# ULHT QUALITY ACCOUNT 2019-20

NHS
United Lincolnshire Hospitals
NHS Trust

OUTSTANDING CARE
personally DELIVERED

# GLOSSARY OF ABBREVIATIONS

| | |
|---|---|
| **A&E** | Accident and Emergency |
| **AAA** | Aortic Abdominal Aneurysm |
| **BAF** | Board Assurance Framework |
| **BTS** | British Thoracic Society |
| **CABG** | Coronary Artery Bypass Graft |
| **CAF** | Cyber Assessment Framework |
| **CCG** | Clinical Commissioning Group(s) |
| **COPD** | Chronic Obstructive Pulmonary Disease |
| **CPA** | Care Programme Approach |
| **CQC** | Care Quality Commission |
| **CQUIN** | Commissioning for Quality and Innovation |
| **CRN** | Clinical Research Network |
| **DATIX** | Incident Reporting System |
| **DNACPR** | Do Not Attempt Cardiopulmonary Resuscitation |
| **DSP Toolkit** | Data Security and Protection Toolkit (DSP Toolkit) |
| **DToC** | Delayed Transfer of Care |
| **DVT** | Deep Vein Thrombosis |
| **ED** | Emergency Department |
| **eDD** | Electronic Discharge Document |
| **EMAS** | East Midlands Ambulance Service |
| **ECIST** | Emergency Care Intensive Support Team |
| **FFAP** | Falls and Frailty Audit Programme |
| **FFT** | Friends and Family Test |
| **GDH** | Grantham District Hospital |
| **GIRFT** | Getting It Right First Time |
| **GP** | General Practitioner |
| **HES** | Hospital Episode Statistics |
| **HQIP** | Health Quality Improvement Partnership |
| **HSMR** | Hospital Standardised Mortality Ratio |
| **IBD** | Inflammatory Bowel Disease |
| **ICNARC** | Intensive Care National Audit and Research Network |
| **ICS** | Integrated Care System |
| **IG** | Information Governance |
| **IIP** | Integrated Improvement Plan |
| **IP&C** | Infection Prevention and Control |
| **IVAB** | Intravenous Antibiotics |
| **KPI** | Key Performance Indicator |
| **LCH** | Lincoln County Hospital |
| **LCRF** | Lincoln Clinical Research Facility |
| **LeDeR** | Learning Disability Mortality Review Programme |
| **LOS** | Length of Stay |
| **LUCADA** | Lung Cancer Audit (National) |
| **MADE** | Multi-Agency Discharge Event |
| **MBRACE** | Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries |
| **MCA** | Mental Capacity Act |
| **MDT** | Multi-Disciplinary Team |
| **MI** | Myocardial Infarction |

| | |
|---|---|
| **MINAP** | Myocardial Infarction National Audit Programme |
| **MoRAG** | Mortality Review Assurance Group |
| **MorALS** | Mortality Assurance and Learning Strategy Group |
| **N/A** | Not Applicable |
| **NBCA** | National Bowel Cancer Audit |
| **NCEPOD** | National Confidential Enquiry into Patient Outcomes and Death |
| **NHS** | National Health Service |
| **NHSi** | National Health Service Improvement |
| **NHSLA** | National Health Service Litigation Authority |
| **NIS** | Network and Information Systems |
| **NICE** | National Institute for Health and Care Excellence |
| **NICOR** | National Institute for Cardiovascular Outcomes Research |
| **NIV** | Non-Invasive Ventilation |
| **NJR** | National Joint Registry |
| **NMC** | Nursing and Midwifery Council |
| **NNAP** | National Neonatal Audit Programme |
| **NPCA** | National Prostate Cancer Audit |
| **NIHR** | National Institute for Health Research |
| **NRLS** | National Reporting Learning System |
| **NVD** | National Vascular Database |
| **PALS** | Patient Advice and Liaison Service |
| **PbR** | Payment by Results |
| **PHB** | Pilgrim Hospital Boston |
| **PHSO** | Parliamentary and Health Service Ombudsman |
| **PICANet** | Paediatric Intensive Care Audit Network |
| **PROMs** | Performance Reported Outcome Measures |
| **QGC** | Quality Governance Committee |
| **QSIR** | Quality, Service Improvement and Redesign |
| **QSOG** | Quality and Safety Oversight Group |
| **RCEM** | Royal College of Emergency Medicine |
| **RCP** | Royal College of Physicians |
| **RCT** | Randomised Control Trials |
| **ReSPECT** | Recommended Summary Plan for Emergency Treatment |
| **RTT** | Referral to treatment |
| **SHMI** | Standardised Hospital-Level Mortality Indicator |
| **SHOT** | Serious Hazards of Transfusion |
| **SOF** | Single Oversight Framework |
| **SOP** | Standard Operating Procedure |
| **SQD** | Safety Quality Dashboard |
| **SSNAP** | Sentinel Stroke National Audit Programme |
| **STP** | Sustainability and Transformation Programme |
| **TARN** | Trauma Audit Research Network |
| **TOM** | Trust Operating Model |
| **UEC** | Urgent and Emergency Care Programme |
| **ULHT** | United Lincolnshire Hospitals NHS Trust |
| **VTE** | Venous Thromboembolism |
| **WTE** | Whole Time Equivalent |
| **7DS** | Seven Day Services |

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## PART 1



## PART 2



## PART 3

NHS
United Lincolnshire Hospitals
NHS Trust

# PART 1

OUTSTANDING CARE
personally DELIVERED

# CHIEF EXECUTIVE'S STATEMENT

Welcome to the Quality Account for United Lincolnshire Hospitals NHS Trust for 2019-20. This document provides an overview of all of the activity that has been taking place within our hospitals to improve quality over the last year.

During the year, we continued to monitor and improve the quality of care that we provide, whilst we remained in quality special measures. We still have more to do but our excellent improvement in mortality rates is an example of where we've made a huge difference. From being flagged as having a high Hospital Standardised Mortality Ratio (HSMR), this year we recorded our lowest ever HSMR and were one of the best performers in the country - a great achievement.

Elsewhere, the year has been very challenging for Lincolnshire's hospitals, with difficulties meeting some of the NHS constitutional standards, continuing financial challenges and record levels of A&E attendances over the winter.

Our new Trust Operating Model (TOM) which is a clinically led Trust operating model was launched at the beginning of the year which has seen us restructure and bring in new senior management capability to help address these challenges and standardise practice across all of our sites and services.

In addition, the results of our most recent Care Quality Commission (CQC) inspection from June and July 2019 rated the Trust as 'Requires Improvement' overall - the same rating it received following the last inspection in 2018.

The CQC recognised that whilst improvements have been made in some areas, there is still much more that needs to be done and we remain in quality special measures for the time being. We also remain in financial special measures as our financial position has not improved.

Many of the issues identified by the CQC and others are around our staffing shortages, estates issues, lack of digital maturity, governance processes and financial pressures. It is also clear that we need to focus on recruitment, leadership, staff training and competencies, staff engagement and addressing workforce inequalities going forward.

We also had the results of an unannounced CQC inspection at our A&E departments at Lincoln County Hospital and Pilgrim Hospital, Boston in January 2020. Overall, both departments were rated as 'Inadequate', the same as they were following our previous inspections.

The report acknowledges the amount of pressure that both departments have been under over the last few months, but also unfortunately identifies a number of areas where inspectors felt significant improvements need to be made. Work is already underway to address the highlighted issues.

We have also seen a number of positive improvements and developments during the year. We have put extensive efforts into improving the involvement and engagement of our staff, which resulted in a record response rate to the National NHS Staff Survey, and some improvements in the results across some areas. We have also achieved our long-held objective of becoming a Smokefree Trust, which we believe is the right thing to do for our staff, patients and visitors.

In August we had a visit from Prime Minister Boris Johnson, who pledged £21.3 million for a new urgent and emergency care unit at Pilgrim hospital, and we continued with our £35 million investment in fire safety measures across our sites, which have really transformed the look and feel of our hospital buildings.

From April 2020, the Trust's new Integrated Improvement Plan will be launched and looks to simplify our ambition as an organisation and how we will work together to improve for the future. Part of this is to provide a simple vision, which is to provide 'Outstanding care, personally delivered'.

We believe that we are moving in the right direction and that, with our excellent staff, we can really make the changes needed to improve the quality and safety of care that we deliver to the people of Lincolnshire.

During March 2020, a global outbreak of Coronavirus (COVID-19) initiated a national incident across the UK. For Lincolnshire's hospitals this meant we had to implement a range of measures to ensure we were prepared for a potential surge in the number of patients we might see. We continue to work closely with national health bodies to inform our plans and ensure that both our patients and staff remain safe and well-cared for.

With NHS Trusts focused on responding to the COVID-19 pandemic, we are not expected to obtain assurance from our external auditor on our quality account for 2019/20.

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.

Andrew Morgan

Chief Executive

# PRIORITIES FOR IMPROVEMENT IN 2020-21

**Deciding our quality priorities for 2020-21**

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

We have ensured that our quality priorities are aligned with this year's Trust's Integrated Improvement Plan (IIP), Lincolnshire-wide system quality priorities and our Commissioning for Quality and Innovation (CQUINs). 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 some of the key areas that were raised in the CQC report published in October 2019.

The following improvement priorities for the Trust have been identified for particular focus in 2020-21. These priorities may be extended over the coming years to ensure they are fully embedded within our organisation. All of the priorities have been selected as they are really important for patient experience and they all encompass the Care Quality Commission(CQC) domains as demonstrated below.

# PRIORITY 1 – CARE OF RESPIRATORY PATIENTS

**Why have we selected this Priority?**

Respiratory disease affects one in five people and is the third largest cause of death in England (after cancer and cardiovascular disease). Hospital admissions for lung disease have risen over the past seven years at three times the rate of all admissions generally.

Respiratory diseases are a major factor in winter pressures faced by the NHS; most respiratory admissions are non-elective and during the winter period these double in number.

The annual economic burden of asthma and COPD on the NHS in the UK is estimated as £3 billion and £1.9 billion respectively. In total, all lung conditions (including lung cancer) directly cost the NHS in the UK £11billion annually.

Incidence and mortality rates from respiratory disease are higher in disadvantaged groups and areas of social deprivation, with the gap widening and leading to worse health outcomes. The most deprived communities have a higher incidence of smoking rates, exposure to higher levels of air pollution, poor housing conditions and exposure to occupational hazards.

**Our Current Status**

The Getting it Right First Time (GIRFT) national team, visited United Lincolnshire Hospitals NHS Trust to review respiratory services on 27th November 2019.

The ambition of the GIRFT programme is to identify examples of innovative, high quality and efficient service delivery. Conversely, it also looks at areas of unwarranted variation in clinical practice and / or divergence from the best evidence-based care. The work culminates in a set of national recommendations aimed at improving the quality of care and reducing expenditure on complications, litigation, procurement and inappropriate treatments.

Two of the areas identified by the GIRFT national team for improvement within respiratory medicine were:

- Non-Invasive Ventilation (NIV) services and NIV in-reach into A&E.
- Management of Chronic Obstructive Pulmonary Disease (COPD), asthma and pneumonia patients.

**What will success look like?**

To deliver against the GIRFT recommendations the following will be implemented:

- Our NIV services are in line with national standards and patient outcomes monitored.
- 25% increase in patients having their blood gas checked 2 hours post commencement of NIV.
- 25% increase in patients having their NIV commenced within 1 hour at the Lincoln site.
- A Trust-wide options appraisal for in-reach NIV service to A&E will be developed – this is inclusive of identifying and managing patients with COVID-19.
- A competency framework for A&E staff.
- 100% of ward staff to have completed their NIV competencies.
- Trust-wide protocol fast track pathway for NIV to meet British Thoracic Society (BTS) standards.
- The asthma service will be reviewed.
- Asthma pathway to be process mapped.
- Asthma bundles are aligned to national guidance and patient outcomes monitored.
- Pathway standardised operating procedure (SOP) for asthmatic patients will be developed and implemented.
- 100% of asthma patients to have been referred to a Respiratory Specialist within 24 hours (Monday – Friday).

**How will we monitor progress?**

In response to the GIRFT visit and recommendations the Trust has developed a Respiratory Improvement Group to manage and implement the improvements suggested.

A quarterly report will be presented at Patient Safety Group.

A quarterly report will be presented at Quality Governance Committee on the progress of their milestones.

Ongoing submission of data for national asthma and COPD audit programme.

# PRIORITY 2 – SAFE DISCHARGE OF OUR PATIENTS

**Why have we selected this Priority?**

Unnecessarily prolonged stays in hospital are bad for patients. This is due to the risk of unnecessary waiting, sleep deprivation, increased risk of falls and fracture, prolonging episodes of acute confusion (delirium) and catching healthcare-associated infections. All can cause an avoidable loss of muscle strength leading to greater physical dependency (commonly referred to as deconditioning). Tackling long stays in hospital reduces risks of patient harm, disability and unwarranted cost, particularly for those who are intrinsically vulnerable because they have mild or moderate frailty and/or cognitive disorder, and for whom a different, more positive outcome can be achieved if the right steps are taken very early in their admission.

A 'Delayed Transfer of Care' (DToC) occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice. DToCs can cause considerable distress and unnecessarily long stays in hospital for patients.

A 25% increase in reported DTOC days across England from 2015-16 to 2016-17 has resulted in pressure to reduce delays, with national targets and requirements set by the Department of Health.

Estimates from the National Audit Office (NAO) amount the cost to the NHS for delayed discharges to be around £800 million a year.

The proportion of delayed transfers due to social care has risen steeply since 2014, but the majority of delays (58% in 2016-17) are still attributed to the NHS.

Numerous studies have shown that effective action by hospitals to improve patient flow beyond A&E has the greatest impact on length of stay. Whole system collaboration to expedite discharges is also important.

**Our Current Status**

As an organisation we have struggled with continuing operational pressures that have seen our hospitals in and out of level three and four escalation status and using escalation beds for many months. Average bed occupancy at ULHT is consistently over 92% (and tends to be higher in winter months). NHS England advises that Trusts should keep bed occupancy below 92%. 85% is sometimes cited as the maximum safe level of occupancy.

We need to change the way we deliver services to ensure we are able to provide safe, quality care that improves the patient's experience and at the level of efficiency which our commissioners and the general public demand of us. Discharge planning needs to be started on admission to enable effective discharge plans to be initiated and families / carers are involved.

It is hoped that DToC rates can be improved through system working with health and social care partners to improve discharge processes, including system wide electronic demand and capacity monitoring, and the implementation of the NHS Trusted Assessor model for patients discharged to care homes. ULHT also has a discharge team working seven days a week.

A number of key initiatives have been adopted at ULHT to minimise discharge delays and to improve the discharge experience for our patients. The 'SAFER' patient flow bundle, 'Red2Green days', long length of stay reviews and '10 by 10' have been shown to reduce the length of stay of those admitted.

It is hoped that implementing these initiatives will allow us to recognise and unblock discharge delays, improve discharge preparedness and reduce bed occupancy which will improve patient safety and experience.

**What will success look like?**

- Improved patient flow across the system as per timetable.

- Reduced length of stay (LOS).
- Increased proportion of patients discharged before 10am.
- Reduced DToC rate.
- Reduced ward moves for new patients admitted.
- Increased proportion of patients discharged with their electronic discharge document (eDD).
- SAFER Patient Flow Bundle utilised in all wards.
- Multi Agency Discharge Event (MADE) strategy to be implemented on a permanent basis and MADE events to be held with system partners.
- Fewer incidents relating to unsafe discharge.
- Lincolnshire Collaborative will meet 6 weekly to review inappropriate admissions and work with our system partners to reduce these.
- Our SHMI data will be analysed to identify themes for patients who die within 30 days of discharge.

**How will we monitor progress?**

There is a Discharge working group who have developed work streams to address the areas that required improving.

A quarterly report will be presented at Patient Safety Group.

A quarterly report will be presented at Quality Governance Committee on the progress of their milestones.

# PRIORITY 3 – CARE OF THE DETERIORATING PATIENT

**Why have we selected this Priority?**

Patients who are admitted to hospital believe that they are entering a place of safety, where they, and their families and carers, have a right to believe that they will receive the best possible care. They feel confident that, should their condition deteriorate, they are in the best place for prompt and effective treatment. NICE guideline CG50 states that there is evidence to the contrary. Patients who are, or become, acutely unwell in hospital may receive suboptimal care. This may be because their deterioration is not recognised, or because despite indications of clinical deterioration it is not appreciated, or not acted upon sufficiently rapidly. Communication and documentation are often poor, experience might be lacking and provision of critical care expertise, including admission to critical care areas, delayed.

While escalation of the deteriorating patient may be appropriate for the majority of our inpatients, it must also be recognised that part of planning effective care should also involve the recognition of care ceilings and which treatments should be offered or indeed accepted by patients. ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices.

