, families and carers up-to-date with treatment being delivered and communicate with integrity, honesty and respectfulness	We will provide you with up-to-date information and will equip you to communicate with patients with honesty, respectfulness and integrity
You are responsible for all patients, families and carers even when not directly in your care	We will promote an environment where together we focus on the needs of patients, families and carers, both those directly and indirectly in your care
You see things from the patient, families and carers perspectives, and listen to seek understanding of their needs	We will support you in meeting our patients' priorities

Excellence

What we expect to see from you	What you can expect from us
You carry out your role professionally, with a smile and make time to listen to patients and colleagues	We will be professional, smile and available to listen when you need us
You are accountable and responsible for your actions and represent ULHT in a positive manner, both when at work and out of work	We will create the right organisational structures and set out clear accountabilities and responsibilities for all staff job roles, professions, teams/services and patients
You are supportive, helpful and reliable, and together with your colleagues achieve the Trust's ambitions and objectives. You understand your role, its standards, expectations and objectives set	We will lead by example and ensure positive behaviours are role modelled and deal with those that do not. We will set clear standards with realistic expectations and objectives

Respect

What we expect to see from you	What you can expect from us
You are always welcoming, friendly and respectful to others. You do not bully, and you challenge those if you experience negative behaviours	We will treat you with respect, value you, your professional expertise and your work. We will deal with those who bully, no matter who they are
You show empathy and are considerate when discussing sensitive and confidential issues with patients and colleagues	We will respond quickly, sensitively and confidentially when dealing with colleague and patient concerns
You recognise people are different and will be non-judgemental, fair and equitable to all	We will manage all our staff consistently, fairly and equitably and we will keep you up-to-date with the latest Trust news. We will inform and invite you to take part in discussions affecting your role and listen to your ideas

2021
A different Lincolnshire
A great ULHT

Excellence in rural healthcare

Developing the workforce to meet future needs

Overall ULHT's scores in the 2018 National Staff Survey are down from 2017 with particular concerns around equality, diversion and inclusion, health and wellbeing, quality of care, bullying and harassment and staff engagement. Whilst the results are disappointing, it is important to view them within the overall contact of a Trust in special measures for quality and finance and with significant issues around recruitment.

The scores for 'recommend ULHT as a place to work' declined to 41.4% in the 2018 survey from 44.1% and as 'a place for care' to 47.4% from 50.6%. It is evident that morale has not improved in the last year. Whilst we are pleased by the response rate to the survey (in line with the national average) and that scores associated with patient safety have improved, overall scores have declined once more. We will review the data and the free text comments and will identify the actions we can take, as part of our People Strategy, to reverse the decline in morale evident since the Trust went into double special measures

Unfortunately those reporting 'bullying, harassment or abuse from managers' increased from 15.9% in 2017 to 19.7% in 2018 and by staff, from 20.2% to 24%. After last year's results we ran a zero tolerance to bullying campaign, but this does not appear to have had an impact. We also initiated work to understand what lay behind the perception that people were being bullied. This work is coming to a conclusion and our view is that we need to do more work to:

- Improve the consistent quality of line management
- Provide vehicles through which people can safely talk about their experience of bullying
- Target certain vulnerable groups, such as newly-qualified nurses and junior doctors

We will not be producing a separate Action Plan but our People Strategy refresh will encompass the issues from the 2018 National Staff Survey and set out how we plan to improve over the next year. This will include the following priorities.

- Addressing the permanent/temporary workforce mix.
- Being clear around our 2021 narrative as a means to give hope to the organisation, ensure our future is seen to be as part of the Lincolnshire system and emphasise that patients (and not finance) are our top priority at all times.
- Re-establishing a connection between the Trust and its leaders and the people who work for it.
- A revised leadership strategy, building on the work undertaken to date
- Creating a sense that the organisation really cares about its staff (looking at the health and well-being issue more broadly)
- Building that sense of the Trust being an organisation with a consistent focus on safety and Learning
- Identifying and managing talent, so that people can build their careers with us
- People at all levels personally owing the challenges, rather than seeing that the solutions lie with the Trust Executives or Human Resources / Organisational Development

- Empowerment of staff and teams, through earned autonomy. Focus on team-building Invest in communications
- Understanding and addressing the issues about bullying and harassment

Equality Diversity & Inclusion

As a Trust, we value equality and human rights in everything we do, and are committed to work with our stakeholders to reduce health inequalities and value equality and diversity within our services and across the health community. We aim to ensure that the services we deliver meet the needs of the population we serve regardless of their age, disability, gender, race, religion/ belief, sexual orientation, marriage and civil partnerships, transgender and pregnancy/maternity.

We aim to continually develop and ensure that equality is incorporated into everything we do, as 'the golden thread' to all our activity. We value equality, diversity and inclusion and have set out our approach in our policies and practices with the aim of ensuring dignity and respect for all.

Since 2018 the Trust has an inclusion strategy which includes our equality objectives for the duration of the strategy 2018-2021. Our inclusion strategy can be accessed on the Trust website: https://www.ulh.nhs.uk/about/equality-diversity/equality-objectives/

The Trust also produces an equality, diversity and inclusion annual report which provides an update on the progress we have made in relation to equality, diversity and inclusion for patients and service users and also for our staff. This is published on our ULHT website.

Freedom to speak up

In October 2016 the Trust complied with the NHS Contract requirement to nominate a Freedom to Speak Up Guardian. As an organisation we are committed to investigating and taking appropriate action where concerns are raised with us, and have arrangements, including the Guardian to ensure staff who raise concerns are fully supported to do so. The Trust Freedom to Speak Up Guardian has lead responsibility to ensure that the appropriate handling of concerns is in place and the effectiveness of the local systems is considered by the board. The Trust has a Freedom to Speak Up Policy which describes the ways staff can speak up and assures them that staff who speak up will not suffer detriment.

How does the Trust support staff to speak up:

- Through its Voicing Your Concerns Policy
- Through the Freedom to Speak Up Guardian
- Through the commitment of the Board to champion the importance of raising concerns. The Board receives a quarterly report on speaking up.
- The FTSU Guardian meets regularly with the Trust Chief Executive

What should staff do if they have a concern:

- Where possible speak to their line manager
- Contact anyone named in the Voicing Your Concerns Policy
- Contact the Trust Freedom to Speak Up Guardian through the dedicated confidential email address freedomtospeakguardian@ulh.nhs.uk
- Make use of one of the national whistleblowing helplines for advice

Guardians of Safe Working

All organisations employing 10 or more trainee doctor trainees are required to appoint a Guardian of Safe Working. This principle was agreed as part of the negotiations around the 2016 junior doctor contract. The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by the Trust. The guardian role provides assurance to the employer that issues of compliance with safe working hours will be addressed, as they arise. The Trust has appointed two Guardians of Safe Working, one who has this responsibility for junior doctors employed at both Lincoln County Hospital and Grantham and District Hospital and a second for Pilgrim Hospital, Boston.

