CARING FOR YOU

NHS
United Lincolnshire Hospitals
NHS Trust

Quality Account 2016/17

Contents

PART 1

Statement of quality from the Chief Executive

United Lincolnshire Hospitals NHS Trust (ULHT) is one of the largest trusts in the country. We provide a comprehensive range of hospital-based medical, surgical, paediatric, obstetric and gynaecological services to 736,700 people of Lincolnshire. In an average year, we treat more than 150,000 accident and emergency patients, over 600,000 outpatients, over 140,000 inpatients, and deliver over 5,000 babies.

The past year has been very challenging for almost all acute trusts in England, including us. We recorded a large financial deficit, struggled to meet national targets such as the maximum four hour wait in accident and emergency and some of the cancer targets. We are working hard to address these challenges and within the year, we did start to see some areas of improvement.

During the year we also received a disappointing Care Quality Commission (CQC) report which saw the Trust placed into special measures for the second time. This report was produced following inspections at Lincoln County Hospital, Pilgrim Hospital, Boston and the A&E department at Grantham and District Hospital in October last year. The CQC identified a range of issues which the Trust is required to tackle, but also many examples of good practice at ULHT.

We are now developing our quality and safety programme in response to the report. This contains a wide range of actions directly focussed on improving the quality of care in the areas identified and provides an opportunity to develop in our areas, and is one of the key work streams of our own 2021 five-year strategy.

As well as reported challenges, we also have much to be proud of. We've made good progress with developing our clinical strategy options. Following extensive staff and clinical engagement, Trust Board, Clinical Executive Committee (CEC) and Clinical Strategy Implementation Group (CSIG) reviewed the draft options in March putting us in a good position for developing a strategic outline case in 2016/17 to inform our own plans and the countywide Sustainability and Transformation Plan (STP)

During the year, the quality of many of our services have been maintained or improved and we have taken forward innovative approaches. We were successful in being a pilot site for the new nursing associate role as well as taking the lead on the development of the first ever apprenticeship degree for the roles of physiotherapist and occupational therapist. The endoscopy units at Boston and Grantham received the esteemed JAG status. Many of our staff have won or been nominated for national, regional and ULHT awards.

What are our plans for 2017/18? It will be a year of transformation for the Trust. As well as aiming to deliver our plans around quality, performance and finance we need to make improvements to the way we work for our patients and begin to transform our approach to the way we manage the movement of urgent care patients around and out of hospital.

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

Jan Sobieraj
Chief Executive Officer

Statement of directors' responsibilities in respect of the quality account

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

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

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

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

Dean Fathers
Chair, Trust Board

Introduction – what is a quality account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. Our Quality Account looks back on how well we have done in the past year at achieving our goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

United Lincolnshire Hospitals NHS Trust welcomes the opportunity to be transparent and to be able to demonstrate how well we are performing, taking into account the views of service users, carers, staff and the public. We can then use this information to make decisions about our services and to identify areas for improvement.

About the Trust

United Lincolnshire Hospitals Trust (ULHT) is one of the biggest acute hospital trusts in England serving a population of around 736,700 people.

Our vision is to 'work together to provide sustainable high quality patient-centred care for the people of Lincolnshire'.

We provide acute and specialist services to people in Lincolnshire and neighbouring counties. Lincolnshire is the second largest county in the UK. It is characterised by dispersed population in towns and in the city of Lincoln and largely rural communities.

We have an annual income of £440 million. Our main contracts are with Lincolnshire East, Lincolnshire West, South Lincolnshire, and South West Lincolnshire Clinical Commissioning Groups (CCGs)

We provide services from three acute hospitals in Lincolnshire:

- Lincoln County Hospital
- Pilgrim Hospital, Boston
- Grantham and District Hospital.

The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by Lincolnshire Community Health Services NHS Trust or local GP clusters. These include:

- Louth County Hospital
- John Coupland Hospital, Gainsborough
- Johnson Community Hospital, Spalding
- Skegness and District General Hospital.

The Trust provides a broad range of other clinical services including community services, population-screening services, and a comprehensive range of planned and unscheduled secondary care services.

We deliver services across:

Audiology	Dermatology	Haematology	Ophthalmology	Respiratory physiology
Breast services	Diabetic medicine	Hepatobiliary and pancreatic surgery	Oral and maxillofacial surgery	Rheumatology
Cardiology	Diagnostic services	Maternity and obstetrics	Orthodontics	Specialist rehabilitation medicine
Chemotherapy	Dietetics	Medical physics	Pain management	Therapies
Children's community Services	Ear, nose and throat	Medical oncology	Palliative care	Trauma and orthopaedics
Clinical immunology	Endocrinology	Neonatology	Pharmacy	Urology
Clinical oncology	Gastroenterology	Nephrology	Radiotherapy	Vascular surgery
Colorectal surgery	General medicine	Neurology	Rehab Medicine	
Community paediatrics	General surgery	Neurophysiology	Research and development	
Critical care	Gynaecology	Nuclear medicine	Respiratory medicine	

PART 2

Areas for improvement in 2017/18

Deciding our quality priorities for 2016/17

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 the QGC throughout the year.

We have ensured that our quality priorities are aligned with this year's Trust objectives for patient safety, clinical effectiveness and patient experience and to the wider annual plan and 2021 strategy. 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 April 2017.

The following improvement priorities for the Trust have been identified for particular focus in 2017/18. The overarching principle for all these work streams is their importance for patient experience: they have been grouped under the section headings below for the purpose of this quality account document.

Patient Safety

- Improving the care of patients with sepsis
- Reduction in the incidence of falls and harm sustained by patients following a fall
- Reduction in the incidence and harm associated with catheter associated urinary tract infections (CAUTI)
- Improve compliance with administration of medication especially in relation diabetic drugs
- Reduce avoidable harm by eliminating avoidable category 4 pressure ulcers and reducing avoidable category 3 pressure ulcers by 50%.

Clinical Effectiveness

- Patients to be discharged with their electronic discharge documents (eDD) and the eDD to be sent to GPs within 24 hours of patients discharge
- Improve responding to and learning from serious incidents
- Reduction in mortality rates

Patient Experience

- Improving the process of Duty of Candour
- Improve the experience for patients with dementia and vulnerable patients

Priority 1 – Improving the care of patients with sepsis

Why we have selected this priority

Sepsis is a common and potentially life-threatening condition triggered by infection. If not treated quickly, sepsis can lead to multiple organ failure and death. Successful management of sepsis requires early recognition and treatment. Reducing harm from sepsis remains a safety priority for 2017-18, as part of our commitment to the Sign up to Safety Campaign.

Our current status

There is a monthly sepsis group who meet monthly. There is good attendance from a large cohort of multidisciplinary staff. The objective of the group is to monitor and amend practice with the aim of improving outcomes for patients with sepsis.

We currently collect compliance with the following in A&E and emergency admission areas:

- Patients who have a National Early Warning Score (NEWS) of 5 or

more are to be screened for sepsis using the sepsis bundle (the sepsis bundle contains questions and a defined criteria to help identify if the patient has sepsis)

- Patients who meet the criteria within the sepsis bundle have intravenous antibiotics within 1 hour

What success will look like
Our targets for the next year are:

- Sepsis nurses to be in post at Lincoln and Pilgrim site, attending Grantham 1 day a week
- Collect compliance with sepsis screening on all inpatient wards
- Collect compliance with administration of intravenous antibiotics on all inpatient wards
- Rolled out the sepsis eBundle to all wards and departments
- Commence harm reviews on patients who have had a delay to their treatment and passed away or who have had a stay in intensive care unit

- Incident forms to be completed when the patient has not been screened or appropriate treatment initiated within 1 hour
- Information for patients and relatives to be displayed on sepsis screening in line with NICE guidance
- Achieve 90% or greater for patients who meet the criteria being screened
- Achieve 90% or greater for intravenous antibiotics administered within 1 hour

How will we assess our progress

There are monthly sepsis meetings chaired by the Trust Sepsis Lead and compliance data is circulated weekly to key personnel.

Priority 2 – Patients to be discharged with their electronic discharge documents (eDD) and the eDD to be sent to GPs within 24 hours of patients discharge

Why we have selected this priority

Discharge summaries are a vital tool to communicate information from Hospital to Primary Care teams; updating GPs about what happened during an admission, and handing over care detailing any follow up care required. Poor quality discharge summaries have been repeatedly demonstrated to lead to increased adverse events in patient care after discharge and need for re-hospitalisation. Research has shown that there is poor information continuity after discharge from hospital. However, a complete, accurate, and timely discharge summary can communicate important information to the GP, prevent adverse events, and reduce hospital readmission.

Our current status

There is a committee who meet 6 weekly to review the compliance with eDDs and to improve the functionality of the system. Our current compliance is 85% for patients going home with their eDD and 94% being sent by day 7.

What success will look like
Our targets for the next year are:

- Develop a deceased eDD template
- Improve functionality of eDD system
- Develop a standard operating policy for wards
- Develop an escalation protocol if eDD is not completed for patients on day of discharge
- Monthly compliance to be sent to all clinical leads
- Send safety briefings
- Achieve 90% or greater for patients to be discharged with their eDD
- Achieve 100% for eDDs to be sent within 5 days

How will we assess our progress

There are monthly eDD meetings chaired by the Medical Director and compliance data is distributed monthly to appropriate staff.

March 2017 – 5,899	
Sent within 1 day	84.96%
Sent within 2 days	87.29%
Sent within 5 days	92.03%
Sent within 7 days	93.83%

Priority 3 – Reduction in mortality rates

Why we have selected this priority

Mortality ratios are a good source of information to help us understand the care provided in hospitals and allow us to target areas for review, investigation and improvement. During 2017/18 we will aim to sustain our Hospital Standardised Mortality Ratio (HSMR) and further improve our Summary Hospital-level Mortality Indicator (SHMI) to the national average (100), and focus on reducing avoidable mortality and improve clinical care received by patients in our hospital.

By focusing on competence in undertaking observations, learning from the outcomes of quarterly audits, and placing greater emphasis on the signs of the deteriorating patient, using patient care bundles, we will be better able to detect early warning signs.

We actively monitor our mortality rates using the following measures and we report on these to the Trust Board and to the Quality and Safety Committee on a monthly basis.

There are two national trust-level mortality indicators:

1. The SHMI is the ratio between the observed number of deaths following admission to the Trust and the expected number of deaths based on the England average, given the characteristics of the patients treated (risk adjusted). It is produced and published quarterly by NHS Digital.

2. The HSMR developed and published by Dr Foster, compares the number of observed deaths at the Trust with a modelled (risk adjusted) expected number.

The HSMR differs from the SHMI in a number of respects, including:

- The SHMI includes all deaths, while the HSMR includes a basket of 56 diagnoses (around 80% of deaths)
- The SHMI includes all discharges and post-discharge deaths (30 day), while the HSMR focuses on in-hospital deaths.
- The HSMR is risk adjusted against 12 factors whereas SHMI risks adjusts against 4 Age, palliative care and social deprivation.

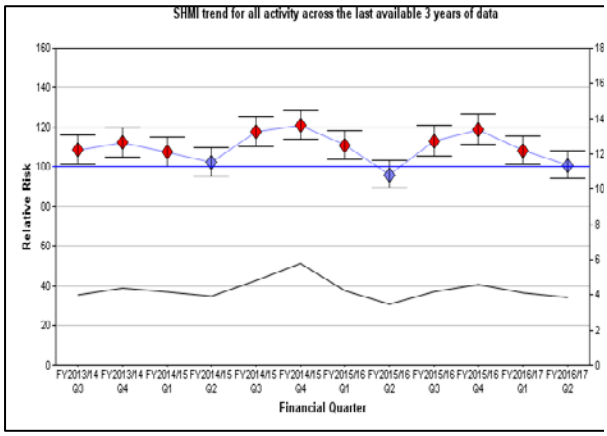
Our current status

The table below shows the Trust's latest published HSMR data from April 2016 to December 2016. SHMI, for the period October 2015 to September 2016. The Trust continues to fall within the 'as expected' banding for both measures.

Trust HSMR and SHMI

	Trust HSMR and SHMI	95% confidence interval
HSMR (Apr 16 – Dec 16)	**102.6**	**97.6 – 107.8**
SHMI (Oct 15 – Sept 16)	**110.3**	**106.68 – 114.01**

SHMI data for each quarter since Q3 2013/14



When a patient dies within our hospitals, a clinical review by the consultant is undertaken to assess if there were any lessons to be learnt. If there were any issues identified this is escalated to the Mortality Review Assurance Group (MoRAG) where another detailed analysis is undertaken

What success will look like
Our targets for the next year are:

- Achieve 85% of all mortalities to have a case note review completed
- Non-compliance of case note reviews of 5 or more to activate a letter from the Associate Medical Director highlighting the importance of completing these reviews
- Work collaboratively with the Clinical Commissioning Groups (CCGs) reviewing mortalities within 48 hours of admission, 30 days of discharge and inappropriate admissions
- Review coding when patients have died to ensure all co-morbidities have been included
- Implement the actions from the 'national guidance on learning from deaths'
- Newsletters to be drafted, one newsletter will include a Mortality Review Assurance Group (MoRAG) case review and lessons learned; and the other will be a revival of the Mortality Matters Newsletter that will look at the specific effects of our mortality reviews; HSMR, SHMI, Review compliance.
- Coordinate quarterly 'Coding Masterclass Workshops'
- Achieve a HSMR of 100 or less
- Achieve a SHMI of 100 or less

How will we assess our progress

We will assess our progress through:

Statistical data are analysed in detail every month at the Patient Safety/Clinical Effectiveness Committee, chaired by the Trust Medical Director. This panel identifies any areas where further analysis is required and monitors progress in all key areas. We wish to see that crude mortality continues to align with national levels and that HSMR remains below the national mean of 100. Where appropriate, individual patient case note reviews are assessed and monitored in detail by the MoRAG, chaired by the Associate Medical Director and lessons learned reported through the Patient Safety Committee to the Board

Priority 4 - Learning from Serious Incidents

Why we have selected this priority

Serious incidents (SIs) which occur within the Trust are reported to the Commissioners. After reporting the incident, a root cause analysis (RCA) investigation is undertaken for each incident reported. An investigation report, including an action plan, is produced following the RCA investigation. This report is reviewed by the Trust's Serious Incident Panel, which consists of the Medical Director, and Director of Nursing. Once approved the report is submitted to the Commissioners, actions arising from the investigation continue to be monitored until they are completed.

Improving patient safety by learning from all adverse events will encourage a safety culture throughout the organisation. The organisation is committed to implementing further training to all staff on how to manage the incidents of all severities which occur within their areas

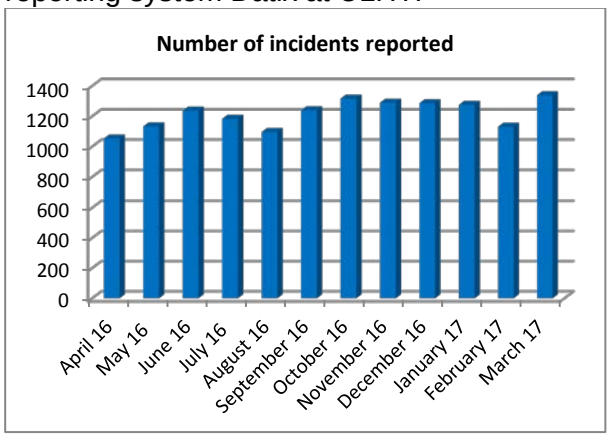
We are trying to improve the learning and subsequent changes in practice from serious incident investigations, in

particular across ULHT and not just in one area. We will continue to focus on timeliness of serious incident reports following an incident investigation to ensure that learning can be shared as soon as possible. We will also continue to follow up actions from incidents in a more systematic way.

Our current status

The National Reporting and Learning System (NRLS) for reported incidents between 01/10/2015 to 31/03/2017 shows that ULHT reported 5,238 incidents during this period which is a rate of 28.69, with the medium reporting rate for this cluster being 39.31 incidents per 1000 bed days. The data is informing we are under reporting around Low and No harm incidents. The NRLS report states that organisations that report more incidents usually have a better and more effective safety culture, demonstrating learning and improving due to understanding and addressing problems. The report highlights that ULHT reported in line with the lowest 25% of reporters.

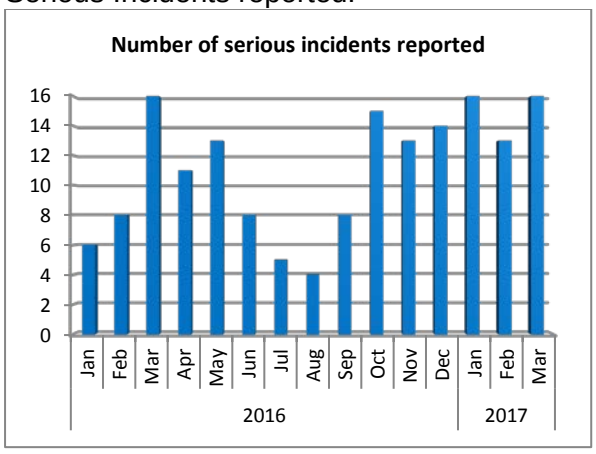
The table below highlights the number of incidents reported via our incident reporting system Datix at ULHT.



