Quality Account

2017/18

2021
A different Lincolnshire
A great ULHT

Excellence in rural healthcare

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PART 1

2021
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CHIEF EXECUTIVES STATEMENT

We are really pleased to be able to share with you our Quality Account for the year 2017/18. It is a great opportunity to showcase all the work that has been taking place in the Trust over the last year. This reflects the significant efforts of our staff who have worked hard to improve the quality of the services we provide. We have been greatly impressed by the commitment of staff to do the best for patients, as well as their dedication to the Trust.

Our performance must be set in the context of 2017/18 having been another very challenging year for the NHS as a whole, with increases in demand across many services and increasing numbers of patients with complex, multiple long term illnesses. To our disappointment the Trust remained in Special Measures for quality and was then placed in Special Measures for finance in September 2017.

We have responded positively to the Special Measures status but despite all the efforts that we have made it is regrettable that the Trust remains in a significant financial deficit, and has failed to meet national targets such as the maximum four hour wait in accident and emergency, some of the cancer targets and some key quality measures. We are working hard to address these challenges and we are encouraged by signs of improvement in different areas of the Trust.

In May / June 2017 we received fire enforcement notices covering the Lincoln and Boston sites. In addressing these the Trust has received capital loans of £9.5m in 2017/18 and re-prioritised the capital programme.

The work will continue into 2018/19 with further central support agreed. The resultant works once complete will significantly improve the safety of our hospitals.

We hope this Quality Account will give a clear perspective on the challenges we face as well as highlighting a number of significant successes. As well as reported challenges, we also have much to be proud of. We've made good progress with developing the future for our services and continued to engage with staff, partners, stakeholders and the public on what this will look like.

We also invested in the future of services with significant investment being made in maternity services through a new maternity unit at Boston and complete refurbishment of the neonatal unit at Lincoln.

Despite many vacancies and a strong reliance upon temporary agency staff and the challenges this brings to improve quality, the Trust has maintained quality standards and has taken forward some innovative approaches. We opened a new bereavement centre at Lincoln, commenced a new ward accreditation scheme to acknowledge quality and improvement and made great innovations in surgery and treatment. Many of our staff have won or been nominated for national, regional and Trust awards.

What are our plans for 2018/19? This will be an exciting year of transformation for the Trust. To lead the transformation of our own services, we are continuing to develop our own five year plan called the 2021 strategy which will have a big focus on quality and safety. We are also collaborating closely with our partners in the wider health and care system .

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 look to introduce new ways of working to help improve the movement of urgent care patients through our hospitals.

We will also look to carry out more elective work and improve how we employ, support, train and develop our workforce. Our plan, whilst realistic is also stretching because this time next year we need to be geared-up to deliver our services in a more sustainable way.

Our foreword to this Quality Account would not be complete without thanking our dedicated and talented staff. Around 7,500 people work at our hospitals, delivering services to the local community, which continue to be safe, and of high quality despite increasing pressures throughout the NHS. We are immensely proud to lead an organisation with so many hard-working colleagues who provide such important services. Thank you to all our staff for their continuing dedication to delivering high quality care.

We hope that you find this report informative and that it demonstrates to you just how hard we are working to really focus on what matters to our patients.

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

Jan Sobieraj
Chief Executive Officer

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 743,400 people.

Our vision is 'Excellence in rural healthcare'.

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.

The total income from patient care activities for 2017-18 is £394,512 is. 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

2021
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PRIORITIES FOR IMPROVEMENT IN 2018/19

Deciding our quality priorities for 2018/19

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 Quality Strategy 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. We have also reviewed our clinical incidents, complaints, feedback from Friends and Family to ensure these are the priorities that matter most to our patients, carers and families.

The following improvement priorities for the Trust have been identified for particular focus in 2018/19. These priorities will be extended over the coming years to ensure they are fully embedded within our organisation. The overarching principle for all these work streams is their importance for patient experience: they have been grouped under the CQC domains below for the purpose of this quality account document.

SAFE

- Learning our lessons where our care should have been better and being open and honest so we put it right next time
- Eliminating avoidable hospital harm
- Eradicating preventable deaths

CARING

- Promoting a positive patient experience to deliver what matters most to our patient, carers & families

EFFECTIVE

- Generating healthcare services fit for the future that are creative and forward thinking

WELL LED

- Providing services by staff who demonstrate our values and behaviours

PRIORITY 1 – PROMOTING A POSITIVE PATIENT EXPERIENCE TO DELIVER WHAT MATTERS MOST TO OUR PATIENTS, CARERS AND FAMILIES

Why have we selected this Priority?

Patient experience is in essence why we all do the jobs that we do; it 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.

Our current status

Our national surveys rank us as 'about the same' as other Trusts except in how we ask our patients about the quality of their care whilst they are still with us; our Friends and Family test (FFT) sees us ranked about 5% below the national averages and our complaints and concerns tell us that our communication, staff attitudes and information giving needs to be better.

It is a 'mixed bag' of measures but the overall message is that we are inconsistent across our services and where some patients have an excellent experience others do not. We know too that where our services struggle such as in our Emergency Departments this results in a poorer experience and that where our staff report poor experience that can also translate into a poorer patient experience.

What will success look like?

- Patient experience metrics will be introduced into the Performance Review framework and directorates held to account
- We will see an improvement on FFT percentage recommends and national survey scores – target is to meet the national average across all streams:

% Recommends Scores

Stream	ULHT	National	Target 2018/19
Emergency care	81%	86%	87%
Inpatients	93%	96%	97%
Outpatients	92%	94%	94%
Maternity antenatal	97%	96%	97%
Maternity birth	95%	97%	97%
Maternity postnatal ward	91%	95%	95%
Maternity postnatal community	97%	98%	98%

% Response Scores

Stream	ULHT	National	Target 2018/19
Emergency care	19%	13%	19%
Inpatients	19%	25%	26%
Outpatients	11%	7%	14%
Maternity antenatal	n/a	n/a	n/a
Maternity birth	11%	23%	23%
Maternity postnatal ward	n/a	n/a	n/a
Maternity postnatal community	n/a	n/a	n/a

- A data analyst will be employed to interrogate and understand our quantitative and qualitative data, develop a structure and process for utilising and triangulating this and develop a system to provide baskets of data sets and reports for services
- From the new data process we will identify hot spots and include within reports and performance processes to provide early intervention
- The 'Academy of FAB NHS Stuff' principles and concept of celebrating improvement and innovation and sharing and learning from others will be mainstreamed under the hashtag #UltimateULHT
- A FAB campaign will run through the year seeking out and sharing examples each month
- FAB experience champions will be identified across directorates and come together 4 times a year to share and learn

How will we assess our progress?
Speciality and Directorate Governance meetings will provide greater detail and accounting for patients experiences which will then provide a multi-level report from that service level upwards to draw trends and themes across the Trust that can then be benchmarked regionally and nationally.

Assurance will be monitored through Patient Experience Committee and Quality Governance Committee and upwardly reported to Trust Board.

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

Why have we selected this Priority?

United Lincolnshire Hospitals NHS Trust (ULHT) is committed to safeguarding patients and service users, ensuring that patient safety is placed at the heart of everything we do. Assuring the safety of patients, is a key priority within the organisation. This requires a collaborative approach to the analysis of patient safety incidents and that the lessons learned from this analysis are shared both across the Trust and with other organisations and agencies, as appropriate.

It is essential that staff understand that the Trust has a learning culture and any investigation is not intended to blame individuals but to seek the causal factors and share the lessons learned; to prevent a recurrence of the patient safety incident.

Recommendations from the Care Quality Commission support the requirements to have an aggregated approach to the analysis of incidents relating to patient harm. The ultimate aim is to reduce the risk of harm to patients through improving the safety and quality of services at ULHT.

Reporting when things go wrong is essential in healthcare. But it is only part of the process of improving patient safety. It is equally important that we look at the underlying causes of patient safety incidents and learn how to prevent them from happening again. When things go wrong, human error is routinely blamed as the cause. However, quick assumptions and routine assignment of individual blame do not get to the heart of the problem.

Closer analysis reveals that there are many underlying causes which contribute to patient safety problems and, in the majority of cases, these causes extend beyond the individual staff member or team involved.

Understanding why a patient safety incident has occurred is an essential part of the investigation and fundamental to ensuring that the incident is not repeated. Only by learning about the underlying causes of the patient safety incident can we implement new ways of working to minimise the risk of future harm. We also need to listen to the patient voice whilst learning from these.

Our current status

The Trust has made radical changes to the management of Serious Incidents in 2017/18 to ensure timely investigation by the most appropriate professionals. However, there remains a delay in responding to serious incidents within 60 working days. At year end of 2017/18 there were 119 overdue serious incidents.

In 2017 the Trust relaunched the Serious Incident Investigation process with two Executive led forums. These meetings are convened weekly and chaired by either the Director of Nursing or the Medical Director. The purpose of the forums is divided into two distinct remits:-

1. Review of 72 hour reports for suspected Serious Incidents. This forum reviews all 72 hour reports to determine incident status and establish terms of reference for onward investigation as appropriate

2. Review of Serious Incident reports. This forum quality assures complete Serious Incident reports to ensure that the investigation has fulfilled the original terms of reference and identified the route cause of the incident.

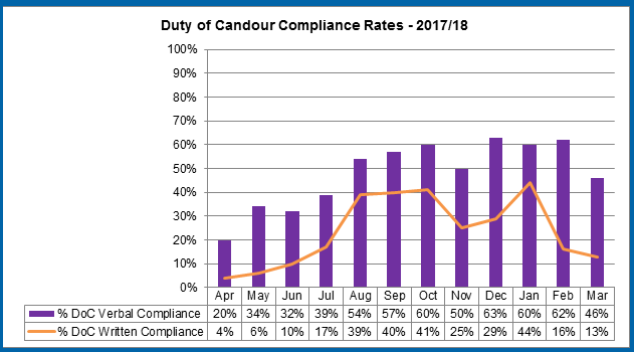
A process has been introduced for the immediate sharing of lessons learnt from Never Events. All Never Events are subject to a 72 hour report which will in summary outline the incident, the immediate learning and mitigation measures and lead contact. This is shared with all staff through a Patient Safety Briefing.

Patient Safety Briefings were introduced in 2015 and remain a key communication tool for dissemination of key safety messages and lessons learned.

All incidents that result in moderate harm or above require that within 10 days 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

In 2017/18 there were 628 incidents with moderate or above harm. Evidence to support compliance with statutory requirements is collected on our incident reporting system; DATIX. In 2017/18 we fulfilled this responsibility for 142 of incidents.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% DoC Verbal Compliance	20%	34%	32%	39%	54%	57%	60%	50%	63%	60%	62%	46%
% DoC Written Compliance	4%	6%	10%	17%	39%	40%	41%	25%	29%	44%	16%	13%

Duty of Candour compliance is subject to an improvement plan; both staff and patient leaflets are being published to be displayed in clinical areas and an e-learning module for staff has been developed.

What will success look like?

Creating a fair and just culture; being transparent when things go wrong and embedding learning, measured by:-

- Continued use of Patient Safety Briefings to disseminate key safety messages and lessons learned
- An increase in low and no harm incident reporting which is recognised nationally as a measure of improved safety culture
- A reduction in Serious Incidents
- Avoidance of Never Events
- Establishment of Learning Lessons Forum
- 100% compliance with the statutory requirement to fulfil Duty of Candour
- All prospective Serious Incidents to have 72 hour report completed within 72 hours of request by Trust Risk Team.
- All Serious incident reports to be completed within 40 working days and forwarded to the Trust Risk Team for quality assurance unless an extension has been agreed, and should be forwarded to the CCG within 60 working days for approval and closure
- Comparative reporting data from the National Reporting and Learning System (NRLS) will show a decrease in the number of moderate and severe harms to be in line with national reporting rates.

How will we assess our progress?

Monthly reports are generated for discussion at Patient Safety Committee. Patient Safety Committee is established as a subcommittee of Quality Governance and Trust Board respectively. There are robust governance arrangements to upwardly report areas of assurance and risk through this framework.

The patient safety committee will receive comparative reporting data from the National Reporting and Learning System (NRLS)

PRIORITY 3 – ELIMINATING AVOIDABLE PATIENT HARM (FALLS)

Why have we selected this Priority?

A fall in hospital can be devastating. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and increased morbidity and mortality. Falling also affects the family members and carers of people who fall, and has an impact on quality of life, health and social care costs.

Falls represent significant cost to trusts and the wider healthcare system. According to the National Learning and Reporting System (NRLS) in 2015/16, as in previous years, falls were the most commonly reported type of incident in acute and community hospitals and the third most commonly reported type of incident in mental health hospitals.

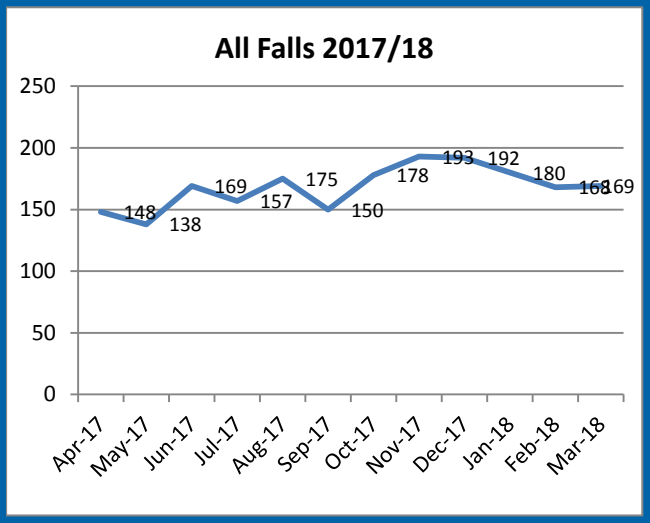
Reported falls among older patients more likely to result in some degree of harm, where harm does result, it is three times more likely to be severe. Older patients are also likely to be relatively frailer before the fall and therefore more likely to sustain more serious harm as a direct result of the fall.

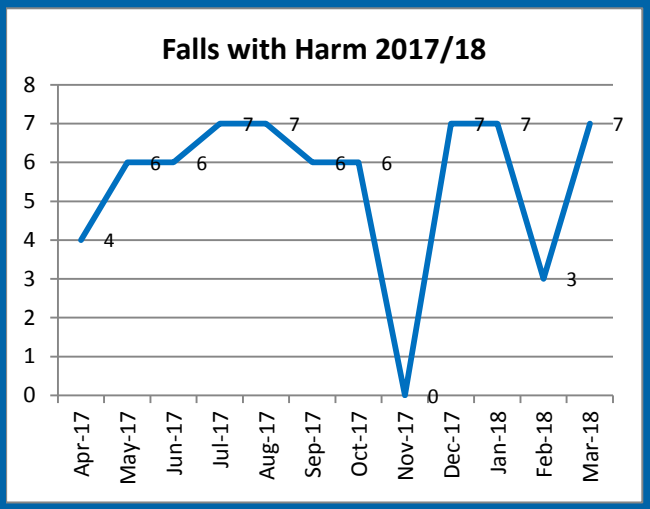
There is evidence (for example the national FallSafe project) that assessments and interventions that take into account a range of factors to identify and treat underlying reasons for falls in hospitals could reduce the incidence of falls by 25-30%.

Our current status

Inpatient hospital falls are one of the highest reported adverse events reported at United Lincolnshire Hospitals NHS Trust. Falls are reported through our incident reporting system; DATIX. United Lincolnshire Hospitals NHS Trust measure patient falls as a per 1000 bed day calculation.

The graphs below depicts the number of falls of all harm level and the number of falls which caused harm on our wards across the Trust. During 2017/18 there were a total of 2017 falls and 66 falls with harm.





The Trust participated, as planned, in the National Audit of Inpatient Falls and Fragility Audit Programme (FFAP) from the Royal College of Physicians the results of which did not provide any deviation from the national averages outlined above. In 2017 the Trust participated in the NHSi Collaborative for Falls prevention. Pilot wards trialled a number of initiatives as Plan, Do, Study, Act (PDSA) cycles prior to broader roll out.

Falls identified as Serious Incidents are investigated with the support of Falls Scrutiny Panel. The Scrutiny Panel involves a Multi-Disciplinary Team convened to provide specialist advice and quality assurance of all Falls investigations.

The Trust launched the Ward Health Accreditation Metrics (WHAM) in September 2017. Ward Health Accreditation Metrics programme is a Patient First initiative which mirrors a similar programme introduced at Salford Royal Hospital. The programme focuses on engaging staff and empowering leaders to improve standards and quality on adult in-patient wards. It is based on the continuous improvement principle of standardisation by recognising, sharing and adhering to best evidence based practice to deliver high quality patient care and experience. In relation to falls the standard is: All patients will be assessed for their risk of falling within 4 hour of admission with action taken to minimise the risk of falls related harm which is fully documented

The Trust also ensure families and cares are fully involved with the plans of care to reduce the falls risk

What will success look like?

Patients will be assessed for their risk of falling within 4 hour of admission with action taken to minimise the risk of falls related harm which is fully documented.

Success will be measured by:-

- Reduction of falls with harm by 10% which will equate to 5 a month with a total of 60 for 2018/19
- Consistent achievement of 90% against all Safety Quality Dashboard metrics
- Establish site falls meetings with ward representation from falls ambassadors
- Dissemination of lessons learned through Serious Incidents through Newsletter.
- Demonstrable momentum for Ward Accreditation domain – reduced number of wards with overall red domain status.

How will we assess our progress?

A Corporate Action Plan has been developed and is split into four key areas, each with a number of work-streams, which have been included to address specific challenges that have been identified as either important areas of work though national evidence base or are specific issues that have been identified through RCA investigations or in discussion with frontline teams. These are:

- Reporting and monitoring systems
- Optimal assessment and recognition
- Evidence based interventions
- Resources, people and equipment

Success and delivery of the action plan in reducing patient falls will be measured through a number of metrics and key performance indicators, and monitored through a robust governance and meeting structure.

Falls are monitored through the following quality measurement tools:-

- Safety Quality Dashboard
- Safety Thermometer
- Ward Health Check
- Ward Accreditation
- DATIX

The Falls Prevention Committee review all available quality measurement tools and report quarterly through Patient Safety Committee. Patient Safety Committee is established as a subcommittee of Quality Governance and Trust Board respectively. There are robust governance arrangements to upwardly report areas of assurance and risk through this framework.

PRIORITY 4 – ELIMINATING AVOIDABLE PATIENT HARM (CAT 3 & 4 PRESSURE DAMAGE)

Why have we selected this Priority?
Avoidable pressure ulcers are a key indicator of the quality and experience of patient care. Despite progress since 2012 in the management of pressure ulcers they remain a significant healthcare problem and nationally 700,000 people are affected by pressure ulcers each year. Treating pressure ulcers costs the NHS more than £3.8 million every day.

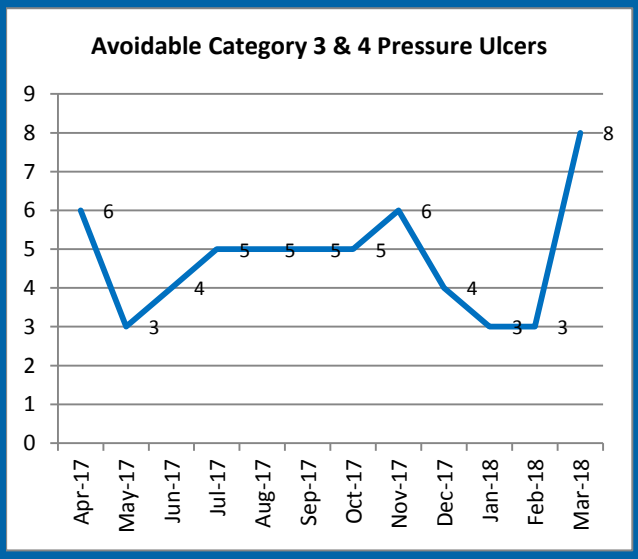
We know that many pressure ulcers are preventable, so when they do occur they can have a profound impact on the overall wellbeing of patients and can be both painful and debilitating (Moore et al 2009). Preventing them will improve care for all vulnerable patients.

Our current status
Hospital acquired pressure damage is one of the highest reported adverse events reported at United Lincolnshire Hospitals NHS Trust. Pressure Damage is reported through our incident reporting system; DATIX.

Pressure Ulcers at category 3 or 4 are recognised as a Serious Incident and as such are investigated with the support of Pressure Ulcer Scrutiny Panel. The Scrutiny Panel involves a Multi-Disciplinary Team convened to provide specialist advice and quality assurance of all Pressure Ulcer investigations.

The Trust launched the Ward Health Accreditation Metrics (WHAM) in September 2017. Ward Health Accreditation Metrics programme is a Patient First initiative which mirrors a similar programme introduced at Salford Royal Hospital. The programme focuses on engaging staff and empowering leaders to improve standards and quality on adult in-patient wards. It is based on the continuous improvement principle of standardisation by recognising, sharing and adhering to best evidence based practice to deliver high quality patient care and experience. In relation to pressure damage the standard is: I will keep you safe from avoidable skin damage. The condition of the patient's skin will be maintained or improved.

For 2017/18 there were 57 avoidable category 3 & 4 pressure ulcers.



What will success look like?

Patients will be assessed for their risk of pressure damage within 4 hours of admission with action taken to minimise the risk of pressure damage which is fully documented, success will be measured by:-

- Reduction of 30% in number of avoidable category 3 and category 4 pressure ulcers. There were 57 avoidable category 3 & 4 pressure ulcers for 2017/18 which will be a trajectory of 40 for 2018/19
- Consistent achievement of 90% against all Safety Quality Dashboard metrics
- Dissemination of lessons learned through Serious Incidents through Newsletter and Lessons Learned Forum
- Collaborative working with community partners inclusive of mirror categorisation tool
- Development of Harm Free Care Assurance Group with Ward Ambassadors supported and developed through link ambassador programme.
- A corporate action plan to be developed to address specific challenges that have been identified as either important areas of work though national evidence base or are specific issues that have been identified through RCA investigations

How will we assess our progress?

Pressure Ulcers are monitored through the following quality measurement tools:-

- Safety Quality Dashboard
- Safety Thermometer
- Ward Health Check
- Ward Accreditation
- DATIX

The Pressure Ulcer Committee review all available quality measurement tools and report quarterly through Patient Safety Committee. Patient Safety Committee is established as a subcommittee of Quality Governance and Trust Board respectively. There are robust governance arrangements to upwardly report areas of assurance and risk through this framework.

PRIORITY 5 – GENERATING HEALTHCARE SERVICES FOR THE FUTURE THAT ARE CREATIVE AND FORWARD

Why have we selected this Priority?
The Seven Day Services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital.

Patients across England will see a revolution in hospital care with the introduction of seven day consultant-led services that are delivered consistently over the coming years.

Ten clinical standards for seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted.

Our current status
ULHT has participated in all NHS England Seven Day Services audits. Participation in April 2018 will conclude completion of the 6th audit to self-assess progress against the 10 clinical standards for seven day services. The following results are from seven day services audit March 2017:

- The overall proportion of patients seen and assessed by a suitable consultant within 14 hours of admission is: 72%
- The overall proportion of patients who required twice daily consultant reviews and were reviewed twice by a consultant was 100 %
- The overall proportion of patients who required a daily consultant review and were reviewed by a consultant was 89 %
- The Trust provided 7 of 9 consultant directed interventions on-site or by formal arrangement – cardiac pacing and renal replacement are the 2 interventions not provided on site or by formal arrangement
- The Trust provided 3 of 6 consultant directed diagnostics on-site or by formal arrangement - Echocardiography, MRI and Ultrasound were not provided at weekend but were provided during weekdays
- The overall proportion of patients made aware of diagnosis, management plan and prognosis within 48 hours of admission is 93%

What will success look like?
ULHT will progress to deliver, through formal arrangements, the four priority clinical standards; namely:-

1. All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital

2. Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:
    a. Within 1 hour for critical patients
    b. Within 12 hours for urgent patients
    c. Within 24 hours for non-urgent patients
3. Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols
4. Patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, 7 days a week, unless it has been determined that this would not affect the patient's care pathway

- Recruitment of Consultants with reference to 7 Day Services working in job plans
- Continued momentum within 2021 programmes to redesign services clinical services

How will we assess our progress?