Each of the Guardians are making themselves very visible to the trainees in order to provide support and have run regular forums. This relationship ensures that the patients receive safe, high quality care from junior doctors, supported by the Guardians of Safe Working. Where junior doctors experience challenges to their contract, examples would be through working longer hours or insufficient time prescribed to educational supervision, then junior doctors are required to submit an Exception Report to their appointed Guardian of Safe Working. The purpose of this Exception Report is to highlight and patterns or trends which need to be addressed with particular specialities to ensure that safe working practices are achieved.

Performance information is currently being collected against the number of Exception Reports submitted, by specialty, by site and by reason. The Guardians report regularly to the Board through the Workforce & OD Committee and within their reports include details of the numbers of exception report and they draw out themes which we use to improve the experience of junior doctors at the Trust.

The Resourcing Team are working closely with the clinical leads to fully understand the requirements of the different grades of doctors in training within each discipline in order that a targeted approach to reducing rota gaps can be planned. Further work to review current processes, ensuring they are fit for purpose and aligned to provide the necessary expertise to support the Divisions and the Post Graduate Education Teams with the starters, leavers and rotations for doctor in training grades. The Resourcing Team will continue to respond to requests for support in reducing rota gaps and continue pursuing alternative solutions. The Trust will also be undertaking a review of the agency usage for doctor in training grades with the aim of implementing solutions to reduce the need for agency workers, which will include, effective rota

co-ordination and the option of rotational posts to fill rota gaps, this will be supported by the introduction of an internal Medical Agency and Bank Temporary Staffing Team, operational with effect from 1st May 2019.

PERFORMANCE AGAINST NATIONAL PRIORITIES AND ACCESS STANDARDS

NHS Improvement's Single Oversight Framework (SOF) has four performance metrics:

- Accident and Emergency (A&E) 4-hour waiting standard
- 62 day GP cancer standard
- Referral to Treatment (RTT) incomplete pathways standard
- 6-week diagnostic waiting times standard

The national standards are:

- 95% for A&E 4 hour waits
- 85% for 62 day GP Cancer
- 92% for RTT incomplete pathways
- 99% for 6-week diagnostic waiting times

Sustainability and Transformation Funds (STF) targets were agreed for each indicator at the start of the financial year; these were submitted to NHS Improvement as part of their monthly monitoring of acute Trusts.

Access Key Performance Indicators		Quarter 1			Quarter 2			Quarter 3			Quarter 4			2018/19	2017/18
		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19		
A&E 4 hours	Actual	70.23 %	74.79 %	74.83 %	71.76 %	72.26 %	69.92 %	69.14 %	64.66 %	67.92 %	65.53 %	64.21 %	71.22 %	69.75% Ⓐ*	70.47%.
	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
62 day GP Cancer	Actual Classic	78%	76.8%	72.1%	74%	82%	78.5%	75.5%	73.4%	69.2%	65.7%	61.3%	75.2%	73%Ⓐ	71.46%
	Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
	Actual Screening	90.5%	88.6%	83.3%	81.8%	91.2%	90.3%	87.5%	83.0%	71.4%	91.9%	89.5%	95%	87%	87.70%
	Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
RTT	Actual	81.70 %	85.32 %	84.29 %	83.83 %	83.26 %	82.03 %	82.84 %	83.74 %	83.07 %	84.64 %	84.87 %	84.73 %	83.69%	87.27%
	Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
6 week diagnostic	Actual	96.73 %	97.60 %	99.03 %	99.17 %	98.37 %	97.22 %	98.02 %	97.75 %	95.62 %	96.91 %	98.06 %	95.86 %	97.53%	97.64%.
	Target	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
C. Diff	Actual	9	8	3	2	6	4	5	5	6	4	0	5	57	69
	Target	4	4	5	5	5	5	5	5	5	5	5	5	58	59
VTE	Actual	97.58 %	96.59 %	97.37 %	97.30 %	97.54 %	96.11 %	95.94 %	95.81 %	95.24 %	97.40 %	96.61 %	96.46 %	96.66%	97.48%
	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Ⓐ Data subjected to external audit scrutiny as part of the process of producing this report
* For the A&E data only type 1 data has been subject to external audit which is 66%

Not Achieved

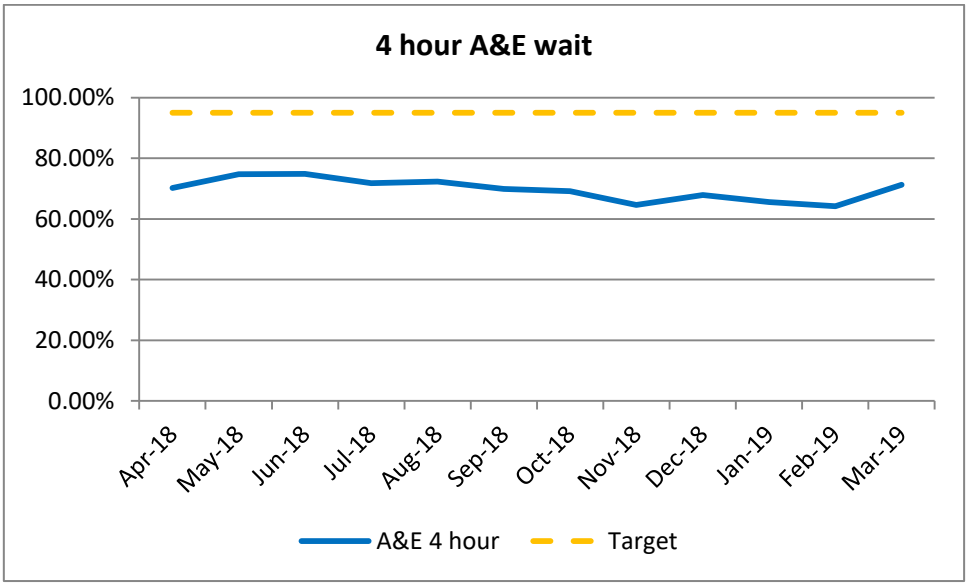
Achieved

Accident and Emergency (A&E) 4-hour waiting standard

A&E Performance remains well below trajectory. The department has been under increased pressure mainly from:

- Increased attendances in record numbers at Lincoln in February and again in March, well above plan and department capacity;
- Bed availability remains inadequate to cope with the demand and having to open additional beds throughout the winter in the ambulatory care area, one of few available spaces available which in turn prevents ambulatory care (designed to see and discharge patients within a day) from working properly, increasing admissions in itself;
- Medical staffing has been poor with a high reliance on locum doctors.

A&E 4 hour performance Apr 18 – Mar 19



The performance for the 4 hour A&E standard for 2017/18 was 70.47%.

ⒶA&E 4 hour performance is calculated as follows:

The denominator (total population for the metric) is defined as the count of all unplanned attendances in the reporting period at A&E departments, whether admitted or not. The numerator is the count of all unplanned attendances admitted, discharged or transferred within 4 hours.

Breaches of the 4 hour target are measured as the count of all unplanned attendances in the reporting period at A&E departments, who were not admitted, discharged or transferred within 4 hours.