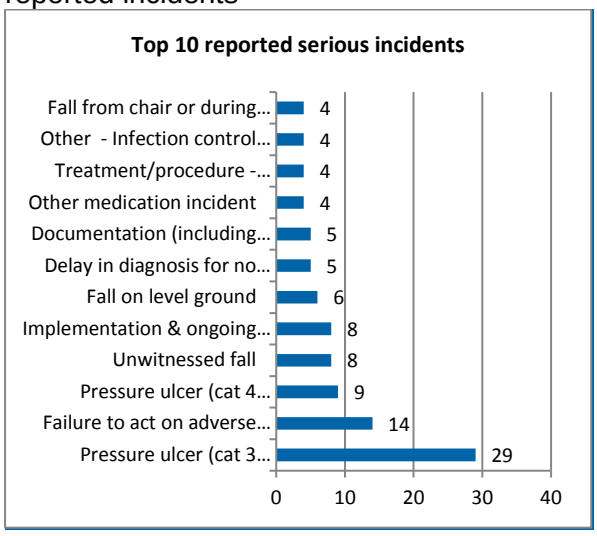
Once a week the Medial Director and Director of Nursing meet with the Risk team, Complaints, Litigation to review the potential serious incidents that have occurred the previous week to ensure they have been graded appropriately or if greater information is required. This meeting also reviews the status of compliance with previous Serious Incidents.

The trust has experienced a delay in responding to serious incidents within the deadline. All actions arising from SI investigations are tracked by the Risk Management Team and reported to the CCG (target is within 2 working days of identification as an Serious Incident) as defined in the Serious Incident Framework issued by the NHS Commissioning Board in September 2015. Serious Incident reports should be completed within 30 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.

The table below highlights the number of Serious Incidents reported.



The table below highlights the top 10 reported incidents



What success will look like
Our targets for the next year are:

Creating a fair and just culture; being transparent when things go wrong and embedding learning, measured by a reduction in Serious Incidents and avoidance of Never Events.

- All Serious incident reports to be completed within 30 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
- Develop a more intelligent approach around reporting management and learning from our incidents
- Update strategy, policy and procedure which will be supported by training so we can demonstrate wider understanding of the importance of managing incidents and reducing harm to patients
- Incident management audit process in place to provide assurance we are learning from incidents
- Introduce innovative ways to share lessons learnt
- Implement scrutiny panels for the common Serious Incidents (already in place for falls and pressure ulcers)
- The Clinical Director for the department will be responsible for allocating a named person to complete the report and ensure the report is completed on time
- Review themes to ensure lessons are learnt

How will we assess our progress

Monthly reports are generated for Patient Safety Committee, Quality Governance Committee and Trust Board.

Priority 5 - Duty of Candour

Why we have selected this priority

The Duty of Candour is important legislation that requires us to be open with patients and to investigate and share the findings when things have gone wrong (in cases where the harm is moderate or greater). This builds on our current policy of being open. We have worked hard to ensure that our staff are aware of their obligations under the duty of candour and have provided support to enable them to do this. We carry out regular monitoring to see how we are doing. Our duty of candour policy outlines the steps that staff should take.

Duty of Candour directs that within 10 days of an incident that has resulted in moderate harm or above occurring, patients or their families should be:
• Notified of the incident
• Offered an apology
• Informed of the actions that are being taken to investigate
• Offered a letter outlining the discussion to date

The Duty of Candour process ensures that our patients receive comprehensive and timely information on what has gone wrong in the provision of their care and assurance on the actions that we will take to reduce the risk of the incident occurring again in the future.

Our current status

Currently we need to increase communication as staff are still not fully aware of the Duty of Candour policy. Training to all staff has been limited. Staff not being fully aware of when to implement Duty of Candour. Our current incident reporting system known as DATIX does not have the appropriate functionality to record the required information to ensure we are compliant with Duty of Candour.

What success will look like
Our targets for the next year are:

• The Trust needs to improve the incident reporting system, to include evidence that Duty of Candour can be recorded. This change will support staff in fulfilling their responsibilities and will enable the monitoring of Trust compliance with the Duty of Candour.
• Weekly reporting to Business Units for actions to complete outstanding Duty of Candours
• Monthly reporting to Quality Governance Committee for assurance
• Develop a robust audit process
• Coordinate training sessions for staff
• Develop an eLearning tool for staff
• Develop an information leaflet for patients
• 100% of patients will receive an apology and written evidence if appropriate
• Staff will be aware of their roles and responsibilities
• A communication strategy will be developed to support the policy
• Policy and procedures to be updated

How will we assess our progress

Compliance is reported to Patient Safety Committee, Quality Governance Committee and Trust Board.

Priority 6 - Reduction in the incidence of falls and harm sustained by patients following a fall

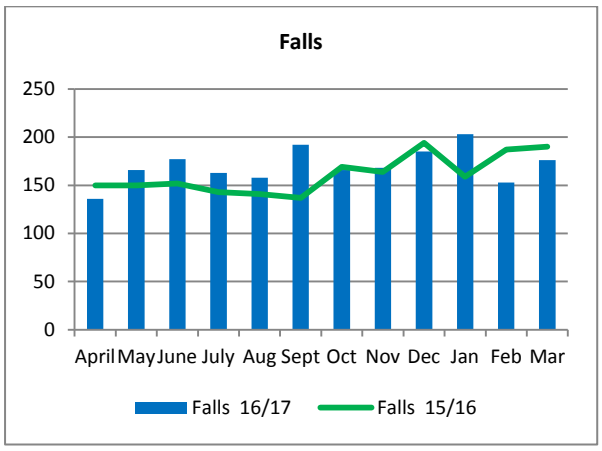
Why we have selected this priority

Falls have been identified from incident reporting and safety thermometer data as a key area for improvement, and feature as the Trust priorities for the year. Improvement plans, led by the Deputy Director of Nursing, are in place and are regularly monitored by the Trust's Patient Safety Committee.

The NHS Safety Thermometer provides a 'temperature check' on harm on one day a week. This can be utilised to measure local progress in providing an environment that is free of harm for patients, along with robust internal monitoring.

Our current status

Over a number of years, patient falls has been one of the highest numbers of incidents reported in the Trust



A patient fall may indicate an underlying health issue or a simple issue with mobility that requires a review. Falls increase the risk of injury–related morbidity or loss of independence and can increase the length of stay of a patient. Reporting patient falls also enables the Trust to analyse areas that may be experiencing an increase in the numbers, and therefore target actions, to reduce the risk. Any fall that results in a fracture or serious harm is reported as a Serious Incident (SI) and is subject to a root cause analysis investigation; 21 such incidents were reported in the year. A full investigation into each case is undertaken by the scrutiny panel and recommendations for change are initiated.

What success will look like
Our targets for the next year are:

• We will participate in the National Audit of Inpatient Falls and Fragility Audit Programme (FFFAP) from the Royal College of Physicians which will provide the Trust with a benchmark.
• We will participate in the NHS Improvement (NHSI) project which is supporting trusts taking part in the collaborative to adopt improvement methodologies and creating a learning community for them to discuss the changes they're implementing and share their findings.
• We will identify and train falls champions in all in-patient areas, starting with those areas with a higher incidence of falls during the past two years
• We will triangulate data in order to understand the root cause of falls
• We will review how we systematically disseminate learning across the Trust

• Reduce falls with harm by 20%

How will we assess our progress

All falls data are reviewed through a specialist falls management team which reports through the Patient Safety Committee to the Board. The committee reviews harmful falls per 1000 bed-days, as well as results from point prevalence audits, progress against action plans and performance against our benchmarks and targets.

Priority 7 - Reduction in the incidence and harm associated with catheter associated urinary tract infections (CAUTI)

Why we have selected this priority

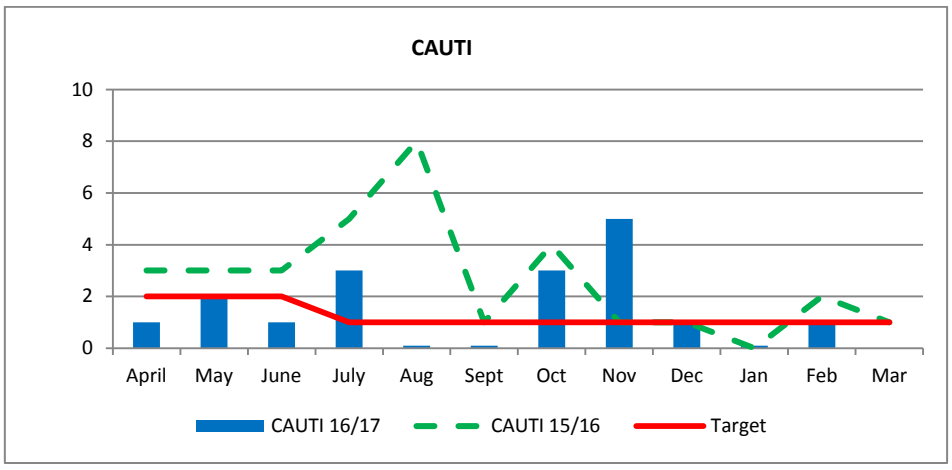
A urinary tract infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney. UTIs are the most common type of healthcare-associated infection reported to the National Healthcare Safety Network (NHSN). UTIs acquired in the hospital, approximately 75% are associated with a urinary catheter, which is a tube inserted into the bladder through the urethra to drain urine. Between 15-25% of hospitalised patients receive urinary catheters during their hospital stay. The most important risk factor for developing a catheter-associated UTI (CAUTI) is prolonged use of the urinary catheter. Therefore, catheters should only be used for appropriate indications and should be removed as soon as they are no longer needed.

The work to avoid harm from CAUTI (Catheter Associated Urinary Tract Infection) has continued within the Trust. Several best practice guidelines have been developed within the Trust to help to achieve harm free care for CAUTI for our patients. These developments have been coordinated by the CAUTI committee. The NHS Safety Thermometer provides a 'temperature check' on harms associated with catheter associated urine infections (CAUTI's). Data is collected nationally on one Wednesday every month.

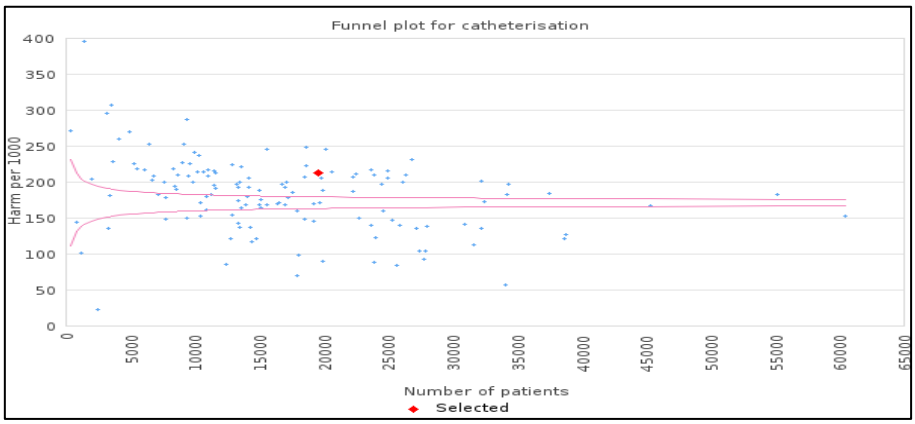
Our current status

The graph below demonstrates our performance with CAUTI from 2015/16 to 2016/17. The results highlight a reduction of 56% in 2016/17 compared to 2015/16.

- 2015/16 Catheters with NEW UTI = 32
- 2016/17 Catheters with NEW UTI = 18 (trajectory 15)



The graph below is from the Safety Thermometer which demonstrates the number of catheters inserted. The Trust is demonstrating an increase of insertion of catheters compared to national data.



What success will look like
Our targets for the next year are:

• We will reduce the number of catheters inserted to national rates
• Work collaboratively with our community colleagues to identify themes and lessons to be learnt
• All CAUTIs are reviewed by the Continence Nurse Specialists
• Themes to be identified and share lessons
• Reduce CAUTI by 20%

How will we assess our progress

There is a monthly CAUTI meeting which reports up to Patient Safety Committee. The committee is responsible of ensuring the reported CAUTIs are correctly reported and investigated.

Priority 8 - Improve compliance with administration of medication in diabetic drugs

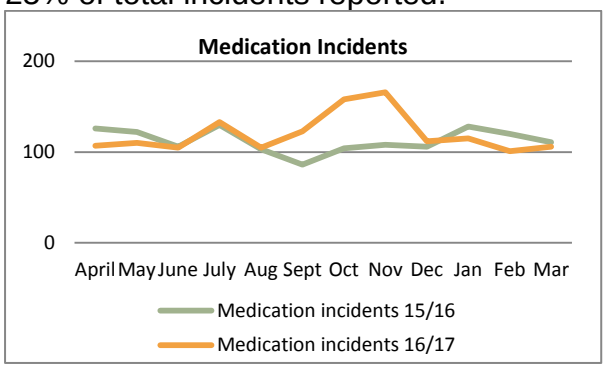
Why we have selected this priority

Medication audits across the Trust suggest there is more work we can do to ensure best practice in safe medication practice at all times.

Reducing medication errors makes a significant contribution to reducing patient harm. Nationally there is a long history of medication errors associated with the use of insulin. The trust also saw an increase in the reporting of clinical incidents involving diabetic management. A deep dive into the pathway for patients who were admitted with Diabetic Ketoacidosis (DKA) has confirmed the importance of this issue.

Our current status

Insulin related medication errors are discussed at the Medicines Safety Committee, Patient Safety Committee and reported to board on a monthly basis. The graph depicts all medication incidents reported and the majority result in no harm. The Trust encourages staff to complete an incident form if there are near misses or if learning can be found. Insulin and anti-diabetic incidents account for 20 - 25% of total incidents reported.



What success will look like
Our targets for the next year are:

• Improve attendance of clinical staff at the medicines optimisation and safety committee
• To reduce the preventable harm associated with medication use.
• To improve the quantity and quality of medication incident reports in collaboration with the clinical areas.
• Commence procurement of Electronic prescribing (ePrescribing) systems, where the ordering, administration and supply of medicines is supported by electronic systems, offer the opportunity to help reduce such risks.
• Commence the Medication Safety Thermometer which follows a three step process in order to identify harm occurring from medication error. Data will be collected on one day each month and enable wards, teams and organisations to understand the burden of medication error and harm, to measure improvement over time and to connect frontline teams to the issues of medication error and harm, enabling immediate

• Improvements to patient care.
• Diabetes nurses to deliver training sessions to groups of staff including nurses, junior doctors and pharmacists
• Increase reporting of medication incidents as this demonstrates a safety reporting and learning culture
• Reduce the proportion of anti-diabetic and insulin incidents causing harm
• Increased shared learning across the Trust

How will we assess our progress

There is a monthly Medicines Optimisation Meeting where the data is interrogated. All are reported on the Trusts incident reporting system and discussed at the speciality governance meetings.

Priority 9 - Improve the experience for patients with dementia and vulnerable patients

Why we have selected this priority

The UK's growing elderly population is placing additional demands on the NHS and this Trust is no exception. One in three of us will develop dementia at some point in our lives and providing compassionate care for this vulnerable group of patients is vital, to ensure they are properly supported in hospital – when the ward environment can be a frightening and disorientating place to be. It's estimated that by 2021, the number of people with dementia in the country will have increased to around one million.

People with learning disabilities are often vulnerable in acute hospital settings and at greater risk of adverse incidents. Illness can be missed particularly where staff have little knowledge of the healthcare needs of this patient group or where specialist knowledge is unavailable to support them.

Many people with mental health needs are brought to Emergency Departments in distress or are seriously disturbed. Some can become more distressed as a consequence of the illness or injury that has brought them to hospital. 60% of acute hospital inpatients over 65 years of age will have a mental health problem and will require additional skills to support them in the hospital environment.

Our current status

We are required to make reasonable adjustments to our service to ensure that all vulnerable patients do not receive a service that is below the standard of any other patient. So to support better dementia diagnosis our aim is to screen, assess and (if necessary) refer patients over the age of 75 when they are admitted to hospital in an emergency. It helps us to provide them with the right type of support and makes sure they get the right specialist care.

What success will look like
Our targets for the next year are:

A Transformation Change Programme for Mental Health & Learning Disability care has been commenced; this will include caring for patients living with dementia. In 2017/2018 we will:

• Review our existing Dementia Strategy working with patients and their families to ensure we continue to provide person centred, compassionate care to our patients and support out families and carers. Early priorities include the implementation of Digital Reminiscence Therapy and wards applying for and completing the Lincolnshire Carers Quality Award indicating they are an area of best practice in caring for carers.
• Explore, develop and deliver care pathways that consider and address the needs of our patients with mental health conditions; we will lead this through our newly developed strategy design and delivery group which has excellent multi-agency membership.

Initial priorities will be focused around self-harm. Mental health Act and Clinical Holding and Restraint.

• Continue to work in close partnership with Learning Disability services to ensure best practice and that our staff are aware of and alert and responsive to our patients particular needs.
• Incorporate Mental Health and Learning disability learnings within the Trusts Mortality Review process.

How will we assess our progress

We will monitor progress of our planned improvements and measures of success through the monthly Patient Experience Committee which reports progress to the Trust Quality Governance Committee. This will be used as a forum to share latest guidelines and review feedback from surveys and audits in order to develop action plans for continued improvement.

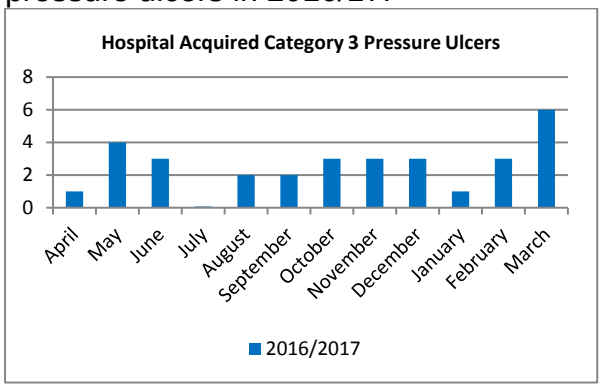
Priority 10 - Reduce avoidable harm by eliminating avoidable category 4 pressure ulcers and reducing avoidable category 3 pressure ulcers by 50%.