Sepsis is a complex condition associated with poor outcomes when the diagnosis is delayed and treatment is not started promptly and in the context of the deteriorating patient has many human and environmental factors that may impede timely delivery of treatment.

Maintenance of an adequate fluid balance is vital to health. Inadequate fluid intake or excessive fluid loss can lead to dehydration, which in turn can affect cardiac and renal function and electrolyte management. Inadequate urine production can lead to volume overload, renal failure and electrolyte toxicity.

## Our Current Status

ReSPECT was introduced in ULHT in February 2019 and is now widely used throughout the Trust, it was intended to be used to address some of the concerns in effectively planning emergency care and treatment plans for patients. Audit work carried out within the Trust demonstrates it is commonly used as a DNACPR tool rather than for all care and treatment decisions and further work must be completed in order to maximise its full potential as an advanced care planning document.

Trust –level audit data from the Safety Quality Dashboard (SQD):

| Metric Title | Nov-2019 | Dec-2019 | Feb-2020 |
|---|---|---|---|
| Number of ReSPECT forms | 108 | 99 | 108 |
| Capacity and representation completed | 86.9% | 83.8% | 88.9% |
| Demographics correct (including date) | 98.1% | 98.0% | 94.4% |
| Patient/family/carer involved (or reason evident) | 91.6% | 90.9% | 95.3% |
| Summary of relevant information completed | 100.0% | 98.0% | 100.0% |
| Full explanation and record of names | 72.9% | 77.8% | 72.0% |
| Name of person involved in the making of the plan | 78.5% | 80.8% | 74.8% |
| Personal preferences completed | 82.7% | 88.1% | 87.3% |
| Clinician details completed | 97.2% | 99.0% | 100.0% |
| Clinical recommendations, care & treatment completed | 84.3% | 88.9% | 89.8% |
| Countersigned by senior clinician within 24 hours | 89.0% | 85.9% | 95.5% |
| CPR recommendations made and signed by a clinician | 100.0% | 100.0% | 100.0% |

Sepsis compliance has improved however, the Trust is not consistently achieving the 90% target for screening and administering IVAB within 1 hour. The Trust results as of February 2020:

| | |
|---|---|
| Sepsis screening compliance for inpatients (adult) | 88.5% |
| Sepsis screening compliance for inpatients (child) | 82.0% |
| IVAB within 1 hour for sepsis for inpatients (adult) | 90.1% |
| IVAB within 1 hour for sepsis for inpatients (child) | 91.0% |
| Sepsis screening compliance in A&E (adult) | 91.5% |
| Sepsis screening compliance in A&E (child) | 86.6% |
| IVAB within 1 hour for sepsis in A&E (adult) | 94.0% |
| IVAB within 1 hour for sepsis in A&E (child) | 100% |

## What will success look like?

- Early detection and treatment of deteriorating patients. 100% clinical members of the resuscitation team to be identified as a potential instructor for the Intermediate Life Support (ILS) course to maximise number of available instructors across all sites, thereby increasing potential course enrolments.

- Acute Illness Management (AIMs) course adopted within the Trust, and all four senior resuscitation practitioners will become full instructors to deliver this course.

- 90% compliance for sepsis 6.

- Improve sepsis learning throughout the Trust with the introduction of a train the trainer scheme. Assessment criteria to be formulated for trainers to be examined against to maintain repeatable standards across the Trust.

- Introduce a fluid balance e-learning package for non-registered staff.

- Effective process for Trust and system wide dissemination to share learning and joint working. This will be overseen by the deteriorating patient group.

- ReSPECT process is being utilised across the Trust and becoming embedded into practice. To audit compliance on 10 sets of notes within the emergency admission wards to improve quality.

**How will we monitor progress?**

There is a Deteriorating Patient working group who have developed work streams to address the areas that required improving.

A quarterly report will be presented at Patient Safety Group.

A quarterly report will be presented at Quality Governance Committee on the progress of their milestones.

# PRIORITY 4 – DELIVERING HARM FREE CARE: DEVELOPING OUR SAFETY CULTURE

**Why have we selected this Priority?**

High reliability organisations are able to deliver effectiveness, efficiency and safety despite them having the potential for high risk and harm and they minimise errors through teamwork, awareness of potential risk and constant improvement. This involves not only preventing errors or failures, but also learning quickly and taking action to prevent reoccurrence. As a healthcare organisation, ULHT is constantly dealing with complex situations and is exposed to significant risk, therefore adopting the principles of a high reliability organisation will be a key part of our approach to creating a culture of safety.

Using a high reliability approach will enable us to develop, implement and embed a safety culture which will ensure that all our staff understand, collaborate, develop and share learning in relation to patient safety across the organisation. It will support our staff to consistently ensure and maintain the safety of our patients and to feel able to report incidents without fear of reprisal; to question practice or resources and feel that they work in an environment of learning, openness and transparency.

**Our Current Status**

ULHT has recognised that a key step in becoming a high reliability organisation is to change our safety culture as currently we do not have the conditions required to consistently ensure and maintain the safety of our patients or for staff to understand, collaborate, develop and share learning in relation to patient safety across the organisation.

The Trust had ten Never Events for 2019-20. An audit was conducted in January 2020 to review compliance with the WHO Surgical Safety Checklist which demonstrated a lack of clarity and consistency across ULHT policies and SOPs which are open to local interpretations.

Improving patient safety by learning from adverse events will encourage a safety culture throughout the organisation. It will also ensure that we can demonstrated sustained changes in practice occur.

The CQC have highlighted that we need to improve learning from incidents. Our Staff survey scores for questions that are used for the ‘safety culture theme’ are below national average and relatively static.

**What will success look like?**

- To move towards becoming a high reliability organisation by focusing on surgical / invasive procedures and safe clinical use of medicines (prescribing and administration).

- Deliver the requirements of the National Patient Safety Strategy for 2020-21.

- Have a theatre safety group to ensure safe care is delivered and to protect our patients from errors, injuries, accidents and infections.

- There will be a programme of enhanced safety visits / safety conversations in Theatres to empower our staff to review redundant or flawed systems and processes to empower our staff to discuss redundant or flawed systems and processes.

- A safety culture survey (from a recognised provider) will be undertaken in Theatres and Emergency Departments.

- Introduce new mechanisms and ways to improve how learning and continuous improvement is shared and spread.

- There will be zero surgical Never Events.

**How will we monitor progress?**

A theatre safety group will develop work streams to address the areas that required improving.

A quarterly report will be presented at Quality Governance Committee on the progress of their milestones.

# PRIORITY 5 – INFECTION PREVENTION AND CONTROL

**Why have we selected this Priority?**

As the national post COVID-19 priority moves through the Restore and Recovery phases, Infection Prevention and Control (IPC) excellence has been identified as one of the key drivers of quality and safety and is at the heart of all forward planning for ULHT. Patients should be cared for on clean and safe environments and by staff who are well trained and supported.

The hygiene code forms the basis of the required standards for IPC in all registered organisations and sets out the ten overarching criteria that ULHT will aspire to achieve embedded compliance to. The hygiene code is comprehensive and there is a significant piece of work to fully understand our true position against compliance.

**Our Current Status**

We are currently in the process of assessing our embedded compliance position against the hygiene code standards. This is a lengthy process as there are over 150 compliance items to be assessed.

As a Trust we are asking a question of each compliance item:

- Can we demonstrate that we have assurance of embedded compliance?

Where any gaps are identified, a robust, risk based plan of action will be produced.

**What will success look like?**

Having oversight, control and ownership of every line item within the hygiene code is the aim. Success will be a detailed and robust plan of action with key milestones for delivery. The milestones will be set to ensure progress is maintained. Once the plan and timescales have been agreed they will be added to the annual work plan for monthly assessment.

- 90% return rate and 95% compliance of the metrics for the Front Line Ownership (FLO) audit.

- 95% return rate and 95% compliance of metrics for the hand hygiene audit.

- 100% of policies to be update (total of 27 policies).

- 5% reduction in all Healthcare Associated Infection (except COVID-19).

**How will we monitor progress?**

The Trust will monitor progress monthly through a report to the Infection Prevention and Control Group chaired by the Director of Infection Prevention and Control.

An upward report will be presented to the board for quality and assurance oversight.

# LOOKING BACK: PROGRESS MADE SINCE PUBLICATION OF 2018-19 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 2019-20 these were:-

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

**Introduction**

The Quality Account for 2018-19 outlined the Trust's proposed quality improvements for the year ahead (2019-20). These priorities were identified following engagement with patients, the public, staff and external stakeholders. During the year 2019-20 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 we will have defined work streams to enable the Trust to deliver on the improvements not achieved in 2019-20.

The Trust has not fully achieved all its priority ambitions however there is evidential progress in several areas with sustained patient safety improvements. We set ourselves ambitious targets and have achieved 92% of the individual elements. Through our governance arrangements we aim to improve our delivery of the priorities by holding the identified leads to account on the

delivery of their priorities. The priorities have also been aligned with the Trust Integrated Improvement Plan.

**Trust performance**

This section provides detail on how the Trust has performed against the four priority ambitions of 2019-20. Results relate to the period 1st April 2019 – 31st March 2020 or the nearest period available. Mechanisms of measurement vary by priority and by the availability of national benchmark.

Benchmark

- Milestone achieved
- Milestone not achieved
- Milestone superseded

## PRIORITY 1 2019-20 – PATIENT AND CARER EXPERIENCE

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

**Data Source**

The FFT is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

A Survey Monkey questionnaire was conducted to collect feedback on valuing patients time which has demonstrated an improvement, however, the data source has changed as the original data collection was ineffective.

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

The FFT data is shared with each Division and is discussed at Speciality Governance Meetings to understand the reasons for the feedback. Top themes are waiting times particularly relating to A&E and discharge. Work to improve demand / capacity, discharge preparedness, flow and ‘red to green’ will have an impact as they become embedded. Communication continues to be a feature with work reviewing our current training, alongside staff charter and behaviours workshops is ongoing.

## PRIORITY 2 2019-20 – I WOULD RECOMMEND MY ORGANISATION AS A PLACE TO WORK IF A FRIEND OR RELATIVE NEEDED TREATMENT, I WOULD BE HAPPY WITH THE STANDARD OF CARE PROVIDED BY THIS ORGANISATION.

**WE SAID WE WOULD:**

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

**Data Source**
Utilising data from within the Organisational Development Team.

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

The 2021 programme has been superseded by the launch of the Integrated Improvement Plan (IIP). The IIP has patients at the heart of this plan.

## PRIORITY 3 2019-20 – ENSURING EFFECTIVE SYSTEMS FOR REVIEWING MORTALITY

| WE SAID WE WOULD: | |
|---|---|
| **Success Measure** | **Result** |
| There will be Medical Examiners available in the Bereavement Centre to complete the initial review and be a point of contact for junior doctors. | |
| Increase in the number of deaths screened by the Medical Examiners. | |
| Specialities will review the cases referred by the Medical Examiners within a timely period. | |
| Bereaved families will have had contact the Medical Examiner / Medical Examiner Assistant. | |
| A strategic learning group will be implemented – Mortality Assurance Learning Strategy (MorALS) Group. | |
| Widespread sharing of lessons learnt promulgated throughout the Trust. | |
| A reduction in SHMI to within expected limits (band 2). | |
| Yearly updates to the 2019-21 Mortality Reduction Strategy. | |

**Data Source**

Datix as this is utilised to input all Medical Examiner reviews.

Utilising data from Dr Foster and NHS Digital for SHMI.

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

MoRALS group has not been initiated due to COVD-I9 and the move to a Lincolnshire wide approach to learning. This group will be launched when the Trust goes into the recovery stage.

## PRIORITY 4 2019-20 – ENSURING PEOPLE ARE BEING CARED FOR IN THE RIGHT PLACE AT THE RIGHT TIME – RESPIRATORY PATIENTS

**WE SAID WE WOULD:**

| Success Measure | Result |
|---|---|
| Completion of key interventions within 4 hours for Chronic Obstructive Pulmonary Disease (COPD) and Community Acquired Pneumonia (CAP) bundles:<br>• Rapid confirmation by chest x-ray<br>• Rapid scoring of disease severity<br>• Guided antibiotic therapy | |
| Improvements in the uptake of bundles for COPD and CAP patients. | |
| Improvements in completion of bundles for COPD and CAP patients. | |
| Development of a Standard Operating Procedure for the prompt delivery of NIV. | |
| Patients who meet evidence-based criteria for acute Non-Invasive Ventilation (NIV) should start NIV within 60 minutes of the blood gas result associated with the clinical decision to provide NIV and within 120 minutes of hospital arrival for patients who present acutely. | |
| Participation in the national British Thoracic Society audits to enable national comparison. | |

**Data Source**

Internal audit conducted to review compliance with care bundles.

National audits to review compliance with NIV.

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

The Trust is participating in the national Getting It Right First Time (GIRFT) programme of which respiratory is a key work stream. The Trust has developed an overarching action plan on the key recommendations made by the GIRFT team of which NIV is included. The Trust has included the NIV pathway within this year's priorities.

Staff are performing the key interventions within 4 hours however they are not utilising the bundles instead documenting the findings within the clinical narrative.

# STATEMENT OF ASSURANCE

**Review of services**

During 2019-20, the United Lincolnshire Hospitals NHS Trust (ULHT) provided and/or subcontracted 103 relevant health services.

The ULHT has reviewed all the data available to them on the quality of care in 103 of these relevant health services.

The income generated by the NHS services reviewed in 2019-20 represents 94.9% of the total income generated from the provision of NHS services by the ULHT for 2019-20.

# PARTICIPATION IN CLINICAL AUDITS

During 2019-20 45 national clinical audits and 4 national confidential enquiries covered relevant health services that ULHT provides.

During that period ULHT participated in 95% of 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 2019-20 are as follows: (see tables below). Audits not achieving 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 2019-20 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 2019-20, 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)<br><br>Saving Lives Improving Mothers Care (MBRRACE-UK) | Yes | January – December 2017 Published October 2019<br><br>2015-2017 Published November 2019 | No case ascertainment reported<br><br>No case ascertainment reported |
| Neonatal Intensive and Special care (NNAP) | Yes | 1st January – 31st December 2018 | Trust 608<br>PHB 237, LCH 371<br>case ascertainment is not reported |
| **Children** | | | |
| Paediatric Intensive Care (PICANet) | N/A | This audit is applicable to specialist centres | N/A |
| Paediatric Cardiac Surgery (NICOR Congenital Heart Disease Audit) | N/A | This audit is only applicable to specialist centres | N/A |

| National Audits | ULHT Participation | Reporting Period | Number and % Required |
|---|---|---|---|
| National Childrens and Young Peoples Asthma Audit | Yes | 1st June 2019- 31st January 2020 Report awaited | Trust 70 LCH 38, PHB 32 |
| Diabetes (RCPH National Paediatric Diabetes Audit) | Yes | 1st April 2018 – 31st March 2019 (report published March 2020) | 277 cases submitted. (case ascertainment is not reported) |
| National Epilepsy 12 Audit | Yes | 5th July 2018 – 30th November 2019 Report awaited | 103 (case ascertainment is not reported |
| **Acute Care** | | | |
| National Emergency Laparotomy Audit (NELA) | Yes | Year 1st December 2018 – 30th November 2019 | Cases submitted PHB 108, LCH 77 |
| Cardiac Arrest (National Cardiac Arrest Audit) ICNARC | Yes | 1st April 2019- 31st December 2019 | Case ascertainment is not reported |
| Intensive Care National Audit Research (ICNARC) | Yes | 1st April 2018- 31st March 2019 | Trust 1226 LCH 697, PHB 529 |
| Care of Children in EDs (RCEM) | Yes | 1st August 2019- 31st January 2020 Report awaited | Trust 371 LCH 230, PHB 141 |
| Mental Health Adults (RCEM) | Yes | 1st August 2019- 31st January 2020 Report awaited | Trust 257 LCH 188, PHB 69 |
| Assessing Cognitive Impairment in Older People (RCEM) | Yes | 1st August 2019- 31st January 2020 Report awaited | Trust 326 LCH 178, PHB 148 |
| National Audit Seizure Management (NASH3) | No | 1st November 2018 - 30th June 2019 | PHB 48/30 (160%) LCH no data submitted |
| National Adult Asthma Audit | Yes | 1st November 2018 – 31st March 2019 Report published December 2019 | Trust 172 LCH 77, PHB 77, GDH 18 Case ascertainment is not reported |
| Chronic Obstructive Pulmonary Disease (COPD) Royal College Physicians | Yes | 14th September 2017– 30th September 2018 | Trust 1025 LCH 467, PHB 427, GDH 131 Case ascertainment is not reported |
| BTS Community Acquired Pneumonia | Yes | 1st December 2018 – 31st January 2019 Report published August 2019 | Trust 86 (71.6%) LCH 28 (46.6%) PHB 58 (96.6%) |
| BTS Non Invasive Ventilation | Yes | 1st February 2019 – 31st March 2019 Report published August 2019 | Trust 21 LCH 17, PHB 4, Case ascertainment is not reported |
| **Long Term Conditions** | | | |
| Diabetes (National Adult Diabetes Audit) | Yes | 1st January 2018 – 31st March 2019 | Case ascertainment is not reported (data is linked to local CCG) |