Depending on the metric being viewed, this is either for just ULHT A&E departments, or includes co-located type 3 services (“streaming” services run by LCHS on the Pilgrim or Lincoln sites), or includes non co-located type 3 services (Minor Injury Units run by LCHS at Gainsborough, Louth, Spalding, Skegness; or the Sleaford out of hours service run by Sleaford Medical Group).

The metric on a daily basis is calculated showing all 3 variants above; on a monthly basis only the ULHT and co-located type 3 activity is included in the metric. The non co-located activity is not included.

Actions undertaken to improve performance

Although the 4 hour performance is below plan we have seen some localised improvements. At Pilgrim the footprint has been redesigned for the speciality beds and also created a new Integrated Assessment Unit (IAC) which sees any patient referred from A&E, regardless of speciality. This is a much faster way of seeing patients and making decisions and allows patients to leave A&E sooner.

The Trust has also started to review operating procedures around what happens when the A&E's are full to have more rapid response and faster patient transfer from the A&E balancing caseload better between the department and the wards. NHS Improvements Emergency Care Improvement Team are also now supporting the trust to develop its acute and emergency services. The Trust has introduced "Frailty Services" at Pilgrim Hospital and is reviewing the existing Frailty model at Lincoln.
The Trust has trained more staff in "triage", the assessment that takes place when patients first attend the department to ensure unwell patients are identified sooner. The standard of patients being seen within 15 minutes of arrival has been at its highest level for the last 3 years.

Ambulance handover delays remain too long. This means that once an ambulance has come to the hospital it is kept waiting when the departments are full which puts pressure on EMAS to attend urgent calls within the community. The Trust is developing Rapid Assessment and Treatment areas with new staffing models to support them. This will allow the organisation to better respond at times of peak pressure.

Although recruitment remains a challenge there are plans now in place, with staff appointed starting over the coming months, to fill more of the doctor vacancies at the consultant, middle grade and junior doctor tiers. Pilgrim Hospital has had some of the biggest challenges and the plan should take them to much smaller numbers over the coming months and into the summer.

Further to the external audit undertaken on A&E data, there was a problem uncovered at Pilgrim A&E in relation to patients who were streamed who then went on to the A&E department (deterioration or incorrect streaming). The clock start time for the A&E element was the time they went into the ULHT A&E department, rather than the earlier time they went into streaming. When the issue was identified a remedial plan was implemented to ensure this issue did not reoccur, the arrival time on Medway should reflect the time the patient arrived at streaming, as this is the patients perspective of being in the A&E department having gone through one front door.

85 records were identified for the period 1st October 2018 to 31st March 2019 that were recorded as waiting under 4 hours on Medway, that would actually have been waiting over 4 hours if the revised start time was used.

This would change the reported position over these 6 months from 67.18% to 67.04%.

Cancer 62 day waits

Cancer performance within the Trust was below the national standard for 14-day and 62-day during 2018/19. 31-day, first treatment and subsequent chemotherapy and radiotherapy were achieved during 10 of the 11 months; however 31-day subsequent surgery performance has been less successful, achieving the standard only 3 times during this period.

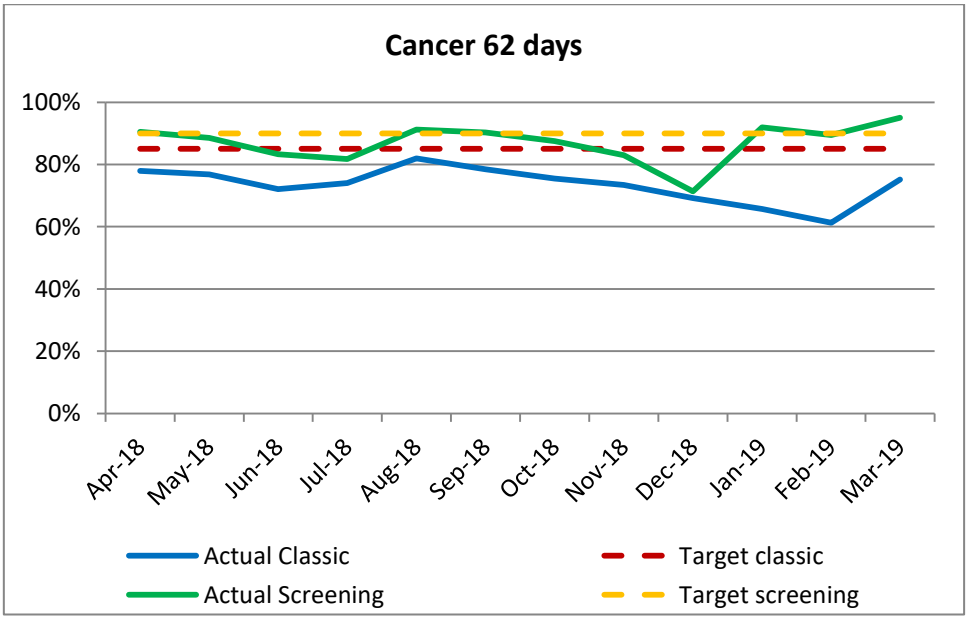
The Screening standard success has been variable due to being a low volume of patients (typically only 20 per month compared to Classic having 150 – 200 per month) and the need for them to be treated in the same chronological and clinical priority as the Classic patients.

During 2018/19 there was a 9% increase in referrals on the suspected cancer pathway compared with the previous year.

For the first two quarters we saw some of the best performance against the 62 Day standard in recent years, maintaining a level consistently above 70% and August 18 being just below the national standard at 82%.

The winters months saw a rapid deterioration of our performance, partly due to challenges with recruiting to Pathology, Radiology and Oncology consultant posts. These are largely resolved except for ongoing difficulties within Pathology that are being managed at director level with support from NHSI.

March 19 performance is forecast to be back on track c.74% and a trajectory has been agreed that will see us delivering the standard by November 2019.



The performance for cancer 62 day classic for 2017/18 was 71.46%

The performance for cancer 62 day screening for 2017/18 was 87.70%

Ⓐ Cancer performance is calculated as follows:

Measures the proportion of people with an urgent GP referral for suspected cancer that began their first definitive treatment within 62 days.

The indicator is a core delivery indicator that spans the whole pathway from referral to first treatment covering the length of time from urgent GP referral, first outpatient appointment, decision to treat and finally first definitive treatment.

The numerator is the number of people with an urgent GP referral for suspected cancer who received first treatment for cancer within 62 days in the reporting period.

The denominator is the total number of people with an urgent GP referral for suspected cancer who were treated in the reporting period.

The operational standard is a published figure of 85% against which CCGs are measured.

The Trust focused on reducing the backlog of patients over 62-days during the latter part of 2018/19, with significant success in getting it down to 46 patients (target of being below 40) in early March but changes in the Divisional structure on top of the already lengthy Pathology waits have resulted in a downturn that is now being managed at Divisional Managing Director level.