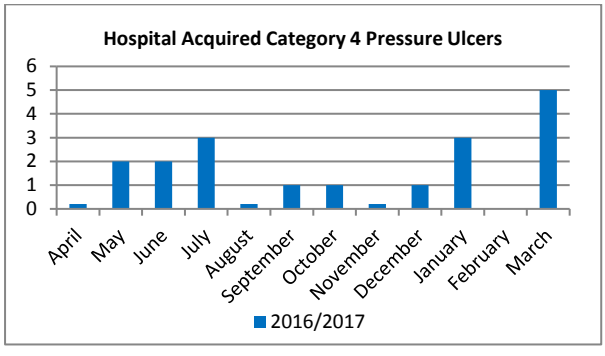
Why we have selected this priority

Pressure ulcers can occur in people who are unwell and immobile, and we know this is a cause of concern for our patients and their families as they can result in patients suffering pain, discomfort and reduced mobility, and may increase their risk of acquiring complications such as infection and prolong their stay in hospital. They are categorised from one to four according to the level of severity.

Our current status

The graphs below depict out Trust compliance for category 3 and 4 pressure ulcers in 2016/17.





What success will look like
Our targets for the next year are:

• Reviewing the quality of data from our reporting systems Datix and PUNT, and triangulating the data to provide clarity and assurance on performance.
• Continuing to undertake investigations of category 3 and 4 pressure ulcers to understand the root cause and identify learning. These investigation will continue to be reviewed at specialist scrutiny panels.
• Increasing awareness of ward performance and reviewing how we share learning across the Trust to change practice.
• Increasing the visibility of the Tissue Viability Nurse Consultant on the wards.
• Reviewing the training programme and delivery methods.
• Continuing to identify and train pressure ulcer link nurses/ambassadors for in-patient areas, ensuring standard resources are available in all ward areas.
• Introducing the tissue viability standard for Ward Accreditation.
• Increasing accountability regarding quality performance through the Nursing Cabinet.
• Developing a Pressure Ulcer Collaborative within Lincolnshire.

How will we assess our progress

• Increasing the frequency of meetings of the Pressure Ulcer Committee

responsible for monitoring performance and progress with the Improvement Programme
• Review of Ward Accreditation performance
• Preparing monthly performance reports for the Patient Safety Committee and Quality Governance Committee

Part 3

Statements of assurance

Review of services

During 2016/17, United Lincolnshire Hospitals NHS Trust (ULHT) provided and/or subcontracted 48 NHS services. We have reviewed all the data available to us on the quality of care in all of these 48 NHS services.

The revenue generated from patient care activities covered by the services in this report was £392.4 million in 2016/17.

Lincolnshire Health and Care (LHAC)

The review of health and care services has an ambition to develop a model of care that will help the health and care community provide quality services that are safe, accessible and suitable for future. Its aims are how to best provide the right service, at the right time, in the right place to achieve the best outcome within the resources available, in addition to integrate the delivery of a health and care model that is seamless to the patient, and finally to achieve financial balance across the health and care system in Lincolnshire.

2021 Strategy

We have been developing our 2021 Strategy that sets out our roadmap for the future delivery of improved services and demonstrating a culture of quality and safety.

We have been consulting on the development of our strategic ambitions for the 2021 programme which are:

Our Patients - to improve year on year the experience of our patients:
- We will proactively seek, listen and respond to all the feedback we receive
- Want to choose us for their care and be our advocates
- Shape how our services run
- Fully involve people in their care

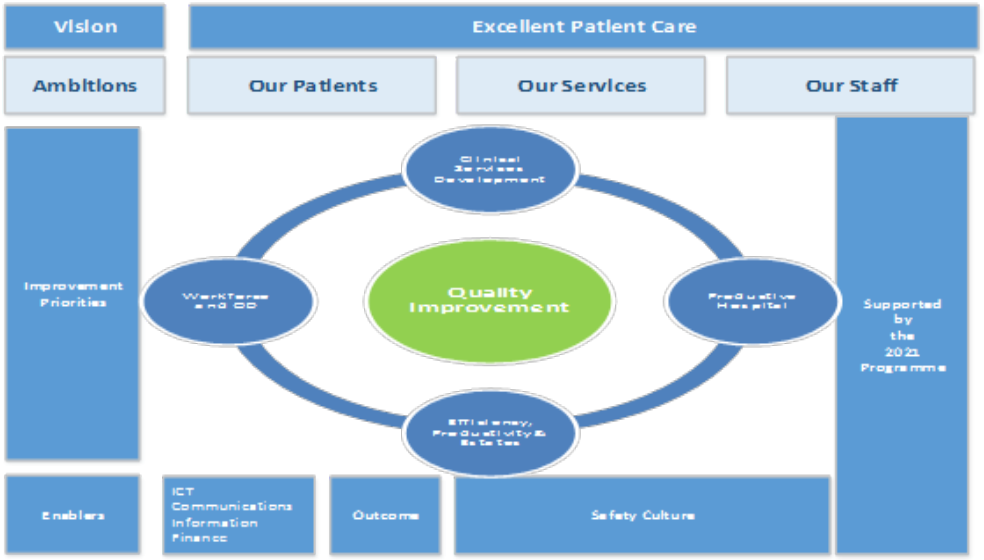
Our Services - to improve year on year the safety of our organisation for patients, visitors and staff and outcomes for our patients:
- Deliver safe services in all settings
- Be centres of excellence
- Be the service provider of choice
- Get things right first time, valuing patient's time
- Focus on service improvement and enhancing quality
- Develop evidence based practice and innovation in all our services

Our Staff - to further develop a highly skilled, motivated and engaged workforce which continually strives to improve patient care and Trust performance:
- Be proud to work at ULHT
- Continuous learning and improvement
- Challenge convention and improve care
- Build capacity and capability in our workforce
- Have an engaged, responsive, flexible and diverse workforce who feel valued, listened to and supported

To deliver the Strategy we have set up a 2021 Programme with work streams for:
- Quality and Safety Improvement
- Clinical Development
- Productive Hospitals

• Financial Efficiency
• Workforce and Organisational Development

These work streams will have a number of projects to deliver to achieve the changes required to meet the 2021 ambitions.



Participation in Clinical Audits

Between 1st April 2016 and 31st March 2017, ULHT took part in 31/34 national clinical audits. In addition, we participated in six national confidential enquiries covering NHS services that United Lincolnshire NHS Trust provides. This means that United Lincolnshire Hospitals Trust participated in 91% of possible national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate.

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

National Audits	ULHT Participation	Reporting Period	Number and % required
Peri- and Neonatal			
Perinatal Mortality (MBRRACE-UK)	Yes	2012-2014	No case ascertainment reported by MBRRACE-UK
Neonatal Intensive and Special care (NNAP)	Yes	1st January – 31st December 2015 (report published September 2016)	1130 (episodes of care) (100%)
Children			
Paediatric Intensive Care (PICANet)	N/A	This audit is only applicable to specialist centres	N/A
Paediatric Cardiac Surgery (NICOR Congenital Heart Disease Audit)	N/A	This audit is only applicable to specialist centres	N/A
Paediatric Pneumonia (British Thoracic Society)	Yes	1st November 2016 – 31st January 2017	Data currently being submitted deadline 30th April 2017
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	1st April 2015 – 31st March 2016 (report published March 2017)	206 cases submitted. (case ascertainment is not reported)
Acute Care			
Emergency Laparotomy (5 year project)	Yes	Year 1st December 2015 – 30th November 2016	Cases submitted 307/311 (98%) of the expected
Cardiac Arrest (National Cardiac Arrest Audit) ICNARC	Yes	1st April 2016- 31st December 2016	LCH 85, GDH 11, PH 63 case ascertainment is not reported
Asthma Adults and Children (RCEM)	Yes	1st January 2016- 30th December 2016	194/194 (100%) eligible cases
Severe Sepsis and Septic Shock in Emergency Department (RCEM)	Yes	1st January 2016- 30th December 2016	193/193 (100%) eligible cases
Consultant Sign Off (RCEM)	Yes	1st January 2016- 30th December 2016	269/269 (100%) eligible cases
Adult Asthma(British Thoracic Society	Yes	1st September 2016- 31st October 2016	22 cases case ascertainment is not reported

National Audits	ULHT Participation	Reporting Period	Number and % required
Chronic Obstructive Pulmonary Disease (COPD) Royal College Physicians	Yes	Commenced February 2017	Data being submitted
Adult Critical Care (Case Mix Programme) ICNARC	Yes	2016/2017	LCH 832/832 (100%) PH 494/494 (100%)
Long Term Conditions			
Diabetes (National Adult Diabetes Audit)	No	-	N/A
Diabetes (National Adult Diabetes Inpatient /Survey/ Audit)	Yes	September 2016	160 (100%) eligible cases
Ulcerative Colitis & Chron's Disease (National IBD Audit) biologics Audit	Yes	Patients newly started on biologics therapy 12th September 2011-29th February 2016	16 case ascertainment is not reported
National Audit Dementia	Yes	1st April 2016 – 30th April 2016	194/194 (100%) eligible cases
Elective Procedures			
Cardiothoracic Transplantation (NHSBT UK Transplant Registry)	N/A	Applicable to specialist centres only	N/A
Liver Transplantation (NHSBT UK Transplant Registry)	N/A	Applicable to specialist centres only	N/A
Cardiac Arrhythmia (NICOR)	Yes	April 2015 – March 2016 Report published February 2017	413 (case ascertainment is not reported)
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Yes	January 2014-December 2014	1076 (100%) eligible cases
National Vascular Registry including NVD -Carotid Interventions Audit)	Yes	2014/2015 2013/2015 2013-2015 1st January 2014 – 31st December 2015	14/12 (117%) 2 more than expected Infra-renal AAA 40/40 (100%) Carotid Endarterectomy Emergency Repair AAA 22 Major Limb Amputation 74
Hip, Knee and Ankle Replacements (National Joint Registry)	Yes	1st January 2016-31st December 2016	1391 cases submitted no case ascertainment

National Audits	ULHT Participation	Reporting Period	Number and % required
National Elective Surgery Patient Reported Outcome Measures (National PROMs Programme) (4 operations) Overall patient participation rate Participation by each PROM 1.Varicose Veins 2.Groin Hernia 3.Hip Replacement 4.Knee Replacement	Yes	PROMs April 2014 – March 2015 Finalised report PROMs April 2015 – March 2016 – Provisional report Patients who completed a pre-operative questionnaire	1273/1974 (64.4%) 1242/1942 (64.0%) 14/15 15/16 1. 74, 35.4%, 102, 51.8% 2. 230,46.2.%, 212, 46.9% 3.474, 76.0%, 434, 73.1% 4. 495, 76.5%, 494, 70.7%
Coronary Artery Bypass Graft (CABG) and Valvular Surgery (Adult Cardiac Surgery Audit)	N/A	Applicable to specialist centres only	N/A
Ophthalmology Audit	No	-	N/A
Cardiovascular Disease			
Stroke Care (National Sentinel Audit of Stroke) SSNAP	Yes	April 2016 – November 2016	761/762 (99.8%) (72 hours) 742/762 (97.3%) (to discharge)
Acute Myocardial Infarction & Other Acute Coronary Syndrome (MINAP)	Yes	1st April 2014 – 31st March 2015. Report published January 2017.	1543 (100%) eligible cases
Heart Failure	No	April 2014- March 2015 Report published July 2016 April 2015 – March 2016 Report not yet published	561/938 (60%) 70% case ascertainment for participation
Pulmonary Hypertension	N/A	Applicable to specialist centres only	N/A
Renal Disease			
Renal Registry and Transplant	Yes	2015 - Data is not specific to ULHT	Data is submitted via Leicester Renal Unit
Cancer			
Prostate Cancer	Yes	1st April 2014 – 31st March	397/560 (71%)
Lung Cancer (LUCADA)	Yes	Patients diagnosed with lung cancer first seen in 2015	378 (no case ascertainment reported

National Audits	ULHT Participation	Reporting Period	Number and % required
Bowel Cancer (NBCA)	Yes	Patients diagnosed between 1st April 2014 and 31st March 2015	264/388 (68%)
Head & Neck Cancer (DAHNO)	Yes	Patients first seen between 1st November 2013 and 31st October 2014	>80% case ascertainment reported by East Midlands Cancer Network – no site data reported
Oesophago-Gastric Cancer (National O-G Cancer Audit)	Yes	Patients diagnosed between 1st April 2013 and 31st March 2015 and followed up for treatment until December 2015	162 (51-60%) case ascertainment
Trauma			
Hip Fracture (National Hip Fracture Database) Includes Falls & Fragility Fractures Audit (FFFAP)	Yes	1st April 2015 – 31st March 2016	788 – PH 318 (95.5), LCH 378 (90.8), GDH 92 (44.6%)
Trauma Audit Research Network (TARN) Trauma	Yes	2016	608 (100%)
Psychological Conditions			
Prescribing in Mental Health Services (POMH)	N/A	Not applicable to acute trusts	N/A
Blood Transfusion			
Blood Transfusion Audits	Yes	2016 Jan – Feb 2016 Red Cell and Platelet transfusions in adult Haematology patients Oct – Nov 2016 Patient blood management in adults undergoing scheduled surgery (awaiting report)	39 cases Case ascertainment is not reported 32 cases

National Audits	ULHT Participation	Reporting Period	Number and % required
Confidential Enquiries			
Acute Non Invasive Ventilation	Yes	2016/2017 Clinical questionnaire Case note Organisational questionnaire completed	 9/9 (100%) 9/9 (100%) 3 /3 (100%)
Chronic Neurodisibility	Yes	2016/2017 Clinical questionnaire Case note Lead clinician questionnaire completed Case note	 7/7 (100%) 7/7 (100%) 4/4 (100%) 3 /4 (75%)
Acute Pancreatitis	Yes	2016/2017 Clinical questionnaire Case note Organisational questionnaire completed	 9/9 (100%) 9/9 (100%) 2/3 (66.6%)
Mental Health	Yes	2016/2017 Clinical questionnaire Case note Organisational questionnaire completed	 15/15 (100%) 15/15 (100%) 3/3 (100%)
Young People's Mental Health (*please note this study is still open and the figures are not yet final)*	Yes	2016/2017 Clinical questionnaire Case note	 8/8 (100%) 0/8 (0%)
Cancer in Children, Teens and Young Adults (*please note this study is still open and the figures are not yet final)*	Yes	2016/2017 ICU Cases SACT Cases	No eligible cases No eligible cases

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 2016/2017 the data period covered may cover previous years.

Glossary:

HQIP – Health Quality Improvement Partnership
SSNAP – Sentinel Stroke National Audit Project
EMAS - East Midlands Ambulance Service
NVD- National Vascular Database

NICOR - National Institute for Cardiovascular Outcomes Research
PROMs – Patient Reported Outcome Measures
AAA – Abdominal Aortic Aneurysm
CEA - Carotid Endarterectomy
RCEM – Royal College Emergency Medicine
MDT – Multidisciplinary Team
PH – Pilgrim Hospital
LCH – Lincoln County Hospital
GDH – Grantham District Hospital

The reports of 26/31 national clinical audits were reviewed by United Lincolnshire Hospitals NHS Trust between 1st April 2016 and 31st March 2017. The remaining audits are still active and will be reviewed over the coming months when the audit reports are published.

Descriptions of actions from a sample of the national audits:

National Audit	Headline results and actions taken
MINAP (heart attack and Ischaemic heart disease)	• Lincolnshire Heart Attack Centre 24/7 continues to provide good quality care and improve on last year's results based on local analysis and national reporting (*national reporting is behind schedule*). • Procedure to open up blocked heart vessels quickly to restore coronary blood flow 95.1% of patients met the door to balloon time of 90 minutes compared to the national average of 88.9% • Collaborative work with EMAS continuing to ensure eligible patients are taken directly to the Heart Attack Centre 85% of patients met the time of call for help to balloon time of 150 minutes compared to the national average of 77% • Prescribing preventative medications above the national average at 100% for all eligible patients • National report publications have been delayed the 2015/2016 report is awaited
TARN (Trauma)	• Trauma meetings held at Lincoln and Pilgrim to discuss findings and share learning • Transfer to Trauma Centre reviewed with the Trauma Network to ensure eligible patients are transferred for specialist care ongoing • Review of data collection process to ensure good quality and completion of data 100% data submissions for the Trust • On-going work to review and improve compliance with standards • Mock trauma call with EMAS completed with a debrief on

	how the call was managed to improve staff knowledge and experience of dealing with a Trauma Call • TARN data coordinator has maintained an excellent strategy to improve the quality reliability of data
Hip Fracture	• Surgery on day of, or day after admission national average 72%, ULHT sites are achieving PH 89.3%, LCH 82.3%, GDH 79.3% • Patients get out of bed by the day following their surgery national average 76%, ULHT sites are achieving PH 58.6 %, LCH 75.4%, GDH 89% • Received bone health assessment PH 100%, LCH 99.7% GDH 55.2%, 80% nationally • Sharing best practice across the trust to improve the patient pathway • 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 • Scoring A-E used for stroke units with A being the highest score to achieve latest report shows Pilgrim as a B and Lincoln as a C • CT scanning within 12 hours above the national average achieving 97.4% at Lincoln and 97.1% compared to the national average of 93.5% Pilgrim Team centred care achieving a score of B • Thrombolysis clot busting medication to help remove clots % thrombolysed within an hour of arrival to hospital 87.9% Lincoln and 85% at Pilgrim compared to the national average of 63% • Strategy to improve data submissions is working well with case ascertainment of 100% (A)
Vascular	• Consultant outcome publication within expected range
Cardiac Arrest	• Education around deteriorating patient is on-going
Bowel cancer data	• Consultants outcome publication within expected range • 92% of cases with a recorded performance status compared to 64% regionally and 77% nationally • 80% data completeness for patients with major surgery compared with 87% regionally, 82% nationally reviewing data submissions to improve
PROMs	• Ongoing recruiting of patients via pre-assessment clinics to complete the questionnaire before surgery 64% of patients completed a pre-operative PROM • Continue to ensure patient leaflets are available in other languages explaining the purpose of PROMs • Data is reported every four months to monitor progress with participation rates and outcome measures
Hip, Knee and Ankle Replacements (National Joint	• Consultant outcome publication within expected range • On-going review of NJR process to improve quality of data submission to the national database

Registry NJR)	• Consultants have access to their own data to review their practice.
Prostate Cancer	• Data quality is being reviewed ongoing to ensure all data is submitted going forward • Moved to Somerset Cancer database
Heart Failure	• Improved data submission for 2016/2017 will see participation improve to above the 70% required national report awaited for this period and the 2015/2016 period due to the National Audit provider not publishing the latest reports. • Improved service to deliver care to patients • Locally achieving Best Practice Tariff since April 2017

Local Clinical Audit

The reports of 142/240 audits registered during the year were reviewed by United Lincolnshire Hospitals NHS Trust between 1st April 2016 and 31st March 2017. The remaining audits are still active and will be reviewed over the next few months.