Provision of 7 Day Services are monitored through the following governance arrangements/measurement tools:-

- National 7DS Audit
- Productive Services Oversight Board

The Productive Services Oversight Board is established as a subcommittee of 2021 Board and Trust Board respectively. There are robust governance arrangements to upwardly report areas of assurance and risk through this framework. These workstrreams will take several years to implement and working with our patients and families will be key to ensure a successful collaboration

PRIORITY 6 –ERADICATING PREVENTABLE DEATHS (SEPSIS)

Why have we selected this Priority?

Sepsis is when the body's response to infection injures its own tissues and organs. Sepsis is a life-threatening condition arising when the body' abnormal, or 'dysregulated', immune response to an infection causes organs to begin to fail.

Sepsis can be triggered by any infection, but most commonly occurs in response to bacterial infections of the lungs, urinary tract, abdominal organs or skin and soft tissues. Caught early, outcomes are excellent. Left unchecked, the patient is likely to spiral to multi-organ failure, septic shock and death

According to the UK Sepsis Trust 44,000 people lose their lives to sepsis every year. £2 billion is the estimated outlay that sepsis costs the NHS annually.

Sepsis is everyone's problem. Few, if any, conditions have such an ability to affect any patient presenting to any facet of healthcare. Spotting sepsis requires vigilance, robust systems such as National Early Warning Score (NEWS), and excellent pathways of communication and response. If we're to save lives, everyone needs to know their role.

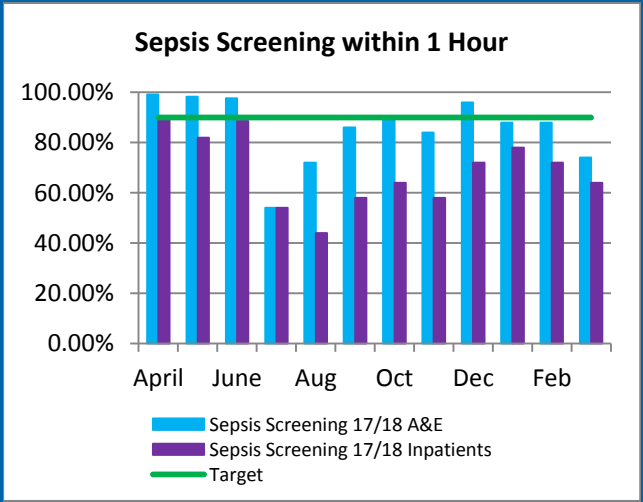
Our current status

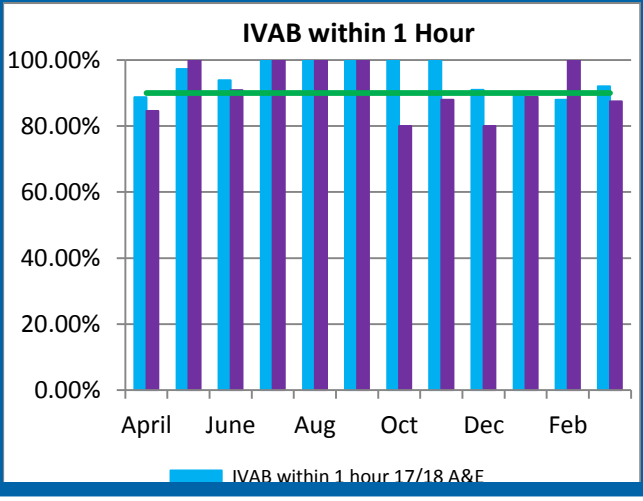
Sepsis is one of the most frequently coded diagnosis groups at United Lincolnshire Hospitals NHS Trust. Prompt identification and treatment is crucial to positive patient outcomes.
United Lincolnshire Hospitals NHS Trust have introduced a range of educational and clinical tools to support timely diagnosis and treatment.

United Lincolnshire Hospitals NHS Trust was one of the first Trusts in the United Kingdom to introduce electronic Sepsis screening.

The below graphs represent performance separated by A&E and Inpatient departments in respect of Commissioning for Quality and Innovation ((CQUIN) data. The target is to achieve 90% for sepsis screening and 90% for Intravenous Antibiotics (IVAB) within 1 hour.

Our current screening performance for 2017/18 was an average for A&E 85.59% and inpatients 68.71%.
For IVAB the average for 2017/18 for A&E was 95.01% and for inpatients was 91.65%.





The Trust launched the Ward Health Accreditation Metrics (WHAM) in September 2017. Ward Health Accreditation Metrics programme is a Patient First initiative which mirrors a similar programme introduced at Salford Royal Hospital. The programme focuses on engaging staff and empowering leaders to improve standards and quality on adult in-patient wards. It is based on the continuous improvement principle of standardisation by recognising, sharing and adhering to best evidence based practice to deliver high quality patient care and experience. In relation to Sepsis the standard is: I will keep you safe from Deteriorating. All patients will have a full set of vital signs taken on admission and as minimum 12 hourly subject to National Early Warning Score (NEWS), including overnight

What will success look like?

Patients will be kept safe from deterioration by:-

- All patients will receive a full set of vital signs observations on arrival and repeated at minimum 12 hourly frequency in accordance with Trust Observations Policy
- All inpatient areas will use electronic screening tool for early Sepsis identification and treatment
- 90% of staff will have undertaken Sepsis e-learning training
- 90% of patients will receive Sepsis Screen within 60 minutes of NEWs 5≥
- 90% of patients with identified red flag Sepsis will receive IV Antibiotics within 60 minutes of diagnosis
- Where there is evidence of deterioration patient records will demonstrate use of Situation, Background, Assessment, Recommendation (SBAR) tool to escalate
- All inpatient and assessment areas will have a Sepsis box or trolley
- 100% of patients that are not screened or treated within 60 minutes will be reviewed through appropriate harm scrutiny process
- EMAS to provide updates to the sepsis committee on the outcomes of

How will we assess our progress?

Sepsis identification and treatment is monitored through the following quality measurement tools:-

- Electronic Observations Data
- E-Bundle
- Ward Health Check
- Ward Accreditation
- DATIX

The Sepsis Task and Finish Group will review all available quality measurement tools and report quarterly through Patient Safety Committee. Patient Safety Committee is established as a subcommittee of Quality Governance and Trust Board respectively. Sepsis is also a key priority on the Trust Quality & Safety Improvement Programme (QSIP) who meet weekly and is chaired by the Director of Nursing. A milestone plan is developed with specific key performance indicators developed. There are robust governance arrangements to upwardly report areas of assurance and risk through this framework.

PRIORITY 7 – PROVIDING SERVICES BY STAFF WHO DEMONSTRATE OUR VALUES AND BEHAVIOURS

Why have we selected this Priority?

Patients must come first in everything the NHS does. All parts of the NHS system should act and collaborate in the interests of patients, always putting patient interest before institutional interest, even when that involves admitting mistakes. As well as working with each other, health service organisations and providers should also involve staff, patients, carers and local communities to ensure they are providing services tailored to local needs.

Every individual who comes into contact with ULHT should always be treated with respect and dignity, regardless of whether they are a patient, carer or member of staff. This value seeks to ensure that ULHT value and respect different needs, aspirations and priorities, and take them into account when designing and delivering services. ULHT aims to foster a spirit of candour and a culture of humility, openness and honesty, where staff communicate clearly and openly with patients, relatives and carers.

Compassionate care ties closely with respect and dignity in that individual patients, carers and relatives must be treated with sensitivity and kindness. The business of the NHS extends beyond providing clinical care and includes alleviating pain, distress, and making people feel valued and that their concerns

Our current status

In October 2016 the Trust complied with the NHS Contract requirement to nominate a Freedom to Speak Up Guardian. As an organisation we are committed to investigating and taking appropriate action where concerns are raised with us, and have arrangements, including a Freedom to Speak Up Guardian to ensure staff who raise concerns are fully supported to do so.

The annual National Staff Survey was sent to every member of Trust staff between September and December 2017. Staff were asked a total of 88 questions relating to:

- Their job
- Their managers
- Their health, well-being and safety at work
- Their personal development
- Their organisation

3231 staff completed the survey giving an increased response rate of 45% (39% in 2016) which indicates that people are keen to tell us what they think. The average response rate for acute Trusts was 45.5%

Across the board the results show a decline in scores since 2016. The two areas where we showed significant improvement were:

1. Had mandatory training in the last 12 months
2. Had appraisal in the last 12 months

In late 2017 ULHT launched the 2021 roadmap set around one vision, three ambitions, five programmes of work, and five values. One programme will specifically look at developing the workforce to meet future need. In practice this will mean that we will recruit and retain more staff and staff will be well trained, healthy and supported which will also encompass flexible working for our staff. As part of the 2021 strategy we have also launched our staff charter. This is based around our five core values and the charter sets out clear expectations of 'what we expect to see from staff' and what 'staff can expect from the Trust' as an employer, describing how together we will deliver our vision and values for all our patients.

Revised membership of the Senior Leadership Forum to include the most senior 200 leaders to consider and contribute to the future of ULHT.

Alongside the charter we have also produced a personal responsibility framework. This will support and underpin the values and gives examples of the behaviours we would wish to see and those we would not wish to see, to help us create a positive, caring working environment.

ULHT have designed a modular leadership programme to ensure staff have the necessary skills and support to lead and develop into new roles ensuring automatic succession planning within disciplines.

A two day workshop was hosted for senior managers to discuss creating positive and engagement work environment. This work included 360° feedback and reflection opportunity.

What will success look like?
We will provide services by staff who demonstrate our values and behaviours. This will be measured by:-

- Implement the 2021 staff engagement programme
- Deliver the 2018/19 leadership programme and establish a talent management strategy
- Collaborate with clinical directorates to determine the future workforce requirements through workforce capacity reviews ensuring right size against activity rate using model hospital data.
- Reduce reliance on agency workforce (medical & nursing) through improved retention and bank strategies
- Increase in positive responses to 49.5% for “Would you recommend ULHT as a place to work” and “Would you recommend the care at ULHT”
- Implement new approach to individual appraisal & performance management with more systematic links to values and behaviours
- Reduction in perceived bullying from staff as measured by national staff survey

Supporting the values will be our Staff Charter, which is further defined by a personal responsibility framework which has been developed in response to consultation with our staff. This Charter will help us achieve a common understanding and recognition of expected behaviours.

How will we assess our progress?
Provision of services by staff who demonstrate our values and behaviours will be monitored through the following quality measurement tools:-

- Senior Leadership Forum Feedback
- National Staff Survey
- Appraisal Rates
- Recruitment and retention figures

The Workforce and Organisational Development Committee will review all available quality measurement tools. The Workforce and Organisational Development Committee is established as a subcommittee of Trust Board. There are robust governance arrangements to upwardly report areas of assurance and risk through this framework.

LOOKING BACK: PROGRESS MADE SINCE PUBLICATION OF 2016/17 QUALITY ACCOUNT

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

In 2017/18 these were:-

1. IMPROVING THE CARE OF PATIENTS WITH SEPSIS
2. PATIENTS TO BE DISCHARGED WITH THEIR eDD & THE eDD TO BE SENT TO THE GP WITHIN 24 HOURS OF DISCHARGE
3. REDUCTION IN MORTALITY RATES
4. LEARNING FROM SERIOUS INCIDENTS
5. DUTY OF CANDOUR
6. REDUCTION IN THE INCIDENCE OF FALLS AND HARM SUSTAINED BY PATIENTS FOLLOWING A FALL
7. REDUCTION IN THE INCIDENCE AND HARM ASSOCIATED WITH CATHETER URINARY TRACT INFECTIONS
8. IMPROVE COMPLIANCE WITH THE ADMINISTRATION OF MEDICATION IN DIABETIC DRUGS
9. IMPROVE THE EXPERIENCE FOR PATIENTS DEMENTIA AND VULNERABLE PATIENTS
10. REDUCE AVOIDABLE HARM BY ELIMINATING AVOIDABLE CATEGORY 4 PRESSURE ULCERS AND REDUCING AVOIDABLE CATEGORY 3 PRESSURE ULCERS BY 50%

Introduction

The Quality Account for 2016/17 outlined the Trusts proposed quality improvements for the year ahead (2017/18). These priorities were identified following engagement with patients, the public, staff, governors and external stakeholders. During the year 2017/18 we have been monitoring our progress against these priority ambitions through our governance framework. The priorities that we have not carried forward will become 'business as usual' and have defined work streams to enable the Trust to deliver on the improvements not achieved in 2016/17.

United Lincolnshire Hospitals NHS Trust has not fully achieved all its priority ambitions however there is evidential progress in a number of areas with sustained patient safety improvements. We set ourselves ambitious targets and have achieved 66% of the individual elements. Improving our Governance arrangements we aim to improve our 2017/18 priorities by holding the identified leads and committees to account on the delivery of their priorities.

Trust performance

This section provides detail on how the trust has performed against the 10 priority ambitions of 2017/18. Results relate to the period 1st April 2017 – 31st March 2018 or the nearest period available. Mechanisms of measurement vary by priority and by the availability of national benchmark.

PRIORITY 1 2017/18 IMPROVING THE CARE OF PATIENTS WITH SEPSIS

WE SAID WE WOULD:	
Success Measure	**Result**
Sepsis nurses to be in post at Lincoln and Pilgrim site, attending Grantham 1 day a week	ACHIEVED
Collect compliance with sepsis screening on all inpatient wards	ACHIEVED
Collect compliance with administration of intravenous antibiotics on all adult inpatient wards	ACHIEVED
Rolled out the sepsis eBundle to all adult wards and departments	ACHIEVED
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	NOT ACHIEVED
Incident forms to be completed when the patient has not been screened or appropriate treatment initiated within 1 hour	ACHIEVED
Information for patients and relatives to be displayed on sepsis screening in line with NICE guidance	ACHIEVED
Achieve 90% or greater for patients who meet the criteria being screened. For 2017/18 we achieved on average for A&E 85.59% and inpatients 68.71% which is an improvement from 2016/17 where A&E and inpatients were not separated however the Trust total was 78.81%.	NOT ACHIEVED
Achieve 90% or greater for intravenous antibiotics administered within 1 hour. For 2017/18 we achieved on average for A&E 95.01% and for inpatients 91.65% which is an improvement from 2016/17 where A&E and inpatients were not separated however the Trust total was 51.23%.	ACHIEVED

SUMMARY

Over the past year there at has been a large emphasis on Sepsis Screening and treatment. There are two full time Sepsis Practitioners in post and the trust has an enhanced awareness through mandatory e-learning education (this is now extended to include paediatric module). For those patients who have not been screened or had the 6 in 60 delivered we request monthly review templates and IR1s to be completed; a thematic analysis is now undertaken following these reviews to identify key themes. Whilst Patient Group Directive (PGD) for intravenous antibiotics (IV) was withdrawn for clinical reasons we have adapted the Sepsis Boxes to include equipment required to deliver the 6 in 60; these are on all adult and maternity inpatient wards. Additionally, East Midlands Ambulance Services are delivering PGD IV antibiotics to patients with suspected Red Flag Sepsis prior to attendance at the emergency department which will further reduce delays in treatment. Although work is still required to ensure our screening and treatment is provided consistently ≤ 60 minutes we have seen an increased engagement from frontline staff and are confident the work streams in place will assist with this.

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

- Roll out the Sepsis E-Bundle to Paediatrics
- Identify a harm pro-forma for 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 and individual accountability letters to be introduced
- Information leaflets for patients and relatives to be available as per NICE guidance
- Achieve 90% or greater for patients who meet the criteria being screened within 60 minutes
- Achieve 90% or greater for intravenous antibiotics administered within 60 minutes
- Revision of Sepsis Bundle following revision of NICE Guidance

- Introduction of National Early Warning Score (NEWS)2
- Design and launch of Maternity Sepsis training
- Sepsis is remaining as a priority for 2018/19

PRIORITY 2 2017/18 PATIENTS TO BE DISCHARGED WITH THEIR ELECTRONIC DISCHARGE DOCUMENT (eDD) & THE eDD TO BE SENT TO THE GP WITHIN 24 HOURS OF A PATIENT DISCHARGE

WE SAID WE WOULD:	
Success Measure	**Result**
Develop a deceased eDD template	ACHIEVED
Improve functionality of eDD system	ACHIEVED
Develop a standard operating policy for wards	ACHIEVED
Develop an escalation protocol if eDD is not completed for patients on day of discharge	ACHIEVED
Monthly compliance to be sent to all clinical leads	ACHIEVED
Send safety briefings	ACHIEVED
Achieve 90% or greater for patients to be discharged with their eDD. For 2017/18 the Trust achieved 85.68% which is an improvement from the 2016/17 data of 79.09% compliance.	NOT ACHIEVED
Achieve 100% for eDDs to be sent within 5 days. For 2017/18 the Trust achieved 91.2% which is an improvement from the 2016/17 data of 86.84% compliance.	NOT ACHIEVED

SUMMARY

- eDD Notification of Deceased Patient template launched September 2017.
- Gold Standards Framework, confirming discharging consultant and bulk supply of medication functionality improved in November 2017.
- Changes in condition communicated to primary care through retrospective addendum
- Standard Operating Procedure (SOP) (including escalation for uncompleted eDD) circulated to all areas and issued to newly-inducting doctors.
- Monthly compliance data sent to all consultants and ward leaders.
- Patient Safety Briefings sent regarding timely eDD completion, consultant referrals on discharge and Notification of Deceased Patient eDD.

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

- Work ongoing to improve eDD functionality – Plans to introduce “one-click” nurse check for medications, timed dispatch for eDDs and self-discharge template.
- Plans to use eDD functionality within Medway being scoped.
- eDD performance will be incorporated within the integrated performance report which is monitored by the Trust Board
- Directorate level Performance Review Meetings (PRM) will have their eDD compliance discussed to ensure greater accountability of performance

PRIORITY 3 2017/18 REDUCTION IN MORTALITY RATES

WE SAID WE WOULD:	
Success Measure	**Result**
Achieve 85% of all mortalities to have a case note review completed. For 2017/18 the Trust achieved an average of 57% compared to 76% in March 2017	NOT ACHIEVED
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	ACHIEVED
Work collaboratively with the Clinical Commissioning Groups (CCGs) reviewing mortalities within 48 hours of admission, 30 days of discharge and inappropriate admissions	ACHIEVED
Review coding when patients have died to ensure all co-morbidities have been included	ACHIEVED
Implement the actions from the 'national guidance on learning from deaths'	ACHIEVED
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.	ACHIEVED
Coordinate quarterly 'Coding Masterclass Workshops'	ACHIEVED
Achieve HSMR within expected limits. HSMR from March 2017 to February 2018 is 102.13 and is within expected limits (latest data available) HSMR (December 2016 to November 2017) was 102.65 and was within expected limits	ACHIEVED
Achieve SHMI within expected limits. SHMI from October 16 to September 17 is 114.90 and is in band 1 and outside of expected limits (latest data available). SHMI (June 16 to July 17) was 112.22 and was in band 1 and outside of expected limits.	NOT ACHIEVED

SUMMARY

- The Trust has strengthened their mortality processes and this has been recognised in the compliance stated above. The development of the mortality strategy will add focus and additional scrutiny with the aim of delivering on the pledge of eradicating preventable deaths within the Trust.
- The Trust achieved 57% compliance with mortality reviews however a business case has been approved to implement the Medical Examiner role who will be responsible for reviewing all deaths initially and if any concerns are identified, referring these deaths for a further review at the Mortality Review Assurance Group (MoRAG) or the Lincolnshire Mortality Collaborative.
- The Trust also did not achieve a SHMI within expected limits. A 2018 – 2021 Mortality Reduction Strategy has been developed which details the improvement work required to get our SHMI within expected limits.

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

The goal is to have an effective mortality programme which will ensure:

- An independent case note review or an investigation will be completed if identified at the initial screening by the Medical Examiner there were failings in the care to provide additional assurances and ensured the Trust is compliant with national guidelines
- Mortality rates are monitored to identify trends and areas of emerging concern
- Findings from all mortality reviews are shared for learning at the appropriate level to ensure risks are identified and acted on
- Where mortality reviews have shown that care falls short of the agreed standard, focused actions are identified to improve care and service delivery
- Resources for mortality reviews are used effectively, training and support are available for staff
- Processes are in place to support accurate and thorough clinical documentation and coding
- The Trust is working to deliver and implement 7 day services
- There is daily senior review for all patients and consultant review every 3 days in seven
- Staff are adhering to the completion of care bundles for specific conditions
- There is appropriate escalation and rescue of the deteriorating patient
- Improve our communication with patients on their diagnosis, management plan and prognosis
- Trust Board currently receive a monthly report on our mortality and will receive progress reports on our compliance with the key performance indictors within the mortality reduction strategy to ensure delivery of key milestones.

PRIORITY 4 2017/18 LEARNING FROM SERIOUS INCIDENTS

WE SAID WE WOULD:	
Success Measure	**Result**
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. At year end of 2017/18 there were 119 overdue serious incidents compared to 56 overdue from 2016/17.	NOT ACHIEVED
Develop a more intelligent approach around reporting management and learning from our incidents	ACHIEVED
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	ACHIEVED
Incident management audit process in place to provide assurance we are learning from incidents	NOT ACHIEVED
Introduce innovative ways to share lessons learnt	ACHIEVED
Implement scrutiny panels for the common Serious Incidents (already in place for falls and pressure ulcers)	NOT ACHIEVED
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	ACHIEVED
Review themes to ensure lessons are learnt	ACHIEVED

SUMMARY

- The trust has adopted a more structured approach to incident and SI management, twice weekly formal meetings have been established attended by the Medical Director, Director of Nursing and other senior members of staff. The meetings are dedicated to improving performance against the national framework requirements, speedier identification of serious incidents and expedition of investigation and reporting and sharing of lessons learned across the organisation and senior clinical involvement throughout the whole process.
- Full review of all open incidents and liaison with clinical teams where outstanding actions identified
- Fortnightly performance figures are circulated to all clinical directors to enable them to monitor compliance against the requirements of the SI policy
- A number of significant changes have been made to the incident reporting system, DATIX, examples are; changes to the workflow used on the incident module to track the status of the investigation, templates added to the documents section, this enables each clinical area to have the ability to pull off their own 72hr reports and SI template and created an incident heading of “Information Governance incidents” to be able to clearly identify those incidents which Information Governance need to be aware of. This has been aligned with requirements set out by Information Commissioners Office.
- A training programme has been commissioned to support staff awareness and also train staff specifically in investigation and reporting skills and extra resource allocated to those most challenged clinical areas.
- The trust acknowledged that performance against national guidelines was below the expected level and extra resource was agreed in September.

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

Creating a fair and just culture; being transparent when things go wrong and embedding learning, measured by:-

- An increase in incident reporting recognised nationally as a measure of improved safety culture
- A reduction in Serious Incidents
- Avoidance of Never Events
- Establishment of Learning Lessons Forum
- 100% compliance with the statutory requirement to fulfil Duty of Candour
- All prospective Serious Incidents to have 72 hour report completed within 72 hours of request by Trust Risk Team.
- All Serious incident reports to be completed within 40 working days and forwarded to the Trust Risk Team for quality assurance unless an extension has been agreed, and should be forwarded to the CCG within 60 working days for approval and closure
- Continued use of Patient Safety Briefings to disseminate key safety messages and lessons learned
- Learning from Serious Incidents is remaining a priority for 2018/19

PRIORITY 5 2017/18 DUTY OF CANDOUR

WE SAID WE WOULD:	
Success Measure	**Result**
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.	ACHEIVED
Weekly reporting to Business Units to complete outstanding DoC	ACHIEVED
Monthly reporting to Quality Governance Committee for assurance	ACHEIVED
Develop a robust audit process	ACHIEVED
Coordinate training sessions for staff	ACHEIVED
Develop an eLearning tool for staff	NOT ACHIEVED
Develop an information leaflet for patients	NOT ACHIEVED
100% of patients will receive an apology and written evidence if appropriate. For 2017/18 the Trust achieved on average 48% for verbal apology and on average 24% for written apology.	NOT ACHEIVED
Staff will be aware of their roles and responsibilities	NOT ACHEIVED
A communication strategy will be developed to support the policy	NOT ACHEIVED
Policy and procedures to be updated	NOT ACHEIVED

SUMMARY

- For 2017/18 the Trust achieved on average 48% for verbal apology and on average 24% for written apology. This is falling very short of the national target of 100%. Work is being done to raise the awareness of Duty of Candour on the wards and other clinical areas.
- In December 2017, incident reporting system, DATIX, was updated to capture the different stages of Duty of Candour. The software is now equipped to record whether the verbal apology given at the time of the incident has been followed up in writing therefore giving a clearer picture of our compliance rate.
- At the time of reporting an incident resulting in moderate/severe/death the reporter is alerted that this is a Duty of Candour incident and requires an immediate apology.
- Weekly performance figures are circulated to all Clinical Directorates to enable them to monitor their areas compliance.
- Development of information leaflets for staff
- Weekly reminders are sent to those who are handlers of non-compliant Duty of Candour incidents.