| National Audits | ULHT Participation | Reporting Period | Number and % Required |
|---|---|---|---|
| Diabetes (National Adult Diabetes Inpatient /Survey/ Audit HARMs) | Yes | September 2019 | Case ascertainment not yet available, report due May 2020 |
| Diabetes National Audit Foot Care | Yes | 2015 - 2018 | Case ascertainment is not reported |
| National Pregnancy in Diabetes Audit | Yes | 2016 - 2018<br>Published October 2019 | Trust 120<br>LCH 70, PHB 50<br>case ascertainment is not reported |
| National IBD Registry Ulcerative Colitis and Crohn's Disease (National IBD Audit) biologics Audit | No | 2018 – 2019<br>Report Published October 2019 | No data submitted |
| National Parkinson's Audit | Yes | 1st May – 30th September 2019<br>Report published February 2020 | Trust 99<br>PHB 23, PHB Physio 16, LCH Occupational Therapy 10, GDH 50<br>case ascertainment is not reported |
| National End of Life Audit | Yes | April – May 2019<br>Report published February 2020 | Trust 86<br>LCH 40, PHB 40, GDH 6 (100%) |
| National Audit Dementia | Yes | April – October 2018<br>Report Published July 2019 | 162/150 (108%) |
| **Elective Procedures** | | | |
| BAUS Urology Nephrectomy | Yes | 1st January 2016 – 31st December 2018 | 178/199 (89%) |
| BAUS Urology Percutaneous Nephrolithotomy | Yes | 1st January 2016 – 31st December 2018 | 26 case ascertainment is not reported |
| BAUS Urology Female Stress Urinary Incontinence | N/A | Applicable to specialist centres only | N/A |
| BAUS Urology Urethroplasty | N/A | Applicable to specialist centres only | N/A |
| Cardiac Arrhythmia (NICOR) | Yes | April 2016 – March 2017<br>Report published July 2019 | 478 case ascertainment is not reported |
| Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit) | Yes | 1st April 2018 – 31st March 2019<br>Report published January 2020 | 1038 eligible cases – case ascertainment is not reported |
| National Vascular Registry including NVD - Carotid Interventions Audit | Yes | 2019 Report<br><br>2018<br><br>2016-2018 | 26 cases Infra-renal AAA, 42 cases Carotid Endarterectomy<br><br>22 cases Emergency Repair Ruptured AAA<br><br>154 cases Major Limb Amputation |

| National Audits | ULHT Participation | Reporting Period | Number and % Required |
|---|---|---|---|
| Rheumatoid and Early Inflammatory Arthritis | Yes | Commenced May 2019 | Not yet reported |
| Hip, Knee, Ankle and Shoulder Replacements (National Joint Registry) | Yes | 1st January – 31st December 2018<br>2019 Report | 1162 – procedures by operation date – case ascertainment is not reported |
| National Elective Surgery Patient Reported Outcome Measures (National PROMs Programme)<br>Overall patient participation rate<br>Participation by each PROM<br><br>1.Hip Replacement<br>2.Knee Replacement | Yes | PROMs April 2018 – March 2019 –Finalised report<br><br><br>Patients who completed a pre-operative questionnaire | 755/849 (88.9%)<br><br><br><br>18/19<br>1. 383, 92.1%<br>2. 372, 85.9% |
| Surgical Site Infection | Yes | 1st May 2019 - 30th September 2019 | case ascertainment is not reported |
| Coronary Artery Bypass Graft (CABG) and Valvular Surgery (Adult Cardiac Surgery Audit) | N/A | Applicable to specialist centres only | N/A |
| National Ophthalmology Database (NOD) Audit | Yes | September 2017 – August 2018 | 1655 (47%) |
| **Cardiovascular Disease** | | | |
| Stroke Care (National Sentinel Audit of Stroke) SSNAP | Yes | April 2019 – December 2019 | 793/796 (99.6%) |
| Acute Myocardial Infarction and Other Acute Coronary Syndrome (MINAP) | Yes | 1st April 2017 – 31st March 2018. Report published November 2019 | 1282 (121.90%) |
| Heart Failure | Yes | April 2017- March 2018 Report | 1062 (91%) |
| **Cancer** | | | |
| Prostate Cancer (NPCA) | Yes | 1st April 2017 – 31st March 2018 | 464 (100%) |
| National Audit of Breast Cancer in Older Patients | Yes | January 2017-December 2017 | Case ascertainment is not reported |
| Lung Cancer (LUCADA) | Yes | Patients diagnosed with lung cancer first seen between 1st January 2017 and 31st December 2017 | 452 cases submitted case ascertainment is not reported |
| Bowel Cancer (NBCA) | Yes | Patients diagnosed between 1st April 2017 and 31st March 2018 | LCH + GDH 204 (70%), PHB 128 (121%) |
| Oesophago-Gastric Cancer (National O-G Cancer Audit) | Yes | Patients diagnosed between 1st April 2016 and 31st March 2018 | 206 (65-74%) (tumour records submitted) |

| National Audits | ULHT Participation | Reporting Period | Number and % Required |
|---|---|---|---|
| **Trauma** | | | |
| Falls and Fragility Fracture Audit Programme (FFAP)<br>Hip Fracture (National Hip Fracture Database)<br>National Audit Inpatient Falls (NAIF) | Yes<br><br><br>Yes | 1st January 2018 – 31st December 2018<br><br>1st January 2019 – 16th August 2019 | Trust 821<br>PHB 342 (95.5%), LCH 479 (107.2%)<br><br>12/12 (100%) |
| Trauma Audit Research Network (TARN) Trauma | Yes | January 2018 – July 2019 (TARN data) | Trust 1092 (100+%)<br>PHB 480 (100+%),LCH 612 (100+%) |
| **Blood Transfusion** | | | |
| National Comparative Blood Transfusion Audit – Medical use of Red Cells | Yes | 2019 | Not yet reported |
| Serious Hazards of Transfusion (SHOT): UK National Haemovigilance | Yes | April 2019 – March 2020 | Trust 14/14 (100%)<br>LCH 8, PHB 5, GDH 1 |

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

During 2019-20 hospitals were eligible to enter data in up to 4 NCEPOD studies. Below is a summary of those studies in which ULHT participated. Studies for which ULHT were exempt are not listed. Action plans are developed for any areas not achieving the recommended standards.

| National | ULHT Participation | Reporting Period | Number and % Required |
|---|---|---|---|
| **Confidential Enquiries** | | | |
| Out Hospital Cardiac Arrest (OHCA) | Yes | 2019-2020<br>Clinical questionnaire<br>Case note<br>Organisational questionnaire completed | <br>13/13 (100%)<br>12/13 (92.3%)<br>3/3 (100%) |
| Dysphagia<br>(This study is still open the figures are not yet final) | Yes | 2019-2020<br>Clinical questionnaire<br>Case note (only one requested)<br>Organisational questionnaire completed | <br>8/10 (80%)<br>1/1 (100%)<br><br>0/3 (0%) |
| Acute Bowel Obstruction<br>(Please note that case notes were limited to 2 per hospital site) | Yes | 2019-2020<br>Clinical questionnaire<br>Case note<br>Organisational questionnaire completed | <br>2/13 (15.3%)<br>4/4 (100%)<br>3/3 (100%) |
| Long Term Ventilation<br>(Please note there was only 1 case eligible included relating to community, case notes were only requested for acute admission therefore not applicable) | Yes | 2019-2020<br>Community Clinical questionnaire<br>Case note<br>Organisational questionnaire completed | <br>1/1 (100%)<br>NA<br>1/1 (100%) |

The reports of 36 national clinical audits were reviewed by the provider in 2019-20 and ULHT intends to take the following actions to improve the quality of healthcare provided (see tables below).

Descriptions of outcomes and improvements 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 as demonstrated on the latest national report published November 2019<br>• Procedure to open up blocked heart vessels quickly to restore coronary blood flow - 96% of patients met the door to balloon time of 90 minutes compared to the national average of 88%<br>• Collaborative work with EMAS continuing to ensure eligible patients are taken directly to the Heart Attack Centre<br>• Prescribing preventative medications above the national average for all eligible patients ULHT has been sustained at 100% PHB, 98.9% LCH<br>• Patients requiring angiography within 72 hours met best practice tariff 6/11 months<br>• Patient outcomes are good with timely interventions and secondary prevention prescribing, which improves patients quality of life following a heart attack |
| **TARN (Trauma)** | • Trauma meetings held at Lincoln and Pilgrim to discuss findings and shared learning continues<br>• Transfer to Trauma Centre continues to be reviewed with the Trauma Network to ensure eligible patients are transferred for specialist care ongoing<br>• On-going work to review and improve compliance with standards with updated reports and dashboards actions discussed at the Trauma meetings<br>• Trauma lead appointed at PHB<br>• Increased ate of survival |
| **Hip Fracture** | • Sharing best practice across the trust to improve the patient pathway data is available via site dashboards which records data live<br>• Monthly governance meeting to review data time to theatre and discuss improvements where needed<br>• Length of stay is similar to the national average of 15 days |

| | |
|---|---|
| | • Patients who did **not** develop a pressure ulcer nationally is 96.7%, PHB 97.9, LCH 97.1%<br><br>• Patients returned to their original residence within 120 days better than the national average, national 70.5%, PHB 80.6%, LCH 74.9% |
| **Stroke** | • Improving compliance with NICE standards strategy in place to improve areas requiring improvement<br><br>• Results are shared at the speciality Governance meetings<br><br>• Scoring A-E used for stroke units with A being the highest score to achieve the latest published report October 2019- December 2019 shows Pilgrim as a D and Lincoln as a C<br><br>• Strategy to improve data submissions is working well with case ascertainment of a high standard 90%+<br><br>• Lower mortality rates compared to the national average |
| **Cardiac Arrest** | • Education and training around deteriorating patient is on-going |
| **Bowel cancer data** | • Review of surgeon outcomes completed and reported<br><br>• Process for submitting data reviewed and has improved from last year case ascertainment from latest report LCH and GDH 70%, PHB 121%. (PHB received 121% as the number of cases submitted was higher than the number expected by the National Bowel Cancer Audit)<br><br>• Data quality reviewed action data from the MDT will be recorded and submitted at the time of the MDT and data issues highlighted for early completion<br><br>• Clinical Nurse Specialists have supported data submissions to NBOCA |
| **PROMs** | • Ongoing recruiting of patients for Hip and knee replacement surgery via pre-assessment clinics to complete the questionnaire before surgery 88.9% of patients completed a pre-operative PROM during 2018/2019<br><br>• Data is reported every four months to monitor progress with participation rates and outcome measures<br><br>• The joint replacement procedure is explained to patients to ensure patients are aware of the risks and benefits of the surgery<br><br>• Patients who had a hip or knee joint replacement reported improvement with daily activities |
| **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 |

| | |
|---|---|
| | • Improve timely data submission monthly review of submissions compared to the number of operations completed<br>• Consultants have access to Clinician feedback to review their own practice and compare to peers |
| **Falls Audit** | • Falls risk assessment in place<br>• Inpatient falls linked to the national hip fracture database automated notification to the site Consultant lead<br>• Review of inpatient falls with a fractured neck of femur by a Consultant lead data submitted on line |
| **Chronic Obstructive Airways Disease (COPD)** | • Data validation process in place<br>• Best practice tariff achieved for one of three quarters of the year reported<br>• Care bundle in place in line with British Thoracic Society (BTS) best practice standards further update will be required April 2020<br>• Compliance with the best practice standards discussed at the Speciality Governance meeting |
| **National Vascular Registry** | • Aortic Abdominal Aneurysms Infra-Renal, 100% discussed at MDT compared to 82% nationally, formal anaesthetic risk assessment 100% compared to 95.4% nationally, Pre-op CT/MR angiography 96% compared to 89.3% nationally<br>• Carotid Endarterectomy time from symptoms to surgery 70% within 14 days<br>• Data reviewed by the clinicians in line with outcome reporting<br>• Mortality rate as expected |
| **National Emergency Laparotomy Audit (NELA)** | • Good process in place to collect and submit data<br>• Best Practice Tariff (BPT) met since April 2019 latest report 96% BPT met. To meet this BPT a consultant anaesthetist and a consultant surgeon are present in theatre. |
| **Intensive Care National Audit (ICNARC)** | • Good compliance with the quality metrics<br>• No outlier alerts<br>• Ongoing data collection and review by the Intensive care units<br>• Review at Speciality Governance<br>• Mortality rate within the expected |

**Local Clinical Audit**

The reports of 98 local clinical audits were reviewed by the provider in 2019-20 and ULHT intends to take the following actions to improve the quality of healthcare provided: (see tables below):

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

Examples of actions taken locally:

| Local Audit | Actions - Improvements |
|---|---|
| Early Neonatal Sepsis Audit (Neonates) | The results showed:<br>• 100% compliance in commencing antibiotics for rIsk factors<br>• Babies with a raised CRP - inflammatory level blood test had a full septic screen<br>• More babies were given full septic screen than indicated by the guideline<br>• Update staff on changes to the guideline |
| Accuracy of Report of Musculoskeletal Radiograph done by Radiographer. (Radiology) | • Compliant<br>• Accuracy of report: 96.5%<br>• Sensitivity of report: 97.1%<br>• Specificity of report: 95.5%<br>• To review and ensure standards are met and maintained |
| NICE TA419 Apremilast for Treating Moderate to Severe Psoriasis (Dermatology) | • 16 patients were identified on Apremilast for psoriasis between Dec 2017 to Dec 2018<br>• Our results showed that at baseline 69% had both PASI and DLQI scores recorded<br>• 56% fulfilled NICE criteria to start Apremilast.<br>• At 16 weeks, 56% compliant with NICE (3 stopped according to guidelines<br>• 6 continued according to guidelines |

| | |
|---|---|
| | • To use online PASI calculator to calculate PASI score in clinic, and to document both PASI and DLQI at baseline and 16 weeks.<br>• All dermatology medical and nursing staff made aware<br>• Apremilast form updated |
| VTE Prophylaxis (Elderly Care) | • VTE risk assessment completed 100%<br>• None had renal impairment<br>• 97% prescribed and given medication in line with guidelines<br>• The risk assessment was not always reviewed by a senior:<br>  o Presented and discussed at the Medicine Audit meeting<br>  o Seniors to ensure assessment is reviewed<br>  o To include as part of the junior doctor induction |

# PARTICIPATION IN CLINICAL RESEARCH

Clinical research is an essential part of maintaining a culture of continuous improvement. Our Research and Innovation Department has a strong record of patient recruitment, as well as collaborative working with other organisations including the National Institute for Health Research (NIHR) East Midlands Clinical Research Network. There is a continuous effort to ensure that high-quality research is a part of the culture at ULHT.

The number of patients receiving relevant health services, provided or sub-contracted by ULHT in 2019-20, that were recruited during that period to participate in research approved by a research ethics committee 1,203. The total number of patients/participants recruited for portfolio and non-portfolio studies was 1,233. These patients/participants were recruited from a range of specialities including the following disease areas: Blood, Cancer, Cardiovascular, Critical Care, Dementias and Neurodegenerative Diseases, Eye, Metabolic and Endocrine, Musculoskeletal, Neurological, Oral and Gastrointestinal, Public Health, Respiratory, Skin, Stroke, Surgery and Trauma and Emergency Care.

The Trust is delivering trials within a wide variety of specialities and recruited from 16 disease areas in 2019-20. 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 by receiving the latest medications and treatment options. The Trust has implemented the findings of trials which has helped the Trust in improving patient care, as well as achieving cost savings.

The Trust is involved in conducting about 89 clinical research studies including studies in follow up. During 2019-20, the following number of patients were recruited:

- Cardiovascular – 122 patients.
- Cancer Randomised Controlled Trials (RCT) – 259 patients.
- Cancer non-RCT – 164 patients.

Since the establishment of the NIHR, the Trust has been using the national system for approving all studies (portfolio and non-portfolio) and to carry out risk assessments. In 2019-20, the Trust has approved 35 portfolio studies.

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

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

- Cancer
- Cardiovascular
- Critical Care
- Metabolic and Endocrine
- Public Health
- Respiratory

# USE OF THE COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) FRAMEWORK

A proportion of ULHT's income in 2019-20 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 2019-20 and the following 12-month period are discussed below.

As Lincolnshire moves towards an Integrated Care System, the vision for quality is focused on developing a single framework for system-wide quality assurance, with a shared commitment to the development of a culture of quality improvement. This would focus on ensuring the delivery of effective care, the assurance of the safety of the services that are offered to patients and supporting people to have a positive experience of care.