Examples of actions taken locally:

Local Audit	Actions - Improvements
Re-audit of radiographs undertaken in the special care baby unit	The results showed: • Reduction in images graded as “Poor” for all 3 examinations • Increase in images graded as “Good” and “Adequate” for all 3 examinations • Both radiographers thought there was improvement in images when reviewing without knowing each others views/assessments • Both radiographers felt that they were stricter in assessment of the criteria! • Continual training
Consent to Treatment or a Procedure	• Improved compliance with explaing the risks and benefits of an operation or procedure • Ensuring patient information leaflets are available for patients through pre-assessment
Post lower limb arthroplasty X-ray compliance	• There is a significant improvement noticed after implementing the change proposed in the first cycle -electronic paperless x-ray request forms for post lower limb arthroplasty patients-

Participation in clinical research

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

The number of patients receiving NHS services provided or sub-contracted by ULHT in 2016/17, who were recruited during that period to participate in research approved by the National Health Research Authority was 1552. Total number of patients/participants recruited for portfolio and non-portfolio studies were over 1600. These patients/participants were recruited from a range of specialities and included patients with cancer, stroke, diabetes, dementia & neurodegenerative diseases, paediatrics and a number of other areas.

The Trust is supporting trials from more specialities as compared to 2016/17. In particular, the Trust is supporting significantly more for the National Institute for Health Research (NIHR), portfolio & commercial studies. 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.

Due to the increased number of commercial and non-commercial trials, Lincolnshire patients are benefitting and receiving latest drugs/treatment free of charge as drugs are supplied by study sponsors. The Trust has implemented findings of trials which has helped the Trust in improving patient care and cost saving.

The Trust is involved in conducting about 200 clinical research studies including studies in follow up. By the end of March 2017, for stroke, Lincoln recruited 54 patients and for Stroke, Pilgrim we recruited 63 patients. In case of cancer Randomised Controlled Trials (RCT), the Trust recruited 149 patients. In the case of Cancer non-RCT, we recruited 137 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 2016/17 financial year, the Trust has approved 40 portfolio and 8 non-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.

In 2016, the Lincolnshire Clinical Research Facility (LCRF) team won a CRN award under the outstanding CRN partner contribution category in the East Midlands CRN. This is in recognition of the huge steps that ULHT has made in research, going from having minimal research activity to having a fully-functioning clinical Research Facility, which is now among

the top recruiting centres in the country, for some clinical trials. In addition, the LCRF clinical trials pharmacy team was shortlisted in the significant contribution of services supporting research category of the awards. This recognises the flexible and innovative approach that ULHT's pharmacy department takes to research, resulting in a large number of drug trials carried out. Our senior Clinical Research Nurse, Helen Walker, won East Midlands CRN under the exemplary investigator contribution category. This recognises the fact that Helen made chief investigator of a multi-centre clinical trial, a great achievement as very few nurses lead research on their own.

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

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

Use of the Commissioning for Quality & Innovation (CQUIN) framework

The CQUIN framework aims to embed quality improvement and innovation at the heart of service provision and commissioner-provider discussions. It also ensures that local quality improvement priorities are discussed and agreed at board level in all organisations. It enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

A proportion of United Lincolnshire Hospitals NHS Trust income in 2016-17 was conditional on achieving quality improvement and innovation goals agreed between United Lincolnshire Hospitals NHS Trust 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.

At the time of writing this Quality Account we are still awaiting the outcome of quarter 4 achievements however we have depicted what we think we will achieve. The total value of the 2016/17 CQUINs equates to £6,074,914 and we are anticipating achieving 85% of the total value. A summary of the achievements of the CQUIN milestones for 2016-17 are demonstrated below.

CQUIN	Q1	Q2	Q3	Q4 expect	Value
Introduction of staff health & wellbeing initiatives					£861,345
Development of an implementation plan and implementation of a healthy food and drink offer					£861,345
Improving the uptake of flu vaccinations					£861,345
Sepsis: Timely Identification &treatment for sepsis in emergency department					£172,269
Sepsis: Timely Identification & treatment for sepsis in inpatient settings.					£172,269
Reduction in antibiotic consumption per 1,000 admissions					£689,076
Empiric review of antibiotic					£172,269
Safeguarding Training					£602,942
Maternity					£861,345
Antimicrobial Stewardship					£861,345
End of Life: e-Learning					£275,630
End of Life: Staff Education					£275,630
End of Life: Link Practitioner					£275,630
Cancer: Release of CNS capacity					£1,154,202
Adult Critical Care Timely Discharge					£310,224
Dose Banding Adult Intravenous Systemic Anticancer					£25,000
Severe Haemophilia Haemtrack - Home Reporting					£39,200

RAG

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

The table below details the 2017/18 CQUINs

CQUIN 2017/18
Improving Staff Health and Wellbeing
Healthy food for NHS staff, visitors and patients
Improving the uptake of flu vaccinations for frontline clinical staff
Timely identification for sepsis in emergency departments
Timely identification for sepsis in acute inpatient settings
Timely treatment for sepsis in emergency departments
Timely treatment for sepsis in acute inpatient settings
Empiric review of antibiotic prescriptions
Reduction in antibiotic consumption
Improving services for people with mental health needs who present to A&E
Set up and operate A&G services for non-urgent GP referrals
All providers to publish ALL of their services and make ALL of their First Outpatient Appointment slots available on eRS by 31 March 2018
Supporting Proactive and Safe Discharge
Severe Haemophilia Haemtrack Patient Home Reporting
Hospital Medicines Optimisation
Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community
NHS Dental Services

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.

The Trust has not been subject to any special reviews or investigations by the CQC under section 48 of the Health & Social Care Act 2008 during 2016/17

In October 2016 United Lincolnshire Hospitals NHS Trust participated in an announced hospital inspection of its core services across all Trusts sites by the Care Quality Commission relating to the following areas of care:

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 April 2017 which rated the Trust as 'Inadequate' overall and placed in 'Special Measures'. The Trust was disappointed with the overall Rating from the CQC of 'Inadequate', especially as the CQC rated 56% of services as good and just 12% were inadequate.

A number of actions were completed at the time of the visit as soon as they were brought to the Trusts attention.

The domains were reported as:

Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Inadequate

The tables below give an overview of each site's ratings

Our ratings for Lincoln County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Inadequate	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Grantham Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good

Our ratings for Pilgrim Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Inadequate	Requires improvement	Inadequate	Inadequate
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Inadequate	N/A	Good	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

The CQC highlighted ten initial concerns where immediate actions were introduced and the table below details the progress to date. The action plan is monitored on a weekly basis by the Quality & Safety Improvement Programme Board which is chaired by the Chief Executive.

	CONCERN	PROGRESS
1	Major Incident Policy	All equipment in date and regularly checked Major incident plans up-to-date in A&E and training in place New CBRN storage facility
2	Self-Harm	Ligature risk assessments carried out in all A&E departments and Paediatrics. Results acted upon with removal of hooks and ligature cutters now available on all ward areas Over 100 A&E staff completed training on the management of patients with regard to self-harm Self-harm and ligature risk audit demonstrated a good understanding of mental health issues and self-harm. All staff knew where ligature cutters were kept.
3	Mental Health	Mental Health Policy approved and training on-going. Currently piloting new Mental Health Triage Assessment form in A&E Lincoln
4	GI Bleed	Out of Hours policy in place and audit in progress. Additional Medical Director support from NHS I in place from May to support development of permanent Pilgrim GI Bleed rota
6	Lorazepam	Management of BPSD and Delirium Policy relaunched Lorazepam audit undertaken Chemical restraint policy will be ratified by CESC in May
7&5	Tracheostomy and Non-Invasive Ventilation	100% of Registered Nurses trained on designated wards with evidence of appropriately trained staff on all shifts for designated wards available from ward rotas and e-roster (from April)
8	SEPSIS Compliance	Commencement of Sepsis Screening - INCREASED from 69% to 91% Admin of IV antibiotics within 1 hour - INCREASED from 39% to 72% Sepsis e-Bundle roll out (SQD audits 50% of patients once per month e-bundle will identify100% of patients with NEWS over 5 every day)
9	Nurse Leadership - Pilgrim	Dedicated Transformation Team in place at Pilgrim including Medical Director support (from NHSI), Deputy Director of Nursing, Director of Operation, new Head of Nursing and Matron (Medicine) and dedicated support to investigate SIs. Improved assurance framework including enhanced review from CCGs.
10	Dignity	94% of Staff on the ward at Pilgrim received formal Dignity Training Dignity forms part of all Daily ward huddles and ward meetings. Ward assurance visits routinely monitor dignity

This layer of activity is an indication of the depth and focus that is being undertaken by staff at all levels of the organisation. It can be clearly seen that difficult decisions have been taken, and will continue to be made to ensure that the trust releases itself from 'Special Measures' as quickly and securely as possible.

The trust, its executive and management team, along with the colleagues see this as an opportunity to correct the issues and problems that have been found and to create a trust that everyone in Lincolnshire can be proud. A point to note for all colleagues, and one that has been emphasised throughout the initial phases of the 'Special Measures' term. Not all of the report was bad news. There were identified several key areas of good and outstanding practice, these were recognised by the assessors throughout their visit and detailed within the report. Some of these are detailed below:

- **The emergency department (ED)** inputted hourly detail into a specific risk tool which had been created, to give an internal escalation level within ED separate to the site operational escalation level. This tool gave an "at a glance" look at the number of patients in ED, time to triage and first assessment, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait. This gave a focus across the trust on where pressure was building and there were local actions for easing pressure.

- **The trust** had introduced a carer's badge, which enabled any family members and trusted friends to be involved in the care of their loved ones. The carer's badge encouraged carer involvement, particularly for patients with additional needs. Being signed up to the carer's badge also gave carers free parking whilst they were in attendance at the hospital.

- **On the care of the elderly wards** a red, amber, green system was used to identify patients who required more assistance than others. Red signified those patients who required the most help, whilst green identified those patients who required the least. This system was also applied to each patient's menu card to signify the amount of support a patient required with eating. Patients with a green sticker were given their meals first. Staff who took meals to patients with a red sticker then stayed to support the patient to eat their meal.

Staff on the children's ward had learnt sign language to enhance their communication skills with children who had hearing difficulties

The following table details the projects the trust is taking forward post CQC inspection. There are some projects that overlap the initial concerns the CQC highlighted.

Project No	Project Name	Scope
QSIP01	Developing the safety culture	Culmination of a number of pieces of work including: learning lessons, freedom to speak up, customer care training
QSIP02	Clinical governance	External review to inform the development of an action plan to strengthen governance across the organisation. Clearing the backlog of existing SIs.
QSIP03	Sepsis	Immediate actions taken which will be developed and sustained across the trust
QSIP04	GI bleed service	Immediate actions taken to manage the risk. Further work to establish a sustainable 24/7 GI bleed rota across the trust
QSIP05	Airway management	Immediate actions taken to address concerns at PHB. These will be rolled out and embedded across the trust
QSIP06	Mental Health Assessment	Immediate actions taken to manage the risks. Further education, training and development in other clinical areas across the trust
QSIP07	Safeguarding	Delivering the plan developed following an external review. Including strategy development, policy review, compliance monitoring and education, training and development
QSIP08	Medicines management	Focus on omitted doses, medicines reconciliation , CD audits and quality of prescribing
QSIP09	Training and competencies	Clarity about core learning and core learning plus for categories of staff following a training needs analysis. ESR reporting on compliance and training rates.
QSIP10	Appraisal and supervision	Development of a positive performance management framework to enhance the appraisal process.
QSIP11	Outpatients	Utilisation of clinic space, clinical review/validation of patient referrals and follow ups, reducing backlogs, resolving environmental issues and finalising leadership and new ways of working
QSIP12	Control of Infection	Implement and embed the agreed IPC action plan and minimising lapses in care, reducing blood culture contamination rate and housekeeping review
QSIP13	Reducing variation in practice in clinical areas	This will contain a number of specific work areas including: DKA and diabetic care, pain assessment / management and hospital at night/deteriorating patient

Data quality

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

• Continuing to embed Medway (Patient Administration System) following the implementation mid-2014, 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
• Preparatory work is underway to upgrade Medway to the latest version (v4.8) which is expected to take place towards the end of 2017
• Continuation of implementing actions identified by the 2015
• Payment by Results Assurance Audit (mainly around clinical coding, produced by the Audit Commission on behalf of Lincolnshire CCGs)
• Review of structure of Data Quality function and wider Information Services structure to ensure the team supports the needs of the Business
• 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 Business Units in the Trust

NHS Number and General Medical Practice Code validity

United Lincolnshire Hospitals Trust submitted records during April to February 2016/17 at the Month 11 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: 99.7% for Admitted Patient care (National performance 99.2%, ULHT 15/16 was 99.2%); 99.8% for Outpatient care (National 99.4%, ULHT 15/16 was 99.8%); and 98.4% for Accident and Emergency care (National 95.6%, ULHT 15/16 was 98.1%)

This included the patient's valid General Medical Practice Code was: 100% for Admitted Patient care (National performance 99.9%, ULHT 15/16 was 100%); 100% for Outpatient care (National 99.8%, ULHT 15/16 was 100%); and 100% for Accident and Emergency care (National 99.0%, ULHT 15/16 was 100%).

Clinical coding error rate

United Lincolnshire Hospitals NHS Trust was subject to the Payment by Results Clinical Coding audit by the Audit Commission in April 2015. Based on the results of this audit, which were based on one clinical area that was the focus of audits nationally, with one supporting area for individual local areas, the focus was on co-morbidities and complications with Thoracic Procedures and Disorders nationally (HRG subchapter DZ), supported by Nervous System Procedures and

Disorders locally (HRG subchapter AA). The performance of the Trust, measured using the error rate of the number of spells affecting price, was 9.5% for admitted patient care (last year's comparable number was 6.9% error rate). However the financial value of these changes equated to a net change of 0.3%.

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 have 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.

Information Governance Toolkit attainment levels

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

For the period of April 2016 to March 2017 ULHT achieved a score of 87%, assessed using the Information Governance toolkit. Unfortunately we were classed as non-compliant due to achieving a level 1 on one standard despite our overall improved compliance.

The Information Governance toolkit sets information governance training compliance at 95% and despite our best efforts we were only able to reach 90% therefore only able to reach a level 1. This will continue to be an area of focus over the next year with an action plan in place and already underway.

Data provided by NHS Digital

The following data relating to national reporting requirements in the Quality Account are provided by NHS Digital.

Domain 1	Preventing people from dying.	**Commentary and other information - *The Trust considers this data is as described as it has been repeated without alteration from NHS Digital***
•<u>Summary Hospital:Level Mortality Indicator (SHMI) Data Source: NHS Digital indicator portal.</u> •**Period: Jul 15 – Jun 16** •**ULHT:** 110.07 Band 2 **National Average:** 100 **Ranges: Best/Worse National performance:** 63.39/117.12 Band 3/1 •**Period: Oct 15 – Sep 16** •**ULHT:** 110.30 Band 2 **National Average:** 100 **Ranges: Best/Worse National performance:** 68.97/116.38 Band 3/1		This data will vary according to many clinical and non-clinical factors. A report is generated monthly and discussed at the Patient Safety Committee. ULHT has taken the following actions to improve this rate and so the quality of its services, by investigating and learning from each patient death. We also manage a robust mortality review programme

Domain 3	Helping people to recover from episodes of ill health or following injury.	**Commentary and other information - *The Trust considers this data is as described as it has been repeated without alteration from NHS Digital***
•<u>Patient Reported Outcome Measures (PROMS) Data Source: NHS Digital Adjusted Average Health Gain;</u> •**Period: Apr 15 – Mar 16** •**ULHT EQ:5D Index: ULHT:** Hernia:0.051 , V Vein:0.071 , Hip:0.415 , Knee: 0.301. **National Avg:** Hernia: 0.088, V Vein: 0.095, Hip:0.438 , Knee: 0.320. •**ULHT EQ:VAS Index: ULHT:** Hernia: -0.80 , V Vein:-5.628 , Hip: 11.45, Knee:5.085 . **National Avg:** Hernia: 0.80, V Vein:-0.5 , Hip: 12.4, Knee:6.2 . •**ULHT Oxford Hip & Knee Index: ULHT:** Hip: 21.01 , Knee: 15.385 . **National Avg:** Hip: 21.6 , Knee: 16.4 . •**Period: Apr 16 – Sep 16** •**ULHT EQ:5D Index: ULHT:** Hernia:0.108 , V Vein: no data , Hip:0.431 , Knee: 0.324. **National Avg:** Hernia: 0.089, V Vein: 0.099, Hip:0.449 , Knee: 0.337. •**ULHT EQ:VAS Index: ULHT:** Hernia: 0.949 , V Vein: no data, Hip: 12.15, Knee:5.675 . **National Avg:** Hernia: -0.1, V Vein:1.4 , Hip: 13.7, Knee:8.1 . •**ULHT Oxford Hip & Knee Index: ULHT:** Hip: 19.643, Knee: 16.085 . **National Avg:** Hip:22.0 , Knee: 16.9. •<u>Patients readmitted to a hospital within 28 days of being discharged Data Source: NHS Digital</u> •**Period: Apr 10-Mar 11** •**ULHT:** 0:15: 8.37%, 16+: 10.16%, **National Average:** Not Available, **Ranges: Best/Worse National performance:** 0:15: 6.43%14.11/% 16+: %9.78/13.02% •**Period: Apr 11 – Mar 12** •**ULHT:** 0:15: 7.97%, 16+: 10.49%, **National Average:** Not Available, **Ranges: Best/Worse National performance:** 0:15: 6.40%/16.9% 16+:9.43 %/13.8% •**PLEASE NOTE THAT THE ABOVE DATA HAS NOT BEEN UPDATED SINCE Dec 2013 on NHS Digital.**		Participation rates are improving, all eligible patients are being offered a PROMs to complete, not all patients complete a questionnaire and decline to take part. Information leaflets are provided and are available in other languages as required. Ongoing monitoring with support from Quality Health. Training for recruitment of patients to PROMs for new staff working in pre-assessment and outpatient clinics. The trusts indicators are within National Expectations. ULHT has taken the following actions to improve this score, and so the quality of its services, by where harm is associated with patient care, an investigation is carried out and changes made where appropriate. We have also formed close links with the CCG to review patients and learn lessons.