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

- To launch the Duty of Candour e-learning package.
- Continue to raise the awareness of Duty of Candour by developing an information leaflet for patients
- Duty of Candour policy to be updated in line with the updated Risk Management policies.
- Develop a process of accountability for non-compliant Duty of Candour incidents.
- Target areas who record a large amount of moderate harm and above incidents to educate them on Duty of Candour.
- Continue to increase the compliance rate
- Duty of Candour is remaining as a priority for 2018/19

PRIORITY 6 2017/18 REDUCTION IN THE INCIDENCE OF FALLS AND HARM SUSTAINED BY PATIENTS FOLLOWING FALL

WE SAID WE WOULD:	
Success Measure	**Result**
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.	ACHIEVED
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.	ACHIEVED
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	ACHIEVED
We will triangulate data in order to understand the root cause of falls	ACHIEVED
We will review how we systematically disseminate learning	NOT ACHIEVED
Reduce falls with harm by 20%. For 2016/17 the Trust had 2043 falls and to reduce falls by 20% we need to have 408 less falls. For 2017/18 the Trust had 2017 falls and only reduced the number by 26.	NOT ACHIEVED

SUMMARY

- Successful trial of Lying & Standing Blood Pressure sticker with initiative now being rolled out across the Trust
- Call Don't Falls Poster introduced in bays/side rooms and ward toilets
- Lying & Standing Blood Pressure focus sessions hosted on all sites with encouraging attendance and engagement (over 350 staff trained across 4 dates)
- Postural Hypotension Leaflet developed for patients, to be considered by Readers Panel with launch in 2018/19
- Strengthened Scrutiny Panel to improve accountability and assurance processes and timely learning from incidents
- Consideration of Falls Prevention e-learning to support Falls Workbook to ensure ease of access and accuracy of compliance figures using Electronic Staff Record (ESR)
- Falls Webpage launched as resource to all staff
- NICE Guidance literature developed with community partners and Public Health to inform patients and carers of falls prevention measures
- Falls with harm have shown a downward trajectory however all falls have increased over 2017/18. The increased awareness and use of preventative measures are believed to be contributing to the reduction in falls with harm, however the ongoing focus on keeping people moving is felt to be resulting in an increased number of slips and controlled falls.

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

- Reduction in hospital falls will be a priority for ULHT in 2018/19
- Number of patient falls in line with National Average (6.83)
- Number of patient falls with harm in line with National Average (0.19)
- Consistent achievement of 90% against all Safety Quality Dashboard metrics
- Establish site falls meetings with ward representation from falls ambassadors
- Dissemination of lessons learned through Serious Incidents through Newsletter.
- Demonstrable momentum for Ward Accreditation domain – reduced number of wards with overall red domain status.
- Falls is remaining a priority for 2018/19

PRIORITY 7 2017/18 REDUCTION IN THE INCIDENCE OF HARM ASSOCIATED WITH CATHETER URINARY TRACT INFECTIONS (CAUTI)

WE SAID WE WOULD:	
Success Measure	**Result**
We will reduce the number of catheters inserted to national rates. For 2017/18 the Trust was scoring an average of 21% compared to a national score of 13% which is a slight reduction compared to 2016/17 the national score was 13.2% compared to ULHT score of 22.9%	NOT ACHIEVED
Work collaboratively with our community colleagues to identify themes and lessons to be learnt	ACHIEVED
All CAUTIs are reviewed by the Continence Nurse Specialists	ACHIEVED
Themes to be identified and share lessons	NOT ACHIEVED
Reduce CAUTI by 20%. For 2016/17 the Trust had 17 CAUTIs and to reduce by 20% we needed to reduce the number by 4 however the Trust had 17 CAUTI for 2017/18.	NOT ACHIEVED

SUMMARY

Safety Quality Dashboard data shows Trust performance for 2017/18 remains consistently below Trust aspiration of 90% against all urinary catheter metrics. Areas of particular concern are inconsistent daily completion of catheter care bundle and trial without catheter.

The Catheter Reduction Group introduced a Catheter Care Bundle affording autonomous removal of catheters within parameters of Trust protocol. This initiative showed an improvement in catheter care, however a reduction of catheter insertion rates was not seen. Therefore after reviewing NICE recommendations for CAUTI reduction the catheter care bundle is being redesigned to adopt HOUDINI protocol. This approach mirrors a number of other acute trusts who have seen measurable reduction in catheter insertion rates and increased autonomous nursing practice.

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

- Will reinforce the need for timely removal of catheters catheter by reviewing our documentation
- Will develop CAUTI e-learning programme and provide teaching sessions especially to areas where catheter care is below the agreed standard
- Will ensure implementation of our programme at the ward level through ward accreditation project by identifying and training continence ambassadors.
- Collaborative work planned with the community providers to develop catheter & continence pathways to commence April 2018
- Participation in NHSi National Improvement Collaboratives for system wide improvement focusing on interventions to reduce healthcare associated UTI including CAUTI
- A detailed action plan to be developed
- We will continue monitoring CAUTI through the bi-monthly CAUTI committee which upwardly reports to Quality Governance and Trust Board

PRIORITY 8 2017/18 IMPROVE COMPLIANCE WITH THE ADMINISTRATION OF MEDICATION DIABETIC DRUGS

WE SAID WE WOULD:	
Success Measure	**Result**
Improve attendance of clinical staff at the medicines optimisation and safety committee	NOT ACHIEVED
To reduce the preventable harm associated with medication use.	ACHIEVED
To improve the quantity and quality of medication incident reports in collaboration with the clinical areas.	ACHIEVED
Commence procurement of Electronic prescribing (e-Prescribing) systems, where the ordering, administration and supply of medicines is supported by electronic systems, offer the opportunity to help reduce such risks.	NOT ACHIEVED
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	NOT ACHIEVED
Improvements to patient care.	ACHIEVED
Diabetes nurses to deliver training sessions to groups of staff including nurses, junior doctors and pharmacists	ACHIEVED
Increase reporting of medication incidents as this demonstrates a safety reporting and learning culture The number of medication incidents in 2017/18 was higher in 8/12 calendar months compared to 2016/17	ACHIEVED
Reduce the proportion of anti-diabetic and insulin incidents causing harm . For year end 2017/18 there were 19% compared to year end 2016/17 there were 17%.	NOT ACHIEVED
Increased shared learning across the Trust	NOT ACHIEVED

SUMMARY

- Quality report revised to include national comparative data from Model Hospital which provides analysis against acute organisations of similar size.
- The number of medication incidents in 2017/18 was higher in 8/12 calendar months compared to 2016/17. This is a clear indicator of improved patient safety reporting culture.
- Introduced safe use of insulin e-learning as core-plus for all clinical staff including pharmacists which needs to be renewed yearly
- There has been a steady improvement however remain far below the benchmark of 100% compliance.

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

- Multi-disciplinary engagement with the wider Medicines Optimisation Agenda especially Senior Medical Staff.
- Increase awareness and sharing of learning from the safety incident reporting
- There is a need to increase reporting of near misses and non-serious incidents to promote learnings across disciplines.
- Number of Prescription Chart sent to pharmacy has been reduced by 50% during February 2018.
- Omitted / delayed dose remains as a concern and work in progress with to improve

engagement with nursing and medical staff to minimise risk for the patient.

- Ongoing monitoring will continue with the medicines management committee which upwardly reports to Quality Governance Committee.

PRIORITY 9 2017/18 IMPROVE THE EXPERIENCE FOR PATIENTS WITH DEMENTIA AND VULNERABLE PATIENTS

WE SAID WE WOULD:	
Success Measure	**Result**
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.	ACHEIVED
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.	ACHEIVED
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.	ACHEIVED
Incorporate Mental Health and Learning disability learnings within the Trusts Mortality Review process.	ACHEIVED

SUMMARY

- Lincolnshire County Council have commenced a county wide review of the Lincolnshire Dementia Strategy and as such we are waiting on this to be completed before developing our internal Trust strategy. However this has not delayed continued developmental work.
- We were successful in a bid to purchase 10 sets of RITA (Reminiscence Interactive Therapy Activities); 4 each for the Lincoln and Pilgrim sites and 2 for Grantham. The system consists of a large touchscreen TV and also a tablet size that holds software from films, games, activities, photographs and songs and can be used individually with patients or in groups. Our staff and patients have quickly embraced the system and seen benefits in terms of patients being less anxious and distressed, greater engagement and involvement, reduction in falls and a reduction in the need for enhanced care.
- Our work around caring for carers has continued to develop and we have welcomed partnership working with Carers First the new county provider for Carers Support services who work hand in hand with Trust staff to ensure we consider the needs of carers at all times. We have also continued to work closely with the Alzheimer's Society and seen the Dementia Family Support Service develop further for our patients with increased referrals and support staff on each of our hospital sites.
- ULHT have designed an innovative Dementia Care Bundle which focuses on the psychological and social needs of our patients living with dementia who are admitted for care. This is being piloted and we envisage it being a really important piece of work going forward.
- The development of the ULHT Mental health & Learning Disability Strategy Delivery Group; this has met 4 times to date and has members from across our Trust but also our colleagues in Mental Health, social care, commissioners and Police. The group is responsible for steering and monitoring progress against our transformation plan.
- Policy for the assessment and management of ligature risk and self-harm has been developed and all core clinical areas have completed risk assessments and actions as indicated. Our emergency care and admissions areas have also had an independent

audit completed to measure compliance and understanding of ligature risk and self-harm.

- Development of a policy for caring for patients who may be detained under the Mental Health Act; this was a complex and challenging piece of work but has been well received and staff have been trained to deliver the best possible care to these patients. The processes include a case review process to support learning from practice.
- Development of a policy and associated training needs analysis for Clinical Holding and Restraint; a training programme has been identified and will be implemented in the coming months.
- Design and development of a Mental Health Training Faculty to help deliver a range of training including Dementia Awareness and Barbara's Story. The faculty has 11 staff members who have themselves received training ready to cascade across the Trust.
- Major involvement in county wide developments designing revised care pathways in light of the Policing and Crime Act 2017 with the changes from this with regards to patients being detained under Section 136 of the Mental Health Act.
- A comprehensive review of NICE guidance and national best practice relating to Mental Health and Learning Disability with a resulting action plan to ensure complete compliance.
- During the last year all of our wards and our outpatient departments received a new resource folder and local training on the new referral pathway for our Learning Disability patients needing support and intervention. The resource folders include risk assessment tools, leaflets and top tips, care plans and national publications.
- We also presented a powerful story to Trust Board of the care of a young man with severe learning disability which demonstrated where stigma and assumptions can impact on care and also showed the learning taken from this.

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

- We will see clinical teams and services taking ownership of their patients experiences; we will see meaningful data and intelligence being used to improve care and care delivery and we will see our patients reporting an improved experience.
- We will have an understanding of how our different sources and types of data relate to each other; we will be able to use this to give meaningful information to teams to use to make improvements.
- We will see greater celebration of good and excellent care and this inspiring other areas to learn from them.
- We will see early signs of deterioration and respond with support and guidance and expert interventions to halt any concerns.
- We will see stories from our patients and our staff used widely to genuinely understand 'this is how it was for me' and to then make a difference and effect change.

PRIORITY 10 2017/18 REDUCE AVOIDABLE HARM BY ELIMINATING AVOIDABLE CATEGORY 4 PRESSURE ULCERS AND REDUCING AVOIDABLE CATEGORY 3 PRESSURE ULCERS

WE SAID WE WOULD:	
Success Measure	**Result**
Review the quality of data from our incident reporting system, DATIX, and PUNT, and triangulate the data to provide clarity and assurance on performance.	ACHIEVED
Continue 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.	ACHIEVED
Increase awareness of ward performance and review how we share learning across the Trust to change practice.	ACHIEVED
Increase the visibility of the Tissue Viability Nurse Consultant on the wards.	ACHIEVED
Review the training programme and delivery methods.	ACHIEVED
Continue to identify and train pressure ulcer link nurses/ambassadors for in-patient areas, ensuring standard resources are available in all ward areas.	ACHIEVED
Introduce the tissue viability standard for Ward Accreditation.	ACHIEVED
Increase accountability regarding quality performance through the Nursing Cabinet which is a meeting with the chief Nurse and Senior Nursing staff.	ACHIEVED
Developing a Pressure Ulcer Collaborative within Lincolnshire.	ACHIEVED

SUMMARY

- Since August 2017 reporting of pressure ulcer incidents has been via a single incident reporting system (DATIX) This has given greater assurance regarding pressure ulcer origin and incidence across all three sites
- Scrutiny panels continue to be undertaken on a monthly basis to investigate the route cause and identify lapses in care. As a result specific action plans are formulated and learning identified.
- Themes and learning from the scrutiny panel investigations are shared at local level and at Trust level via newsletters.
- All member of the Tissue Viability team have worked hard to increase their visibility on the wards and have increased their support and targeted education to ward teams where category 3 or 4 pressure ulcers continue to be reported.
- Training programmes are under review. The aim is to introduce pressure ulcer prevention and management as a mandatory session. PUPCA continues at ward level although % of compliance remains low. The tissue viability team continue to provide ad hoc training to both registered nurses and unregistered staff as requested at ward level. Pressure ulcer prevention training is delivered to HCSW on the induction programme along with preceptorship days for all newly qualified staff across all sites
- Link nurse/ ambassador meetings to both registered and unregistered nurses continue quarterly on all sites to ensure consistency of education and wound care updates across the Trust
- Collaborative working has commenced with community colleagues. Going forward we plan to combine community and acute formularies and review pressure ulcer classification.

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

- Formulate a more structure approach regarding ongoing education
- Formulate a more robust process for sharing learning of lessons in order to change

current practice and eliminate / reduce hospital acquired pressure ulcers

- Reduction in hospital pressure ulcers will be a priority for ULHT in 2018/19
- The scrutiny panel process is being strengthened from April 2018 to improve accountability and assurance processes and timely learning from incidents.
- Category 3 & 4 pressure ulcers is continuing as a priority for 2018/19.

STATEMENT OF ASSURANCE

Review of services

During 2017/18, United Lincolnshire Hospitals NHS Trust (ULHT) provided and/or subcontracted 48 relevant health services. The United Lincolnshire Hospitals NHS Trust has reviewed all the data available to them on the quality of care in 48 of these relevant health services.

The income generated by the NHS services reviewed in 2017/18 represents 90.7% of the total income generated from the provision of NHS services by the United Lincolnshire Hospitals NHS Trust for 2017/18.

2021 Strategy

We have developed our 2021 Strategy that sets out our roadmap for the future delivery of improved services and demonstrates a culture of quality and safety. We have been consulting on the development of our strategic ambitions for the 2021 programme which are:

To deliver the Strategy we have set up a 2021 Programme with work streams for:

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

During 2017/18 37 national clinical audits and 5 national confidential enquiries covered relevant health services that ULHT provides.

During that period ULHT participated in 92.5% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that ULHT was eligible to participate in during 2017/18 are as follows: (see tables below). Audits not achieving full compliance have an action plan developed to enable the Trust to achieve full compliance.

The national clinical audits and national confidential enquiries that ULHT participated in during 2017/18 are as follows: (see tables below)

The national clinical audits and national confidential enquiries that ULHT participated in, and for which data collection was completed during 2017/18 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audits	ULHT Participation	Reporting Period	Number and % required
Peri- and Neonatal			
Perinatal Mortality Surveillance (MBRRACE-UK) Saving Lives Improving Mothers Care (MBRRACE-UK)	Yes	January – December 2015 2013-2015	No case ascertainment reported
Neonatal Intensive and Special care (NNAP)	Yes	1st January – 31st December 2016	No case ascertainment reported
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	63 case submitted, case ascertainment is not reported
Diabetes (RCPH National Paediatric Diabetes Audit) Hospital Admissions and Complications (part 2	Yes	1st April 2015 – 31st March 2016 (report published March 2017)1st April 2012 –	206 cases submitted. (case ascertainment is not reported) Case ascertainment not

report)		31st March 2015	reported
National Audits	**ULHT Participation**	**Reporting Period**	**Number and % required**
Acute Care			
Emergency Laparotomy	Yes	Year 1st December 2015 – 30th November 2016	Cases submitted 314/297 (105%) of the expected
Cardiac Arrest (National Cardiac Arrest Audit) ICNARC	Yes	1st April 2017- 31st December 2017	case ascertainment is not reported
Pain in Children (moderate and severe) (RCEM)	Yes	1st January 2017- 30th December 2017	232 eligible cases data submitted report due May 2018
Procedural Sedation (RCEM)	Yes	1st January 2017- 30th December 2017	72 eligible cases data submitted report due May 2018
Fracture Neck of Femur (RCEM)	Yes	1st January 2017- 30th December 2017	212 eligible cases data submitted report due May 2018
Chronic Obstructive Pulmonary Disease (COPD) Royal College Physicians	Yes	1st February 2017 – 13th September 2017	LCH 163, PH 137, GDH 52 eligible cases Case ascertainment is not reported
Adult Critical Care (Case Mix Programme) ICNARC	Yes	1st April 2017 - 31st December 2017	966 (100%) LCH 562, PH 404
Long Term Conditions			
Diabetes (National Adult Diabetes Audit)	Yes	1st January 2016 – 31st March 2017	Case ascertainment is not reported (data is linked to local CCG)
Diabetes (National Adult Diabetes Inpatient /Survey/ Audit)	Yes	September 2017	183 (100%) eligible cases
Diabetes National Audit Foot Care	Yes	2014 - 2017	Case ascertainment is not reported
National Pregnancy in Diabetes Audit	Yes	2014-2016	76, LCH 44, PH 32 Case ascertainment is not reported
National IBD Registry Ulcerative Colitis & Crohn's Disease (National IBD Audit) biologics Audit	No	The IBD Registry requires a fee to be paid to participate this is currently under review	N/A
National Parkinson's Audit	Yes	2017	116 Case ascertainment is not reported
National Audit Dementia	Yes	1st April 2016 – 30th April 2016	194/194 (100%) eligible cases
Elective Procedures			
BAUS Urology Cystectomy	Yes	2014 - 2016	30/29 (103%)
BAUS Urology Nephrectomy	Yes	1st January 2014 – 31st December 2016	151 (89%)

National Audits	ULHT Participation	Reporting Period	Number and % required
BAUS Urology Percutaneous Nephrolithotomy	Yes	1st January 2014 – 31st December 2016	33 Case ascertainment is not reported
BAUS Urology Radical Prostatectomy	Yes	1st January 2014 – 31st December 2016	82 (87%)
BAUS Urology Female Stress Urinary Incontinence	Yes	1st January 2014 – 31st December 2016	9/17 (52.94%)
BAUS Urology Urethroplasty	N/A	Applicable to specialist centres only	N/A
National Audits	**ULHT Participation**	**Reporting Period**	**Number and % required**
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 2015-December 2015 Report published September 2017	1153 (100%) eligible cases
National Vascular Registry including NVD - Carotid Interventions Audit)	Yes	2016 2014 - 2016	31 Infra-renal AAA, 47 Carotid Endarterectomy Emergency Repair AAA 28,Lower Limb Bypass 207 Major Limb Amputation 117
Hip, Knee and Ankle Replacements (National Joint Registry)	Yes	1st January 2017-31st December 2017	1382 cases submitted no case ascertainment
National Elective Surgery Patient Reported Outcome Measures (National PROMs Programme) Overall patient participation rate Participation by each PROM 1.Varicose Veins 2.Groin Hernia 3.Hip Replacement 4.Knee Replacement	Yes	PROMs April 2015 – March 2016 Finalised report PROMs April 2016 – March 2017 – Provisional report Patients who completed a pre-operative questionnaire	1244/1942 (64.1%) 1041/1334 (78%) 15/16 16/17 1. 102, 51.8%, N/A 2. 212,46.9.%, N/A 3.435, 73.2%, 437, 76.3% 4. 495, 70.8%, 604, 79.4%
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

National Audits	ULHT Participation	Reporting Period	Number and % required
Cardiovascular Disease			
Stroke Care (National Sentinel Audit of Stroke) SSNAP	Yes	April 2017 – November 2017	706/713 (99%) (72 hours), 673/676 (99.5%) (to discharge)
Acute Myocardial Infarction & Other Acute Coronary Syndrome (MINAP)	Yes	1st April 2015 – 31st March 2016. Report published June 2017 2016/2017 report not yet published.	1386 (100%) eligible cases
Heart Failure	No	April 2015- March 2016 Report published August 2017 April 2016 – March 2017 Report not yet published	679/999 (68%) 70% case ascertainment for participation
Cancer			
Prostate Cancer	Yes	1st April 2015 – 31st March 2016	580 no case ascertainment reported
Lung Cancer (LUCADA)	Yes	Patients diagnosed with lung cancer first seen in 2016	no case ascertainment reported
Bowel Cancer (NBCA)	Yes	Patients diagnosed between 1st April 2015 and 31st March 2016	LCH + GDH 176/235 (75%) PH 112/109 (103%)
Oesophago-Gastric Cancer (National O-G Cancer Audit)	Yes	Patients diagnosed between 1st April 2012 and 31st March 2016 tumour records submitted	128 (<50%) case ascertainment
Trauma			
Hip Fracture (National Hip Fracture Database) Includes National Falls & Fragility Fractures Audit (FFFAP)	Yes Yes	1st April 2016 – 31st March 2017 2017	PH 335 (99.4), LCH 352 (86.8), GDH 78 (77%) Case ascertainment not reported
Trauma Audit Research Network (TARN) Trauma	Yes	2017	PH 253 (100%) LCH 337 (91%)
Psychological Conditions			
Prescribing in Mental Health Services (POMH)	N/A	Not applicable to acute trusts	N/A
Blood Transfusion			
Blood Transfusion Audits	Yes	2017 1st – 31st July 2017 Red Cell and Platelet transfusions in adult Haematology patients	16 cases Case ascertainment is not reported

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

During 2017/18 hospitals were eligible to enter data in up to 5 NCEPOD studies. Below is a summary of those studies in which ULHT participated. Studies for which ULHT were exempt are not listed. Action plans are developed for any areas not achieving the recommended standards.

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

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 2017/2018 the data period covered may cover previous years.

The reports of 32 national clinical audits were reviewed by the provider in 2017/18 and ULHT intends to take the following actions to improve the quality of healthcare provided (see tables below).