In 2019-2020 the focus will be on ensuring that quality improvement is embedded into everyone's business, and to support the delivery of consistently high-quality care. In moving towards this vision and ambition for Lincolnshire, it is recognised that it is necessary to develop an integrated and collaborative approach to quality governance and assurance across Lincolnshire, that minimises duplication, reduces variation and delivers improved outcomes for the people of Lincolnshire. The Trust has agreed to utilise the CQUIN funding to develop and implement the quality priorities and will not be participating in the national CQUIN schemes.

Due to COVID-19 Q4 attainment was granted automatically. A summary of the achievements of the CQUIN milestones for 2019-20 is demonstrated below:

**CQUIN schemes**

| CQUIN | Q1 | Q2 | Q3 | Q4 | Value | Value Received |
|---|---|---|---|---|---|---|
| Ensuring effective systems for learning from healthcare incidents and deaths in all care settings | | | | | £107,0975 | £107,0975 |
| Recommend my organisation as a place to work / if a friend or relative needed treatment, I would be happy with the standard of care provided by the organisation | | | | | £107,0975 | £107,0975 |
| Ensuring people are being cared for in the right place at the right time - Respiratory patients | | | | | £107,0975 | £107,0975 |
| Deteriorating Patient, empowering staff to monitor, manage and escalate the physiological deterioration and further developing our approach to patients with sepsis | | | | | £107,0975 | £107,0975 |

**Specialised CQUIN schemes**

| CQUIN | Q1 | Q2 | Q3 | Q4 | Value | Received |
|---|---|---|---|---|---|---|
| Hospital Medicines Optimisation | | | | | £205,528 | £161,731 |
| Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community | | | | | £14,643 | £14,643 |
| Active involvement of clinicians in clinical engagement to create a culture of care, where primary care and secondary care clinicians view collaboration as valuable and an essential approach to further improve NHS dental services to achieve the change and developments required to produce a modernised NHS | | | | | £60,534 | £60,534 |

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

For 2019-20, £4,564,605 of ULHT's contracted income was conditional on the achievement of these CQUIN indicators (£8,139,192 in 2018-19). The Trust has received 99.0% of the total CQUIN value for 2019-20.

The following CQUINs have been selected by the Trust for 2020-21:

- Care of the respiratory patient
- Safe discharge of our patients
- Care of the deteriorating patient
- Embedding organisational development schemes

# 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 28th June 2019 and 27th February 2020. The CQC has taken enforcement action against ULHT during 2019-20.

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

Between 11th June to 18th July 2019, CQC inspected a total of five core services provided by the Trust across four locations. They inspected urgent and emergency services, medical care (including older people's care), critical care, maternity and services for children and young people at Lincoln County and Pilgrim Hospital. They did not inspect services at Grantham and District Hospital or County Hospital, Louth. There was also a review of the well-led domain at Trust level.

The CQC rate the Trust on the following domains:

**Safe**

Are people protected from abuse and avoidable harm?

**Effective**

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

**Caring**

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

**Responsive**

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

**Well-led**

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

The Trust received its final report in October 2019 which rated the Trust as 'Requires Improvement' overall, however to remain in 'Special Measures' so the Trust can receive the support required to make further improvements.

The Trust's ratings for whether its services safe, effective, caring, responsive and well-led remained the same as in 2018. Services for safe, effective, responsive and well-led all remained as 'Requires Improvement' and 'Good' for caring.

The CQC made an unannounced visit to A&E at Lincoln County Hospital and Pilgrim Hospital on the 7th January 2020 which was to follow up actions the Trust had taken following the CQC focused inspection on the 11th June to 18th July 2019. The report was published on the 27th February 2020.

The key findings from the CQC visit between 11th June to 18th July 2019:

- Some services did not always have enough staff to care for patients and keep them safe.

- Managers monitored the effectiveness of the service and used the findings to make improvements but did not always achieve good outcomes for patients. In some services not all key services were available seven days a week.

- Services did not always plan care to meet the needs of local people or take account of patients' individual needs. People could not always access some services when they needed it and had to wait too long for treatment.

- Leaders did not always run services well using reliable information systems and support staff to develop their skills. Services did not always engage well with patients and the community to plan and manage services and not all staff were committed to improving services continually.

However, the CQC did acknowledge there were improvements since their previous visit in 2018:

- Most staff understood how to protect patients from abuse. Services controlled infection risk well and most services managed medicines well. Services managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

- Staff mostly provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Services mostly made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.

- Staff mostly treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

- Services made it easy for people to give feedback.

- Most services supported staff to develop their skills. Most staff understood the service's vision and values, and how to apply them in their work. Most staff were focused on the needs of patients receiving care. Services engaged well with patients and the community to plan and manage services.

The Trust has developed the Integrated Improvement Plan which aligns the CQC 'Should Do' and 'Must Do' to the Trusts key priorities. The Integrated Improvement Plan is the single-vehicle that ULHT will adopt to deliver improvements for patients, staff and ULHT as an organisation.

**The CQC domains were reported as:**

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

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

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Lincoln County Hospital | Requires improvement →← Oct 2019 | Requires improvement →← Oct 2019 | Good →← Oct 2019 | Requires improvement →← Oct 2019 | Requires improvement →← Oct 2019 | Requires improvement →← Oct 2019 |
| Pilgrim Hospital | Inadequate ↓ Oct 2019 | Requires improvement →← Oct 2019 | Requires improvement ↓ Oct 2019 | Requires improvement ↑ Oct 2019 | Requires improvement ↑ Oct 2019 | Requires improvement ↑ Oct 2019 |
| Grantham and District Hospital | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| County Hospital, Louth | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| **Overall trust** | Requires improvement →← Oct 2019 | Requires improvement →← Oct 2019 | Good →← Oct 2019 | Requires improvement →← Oct 2019 | Requires improvement →← Oct 2019 | Requires improvement →← Oct 2019 |

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

**Ratings for Lincoln County Hospital compared to previous CQC visit**

**Ratings for Lincoln County Hospital**

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Inadequate ↓ Oct 2019 | Inadequate ↓ Oct 2019 | Requires improvement ↓ Oct 2019 | Inadequate ↓ Oct 2019 | Inadequate ↓ Oct 2019 | Inadequate ↓ Oct 2019 |
| Medical care (including older people's care) | Requires improvement →← Oct 2019 | Requires improvement ↓ Oct 2019 | Good →← Oct 2019 | Requires improvement →← Oct 2019 | Requires improvement ↓ Oct 2019 | Requires improvement →← Oct 2019 |
| Surgery | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| Critical care | Good →← Oct 2019 | Good →← Oct 2019 | Good →← Oct 2019 | Outstanding →← Oct 2019 | Good →← Oct 2019 | Good →← Oct 2019 |
| Maternity | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 | Good Oct 2019 |
| Services for children and young people | Requires improvement →← Oct 2019 | Requires improvement ↓ Oct 2019 | Good →← Oct 2019 | Requires improvement ↓ Oct 2019 | Requires improvement ↓ Oct 2019 | Requires improvement ↓ Oct 2019 |
| End of life care | Requires improvement Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 |
| Outpatients | Requires improvement Jul 2018 | N/A | Good Jul 2018 | Requires improvement Jul 2018 | Requires improvement Jul 2018 | Requires improvement Jul 2018 |
| **Overall*** | Requires improvement →← Oct 2019 | Requires improvement →← Oct 2019 | Good →← Oct 2019 | Requires improvement →← Oct 2019 | Requires improvement →← Oct 2019 | Requires improvement →← Oct 2019 |

## Ratings for Grantham and District Hospital previous CQC visit in 2018

**Ratings for Grantham and District Hospital**

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

## Ratings for Pilgrim Hospital compared to previous CQC visit

**Ratings for Pilgrim Hospital**

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Inadequate → ← Oct 2019 | Inadequate → ← Oct 2019 | Requires improvement ↑ Oct 2019 | Inadequate → ← Oct 2019 | Requires improvement ↑ Oct 2019 | Inadequate → ← Oct 2019 |
| Medical care (including older people's care) | Requires improvement → ← Oct 2019 | Requires improvement ↓ Oct 2019 | Requires improvement ↓ Oct 2019 | Requires improvement ↓ Oct 2019 | Requires improvement → ← Oct 2019 | Requires improvement → ← Oct 2019 |
| Surgery | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Requires improvement Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| Critical care | Good → ← Oct 2019 | Good → ← Oct 2019 | Good → ← Oct 2019 | Good → ← Oct 2019 | Good → ← Oct 2019 | Good → ← Oct 2019 |
| Maternity | Good Oct 2019 | Requires improvement Oct 2019 | Good Oct 2019 | Requires improvement Oct 2019 | Requires improvement Oct 2019 | Requires improvement Oct 2019 |
| Services for children and young people | Inadequate ↓ Oct 2019 | Requires improvement → ← Oct 2019 | Good → ← Oct 2019 | Requires improvement ↑ Oct 2019 | Inadequate → ← Oct 2019 | Inadequate → ← Oct 2019 |
| End of life care | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 |
| Outpatients | Requires improvement Jul 2018 | N/A | Good Jul 2018 | Requires improvement Jul 2018 | Requires improvement Jul 2018 | Requires improvement Jul 2018 |
| **Overall*** | Inadequate ↓ Oct 2019 | Requires improvement → ← Oct 2019 | Requires improvement ↓ Oct 2019 | Requires improvement ↑ Oct 2019 | Requires improvement ↑ Oct 2019 | Requires improvement ↑ Oct 2019 |

## Ratings for Louth Hospital from previous CQC visit in 2018

**Ratings for County Hospital, Louth**

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Surgery | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |
| Outpatients and Diagnostic Imaging | Good Mar 2015 | N/A | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 | Good Mar 2015 |
| **Overall*** | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 | Good Jul 2018 |

# DATA QUALITY

**NHS Number and General Medical Practice Code validity**

ULHT submitted records during April 2019 to December 2019 at the Month 9 inclusion date to the Secondary Uses service for inclusion in the Hospital Episode Statistics (HES), which are included in the latest published data. The percentage of records in the published data:

which included the patient's valid NHS number was:

- 99.8% for admitted patient care (National performance 99.4%)
- 99.9% for outpatient care (National 99.7%)
- 98.8% for accident and emergency care (National 97.7%)

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

- 100.0% for admitted patient care (National performance 99.7%)
- 100.0% for outpatient care (National 99.6%)
- 99.9% for accident and emergency care (National 98.8%)

**Information Governance Toolkit attainment levels**

All organisations that have access to NHS patient data and systems must complete the Data Security and Protection Toolkit (DSP Toolkit) to demonstrate that they are practicing good data security and that personal information is handled correctly. The DSP Toolkit encompasses the 10 National Data Guardian's data security standards as set out in the Data Security and Protection Standards for health and care. It also includes the requirements of Cyber Essentials and the key elements of the Network and Information Systems (NIS) Regulations 2018 Cyber Assessment Framework (CAF).

There are no longer attainment levels, instead the toolkit works on either 'standards met' or 'standards not met'. All organisations are expected to achieve 'standards met' on the DSP Toolkit.

ULHT's toolkit publication for 2018-19 was 'standards not met'. Due to this we were required to provide an improvement plan detailing how we were going to bridge the gap to meet the DSP Toolkit 'Standards Met'. The Trust is required to meet these actions by 30th September 2020.

**Clinical coding**

ULHT was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

**Data quality**

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

- Continually review the main Key Performance Indicators (KPIs) that are reported to the Trust Board and Board Committees. This involves understanding the metric itself, how it is calculated and assurance around underlying robustness of the metric, data source and collation/publishing.

- This led to the introduction of a Data Quality Kite-mark assigned to individual KPIs alerting the end user to 4 indicators: Timeliness, Completeness, Validation and Process. Further work will ensure that all metrics are assigned a kite-mark, and those assigned already are reviewed and updated as required.

- 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 ongoing to test upgrades to the latest version of Medway.

- Following the restructure of the Clinical Coding department, increasing established head count to 41WTE (whole-time equivalents), we are looking at what improvements can be made, including internal audit and training, and improved engagement with the four Clinical Divisions.

- An example of this is the “Coding Triangle”, which is a clinician, manager and clinical coder working together on a particular pathway or dataset to ensure that what happens to the patient is recorded accurately by the clinician and interpreted and coded correctly by the Clinical Coder.

- The structure of the Data Quality function and wider Information Services team has been reviewed to ensure we support the needs of the Trust. A business case is being developed to support this additional resource requirement.

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

# LEARNING FROM DEATHS

In March 2017, the National Quality Board (NQB) introduced guidance for NHS providers on how they should learn from the deaths of people in their care. The purpose of the guidance is to help standardise and improve the way acute, mental health and community Trusts identify, report, review, investigate and learn from deaths, and engage with bereaved families and carers in this process.

| Measure | QTR 1<br>Apr 19 – Jun 19 | QTR 2<br>Jul 19 – Sep 19 | QTR 3<br>Oct 19 – Dec 19 | QTR 4<br>Jan 20 – Mar 20 | Comments |
|---|---|---|---|---|---|
| **Number of patients that have died within ULHT** | 498 | 490 | 593 | 595 | During 2019-20, 2176 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.**<br>For 2019-20 the reviews and investigations are conducted as one however this will change in the future | 287 | 311 | 431 | 462 | By March 2020, 1491 case record reviews and investigations have been carried out in relation to 2176 of deaths included above. In 1491 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. |
| **Number/percentage of deaths that escalated with problems in care**<br>In relation to each quarter, this consisted of:<br>20 representing 4.02% for the first quarter<br>42 representing 8.57% for the second quarter<br>40 representing 6.75% for the third quarter<br>10 representing 1.68% for the fourth quarter | 20 | 42 | 40 | 10 | 112 representing 5.15% 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.<br><br>These numbers have been estimated using the grading system that highlights potential areas of concern in care. All cases that are graded 2 and 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 in-depth 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 Dr Foster Diagnosis Alerts. We have disseminated learning on a number of thematic lessons using a modality of communication systems:

- Sepsis Care Bundles
- Fluid management
- Appropriate management of pleural effusion
- Unstable angina patients and risk stratification
- Misplaced nasogastric tube Never Event
- Non-invasive Ventilation (NIV)
- Administration of medication by the wrong route
- Monitoring anticoagulation/INR checking on discharge
- Opiate toxicity
- In-depth Diagnosis Alert reviews undertaken
- Review on patients who passed away within 30 days of discharge

**Description of actions that ULHT have taken in 2019/20, and proposes to take forward in consequence of what the ULHT has learnt.**

ULHT have taken the following actions to promulgate learning throughout the Trust:

- Patient Safety Briefings in relation to thematic reviews from investigations
- Clinical Coding Masterclass held Tri-annually- The importance of accurate documentation
- Increasing the number of Medical Examiner's within the Trust to screen deaths and escalate to concerns to the appropriate Specialty or Trust-wide learning
- In-depth reviews undertaken for alerting diagnoses and learnings disseminated to the appropriate forums and assurance given to Patient Safety Group

**Assessment of the impact of actions which were taken by ULHT during 2019-20**

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

- Sustained reduction of our HSMR and in the top 25% nationally
- Speciality Governance Meetings have specific information pertaining to their mortality
- Increased engagement and understanding of mortality from across different staff groups

| Measure | QTR 1<br>Apr 19 – Jun 19 | QTR 2<br>Jul 19 – Sep 19 | QTR 3<br>Oct 19 – Dec 19 | QTR 4<br>Jan 20 – Mar 20 | Comments |
|---|---|---|---|---|---|
| Number of reviews / investigations completed which took place before the start of the reporting period | 160 | 82 | 33 | 17 | 292 case record reviews and investigations completed after 31st March 2019 which related to deaths which took place before the start of the reporting period. |
| Number/Percentage of deaths that are judged likely not to be problems in care | 478 | 448 | 553 | 585 | 2064 representing 94.85% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the grading system below. |

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

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

| Measure | QTR 1<br>Apr 19 – Jun 19 | QTR 2<br>Jul 19 – Sep 19 | QTR 3<br>Oct 19 – Dec 19 | QTR 4<br>Jan 20 – Mar 20 | Comments |
|---|---|---|---|---|---|
| A revised estimate of Number/Percentage of deaths that are judged likely not to be problems in care | N/A | N/A | N/A | N/A | 0 representing 0% of the patient deaths during 2019/20 are judged to be more likely than not to have been due to problems in the care provided to the patient.<br><br>All are included in the table above. |

# NHS DIGITAL INDICATORS

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

## Domain 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**

| Description | Nov18-Oct19 | Dec18-Nov19 | ULHT |
|---|---|---|---|
| ULHT SHMI / Band | 109.85/2 | 109.73/2 | 109.73/2 |
| National Average | 100.36 | 100.39 | 100.39 |
| Best(B) / Worse(W) National Performance | 69.09(B)/ 119.57(W) | 68.89(B)/ 119.99(W) | 68.89(B)/ 119.99(W) |

**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**

| Description | Dec 18-Nov 19 | Jan19-Dec19 | Jan19-Dec19 |
|---|---|---|---|
| ULHT % | 30 | 29 | 29 |
| National Average % | 36 | 36 | 36 |
| Best(B) / Worse(W) National Performance % | 58(B) / 11(W) | 59(B)/ 10(W) | 59(B) / 10(W) |

The ULHT considers that this data is as described for the following reasons:

Our patients' data is submitted to the Secondary Uses Service and is linked to data from the Office for National Statistics death registrations to capture deaths which occur outside of hospital.