Domain 4	Ensuring people have a positive experience of care.	**Commentary and other information** - ***The Trust considers this data is as described as it has been repeated without alteration from NHS Digital***

•**Responsiveness to the personal needs of patients**
•**Period: 2014/15**
•**ULHT:** 74.9 **National average:** 77.3 **Range Best/worse National Performance:** 87.4/67.4

•**Period: 2015/16**
•**ULHT:** 75.7 **National average:** 76.6 **Range Best/worse National Performance:** 88.0/70.6

•**Staff who would recommend the Trust to their family and friends**
•**Taken from question:** 21d. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation
•**Period:2015**
•**ULHT:** Strongly Agree: 12%, Agreed: 42% **National average:** Strongly Agree: 20%, Agreed:50%
•**Range Best/worse National Performance:** Strongly Agree: 37%/9%, Agreed: 58%/32%

•**Period:2016**
•**ULHT:** Strongly Agree: 23%, Agreed: 50% **National average:** Strongly Agree: 21%, Agreed: 48%
•**Range Best/worse National Performance:** Strongly Agree: 100%/4%, Agreed: 69%/0%

•**Patients who would recommend the trust to there family of friends: Percentage recommended:**

•**Period: Jan-17**
•**ULHT A&E:** 83% **National average:** 87% **Range Best/worse National Performance:** 100%/45%
•**ULHT Inpatients:** 93% **National average:** 95% **Range Best/worse National Performance:** 100%/80%
•**ULHT Maternity:** 100% **National average:** 96% **Range Best/worse National Performance:** 100%/75%

•**Period: Feb-17**
•**ULHT A&E:** 82% **National average:** 87% **Range Best/worse National Performance:** 100%/48%
•**ULHT Inpatients:**93% **National average:** 96% **Range Best/worse National Performance:** 100%/76%
•**ULHT Maternity:** 90% **National average:** 96% **Range Best/worse National Performance:** 100%/71%

The Trust recognises though improvements have taken place in these data, they are below national means.
ULHT has taken the following actions to improve this score, and so the quality of its services, by
implementing a programme of work supervised by the Chief Nurse to further improve patient experience. We actively encourage feedback from patients and use this feedback to make improvements and share lessons learnt.

The Trust recognises that we are within National ranges for these data and have improved during the period.
ULHT intends to take the following actions to improve this percentage and so the quality of its services, by developing a compelling shared strategic vision, adopting supportive and inclusive leadership styles, giving staff the tools to lead service transformation and establishing a culture based on integrity and trust.

ULHT intends to take the following actions to improve this percentage and so the quality of its services, by strengthening the reporting for patients and staff to enable easy access. The comments will be used to develop service improvement initiatives.

Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm.	Commentary and other information - *The Trust considers this data is as described as it has been repeated without alteration from NHS Digital*
•**Patients admitted to hospital who were risk assessed for venous thromboembolism** •**Period: Quarter 2 (July 16-Septemeber 16)** •**ULHT:** 96.08% **National average:** 95.51% **Range Best/worse National Performance:** 100%/72.14% •**Period: Quarter 3 (October 16-December 16)** •**ULHT:** 96.72% **National average:** 95.64% **Range Best/worse National Performance:** 100%/76.48% •**Rate of C.Difficile infection; rate per 100,000 bed days** •**Period: 2014/2015** •**ULHT:** 29 **National average:** 40.8 **Range Best/worse National Performance:** 0/115 •**Period: 2015/2016** •**ULHT:** 32.2 **National average:** 40.8 **Range Best/worse National Performance:** 0/111.1 •**Patient safety incidents and the percentage that resulted in severe harm or death** •**Period: Apr 15-Sep 16** •**ULHT:** 1.74% **National average:** N/A for this time period **Range Best/worse National Performance:** 0.07%/2.92 •**Total Incidents No:** 4078 **Severe/Death No.:** 71 **Rate per 1000 bed days:** 28.7 (all), 0.5 (Severe/death) •**Period: Oct 15-Mar 16** •**ULHT:** 1.74% **National average:** N/A for this time period **Range Best/worse National Performance:** 0%/2.04% •**Total Incidents No: 5238** **Severe/Death No.: 9**1 **Rate per 1000 bed days:** 18.1 (all), 0.31 (Severe/death)		ULHT performance in this is above the national average. ULHT has taken the following actions to improve this percentage and so the quality of its services, by continuing to work hard to ensure that each patient is appropriately risk-assessed and that prophylaxis is provided accordingly. Compliance data is distributed to all staff monthly. ULHT considers that these data represent strong performance in infection control and prevention. ULHT has taken the following actions to improve this rate and so the quality of its services, by ensuring details of cases and relevant issues are available to primary care colleagues, to help raise awareness and mitigate risk. ULHT has taken the following actions to improve this rate and so the quality of its services, by ensuring all incidents resulting in severe harm or death have an in-depth analysis of what happened and the lessons are shared.

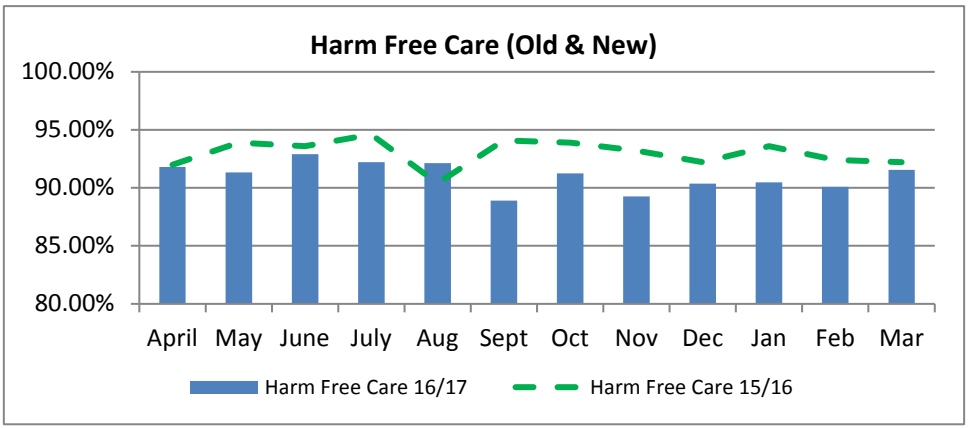
Review of quality performance

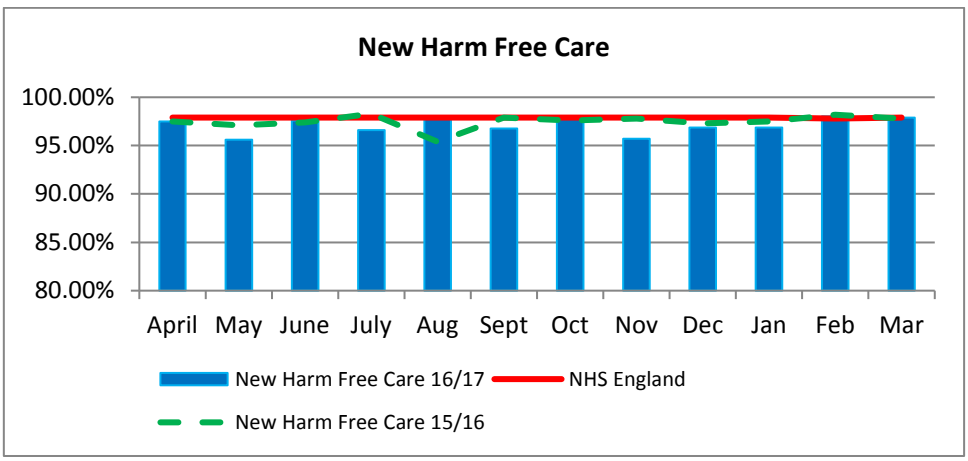
Safety Thermometer

The safety of our patients is a key priority in our quality improvement work. We continue to run a patient safety programme. Our aim is to reduce levels of harm to patients whilst in hospital and we measure this through harms like pressure ulcer rates, infection rates, thrombosis events, and the number of patients falling in hospital. All of these can lead to pain and distress for our patients and extra days or weeks in hospital.

Our aim fits with a continuing national priority across the NHS to measure the incidence of pressure ulcers (sores), falls, urine infections from catheters, and blood clots, through a system called the Safety Thermometer. The NHS Safety Thermometer provides a 'temperature check' on harms and data is collected nationally on one Wednesday every month.

We have reported on harm free care since April 2012. When comparing our performance from April 2016 to March 2017 harm free care has decreased although there are fluctuations. Harm free care comprises of harms from the community whereas New Harm Free Care comprises of harms post admission. New Harm Free care has remained in line to national data. A Safety Thermometer dashboard is produced monthly and distributed to all staff and is also tracked on the Ward Health check which updates monthly.





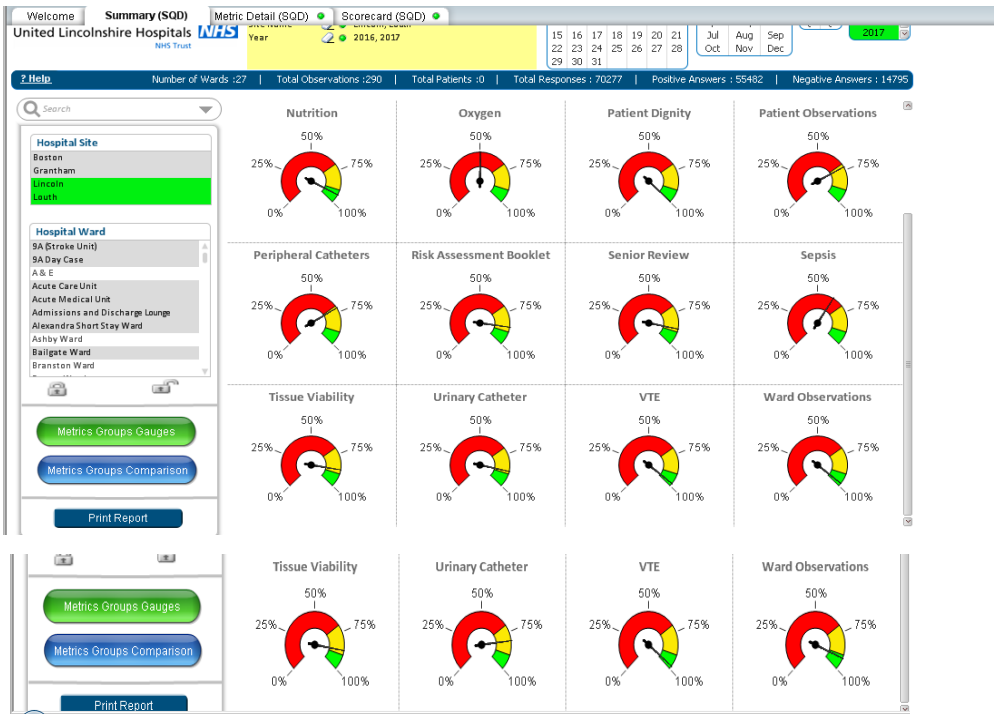
Safety Quality Dashboard (SQD)

The Safety & Quality Dashboard (SQD) is a dashboard developed to provide staff with relevant and timely information to inform daily decisions to improve the safety & quality of patient care. The SQD has been rolled out across ULHT since January 2012. This programme audits the assessment, identification of risks, delivery and evaluation of care against agreed standards for each patient. We have modified the standards and their content to reflect changing practice and recommendations.

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

Metrics collected on the SQD Metrics are divided into key groupings as shown in the table below. In all, over 70 essential quality metrics are included for display at ward level.

The illustration below shows how data is displayed on the ward.



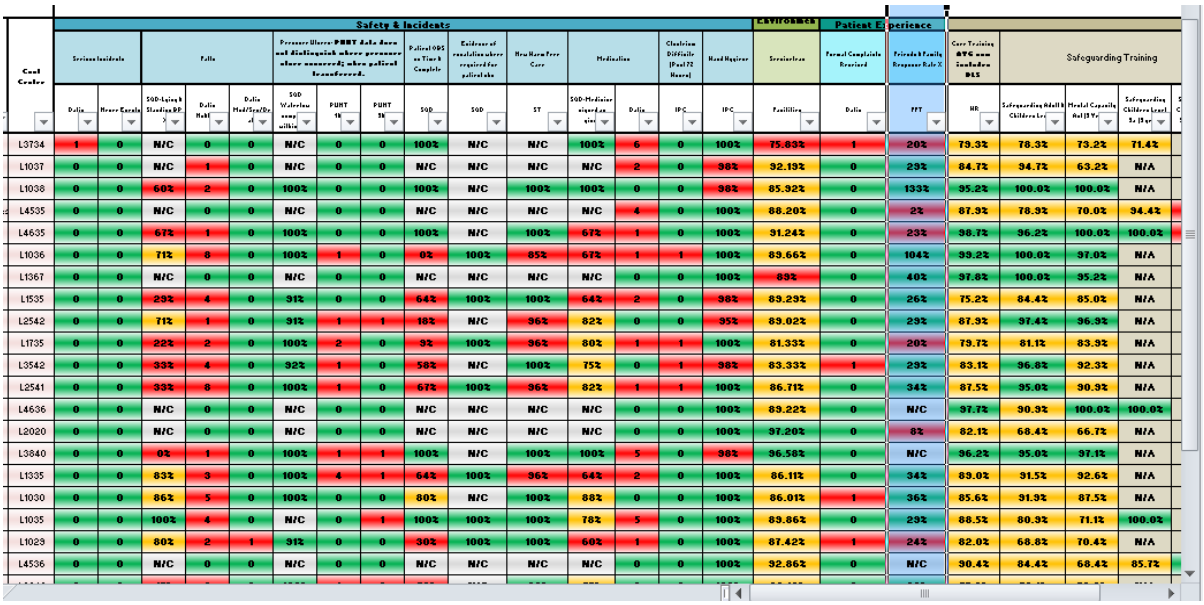
Ward Health Check

Following on from the development of the Trust Safety and Quality Dashboard and the recommendations of the Keogh review team, the Trust developed the Ward Health Check which brings together several key sources of data. Access to and use of good quality information is a key component of performance measurement and improvement for high quality, safe and reliable healthcare. Performance improvement

involves monitoring the current level of performance and instituting changes where performance is not at the desired level. The Ward Health Check supports the Trust to improve the safety and quality of care by providing information about the current level of performance and identifying where there are opportunities for improvement

The Ward Health Check contains key information on incidents, quality, environment, patient experience, staff experience and staff specific metrics for each ward and department. This allows the staff and managers to triangulate data from various sources which enables early intelligence to enable actions to be put into place if required and is used within appraisals for Ward Leaders.

The illustration below shows how data is displayed for each ward



Quality Aim for 2017/18

In 2017/18 we will use the information from the SQD, Ward Health Check and a range of other quality markers as the foundation for a ward accreditation programme. The work on developing this programme has already started with our senior clinical teams we plan to start to test with our high achieving wards as a means to recognise their success.

Sign up to Safety

In 2014 a national campaign was launched by the Secretary of State for Health called the Sign up to Safety Campaign, with a three year objective to reduce avoidable patient harm by 50% and save 6,000 lives across the NHS. Those Trusts who signed up to the campaign were required to develop a Safety Improvement Plan (SIP) which sets out the actions each Trust will take to reduce patient harm and improve safety over the next three years.

The Trust signed up to the Campaign in January 2015 publishing our five pledges focusing on putting safety first,

continually learning, honesty, collaboration, and support.

The Trust's Safety Improvement Plan sets out the organisation's 3 year plans in relation to quality and safety, and builds on existing quality improvement work as outlined in the 2016 Quality Strategy. Our Safety Improvement Plan has identified the quality and safety priorities to be implemented that will significantly reduce patient harm at the Trust. The themes were identified through a prioritisation process which involved reviewing safety measurement and monitoring data, including the Trust's claims profile.

We were pleased to be awarded £31k by the NHSLA to support a Human Factors programme following submission of a bid alongside our Safety Improvement Plan. The Trust is training eight staff to enable a Human Factors Faculty to be developed at the Trust which will roll out a bespoke programme for our staff.

The main focus for 2017/18 is continued delivery of Human Factors training, falls and pressure ulcer prevention. Priorities align with the organisations quality strategy to ensure that at the cessation of the national campaign projects will continue through established forums.

Duty of Candour

We have made this a priority for 2017/28 as we still need to strengthen our processes to ensure all patients receive a timely apology verbally and written if required. Duty of Candour is a statutory legal and contractual responsibility for NHS Trusts and ensures openness and honesty with patients or their families when things go wrong and patients are harmed as a result.