Descriptions of actions from a sample of the national audits:

National Audit	Headline results and actions taken
MINAP (heart attack and Ischaemic heart disease)	• Lincolnshire Heart Attack Centre 24/7 continues to provide good quality care year on year local reporting of latest results as national reporting is still behind schedule 2016/2017 report awaited • Procedure to open up blocked heart vessels quickly to restore coronary blood flow 95.7% 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 63.2% of patients met the time of call for help to balloon time of 150 minutes compared to the national average of 77% there has been a change to how calls are being assessed • Prescribing preventative medications above the national average at for all eligible patients ULHT range is between 99.5 – 100%, compared to national average of 75.5 – 98% • Patients requiring angiography within 72 hours met best practice tariff • National report publications have been delayed the 2016/2017 report is awaited
TARN (Trauma)	• Trauma meetings held at Lincoln and Pilgrim to discuss findings and share learning • Transfer to Trauma Centre continues to be reviewed with the Trauma Network to ensure eligible patients are transferred for specialist care ongoing • There is a robust data collection process across the Trust with good data submission which is maintained by the TARN project officer • On-going work to review and improve compliance with standards with

	updated reports and dashboards
Hip Fracture	• Prompt surgery after admission national average 72.5%%, ULHT sites are achieving PH 90.6%, LCH 78.9%, GDH 76.6% • Physiotherapy assessment by the day following their surgery national average 90.4%, ULHT sites are achieving PH 95.7 %, LCH 86%, GDH 92.2% • Received Orthogeriatrician assessment perioperative PH 98.8%, LCH 96.3% GDH 56.4%, 88.7% nationally. Orthogeriatrician appointed at Grantham 2018 • Sharing best practice across the trust to improve the patient pathway data is available via site dashboards which records data live • Monthly governance meeting to review data and discuss improvements where needed
Stroke	• Improving compliance with NICE standards strategy in place to improve areas requiring improvement • Results are shared at the speciality Governance meetings • Scoring A-E used for stroke units with A being the highest score to achieve latest published report shows Pilgrim as a B and Lincoln as a B • CT scanning within 12 hours above the national average achieving 96.5% at Lincoln and 96.5% at Pilgrim compared to the national average of 94.5% • Thrombolysis clot busting medication to help remove clots % thrombolysed within an hour of arrival to hospital 68.8% Lincoln and 69.6% at Pilgrim compared to the national average of 63.9% • Strategy to improve data submissions is working well with case ascertainment of 99.5% (A)
Cardiac Arrest	• Education and training around deteriorating patient is on-going • Results are presented to the Patient Safety Committee and discussed with staff
Bowel cancer data	• Review of outcomes completed and reported • Process for submitting data reviewed to improve case ascertainment from 68%, latest report LCH 75%, PH 103% • Data quality reviewed action data from the MDT will be recorded and submitted at the time of the MDT
PROMs	• Ongoing recruiting of patients for Hip and knee replacement surgery via pre-assessment clinics to complete the questionnaire before surgery, 78% of patients completed a pre-operative PROM during

	2016/2017. This is above the national average for recruiting patients. • NHS England review of PROMs, the varicose vein surgery and the groin hernia surgery has been discontinued nationally • Data is reported every four months to monitor progress with participation rates and outcome measures. For 2016/17 the Trust was slightly below the national average for outcomes
Hip, Knee and Ankle Replacements (National Joint Registry NJR)	• On-going review of NJR process to improve quality of data submission to the national database annual data quality audit taking place • Consultants have access to Clinician feedback to review their own practice. • Review of Orthopaedic service completed
Falls Audit	• Improvement work is ongoing • Results are improving with some good compliance with the recent national audit
Heart Failure	• Data submission for 2017/2018 will see participation at or above the 70% required national report awaited for this period and the 2016/2017 period due to the National Audit provider not publishing the latest reports. • Heart Failure Nurses have Improved the service to deliver care to patients • Locally achieving Best Practice Tariff each month with 70% data submission and 60% specialist review

Local Clinical Audit

The reports of 78 local clinical audits were reviewed by the provider in 2017/18 and ULHT intends to take the following actions to improve the quality of healthcare provided: (see tables below). The local audit plan is linked to National Institute for Health and Clinical Excellence (NICE), CQC, Best practice and kay priorities for the Trust.

Examples of actions taken locally:

Local Audit	Actions - Improvements
Re-audit of VTE Risk Assessment	The results showed: • Improved compliance with VTE risk assessment at 95% from 90% • Prescribing of stockings or medication to prevent clots imporved and compliance was good • All junior doctors to be updated at Induction that the VTE risk assessment must be reviewed at the next senior review
Out of Hours Upper GI Bleed	• Care Pathway was followed in the majority of cases • None of the cases required an urgent endoscopy out of hours • Junior doctors to be informed at Induction of the GI Bleed pathway
Improving Orthopaedic Pain Management of Total Knee Replacement	• The first cycle of audit identified that the pain management guideline was not being followed with 0% being prescribed as the guideline • Education of staff on the pain management guidleine • Second cycle of audit the pain management guideline was follwed in 88% of cases this increased to 96% where an alternative was given due to patients not tolerating the guideline specified medication
Out of hospital cardiac arrests due to a suspected ACS with a reduced GCS	In September 2014 NICE CG167 quality statement 5 recommended that the level of consciousness in a patients with a suspected ACS should not affect eligibility for coronary angiography and primary PCI • Pre-hospital pathway developed to divert all suitable patients to the “Heart Attack Centre” • Patients taken direct for PPCI with anaesthetic support • Team work approach with local ambulance service (EMAS/ Helimed) and ITU • 44/88 (50%) survived to discharge

PARTICIPATION IN CLINICAL RESEARCH

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

The number of patients receiving NHS services provided or sub-contracted by ULHT in 2017/18, who were recruited during that period to participate in research approved by a research ethics committee (National Health Research Authority) was 1474. 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 delivering trials within a wide variety of specialities. In particular, the Trust is delivering more commercial studies for the NIHR as compared to 2016/2017. This increasing level of participation in clinical research demonstrates ULHT's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. In addition, by participating in NIHR portfolio trials and recruiting patients, the Trust is playing an important role in improving patient care and in developing new and innovative drugs, treatment and services. Research evidence shows that hospitals that participate in clinical trials have been shown to improve patient care and outcomes.

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

The Trust is involved in conducting about 200 clinical research studies including studies in follow up. By the end of March 2018, for cardiovascular, Lincoln recruited 118 patients. In case of cancer Randomised Controlled Trials (RCT), the Trust recruited 194 patients. In the case of Cancer non-RCT, we recruited 106 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 2017/18 financial year, the Trust has approved 31 portfolio and 13 non-portfolio studies.

In the last three years, over 30 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 previous 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. Additionally, Helene Jones - Won EDGE Innovator of the Year award 2017. Helene is a joint PhD fellow at University of Leicester and completing her work within the research sector at ULHT.

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

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

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

A proportion of ULHT's income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between ULHT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2017/18 and for the following 12 month period are discussed below.

For the first time NHS England have published a two year scheme which will potentially provide greater certainty and stability on the CQUIN goals for the Trust to focus on implementing the initiatives. The CQUIN scheme is intended to deliver clinical quality improvements and drive transformational change. The scheme is designed to support the ambitions of the Five Year Forward View and directly link to the NHS Mandate and it now focuses on two areas:

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

Supporting local areas:

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

At the time of writing this Quality Account we are still awaiting the outcome of quarter 4 achievements however we have depicted what we think we will achieve. A summary of the achievements of the CQUIN milestones for 2017/18 are demonstrated below.

	CQUIN	Q1	Q2	Q3	Q4 (expect)	Financial
1a	Improving Staff Health and Wellbeing					£235,130
1b	Healthy food for NHS staff, visitors and patients					£235,130
1C	Improving the uptake of flu vaccinations					£235,130
2a	Timely identification for sepsis					£176,348
2b	Timely treatment for sepsis					£176,348
2c	Empiric review of antibiotic prescriptions					£176,348
2d	Reduction in antibiotic consumption					£176,348
4	Improving services for people with mental					£705,390

	health needs who present to A&E					
6	A&G services for non-urgent GP referrals					£705,390
7	First Outpatient Appointment slots available on eRS					£705,390
8	Supporting Proactive and Safe Discharge					£705,390

Specialised

	CQUIN	Q1	Q2	Q3	Q4 (expect)	Financial
B12	Severe Haemophilia Haemtrack Patient Home Reporting					£69,917
GE3	Hospital Medicines Optimisation					£188,355
AF1	Embedding the Armed Forces Covenant					£34,018
1	NHS Dental Services					£122,152

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

The national and specialised CQUINs are 2 year CQUINs and the majority will therefore carry forward to 2018/19. The CQUINs not carrying forward for next year are:

- First Outpatient Appointment slots available on eRS
- Supporting Proactive and Safe Discharge

The Trust will participate in the following CQUIN for 2018/19:

- Preventing ill health by risky behaviours – alcohol and tobacco

CARE QUALITY COMMISSION (CQC) STATEMENTS

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

ULHT is required to register with the Care Quality Commission (CQC) and its current registration status is registered. ULHT has the following conditions on registration: the Trust was given regulatory action on section 31 on 20/02/2018. The CQC has taken enforcement action against ULHT during 2017/18.

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

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. The Trust has been reviewed in April 2018 and we are awaiting the outcome of this visit.

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:-

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

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

There were identified several key areas of good practice, these were recognised by the assessors throughout their visit and detailed within the report. Some of these are detailed below:

- Endoscopy Departments at Lincoln and Boston site both have Joint Advisory Group accreditation

- Introduction of carers badge enables family members and trusted friends to be involv the care of loved ones.

- Chaplaincy services represented a range of faiths and provided support across all beliefs.

- Staff knew who the Executive team were and felt that the Chief Executive was approachable.

- The Emergency Department were using a ULHT designed discharge tool to facilitate safe discharge for vulnerable patients.

- Emergency Departments used data to proactively risk assess internal escalation leve

- Staff on Pilgrim Hospital Paediatric Ward had learnt sign language to enhance communication with patients

- Introduction of PAT dog (therapeutic visit) for patients on rehabilitation ward.

ULHT has made the following progress by 31 March 2018 in taking such action: (see tables below)

Project Name	Achievements in 2017/18
Developing the safety culture	• Launch of Leadership Charter as part of Staff Charter • Senior Leadership Forum relaunched with participation from top 250 senior leaders at ULHT • ULHT values launched as part of overall 2021 programme • Freedom to Speak Out Policy agreed and guardian launch to staff through internal communications messages • General induction reviewed to deliver robust training covering all safety requirements for temporary staff
Clinical Governance	• Format and Board Meetings reviewed to strengthen assurance and challenge • Specialty Governance processes and monitoring arrangements reviewed and strengthened • Corporate risk register being updated
Sepsis	• All adult inpatients and A&E departments live with electronic observations • Introduction of maternity e-bundle • Expansion of core training to include paediatric module with plans to introduce maternity • PGD protocol introduced in collaboration with EMAS • Launch of Sepsis boxes to inpatient adult areas
GI bleed service	• Upper GI Haemorrhage Policy launched trust wide • Pilgrim Out of Hours GI Bleed Service model agreed
Airway management	• Community wide pathway review group established • Redeployment of trust equipment to support safe service on Lincoln and Boston sites complete
Mental Health Assessment	• 90% (525 staff) of the staff cohort have completed ligature risk and self-harm training. • Clinical Holding and Restraint Policy launched • 90% of identified staff cohort will have completed clinical holding and restraint training by November 2018 • Learning Disability Nurses in post funded by Lincolnshire Partnership NHS

	Foundation (LPFT)
Safeguarding	• Safeguarding strategy developed • Mental Capacity Act and Deprivation of Liberty Policy reviewed and being embedded across the organisation • Safeguarding Children and Young People Policies reviewed and ongoing work to embed across the organisation • Safeguarding Assurance Tool (SAT) being piloted with a view to roll out later in the year
Medicines management	• In collaboration with NHSi medicine pathway mapping and pharmacy diagnostic deep dive completed
Training and competencies	• Review of core learning completed and launched to all staff • Project Plan for Core Learning Plus agreed • 90.7% had completed their core training by March 2018 compared to March 2017 the Trust were achieved 89%
Appraisal and supervision	• 85% of staff recorded as having a completed appraisal in March 2018 compared to March 2017 where the Trust scored 65% • Revised individual performance management approach (incorporating appraisal) developed for launch in 2018/19
Outpatients	• Electronic clinic room booking plan implemented • Harm Reviews included in all outcome forms to measure patient related outcomes
Control of Infection	• Quarterly learning events for all IPC Link Practitioners • Board development session on Infection Prevention held • Mortality Review undertaken for all IPC related deaths • Facilitation of peer review by National CDI Lead to identify additional areas of improvement • Health Economy Project Group established • Launch of revised Dress Code Policy
Reducing variation in practice in clinical areas	• Review of Hospital at Night Service to be launched
Clinical Staffing Nursing/Medical	• Nursing and Midwifery establishment review agreed by Trust Board • Compulsory completion of care certificate for all new HCSW (from September 2017) • Business Case of allocate system approved • Consistently reduce medical agency staff to maximum of 10Pas • Internal bank rates increased to improve fill rate • 400 more registered nurses joined the bank
Medical Engagement	• Medical Engagement survey launched
Strengthening Support for Pilgrim	• Launch of Ward Accreditation Programme with 5 quality matrons. • Nursing Quality Assurance Framework to develop and monitor implementation plans from Ward Accreditation • Additional senior support to deliver QSIP in place at Pilgrim Hospital
Estates and Environment	• Requirements for Fire Improvement Works submitted and approved by NHSi • Estates and Facilities priorities rationalised, costed and agreed

DATA QUALITY

NHS Number and General Medical Practice Code validity

United Lincolnshire Hospitals NHS Trust submitted records during April 2017 to January 2018 at the Month 10 inclusion date to the Secondary Uses service for inclusion in the Hospital Episode Statistics (HES), which are included in the latest published data. The percentage of records in the published data:

which included the patient's valid NHS number was:

- 99.7% for admitted patient care (National performance 99.4%);
- 99.8% for outpatient care (National 99.5%);
- 98.7% for accident and emergency care (National 97.3%)

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

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

Information Governance Toolkit attainment levels

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

United Lincolnshire Hospitals NHS Trust Information Governance Assessment Report overall score for 2017/18 was 90% and was graded red. 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 we achieved 86.49% therefore able to reach level 1. This will continue to be an area of focus over the next year with an action plan in place and already underway.

Clinical coding

United Lincolnshire Hospitals NHS was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. The Trust, however commissioned a Payment by Results Clinical Coding audit by CHKS in November 2017. Based on the results of this audit, there were a number of recommendations made to improve the capture of information from clinical notes into Medway PAS for onward use in financial and quality measures. The audit specifically focussed on poor performing areas based on CHKS internal benchmarking using a number of different data quality metrics available from HES data (via NHS Digital). The recommendations ranged from improvements

to the content and filing of clinical notes, through to wider engagement with Clinical teams to support Clinical Coding. This will be supported by a review of the Clinical Coding structure.

As mentioned above, the Data Quality strategy will include accurate and comprehensive capture of information within the clinical notes, which is then translated into clinical codes by the Coders. In addition to this, Clinical Coding Masterclasses have been held with Clinicians, led by the Clinical Coding Manager. This has reinforced the importance of the clinical notes being accurate and complete, as well as improving the Coding/Clinician relationships.

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

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

Data quality

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

- Further embedding and exploitation of the Medway (Patient Administration System) following the implementation mid-2014 and subsequent upgrade to v4.8 in October 2017, process maps and standard operating procedures continue to be reviewed for patient flow through hospital (outpatients, day cases, inpatients) and data quality reports identified at key stages to ensure any data input errors are flagged earlier and highlighted to relevant teams for correction and any training needs identified.

- Work is underway to perform ongoing upgrades to the latest version of Medway.

- Continuation of implementing actions identified by the 2017 CHKS Audit on PbR income (mainly around clinical coding).

- Review of structure of Data Quality function and wider Information Services structure to ensure the team supports the needs of the Trust.

- Further development of the data warehouse and front end visualisation tools that will enable more timely reporting of information and assist with data quality reporting throughout the Clinical Directorates in the Trust.

Learning From Deaths

United Lincolnshire Hospitals NHS Trust have been reviewing deaths of patients and disseminating learning from 2008. Our process over the years has expanded and become more robust when the Keogh Review identified ULHT as one of the 14 Trusts as an outlier for mortality. Our processes have been developed further since the release of the National Quality Board Learning from Deaths published in March 2017.
The measures below are outlined by the NHS Quality Account legislation 27 for the year 2017/18

Measure	QTR 1 Apr 17-Jun 17	QTR 2 Jul 17-Sep 17	QTR 3 Oct 17-Dec 17	QTR 4 Jan 18-Mar 18	Comments
Number of patients that have died within ULHT.	602	598	731	858	During 2017/18, 2789 of ULHT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
Number of deaths that have had a case record review/Investigation. For 2017/18 the reviews and investigations are conducted as one however this will change in the future	420	387	362	184	By March 2018, 1353 case record reviews / investigations have been carried out in relation to 2789 of deaths included above . In 1353 of cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was :
Number/percentage of deaths that escalated with problems in care. In relation to each quarter, this consisted of: 29 representing 6.9% for the first quarter 32 representing 8.3% for the second quarter 27 representing 7.5% for the third quarter 9 representing 4.9% for the fourth quarter	29/6.9%	32/8.3%	27/7.5%	9/4.9%	97 representing 6.9% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using the grading system that highlights potential areas of concern in care. All cases that are graded 2&3 automatically get escalated to our Mortality Surveillance Group (MoRAG) for further review. A selection of reviews graded 1 or below are also referred for a more indepth analysis.

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

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

- Fluid Balance management
- Diabetic ketoacidosis management
- Hyperkalaemia Management
- Documentation/Coding accuracy-Comorbidities, Palliative Care and Charlson Index.
- Sepsis Bundle management
- VTE management
- Appropriate admissions and discharges
- Oxygen Prescribing Management
- Pleural Effusion Management
- Cause of death documentation
- End of life and referrals to palliative care
- Importance of drug interactions
- Antibiotic formulary prescribing

Description of actions that ULHT have taken in 2017/18, and proposes to take forward in consequence of what the ULHT has learnt.

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

Development of Mortality Matters and Mortality Review Assurance Group (MoRAG) case note briefings disseminated Trust wide
Clinical Coding Masterclass (quarterly) - to understand the importance of accurate documentation and how this impacts on mortality and finances
Patient Safety Briefings and conferences, to disseminate learning
Development of the Specialty Governance Toolkit
Development of the deceased electronic discharge document (eDD)
Redesign of the Serious Incident process
Lincolnshire Mortality Collaborative has been established- Multi-disciplinary agency group involving ULHT, CCG, LCHS, LPFT and General Practitioners that review cases and discuss, resolve and circulate county wide learning.
Ongoing audits to assess accuracy of palliative care, comorbidities and charlson index against documentation
The Trust is to appoint Medical examiners on the Pilgrim and Lincoln site
Opening of the Bereavement Centre on the Lincoln Site

Assessment of the impact of actions which were taken by ULHT during 2017/18

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

Increase in staff engagement with the governance process and understanding the importance of accurate documentation
All briefings are disseminated via communications to all staff, circulated to management groups and via specialty governance to ensure staff are appraised of the issues identified and the shared learning to be adopted
The Trust has seen an increase in our depth of coding for comorbidities
The Trusts HSMR has reduced to expected limits
Increase of palliative care referrals
Improved turnaround for Serious Incident closures
Engagement county wide and working together collaboratively to resolve issues and spread learning

Measure	QTR 1 Apr 17-Jun 17	QTR 2 Jul 17-Sep 17	QTR 3 Oct 17-Dec 17	QTR 4 Jan 18-Mar 18	Comments
Number of reviews / investigations completed which took place before the start of the reporting period.	426	157	49	28	660 case record reviews and investigations completed after 31st March 2017 which related to deaths which took place before the start of the reporting period.
Number/Percent of deaths that are judged likely not to be problems in care	391/93.1%	355/91.7%	335/92.5%	175/95.1%	1256 representing 93% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the grading system below.

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

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

Measure	QTR 1 Apr 17-Jun 17	QTR 2 Jul 17-Sep 17	QTR 3 Oct 17-Dec 17	QTR 4 Jan 18-Mar 18	Comments
A revised estimate of Number/Percent of deaths that are judged likely not to be problems in care	-	-	-	-	0 representing 0 % of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient. All are included in the table above.

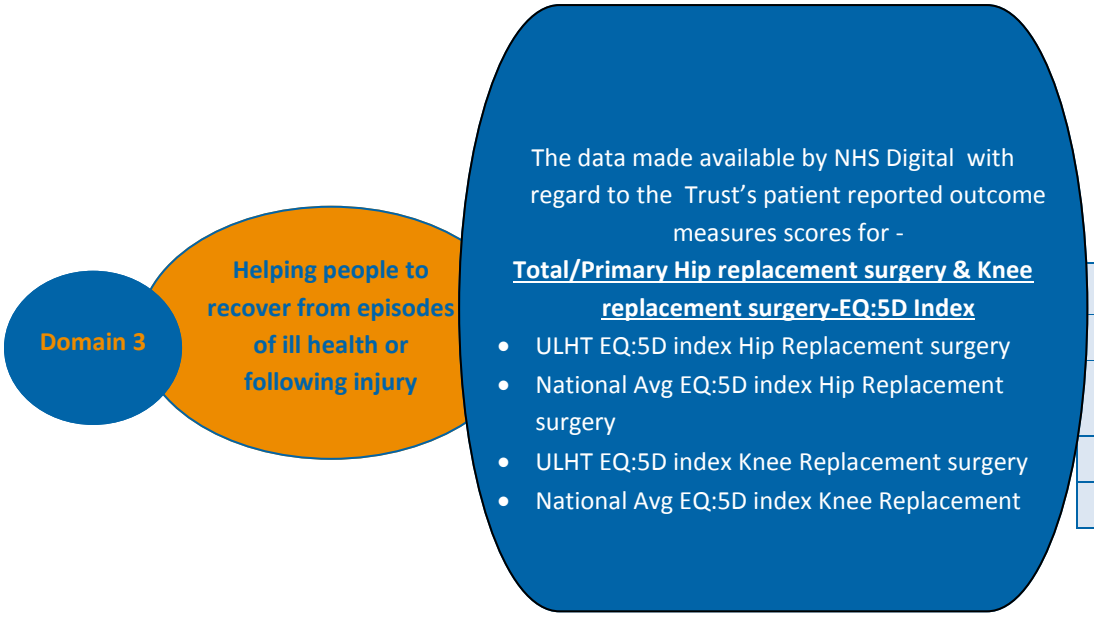
NHS Digital Quality Account Indicators

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

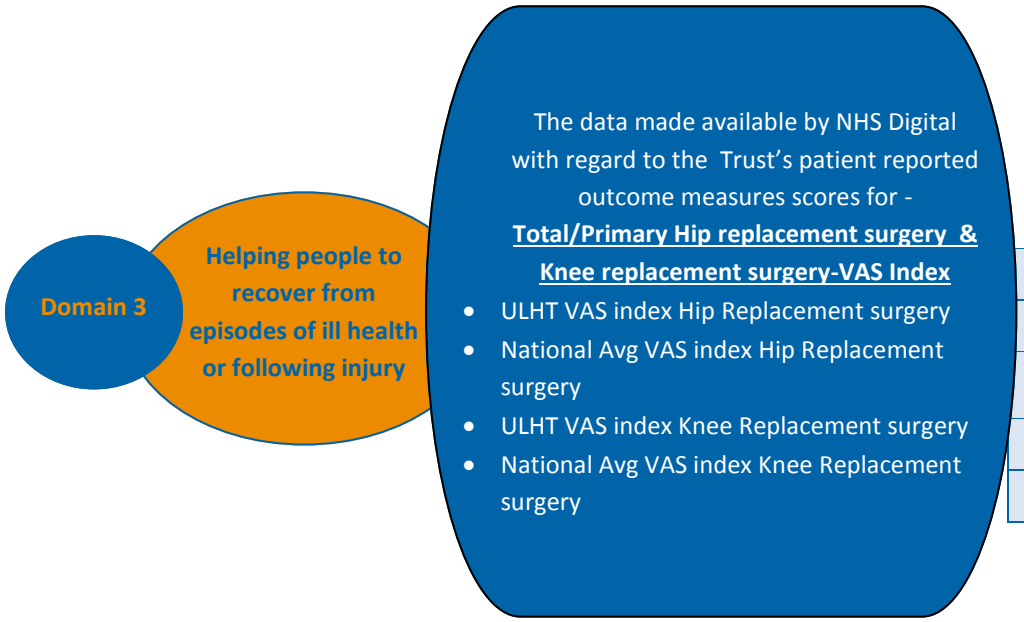
Domain	Measure	Description	Jul 16-Jun 17	Oct 16 -Sep 17	*ULHT
Domain 1	Preventing people from dying prematurely	The data made available to the trust by NHS Digital with regard to - **The value and banding of the Summary Hospital-level Mortality Indicator (SHMI) for the Trust for the reporting period** • ULHT SHMI/Band • National Average • Best/Worse National Performance	112.22/1 100.50 72.61/122.77	114.90/1 100.50 72.7/124.73	114.90/1 100.50 72.7/124.73
Domain 1	Preventing people from dying prematurely	The data made available to the trust by NHS Digital with regard to - **The percentage of patient deaths with palliative care coded at either diagnoses or speciality level for the trust for the reporting period** • ULHT • National Average • Best/Worse National Performance	25% 30.8% 58.3%/11.2%	25.4% 31.2% 59.5/11.5%	25.4% 31.2% 59.5/11.5%

ULHT considers that this data is as described for the following reasons:
Our patient data is submitted to Secondary User Services which is validated.
ULHT intends to take the following actions to improve this mortality rate and so the quality of its services, by developing a mortality reduction strategy and appointing Medical Examiners. The Trust is also below the national average for palliative care coding, which the Trust is cross referencing the in-house palliative care data with that of Health Informatics and Clinical Information System.
** This is the latest data ULHT has available internally*

Domain	Measure	Description	2015/16	2016/17	*ULHT



2015/16	2016/17	2017/18
NA/0.41	0.40/0.41	N/Av
NA/0.44	0.44/0.44	N/Av
NA/0.30	0.32/0.33	N/Av
NA/0.32	0.32/0.33	N/Av



2015/16	2016/17	2017/18
NA/11.58	11.92/12.58	N/Av
NA/12.40	13.18/13.53	N/Av
NA/5.10	5.32/5.80	N/Av
NA/6.22	6.86/7.02	N/Av

Domain 3

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

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

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

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

2015/16	2016/17	2017/18
NA/21.00	19.93/20.58	N/Av
NA/21.61	21.29/21.73	N/Av
NA/15.31	15.81/15.94	N/Av
NA/16.37	16.32/16.47	N/Av

ULHT considers that this data is as described for the following reasons:
The data is taken from NHS Digital PROMs data set.
ULHT intends to take the following actions to improve PROMS outcomes and so the quality of its services by continuing to look at the issues for hips and knee outcome scores in greater detail in particular those patients who have had a negative outcome. The Trust is also reviewing how the data is collected to ensure there is a robust process.
. This is the latest data ULHT has available internally*

Domain	Measure	Description	2010-11	2011-12	*ULHT

Domain 3

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

The data made available to the trust by NHS Digital with regard to the percentage of patients aged—(i) 0 to 15; and(ii) 16 or over,

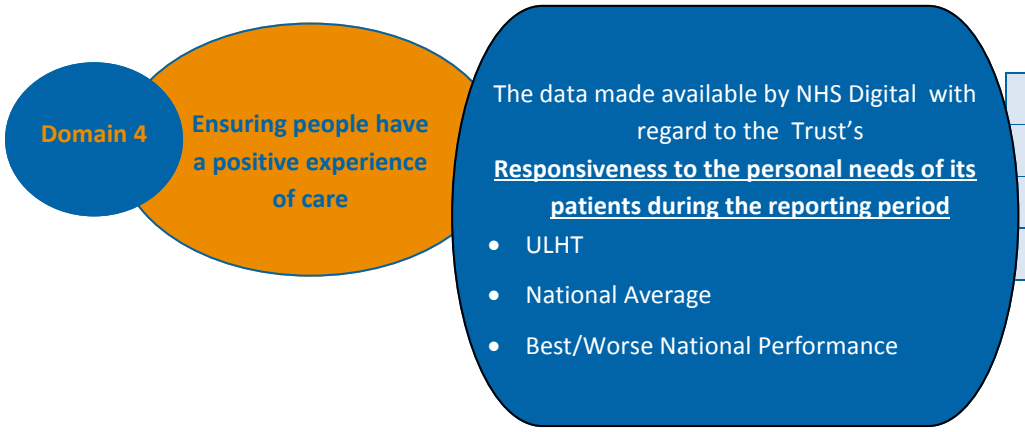
Readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period (emergency readmissions).