Actions undertaken to improve performance

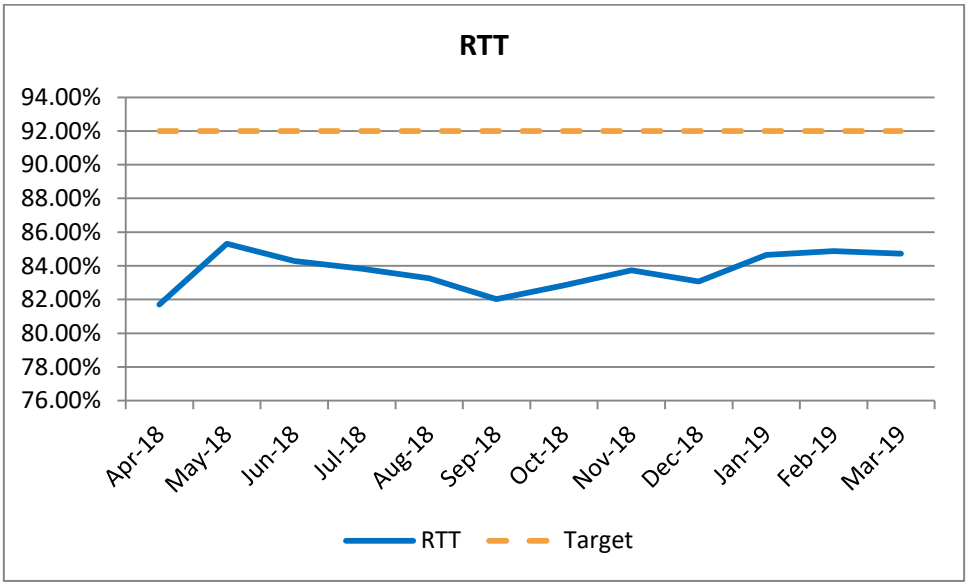
During the course of 2018/19 a programme of improvement has been undertaken within the Trust, with support from CCG colleagues, in order to improve the timeliness of assessment, diagnosis and treatment of patients on cancer pathways. This improvement programme is overseen at a corporate level via the fortnightly cancer recovery and delivery group chaired by the Deputy Director of Operations for Planned Care/Divisional Managing Director for Clinical Support Services.

The external auditors uncovered issues with the referrals received via the fax process. Of the 22 fax referrals reviewed, for 3 referrals the ‘start date’ cannot be agreed to supporting the documentation within the Trust. In one further referral case which was reported as meeting the target, the ‘start clock’ should have been started fifteen days earlier. Guidance states that the clock commences on the day the referral is received. This issue will be resolved as all referrals will be through choose & Book and fax referrals will no longer be received.

18 weeks – Referral to Treatment (RTT)

The national compliance standard continued to be that at least 92% of patients should be waiting less than 18 weeks between referral to treatment. During the year 2018/19, the volume of patients waiting over 18 weeks for treatment grew in a number of our specialities and the overall standard was not delivered in any single month. Our non-compliance has resulted from a growth in outpatient referrals and the high volume of elective cancellations during the prolonged winter pressure period.

RTT compliance Apr 18 – March 19



The performance for RTT for 2017/18 was 87.27%

The following actions are in place to improve the position:

- Trust board have supported a continuation of the pilot in Trauma & Orthopaedic (major elective hub at Grantham) in the light of positive achievements.
- CCG funded external validation team in place since late December, validating lists in 4 key specialities and identifying lessons learnt. To date just under 20,000 pathways have been validated with around 10% seeing clock stops added.
- Intensive Support Team (IST) agreement to work with Surgical Division to utilise their demand and capacity tools to review general surgery, urology and Ear Nose & Throat (ENT) to support improved RTT recovery planning.
- Finalised checks for 2019/20 to ensure contracted volumes (and relevant efficiency plans) support RTT delivery

Clostridium Difficile

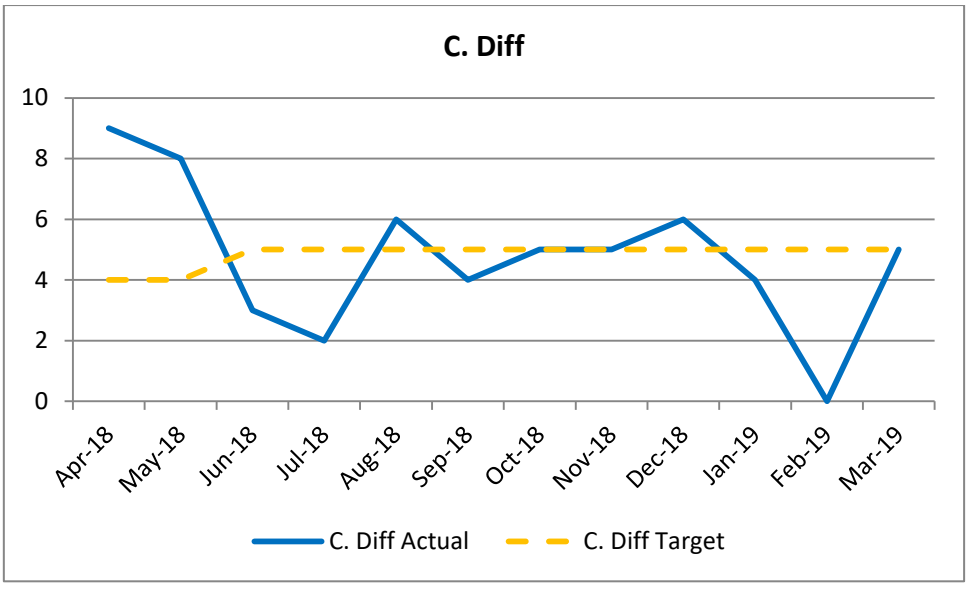
For 2018/19 the Trust has seen a fluctuation in monthly case numbers. The Trust had 57 cases. The Trust is under the threshold trajectory for 2018/19 by 1 case and the picture is more stable. Further improvements are needed in the areas of:

- Hand hygiene
- Cleanliness of care equipment
- Cleanliness of the physical environment
- Appropriate use of antibiotic treatments
- Timeliness of isolation of suspected infectious patients

Actions in place include:

- Discussion around the use of high risk antibiotics to review the antibiotic formulary and educate prescribers to make sensible choices around the use of high risk antibiotics.
- Continued focus Trust-wide on rapid isolation and testing of patients with suspected symptoms of C. Diff.
- Frequent visits by Infection Control & Infection (IP&C) Nurses to areas deemed to be high risk
- Prompt review of new Clostridium Difficile cases
- Enhanced cleaning regime in place on areas where there are symptomatic patients with known infection
- All toilets and sluices Trust-wide are being routinely disinfected with a chlorine-based disinfectant
- 4 Hydrogen Peroxide Vapour units have been purchased and the estates team are undergoing training on their use.

C. Diff rates Apr 18 – Mar 19



The performance for C.Diff for 2017/18 was 69 cases.