Duty of Candour directs that within 10 days of an incident that has resulted in moderate harm or above occurring, patients or their families should be:
• Notified of the incident
• Offered an apology
• Informed of the actions that are being taken to investigate
• Offered a letter outlining the discussion to date

The outcomes of any investigations should be shared thereafter with patients or their families.

During 2015-16 we have implemented a range of initiatives to help our staff comply with Duty of Candour including the delivery of bespoke training, mechanisms for recording compliance, template letters and concise policy and procedures.
We are in the process of developing an eLearning programme for our staff. We are also introducing a more robust audit process which will identify any incidents where Duty of Candour may not have been completed fully within the 10 day timeline.

The Duty of Candour process ensures that our patients receive comprehensive and timely information on what has gone wrong in the provision of their care and assurance on the actions that we will take to reduce the risk of the incident occurring again in the future. The compliance is reported monthly to the Patient Safety Committee and upwardly to Quality Governance Committee and Trust Board.

Patient Experience

Our Trust uses the Beryl Institute definition of patient experience; 'the

sum of all interactions, shaped by an organisations culture, that influences patient perceptions across the continuum of care'. Patient experience is all about how we interact and care for our patients; the values we hold and expect as an organisation and the resulting care that we provide across all of our services. A positive patient experience is about being comfortable, being cared for in a clean and safe environment, having skilled and compassionate, caring staff and our patients and their families being given information to make choices and being involved in decisions. It's also about being listened to and involved in decisions, being talked to with respect, honesty and dignity.

Following the review of our Patient Experience Strategy in 2016 we have identified 6 ambitions as we move towards 2021 all striving towards the delivery of outstanding patient and carer experience and a detailed work-plan has been developed

We successfully rolled out our Carers Badge initiative that we piloted in 2016 and the work was recognised nationally being awarded a 2016 FabNHS Stuff Award. This initiative enables carers to be visible and involved in a patients care on the ward and to promote them being seen as expert partners in care.

We have a robust Patient Experience Committee which oversees the wide range of patient feedback data received within the Trust; this includes for example Friends & Family test, feedback from Health watch, national surveys and patient Opinion; the committee reviews reports from complaints and our new Lessons Learned Forum and every month the Trust Board meeting commences with a patient story ensuring that our patients voice is heard throughout the organisation.

A wealth of patient and carer feedback data is gathered from a wide range of sources and to help with ownership at service level and making the best use of this incredibly valuable data 'Patient Experience Ambassadors' are being identified within each of our business units to establish a champion network providing a conduit in and out of services directly to the patient experience team. This is an exciting new development and we hope the network will grow during 2017 – 2018.

We have a range of plans and projects for 2017 including the launch of our Ask me Campaign identifying the needs of patients with a sensory impairment; a refresh and relaunch of our Dignity Pledges and hosting a Patient Experience Conference

Innovation and improvement – Staff Engagement

There is a robust evidence base to show that higher levels of staff engagement lead to:

• Better patient satisfaction
• Lower mortality rates
• Lower hospital acquired infections
• Lower levels of absence
• Staff being less likely to report suffering from work related stress
•Improved turnover

The more engaged our staff feel, the better the outcomes for our patients. On its own, this is a compelling reason to make sure we engage our staff, but we also know that engagement, done consistently well in a way that staff feel is genuine and meaningful, will make ULHT a great place for our staff to work, where they are proud of the organisation and the care we deliver. Furthermore, it will be a place where people want to come and work.

For us, staff engagement is and will continue to be one of our highest priorities. Only by appreciating our staff, listening to them, involving them in decision making, and trusting them to get on with doing the right thing, will we be able to deliver our targets and goals in this plan. Our staff engagement score in the national staff survey is improving year on year, but we know we have some way to go to achieve our ambition of being in the top 20% of acute trusts nationally.

The Trust's approach to our staff engagement has been based on a number of building blocks:

• Develop a compelling shared strategic vision
• Build collective and distributed leadership
• Adopt supportive and inclusive leadership styles
• Give staff the tools to lead service transformation
• Establish a culture based on integrity and trust
• Place staff engagement firmly on the Board agenda

We have during the course of the year reviewed our approach and, whilst there are strengths in what we have done to date, which is reflected in improved engagement scores, we do more to ensure our staff are engaged with the Trust and what it is seeking to achieve. We have agreed additional actions which focus on the core drivers of engagement, as identified by Engaging for Success:

• Visible, empowering leadership, providing a strong strategic narrative
• Engaging managers, who focus on their people, treat them as individuals
• Employee voice – involved, listened to, contributing
• Organisational integrity – Living the values

To support this we also recognise we need to focus on leadership of the engagement agenda, how we communicate with staff around our ambitions on engagement and how we measure progress, outside of the national survey.

We will ensure that our expectations around engagement, and indeed all our values, underpin and are embedded in all of our people policies and processes. We will expect every one of our staff to consistently live out our values. We need to ensure we that we set out clearly our expectations of staff, equip them to deliver according to those expectations, give them opportunities to talk about their experiences in seeking to do so and

everyone to account, at all levels in the organisation for doing so.

Supporting our workforce to deliver high quality care

The profile of the NHS workforce is changing in response to a number of factors; there are workforce shortages in some specialties nationally, for example A&E Consultants and Interventional Radiologists. ULHT competes with other Trusts in the NHS and struggles to attract these practitioners into Lincolnshire. Our aim is to continue to maintain staffing levels whilst boosting numbers in some areas of nursing, medicine and Allied Health Professionals.

The largest staff group is nursing and midwifery and this group is by far one of the leading most difficult to recruit to which is evidenced in the current national picture with many other NHS Trusts considering and implementing alternative ways of recruiting and attracting nursing staff to their organisations.

The next few years will see transformational change across the health and social care landscape, both nationally and locally, and the strategy will need to support the delivery of a high performing organisation, which maximises both the delivery of patient care and the opportunities to develop and utilise knowledge and skills across boundaries, during a period of major change.

This will require a clear focus upon the culture of the organisation and the need to develop our staff to consider how the future requirements of patients will call upon us to think differently, as we consider what ULHT will need deliver in the future and how and where services are delivered. We need a workforce that has the skills and behaviours to work across boundaries as we move towards a more integrated model of health and social care.

We firmly believe that there is a clear correlation between a good employee experience and the quality of care that is given to patients. We believe staff who are engaged and empowered are more motivated and committed to delivering the highest standards of patient care. Patient care is not just a process; it is when we are at our most vulnerable and care is more than just treatment or intervention.

Integral to all of our plans is the need to deliver effective leadership at all levels to ensure that we truly embed our vision and values, along with the right behaviours. With this in mind we have developed the Senior Leadership Development Programme which develops influential, strategic leaders who act as role models and ambassadors, who understand and can enhance their impact both within and externally to the organisation and use this to directly improve the care we offer to our patients.

Integral to out learning on incidents we have implemented a training programme on Root Cause Analysis (RCA). When incidents do happen it is important that lessons are learned to prevent the same incident occurring elsewhere. RCA investigation is a well-recognised way of doing this. RCA Investigations identify how and why patient safety incidents happen. Analysis is used to identify areas for change and to develop recommendations which deliver safer care for our patients.

We aim to encourage our employees to take responsibility for their own

health and wellbeing and to have a supportive self-help approach. We recognise that our employees have a direct impact on our clinical outcomes and the experience of our patients. When our staff are healthy, well and satisfied, the experience of our patients improves. We acknowledge that the work and health and wellbeing of our employees are interlinked, and as a Trust, we commit to developing a culture of promoting the health and wellbeing of all our staff.

Within our latest staff survey for % experiencing harassment, bullying or abuse from staff in last 12 months showed a decrease of 4% from 2015 to 25% and for % believing the organisation provides equal opportunities for career progression / promotion is 87%.

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.

LOOKING BACK: Progress made since publication of 2015/16 Quality Account

This section of the report presents in brief the Trust's progress since the publication of the 2015/16 Quality Account against the quality improvement priorities agreed.

Introduction

The Quality Account for 2015/16 outlined the Trust's proposed quality improvements for the year ahead (2016/17). These priorities were identified as a result of engagement with patients, the public, staff, members, governors and external stakeholders through face-to-face meetings. During the year we have been monitoring progress against the targets we set ourselves. Not all of the goals we set ourselves have been achieved although good progress can be described in a number of areas. It remains our ambition to achieve these goals and therefore they are carried into 2016/17 as our quality ambitions, underpinned by a series of in-year improvements

Trust performance

This section provides details on how the Trust has performed against its 2015/16 priorities. The results relate to the period April 2015 to March 2016 or the most recent available period. Where available, comparative information is also given which may

vary depending on the measure and may be the Trust's 2014/15 outturn position, the national position or a regulatory target.

Overview of 2015/16 priorities
Priority 1 - Reducing hospital mortality with a key focus on Septicaemia
Priority 2 - Reducing harmful falls
Priority 3 - Increasing the reliability of checking and charting
Priority 4 - Reducing harmful infections
Priority 5 - Improving the patients experience in out - patients
Priority 6 - Achieve our constitutional standards in cancer, referral to treatment and emergency access

Priority 1 - Reducing hospital mortality with a key focus on Septicaemia

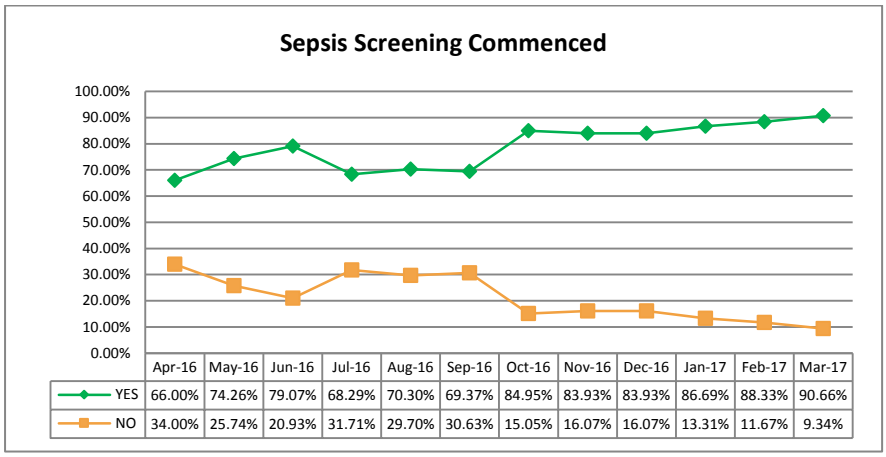
The first priority was around improving the management of patients with sepsis. Sepsis is a time-critical condition that can lead to organ damage, multi-organ failure, septic shock and eventually death. As a key component of the Trusts quality improvements initiatives, an improvement committee was coordinated to reduce harm and mortality caused by sepsis. A successful business case was completed to employ two sepsis nurses, one at Lincoln and one at Pilgrim. They will have shared responsibilities for Grantham site.

During the last year, the Trust has audited compliance with sepsis six delivery in the emergency department, Emergency Admission Units and wards. Clinical teams in the emergency admission department and emergency admission wards receive a weekly performance report on how they have performed with identification of sepsis and initiation of the sepsis 6 bundle and a particular focus is the administration of intravenous antibiotics within 1 hour. Since April 2016 monthly compliance rates have risen month despite significant winter pressures.
In addition, in 2014, the Trust became part of the NHS England's 'Sign up to Safety' initiative which aims to strengthen patient safety in the NHS and make it the safest healthcare system in the world. The Trust's 'Sign up to Safety' patient safety improvement plan was focused around improving the management of sepsis.

A key component of this plan was to implement the updated 'sepsis 6' bundle which refers to a set of six clinical interventions that should be administered within the critical first hour. Over the last year the roll out of this plan has continued across the different wards and has included activities such as:

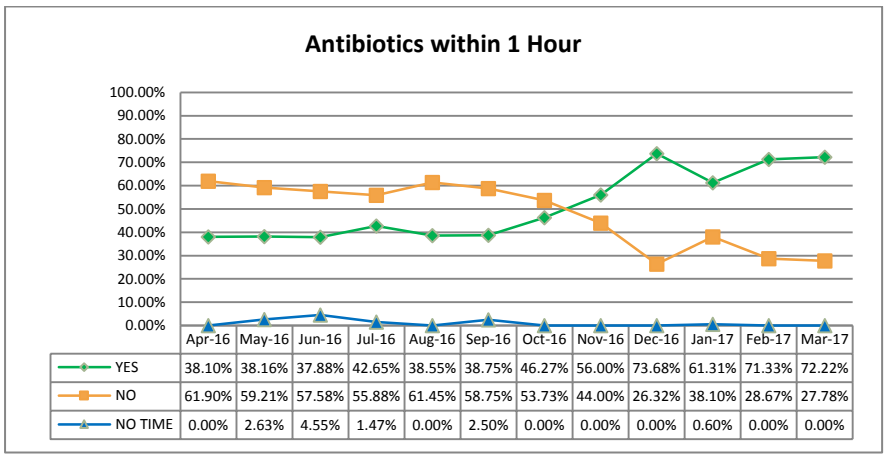
- strengthening the staff's knowledge on sepsis
- employing sepsis nurses
- developed an eLearning module
- developed an eSepsis bundle
- developed a protocol to allow nurses to prescribe antibiotics
- designed sepsis boxes
- daily data collection and weekly reporting to monitor compliance on the screening and completion of the Sepsis 6 bundle.

The tables below demonstrate the trust's performance with compliance with the sepsis bundle.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
YES	66.00%	74.26%	79.07%	68.29%	70.30%	69.37%	84.95%	83.93%	83.93%	86.69%	88.33%	90.66%
NO	34.00%	25.74%	20.93%	31.71%	29.70%	30.63%	15.05%	16.07%	16.07%	13.31%	11.67%	9.34%

Sepsis screening has improved by 24%



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
YES	38.10%	38.16%	37.88%	42.65%	38.55%	38.75%	46.27%	56.00%	73.68%	61.31%	71.33%	72.22%
NO	61.90%	59.21%	57.58%	55.88%	61.45%	58.75%	53.73%	44.00%	26.32%	38.10%	28.67%	27.78%
NO TIME	0.00%	2.63%	4.55%	1.47%	0.00%	2.50%	0.00%	0.00%	0.00%	0.60%	0.00%	0.00%

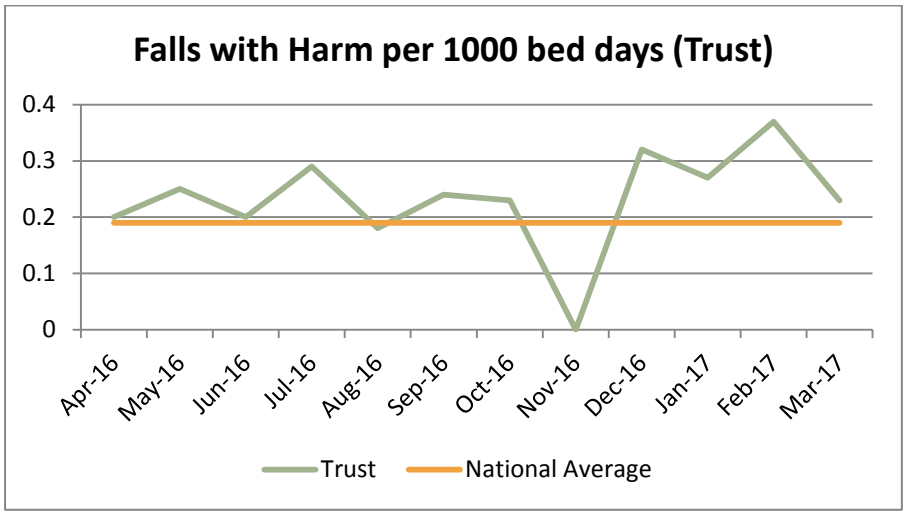
Administration of antibiotics has improved by 34%

Priority 2 - Reducing harmful falls

The second priority was reducing falls with harm with an overarching goal to:

• reduce falls by 30% as measured by reported incidents on the Trusts reporting system Datix per 1000 occupied bed days

It is recognised that falls are one of our highest priority areas in reducing harm in the hospital setting. A number of successful initiatives have been put in place over the past year to support falls reduction.



Reduced severe harm from falls by 12%

Although we did not achieve our target of 30% for falls with harm we did reduce our falls with severe harm or death by 12%. We have rolled this priority over to next year. All falls with severe harm or death are declared as a serious incident and the ward leader presents the report at the scrutiny panel to determine root cause and there are clear identified actions to be delivered. All actions are monitored to ensure they are completed.

Our falls group, chaired by the Deputy Director of Nursing, with medical staff, physiotherapy and nursing members, has introduced a number of falls prevention initiatives, including a new way to help with assessment of patients and planning of care.

We will continue to report monthly on progress at meetings with our commissioners and at the Board.

Priority 3 - Increasing the reliability of checking and charting

The third priority was increasing the reliability of: completing assessments for patients at risk:
• implementing the ward accreditation programme
• rolling out the electronic observation system.

At our Trust we developed and implemented the safety quality dashboard (SQD). This provides information electronically to all staff to enable them to assess how they are performing in relation to quality and patient safety. These metrics are collected monthly on each ward on 50% of the patients.

The aim was to improve checking and charting to 90% and the graph below demonstrates of around 88%. The metrics are continually being reviewed and updated.