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

2010/11	2011/12	2017/18
8.37%/10.16%	7.97%/10.49%	9.6%/7.3%
N/A	N/A	N/Av
6.43%-14.11%/ 9.78%-13.02%	6.40%-16.9%/ 9.43%-13.8%	N/Av

ULHT considers that this data is as described for the following reasons:
The data is taken from the Trust's Patient Administration System.
ULHT intends to take the following actions to improve this indicator and so the quality of its services by working with our wider Health and Social Care Community. 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.
The Trust is adopting the SAFER standards in relation to patient discharge planning.
** This is the latest data ULHT has available internally*

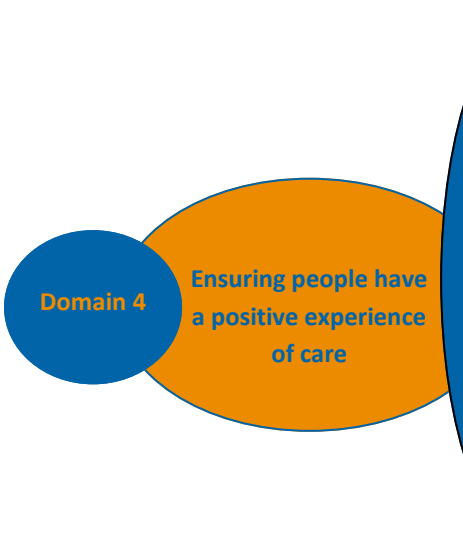
Domain	Measure	Description	2015/16	2016/17	*ULHT



2015/16	2016/17	2017/18
67.5	65.7	N/Av
69.6	68.1	N/Av
85.2/60.0	58.9/86.2	N/Av

ULHT considers that this data is as described for the following reasons:
The data is provided by the national survey contractor.
ULHT intends to take the following actions to improve this indicator and so the quality of its services by developing a comprehensive patient experience strategy.
** This is the latest data ULHT has available internally*

Domain	Measure	Description	2016	2017	*ULHT



The data made available by NHS Digital with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period

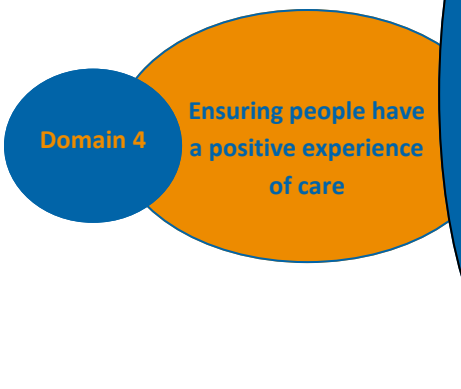
Who would recommend the trust as a provider of care to their to family & friends

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

2016	2017	2018
23/50	9/42	51
21/48	21/48	N/Av
8/82	0/70	N/Av

ULHT considers that this data is as described for the following reasons:
The data has been sources from NHS Digital and compared to published survey results.
ULHT intends to take the following actions to improve this indicator and so the quality of its services by developing and implementing the Staff Charter. Incorporated within the 2021 strategy the Trust is developing the workforce to meet future needs.
** This is the latest data ULHT has available internally*

Domain	Measure	Description	Dec 2017	Jan 2018	*ULHT



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

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

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

Dec 2017	Jan 2018	Apr 2018
91/95/100-64	81/86/100-66	82/N/Av
91/95/100-64	93/95/100-75	93/N/Av
95/97/100-80	98/97/100-74	98.5/N/Av

ULHT considers that this data is as described for the following reasons:
The data has been sources from NHS Digital and compared to published survey results.
ULHT intends to take the following actions to improve this indicator and so the quality of its services by redesigning our clinical services and delivery of the productive services. The Trust will also strengthen the reporting for patients and staff to enable easy access. The comments will be used to develop service improvement initiatives.
** This is the latest data ULHT has available internally*

Domain	Measure	Description	Jul 17-Sep 17	Oct 17-Dec 17	*ULHT

Domain 5 Ⓐ

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

The data made available to the Trust by NHS Digital with regard to the **percentage of Patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.**

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

QTR2 Jul 17-Sep 17	QTR3 Oct 17-Dec 17	2017/18
97.45	97.17	97.48
95.25	95.36	N/Av
100-71.88	100-76.08	N/Av

ULHT considers that this data is as described for the following reasons:
The data has been sourced from NHS Digital and compared to internal data.
ULHT intends to take the following actions to improve this indicator and so the quality of its services by continuing to be above the national average. The Trust will continue to complete detailed analysis on all hospital acquired thrombosis and share learning.
** This is the latest data ULHT has available internally*

Domain	Measure	Description	2015-16	2016-17	*ULHT

Domain 5 Ⓐ

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

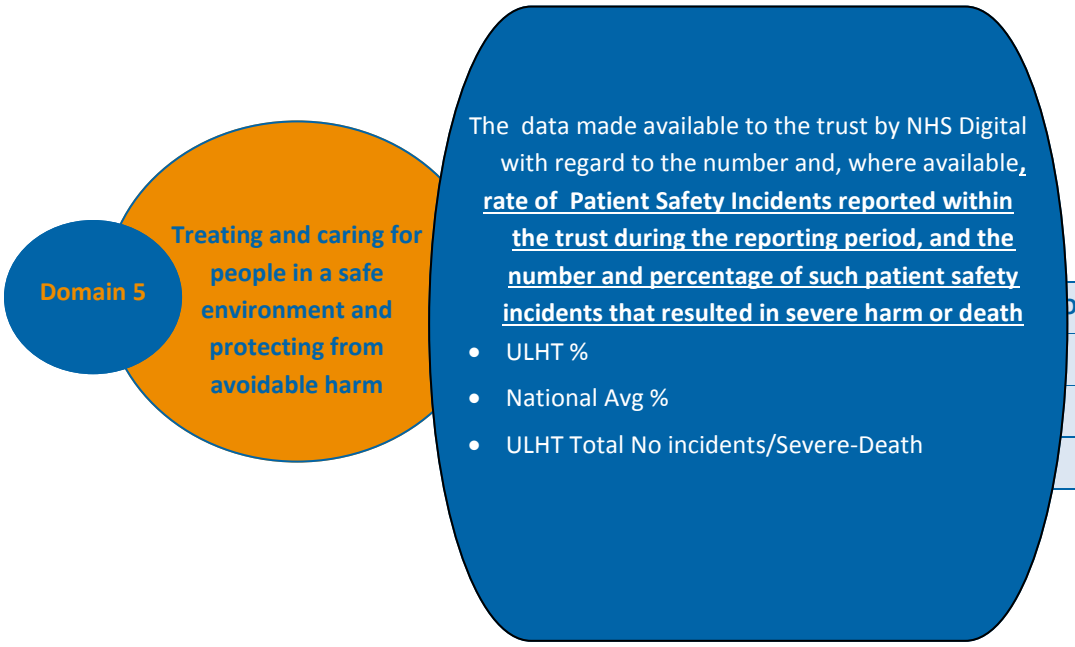
The data made available to the trust by NHS Digital with regard to the **rate per 100,000 bed days of cases of Cdifficile infection reported within the trust amongst patients aged 2 or over during the reported period**

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

2015/16	2016/17	2017/18
14.2	15.3	19.1
14.9	13.2	N/Av
0-67.2	0-82.7	N/Av

ULHT considers that this data is as described for the following reasons:
The data has been sourced from NHS Digital and compared to internal data.
ULHT intends to take the following actions to improve this indicator and so the quality of its services by reviewing each case and share learning.
** This is the latest data ULHT has available internally*

Domain	Measure	Description	Oct 15-Mar 16	Oct 16- Mar 17	*ULHT



Oct 15-Mar 16	Oct 16-Mar 17	Apr 17-Mar 18
1.74	1.45	1.68
N/A	N/A	N/Av
5238/91	5917/86	12515/210

ULHT considers that this data is as described for the following reasons:
The data has been sourced from NHS Digital and compared to internal data.
ULHT intends to take the following actions to improve this indicator and so the quality of its services by updating their reporting system and encouraging staff to report. The Trust has also updated and streamlined their serious incident process.
** This is the latest data ULHT has available internally*

Explanatory Notes

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

Summary Hospital-level Mortality Indicator SHMI

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

Patient Reported Outcome Measures (PROMS)

PROMS is an optional questionnaire that is filled out in pre-operative surgery and a follow up questionnaire is sent post-surgery. The measures required for the Quality Account is to report on the Adjusted Average Health Gain for Hip Replacement Primary, Total Hip Replacement, Knee Replacement Primary and Total Knee Replacement, rounded to two decimal places. The data does not include Knee or Hip replacement revisions. For April 2017-September 2017 published data could not be used for ULHT as there were not sufficient modelled records to equate an adjusted health gain for procedures within this time period.
NHS England undertook a consultation on the national PROMs programme in 2016. As a result of the findings of that consultation, NHS England has taken the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections. As a result of the NHS England consultation the Trust has not participated in the collection of the varicose vein and groin hernia surgery due to the low number of patients that would be available for this cohort which would not allow for sufficient modelled records to equate for an adjusted health gain.

Readmission within 28 days of discharge

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

Responsiveness to inpatients personal needs

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

Staff Survey

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

Friends and Family Test

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

Clostridium Difficile Infection Ⓐ

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

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

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

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

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

The Trust 2017/18 position for C.difficile for patients over two years old was 69 against a trajectory of 59 which equates to 19.1 per 100,000 bed days. The annual trajectory for 2018/19 has been set at 58 cases. As a trust we are focussing on the 5 key themes to managing increases in C.difficile cases. These are; Hand hygiene, Cleanliness of care equipment, Cleanliness of the environment, Timely isolation of patients on suspicion of infectious illness and Antimicrobial prescribing. Each case is investigated for lapses in care.

Venous Thromboembolism (VTE) Risk Assessment Ⓐ

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

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

The patients out of scope are patients under 18 years (however in March 2018 NICE updated their guidelines and have lowered the age to 16 years and above from 18 years), people attending outpatients and people attending A&E who are not admitted. The Trust signed up to the Midland and East Cohort agreement, however, it has been highlighted that all patients who attend endoscopy have been excluded, only endoscopy patients with a spell length of 0 (day cases) should be excluded. The surgical assessment ward where a patient has had a stay/spell length of 2 days or less have also been excluded from our reporting, however these patients should have been included. The Trust is in the process of amending the cohorts to comply with NICE guidance and the Midland and East Cohort agreement. The National target is for at least 95% of patients to be risk assessed for VTE within 24 hours of admission. The results are collated through an electronic system known as Medway. The Trust has achieved greater than 95% for assessing patients for VTE for the previous 3 years and going forward the compliance will be amended to include all appropriate cohorts.
2015/16 = 95.18%
2016/17 = 96.75%
2017/18 = 97.48%

Patient Safety Incidents

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

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

Domain 1

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

Domain 2

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

Domain 4

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

PART 3

2021
A different Lincolnshire
A great ULHT

Excellence in rural healthcare

REVIEW OF QUALITY PERFORMANCE

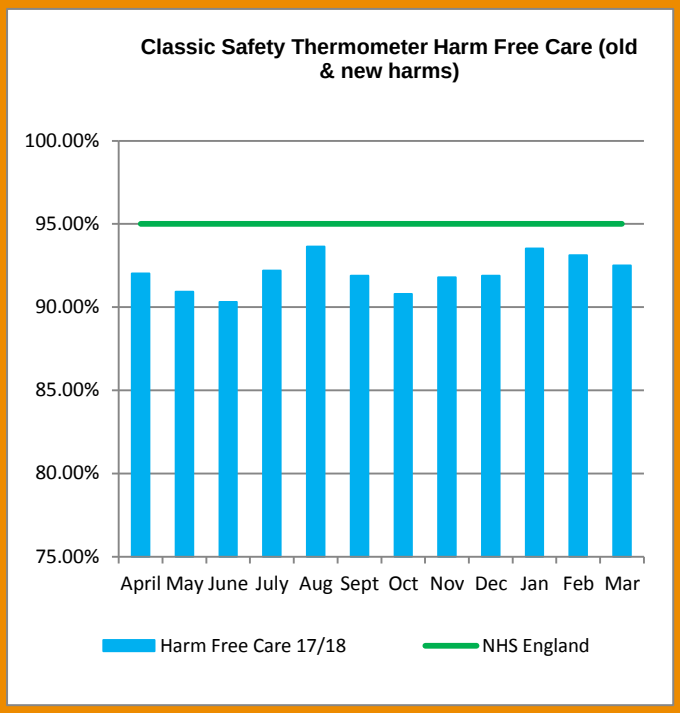
Safety Thermometer

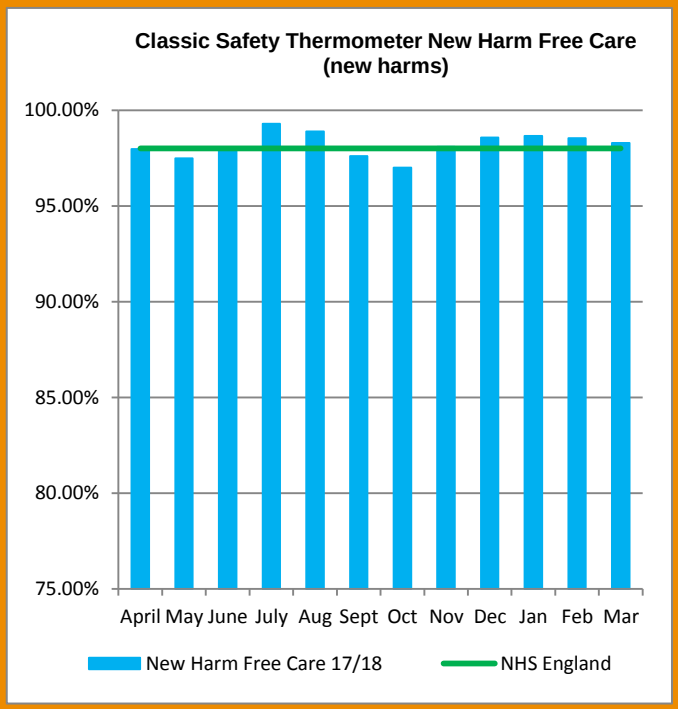
The safety of our patients is a key priority in our quality improvement work. Our aim is to reduce levels of harm to patients whilst in hospital and we measure this through harms like pressure ulcer rates, infection rates, thrombosis events, and the number of patients falling in hospital. All of these 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 for all inpatients.

We have reported on harm free care since April 2012. When comparing our performance from April 2017 to March 2018 harm free care has seen fluctuations. Harm free care comprises of harms from the community whereas New Harm Free Care comprises of harms post admission. Discussions with Royal Salford Hospital (administrators of the Safety Thermometer) highlighted significant local and national variation in interpretation of the Thermometer Guidance.

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 is used across adult wards, A&E and Paediatrics. 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 are divided into key groupings as shown in the table below. In all, over 64 essential quality metrics are included for consideration at ward level.

Dashboard results are shared with the Ward Leader each month and are incorporated within the Ward Health Check and Quality Dashboard which is shared through the Trust Governance Framework.

DNACPR	**PATIENT OBSERVATIONS**	**WARD OBSERVATIONS**	**MEDICATIONS**
CATHETERS	**FALLS ASSESSMENT**	**FLUID MANAGEMENT**	**NUTRITION**
OXYGEN	**PERIPHERAL CANNULAS**	**TISSUE VIABILITY**	**SENIOR REVIEW**
RISK ASSESSMENT			

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.

Data is also incorporated into a monthly trend analysis which triangulates information from each site and identifies areas of outlying performance over a quarterly period for local remedy. Both documents provide an overview of safety measures against workforce and organisational development numbers.

Ward Health Accreditation Metrics (WHAM)

The Trust's Ward Health Accreditation Metrics programme is a Patient First initiative which mirrors a similar programme introduced at Salford Royal Hospital. The programme focuses on engaging staff and empowering leaders to improve standards and quality on adult in-patient wards. It is based on the continuous improvement principle of standardisation by recognising, sharing and adhering to best evidence based practice to deliver high quality patient care and experience.

The Ward Health Accreditation Metrics programme was implemented to ensure that there was a reduction in variation in practice and to also identify and confirm with wards teams and ward leaders the standards expected. The initial part of the programme required the standards to be agreed across the organisation, the accreditation programme ensures wards are consistently measured against these standards.

Wards progress through red, amber and green standards as they achieve the designated targets for consistent practice and performance with an aim ultimately of acquiring Blue accreditation status. To achieve this a ward will have needed to demonstrate consistency of practice over a 2 year period and also provide evidence of improvement work completed.
The accreditation framework is designed around 13 standards which are aligned to the CQC fundamental standards, CQC KLOE, 10 commitments, 6 C's, NMC code and the Health and social care act 2008.

The ULHT 13 standards are:

1. SAFEGUARDING
2. DETERIORATING PATIENT
3. INFECTION CONTROL
4. FALLS
5. TISSUE VIABILITY
6. MEDICINES SAFETY
7. PATIENT FLOW
8. END OF LIFE CARE
9. CONTINENCE
10. NUTRITION
11. PATIENT EXPERIENCE
12. RISK MANAGEMENT
13. BUILDING A BRILLIANT TEAM

The programme sets clear expectations of the quality of care delivered to patients, consistently by all staff from the Multi-Disciplinary Team working on wards and departments. Ward Health Accreditation sets ambitious but realistic goals that takes wards on a quality improvement journey. Based on learning from other Hospitals the Ward Health Accreditation programme has the following benefits:

- Sets consistent expectations of patient care delivery across the Trust
- Provides strong focus to the ward and department leadership team
- Strengthens ward and department leadership
- Introduces continuous quality improvement cycles
- Reduces avoidable harm
- Improves patient experience
- Improves staff experience
- Evidences compliance against regulatory standards thus improving CQC ratings
- Improved clinical efficiency and effectiveness
- Sharing good practice

The ULHT 13 standards will be reviewed annually and updated to ensure that they are up to date and contemporaneous highlighting the best practice available. The Quality Matron team will ensure that the common themes and gaps in practice are identified and plans put in place to

improve, not only at a ward level but at across the organisation as a whole to ensure that variation in practice is reduced.

Quality Aim for 2018/19

In 2018/19 we will use the information from the SQD, Ward Health Check and the ward accreditation programme with the appointment of 5 quality matrons.

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 set out the organisation's 3 year plan 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. Funds enabled the establishment of a Human Factors Faculty consisting of 8 Multi-Disciplinary professionals trained to provide ongoing Human Factors training to staff.

The Human Factors Faculty will commence initial pilot training at Pilgrim Hospital in Emergency Department and Admissions Unit in April 2018. Safety culture surveys and other intelligence will be used to measure the success of initial pilot and design ongoing milestone plan. Key elements of the training programme will include but are not limited to:-

- Why we make errors
- Communication

- Dealing with difficult people
- Leadership and Team Working
- Briefing & Debriefing
- Situational Awareness

Prioritisation of delivery will be determined by individual area risk status and approach will ensure sustainability of training irrespective of longevity of the national campaign.

National Institute for Health and Care Excellence (NICE)

NICE guidelines are evidence-based recommendations for health and care in England. They set out the care and services suitable for most people with a specific condition or need, and people in particular circumstances or settings. When NICE produce a guideline for a specific condition the Trust has to complete a baseline assessment to ascertain if they are compliant with the NICE recommendations. The Trust has struggled to ensure all baseline assessments are completed. The risk for compliance with NICE has been added to the Trust Risk register and the plan is for the completion of these baseline assessments is added to the consultant job plans.

Duty of Candour

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.

For 2017/18 the Trust achieved on average 48% for verbal apology and on average 24% for written apology. We are falling short of the trajectory set by the Commissioner.

In December 2017, the incident reporting system, DATIX, was updated to capture the different stages of Duty of Candour. The software is now equipped to record whether the verbal apology given at the time of the incident has been followed up in writing therefore giving a clearer picture of our compliance rate.

Weekly performance figures are circulated to all Clinical Directorates to enable them to monitor their areas compliance and weekly reminders are sent to those who are handlers of non-compliant Duty of Candour incidents.

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

Patients tell us that good hospital care depends on getting the basics right. It is important to patients to receive good nutrition and hydration, to feel safe and cared for, to have care provided in clean and pleasant environments, and to feel trust and confidence in those caring for them. With over twelve thousand patient admissions every month, our goals for providing a high quality, consistently positive patient experience may be ambitious but they are essential. Our highest priority is to provide care, treatment and facilities to meet the fundamental needs of patients, relatives and carers who use our services.

Improving patient experience makes good sense for patients because:

- The reduction of anxiety and fear can speed the healing process and shorten patient's length of stay and decrease their acuity levels
- The provision of information reduces post-operative complications
- Good communication/information enables people to (self) manage their illnesses more effectively
- Effective communication improves treatment and medications compliance

Improving patient experience makes good business sense because:

- Patients are increasingly using the internet to rate their experience, affecting organisational reputations
- The NHS choice programme has expanded under the Liberating the NHS reform programme (DoH 2012), further empowering patients to choose services perceived to provide the best care and treatment
- Hospitals suffer financial penalties when the quality of care is poor
- A positive patient experience affects staff experience and can impact on recruitment and retention
- Providing a good patient experience ensures organisations meet their statutory and regulatory obligations

The Trust has developed a patient experience strategy which details the key actions to achieve the ambitions. There are six key ambitions within this pledge to enable us to deliver our ambition of promoting a positive patient experience to deliver what matters most to our patient, carers and families.