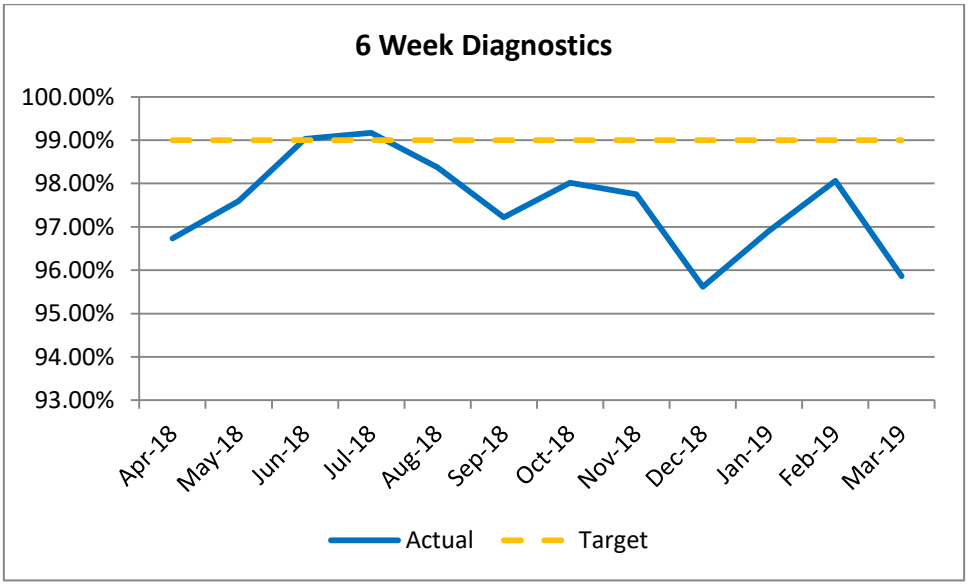
Since May 2018, a joint working team of IP&C Nurses, Antimicrobial Pharmacists and Microbiologists have initiated weekly targeted hotspot visits to areas where inpatients have been identified as Clostridium Difficile. During these visits, the team challenge prescribing decisions, care pathways and IP&C practices. This appears to have made a significant impact on the numbers of Clostridium Difficile cases being reported.

The IP&C team will also have a significant push on the other 4 targeted areas mentioned above to further support reduction in cases. The Consultant Antimicrobial Pharmacist has analysed the antibiotic record for each Clostridium Difficile patient throughout 2017/18 and 2018/19 to date so that a more thorough drill down of the issues can be undertaken.

6 week wait diagnostic procedures

This standard covers the top 15 high volume diagnostic tests. The expectation is that, at each month-end, 99% of patients waiting for these tests should have been waiting for less than six weeks. The Trust achieved this standard in June and July 2018, but did not achieve it for any of the other months during 2018/19.

6 Week diagnostic compliance Apr 18 – Mar 19



The performance for diagnostics for 2017/18 was 97.64%.

The diagnostic target has been under pressure over the last few months due to the following:

- Increase in demand across all areas
- The increase in cancer 7 day diagnostic performance cause the reduction in the waiting list size so fewer breaches were allowed in the 1% allowance. (In April we were allowed around

75 breaches within the 1% tolerance in January we were allowed around 55 breaches in the 1% tolerance.

- Breakdown of ageing equipment has caused last minute breaches that could not be fitted into the month due to loss of capacity
- Conflicting pressures and increase in demand from cancer, emergency and inpatient has taken capacity away from routine requests

Actions in place include:

- Using outsourced vans such as Computerised Tomography (CT) and Magnetic resonance imaging (MRI)
- Requesting new equipment to replace old
- Reviewing more effective ways of working such as increasing their efficiently (endoscopy is undergoing a Trust wide programme and is showing to have great outcomes and minimal breaches now)
- Booking processes are being looked at in cardiology for the echoes so that errors are reduced
- Collaborative working between departments to reduce breaches

ANNEX 1

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STAKEHOLDER COMMENTS

NHS Lincolnshire East Clinical Commissioning Group (Lead Commissioner)

United Lincolnshire Hospitals NHS Trust Annual Quality Account 2018 – 2019

NHS Lincolnshire East Clinical Commissioning Group (the commissioners) welcomes the opportunity to review and comment on the United Lincolnshire Hospitals NHS Trust (the trust) Draft Annual Quality Account 2018 – 19.

The Quality Account provides information on the quality priorities that the trust has focussed on during 2018 – 2019. The trust has made progress against key elements of each of the priorities, achieving 74% of the individual elements. However the trust still has improvements to make before the levels of avoidable harm achieve the levels expected by the commissioner for an acute provider. In addition the commissioners would like to see more detailed plans of how the priorities, that did not achieve, will be monitored through business as usual as the majority of them have not been identified as a priority for next year and are not being carried forward into 2019 - 2020. The commissioner sees these priorities as essential to the on-going improvements in patient safety.

Looking forward to the 2019 – 2020 Quality Priorities the commissioner supports the four priorities and the supporting detailed activities. The commissioner recognises the priorities have been developed following key stakeholder engagement and is supportive of the fact that they are linked to the Care Quality Commission domains and in line with some of the Lincolnshire Wide System Priorities. Continued focus on the previous quality priorities in addition to focussing these new ones will support the trust to exit the Care Quality Commission Special Measures process.

Whilst supportive of the above the commissioners do consider the activities to be limited and a number would be considered core processes for any organisation undertaking NHS work. The commissioner recognises the importance of patient and staff experience however believes there would be scope to extend these priorities to ensure the delivery of safe care for the population of Lincolnshire.

The Quality Account demonstrates some examples of some good work undertaken by the trust over the past year and the commissioner's note there has been some improvements in the quality of services delivered to patients. However these improvements remain inconsistent against all sites and all services. Some deterioration has been noted in the quality of services provided however the commissioners recognise the actions the trust has in place to address this.

The trust has made a significant improvement in 2018 – 2019 in the management of Serious Incidents and compliance with Duty of Candour. Following the development of the 2018 - 2021 Mortality Reduction strategy, Hospital Standardised Mortality Ratio (HSMR) is now below expected levels, and the trust is demonstrating a reduction in Summary Hospital Mortality Indicator (SHMI), which is noted to have a six month time delay and the forecast is for the SHMI is to continue in line with the HSMR data.

The commissioner is concerned with regards to the number of Never Events reported for the year and the theme emerging with wrong site surgery. The commissioner will continue to monitor this issue at the regular trust and commissioner meetings and will expect a robust corrective action plan to be submitted to support improvements in surgical practice.

The security of information is of crucial importance and it is disappointing that the trust has not achieved the required standard of the Data Security and Protection Tool Kit (was Information Governance Toolkit) for the third year in succession.

The commissioner can confirm that up to the end of quarter three the trust has made significant improvements with regards to the delivery of CQUINS. The expected end of year position as detailed in the account does align with the commissioners expectations.

The commissioners note the progress against the twelve quality and safety projects the trust has taken forward following the CQC inspection, and recognises the detail that underpins this work. It would be helpful to have more granular information which would help commissioners to understand which of these have been achieved in full.

The commissioner supports the developments undertaken by the trust to improve the safety concerns for the provision of Children & Young Peoples Services. These concerns were identified by the Care Quality Commission, the commissioner and the trust.