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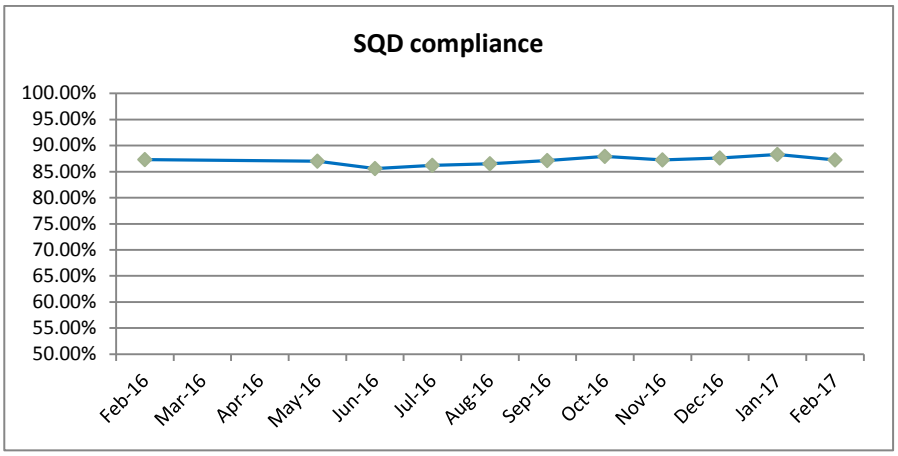

Checking & charting achieved 88%

Ward Accreditation Programme

The approach is to establish a programme that will improve quality, patient safety and outcomes for patients and carers. It is designed to support ward, unit and department managers to understand how they deliver care, identify what works well and where further improvements are needed.

Currently we collate a variety of information, from a variety of sources and it is considered in a variety of arenas. The development of the ward accreditation programme will enable us to consider identified metrics, aligned to each of the corporate aims, in a triangulated fashion, enabling more proactive identification of risk, good practice and performance management.

The programme is designed to incorporate elements from care, experience, effectiveness, environment and leadership, together

with workforce metrics and finance metrics, enabling the ward/department to be performance managed in a holistic manner.

Electronic Observations (vital signs)

Recording and monitoring vital signs is an important part of care. The system, which is called ‘e-Obs’, is a digital solution to record the vital signs of a patient. A mobile device is used by the nursing staff to collect and store patient observations, creating a score that can assist in making clinical judgments when treating a patient.

This scoring can help indicate signs of deterioration for example sepsis. This enables a nurse to remain with the patient should their observations deteriorate, as alerts can be sent automatically to the responding teams who can then come and review the patient. It also allows the consultants when away from the wards to keep track of their patients and have a ‘bird’s eye’ view of the ward from afar.

Priority 4 – Reducing harmful infections

The Trust's fourth priority was to minimise hospital acquired infections related to MRSA, C.difficile. MRSA is a form of bacterial infection that is resistant to a number of widely used antibiotics. It can lead to life threatening sepsis if it is not diagnosed early and treated effectively. C.difficile is a type of bacterial infection that affects the digestive system and can result in diarrhoea.

Over the last year, the Trust has continued to undertake a range of initiatives to help reduce such infections including screening patients on admission for MRSA, maintaining high levels of cleanliness in our clinical areas, training our staff so that they work in ways to reduce the risk of cross-infection occurring, and having a robust antimicrobial stewardship programme which ensures that antibiotics are used appropriately.

One of the challenging tasks for the infection control team is sustaining and maintaining the strong and robust service. Actions that have been taken include:

• Improving the audit process within surveillance
• Awareness weeks to educate staff and visitors held across the trust
• Hand hygiene awareness weeks/training sessions held throughout the year across the trust at regular intervals
• Monthly audit results for hand hygiene published
• Learning outcomes from RCA's are published on the hospital intranet.

The results below demonstrate our compliance.

Priority 5 - Improving the patients experience in out – patients

To ensure that outpatient services are safe and responsive to patients and current performance issues are resolved, the Outpatient Department, Access, Booking and Choice functions have been incorporated within the management and governance infrastructure of a defined Business Unit (Clinical Support Services Business Unit). This will provide a single point of accountability and single senior management team.

As part of the 2016/17 Transformation Programme the trust developed a detailed improvement programme:

Environment

During 2016/17 the Trust have completed the upgrade of Lincoln Orthodontics and Maxillofacial services, lighting in the main outpatient areas and Audiology work is on track to complete in June.

Workforce

The Trust have successfully completed following organisational developments:
• Development and approval of the Outpatient Management structure in place

• Development of an Outpatient Administration which incorporated redefining the professional functions of the Access, Booking & Choice and Health Records Management teams. This included dedicate Health Record Management responsibilities for each hospital site.
• Developed an Outpatient Matron structure (Lincoln & Louth ; Boston & Grantham) which incorporates a substantive structure for nursing roles, with greater managerial coordination and flexibility to increase and decrease service capacity within all hospital sites, to better meet the needs of patients.
• Management of Follow-Up (FU) Patients which continues to focus on reduction of overdue FU patients and risk mitigation of delayed appointments. The Trust is validating all patients on the waiting list to ensure the patient have appropriate and safe follow up.

Outpatient Systems & Process

The Trust has focused upon delivery and establishment of responsive, effective and efficient systems and processes; we have delivered following:
• Implemented electronic outcome process to replace paper outcomes process
• Implemented Electronic Patient calling and Electronic patient information screens at Lincoln main outpatient area
• Interactive voice reminder system for follow-up and new patient appointments implemented.
• Business case developed and approved to improve the unavailability, poor condition of health records and relevant staff shortages.

OPD Utilisation

Implemented a dashboard to monitor clinic utilisation and weekly capacity issues. This is monitored by the outpatient capacity meetings to support delivery of responsive services in all sites.

Patient experience

During 2016/17 the Trust has improved patient experience by using a number of projects that align to multiple work streams. The Friends

and Family Test (FFT) performance is monitored monthly by the Outpatient Transformation Programme Board. The FFT percentage of recommendations has improved over the last two years. In 2016/17 Quarter 4 outpatient services FFT recommendations were 93% and this is a 4% increase compared to 2015/16 Quarter 1.

The Outpatient Improvement Committee will continue to oversee outpatient improvement and a comprehensive improvement plan has been developed to address the CQC concerns and continue to improve the outpatient services in line with 2021 strategy.

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

National NHS constitutional standards apply to all Trusts and these standards sets clear guidance and expectations for key treatments and focuses on the key areas of rapid Emergency Access for patients within 4 hours, 18 week standard for referral to Treatment and National waiting times. The Trust is committed to ensuring that we deliver high quality services against these important standards. Our compliance with these standards during 2016/17 has been a significant challenge to the organisation although there have been improvements.

Emergency Access

The national performance picture puts into context the challenges faced by Acute Trusts because of a set of complicated and complex issues – demographics, rising patient expectations and long term pressures that have built up over a considerable length of time. Numbers of people presenting at A&E is increasing which puts pressure on our bed availability if we are not able to discharge patients safely and quickly through the hospital. The likely consequence of patients going home too quickly is re-admission.
Demand is continuing at unprecedented levels (March has the highest recorded two-week wait referral rate, 18% higher than same period last year) and the increased number of referrals coming into the Trust.

The Trust has implemented many of their aspirations for the 4 hour emergency access standard:

• A discharge hub which works year-round as opposed to just winter months
• A frailty lead has been appointed
• SAFER bundle implemented
• Ongoing working with our commissioning colleagues to reduce length of stay and attendances

Referral to Treatment

The Trust has implemented all of their aspirations for the 18 week Referral to Treatment standard:
• 11 specialities have each produced recovery action plans which set out short term actions to improve speciality level performance – General Surgery, Orthopaedics, Ear Nose & Throat (ENT), Gastro, Respiratory, Dermatology, Cardiology, Neurology, Endocrine, Rheumatology, Vascular. Key actions contained within these plans include increasing internal capacity through additional outpatient and theatre sessions from our existing workforce and utilisation of additional locum capacity.

• The Trust has reviewed Neurology and ENT services
• Plans were in place in February to deliver additional activity (primarily in outpatients) resulting in c.400 clockstops and c.300 in March. The Clinical Directorates have plans to deliver over 300 additional clockstops above standard activity in April.
• The Trust meets monthly with the commissioners to review priorities Where activity levels are significantly above the contract level the CCGs are being asked to initiate actions to support the Trust by controlling referral rates into these specialities.
• Internal theatre productivity and scheduling improvement programme is in place, in order to increase theatre productivity initially within

Orthopaedics, but then to be expanded to include further specialities.
• Trust Board receive a monthly integrated performance report detailing compliance with the constitutional standards.

Cancer

The Trust has all many of their aspirations for national cancer waiting times:

• The Trust holds a fortnightly Cancer Recovery and Delivery meeting, chaired by the Deputy Director, in order to provide an oversight of the change programme set out in the Trust's Cancer Action Plan, holding Business Units to account for performance and delivery against the action plan
• The 7 Day Horizon (potentially cuts a week out of pathway by making the First Appointment within 7 days of referral as opposed to 14 days) has now been successfully deployed in all areas that are appropriate.
• The Upper Gastrointestinal Straight to Test pilot has proven to be successful and county-wide roll-out of the service will be from May 2017. Likewise plans are being developed to roll out the lower Gastrointestinal straight to test pathway to all sites.
• Radiology are currently piloting a new booking process, where appropriate patients are asked to go directly to Radiology reception, following their outpatient clinic appointment, in order to book their Radiology diagnostic appointment before they leave the Hospital. It is anticipated that this will reduce the time from referral to diagnostic test being completed.
As detailed above the work will continue to improve our constitutional standards.

External regulation and assurance

Care Quality Commission (CQC)

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

Clinical Negligence Scheme for Trusts ULHT Maternity Services

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

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

Stakeholder comments

NHS Lincolnshire East Clinical Commissioning Group (Lead Commissioner)

NHS East Lincolnshire Clinical Commissioning Group (the commissioners) welcomes the opportunity to review and comment on the draft United Lincolnshire Hospitals NHS Trust (the trust) Annual Quality Account 2016 – 17.

The Quality Account provides comprehensive information on the quality priorities the trust has focussed on during the past year, it is clear that a number of the quality priorities have been a challenge for the trust, including treating sepsis and reducing hospital infections. These issues have been identified in both the recent Care Quality Commission Inspection and the regular joint provider and commissioner quality review meetings.

In looking forward to 2017 – 18, it is unclear how the quality priorities have been developed and whether patients and the public have had the opportunity to shape the quality priorities for the organisation. In addition, the commissioners would have welcomed a focus on pressure ulcers. Whilst the commissioners recognise that the organisation have focused on this area in previous years, it still remains as area of concern for patients.

As would be expected, the commissioners are extremely concerned that the trust has returned into special measures, following the recent CQC report in April of this year, as previous improvements had not been sustained by the organisation. In response to this the commissioners are working with the organisation in a number of innovative ways to improve the quality and safety of the services for patients.

The quality account describes the processes used by the trust to undertake activities for example how the trust internally reviews quality, patient experience and the health and wellbeing of staff. These processes are recognised as the key foundations for safe care.

In reading the quality account, it would have been useful to have had a more detailed section on the organisations patient safety incidents, and the key themes and trends and how these have impacted upon patient care. The information does not provide a real sense of changes to practice or how learning is shared and embedded within the organisation. There is a concern as the trust is within the lowest 25% of trusts in the country for reporting incidents to the National Reporting and Learning System which is used to drive forward the patient safety agenda.

The security of patient information (and all information) is of crucial importance and the commissioners are disappointed that the trust has not maintained the Level 2 standard of the Information Governance Toolkit achieved last year and is a level 1 organisation.

The commissioner can confirm that up to the end of quarter three the trust has achieved 40.45 % of the years

CQUIN monies to date. The commissioner cannot confirm the final quarter 4 position at this moment as the joint commissioner and trust review, verification and approval process is scheduled for July 2017. However, the expected end of year position as detailed in the report does align with the commissioners expectations.

The commissioner is pleased to see the good work undertaken by the trust in Research and Development which benefits all patients treated by the trust. The trust has also worked hard to enhance the systems and processes supporting patient experience.

The commissioner confirms that to the best of our knowledge the accuracy of the information presented within the working draft of the Quality Account submitted is a true reflection of the quality delivered by United Lincolnshire Hospitals NHS Trust based upon the information submitted to the Quality Contract Meetings.

The commissioner can also confirm that the additional reporting requirements for 2016 – 17 are included within this set of draft accounts although a number of final numerics, percentages and external assurance statements will require inclusion in the final issued version.

NHS Lincolnshire East Clinical Commissioning Group looks forward to continuing to work with the trust over the coming year to further improve the quality of services available in order to deliver better quality and outcomes for the people of Lincolnshire.

Tracy Pilcher Chief Nurse NHS Lincolnshire East Clinical Commissioning Group

Health Scrutiny Committee for Lincolnshire

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

Progress on Priorities for Improvement for 2016-17

Each of the six priorities for 2016-17 is considered in turn:

• Priority 1 – Reducing Mortality with a Focus on Sepsis – We note the Trust's achievement of increased screening rates for sepsis; and for the one-hour administration of intravenous antibiotics. We note that both reducing mortality and reducing sepsis will be carried to 2017-18 as priorities.
• Priority 2 – Reducing Harmful Falls – We congratulate the Trust on achieving a reduction of harmful falls by 12%. Again we note that reducing falls will be carried forward as a priority for 2017-18.
• Priority 3 – Checking and Charting – We are pleased that some progress has been made, although the target of 90% compliance was narrowly missed.
• Priority 4 – Reducing Harmful Infections – We note that the target for zero cases of MRSA was not met, although only one case was recorded.
• Priority 5 - Improving Outpatients – We are pleased with the increased patient satisfaction levels with outpatient services, and welcome the 93% score on the Friends and Family Test.
• Priority 6 – Constitutional Standards - We accept that there have been challenges meeting the three constitutional standards in cancer care; referral to treatment; and emergency care. These challenges will continue in the coming year. We note that monitoring progress with constitutional standards will now be a core activity for the Trust.

Priorities for Improvement for 2017-18

We support the inclusion of ten priorities for improvement for 2017 18 and we accept the rationale for their inclusion: the Trust is responding to national requirements; and to the Care Quality Commission report of April 2017. We have been assured by representatives of the Trust that it will be able to undertake programmes of work to make progress with each priority. We believe the priorities are clearly presented, with a clear indication of a target or activity required.

We would like to make comments on the following priorities:

• Improving Sepsis Care – We acknowledge that this as a national priority and also a requirement arising from the Care Quality Commission report of April 2017. We look forward to the Trust making particular progress with this priority.
• Electronic Discharge Documents – We stress the importance of information being passed to the GP when a patient is discharged, as it is acknowledged that without this information patients are at a greater risk of readmission to hospital. We therefore support the target of 100% of Electronic Discharge Documents being sent to GPs within five days.
• Learning from Serious Incidents – We support this priority for improvement and we note that 38% of serious incidents arise from avoidable pressure ulcers, which is the subject of a specific priority.
• Reducing Harm by Eliminating Avoidable Category 4 Pressure Ulcers and Reducing Avoidable Category 3 Pressure Ulcers by 50% - We support

these specific targets, and look forward to the Trust making progress in this area.

• Reducing Falls and Reducing Harm from Falls – We understand and support his priority, which is both a national priority and is also a topic in the Lincolnshire Joint Strategic Needs Assessment.

• Improving the Administration of Diabetic Drugs – Again we understand the national evidence supporting the inclusion of this priority.

• Improving the Experience of Patients with Dementia and Vulnerable Patients – On the basis that 60% of inpatients have a mental health problem, the rationale for the inclusion of this priority is accepted.

We understand that the Trust has arrangements in place to monitor progress with these priorities, with any serious issues escalated to the Trust Board.

Care Quality Commission

We note that the Quality Account includes the most recent ratings from the Care Quality Commission (CQC). Whilst we note that the CQC rated 56% of the Trust's services as 'good' and only 12% as 'inadequate', we understand that addressing the findings in the CQC report represents a significant challenge for the Trust. This challenge is more pronounced at Pilgrim Hospital, where two services were rated as 'inadequate'. The Health Scrutiny Committee will be seeking assurances from the Trust throughout the coming year that it is meeting the requirements and recommendations of the CQC.

Presentation of the Document

We are grateful for the opportunity to have made provided direct feedback on the presentation of the Quality Account with representatives from the Trust. We are also pleased with the overall presentation of the document. The statistics and presentation are clear, with explanations for the lay reader.

Engagement with the Health Scrutiny Committee

The Health Scrutiny Committee for Lincolnshire is grateful to the Trust for the opportunity to provide direct feedback on the Trust's proposed priorities for 2017 18.

During 2016-17, representatives from the Trust attended meetings of the Health Scrutiny Committee for Lincolnshire on four occasions. The Committee also established a working group, which met with managers from the Trust on two occasions, to provide feedback on the Trust's 2021 Strategy.

Conclusion

The Health Scrutiny Committee for Lincolnshire looks forward to continued engagement with the Trust in the coming year; and for improvements in the Quality Account priorities. The Committee also will be seeking assurances during the year that the requirements of the CQC report of April 2017 will be addressed.

Health Scrutiny Committee for Healthwatch Lincolnshire

Progress on Priorities for 2016-17
We noted the progress on the 6 priorities for last year, and we also observed that a number of last year's priorities have rolled into the 2017-18 priorities specifically around sepsis, falls and infections. We acknowledge the development of the work and achievements around specifically MRSA and C. difficile infection rates for the Trust.

Whilst Healthwatch Lincolnshire recognises the efforts made to improve the outpatient experience we still continue to see patient feedback regarding poor experiences of the outpatient departments, we would like to continue working with the Trust to assess changes in patient experiences throughout the forthcoming year.

It was not completely clear from the Quality Account what tangible improvements had been made to the patient's outcomes for priority 6 around achieving the constitutional standards for cancer; referral to treatment and emergency access.

We are encouraged to see the continuation of the some of the priorities as they are key to the patient experience.

Priorities for 2017-18
Healthwatch support the Trust's 9 priorities for 2017-18 and accept the rationale for their selection.

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

PRIORITY 1 IMPROVING CARE OF PATIENTS WITH SEPSIS, we feel there has been a long history relating to the challenges around this aspect of care. We note this work was already started in 2016-17 and we hope to see continued and consistent improvements going forward.

PRIORITY 2 PATIENTS TO BE DISCHARGED WITH THEIR ELECTRONIC DISCHARGE DOCUMENTS. Communication is always a key theme within the patient experience journey which not only impacts directly on care but also on the holistic wellbeing of the patient.