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 financial 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.

The annual National Staff Survey was sent to every member of Trust staff between September and December 2017. Staff were asked a total of 88 questions relating to:

- Their job
- Their managers
- Their health, well-being and safety at work
- Their personal development
- Their organisation

3231 staff completed the survey giving an increased response rate of 45% (39% in 2016) which indicates that people are keen to tell us what they think. The average response rate for acute Trusts was 45.5%.

Across the board the results show a decline in scores since 2016. The two areas where we showed significant improvement were:

- Had mandatory training in the last 12 months
- Had appraisal in the last 12 months

The remaining scores have deteriorated, including:

- Care of patients is the organisation's top priority
- Satisfied with the extent the organisation values my work
- Able to provide the care I aspire to
- Would feel secure raising concerns about unsafe clinical practice
- Would recommend ULHT as a place to work

The percentage score for staff experiencing harassment, bullying or abuse from staff in the last 12 months was 27% from white staff and 32% from Black and minority ethnic (BME) staff. This is a deterioration from our previous scores in 2016 and higher than the national average.

The percentage score of staff believing that the organisation provides equal opportunities for career progression or promotion for 2017 was 83% for white staff and 78%for BME staff. This is a deterioration of the 2016 score for white staff however the Trust scored the same from BME staff. This is lower than the national average score.

The below table outlines overarching corporate themes alongside immediate action taken the address**:**

Corporate Theme	Action
Staff Optimism	• 2021 launch – new vision & ambitions • Further 2021 communication and engagement plan in development • Values relaunched as part of 2021, with staff charter to bring values to life
Patient Safety Focus	• 2021 launch with key messages about quality and finance and new vision "Excellence in Rural Healthcare" • Amalgamated organisational development and patient experience teams to ensure patient centred in approach • Planning to run a "FAB" campaign around what we doing to improve patient care • Quality Improvement Programme to introduce quality improvement techniques • 2021 People Reference Groups to build in key messages to discuss, debate and resolve ideas
Freedom to Speak Up	• New SI process in place • Freedom to Speak Up Guardian role publicised • Training and education for risk and SI process and use of incident reporting system, DATIX, – linked to local management and assurance • Link to Appraisal key questions – i.e. have you raised concerns and how has that made you feel? • Will be part of leadership training
Staffing Levels	• Further communication strategies linking cost and quality
Staff Value	• Work to develop the "employment brand" or "offer" to staff • Review of benefits package underway • New approach to recognition, from "thank-you" to staff awards • Further analysis to identify the differences between staff who are engaged/feel valued and those who do not. • Potential career days • Publicise where people have progressed their careers in ULHT
Staff Well Being	• Promote our well-being offer • Link to the staff charter • Exploration of pre-exit questionnaires
Staff Engagement	• 2021 Improvement Methodology launched – opportunity for staff to get involved in change – link to promoting these improvements through a promotional catalogue of case studies • Staff forums linked to each 2021 programme • 2021 Big Conversations to engage staff around the key issues in honest conversations and generate key issues to further discuss in the People

	Reference Groups, with regular feedback of key issues into the 2021 Newsletter
Quality of management	• Expectations of managers set out in staff charter/behavioural framework • Two day management programme • Leadership programme to be launched in April 18 • Management assessment centre to run in March 18 • New individual performance management system (appraisal) to be introduced in April 18
Staff Development	• Talent Academy work to create development pathways for staff (particularly staff joining the Trust) • Work planned to better define our development offer for establishment members of staff to assist in recruitment and retention
Unity of sites	• Review of induction underway – corporate induction, local induction and induction of temporary staff covered • Medical engagement work • Exploration of "one day in the life off" shadowing opportunities
Behaviours of Staff	• Launch of staff charter and behavioural framework • Use of "special measures" for teams in distress • Work to promote the values and charter • Embed charter in key workforce processes e.g. recruitment, performance management • Further campaigns around zero tolerance of bullying.
Communication	• Executive & Non-Executive 2021 briefings (followed other face-to-face conversations led by Staff Engagement Group earlier in year) • Team brief introduced as part of suite of communications tools • Team brief cascade not effective • Focus on why core messages are not getting across

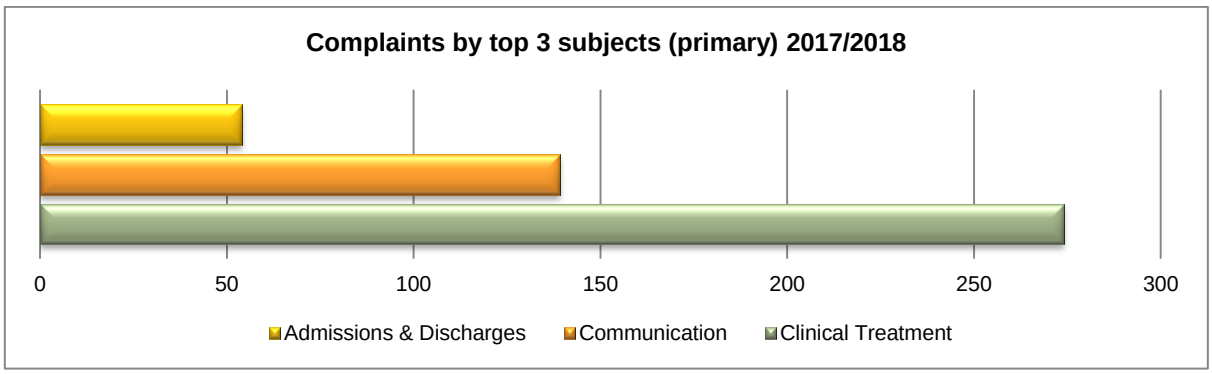
The four areas where we were significantly better than other similar organisations were:

1. Not experienced physical violence from managers
2. Not experienced discrimination for patients/service users, their relatives or other members of the public
3. Had mandatory training in the last 12 months
4. Receive regular updates on patient/service user feedback in my directorate/department

Patient Complaints

There were 744 Complaints received during 2017/18. The top three themes were identified as:

Clinical Treatment	274
Communication	139
Admissions & Discharges	54



The top three complaints were analysed further to enable greater intelligence on the themes identified.

Top 3 Sub-subjects of complaints relating to Clinical Treatment

- Delay or failure to diagnose – 68
- Delay or failure in treatment or procedure – 47
- Injury sustained during treatment or operation – 22

Top 3 Sub-subjects of complaints relating to Communication

- Communication with Patients – 58
- Communication with relatives/carers – 29
- Conflicting information – 7

Top 3 Sub-subjects of complaints relating to Admissions and Discharges

- Discharged too early – 21
- Discharge, lack of/poor planning – 8
- Discharged at an inapropriate time – 5

Communication themes continue to be recognised and acknowledged as an area for development across the Trust. The majority of the complaints raised regarding clinical care and admissions & discharges also contained an element of poor communication within.

To enable shared learning the Lessons Learned Committee is being re-energised. The Quality & Safety Officers (QSO) will ensure the issues identified are discussed and action plans are being monitored and acted upon at the Speciality Governance Committees.

The Trust has delivered communication training to equip staff with the appropriate communication skill set. This training encompasses the importance of good communication and how we deliver the communication with patients, their loved ones and each other. The training also ensures staff check their understanding of the information we have given them.

The Trust has changed the induction session from explaining the investigation process of complaints and PALS to helping staff understand how we can avoid complaints and concerns from our patients/relatives by being a good listener and by improving our communication skills.

The Complaints Team are also in the process of working with the departments and wards who are alerting with specific issues being raised within complaints. The aim of this stratey is to prevent further occurrances and to help staff understand and address any concerns immediatley prior to getting to a formal complaint.

The Complaints Team are working closely with the Heads of Service to ensure they are aware of the issues that are being raised within their speciality and to put strategies in place to stop the issue from reoccurring.

At the end of the financial year 2017/2018 there were 10 complaints overdue against the 257 that were open across the Trust.

	Surgery	Medicine	Grantham
Lincoln	4	1	
Pilgrim		4	
Grantham			1

The Complaints team work closely with the Case Managers to ensure that these are completed as a matter of urgency.

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

Examples of learning and actions identified following complaints/Ombudsman investigations:

- Training in lying and standing blood pressure
- Introduction of falls risk wrist bands introduction of falls risk sticker in patients notes
- introduction of a yellow 'square' a symbol to place over the bed if someone is at risk of falls.
- Dementia Practitioners now in place providing support for patients with dementia by reviewing newly admitted dementia patients particularly those with complex care needs.
- Introduction of the Carers Policy and Carers Badge to encourage family/carers to contribute to patient's care.
- Falls rate and harm are closely monitored with monthly reports from ward to board.
- Complaints team to negotiate a mutually agreed time and frequency that is proportionate to the complexities of each individual complaint.
- Teaching Session within A&E to include the need to thoroughly clean and irrigate bite wounds, and to ensure that appropriate antibiotic is prescribed as per NICE guidance.
- To include this information within the junior doctor's handbook.
- Teaching Session within A&E to include the need to thoroughly clean and irrigate bite wounds, and to ensure that appropriate antibiotic is prescribed as per NICE guidance. To include this information within the junior doctor's handbook.
- An electronic referral system has been designed for all Sarcoma referrals to avoid delays from recurring.
- The Radiology department is currently training senior radiographers to perform interventional procedures such as biopsies.
- To implement a spreadsheet to facilitate the tracking of patients referred to another centre for tests or interventions which will be used by the surgical secretaries.
- Implementation of a critical care outreach team who are automatically alerted to patients that score on observations.
- Implementation of NEWS and move from track and trigger score/implementation of new electronic observation boards

- Waiting list for coronary angiography is currently 8-9 weeks - the Trust is working to correct this by restructuring the Cath Lab scheduling and performing more angiograms.
- Nurse Endoscopists have had extended training to enable in-patients to be added to their lists.
- Daily communication between the Endoscopy Unit and management staff on cancelled outpatient slots that can be utilised.
- Weekly auditing of antimicrobial prescribing standards as part of Trust wide Antimicrobial CQUIN.
- Better use of all about me booklet for complex patients.
- Improved Communication between Medical staff/Nursing staff and patients and relatives. Communication Training developed for all staff to attend to highlight importance of improved communication and the benefits to staff and patients/relatives.

Health & Safety

On 15 May 2017 Lincoln Crown Court found the Trust in breach of Section 3 of the Health and Safety at Work Act 1974. The incident which led to the prosecution, was the death of a patient at Pilgrim Hospital on 10 April 2012 following an accident whilst using a standing hoist. The case has identified a need for focused training on complex equipment with clear reference to the manufacturer's Information for Use (IFU). The Trust must be able to evidence the competency training, and systems for maintaining competence including refresher training, for specific types of equipment which are complex enough to require focused training. The Trust is working in partnership with a key stakeholder to provide this focused training.

Staff Engagement Scores

Nine questions from the National Staff Survey highlight aspects of staff engagement, motivation, involvement and advocacy. Scores to these questions are given on a 1-5 scale to match the national NHS Key Findings report on staff engagement. The overall staff engagement score for the Trust is 3.62 which is lower than the national average of 3.76.

Guardians of Safe Working

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

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

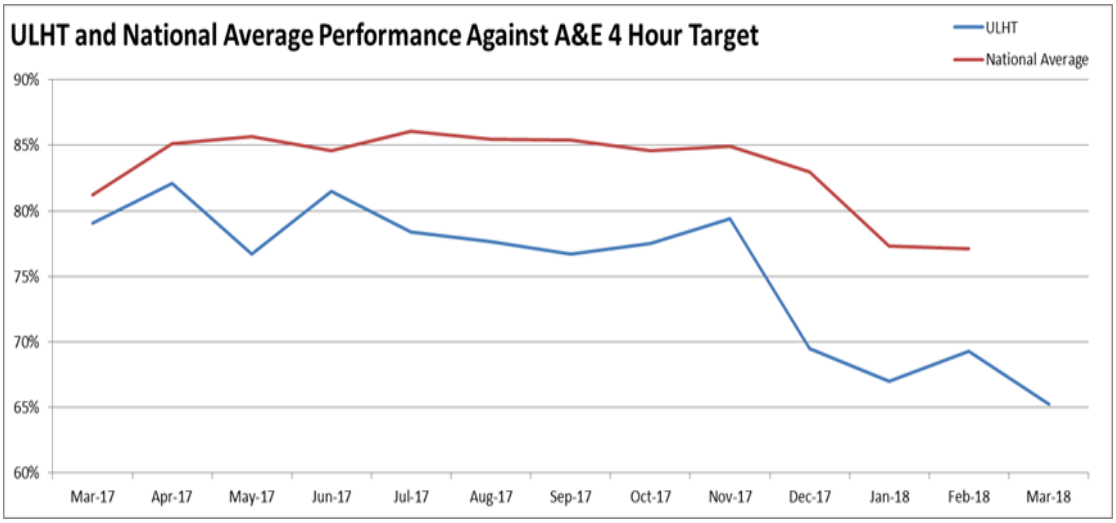
Exception Report is to highlight and patterns or trends which need to be addressed with particular specialities to ensure that safe working practices are achieved.

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

Constitutional Services

A&E 4 hour target

The Trusts performance for urgent care has been below plan and below the national average throughout 2017/18. Against the 4-hour target performance has been poor and we have seen long delays for ambulances bringing patients in to the hospital. The graph below details the performance of ULHT compared to national performance.



Improvement plans as well as winter plans included greater actions, larger investment and larger ambitions for improving performance than in previous years. This is set against a greatly reduced level of substantive medical and nursing staffing in A&Es compared to previous years, and an increasingly more acute, and greater proportion of acutely unwell patients, particularly in winter. As a result relatively few of the improvement schemes made substantial impact on performance. With key challenges around staffing levels reducing the effect of many of the schemes, often with disproportionate levels of agency and locum staff being employed to fill substantial gaps.

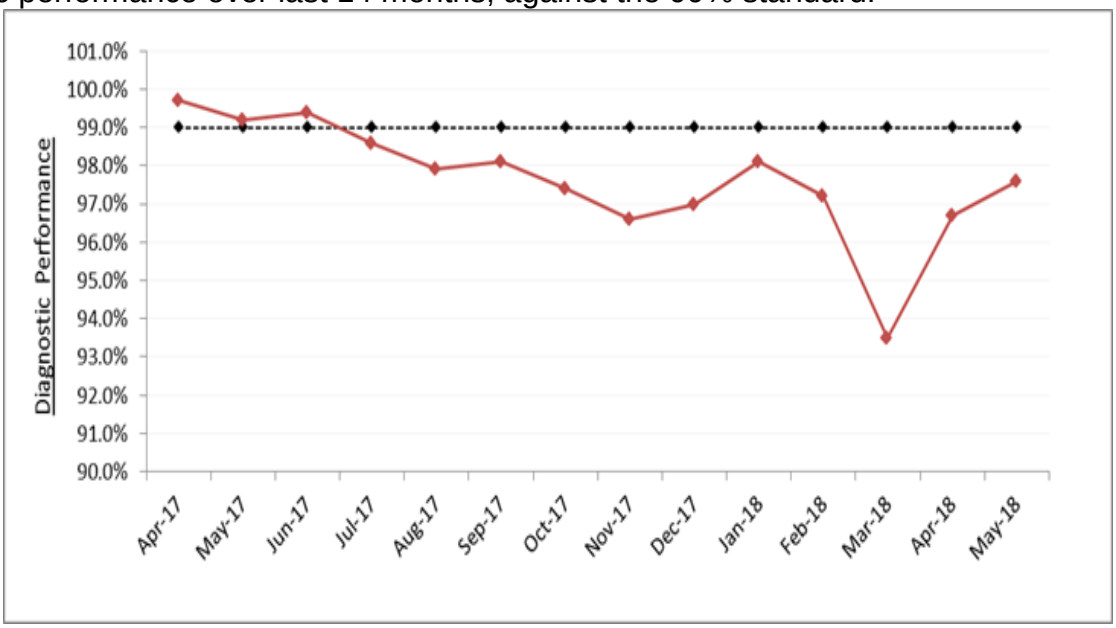
The Trust has seen high bed occupancy rates throughout the year and in particular over the winter months when hospitals see higher admissions of patients with more complex conditions which take longer to treat. These more complex conditions increase the length of stay (LoS) in hospital which means less beds are available for patients waiting to be admitted from the GP or the “emergency admissions” in the A&E department.

There has been an increase in LOS on all sites (GK – Grantham, LC – Lincoln County, PH – Pilgrim Hospital Boston) over the winter months. To reduce LoS and bed occupancy the trust implemented the SAFER patient flow bundle – a series of good practice initiatives to get patients

treated efficiently and the “Red to Green” initiative which attempts to eliminate delays and supports the SAFER bundle. There have also been a number of “surge” planning weeks, sometimes called system reset or “Perfect Weeks” where additional resources and support from partner agencies such as Lincolnshire Community Health Services NHS Trust, Adult Social Care and commissioners is put in place to support patient’s recovery and discharge.

Diagnostics

Diagnostic performance over last 14 months, against the 99% standard:



Key issues since July have primarily been within Echocardiography and Endoscopy departments:
Echocardiography

- Echocardiography breach themes related to capacity restrictions due to staffing vacancies, maternity leave and sickness
- There has also been increased inpatient demand
- There was a lack of clear waiting list visibility

Endoscopy

- During the beginning of 2017/18 there were issues relating to failure of escalation and administrative processes
- During the latter of 2017/18 the issues were primarily around mechanical failures and issues with water sample results leading to reduced capacity.
- Deterioration in February and March were the result of the unexpected closure of Grantham suite during planned building works.
- The impact of adverse weather conditions.

Actions to address the above included:
The Cardiology Team have produced and delivered a recovery action plan in order to address this position. The plan included:

- Provision of additional capacity through internal resources
- Action completed to improve data quality and visibility, with Cardiac Physiology now having a dedicated new and follow-up waiting list within Medway for the first time.
- Improved rota management and standardisation of booking rules completed
- Workforce review completed.

- The service has finalised a detailed capacity and demand review, with a view to formulating a Business Case to address capacity gaps.

Issues within Endoscopy relating to mechanical failures and water samples were resolved in January. The service utilised Medinet to support additional capacity, as well as undertaking additional internal sessions, although uptake of additional sessions has been more limited since the standardisation of payments for Agenda for Change (AFC) staff around these sessions was introduced in mid-January 2018.

A business case has been approved to enable provision of extended working within the Endoscopy units from April.

Cancer Services

Cancer performance within ULHT was below the national standards for 14-day and 62-day during 2017/18. 31-day first treatment, subsequent Chemotherapy and subsequent Radiotherapy are on track to achieve during 10 of the 12 months, however 31-day subsequent surgery performance has been less consistent. The table below shows 2017/18 performance for each cancer standard split by quarter, including March's partially validated position:

17/18	Q1	Q2	Q3	Q4		YTD		Std
14 Day	90.50%	87.50%	91.20%	83.40%		88.20%		93%
Breast	75.40%	91.70%	89.60%	54.90%		74.10%		93%
31 First	95.80%	96.40%	96.80%	96.90%		96.50%		96%
31 Drug	99.00%	99.60%	98.10%	99.30%		99.00%		98%
31 RT	93.40%	96.00%	97.30%	97.80%		96.20%		94%
31 Surgery	91.40%	91.70%	96.60%	90.70%		92.40%		94%
62 Classic	69.90%	69.00%	70.90%	75.50%		71.30%		85%
62 Screen	84.10%	87.90%	90.10%	87.20%		87.60%		90%
62 Upgrade	84.60%	89.90%	82.20%	90.10%		86.60%		85%

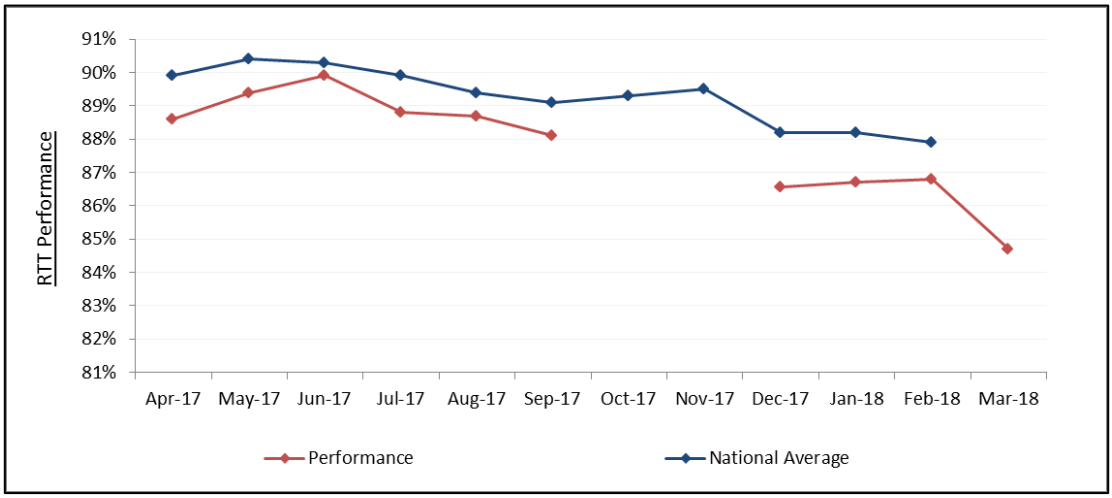
There was a 9% increase in referrals on a suspect cancer pathway during 2017/18 compared with the previous year, nationally there was a 4% increase comparing the same periods. However, conversion rates remained broadly in line with the national average. In addition, the delivery of cancer treatments was significantly affected during the winter by the impact of Urgent Care pressures and adverse weather.

During the course of 2017/18 a programme of improvement has been undertaken within the Trust in order to improve the timeliness of assessment, diagnosis and treatment of patients on cancer pathways. This improvement programme was overseen at a corporate level via the fortnightly Cancer Recovery and Delivery Group.

Referral to Treatment (RTT)

RTT performance deteriorated during 2017/18 within the Trust and the country as a whole, as illustrated by the below graph. The Trust's incomplete performance in April 2017 was 88.6%, and had deteriorated to 84.7% by March 2018. The Trust did not submit RTT performance data for 2 months during 2017/18 (October and November) due to the impact of the Medway upgrade, and the requirement to construct a new Business Intelligence report. The enhanced reporting functionality following the Medway upgrade enabled patients at the pre-operative stage between

outpatients and inpatients to be included within the reported figures, which contributed to a deterioration within the Trust's reported performance.



In addition, the level of cancelled operations during 2017/18 has led to a significant increase in the backlog of patients waiting over 18 weeks on an admitted pathway. During 2017/18, 4853 operations were cancelled on the day or day before surgery, which is an 83% increase compared with 2016/17. The highest volume cancellation reason was the lack of beds as a result of urgent care pressures. The volume of patients waiting over 18 weeks for an operation rose from 1018 at the end of April to 2456 at the end of March.

A third key factor within the deterioration of the Trust's RTT performance at the end of the year was the cancellation of 2750 outpatient appointments at the end of February/beginning of March as a result of the adverse weather conditions.

For 2018/19 an action plan is being approved by the Trust Board to improve our constitutional standards.

Seven Day Services

The Seven Day Services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital.

Patients across England will see a revolution in hospital care with the introduction of seven day consultant-led services that are delivered consistently over the coming years.

Ten clinical standards for seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven day services should achieve no matter when or where patients are admitted.

ULHT has participated in all NHS England Seven Day Services audits. The Trust has appointed a clinical lead for Seven Day Services. Participation in April 2018 will conclude completion of the 6th audit to self-assess progress against the 10 clinical standards for seven day services. Progress against the four priority standards will be closely monitored through Priority 5 of 2018/19 Generating Healthcare Services for the Future that are Creative and Forward Thinking.

Paediatric Services

Over the past three years, the paediatric service has experienced both medical and nursing staffing challenges which have been partially mitigated by temporarily closing beds, increased skill mix through the introduction of nursery nurses, adult registered nurses and significant utilisation of both locum and agency medical staff. However, the position at the end of March 2018 was forecast to further deteriorate within both the nursing and medical workforce.