The commissioner can confirm that this Quality Report has been critically appraised against the 2010 Quality Account Regulations and subsequent additions to the regulations in 2017 and 2018. The results of this appraisal have been issued to the trust.

The commissioner looks forward to working with the Trust over the coming year to further improve the quality of services available for the population of Lincolnshire in order to deliver better outcomes and the best possible patient experience.

Elizabeth Ball
Chief Nurse
NHS Lincolnshire East Clinical Commissioning Group

Healthwatch Lincolnshire
ULHT Trust Quality Account Statement for 2018/19

Summary

Healthwatch Lincolnshire Quality Account Working Group: Sarah Fletcher (CEO), John Bains (Board Chair), Clive Green (Trustee), David Gaskell (Trustee) Maria Prior (Trustee), Nicola Clarke (Partnership & Development Manager), Julie Evans (Signpost Officer)

Healthwatch Lincolnshire would like to thank Sally Seeley and Bernadine Gallen **for the energetic and committed presentation of the ULHT Quality Account** and meeting with our representatives. We acknowledge the work the Trust has done over the past 12 months to improve overall performance. On behalf of patients, carers and families, we would like to thank all staff for their hard work and dedication in achieving this.

We welcome the Trust's response to concerns raised and information shared by Healthwatch Lincolnshire and we look forward to building upon this relationship further, **specifically noting our opportunity to link in with the Trust around collective and mystery shopper work across the Trust sites.**

Healthwatch Lincolnshire welcome the joint system CQUIN approach and would anticipate that all opportunities to work collaboratively will be maximised including the use of the Care Portal, and that it will become a mandatory tool and not continue to be an untapped resource.

Quality Accounts are an important way for local NHS services to report on quality. They also provide an opportunity to show improvements to local communities and stakeholders. With this in mind, we have identified opportunities within the report that could be elaborated on further for the benefit of readers understanding and clarity.

We do feel that the positive work the Trust has managed to achieve around paediatrics in Boston and described within the Quality Account really needs to be communicated in the public.

We understand the Trust are awaiting the next CQC visit within the next 6 months and we wish them well with that.

Commentary relating to the previous year's Quality Accounts 18/19

1: Promoting a positive patient experience: The Trust achieved the majority of this priority but didn't achieve the FFT%. ULHT felt targets were aspirational, however there was considerable learning from the patient experience.

2: Learning lessons where care should have been better at being open and honest: This was reported as a 'mixed bag' but as a result 'lessons learned' are being shared on the shop floor in different communication styles to meet the needs of staff. We note that the Trust did not achieve the never event target, however we heard how they were creating WHO checklists for all procedures taking place in the Trust. **HWL continues to be concerned that never events are still occurring within the Trusts particularly when they relate to wrong site surgery, midazolam medication incidents as examples.**

4: Eliminating avoidable patient harms (CATEGORY 3/4 PRESSURE ULCERS) achieved. **Healthwatch were very concerned that the Trust didn't achieve the target with alarming numbers of category 3 and 4 pressure ulcers. However now the Trust has moved towards implementing the national categorisation, the number of 3 and 4 pressure ulcers has reduced.**

5: Generating healthcare for the future, this the Trust explained was all part of the 7 day service and with patients being reviewed within 14 hours. This wasn't achieved, **however encouraging to hear that the Trust is interrogating the data to drill down the specific issues related to speciality areas not achieving the 14 hour target.**

6: Eradicating preventable deaths (SEPSIS). The target and priority around sepsis was not achieved and **Healthwatch are concerned patients are being put at risk. However it was explained that paediatrics often breach the hour target for legitimate reasons. Therefore, for the purpose for the Quality Account we feel the split between adult and children's data would be useful to the reader and also an explanation that the Trust is actually compliant in both areas.**

7: Providing services by staff who demonstrate our values and behaviours, **Healthwatch were disappointed by the continued poor staff survey results despite the investment over the last year of working with staff and particularly the bullying culture. The biggest issue related to this the Trust feel is due to high numbers of agency staff. Healthwatch hope that the Trust will eradicate the cultural issues within the workforce, otherwise we fear that irrespective of the new medical school and the new apprenticeship programmes, new entrants will continue to leave the sector.**

Priorities and challenges for the forthcoming year 19/20

In relation to the overall priorities Healthwatch feel that they are a positive approach to focusing on the bigger picture and considering the patient and workforce at the centre.

Priority 1: Patient and Carer Experience – **Healthwatch are concerned that the report is lacking in information on how ULHT will address the lack of value placed on patient experience data by some medical colleagues and business teams. Healthwatch would also suggest to the Trust that redevelopment and learning from the review and changes to the complaints process is incorporated within this priority.**

Priority 2: I would recommend my organisation as a place to work – **Healthwatch recognise that the high numbers of locum and agency staff are a barrier to improving staff satisfaction and morale. Healthwatch believe that until the Trust and system are able to employ a stable and committed workforce the challenges will continue.**

Priority 3: Ensuring effective systems for reviewing mortality – **Healthwatch has looked at mortality previously and we are encouraged to hear that SHIMU figures are coming down. We recognise that the unexpected out of hospital deaths 30 days post admission are an area of concern, but also recognise that the deaths maybe outside the Trusts control. We hope the system will review and challenge how this data is more accurately reported and furthermore, ensure that patients are managed in the right way, in the right place, first time.**

Themes and Trends Healthwatch have heard over the last 12 months

The following highlights some of themes that we hear on a regular basis from patients, carers and families. We would ask the Trust to continue to review and address what their customers are telling them.

- Good feedback on the Elderly Care Team
- Dermatology once in the service is reported as good
- Some Wards are better than others, with no consistency
- Accessible information is not being received by patients
- Lack of communication between internal services
- Clinics cancelled at last minute with patients not informed
- Diagnostic results not being received in a timely way by patients
- Carers feeling excluded from the personalised care of their loved ones,
- Concerns from HWL about fragility of services

Lincolnshire COUNTY COUNCIL Working for a better future	**HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**

Statement on United Lincolnshire Hospitals NHS Trust's *Quality Account* for 2018/19

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

Presentation of the Document

We are pleased to see a clear statement as to whether the success measures supporting each priority have been achieved. We accept that the level of detail provided is prescribed by the regulations and guidance from the regulators. We urge as much effort is made as possible to make the document accessible to members of the public. It is important that the achievements of the Trust are highlighted as much as the areas needing improvement.

When the draft quality account was presented, we were advised that it might be possible to make it accessible in other languages.

Progress on Priorities for Improvement for 2018-19

The seven priorities for 2018-19 are considered in turn: -

- Priority 1 - Promoting a Positive Patient Experience – We are pleased to see that six of the seven success measures were achieved. We understand improved target setting will address the measure, which was not achieved.
- Priority 2 - Learning Lessons and Being Open and Honest – We congratulate the Trust on the 40% reduction in the number of serious incidents; and the 100% compliance with the duty of candour. It is also important that the Trust shares its learning from the serious incidents and never events.
- Priority 3 - Eliminating Avoidable Patient Harm (Falls) - Four of the five success measures were achieved. Most notable is the reduction in the number of falls leading to harm.