PRIORITY 3 REDUCTION IN MORTALITY RATES. We are pleased to see the progress made so far in this area, however believe that the consultant case review after a death needs an independent clinician's for effective evaluation.

PRIORITY 5 DUTY OF CANDOUR. We acknowledge that the NHS as a whole has found application of this duty difficult and we encourage the development of this priority and very much look forward to hearing about the achievements.

PRIORITY 7 REDUCTION IN THE INCIDENCE OF HARM ASSOCIATED WITH CATHETER ASSOCIATED URINARY TRACT INFECTIONS. The inclusion of this priority demonstrates an intention to continue the previous work in relation to infection and infection prevention. We would welcome an updated position on developments at the end of this calendar year from the Trust.

PRIORITY 8 IMPROVE COMPLIANCE WITH ADMINISTRATION OF MEDICATION IN DIABETIC DRUGS. We read with interest the degree to which medication, errors and incidents relate to diabetic drugs. More importantly we are mindful of the overarching impact

that errors have on the organisation as well as the patient in terms of harms, experiences, time, resources and cost. We would hope that as part of the Medicines Safety Committee and Patient Safety Committee reporting, the views and experiences of patients with diabetes will be sought.

PRIORITY 9 IMPROVE THE EXPERIEINCE FOR PATIENTS WITH DEMENTIA AND VULNERABLE PATIENTS, we are fully supportive of this measure, however do not feel the Quality Account goes far enough to identify specific measurable. We are mindful of feedback we have received related to vulnerable and learning disability patients specifically in the hospital setting where patient outcomes are required at a very person centred level. We note the positive steps taken to implement the Carers Badge and we look forward to further development of this throughout the hospital.

Engagement with Healthwatch Lincolnshire
Healthwatch Lincolnshire continue to work with the Trust and in the last year have focussed on Delayed Discharge, Mystery Shopper activity within A&E, talking to patients within the Cancer clinics with a focus on the 2 week wait and attendance at Pain Clinics across the sites. In addition to which, we have supplied monthly detailed breakdowns of the feedback given to us by patients and their families/carers.

Healthwatch Lincolnshire would like to formally say that it welcomes the enthusiasm and commitment the Trust has shown in supporting and following through recommendations made by Healthwatch. Whilst we believe there is more to be done to support the Trust in gathering an independent perspective of the patient journey and completion of actions and recommendations, we feel the relationship is positive and ready for future development, we shall be following this up during the year.

Care Quality Commission
The Quality Account refers to the CQC inspection of the Trust, and we acknowledge the Trusts disappointment at being in special measures once again. We do not intend to dwell on the report but rather state we are pleased that some of the priorities for this forthcoming year will directly support some of the underperforming areas. What we would like to emphasise is that for too long we have heard the ‘words of improvement’ but now it is a critical time to demonstrate the changes and improvements to the public in a sustainable way.

Conclusion
Healthwatch Lincolnshire is pleased to have had an opportunity to make comment on the ULHT Quality Account, and accept that it has been a challenging few years for the Trust but we hope to see quantifiable activity throughout the year and the continued working relationship with Healthwatch Lincolnshire.

Governance Statement 2016/17

Scope of responsibility

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

The Trust works in partnership with local health and social care community and is accountable for the delivery of its patient services through the

contracts it holds with its commissioners. The majority of the Trust's contracted activity is commissioned, by the Lincolnshire Clinical Commissioning Groups and by the Area Team for Specialised Services.

The governance framework of the organisation

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

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

The system of internal control has been in place in United Lincolnshire Hospitals NHS Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

Trust Board and Committee Structure

The Trust Board meets on a monthly basis and consists of a Chair, 5 voting Executive Directors, including the Chief Executive and 7 Non-Executive Directors (currently one vacant post). Three non-voting Executive Directors, the Chief Operating Officer, Director of Estates and Facilities, and the Director of Human Resources and Organisational Development also attend meetings of the Trust Board.

There have been some key personnel changes at Executive and Non - Executive level during 2016/17 including the appointment of a new Chair from April 2016 and the Trust has just completed a recruitment

process to fill the one Non Executive vacancy existing at the end of March 2017. The Board recognises the importance of measuring its own effectiveness and completed a self-assessment against the well led framework and this will be followed up by an external provider review during 2017/18. The Chief Executive and Chair have set board level objectives for all Trust Board members.

The Trust Board focusses on strategic issues, whilst also receiving assurances in relation to the Trust performance on quality, the NHS constitutional standards and finance. It achieved this through the following

- Chief Executive and Chair updates on the internal and external environment at Trust Board.
- Monthly Board development sessions covering key strategic and development issues.
- Continuous review of committee structure.

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

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance with relevant principles of the Code is considered to be good practice. This Governance Statement is intended to demonstrate how the Trust had regard to the principles set out in the Code considered appropriate for Trusts.

Supporting Committee Structures

To support the Trust Board in carrying out its duties effectively, committees reporting to the Board are formally established with Board approved terms of reference. A review of the committee structure was completed in the year to ensure that it continued to deliver robust governance and assurance. Each Assurance committee of the Board has its own agreed sub structures and the Assurance Committees receive reports as outlined within their terms of reference and work programme. Each Committee provides an Assurance and Exception report to each meeting of the Trust Board.

The key committees for governance and assurance are as follows:

Audit Committee - delegated to approve the annual accounts on behalf of the board and provide assurance in relation to Internal and external audit, counter fraud and security management, financial reporting, integrated governance, risk management and internal control, and the annual governance statement. During 2016/17 key areas of work for the committee were:

- Reviewing and approving the annual accounts and annual governance statement
- Receiving the Integrated Strategic Risk Register/ Board Assurance Framework
- Agreeing internal and external audit plans and monitoring progress
- Receiving reports of waivers, losses and compensations
- Monitoring counter fraud investigations
- Assurance on Corporate Risk Register and Risk processes within the Trust and oversight of risk improvement plans

Quality Governance Assurance Committee –provides assurance to the Trust Board that appropriate and

effective governance mechanisms are in place for all aspects of Quality Governance and risk. During 2016/17 key areas of work for the committee were:

- Review of the Board Assurance Framework/ Integrated Strategic Risk Register
- Receiving assurance reports from Health and Safety Committee, Safeguarding Committee, Infection Prevention and Control Committee
- Assurance on the Quality Account
- Review of complaints, patient experience and incidents

Finance, Service Improvement and Delivery Assurance Committee – provide assurances to the Trust Board on financial and performance issues. During 2016/17 key areas of work for the committee were:

- Assurance on Trust key financial duties
- Scrutiny of efficiency programmes
- Review of progress against capital programme
- Assurance on monitor compliance framework and performance
- Review of recovery actions against key duties and performance

Workforce and Organisational Development Assurance Committee - provides the Board with assurance concerning all aspects of workforce and organisational development.

- Assurance on key workforce plans and priorities
- Monitoring of workforce performance indicators
- Assurance on legal and regulatory requirements
- Development and delivery of workforce and OD strategy and the workforce culture

Attendance at Board and Committees (Voting Membership)

Board/ Committee	Attendance
Trust Board	91%
Audit Committee	83%
Quality Governance Committee	64%
Finance, Service Improvement and Delivery Committee	73%
Workforce and OD Committee	80%

Risk assessment

The overall responsibility for risk management rests with all members of the Board. The Executive lead for risk management has transferred from the Director of Human Resources and Organisational Development to the Deputy Chief Executive. This has led to the development of an integrated Strategic Risk Register and Board Assurance Framework, together with an in improvement plan to strengthen the risk management strategy, policy and processes within the organisation. The Director of Finance has specific responsibility for financial risks within the Trust, with the Medical Director and Director of Nursing holding specific responsibilities for the management of clinical risks and adverse incidents.

There is a strengthened risk governance framework which defines the management, monitoring and reporting of risk, with a Strategic Risk Management Group to validate the Corporate Risk Registers which are monitored through the Board Committees and at Trust Board level. The Corporate and Operational Risks are managed locally and through the local governance processes. The Trust

operates and maintains an approved Risk Management Strategy, Policy and Procedures that identifies the levels of accountability, roles and responsibilities for all staff within the organisation.

The Trust's Risk Management Strategy, Policy and Procedures defines the types of risks that may impact the Trust and the overall Trusts approach to risk assessment. The Integrated Strategic Risk Register and Board Assurance Framework captures the Trusts risks in line with the delivery of objectives, and this forms part of the risk reports to the Board's Committees together with the Corporate Risk Register to escalate any strategic risks to the Board, together with forming part of the Trust Board's risk management agenda. Operational risks are captured within the Business Unit.

Risks are identified within the Trust and recorded onto the Trusts reporting system Datix, they are reviewed by managers and the management of those risks identified with mitigation actions and a risk rating. This risk rating, which is defined in the Trusts Risk Management Policy and Procedures, is derived from evaluating the likelihood and severity of an occurrence that may impact on the Trusts objectives.

A review of the risks recorded onto the Trusts Risk Register over the last year has seen the number of open risks reduced considerably demonstrating a higher level of management of risks. This review has seen certain categories or risks reduced e.g. Estates and Facilities which are actively managing their local risk register. There has been a Risk Validation Group, which challenges and validates risk ratings, mitigation actions and ownership.

The major risks to the Trust relate to financial stability and recovery, with the key mitigation actions being to develop a long term financial strategy which will be aligned to the Sustainable Transformation Plan, Two-Year Operational and Financial Plan and robust performance framework. There are risks to sustaining and adequate workforce, with key mitigation with a People Strategy and Workforce Plans which will address recruitment and retention difficulties covering key skills across critical clinical skills. There are risks relating to Estates statutory compliance. The major clinical risks relate to the management of care relating to sepsis and GI bleeds.

During 2016/17 the Board devoted a Board Development workshop to review the governance arrangements for risk, and agree improvements to the risk framework. Each of the Board Committees discuss and challenge the risk on the Corporate Risk Register, together with the Strategic Risk Register aligned to the Trust's strategic objectives. A review of risk has been undertaken which has a clear Improvement Plan which is overseen by the Strategic Risk Management Group with reporting the progress to the Trust Committees and the Trust Board.

New and emerging risks, corporate, clinical and operational are identified from a variety of sources within the Trust; learning from adverse events; the Quality Governance Committee; the Financial, Service Improvement and Delivery Committee; the Workforce and Organisational Development Committee; the Integrated Performance Report; various dashboards; Quality Impact

Assessments; Internal Review Audits; Clinical areas business units.

The Trust assures itself of the quality and accuracy of elective waiting time data through specific training for staff, the use of electronic solutions to improve accuracy, validation processes linked to systems and inclusion in the internal and external audit work programmes. The risks associated with elective waiting times and specifically those attached to the Patient Administration System (PAS) have been reviewed and assurance sought at the Finance, Service Improvement and Delivery Assurance Committee throughout the year and within the outpatient improvement programme plan.

The Trust reported six data security breaches to the Information Commissioner in 2016/2017; which have now been closed with the agreement of the ICO. The Trust is compliant with all level 2 standards of the IG toolkit apart from the achievement of staff training in IG to 95%.

The risk and control framework

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

The Trusts Risk Management Policy and Procedures are in place which encourage staff to report adverse incidents and near misses in order to minimise risk and take action to prevent recurrence. During 2016/17 incident reporting and analysis has been reviewed as part of the risk review and improvements have been identified, which will be supported by a refreshed Strategy, Policy and Procedures. The Trust has also introduced weekly Serious Incident review meetings chaired by the Medical Director and the Director of Nursing tracking action plans and lessons learned to be shared.

Through the risk review, there have been dedicated actions to ensure that the risk registers are validated and that there is better capture processes and systems for strategic, corporate and operational risks. There is further development to give key managers at all levels the facility to identify managers and escalate (where necessary) the main risks in their areas of work. Risk assessments contribute to the Trust's risk register and encompass both clinical and non-clinical risks.

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

Risk Management training commences at induction with further training in risk management provided through the

mandatory training programme. The training reinforces individuals' accountabilities with respect to incident reporting and risk management and enables staff to assess and manage risks within their sphere of responsibility.

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

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

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

The Audit Committee assess the overall adequacy of the Assurance Framework on behalf of the Accountable Officer and the Board, and advise the Board in relation to the systems, processes and controls in place in order to have co-ordinated and effective risk mitigation in achieving the Trust's objectives. This enables the Board to discharge its responsibilities for governance and understand the balance of clinical, operational and financial risk. Throughout 2016/17, the Board has identified and monitored against key objectives within the Integrated Strategic Risk Register and the Board Assurance Framework. The controls and assurances in relation to the strategic objectives are reported to the Board each month with assurance from the Board Committees on their parts of the Assurance Framework relevant to their Terms of Reference . The risk review identified improvements to the risk framework which is supported by the improved monitoring and reporting through to the Board Committees and the Trust Board.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work. The Overall Head of Internal Audit Opinion gave a limited assurance. The Trust is continuing to work to improve control in those areas highlighted by audit and to strengthen the effectiveness of the Board Assurance Framework. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by:

- Care Quality Commission visits
- Delivery of Internal and External Audit Plans
- Friends and Family Test
- Staff Survey results

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee and the Assurance Committees. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Internal Audit reviews undertaken during 2016/17 led to the Head of Internal Audit providing a limited assurance opinion on the system of internal control in the Trust. In reaching this opinion the review assessed

- The design and operation of the Assurance Framework;
- The arrangements for the management of risk;
- The outcome of individual assignments within 2016/17 Internal Audit Plan;
- The extent to which the Trust responded to audit recommendations as identified as part of our follow up work

The Trust has produced a Quality Account, and has taken steps to assure itself of the accuracy of this document by referencing Information Services within the organisation, the Quality Governance Assurance Committee and Internal and External audit processes.

A detailed internal review of risk management was conducted during 2016 alongside a review by internal audit and an independent review following the CQC report and all recommended actions in improvement are being monitored through the Strategic Risk Management Group and Audit Committee.

Significant Issues

During the year the Trust identified the following significant control issues. During October 2016 the CQC carried out a follow up inspection and found that the Trust had a range of issues which it needed to tackle. As a result of this the Trust was assessed as inadequate and placed in Special Measures.

The CQC highlighted the following areas which required improvement:

- Identifying and treating patients with sepsis
- Strengthening senior leadership at Pilgrim Hospital
- Caring for patients with mental health problems
- Major incident planning

These areas have been a focus for immediate actions by the Trust since October and a further inspection is expected during 2017/18.

During the year the Trust has faced significant financial challenges, which are expected to continue during 2017/18. The Trust is operating in a difficult health economy and is working with commissioners, local health and social care partners and local authorities to review care pathways and explore alternative models of care in an attempt to address these challenges and deliver a sustainable five year plan linked to the Lincolnshire Strategic Transformation Plan (STP).

Workforce remains a significant strategic and operational challenge. Plans for 2017/18 and beyond are

focussing on improving retention, making Lincolnshire a more attractive place to work and reducing dependency on agency staff.

The Trust Internal Auditors provided the Trust with a limited assurance from the Head of Internal Audit Opinion for 2016/17 and highlighted the number of their reviews which had resulted in a limited assurance being provided. One high risk issue was reported as a result of Internal Audits 2016/17 work. This related to the slippage in the planned timetable for identifying and agreeing efficiency schemes within the 2017-18 Financial Efficiency Plan. The Trust has agreed to ensure robust governance processes and Executive ownership and oversight provide for appropriate reporting and challenge.

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

Accountable Officer : Mr Jan Sobieraj, Chief Executive
Organisation: United Lincolnshire Hospitals NHS Trust
Signature
Date

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

KPMG

We are required to perform an independent assurance engagement in respect of United Lincolnshire Hospitals NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism, as set out on page 54 of the Quality Account
- Percentage of patient safety incidents resulting in severe harm or death as set out on page 54 of the Quality Account

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

Respective responsibilities of the Directors and the auditor

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

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

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

appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

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

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

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

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

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

- Board minutes for the period April 2016 to June 2017;
- papers relating to quality reported to the Board over the period April 2016 to June 2017;
- feedback from the Commissioners;
- feedback from Local Healthwatch;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- the latest (2016) national in-patient survey;
- the latest (2016) national staff survey;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2017;
- the annual governance statement dated 26 May 2017; and
- the Care Quality Commission's Inspection Report dated 11 April 2017.

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

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

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent

permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and United Lincolnshire Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

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

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

Basis for disclaimer of conclusion on the Patient Safety Incidents indicator

We are unable to confirm that the dimensions of data quality for completeness, reliability and validity have been met for the Patient Safety Incidents indicator included in the Quality Account:

- The indicator is expressed as a ratio and the denominator (all incidents reported) implies an assurance over the reporting of all incidents, whatever the level of severity. There is a risk to the completeness of data collected in respect of the denominator regardless of their severity, as it

relies on all incidents being reported.

- There are concerns relating to the reliability of the information system used by the Trust to record, manage and report incidents. The Trust is not using the latest version of the system and Internal Audit's testing of the data held on the system identified uncertainty regarding its reliability. Following 18 months of live changes to the system it is not possible to agree the current summary information to the 'frozen' NHS Digital submitted data.
- There are also difficulties in relation to the validity of the data as there is a backlog of over one month in the Trust's arrangements for reviewing, validating the classification and clearing low level incidents, some of which may be reclassified into the severe harm or death category. There is also clinical judgement required in grading incidents as "severe harm" which is moderated at both a Trust and national level. This clinical judgement means that there is an inherent uncertainty in the presentation of the indicator which cannot at this stage be audited.

Consequently we are unable to give limited assurance on the Patient Safety Incidents indicator included in the Quality Account for the year ended 31 March 2017.

Conclusion

Based on the results of our procedures, with the exception of the matters reported in the basis for disclaimer of conclusion on the Patient Safety Incidents indicator above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Account subject to limited assurance (Percentage of patients risk-assessed for venous thromboembolism) has not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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29 June 2017