The ULHT intends to take the following actions to improve this mortality rate and so the quality of its services, by:

- Implementing the actions defined within the Mortality Reduction Strategy
- Monitoring compliance with Sepsis Screening
- Monitoring compliance with Care Bundles
- Increase the number of Medical Examiners the Trust has in post

## Domain 3 Helping people to recover from episodes of ill health or following injury

**The data made available by NHS Digital with regard to the Trust's patient reported outcome measures scores for - Total/Primary Hip replacement surgery & Knee replacement surgery-EQ:5D Index**

| Description | 2017-18 | 2018-19 | 2019-20* |
|---|---|---|---|
| ULHT EQ:5D index Hip Replacement surgery - (L) Low, (H) High | 0.46(L)/0.46(H) | 0.45(L)/0.46(H) | N/Av |
| National Avg EQ:5D index Hip Replacement surgery - (L) Low, (H) High | 0.46(L)/0.47(H) | 0.46(L)/0.47(H) | N/Av |
| ULHT EQ:5D index Knee Replacement surgery - (L) Low, (H) High | 0.33(L)/0.33(H) | 0.32(L)/0.33(H) | N/Av |
| National Avg EQ:5D index Knee Replacement surgery - (L) Low, (H) High | 0.34(L)/0.34(H) | 0.34(L)/0.34(H) | N/Av |

**The data made available by NHS Digital with regard to the Trust's patient reported outcome measures scores for - Total/Primary Hip replacement surgery & Knee replacement surgery-VAS Index**

| Description | 2017-18 | 2018-19 | 2019-20* |
|---|---|---|---|
| ULHT VAS index Hip Replacement surgery - (L) Low, (H) High | 12.63(L)/12.69(H) | 12.85(L)/13.16(H) | N/Av |
| National Avg VAS index Hip Replacement surgery - (L) Low, (H) High | 13.90(L)/14.20(H) | 14.10(L)/14.40(H) | N/Av |
| ULHT VAS index Knee Replacement surgery - (L) Low, (H) High | 7.11(L)/7.62(H) | 6.04(L)/6.31(H) | N/Av |
| National Avg VAS index Knee Replacement surgery - (L) Low, (H) High | 8.20(L)/8.30(H) | 7.50(L)/7.60(H) | N/Av |

**The data made available by NHS Digital with regard to the Trust's patient reported outcome measures scores for - Total/Primary Hip replacement surgery and Knee Replacement Surgery-Oxford Score**

| Description | 2017-18 | 2018-19 | 2019-20* |
|---|---|---|---|
| ULHT Oxford hip surgery score - (L) Low, (H) High | 21.63(L)/22.29(H) | 20.83(L)/21.01(H) | N/Av |
| National Avg Oxford Hip surgery score - (L) Low, (H) High | 22.20(L)/22.70(H) | 22.30(L)/22.70(H) | N/Av |
| ULHT Oxford Knee surgery score - (L) Low, (H) High | 16.80(L)/16.91(H) | 16.48(L)/16.54(H) | N/Av |
| National Avg Oxford Knee surgery score - (L) Low, (H) High | 17.10(L)/17.30(H) | 17.2(L)/17.30(H) | N/Av |

The ULHT considers that this data is as described for the following reasons:

The data is taken from NHS Digital PROMs data set.

The ULHT intends to take the following actions to improve PROMS outcomes and so the quality of its services by

- The Clinical Team reviewing their data
- Providing clear expectations to patients prior to surgery

*Data available is the percentage improved not the index figure and is only for primary not revisions.*

*Therefore, National performance is not available.*

**ULHT and National Performance data is not available at this time*

**The data made available to the trust by NHS Digital with regard to the percentage of patients aged— (i) 0 to 15 - Readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the trust during the reporting period (emergency readmissions)**

| Description | 2017-2018 | 2018-2019 | 2019-2020** |
|---|---|---|---|
| ULHT readmitted within 30 days: 0-15 | 11.4% | 11.5% | 12.23% |
| *National Average: 0-15 | N/Av | N/Av | N/Av |
| Best(B) / Worse(W) National Performance: 0-15 | 1.7%(B) / 54.9%(W) | 1.8%(B) / 69.2%(W) | N/Av |

**The data made available to the trust by NHS Digital with regard to the percentage of patients aged— (ii) 16 or over - Readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the trust during the reporting period (emergency readmissions)**

| Description | 2017-2018 | 2018-2019 | 2019-2020** |
|---|---|---|---|
| ULHT readmitted within 30 days: 16+ | 11.7% | 11.9% | N/Av |
| *National Average: 16+ | N/Av | N/Av | N/Av |
| Best(B) / Worse(W) National Performance: 16+ | 2.2%(B) / 64.1%(W) | 2.1%(B) / 57.5%(W) | N/Av |

The ULHT considers that this data is as described for the following reasons:

The data is taken from the Trust's Patient Administration System (Medway).

The ULHT intends to take the following actions to improve this indicator and so the quality of its services by:

- Improving communications with GP practices so that they can do more effective patient follow up work
- Working collaboratively with the CCG to ensure Gold Standard Framework is implemented
- Ensuring ReSPECT forms are completed appropriately

** National Performance data is not available*

***Data not available for 2019-20 at this time*

## Domain 4 Ensuring people have a positive experience of care

**The data made available by NHS Digital with regard to the Trust's Responsiveness to the personal needs of its patients during the reporting period**

| Description | 2017-18 | 2018-19 | 2019-20* |
|---|---|---|---|
| ULHT | 66.8 | 64.6 | N/Av |
| National Average | 68.6 | 67.2 | N/Av |
| Best(B) / Worse(W) National Performance | 85.0(B) / 60.5(W) | 85(B) / 58.9(W) | N/Av |

The ULHT considers that this data is as described for the following reasons:

The data is provided by the national survey contractor.

The ULHT intends to take the following actions to improve this indicator and so the quality of its services by

- Launching the Integrated Improvement Plan (IIP) which is our 5-year Improvement Plan

**ULHT and National Performance data is not available at this time*

**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 and friends**

| Description | 2018 | 2019 | 2020* |
|---|---|---|---|
| ULHT Strongly agree(SA) /Agreed (A) | 9%(SA)/ 39%(A) | 10%(SA)/ 40%(A) | N/Av |
| National Average Strongly agree(SA) /Agreed(A) | 20%(SA)/ 50%(A) | 21%(SA)/ 49%(A) | N/Av |
| Best(B) / Worse(W) National Performance | 77% (B) / 0%(W) | 93%(B) / 0%(W) | N/Av |

The 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.

The ULHT intends to take the following actions to improve this indicator and so the quality of its services by

- Launching the Integrated Improvement Plan (IIP) which is our 5-year Improvement Plan. The IIP identifies the key priorities for the Trust over the next 5 years 2020-2025 ensuring we are focused on the right things for both our patients and our staff.

**ULHT and National Performance data is not available at this time*

**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**

| Description | Dec 2019 | Jan 2020 | Feb 2020 |
|---|---|---|---|
| ULHT A&E / National Avg/ Best(B)-Worst(W) | 83 /84 / 100(B)-50(W) | 82 /85 / 100(B)-34(W) | 82 /82 / 99(B) - 40(W) |
| ULHT Inpatients/National Avg/ Best(B)-Worst(W) | 93 /96 / 100(B)-82(W) | 93 /96 / 100(B)-80(W) | 93 /96 / 100(B)-73(W) |
| ULHT Maternity /National Avg/ Best(B)-Worst(W) | 100 /97 / 100(B)-65(W) | 99 /97 / 100(B)-80(W) | 97 /97 / 100(B)-86(W) |

The 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.

The ULHT intends to take the following actions to improve this indicator and so the quality of its services by:

- Improving our communication and keeping our patients informed and updated on their care and treatment.

## 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.**

| Description | QTR1 Apr 19-Jun 19 | QTR2 Jul 19-Sep19 | QTR3 Oct 19-Dec 19 |
|---|---|---|---|
| ULHT % | 97.19% | 97.58% | 97.93% |
| National Avg % | 95.63% | 95.47% | 95.33% |
| Best(B) / Worst(W) National Performance % | 100%(B) /69.76%(W) | 100%(B) / 71.72%(W) | 100%(B) / 71.59%(W) |

The 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.

The ULHT intends to take the following actions to improve this indicator and so the quality of its services by:

- Provide pharmacological and / or mechanical thromboprophylaxis to eligible patients
- Provide VTE risk assessment rate data to clinical areas
- Present to the Thrombosis Prevention Group to highlight where changes to practice are required

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

| Description | 2017/18 | 2018/19 | 2019/20* |
|---|---|---|---|
| ULHT | 18.3 | 13.8 | 18.0 |
| National Avg | 13.6 | 12.2 | N/A |
| Best(B)-Worst(W) National Performance | 0(B)/ 90.4(W) | 0(B)/ 79.7(W) | N/A |

The 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.

The ULHT intends to take the following actions to improve this indicator and so the quality of its services by:

- The data set is used to inform meetings that take place. Clinical teams are able to direct the focus of actions and interventions to ensure that infection numbers are as low as possible

** This is the latest data ULHT has available internally therefore National performance is not available*

**The data made available to the Trust by NHS Digital with regard to the number and, where available, rate of Patient Safety Incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death**

| Description | Oct 17-Mar 18 | Oct 18- Mar 19 | Oct 19-Mar 20 |
|---|---|---|---|
| ULHT % | 1.55 | 0.75 | 0.52 |
| National Avg % | N/A | N/A | N/A |
| ULHT Total No of Incidents (T) / Severe or Death (SD) | 6,399(T) / 99(SD) | 6,291 (T) / 47 (SD) | 6316(T) / 33(SD) |

The 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.

The ULHT intends to take the following actions to improve this indicator and so the quality of its services by:

- Actively encourage a culture of open reporting and widespread sharing of learning from incidents to improve patient safety
- Undertaking a structured programme of work to ensure that we learn and improve
- Being open and transparent about our safety work, our incidents and our actions for improvement

** National Performance data is not available at this time*

**Explanatory Notes**

All data published as descripted and provided from NHS Digital website correct at time of reporting for the periods available.

https://digital.nhs.uk/data-and-information/indicators/indicator-portal-collection/quality-accounts

**Summary Hospital-level Mortality Indicator SHMI**

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

**Patient Reported Outcome Measures (PROMS)**

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

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

**Readmission within 28 days of discharge**

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

**Responsiveness to inpatients personal needs**

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

**Staff Survey**

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

## Friends and Family Test

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

## Clostridioides 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.

Clostridioides Difficile 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. Clostridioides 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 Clostridioides Difficile infection in the community and outpatient setting is increasing.

The description is the rate of Clostridioides 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 Clostridioides 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 Clostridioides Difficile infection, and has a positive laboratory test result for Clostridioides Difficile recognised as a case according to the trust's diagnostic algorithm. A Clostridioides Difficile episode lasts for 28 days, with day one being the date the first positive specimen was collected. A second positive result for the same patient, if collected more than 28 days after the first positive specimen, should be reported as a separate case, irrespective of the number of specimens taken in the intervening period, or where they were taken. Specimens taken from deceased patients are to be included.

The following cases are excluded from the indicator:

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

## Venous Thromboembolism (VTE) Risk Assessment

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

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

The patients out of scope are patients under 18 years (however in March 2018 NICE updated their guidelines and have lowered the age to 16 years and above from 18 years), people attending outpatients and people attending A&E who are not admitted. The Trust signed up to the Midland and East Cohort agreement. The National target is for at least 95% of patients to be risk assessed for VTE within 24 hours of admission. The results are collated through an electronic system known as Medway.
Compliance with VTE assessment:
2018-19 = 96.66%
2019-20 = 97.23%

**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

NHS
United Lincolnshire Hospitals
NHS Trust

OUTSTANDING CARE
personally DELIVERED

# REVIEW OF QUALITY PERFORMANCE

## PATIENT SAFETY

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

### Coronavirus (COVID-19)

During March 2020, a global outbreak of Coronavirus (COVID-19) initiated a national incident across the UK. For Lincolnshire's hospitals this meant the Trust had to implement a range of measures to ensure we were prepared for a potential surge in the number of patients we might see.

We continue to work closely with national health bodies to inform our plans and ensure that both our patients and staff remain safe and well-cared for, following Public Health England guidance at all times around the appropriate use of PPE.

Patient pathways were reviewed to consider what impact a surge in patients may have had on services. Some areas in our hospitals were segregated, outpatient appointments and non-urgent operations were cancelled to ensure that plenty of capacity was created in our hospitals.

For our patients we introduced the use of video consultations for a number of services. This meant that patients were still able to attend appointments and access medical care.

The Trust had to make the difficult decision to suspend visiting to help protect staff and patients from any increased risk of exposure to the virus. This applied to all areas apart from in specific circumstances. As part of our response to this, we created a Family Liaison Team to ensure that patients were able to keep in touch with loved ones and receive items they needed.

For staff we have also been able to secure a free meal per day for staff, as well as free parking. For patients, free parking and TV services and phone calls have been provided to help support them during the pandemic.

As the pandemic progresses, we will continue to monitor the situation and react accordingly to ensure that our patients continue to receive the best quality care in Lincolnshire. Within the 2020-21 Quality Account there will be a narrative detailing the changes and learning that occurred.

**Never Events**

It was very disappointing that we had ten Never Events this year. We are committed to ensuring that we create safe systems and processes in order to protect our staff and patients from Never Events occurring. We will ensure we support staff across the organisation to implement learning from these events, as set out in the action plans, and provide assurances that this has been completed.

Never Events are a specific type of Serious Incident defined by NHS Improvements as “patient safety incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers”.

The Trust declared 10 Never Events in the 2019-20 financial year, in the following categories:

- 4 Wrong-site surgery (3 in Theatres; 1 in Outpatients)
- 1 Wrong implant / prosthesis (Theatres)
- 1 Wrong route administration of IV medication (A&E)
- 2 Retained foreign object post-procedure (1 in Theatres; 1 in Labour Ward)
- 2 Mis-placed naso-gastric tube (Medical Wards)

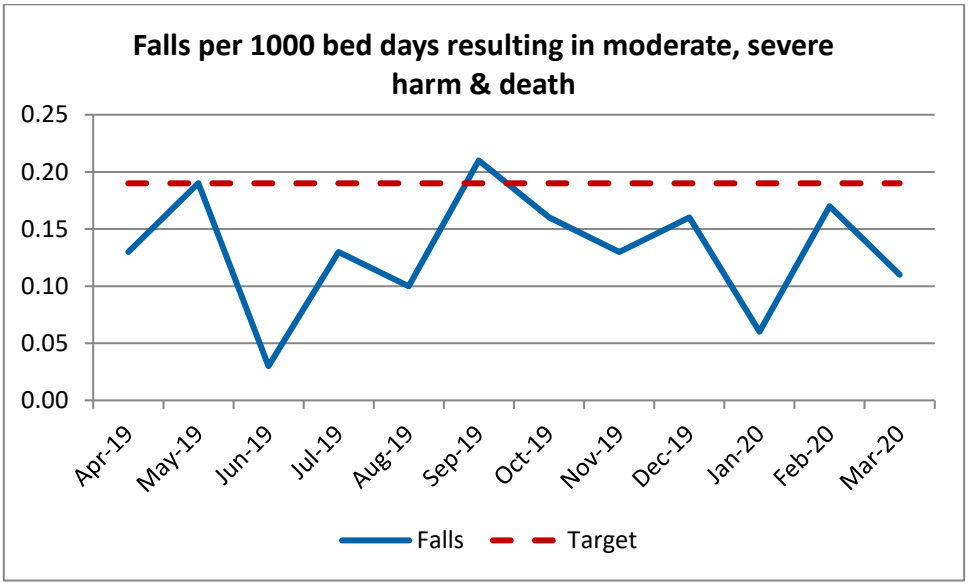
As a result of lessons learned from investigating these Never Events, some of the improvements the Trust has made include:

- Amendments to the surgical safety checklist used for dental extractions and introduction of a new mouth diagram form
- Tighter controls over the management of surgical equipment when used for Obstetric procedures in operating theatres
- Competency checks for agency nursing staff in the management of nasogastric tubes
- Strengthened medicines management practice in all Emergency Departments
- Additional safety checks when undertaking implant surgery
- Inclusion of a diagram in the safety checklist for facial surgery

**Reducing harm from our Falls**

Falls are the most common cause of injury in a hospital and result in both psychological and physical harm including, bleeding, fractures, or even death in vulnerable patients. Falls have an annual cost to the NHS of £2.3 billion, with an average cost of £2,600 per fall. Annually there are over 200,000 falls reported to the National Reporting and Learning System (NRLS) across the health economy. Falls have a significant and lasting impact for patients and those resulting in harm are more likely to occur in acute Trusts.