- Priority 4 - Eliminating Avoidable Patient Harm (Pressure Ulcers) – We understand that the adoption of NHS Improvement's ulcer categorisation principles will lead to improvements in reducing harm.
- Priority 5 - Creative and Seven Day Services – Four of the six success measures have been achieved. We note that improving weekend access to echocardiography and ultrasound will be a positive move.
- Priority 6 - Eradicating Preventable Deaths (Sepsis) – We note there has been some progress during 2018/19, and would like to see the improvements in screening and the administration of treatment in the year ahead.
- Priority 7 - Demonstrating Values and Behaviours – Reducing the reliance on agency staff is a substantial challenge for the Trust. The increase in the levels of perceived bullying is also a concern.

Priorities for Improvement for 2019-2020

We support the inclusion of four priorities for improvement for 2019 20 and we accept the rationale for their inclusion. The reduction of the number of priorities from seven to four will help the Trust focus on achieving the targets for these priorities.

We recognise that one of the national mortality indicators [Summary-level Hospital Mortality Index] takes account of deaths within 30 days of discharge from hospital. We have been advised that in some instances patients at the end of their life should not have been admitted to hospital and this is in part a reflection of the overall health and care economy.

Care Quality Commission

We are pleased that following an inspection by the Care Quality Commission in March 2018, the Trust's overall rating moved from ‘inadequate’ to ‘requires improvement’. Further reports during the year at the Emergency Department at Pilgrim Hospital have confirmed its rating of ‘inadequate’. This continues to be a concern for the Committee and we will return to this topic during the year.

Workforce

We note the Trust remains in double special measures for quality and finance. As noted in this report this impacts on staff morale; and recruitment and retention. These impacts can be increased by any form of negative publicity.

We also note that expenditure on locums has been £35 million over the year (against a target of £20 million). We see the Trust has referred to the negative impacts on these levels of locums on overall performance.

Engagement with the Health Scrutiny Committee for Lincolnshire

During 2018-19, there has been frequent engagement with the Health Scrutiny Committee for Lincolnshire.

We look forward to continued engagement with the Trust's senior managers in the coming year, and we understand clinicians will be directly engaging with the Committee on the specific topics within the Healthy Conversation engagement exercise.

Grantham Accident and Emergency

The Committee would have liked the Quality Account to have made reference to Grantham A&E, which has been closed between 6.30 pm and 8.00 am since August 2016 and recently passed the threshold of 1,000 nights of closure. This closure was originally made on a temporary basis on the grounds of middle-grade doctor staffing. The Committee has previously recorded its opposition to the way this temporary closure has become 'permanent' and its concerns over the absence of A&E facilities in the Grantham and surrounding area overnight. The Committee will be looking for a resolution to this matter as part of the proposals brought forward by the Lincolnshire Sustainability and Transformation Partnership.

Paediatric Services

We are pleased that the Quality Account includes a summary of the developments in paediatric services, which has been a major challenge for the Trust over the last year. The Committee will be considering the impact of the children and young person assessment unit in the coming months.

Conclusion

The Committee is grateful for the opportunity to make a statement on the draft Quality Account. The Committee looks forward to progress with the four quality improvement priorities in the coming year.

Explanation of changes from stakeholder feedback

Summary of changes made in receipt from NHS Lincolnshire East Clinical Commissioning Group (Lead Commissioner)

To see more detailed plans of how the priorities, that did not achieve, will be monitored through business as usual as the majority of them have not been identified as a priority for next year and are not being carried forward into 19/20 - *all priorities that have not achieved have a narrative on what we need to do to achieve our success measure going forward and which committee will be responsible for the actions.*

It would be helpful to have more granular information which would help commissioners to understand which of the twelve quality and safety projects the trust has taken forward following the CQC inspection have been achieved in full – *these projects are progressing through into 2019/20.*

Summary of changes made in receipt from Health Scrutiny Committee for Healthwatch Lincolnshire

Priority 6 2018/19 Sepsis – *The data was split between adults and paediatrics*

Priority 1 2019/20 Patient and Carer Experience – *complaints process has been incorporated within this priority.*

Summary of changes made in receipt from Health Scrutiny Committee for Lincolnshire

Make the Quality Account accessible in other languages – *this was discussed with the Patient Experience Lead and it will not be feasible to convert this document into different languages.*

Grantham A&E which has been closed between 6.30 pm and 8.00 am since August 2016 and recently passed the threshold of 1,000 nights of closure – *a narrative has now been included within the quality account.*

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STATEMENT OF DIRECTORS' RESPONSIBILITIES

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS trust boards on the form and content of annual quality account (which incorporate the above legal requirements) and on the arrangements that NHS trust boards should put in place to support the data quality for the preparation of the quality account.

In preparing the quality account, directors are required to take steps to satisfy themselves that:

- The content of the quality account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance; Detailed requirements for quality account 2018/19;

- The content of the quality account is not inconsistent with internal and external sources of information including;

- Board minutes for the financial year, April 2018 and up to 4th June 2019 ("the period");

- Papers relating to quality reported to the Board over the period April 2018 to the date of signing this statement;

- Feedback from the Commissioners Lincolnshire East Clinical Commissioning Group on behalf of the Lincolnshire Federated Quality Function dated 4th June 2019;

- Feedback from local Healthwatch organisations Healthwatch Lincolnshire dated 17th May 2019;

- Feedback from the Overview and Scrutiny Committee, Lincolnshire County Council Health Scrutiny Committee dated 28th May 2019;

- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2017/18;

- The latest national patient survey, CQC Survey Coordination Centre Maternity Care Pathway Reports: antenatal care, dated January 2018;

- The latest national patient survey, CQC Survey Coordination Centre Maternity Care Pathway Reports: labour and birth, dated 2018;

- The latest national patient survey, CQC Survey Coordination Centre Maternity Care Pathway Reports: postnatal care, dated 2018;

- The latest national patient survey, CQC Survey Coordination Centre Patient Survey Report, dated 2017;

- NHS England National Cancer Patient Experience Survey, published September 2018;

- The latest national and staff survey, Survey Coordination Centre, United Lincolnshire Hospitals NHS Trust, NHS Staff Survey Benchmark Report dated 2018;

- Care Quality Commission inspection, CQC Pilgrim Hospital Quality Report, Inspection dated 30th November 2018;

- Care Quality Commission United Lincolnshire Hospitals NHS Trust Inspection Report, dated 3rd July 2018;

- Care Quality Commission Pilgrim Hospital, Quality Report dated 3rd April 2019;

- The Head of Internal Audit's draft annual opinion over the Trust's control environment dated 2018/19; and

- Minutes of the Quality Governance Committee meetings January and February 2019.

- The quality account presents a balanced picture of the NHS 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 NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality account.

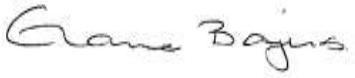
- The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality account.