There was significant increase to the risk of identified gaps on the tier 2 (Middle Grade) rota in addition to the longstanding nursing recruitment and sickness issues on the PHB site. The position had been further compounded due to the short term need to support the Emergency Department (ED) at PHB with Registered Children's Nurses (RNC).

Following inspection of the ED at Pilgrim Hospital by the CQC between 15 and 17 February 2018, conditions were placed on the organisation. The Trust was requested to provide assurance that the ED was staffed with appropriate numbers of competent staff to meet the needs of children & young people within the emergency pathway. Due to the staffing numbers of RNC within ED and adult nurses with children's competencies, the Women's & Children's Clinical Directorate (W&CCD) were requested by the Executive Team to review the RNC's in post establishment on Ward 4a, to see if it would be feasible to support the ED Registered Nurse establishment with RNC. This action would provide the assurance that on every shift within ED there was 1 RNC able to provide care to children & young people.

The option of providing assurance through providing 3 WTE RNC from within the children's ward (4a) at PHB establishment was considered by the Executive team and agreed as a short term option. To facilitate this, the bed capacity had to be reduced from 12 to 8 beds due to the availability of the registered workforce. The impact was that a temporary stop to children's elective activity was required.

The high demand for paediatric staff in the UK has made recruitment a volatile situation and we are working hard to recruit staff and have carried out extensive worldwide recruitment. These efforts to recruit will continue. We are working with medical agencies, to find agency and locum medical staff to support the rota at Pilgrim in order to keep the services running safely.

We are also working with Health Education England, and other health partners and our regulators, to ensure we can provide safe, efficient and high quality services to our patients and support to our staff.

The Trust has recently recruited two agency paediatric consultants to provide senior input onto the rota and we now have enough nurses to safely staff up to 12 children's inpatient beds. While the numbers of beds available will fluctuate depending on the nurses available, this current situation does mean that we can now carry out planned surgery on children at Pilgrim Hospital.

The supply of junior doctors from Health Education England from August is now fragile, while we are doing everything we can to maintain children's services at Pilgrim, we will develop contingency plans to manage a shortage by moving some Paediatric and Obstetrics services to Lincoln, if needed, in case the safety of current services cannot be sustained. This does not mean that services will close, it means that we will be prepared should the staffing situation worsen. If we do not have the staff at Pilgrim, the safest option will be to have one safely staffed children's unit at Lincoln, rather than two poorly staffed services on both sites.

The Trust have asked the Royal college of Paediatrics and Child Health to review our services and offer their expertise on best practice and safety in the longer term, and this will commence during June.

Staff charter

NHS
United Lincolnshire Hospitals
NHS Trust

Safety

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

Compassion

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

Patient-centred

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

Excellence

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

Respect

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

2021
A different Lincolnshire
A great ULHT

Excellence in rural healthcare

Developing the workforce to meet future needs

One of the five improvement programmes in the ULHT 2021 Strategy relates to the workforce. As part of the Strategy we have identified a number of ambitions for our workforce, as follows:

- Will be proud to work at ULHT
- Will feel valued, motivated and adaptive to change
- Will challenge convention and improve the way we do things

We will deliver the workforce improvement programme through the delivery of the ULHT People Strategy. The Strategy focuses on what we must do to tackle the two strategic risks relating to workforce:

- Failure to sustain adequate workforce
- Failure to sustain engaged workforce

The priorities within the People Strategy are essentially therefore about either “workforce skills and numbers” or “engagement through change.”

The next few years will see transformational change across the health and social care landscape, both nationally and locally. Through the Sustainability and Transformation Plan, we will see in Lincolnshire a significant change in the way services are provided, with a greater focus on services being provided close to where people live. This will require changes in roles and skills and where those roles are delivered. We work closely with our STP partners and through the LWAB to ensure we are collectively developing and supporting the workforce we need for the future.

The NHS has recently consulted on a Workforce Strategy for the NHS. This has recognised the challenge of ensuring an adequate workforce at a time when demands are growing and the numbers joining key professional groups, like nursing, are reducing as the workforce overall gets older. There are shortages already in medical disciplines and these shortages are exacerbated by the challenge of attracting candidates to Lincolnshire in a tight recruitment market. The national strategy sets out plans to address shortages, whilst creating pipelines for new roles which will supplement the existing skill mix.

In Lincolnshire we have been working collaboratively to develop a healthcare brand to assist in our recruitment efforts. Alongside this we have defined more clearly the “offer” of ULHT as an organisation; how we can sell the opportunity to work in an organisation striving for “Excellence In Rural Healthcare” and offer development opportunities for staff as part of a broad approach to their health and well-being.

We recognise though that it will be very difficult to recruit to all the medical and clinical vacancies that we are currently carrying. We are looking hard at our current establishment, to see if it is correct in terms of total numbers and whether we can change the skill mix and embrace new roles, where it may be easier to recruit, such as nurse associates and physician associates. The Trust hosts the Lincolnshire Talent Academy, which supports new pipelines of talent, whether that is promoting NHS careers in schools, supporting apprenticeships or developing “trailblazers” for AHP careers or clinical pharmacists.

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 a new Leadership Development Programme which develops influential, compassionate and inclusive 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.

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.

Above all, we need to strengthen the engagement of all our staff with the 2021 strategy for our future, with the vision of “Excellence in Rural Health” and our organisational values, which focus on quality, safety and the customer experience. In this way we will create a greater sense of hope and a belief in the improvement journey the Trust is on.

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.

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

GLOSSARY OF ABBREVIATIONS

A&E	Accident & Emergency
A&G	Advice & Guidance
AAA	Aortic Abdominal Aneurysm
AoMRC	Academy of Medical Royal Colleges
CABG	Coronary Artery Bypass Graft
CAUTI	Catheter Associated Urinary Tract Infection
CCG	Clinical Commissioning Group(s)
CEG	Clinical Executive Group
CEA	Carotid Endarterectomy
COPD	Chronic Obstructive Pulmonary Disease
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRN	Clinical Research Network
CSIG	Clinical Strategy Implementation Group
CT	Computerised Tomography
DATIX	Incident Reporting System
DKA	Diabetic Ketoacidosis
DoC	Duty of Candour
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
eDD	Electronic Discharge Document
EMAS	East Midlands Ambulance Service
eRS	Electronic Referral System
ESR	Electronic Staff Record
FEP	Financial Efficiency Plan
FFAP	Falls and Frailty Audit Programme
FFT	Friends & Family Test
GDH	Grantham District Hospital
GI	Gastrointestinal
HCSW	Health Care Support Worker
HES	Hospital Episode Statistics
HQIP	Health Quality Improvement Partnership
HRG	Healthcare Resource Group
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care National Audit & Research Network
ICU	Intensive Care Unit
IG	Information Governance
IV	Intravenous
IVAB	Intravenous Antibiotics
KLOE	Key Lines of Enquiry
LCH	Lincoln County Hospital
LCRF	Lincoln Clinical Research Facility
LeDeR	Learning Disability Mortality Review Programme
LUCADA	Lung Cancer Audit (National)
MDT	Multi-Disciplinary Team

MINAP	Myocardial Infarction National Audit Programme
MoRAG	Mortality Review Assurance Group
MRI	Magnet Resonance Imaging
N/A	Not Applicable
NBCA	National Bowel Cancer Audit
NCEPOD	National Confidential Enquiry into Patient Outcomes Database
NEWs/NEWs2	National Early Warning Scores
NHS	National Health Service
NHSBT	National Health Service Blood & Transplant
NHSi	National Health Service Improvement
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Health and Care Excellence
NICOR	National Institute for Cardiovascular Outcomes Research
NMC	Nursing & Midwifery Council
NNAP	National Neonatal Audit Programme
NIHR	National Institute for Health Research
NRLS	National Reporting Learning System
NVD	National Vascular Database
OD	Organisational Development
PAS	Patient Administration System
PAT (dog)	Pets as Therapy
PDSA	Plan Do Study Act
PGD	Patient Group Directive
PHB	Pilgrim Hospital
PICANet	Paediatric Intensive Care Audit Network
POMH	Prescribing Observatory for Mental Health
PROMs	Performance Reported Outcome Measures
PUNT	Pressure Ulcer Notification Tool
PUPCA	Pressure Ulcer Prevention Competency Assessment
QGC	Quality Governance Committee
QSIPB	Quality & Safety Improvement Programme Board
RCEM	Royal College of Emergency Medicine
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
RCT	Randomised Control Trials
RITA	Reminiscence Interactive Therapy Activities
SACT	Systemic Anti-Cancer Therapy
SHMI	Standardised Hospital Mortality Indicator
SI	Serious Incident
SIP	Safety Improvement Plan
SOP	Standard Operating Procedure
SQD	Safety Quality Dashboard
SSNAP	Sentinel Stroke National Audit Programme
ST	Safety Thermometer
STP	Sustainability & Transformation Programme
TARN	Trauma Audit Research Network
ULHT	United Lincolnshire Hospitals NHS Trust
WHAM	Ward Health Accreditation Metrics
WHC	Ward Health Check

7DS 7 Day Services

ANNEX 1

2021
A different Lincolnshire
A great ULHT

Excellence in rural healthcare

STAKEHOLDER COMMENTS

NHS Lincolnshire East Clinical Commissioning Group (Lead Commissioner)

NHS Lincolnshire East Clinical Commissioning Group (the commissioners) welcomes the opportunity to review and comment on the United Lincolnshire Hospitals NHS Trust (the trust) Draft Annual Quality Account 2017 – 18.

The Quality Account provides information on the quality priorities that the trust has focussed on during 2017 – 18. The trust still has some way to go before the levels of mortality and avoidable harm achieve the levels expected by the commissioner for a large acute provider. In addition, the commissioners would like to see more detailed plans required to support the priorities not achieved last year, as a number of these priorities have not been achieved and the trust have identified these as a priority for the forth coming year.

Looking forward to the 2018 – 19 Quality Priorities the commissioner supports the seven priorities and the supporting detailed activities. The range of activities is wide and reaches into all areas of the trust, this is necessary to enable the trust to exit the Care Quality Commission Special Measures process that the trust has entered for the second time in recent years.

Whilst supportive of the above the commissioners do consider the activities to be the minimum standard of care required for the safe delivery of care for the population of Lincolnshire.

The Quality Account has examples of some good work undertaken by the trust over the past year and the commissioner's note there has been some improvements in the quality of services. However these improvements are not consistent against all sites and all services and it is important to note that there has been some deterioration in the quality of services provided.

A continued challenge for the trust is the management of Serious Incidents, ensuring the lessons from these incidents are understood, changes to clinical practice are undertaken and these changes become embedded throughout the organisation. Whilst some improvements can be demonstrated, there is more work to be undertaken over the coming year. The trusts compliance with Duty of Candour has deteriorated over recent months.

Compliance against NICE Guidance is another challenge for the trust and it would be helpful to understand the improvement plan required to address this essential area of practice.

The security of information is of crucial importance and it is disappointing that the trust has not achieved the required Level 2 standard of the Information Governance Toolkit for the second year in succession.

The commissioner can confirm that up to the end of quarter three the trust has achieved 40% of the years CQUIN monies to date. The expected end of year position as detailed in the account does align with the commissioners expectations.

The commissioners note the progress against quality and safety projects the trust has taken forward following the CQC inspection however; more granular information would help to understand which of these have been achieved in full.

Given the considerable safety concerns expressed by the organisation in relation to children and young people services, the commissioners would have expected to have seen this area as a priority for the trust for the coming year.

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

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

Tracy Pilcher
Chief Nurse
NHS Lincolnshire East Clinical Commissioning Group

Health Scrutiny Committee for Healthwatch Lincolnshire

Wednesday 9th May 2018
United Lincolnshire Hospital Trust, Presented by Bernie Gallen

Healthwatch Lincolnshire Quality Account Working Group: Sarah Fletcher (CEO), John Bains (Board Chair), Clive Green (Trustee), Pauline Mountain (Trustee), Nicola Tallent (Partnership & Development Manager), Pam Royales (PA Administrator)

Healthwatch Lincolnshire would like to thank Bernie for presenting the ULHT Quality Account and meeting with our representatives.

Healthwatch Lincolnshire share all relevant patient experiences we receive with ULHT and thank you for responding which is generally within 20 working days. Your responses are shared in turn with the patient, carer or service user who raised the issue, in many cases this provides them with a level of closure they may not otherwise receive.

We believe learning through patient feedback and experiences is an essential part of any service improvement and acknowledge your Trusts work to better assess what has occurred. We consider it important to also include any actions that are being implemented by your Trust which demonstrates how this learning is being used and would welcome this addition in future. Healthwatch Lincolnshire's observation is that the quality account should be explicit in making this priority more meaningful for patients to recognise.

We welcome the proposal that there will be a dedicated team for Serious Incidents to work with Clinicians' and appreciate that this work has initially been set up for a period of 12 months. We understand that this intervention should be extended in line with the priority. Healthwatch Lincolnshire also praise the recruitment of the 5 Quality Matron Posts and recognise the positive impact this should make to ULHT services, wards, nursing staff and most importantly patients. We acknowledge ULHT work with Salford to achieve this.

We find it unacceptable that although falls have been a priority for a number of years improvement has not been seen and would be keen to hear more about the Trusts work to improve the number of falls, particularly due to the impact this has on patients. Could the Trust reassure that lack of staff contribute to these high figures?

7 day services - we feel that the Quality Account raises expectations which will be a challenge for your Trust. It was mentioned on more than one occasion by your representative that in reality to achieve this target, you would need services to be delivered for the public at a single site. Healthwatch is keen to know how plans to provide a 7 day service will be made available for the public to assess and comment?

We would like to congratulate the Trusts involvement in the drive and subsequent success for the provision of a Medical School in Lincolnshire, this is a very positive achievement for the county. Let it be hoped that people can then be encouraged to stay in Lincolnshire to work.

Sepsis - we acknowledge improvement from last year's target and would be keen to see the inclusion of how improvement and correlation is acknowledged between the introduction of Sepsis care by EMAS during the last year, and the continuation treatment within the Trust, and how this impacts patient's positive outcomes.

Catheter related urine infections within ULHT are double the national rates the reason for this is unknown and should be further investigated.

The low incident reporting levels may suggest that there is a culture within the Trust and we are concerned that there is a suggestion that staff do not feel comfortable with reporting incidents. In the Staff Survey we are informed about the lower level of staff satisfaction within the Trust, Healthwatch will be keen to see any improvement on this target next year.

CQC inspection - we understand that ULHT has received another visit from the 10th April and as yet no report has been forwarded to the Trust. Healthwatch suggest that ULHT request NHSI to query with CQC the length of time the organisation needs to submit their report. This is particularly pertinent with your current Systems Improvement Work and in order to maximise the pace of intervention and change .

We hear consistent messages of complaint relating to issues around administration. We agree with the focus on improving MEDWAY as this is an area that impacts patients. We continually have Patients tell us they are receiving multiple appointment letters, this in turn results in more DNA's being reported.

We agree with your priority for this year that pressure sores has been recognised. There appears to be some issues with documenting these. If documentation is not completed it is unclear if the patient has presented in A&E with the sore. On the wards poor documentation fails to determine that a patient has been 'turned' regularly. On behalf of patients we would ask administration reporting to be a focus.

HWL questions the overall aspirational feel to the Trusts plans for the coming year in this Account, and would ask whether the Trust believe if they are realistic or achievable? To what extent will recruitment and staffing issues affect plans?

We believe more recognition is needed for Carers who support patients, this should include 'Carers' being included in your headlines for the ambitions.

Healthwatch constantly hears about anomalies across your different sites i.e. concerns that the report does not try to standardise practices/protocol within the Trust. It is apparent that documentation differs between the three sites which is unacceptable. To ensure patient continuity across all services on behalf of patients we welcome much more focus on standardising such practices.

We request that on page 60 a national benchmark to be included.

On page 57, Patient Experiences the wording ‘Episodes’ to be changed to ‘Admissions’ as this simple miswording gives a negative effect from the onset.

Healthwatch Lincolnshire would like to express concerns about the impact of STP on ULHT services. In particular, the Trusts involvement in Care Portal; Integrated Neighbourhood Working; Service Transformation, Inter-organisational working etc and it would be helpful to see this reflected in future quality accounts. In fact, we were concerned to see STP was not included as a priority for 2018/19.

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

Statement on United Lincolnshire Hospitals NHS
Trust's Quality Account for 2017/18

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

Progress on Priorities for Improvement for 2017-18

We are pleased to see a clear statement as to whether the success measures supporting each priority have been achieved. The ten priorities for 2017-18 are considered in turn: -

- Priority 1 – Improving the Care of Patients with Sepsis – We note the Trust's achievement to date on sepsis care, and that further work on this will be continued into 2018-19.
- Priority 2 – Electronic Discharge Document – Six out of eight targets were achieved for this priority. Whilst this priority is not forming part of the Quality Account in the coming year, the Committee understands that further work will be undertaken to improve the issuing of the Electronic Discharge Document to GPs.
- Priority 3 – Reduction in Mortality Rates – We note that the Trust has appointed a medical examiner for the initial screening of case notes. Also further improvements have been made in the arrangements for coding, which should ensure co-morbidities are correctly recorded.
- Priority 4 - Learning from Serious Incidents – Three of the eight targets were not achieved and as a result this priority is being carried forward into 2018-19.
- Priority 5 - The Duty of Candour – Six of the ten targets were not achieved, so the Committee understands the reason for this being rolled forward into 2018 19 as part of the Demonstrating Values and Behaviours priority.
- Priority 6 - Reducing Falls and Incidences of Harm – We are pleased that four of the six targets were achieved in this important area.
- Priority 7 – Reducing Harm from Urinary Tract Infections – Only two of the five targets were achieved in 2017-18 and as a result we note this has been rolled forward into Priority 6 in the coming year.

- Priority 8 – Diabetic Drugs – We understand that the Trust has appointed a new chief pharmacist, whose role will be to facilitate improvements in the prescribing of drugs.
- Priority 9 – Patient Experience: Dementia and Vulnerable Patients – We are pleased to see that all five targets for this priority were achieved.
- Priority 10 – Pressure Ulcers – We are pleased to see that eight of the nine targets for this priority were achieved. The importance of this priority will see it being rolled forward into 2018-19.

Priorities for Improvement for 2018-19

We support the inclusion of seven priorities for improvement for 2018 19 and we accept the rationale for their inclusion. The reduction of the number of priorities from ten to seven will help the Trust focus on achieving the targets for these priorities.

- We would like to make comments on the following priorities:

- Priority 1 - Promoting a Positive Patient Experience – We encourage the Trust to make it easy for patients and their families to pass on compliments to the staff at the Trust.
- Priority 2 - Learning Lessons and Being Open and Honest –This priority refers to the avoidance of never events as one of its success measures. The continuation of patient safety briefings is strongly supported.
- Priority 3 - Eliminating Avoidable Patient Harm (Falls) - Assessing all patients for risk of falls within four hours of admission is strongly supported. We also not the use of double-sides grip socks as a means of reducing the risk of falls.
- Priority4 - Eliminating Avoidable Patient Harm (Pressure Ulcers) - We strongly support the target of reducing the number of category 3 and 4 pressure ulcers by 30%.
- Priority 5 - Seven Day Services - This priority is based on a national agenda and the Committee understands that progress will be dependent on the recruitment of staff.
- Priority 6 - Eradicating Preventable Deaths – We strongly support the inclusion of this priority, as sepsis remains a challenge to the NHS.
- Priority 7 - Demonstrating Values and Behaviours – The Committee would like further consideration to be given to the issue of flexible working arrangements, to assist recruitment. Progress in this area would support the enhancement of the Trust's reputation.

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Care Quality Commission

We note at the time we reviewed the draft Quality Account that the most recent published report from the Care Quality Commission was in April 2017, which resulted in the Trust being placed in special measures. We look forward to improvements from the Trust, following the April 2018 inspection.

Presentation of the Document

The Quality Account is well presented and should be accessible to an interested lay reader. The document includes a glossary of terms, which is also welcomed. The design and formatting also assist the ease of access of the document.

Engagement with the Health Scrutiny Committee

During 2017-18, there has been frequent engagement with the Health Scrutiny Committee for Lincolnshire, with the Trust's Chief Executive attending the Committee on seven occasions. These attendances have enabled the Committee to scrutinise the Trust's response to its 'double' special measures. The Committee has also focused on the continued overnight closure of Grantham Hospital's Accident and Emergency Department, which remains a serious concern for the Committee.

We look forward to continued engagement with the Trust's senior managers in the coming year.

Lincolnshire Sustainability and Transformation Plan

In the section on Quality and Innovation reference is made to the Lincolnshire Sustainability and Transformation Plan (STP). We do not expect the STP to have an impact on the quality of the Trust's services in the coming year, but this is something that could impact on quality in the future.

Conclusion

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

Explanation of changes from stakeholder feedback

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

The commissioners would like to see more detailed plans required to support the priorities not achieved last year, as a number of these priorities have not been achieved and the trust have identified these as a priority for the forth coming year.
The priorities have been updated with more detailed plans to support the Trust in delivering their milestones

Compliance against NICE Guidance is another challenge for the trust and it would be helpful to understand the improvement plan required to address this essential area of practice.
A NICE summary and plans have now been included

The commissioners note the progress against quality and safety projects the trust has taken forward following the CQC inspection however; more granular information would help to understand which of these have been achieved in full.
The detail within the projects has been updated and extended to include the actual performance for 2017/18.

Given the considerable safety concerns expressed by the organisation in relation to children and young people services, the commissioners would have expected to have seen this area as a priority for the trust for the coming year.
As the true extent of this was identified towards the end of March 2018 a statement has been added to the Quality Account to address the issues identified within paediatrics and the plans that being put into place.

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

Recommendation made to make how learning will be taken from patient feedback more explicit in future reports.
The milestones within Priority 1 – promoting a positive patient experience Have been modified to ensure the milestones are explicit and measurable

We find it unacceptable that although falls have been a priority for a number of years improvement has not been seen and would be keen to hear more about the Trusts work to improve the number of falls, particularly due to the impact this has on patients. Could the Trust reassure that lack of staff contribute to these high figures?
Priority 3 – Falls has been updated to include a corporate action plan has been developed and is split into four key areas, one of which is for resources, people and equipment

Healthwatch is keen to know how plans to provide a 7 day service will be made available for the public to assess and comment?
Working with our patients and families has been added to how we will assess our progress

Sepsis - we acknowledge improvement from last year's target and would be keen to see the inclusion of how improvement and correlation is acknowledged between the introduction of Sepsis care by EMAS during the last year, and the continuation treatment within the Trust, and how this impacts patient's positive outcomes.
EMAS to provide updates to the sepsis committee has been added to how will success look like.

Catheter related urine infections within ULHT are double the national rates the reason for this is unknown and should be further investigated.
We will continue monitoring CAUTI through the bi-monthly CAUTI committee which upwardly reports to Quality Governance and Trust Board

HWL questions the overall aspirational feel to the Trusts plans for the coming year in this Account, and would ask whether the Trust believe if they are realistic or achievable? To what extent will recruitment and staffing issues affect plans?
The Seven Day Services programme is a national programme and for these to come to fruition will take a number of years to achieve and staffing issues may have an impact on delivery which will be addressed at the Productive Services Oversight Board

We request that a national benchmark to be included for staff engagement scores .
This has been added

Patient Experiences the wording 'Episodes' to be changed to 'Admissions' as this simple miswording gives a negative effect from the onset.
This has been changed

Summary of changes made in receipt from Health Scrutiny Committee for Lincolnshire
Priority 7 - Demonstrating Values and Behaviours – The Committee would like further consideration to be given to the issue of flexible working arrangements, to assist recruitment. Progress in this area would support the enhancement of the Trust's reputation.
This is incorporated within the Trust's workforce strategy.

ANNEX 2

2021
A different Lincolnshire
A great ULHT

Excellence in rural healthcare

STATEMENT OF DIRECTORS' RESPONSIBILITIES

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, 2012 and 2017 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.

Jan Sobieraj
Chief Executive Officer

Elaine Baylis
Chair, Trust Board

ANNEX 3

2021
A different Lincolnshire
A great ULHT

Excellence in rural healthcare

GOVERNANCE STATEMENT

Annual Governance Statement 2017/18

Scope of responsibility
As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of United Lincolnshire Hospitals NHS Trust, to 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 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk
The Chief Executive, as the Accountable Officer (AO) for the Trust, is responsible for:
 The establishment and maintenance of effective corporate governance and internal control arrangements; and
 Being open and communicating effectively about the Trust's management of risks, both internally and externally.