**Falls resulting in moderate, severe harm and death April 2019 – March 2020**




The national average for falls resulting in moderate, severe harm and death is 0.19. The Trust has been below average for eleven of the twelve month for 2019/20.

The Trust has commenced a dedicated falls incident review panel which meets recurrently with senior nursing, medical, Allied Health Professional and CCG representation to review incidents when a patient has experienced harm as a result of a fall in order to identify lessons to be learnt and shared to help reduce recurrence.

There is a Trust Wide Frailty Clinical Nurse Specialist in post who will support wards in caring for our frailer patients and provide an additional focus on Falls improvement within the organisation.

We have started conducting Focus on Falls Safety Support visits by the Frailty Nurse Specialist, Frailty Consultant Nurse and Senior Nurse on wards and departments within the organisation. Working with the ward teams to review falls safety specific to their area and help to develop falls safety learning plans and share areas of good practice identified.

'FaLLS -Focus and Lessons Learned Sharing' safety messages and newsletter have been developed to support wider sharing.

The Frailty Clinical Nurse Specialist has commenced monthly site drop-in clinics for falls link nurses.

A staff educational passport for frailty has been developed, a schedule of regular training sessions will be available on all aspects of frailty including falls prevention.

We have introduced a standardised Falls Grab Pack across the Trust with all documentation and guidance to follow if a patient falls.

We now have a dedicated Frailty team of trainee Advanced Care Practitioners working predominantly in our Emergency Departments who incorporate Falls assessments routinely into their comprehensive geriatric assessments this then proactively benefits patients being admitted as triggers for falls are considered at the start of their admission.

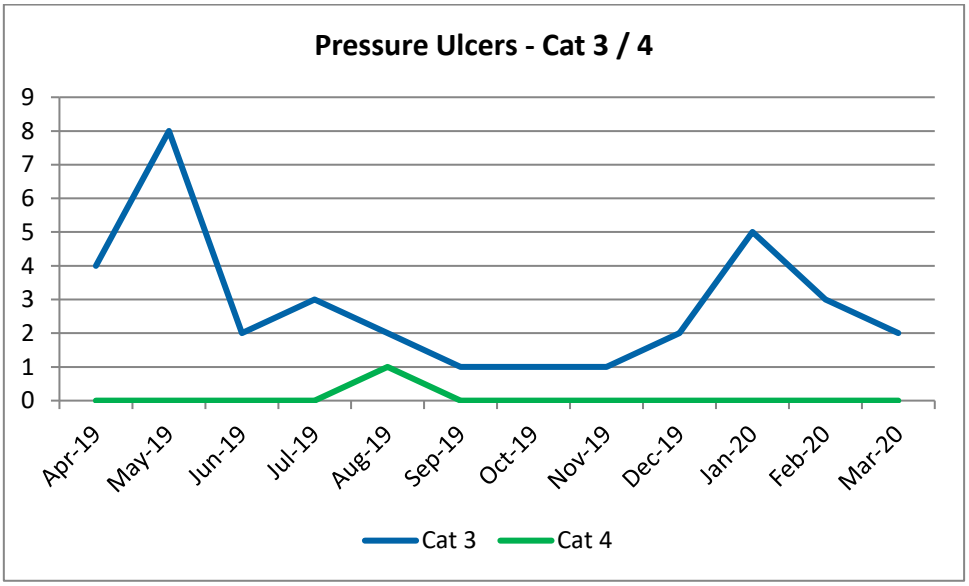
We have been actively involved at the first meeting of a Lincolnshire wide Falls Stakeholder collaboration and will continue to look at ways we can work together with partner agencies to support people at risk of falling in and out of hospital.

The Trust has introduced a Lying and Standing blood pressure sticker for easy identification in medical notes when a patient's blood pressure may put them at an increased risk of falling and requires a medical review.

**Reducing our harm from Pressure Ulcers**

It is estimated that 80-95% of all pressure ulcers are avoidable. Pressure ulcers (also known as pressure sores or bedsores) are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. They can happen to anyone, but usually affect people confined to bed or who sit in a chair or wheelchair for long periods of time.

**Category 3 and 4 pressure ulcers April 2019 – March 2020**




The Trust had 34 category 3 pressure ulcers compared to a benchmark of 51 or less
The Trust had 1 category 4 pressure ulcer compared to a benchmark of 16 or less.
There is no national benchmark for reduction of pressure ulcers.

The Trust continues to hold a regular pressure ulcer incident review panel which meets regularly with tissue viability specialist, senior nursing, allied health professional and CCG representation. The team review the care provided for patients who have developed a pressure ulcer to identify areas that require improvement and lessons that require wider sharing.

The tissue viability clinical nurse specialist team utilise the electronic referral and Datix incident reporting systems to review and validate all categories of pressure ulcers and moisture damage that have developed. This supports a conversation with staff to check what actions have already been taken and prompt them to do any additional care actions that would help prevent deterioration.

Link Nurses from across hospital sites have attended Trust-wide tissue viability study days to encourage networking and increased opportunities for sharing. The study days have provided education and training on a range of tissue viability focus areas including pressure ulcer prevention and wound care.

Tissue Viability training has been reviewed and a new e-learning package has been developed and will be launched soon. Tissue viability sessions continue to be delivered for newly registered nurses and new health care support workers.

The Tissue Viability team have been working collaboratively with community colleagues to share practice and have developed a new joint wound formulary. A study day is being planned to launch the joint wound formulary.

## CLINICAL EFFECTIVENESS

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

### Understanding, measuring and reducing patient mortality

NHS England uses two different measures called Hospital Standardised Mortality Rate (HSMR) and Summary of Hospital Level Mortality Indicator (SHMI) to measure mortality rates across NHS providers. Each is a subjective measure which needs to be interpreted with caution. SHMI and HSMR are risk-adjusted indicators which measure whether mortality associated with hospitalisation and post-discharge are in line with predictions.

This provides greater clarity in the understanding and monitoring of mortality. The HSMR and SHMI are available monthly and SHMI includes deaths 30 days after discharge. Hospitals need to monitor their data and understand variation. A statistically higher than expected mortality may

indicate problems with the quality of care provided and should be investigated further using a robust and reliable method of evaluation and analysis.
Due to the current global pandemic of COVID-19, the Trust is unsure of what impact this will have on our mortality rates. The Trust has appointed interim Medical Examiners as our substantive Medical Examiners have been redeployed back into their clinical specialities. The legislation changed during the pandemic to allow the interim Medical Examiners to complete the Medical Certificate of Cause of Death (MCCD). Case note reviews have been conducted on all deaths to identify if there were any care delivery issues, and if identified these would be investigated through the standard Trust processes. The outputs from the case note reviews during this pandemic will be presented at Patient Safety Group and Quality Governance Committee.

The Trust has developed a 2018-2021 Mortality Reduction Strategy, to ensure there is an effective mortality review programme in place that identifies areas for improvement, and an effective governance structure that monitors the delivery of improvements.

The Mortality Reduction Strategy states that:

- All cases where patients have died are reviewed by the Medical Examiner and if there are concerns the cases are escalated for an in-depth review or investigation
- 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 upon
- Where mortality reviews have shown that care falls short of the agreed standard, focused actions are identified to improve care and service delivery
- Processes are in place to support accurate and thorough clinical documentation and coding
- Staff are adhering to the completion of care bundles for specific conditions
- There is appropriate escalation and rescue of the deteriorating patient

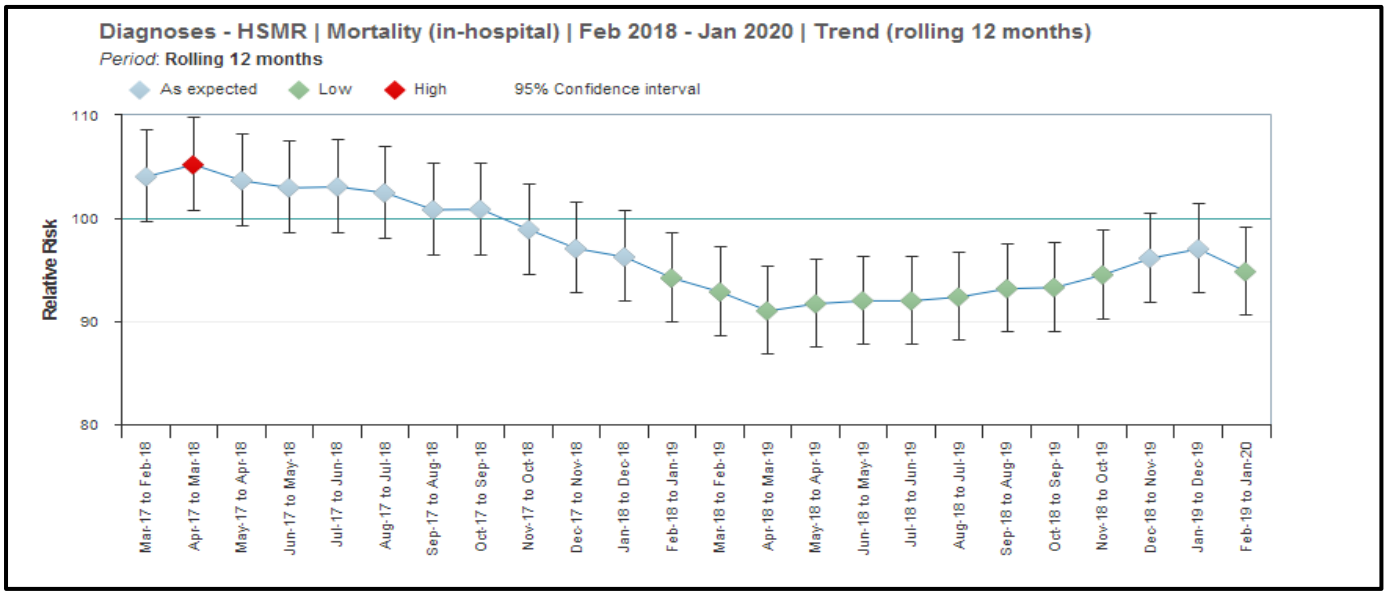
HSMR compares an organisation’s actual number of deaths with their expected number of deaths. The prediction calculation takes into consideration the following criteria:

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

- Co-Morbidities

Standardisation of the ratio allows a valid comparison between different hospitals.

**HSMR February 2018 – January 2020 (rolling year)**



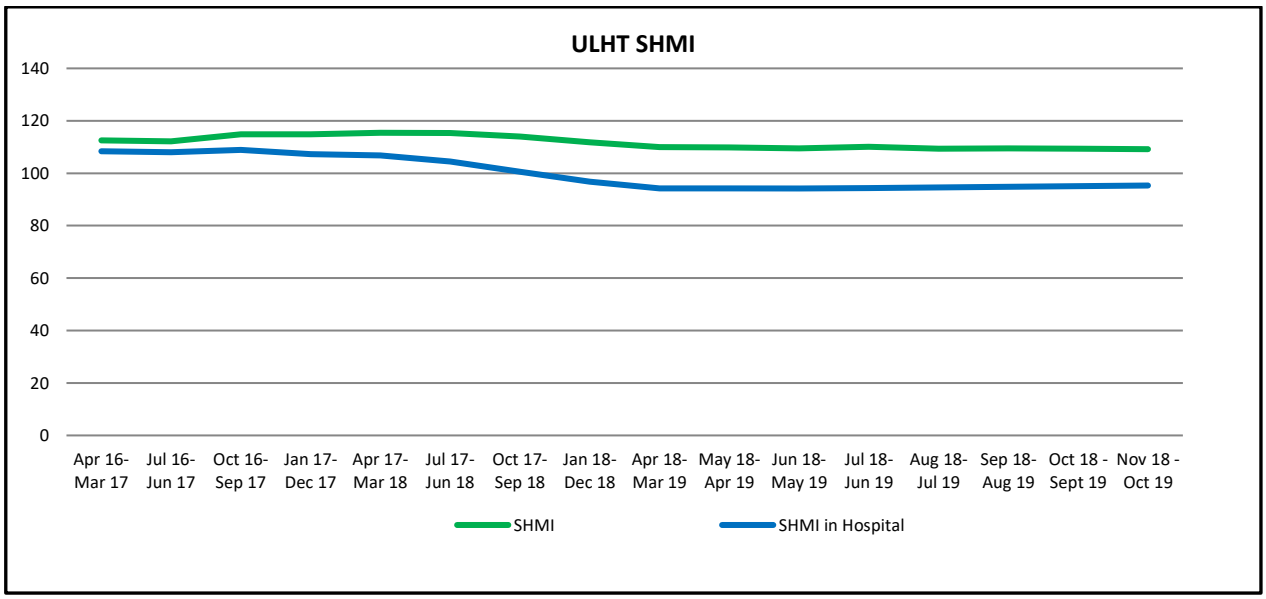

From October 2018 the Trust has been consistently below the national standard of 100. The data is published with a 3-month time delay.

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

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

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

**SHMI April 2016 – October 2019 (rolling year)**




The data is published with a 6-month time delay.

In hospital SHMI is 95.29, however, reviewing SHMI as a whole the Trusts score is 109.18 from November 2018 – October 2019.

The Trust is liaising with the Clinical Commissioning Group (CCG) within Lincolnshire to explore the reasons for the higher SHMI out of hospital.

**Seven Day Services**

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

| | |
|---|---|
| **Priority Clinical Standards** | • **Standard 2: Time to Consultant Review**<br>• **Standard 5: Diagnostics**<br>• **Standard 6: Consultant Directed Interventions**<br>• **Standard 8: On-going Daily Consultant Directed Review** |

| Standard 2 | Standard 5 | Standard 6 | Standard 8 |
|---|---|---|---|
| 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 | Access to Consultant-directed Diagnostics within one hour if critical, 12 hours if urgent and 24 hours for non-urgent patients<br>• Within 1 hour for critical patients<br>• Within 12 hours for urgent patients | 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 | Patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours |

The Trust had to submit a Board Assurance Framework (BAF) detailing their compliance with the four clinical priority standards. The BAF is presented at Quality Governance Committee and upwardly reported to Trust Board prior to being submitted nationally.

The Trust has made improvements since commencing the audits, however, the Trust is not achieving the 90% standard for clinical standards 2, 6 or 8.

We continue to face challenges in achieving these standards, however benchmarking across the East Midlands and the country shows that we are within national and regional parameters.

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

## GETTING IT RIGHT FIRST TIME (GIRFT)

Getting It Right First Time (GIRFT) is a National NHS improvement programme that began in 2016, it is delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust. The programme is designed to improve the quality of care within the NHS by reducing unwarranted variations through sharing best practice between Acute Hospital Trusts and standardising services across the NHS system. The programme identifies where changes are required to improve patient care, outcomes and experience. Also identifying areas to improve efficiencies, reduce unnecessary procedures and appropriately reduce cost.

The programme is led by Clinicians that have been identified as experts in their fields. There are currently 45 live work streams nationally; 40 Surgical and Medical work streams with 5 that have been identified as cross-cutting schemes that impact on all services. The National team engages with each Trust and organises visits at Specialty level known as “Deep Dive Visits”, they provide local data packs prior to the visit using the NHS Improvement, Hospital Episode Statistics and Model Hospital data to help identify areas for improvement within the Trust.

The Trust has engaged in the programme since it’s infancy with the first of our visits being General Surgery and Orthopaedics in 2016. To date ULHT has had 19 deep dive visits across Surgical and Medical Specialties and 4 cross-cutting schemes.

The deep dive visits are attended by National GIRFT Team members, ULHT’s Clinicians, Nursing, Finance, Clinical Coding, Executive representation, Clinical and administration support staff across the specialty. The visits provoke discussion and understanding and provides the Trust with an opportunity to advise the National Team of any improvements in outcomes since the data pack was published. The interactive discussion at these deep dive visits also provides an opportunity to identify and discuss further opportunities for improvement in our services.

Following the deep dive visits, the National Team compile a comprehensive local improvement recommendation plan that the Trust has to implement to ensure compliance with the GIRFT recommendations. Once the National Team has visited 90% of Trusts for a specific clinical or cross-cutting specialty a national report is produced encompassing the learning and recommendations gathered from all local visits. The Trust is asked to incorporate all national

recommendations into their local GIRFT action plan. The Trust updates the National GIRFT Team frequently with progress against delivery of the GIRFT action plan.

ULHT has so far fully implemented / completed 20% of recommendations provided by the GIRFT programme, with 51% of actions in progress across the Trust and 29% pending national and local agreement.