By order of the board

Jan Sobieraj

Chief Executive Officer
21st June 2019

Elaine Baylis



Chair, Trust Board
21st June 2019

ANNEX 3

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

Price Waterhouse Cooper

Independent Auditors' Limited Assurance Report to the Directors of United Lincolnshire Hospitals NHS Trust on the Annual Quality Account

We have been engaged by the Directors of United Lincolnshire Hospitals NHS Trust ("the Trust") to perform an independent assurance engagement in respect of United Lincolnshire Hospitals NHS Trust's Quality Account for the year ended 31 March 2019 (the "Quality Account") and specified performance indicators contained therein.

NHS trusts are required under 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, subsequent amendments, and the NHS Improvement ("NHSI") updates set out in their letter to trusts dated 17 December 2018 entitled 'Quality accounts: reporting arrangements 2018/19'. These documents together will be referred to as the "regulations".

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Account, consist of the following indicators:

Specified Indicators	**Specified indicators criteria** (exact page number if possible, or title of section where criteria can be found)
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.	The performance indicator is on page 103 and the criteria are set out on pages 104 and 105.
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.	The performance indicator is on page 103 and the criteria are set out on page 107.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Account each year in accordance with the regulations. The Directors are also responsible for the conformity of the specified indicators criteria with the assessment criteria set out in the 'Detailed requirements for external assurance for quality reports 2018/19' issued by NHSI (the "detailed guidance"), and for reporting the specified indicators in accordance with those criteria, as referred to on the pages of the Quality Account listed above.

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 does not incorporate the matters required to be reported on as specified in the regulations;
- The Quality Account is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the criteria set out in the detailed guidance.

We read the Quality Account and consider whether it addresses the content requirements of the regulations; and 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 consistent with the following documents:

- Board minutes for the financial year, April 2018 and up to 4th June 2019 ("the period");
- Papers relating to quality reported to the Board over the period April 2018 to the date of signing this limited assurance report;
- Feedback from the Commissioners Lincolnshire East Clinical Commissioning Group on behalf of the Lincolnshire Federated Quality Function dated 4th June 2019;
- Feedback from local Healthwatch organisations Healthwatch Lincolnshire dated 17th May 2019;
- Feedback from the Overview and Scrutiny Committee, Lincolnshire County Council Health Scrutiny Committee dated 28th May 2019;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2017/18;
- The latest national patient survey, CQC Survey Coordination Centre Maternity Care Pathway Reports: antenatal care, dated January 2018;
- The latest national patient survey, CQC Survey Coordination Centre Maternity Care Pathway Reports: labour and birth, dated 2018;

- The latest national patient survey, CQC Survey Coordination Centre Maternity Care Pathway Reports: postnatal care, dated 2018
- The latest national patient survey, CQC Survey Coordination Centre Patient Survey Report, dated 2017;
- NHS England National Cancer Patient Experience Survey, published September 2018;
- The latest national staff survey, Survey Coordination Centre, United Lincolnshire Hospitals NHS Trust, NHS Staff Survey Benchmark Report dated 2018;
- Care Quality Commission inspection, CQC Pilgrim Hospital Quality Report, Inspection dated 30th November 2018;
- Care Quality Commission United Lincolnshire Hospitals NHS Trust Inspection Report, dated 3rd July 2018;
- Care Quality Commission Pilgrim Hospital, Quality Report dated 3rd April 2019;
- The Head of Internal Audit's draft annual opinion over the Trust's control environment dated 2018/19; and
- Minutes of the Quality Governance Committee meetings January and February 2019.

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

Our Independence and Quality Control

We complied with the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Directors of United Lincolnshire Hospitals NHS Trust as a body, to assist the Directors in reporting the Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Directors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors as a body and the 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 in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ("ISAE 3000 (Revised)"). Our limited assurance procedures included:

- reviewing the content of the Quality Account against the requirements included within the detailed guidance;
- reviewing the Quality Account for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis, of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less 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 and the detailed guidance.

The nature, form and content required of Quality Accounts are determined by the Department of Health and Social Care. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Trusts.
In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Account, which have been determined locally by the Trust.

Conclusion

Basis for Disclaimer of Conclusion - Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

The Trust is required to report Type 3 department performance within the indicator. As the Trust does not have access to supporting records for these attendances we have been unable to obtain evidence as to whether the attendances have been recorded and reported in accordance with the NHSI reporting criteria.

In addition to the point above, NHSI's guidance sets out that patient activity should only be recorded by one of the two providers when combined figures are reported. The Trust and its outsourced Type 3 providers refer patients between each other, making adjustments for clock starts and stop times, but it was not possible to determine whether the patient is recorded in the Trust's and the outsourced providers data.

In addition, NHS England's definition for "the Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge" specifies that the clock start time for patients arriving by ambulance is when hand over occurs, or 15 minutes after the ambulance arrives at A&E, whichever is earlier.

Although the Trust receives data from the Ambulance Trust on ambulance arrival times, it is not used to record the arrival times of patients under the indicator as the Trust believes there are issues with the completeness and accuracy of the data received. As a result, we are unable to determine whether the correct ambulance arrival time (plus 15 minutes) for each patient arriving by ambulance has been recorded under the indicator. Ambulance patients account for 32% of total attendances.

The Trust is required to ensure that patients who enter A&E are timed from arrival to departure. At one of the Trust's three hospitals, where there is an A&E department, there have been 401 patients where the clock start time has been incorrectly recorded. This has led to 85 patients reported incorrectly as a 'met' when they should have been reported as a 'breach'. The Trust has cleansed the data to reflect the changes, however we are unable to confirm whether there are any further instances of this occurring that have not been corrected.

Basis for Disclaimer of Conclusion – Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

Under this indicator, the Trust is required to start the clock on the date a referral is received at the Trust. For fax referrals, we found instances where the date of receipt of the fax could not be confirmed to supporting evidence such as a manual or electronic date stamp on the fax, and therefore we cannot conclude that the correct start clock time and met/breach status has been applied to all fax cases.

In addition, we identified one referral completed via a fax referral form but received via email where the clock start date was incorrectly taken as the date a patient was contacted to book an appointment rather than the date the referral was received. This resulted in the case being reported as meeting the target when in fact it was a breach. The population of referrals that involve manual intervention when setting the start clock represent 24% of referrals received at the Trust, the Trust cannot identify the proportion of these which relate to fax referrals only.

Disclaimer of conclusion

Because the data required to support the A&E four hour wait indicator is not available, as described in the Basis for Disclaimer of Conclusion paragraph, we have not been able to form a conclusion on the A&E four hour wait indicator.

In addition, because the evidence required to support the Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers indicator is not available and because of the issues identified as described in the Basis for Disclaimer of Conclusion paragraph, we have not been able to form a conclusion on the 62 day cancer wait indicator.

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 2019:

- The Quality Account does not incorporate the matters required to be reported on as specified in the regulations; and
- The Quality Account is not consistent in all material respects with the documents specified above.

PricewaterhouseCoopers LLP
Donington Court,
Castle Donington,
DE74 2UZ

25 June 2019

The maintenance and integrity of the United Lincolnshire Hospitals NHS Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.