The Medical Director, as the Executive lead for risk management is responsible for:
 Monitoring the consistent application of the Risk Management Policy throughout the Trust; and
 Retaining a suitable level of professional risk management expertise to support the effective implementation of the Policy.

Members of directorate management teams are responsible for:

The consistent application of the Policy within their areas of accountability;
 The management of specific risks that have been assigned to them and are recorded in the risk register, in accordance with the criteria set out in the policy; and
 Reporting on risk management matters as required to ensure that risk management performance can be monitored, assurance provided and risks escalated to a more senior level of management where appropriate.
All members of staff are responsible for:
 Applying the Policy to any relevant risk management undertaken in the course of their duties; and
 The completion of any risk management related mandatory core learning.

The risk and control framework
The basic principle at the heart of the Trust's risk management approach is that an awareness and understanding of risk should be used to inform decision making at all levels. This requires not only the active engagement of all staff with risk management activity in practice, but also the integration of risk management principles and techniques within the formal governance arrangements of the organisation. This approach will enable major strategic, policy and investment decisions to be made with a full and reliable appreciation of the risks associated with them as well as any existing risks that those decisions may serve to mitigate.

During 2017/18 following internal audit review and an external governance review the Trust identified significant weaknesses in it risk and control framework. The Trust appointed a new risk manager in early 2018 who has progressed improvements to the framework since appointment. These are now in the early stages of being embedded.

The Board Assurance Framework (BAF) is an important document that enables the Trust Board to maintain effective oversight of strategic risk management within the organisation. The Trust Board identifies and defines strategic risks to its objectives and assigns each of those risks to a lead non-executive assurance committee for routine review and evaluation.

The role of the lead assurance committee is to consider evidence provided by members of the Executive Team in relation to relevant corporate risks, to enable the committee to make an informed judgement as to the level of assurance that can be provided to the Trust Board and assess the overall extent of strategic risk exposure at that time.

The role of the audit committee is to consider the appropriateness and effectiveness of the BAF as a key component of the Trust's internal control arrangements.
A strategic risk is defined as a risk that is Trust-wide in scope and extreme in terms of its potential severity. These are the risks that would fundamentally destabilise the organisation if they were to materialise.

The BAF has been identified as an area of particular weakness, and was not fit for purpose in 2017/18. There are 4 key strategic risks defined within the BAF. Strategic risks are owned by the Trust Board, with responsibility for regular oversight being delegated to appropriate assurance committees. Relevant Key Risk Indicators (KRIs) were identified in relation to each strategic risk in the BAF. Reporting against these KRIs was included in regular management reports that provide the lead committees with evidence that associated corporate risks are being managed effectively. Lead assurance committees reviewed and challenged each corporate risk that is included in the BAF, to provide guidance and set expectations to support Trust management teams in developing and delivering their risk treatment strategies.

The Trust's risk appetite was not Board approved, therefore effective use was limited.
Quality governance arrangements have been reviewed following an external governance review and progress is being made to implement a new quality governance structure and improvement plans. The Integrated performance report is also under review in response to challenge from the Board about its adequacy to meet the Board's needs. Compliance with the CQC registration requirements are considered both by the Trust Board and quality governance committee through reporting from the quality and safety improvement board.

Risks to data security are specifically highlighted within the revised 2018/19 BAF. The treatment of these risks is through a cyber security plan and digital strategy which are reviewed at Audit Committee and Finance Service Improvement and Delivery Assurance Committee.

During 2017/18, the Trust, in common with many areas of the NHS experienced a cyber-attack. The WannaCry world-wide cyber-attack infected 230k computers in 150 countries within a day. It exploited weakness in Windows operating systems sharing and affected 23 PCs and 14 servers mainly at Lincoln.

The impact of this was that the majority of ICT services and networks across the Lincolnshire community were shut down to allow the Trust to clean-up the limited infection and ensure that there was no risk to our data. This resulted in some disruption to patient services in particular those that depend on the use of supporting functions that are heavily reliant on ICT systems such as diagnostics and pathology, with departments having to enact local business continuity plans. The cost of the cyber-attack in lost income to the Trust was £0.3m.

The Trust has subsequently prioritised the following actions to reduce the risk and potential impact of future attacks:
 Successfully bid for external central capital funding of £0.9m as well as prioritising cyber investment locally, resulting in a total of investment of over £1.2m
 Commenced a number of major ICT infrastructure projects
 Planned and prioritised further investment in 2018/19
 Completed two external assessments to help prioritise resources

The four key strategic risks to the organisation during 2017/18 that were the focus of consideration by the Trust Board and Executive were:
 The Trust financial position;
 The ability of the Trust to attract and retain staff;
 The condition of the Trust estate, including the fire enforcement issues; and
 Maintenance and replacement of equipment.

Significant clinical risks are also highlighted within the Trust Board Assurance Framework specifically:
 A significant, widespread deterioration in the quality and safety of nursing care impacting on a large number of patients across directorates;

A significant, widespread deterioration in the effectiveness of safeguarding practice impacting on the care of vulnerable people across directorates;
 A significant, widespread deterioration in safe medicines management practice impacting on a large number of patients across directorates; and
 An uncontrolled outbreak of serious infectious disease affecting a large number of patients, staff and visitors across directorates.
Managed and mitigated through:
 Clinical service structures & resources;
 Clinical governance arrangements at Trust, directorate & service levels;
 Clinical policies, procedures, guidelines, pathways, supporting documentation, audit programme & training;
 Clinical staff recruitment, induction, mandatory training, registration & re-validation;
 Quality & safety improvement planning process & plans;
 Defined safe staffing levels;
 Ward accreditation programme;
 Health, safety & security policies, guidance, monitoring and training;
 Patient experience policies, procedures, training and services; and
 Infection, prevention & control management framework.

The Trust was subject to an external governance review and in response to this appointed an Interim Director of Clinical Governance who commenced work revising the processes for the management of clinical risk. This has included strengthening of specialty governance arrangements and greater Executive oversight through performance review processes.
And outcomes assessed through:
- Number and severity of patient safety incidents;
- Number of Serious Incidents / Never Events;
- Number and severity of Healthcare Acquired Infections (HCAIs);
- Number and severity of safeguarding incidents;
- Number and severity of medication safety incidents;
- Harm free care rate;
- Hospital Standardised Mortality Ratio (HSMR);
- Number and type of complaints;
- Number and& severity of health and safety incidents;
- Friends and Family Test and patient feedback data;
- Delivery of constitutional standards;

The Trust self-assessed through a board development process in 2017/18 against the well led framework and has an action plan to deliver improvements. The Trust will also use the output from the CQC well led assessment when published (expected June 2018) to further support this assessment and identify actions.

The Trust had identified non-compliance with governance regulations and standards as a key risk within the Board Assurance Framework. The Board continue to focus on accessing support and strengthening the arrangements in place.

The Trust has been subject to a number of external reviews which led to the Board leading a review of its governance arrangements during 2017/18. The quality governance review has led to a new streamlined integrated approach being implemented under the leadership of the Medical Director. Reporting to the Audit Committee has been improved by the Director of Finance, Procurement and Corporate Affairs with regular assurance given in relation to compliance of internal control weaknesses, Board Assurance Framework and the Risk Management Improvement Plans. This process is in its early stages and continues to be embedded.
The Trust Board charges its assurance committees with providing upward reports highlighting areas of assurance in relation to risks to achievement of the strategic objectives. The Interim Chair has encouraged challenge and rigour at Board meetings around the reports presented and assurances given.

The primary objective of Risk Management policy is to establish the foundations for consistent and effective risk management to become embedded in routine management activity throughout the Trust. It sets out clear definitions, responsibilities, and essential management requirements that enable risks to be managed in a consistent manner throughout the organisation to support the delivery of safer, more efficient, more effective and more resilient services. The policy aims to support the Trust in delivering against corporate governance requirements for maintaining an effective internal control environment, as reviewed by internal and external audit.

Every directorate within the Trust is expected to make active use of the Datix risk register to support their management of risks. In addition, directorates provide a regular report on the content of their risk registers as part of the Trust's performance management arrangements.

The Trust is not fully compliant with the registration requirements of the Care Quality Commission. The Trust had conditions placed on its licence in February 2018 in relation to A&E services at Pilgrim Hospital.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. This includes equality impact assessments being required on all new Trust business cases, strategies and policy developments.

The Trust has undertaken risk assessments and carbon deduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

Modern Slavery and Human Trafficking Act 2015
The Trust's approach in meeting the requirements of the above Act has been to develop a statement in conjunction with the Trust's Head of Procurement. The provision of the statement is considered to be an element of the Trust's commitment and demonstration of the need to be aware of this requirement, and associated values relating to equality, diversity and community relations.

Review of economy, efficiency and effectiveness of the use of resources
The Trust was placed in financial special measures during 2017/18 and the Board has received assurance reports from the Finance, Service Improvement and Delivery Committee following its monthly review of Trust financial and operational performance. The Trust has appointed an external organisation to support in its delivery of an efficiency programme during 2017/18 and has been subject to regular review of this process by NHS Improvement and NHS England.

The Trust planning process ensured the annual plan incorporated the 2021 strategy, key strategic objectives prioritisation aligned with the Trust key risks and national performance standards, as well as financial planning and management.

The external organisation CHKS were engaged by the Trust to undertake a Data Quality and Income Review, and their report was provided in December 2017.

They concluded that:
'Based on our review of data quality and contractual arrangements at United Lincolnshire Hospitals NHS Trust we have identified £14,932,352 undercharge at the Trust if activity was billed appropriately to commissioners under national payment rules.

The main challenges identified through the risk assessment were:
 addressing data quality issues impacting on income, in particular the clinical coding of admitted patient care, and
 agreeing changes to local tariffs and classification of non-consultant led activity with commissioners.'

The Action plan arising out of this piece of work is being monitored by the Finance, Service Improvement and Delivery Committee and the Audit Committee.
The National Health Service Act 2006 requires that 'in auditing the accounts of any NHS trust an auditor must by examination of the accounts and otherwise satisfy himself that... (d) the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources'. External audit planning work involved an assessment against a number of criteria, including those issued by the National Audit Office, to identify any significant risks to the above conclusion. External Audit present to the Audit Committee any significant risks identified and the planned audit response for consideration by the Committee.

The Board receive reports from External Audit and Internal Audit through the Audit Committee and the Assurance Committees.

Recruitment and retention has become an increasing area for concern. The chart below shows vacancy rates for the Trust overall and separately for Medical staff (M&D), Registered Nurses (N&M Reg) and Allied Health Professionals (AHP) in the last 12 months. What this shows is an increasing vacancy rate from September 2017. This is in part driven by an increasing turnover rate, which has increased from 8.7% to 9.76% in the same period.

The recruitment market for many medical staff, some AHPs and Registered Nurses is challenging, as is recognised in the Draft NHS Workforce Strategy. This is exacerbated by the difficulty of recruiting to Lincolnshire. The Trust has invested in additional staff to support recruitment activity to traditional roles and is using agencies to recruit from both the UK and overseas.

Alongside this, we are looking at our overall workforce model and establishment and the introduction of new roles, to reduce the need for roles to which we find it hard to recruit. We are also focused on increasing retention levels. Whilst our overall turnover rate remains lower than equivalent Trusts, we will explore ways to improve the morale of our staff and retain them for longer.

Stakeholder engagement
We commenced a programme of engagement events with patients, members of the public, staff and other key stakeholders in year to help inform and develop the clinical and financial strategies as part of the 2021 programme, to support aspirations of moving out of both quality and financial special measures.

Information governance
The Trust had one level 3 information governance incident which was reported to the Information Commissioners Office in January 2018. The ICO were satisfied with action taken by the Trust.

Annual Quality Account
The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Steps which have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data include the following:
 The Medical Director is the Executive lead for the Quality Account with designated personal responsibility for patient safety and quality on behalf of the Trust Board.
 The Annual Quality Account Report 2017/18 provides a narrative of progress toward achieving the quality improvement indicators agreed by the Trust Board.
 The Trust has a robust process for scrutinising and revising local policies and monitoring compliance with NICE and other best practice guidelines. Annual audit programmes include the assessment of compliance with best practice guidance at both local and national level. This provides

assurances to the Board that the quality of clinical care is based on the best clinical practice recognised nationally and that policies are up to date, appropriate and meet legislative obligations.
 The Quality Account is compiled following internal and external consultation, in order to inform the improvement indicators. Data are provided by nominated Trust leads. These leads are responsible for scrutinising the data they provide to ensure accuracy. The Medical Director is ultimately accountable to the Trust Board and its committees for the accuracy of the Quality Account Report.
 The Quality Account is subject to challenge at the Quality Governance Committee on both substantive issues and data quality. Where variance against targets is identified, the leads for individual measures are held to account. Following scrutiny at this Committee, the Quality Account is reported to the Audit Committee and the Trust Board. The Board is required both to attest to the accuracy of the data and ensure that improvements against the targets are maintained.
 The Quality Account Report has been prepared in accordance with NHS Improvement's annual reporting guidance, as well as the standards to support data quality for the preparation of the Quality Report;
 Internal and external data audits are undertaken, focusing on data quality and associated process and procedures.

The quality reporting process is led by the Medical Director. The Quality Governance Committee reports directly to the Board on quality issues. It is working to ensure that appropriate assurance on quality governance is provided, in order to enable the Board and the Audit Committee to be satisfied on this area of internal control. The Quality Governance Committee is chaired by a Non-Executive Director.

The Quality Governance Assurance Committee has, on behalf of the Board, sought assurances relating to the Quality Account. The independent auditors present an assurance report to the Trust Board following their review.

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.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports including:

- Internal Audit Reports
- Head of Internal Audit Opinion
- External Audit Reports
- Internal and External Peer Reviews
- Clinical Audit Reports
- Patient Surveys

• Staff Survey
• Care Quality Commission Intelligent Monitoring
• Senior Leadership Walk-rounds
• Care Quality Commission – registration and reports
• Equality and Diversity Reports
• General Medical Council Reports

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, the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board
The Board have received assurance reports from the Audit Committee, Quality Governance Assurance Committee, Finance, Service Improvement and Delivery Assurance Committee and Workforce and OD Assurance Committee as well as considering the Trust Integrated Performance Report and Board Assurance Framework. The Board continue to direct their work to improve the identified weaknesses in the control framework and governance arrangements.
The Audit Committee
The Audit Committee have advised the Board on the effectiveness of the systems of control through their upward report to the Trust Board. The Committee have considered the Board Assurance Framework and the risk improvement plans and have monitored the delivery of internal and external audit plans.

Clinical Audit
During 2017/18 the Trust participated in 91% of possible national clinical audits and all of the national confidential enquiries in which it was eligible. The Trust benefitted from participating in gaining assurance that the services delivered are safe and effective, and outcomes were good based on evidenced based practice and standards of care.
Internal Audit

The Head of Internal Audit provided an opinion of Limited Assurance for the Trust and reported that there were weaknesses in the design and / or inconsistent application of the framework of governance, risk management and control that could result in failure to achieve the organisation's objectives. The Opinion was based on a review of the systems of internal control, primarily through the operation of the Board Assurance Framework in the year to date, the outcome of individual assignments completed and the Trust response to recommendations made. A moderate assurance was given in terms of follow up actions and outturn internal audit plan, but only limited assurance in respect of design and operation of the BAF

The opinion acknowledged that the senior management team has taken steps to establish a stronger framework for the Trust to operate within. Specifically action was being taken to strengthen focus on areas of governance and risk management. This represented some of the fundamental control arrangements required if the Trust was to establish a strong position from which to achieve its strategic objectives. Progress was starting to show through in improved implementation rate of audit actions at follow up. However, at this point in time although the Trust was establishing a sound base to set a positive path to improvement and had people in place to take this forward, this had yet to become embedded and achieve improved outcomes. The audit plan for 2018/19 continues to have focus in key areas that assist the Trust in establishing a robust second line of defence.

The Trust remains in special measures for quality following a CQC inspection in October 2016.

Conclusion
During the year the Trust identified the following significant control issues:

The Trust remained in special measures following a CQC inspection in October 2016 which assessed the Trust as inadequate and highlighted a range of issues which it needed to tackle. Following the 2016 inspection the Trust implemented a quality and safety improvement programme, a further well led inspection was carried out by the CQC in April 2018, the result of this review is still awaited.

The Trust has continued to face significant financial challenges which are expected to continue during 2018/19. In September 2017 the Trust was placed in Financial Special Measures.
The Lincolnshire health system faces a significant financial challenge, both now and in the longer term. Local health and social care organisations continue to work together to identify ways in which we can collaborate to meet this challenge. The Local Health Economy work continues to deliver the Sustainability and Transformation Partnership (STP). Partners across the local health and care system have agreed to work together to deliver the STP.
The plan for Lincolnshire covers hospital services, community healthcare, mental health, social care and GP services. It has been developed by all local NHS organisations, including ours, and addresses the issues highlighted in the Lincolnshire Sustainability and Transformation Partnership (October 2016) which showed that local needs are growing and changing, demand on health services is increasing, the current system does not meet the standards of care we aspire to as a health system and our collective financial challenge is significant and growing.

The Trust also faces operational pressures with increasing demand. The organisation saw growth in A&E attends of 2%, urgent 2 week wait referrals 5.5% and increased GP referrals 3.8%. This is particularly difficult to deliver when many services have workforce or infrastructure challenges. As a result constitutional standards have not been met.

The Trust has significant recruitment and retention challenges, partly due to being in a large rural health system. The additional impact of working in a challenged organisation leads to an increasing reliance on agency staff to maintain services, this in turn increasing the challenge to improve quality. The Trust has been subject to fire enforcement notices for its Lincoln County Hospital and Pilgrim Hospital Boston sites.

Overall, the Trust is clear on the issues and good progress has been made in developing and implementing improvement plans, however it is recognised that there is significant weakness in the current governance arrangements. The reason behind many of the issues is historical and there are many reasons for this - most notable are: the difficulty in attracting staff resulting in some difficult decisions for some services (notably Emergency Department), demand and acuity, geographical dispersement of sites, poor condition of the historical estate, and effective partnership working. 17/18 was a year of building foundations and 18/19 will make further progress in improving governance through several vehicles, e.g. 2021 strategy development and working actively in partnership with the STP on an Acute Services Review.

Of particular note, governance arrangements will be strengthened. The Board Assurance Framework is being refreshed for both format and content to ensure it is fit for purpose. The Committee and organisation structure will be reviewed to make necessary changes to effectively provide assurance and drive improvements. The Trust has adopted an Enterprise Risk Management (ERM) framework as the basis for the structure of its risk registers.

It is expected these actions will support the aspirations and ambition into the new year.

Signed……..
Chief Executive Date: 25th May 2018

ANNEX 4

2021
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Excellence in rural healthcare

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

We are required to perform an independent assurance engagement in respect of United Lincolnshire Hospitals NHS Trust's Quality Account for the year ended 31 March 2018 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011, the National Health Service (Quality Account) Amendment Regulations 2012, the National Health Service (Quality Account) Amendment Regulations 2017. This is supplemented by subsequent amendments to Quality Account Regulation and content as outlined by NHS Improvement ('NHSI') in their letter to NHS trusts, dated 26 January 2018 'Quality Accounts: reporting arrangements'. These documents will be referred to as "the Regulations".

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following indicators, marked with the symbol Ⓐ in the Quality Account:

- rate of clostridium difficile infections - page 75 in the quality account; and
- percentage of patients risk-assessed for venous thromboembolism (VTE)- pages 75 and 76 in the quality account.

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

Respective responsibilities of Directors and auditors

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 does not incorporate the matters required to be reported on as specified in the NHS Choices Auditor Guidance 2014-15 and the the National Health Service (Quality Account) Regulations 2010, National Health Service (Quality Account) Amendment Regulations 2011,the National Health Service (Quality Account) Amendment Regulations 2012 and the National Health Service (Quality Account) Amendment Regulations 2017 (together the "Regulations"), and NHS Improvement updates on content as set out in their letter to Trusts dated 26 January 2018 'Quality Accounts: reporting arrangements 2017/18';
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not stated in all material respects in accordance with the criteria set out on page 42 (Percentage of patients risk-assessed for venous thromboembolism (VTE)) and page 43 (Rate of clostridium difficile infections) of the NHS Choices Auditor Guidance 2014-15 (issued by DH) 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 2017 to April 2018;
- papers relating to quality reported to the Board over the period April 2017 to April 2018;
- Minutes from the Quality Governance Committee dated 11th January 2018 and 17th April 2018 or the period April 2017 to the date of signing the limited assurance report;
- Feedback from the Commissioners: Lincolnshire Federated Clinical Commissioning Group Quality Function Statement, dated 04/06/2018;
- Feedback from the Healthwatch Lincolnshire Quality Account Working Group, dated 09/05/2018;
- Feedback from Overview and Scrutiny Committees: Lincolnshire County Council Scrutiny Committee, dated 08/06/2018;
- The Trust's complaints report: United Lincolnshire Hospitals NHS Trust Scorecard Report, dated April 2018;
- Local and national NHS patient surveys: Emergency Department survey, dated 17/10/2017; Maternity Inpatient survey, dated 30/01/2018; and Children and Young People Inpatient Survey, dated 28/11/2017;
- The 2017 national NHS staff survey: 2017 National NHS staff survey results from Lincolnshire Hospitals NHS Trust;
- Care Quality Commission inspection report: United Lincolnshire Hospitals NHS Trust Quality Report, dated 11/04/2017;
- Results of the Payment by Results coding review: Audit Letter on the CHKS audit, dated 23/02/2018; and
- The Head of Internal Audit's draft annual opinion over the Trust's control environment dated May 2018.

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 in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000 (Revised)'). Our limited assurance procedures included:

- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Trust in preparation of the specified indicators;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- 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 – The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

At United Lincolnshire Hospital NHS Trust, VTE assessments are completed on paper forms. A clinician then completes an electronic proforma on the patient information system to indicate that an assessment has been completed. If the electronic proforma is completed on the patient information system, then that case is reported as having a VTE assessment completed. The paper form contains the details of what has been assessed, by whom and when, and is stored in the patient's paper notes.

We sampled 15 assessments to check the assessment had been completed and subsequently reported correctly. From this sample we found one instance where the paper assessment had not been completed adequately: there were omissions where information relevant to the patient's health and status should have been documented. In addition, the date this assessment was completed was illegible. As a result, we are unable to determine whether a VTE assessment had been completed for this case. The Trust was not able to confirm this issue is isolated to this one case, and that the issue is not replicated across all assessments reported as completed.

In addition, we reconciled the detailed population for the indicator against the national criteria and locally approved exclusions permitted by the guidance, and found evidence that cohorts of patients had been incorrectly excluded from the need to have a VTE assessment completed during the year. Therefore, in some cases, patients have not had a risk assessment completed when they should have.

Where patients are excluded from the need to have a VTE assessment completed, these should not be reported in either the numerator or denominator, as they are exempt. However, at the Trust, patients who are exempt and do not require a VTE assessment to be completed have been included in both the numerator and denominator figures. This has the impact of showing the Trust has completed more assessments than it actually has and has distorted the reported percentage of patients risk-assessed for VTE. The Trust is unable to quantify the extent of the impact.

Conclusion including disclaimer of conclusion on VTE indicator

In our opinion, because of the significance of the matters described in the Basis for Disclaimer Conclusion paragraph, we have not been able to form a conclusion on the VTE indicator.

Based on the results of our procedures nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Account does not incorporate the matters required to be reported on as specified in the NHS Choices Auditor Guidance 2014-15 and the National Health Service (Quality Account) Regulations 2010, National Health Service (Quality Account) Amendment Regulations 2011,the National Health Service (Quality Account) Amendment Regulations 2012 and the National Health Service (Quality Account) Amendment Regulations 2017 (together the "Regulations"), and NHS Improvement updates on content as set out in their letter to Trusts dated 26 January 2018 'Quality Accounts: reporting arrangements 2017/18';
- the Quality Account is not consistent in all material respects with the documents specified above; and

- the "rate of clostridium difficile infections" has not been stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the NHS Choices Auditor Guidance 2014-15 (issued by DH).

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Donington Court,
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Date: 28 June 2018.

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