## PATIENT EXPERIENCE

### Complaints

Patients and carers can raise a concern in a number of ways. One way is via the Patient Advice and Liaison Service (PALS). They will try to resolve any issues. If this is not successful, or the concern is too complex, PALS will pass this on to the Complaints Department. The other way patients can raise concerns is by directly contacting the Complaints Team. The complaint will be passed on to the relevant Division to respond. Once received, individual Divisions work closely with the complaints team to resolve those concerns which do not require a full formal investigation. A formal complaint is one in which the complainant asks for an investigation and written response.

Complaints are a key source of feedback for the Trust and informs us about our patients' views regarding the quality of services and care provided. All formal complaints received are taken seriously and are responded to appropriately on an individual basis and are fully investigated through the Trust's complaints procedure. All staff are encouraged to respond to concerns raised by patients and relatives as soon as they become aware of them, rather than waiting to receive a formal written complaint and our PALS services support this.

It is imperative that complainants feel that they are treated with respect and receive an open, honest and timely response to their concerns. Complaints response times are monitored by the Complaints Department and the Executive Team. All complaints are allocated a 35 working day response timescale including the cases that are referred back for further investigation. This is to ensure that the processes stay aligned and so that we acknowledge, investigate and respond to the complaints within a timely manner. However, should it become apparent that the investigation may take longer we will contact the complainant and explain the reasons for the delay and a further date will be agreed.

Learning from complaints takes place at a number of levels. The service, department or specialty identifies any immediate learning and actions that can be taken locally.

A quarterly report identifies themes, trends and suggestions for improvement based on a variety of feedback. This report is discussed at our Patient Safety Group and Quality Governance Committee.

Complaint data is triangulated with other information such as incidents, serious incidents, inquest conclusions and claims information to ensure a full picture of emerging and persistent issues is recognised and described. Learning from complaints is shared with staff at a variety of meetings.

To help improve the management of all complaints we have further reviewed and streamlined the process. The improvements for the response rates will be seen in 2020-21. The table below provides a summary of the key complaints performance indicators monitored within the Trust:

| Measure | Target | 2019-20 | 2018-19 |
|---|---|---|---|
| New complaints received | N/A | 721 | 739 |
| Acknowledged all complaints within 3 days | 95% | 100% | 95% |
| Response Rates | 35 days | 40% | 56% |

**Parliamentary and Health Service Ombudsman (PHSO)**

The Trust aims to resolve complaints at local level following thorough investigations, written responses, meetings with complainants and in some cases seeking an external opinion from a clinician outside the organisation. However, when local resolution has been exhausted the complainant can refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO) for consideration and investigation.

A total number of 18 complaints were referred to the Ombudsman during 2019-20 compared to 24 complaints during 2018-19. The numbers broken down across hospital sites equate to

- 10 from Lincoln
- 8 from Pilgrim
- 0 from Grantham

Of the 18 complaints, 3 have been identified for formal investigation, 2 cases are still being assessed and 13 have been rejected by the Ombudsman. This equates to 72% of all cases

referred to the Ombudsman during 2019-20 being rejected. The cases were either referred back to the Trust to undertake further work at local resolution (2 cases) with the remaining 11 not meeting the Ombudsman's criteria for investigation as the Trust had adequately addressed and resolved the concerns raised. The increase in cases rejected by the Ombudsman indicates that the quality of the response sent to complainants has improved and reflects the hard work that has been undertaken by the complaints team to ensure that all the concerns raised have been addressed to a high standard.

When we examine the 18 cases referred to the Ombudsman, there is no specific pattern in terms of speciality area. Cases include Orthopaedics, Care of the Elderly, Stroke, Dermatology, ENT, Rehabilitation and Paediatrics. Complaint themes continue to centre around medical care including delay in diagnosis, poor communication (with patients and other NHS organisations) nutritional decisions, end of life care, radiology reporting standards and decisions around discharge planning.

In addition to the 18 new cases referred to the Ombudsman an additional 9 cases were closed. These cases were referred to the Ombudsman the previous year but closed during 2019-20. Of these 9 cases, 1 case was upheld, 5 were partly upheld, 2 were not upheld and 1 case was referred back to local resolution.

If the Ombudsman considers that there has been injustice as a result of the care/treatment provided to an individual the Ombudsman will consider whether it would be appropriate to recommend a financial remedy payment. Financial Remedy Payments made to complainants during 2019-20 totalled £3,850.

**Improving complaint handling**

The Complaints Team are constantly reviewing their processes to ensure timely and quality responses are sent. The Complaints Team have:

- Complaint responses are now in letter formats with the complainant's questions and the Trusts responses clearly documented.
- Responses are quality checked prior to being signed off by the Executive Team

- A review of the complaint process for re-opened complaints, which has now been successfully implemented to ensure high quality timely responses.
- Continue to promote local resolution of complaints as they arise. Encourage meetings with complainants at an early stage of investigations, as beneficial method of sensitively addressing concerns.

One of the main drivers in investigating complaints is to identify opportunities for learning and changes in practice to improve services for patients. Actions and improvements are an integral component of the investigation process. Complaints are discussed at specialty governance meetings.

Examples of learning and actions identified following complaint investigations:

Clinical Support Services:

Following a medicine dispensing error, an action plan has been put in place to ensure that all staff involved have their competencies reassessed. They have also been asked to complete a reflective piece of learning regarding accuracy checking and medication dispensing.

Family Health:

Delay in treatment/procedure regarding post-partum bleeding.

Following the complaint, there has been a review of the guidelines for the management of postpartum bleeding to ensure that a second scan is considered even if the previous scan has been normal. A training programme is also being implemented.

Medicine:

Delay in diagnosing amyloidosis

It has been acknowledged that this is a very difficult condition to diagnose. As a result of the complaint, all cardiologists have undertaken a teaching session to learn more about the amyloidosis to raise awareness of the condition.

Poor documentation of fluid and intake monitoring.

As a result, the Trust has introduced a mandatory fluid balance core training for all staff and the introduction of a fluid balance policy. The purpose of the policy is to ensure that staff are

aware of the importance of fluid balance monitoring. This will also enable all staff to commence, complete and discontinue fluid balance monitoring competently and effectively

Surgery:

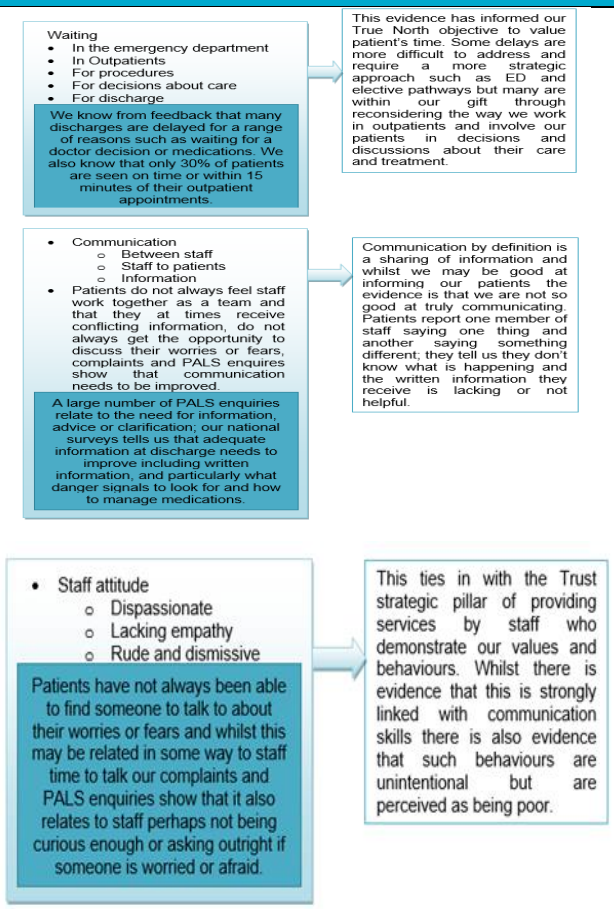
Injury sustained during treatment.

Poor communication with the family, who were not made aware that during the procedure there is a risk of a skin tear even where precautions have been taken. The family or patient were not made aware that this had happened.

As a result, the orthopaedic team have changed their emergency cover to allow the same surgeons to follow up their own patients care post operatively.

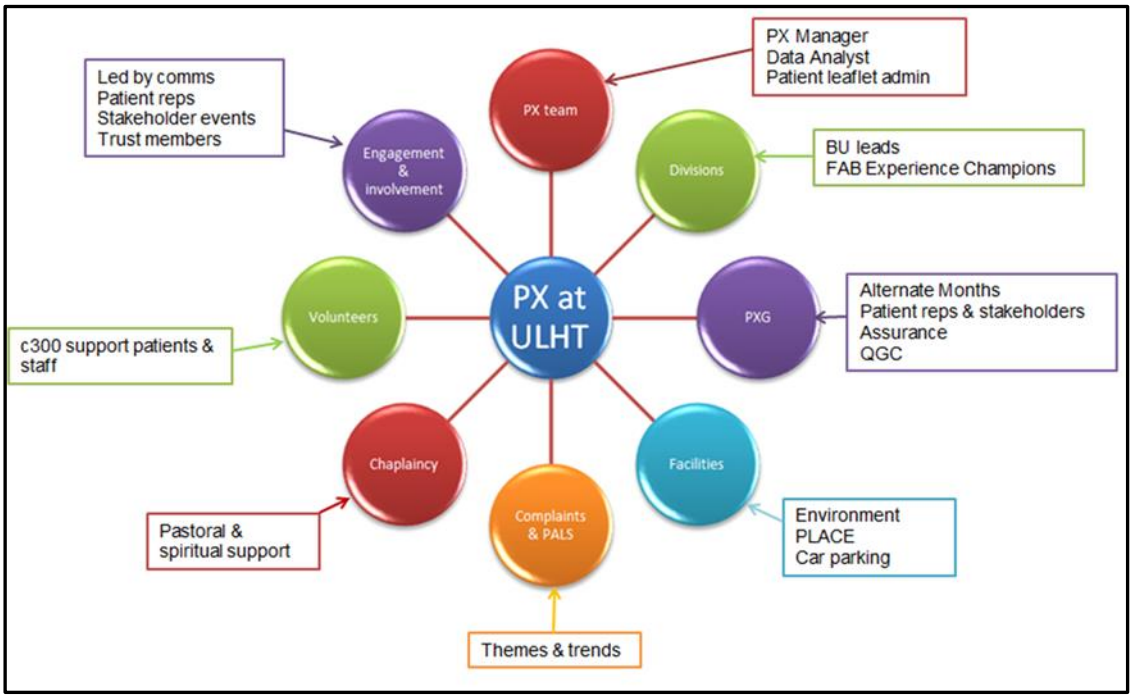
**Patient Experience Plan**

The 2016-2019 Patient Experience Strategy has been reviewed and a new 3 year Patient and Carer Experience Plan developed. The objectives for this have been drawn from what our patients are telling us.

| FFT, national surveys, PALS and complaints: | National survey at a more granular level: |
|---|---|
|  | • Privacy in ED - this relates particularly to corridor waits and a crowded department.<br>• Length of time on the waiting list for admission and whether admission date was changed<br>• Help to eat meals and to wash and keep clean.<br>• Level of confidence and trust in our doctors and that doctors and nurses in some cases talk over patients as if they weren't there.<br>• Keeping patients informed and up to date on their care and treatment; patients are too frequently moved to different wards and this can cause concern and delay discussions and decisions about care.<br>• Discharge concerns relate particularly to being involved in decisions and having written information on what to do post-discharge.<br>• Asking patients about the quality of care during their hospital stay. |

Addressing these 5 principles have been developed:

1. Staff engagement and experience – recognising that to achieve a patient centred approach we must also address staff experience
2. Engaging patients, carers and staff – embedding a culture of genuine involvement and engagement; welcoming patients and carers as expert partners and using their experience to drive improvements and developments
3. Meaningful measurement – measuring well, measuring relentlessly, measuring the right things and acting swiftly on the intelligence is key to meaningful data
4. Turning data into intelligence and action – it is important to triangulate our data alongside other metrics such as staffing and safety indicators; the data itself isn't the objective it's turning it into improvement and innovation
5. Realising our potential – working with leaders across the organisation to unlock their teams' potential




This new plan has drawn on national and local imperatives and provides the blueprint for Patient Experience over the next 3 years and the following illustrations demonstrate some of this year's achievements.

**Academy of FAB NHS Stuff**

ULHT became the first Academy of FAB Stuff Accredited Trust. This is in recognition of an organisation that is committed to the overarching values and ambitions, specifically in relation to leadership and actively supporting this is an improvement philosophy encouraging everyone to share best practice. The Academy principles encourage staff to own change for the benefit of patients and staff. The Trust has won 2 national FAB awards and been finalists for others.

The Trust has launched the following as part of the FAB stuff:

- Caring for Carers
- Swan Scheme patient jewellery pouches
- Spiritual care boxes
- Lincoln Care Home Service (joint submission)
- Ward information placemats
- We have woven FAB principles into our QI programmes

The Trust has held four highly successful FAB-Change days with hundreds of staff pledges and project ‘shares’ and three Patient Experience conferences where FAB has been a pivotal feature. The FAB concept has motivated and enthused staff and encouraged them to seek out what is working well elsewhere but also to celebrate their local improvements such as those shown above shared nationally by our staff alongside many more.



**Development of FAB Experience Champions**

Designed to provide a link in to clinical teams the champion's network 'recruited' 73 staff since its launch in the early summer of 2019. The role of the champion is to seek out, listen and respond to the voice of the patient and carers at service level and to be the champion for that team. A full support package for champions was developed which included guides and resources and training and wards have stepped up to the challenge with development of local patient experience improvements such as a Carers Corner, patient information noticeboards, post discharge follow up contact, development of 'Grab Packs' for patients with Autism, development of Georges Garden and local patient surveys and forum events with actions to address issues raised.


**Launch of the Single Unified Patient Experience Reporting Board – SUPERB**

SUPERB has become the 'go-to' interactive dashboard for our patient experience metrics and enables comparisons and triangulation across FFT, PALS and complaints and Care Opinion with national surveys data looking to be incorporated in the coming months. Explorative work was undertaken with an external company called Hertzian to include semantic and sentiment analysis which will be further developed in 2020-2021. SUPERB was showcased at the #GIANT19 event in October and the work was a finalist at the Lincolnshire 2019 Health Awards.

We know that SUPERB is beginning to become socialised within our services now, for example matrons have discussed how it has been used within team meetings to look at what patients are saying and discuss collectively how to address any issues raised. There have been links established with the Quality Matrons and the accreditation programme to draw out hot spots and hot topics to then create action plans to support wards. SUPERB and other Patient

Experience Metrics have been used as part of the local improvement and service development projects within Pilgrim ED and paediatrics with the data being used to measure and monitor progress and impact.


**Development of real-time surveying**

With the aim to provide teams with timely, triangulated, meaningful and accessible intelligence the real-time surveying project has progressed well with the launch paused only due to COVID-19. The process will be run by a team of specially recruited team of Patient Experience Surveyors and data input directly into iPads, collated and manipulated and then sent directly to team leaders. The team are ready to launch once the Trust exits COVID restrictions.

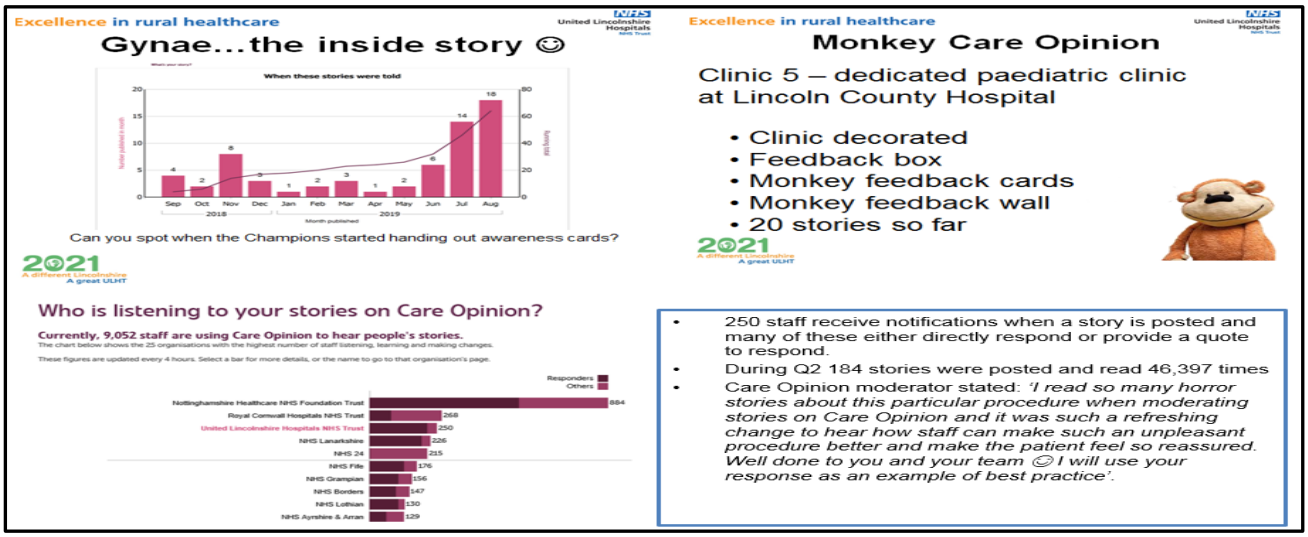
**Widening involvement of patients and carers to hear their stories and voices**

A number of initiatives have been developed but their April launch dates have been paused due to the onset of the Coronavirus: COVID-19; these include:

- The Gift of a Story – putting our patient stories into a digital format enabling sharing and longevity of their use
- Empathy museum – development of a library of staff and patient stories to focus on empathy; understanding others perspectives
- Schwartz Rounding – funding and project plan well developed and ready to restart once current restrictions are eased.

**Presentation to national Care Opinion conference**

ULHT presented at the Care Opinion national conference to showcase the Trusts process for seeking, listening and responding to patients stories. ULHT are in the top 3 ranking of Trusts using Care Opinion and offer support to other Trusts. 250 staff receive direct notifications of stories being posted and are able to directly respond and they share the stories with the team. Negative or critical stories prompt direct contact and response to patients and teams use these to make improvements. Examples included the introduction of a new approach to toast at breakfast to the introduction of placements which detail ward routine and how to contact medical teams.




**Patient Experience Conference 2019**

This year's conference focused on empathy and communication and had presentations from patients and staff. The conference overall was evaluated as excellent from the over 120 staff who attended. Patient representatives told their stories and one in particular led to the patient revisiting the ward and working alongside matron and ward staff to instigate small but impactful changes to the environment and how day appointments are handled. This patient also used her story in teaching sessions.


**FAB Change Day 2019**

In 2017 The Academy of FAB NHS Stuff took over the running of NHS Change Days and here at ULHT we have celebrated and supported them every year. In 2019 we had a range of initiatives including:

- Randomised Coffee Trial – with over 200 people taking part
- High Fives – the giving of simple High Five 'handprints to reward and recognise colleagues and say well done
- Search and Share – encouraging staff to check out the FAB Academy, search for what others are doing and to adapt and adopt quality improvements – and equally to share the great work happening at ULHT. We tied this in with the ULHT QIP and QSIR programmes
- Developed a beginner's guide to Twitter to inspire staff to join up and communicate with healthcare colleagues across the country
- Quizzes and fun events and many random acts of kindness throughout the week that culminated in our appearance at the #GIANT19 event in front of a global audience and being awarded Academy accreditation by Simon Stevens

FAB Change Day is embraced each year with fun, inspiration and motivation for staff. It is an opportunity for staff to look inwards as well as see what other Trusts are doing as often staff can feel they are not perhaps making that much of a difference or have anything to celebrate – a fact that is more than  often totally untrue. From the Coffee Trial relationships have continued such as between a healthcare assistant and a senior manager who keep in touch and share each other's work worlds and perspectives.

Excellence in rural healthcare

The Academy of Fabulous Stuff

#FabChange19

NHS United Lincolnshire Hospitals NHS Trust

# #FabChange19

## Tuesday 15th October – #FabChange19 fun and games!

At the Academy we are all about having fun and spreading inspiration, positivity, motivation and passion! Here are just three of the things we have lined up for you!

**Randomised Coffee Trial (RCT).**
Over a hundred people signed up to join this year's RCT and have now been randomly paired with people from across the Trust to spend a few minutes getting to know each other over a cuppa.
Benefits of RCTs include:

- They are a really good way of creating links within the organisation and encouraging us to collaborate.
- People discover amazing connections with people that they are matched to – we call this the transformational power of serendipity!
- They give permission and opportunity to meet colleagues who are not necessarily involved in our day to day work.
- People enjoy the experience and it contributes to feelings of motivation and being inspired.
- They support wellbeing: providing an opportunity to step outside of our work, take a break and pause while we learn more about our colleagues.
- RCTs offer the chance to make time to talk to the people we should be talking to anyway and to meet people who we won't be directly working with but it's nice to know who they are!


**High Five!**
Recognising and appreciating our colleagues is incredibly motivating; giving a High Five could be for having done a great piece of work, landed a project that is showing results, coming up with a great idea – but equally it doesn't have to be for something huge or monumental; it can be for being a great co-worker, for being there for you, for giving their best, for being great to work with.....it's the gesture and the appreciation that makes a real difference.

So why not send a High Five to someone you know – to say well done or thanks. Cards have been sent to lots of people around the Trust or you can email jennie.negus@ulh.nhs.uk or sharon.kidd@ulh.nhs.uk for a few – or you can make your own (though ours have clever QR codes on them that take you to the websites!)


## Mental Health, Learning Disability and Autism

Whilst strategically sitting within the Safeguarding agenda this work has its core in patient experience and there have been a number of achievements across the last 12 months including:

**Mental Health Q1 achievements**

- Greater Trust awareness about MH issues & care
- All policies up to date.; including new Close Observation Policy.
- All MHA pathways reviewed with LPFT.
- Ligature risk assessments up to date in all areas & new review schedule agreed.
- Adult MH risk assessment designed and being rolled out.
- Core Plus MHLD&A awareness training from July 1st.
- Clinical Holding training progressing well now with support from PMO.
- 360 assurance action plan completed.
- Training sessions held with Gold & Silver commanders & SDMs

New core plus training commenced 1st July 2019.

**Learning Disability – Q1 achievements**

- Completed appraisal against NHSI LD Improvement Standards & actions identified.
- Close working with LPFT LD liaison team.
- Access to LPFT Experts by Experience.
- Core Plus MHLD&A awareness training from July 1st.
- Signed up to Treat Me Well (TMW) campaign & two very successful workshops held in May.
- New TMW steering group convened to meet in August & lead LD improvement work. Membership includes patients, experts by experience, carers and care providers.
- LD Bundle developed and launched.
- TMW focus for #LDWeek19

Learning from case reviews considers patient and staff experience as well as clinical or operational decisions & actions

Very successful start to Treat Me Well campaign & ULHT led multi-agency action group convened.

**Autism – Q1 achievements**

- Lincolnshire Strategy presented to 2021 Board & Trust signed commitment statement.
- Very active ULHT Steering Group with x 2 experts by experience.
- Close Observation Policy includes specific needs for Autistic patients.
- First 3 services identified for undertaking Reasonable Adjustment mark:
  - LCH OT
  - Navenby Ward
  - Recruitment team

#LDWeek19 week long campaign a huge success

Launch of LD Bundle; MHA bundle due for release in August.

**Integrated Improvement Plan (IIP)**

The Integrated Improvement Plan (IIP) is our 5-year Improvement Plan. It identifies the key priorities for the Trust over the next 5 years 2020-2025 ensuring we are focused on the right things for both our patients and our staff. The Trust is now seeking to move from a short term, reactive approach to quality and safety to a more comprehensive and planned approach. This streamlined approach will help to make a real difference for our patients and support our staff to deliver the high standards of care to which we all aspire. Effective partnerships across the Lincolnshire health community are vital for achieving our overall goals and we are committed to working as one health and care system.

Within the Trust IIP the strategic framework 2020-2025 provides our future direction:

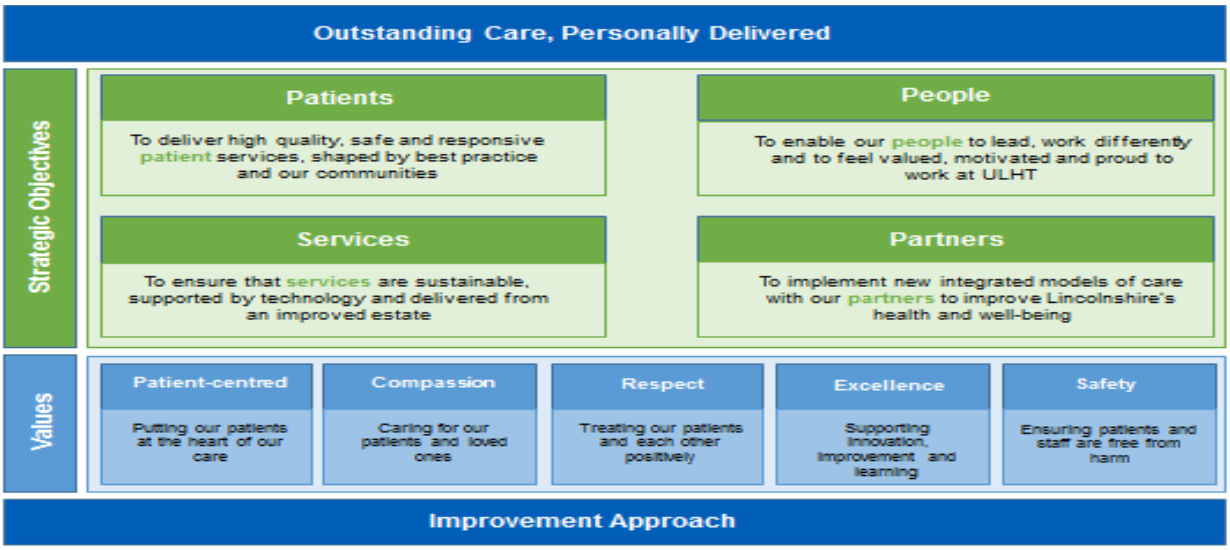
**Patients** - To deliver high quality, safe and responsive patient services, shaped by best practice and our communities.

**People** - To enable our people to lead, work differently and to feel valued, motivated and proud to work at ULHT.

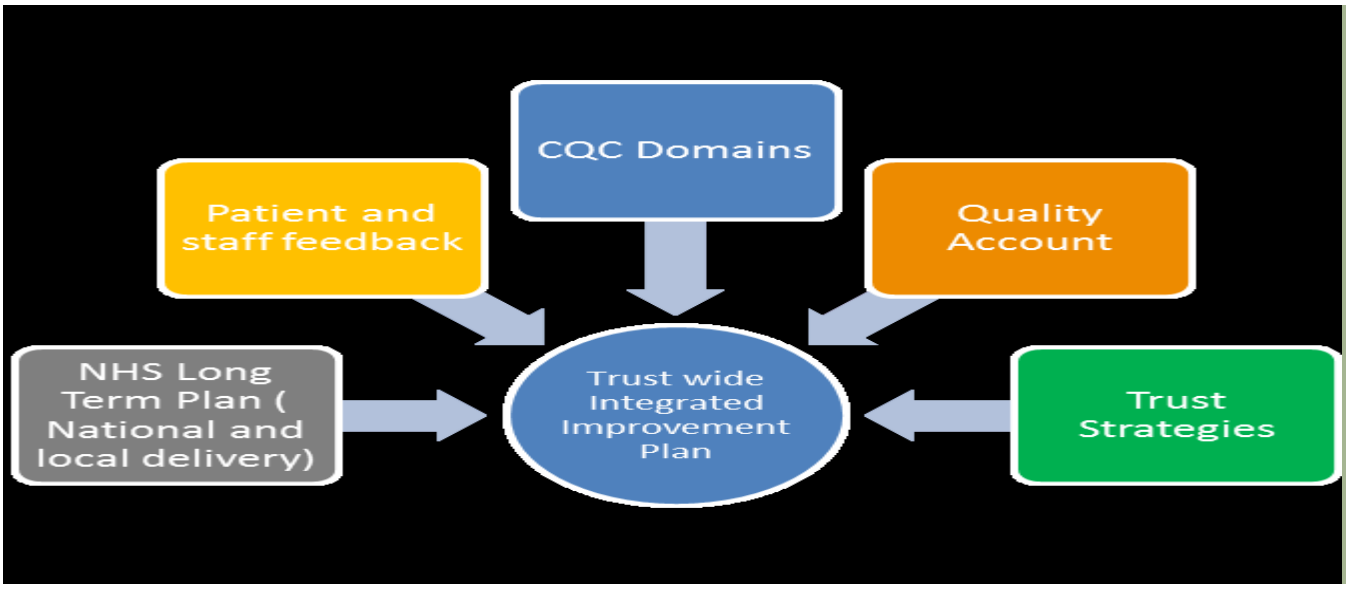
**Services** - To ensure that services are sustainable supported by technology and delivered from an improved state.

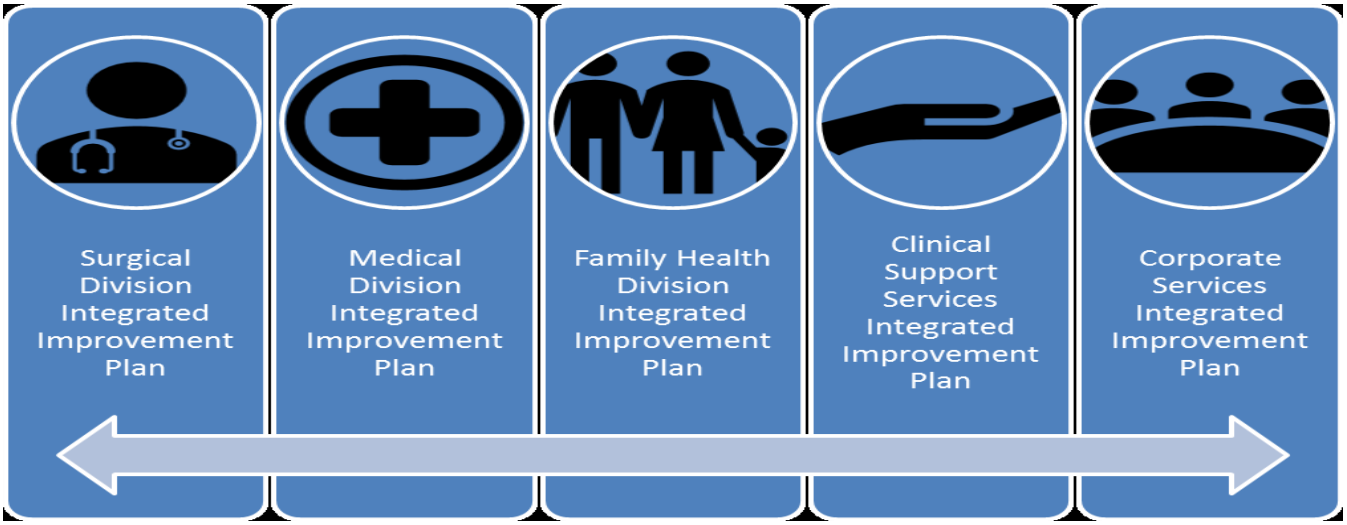
**Partners** - To implement new integrated models of care with our partners to improve Lincolnshire health and well-being.

**Our strategic framework 2020-2025 provides our future direction:**



**Our Trust Integrated Improvement Plan will be at the centre of all we do, supported by our Trust values**




| Strategic Objectives | **Patients** To deliver high quality, safe and responsive **patient** services, shaped by best practice and our communities | **People** To enable our **people** to lead, work differently and to feel valued, motivated and proud to work at ULHT | **Services** To ensure that **services** are sustainable, supported by technology and delivered from an improved estate. | **Partners** To implement new integrated models of care with our **partners** to improve Lincolnshire's health and well-being. |
|---|---|---|---|---|
| **Our 5 year priorities** | Deliver Harm Free Care<br><br>Improve patient experience<br><br>Improve clinical outcomes | A modern and progressive workforce<br><br>Making ULHT the best place to work<br><br>Well-led services | Modern, clean and fit for purpose environment<br><br>Efficient use of our resources<br><br>Enhanced data and digital capability | Establish new evidence-based models of care<br><br>Advancing professional practice with partners<br><br>To become a University Hospitals Teaching Trust |

| | | | | |
|---|---|---|---|---|
| **Our Outcomes** | HSMR and SHMI are within the top quartile nationally<br><br>Patient Surveys in top quartile<br><br>Top quartile for national clinical audits and benchmarking<br><br>To meet all of our regulatory requirements | Top quartile for vacancy and turnover rates<br><br>Staff Survey results in top quartile<br><br>Rated outstanding for Well-led | Capital funding secured to deliver trust strategies<br><br>Financial Plan delivered<br><br>Staff will have access to real time-data via electronic systems | All nationally required access standards delivered<br><br>A full partner in a functioning ICS<br><br>Reduced activity delivered in acute setting<br><br>Acute Service Review delivered in partnership<br><br>To be a University Hospitals Teaching Trust |

**Equality Diversity and Inclusion**

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

We aim to continually develop and ensure that equality is incorporated into everything we do, as 'the golden thread' to all our activity. We value equality, diversity and inclusion and have set out our approach in our policies and practices with the aim of ensuring dignity and respect for all. Since 2018 the Trust has an inclusion strategy which includes our equality objectives for the duration of the strategy 2018-2021. Our inclusion strategy can be accessed on the Trust website: https://www.ulh.nhs.uk/about/equality-diversity/equality-objectives/

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

**Celebrations and recognition of dedicated hospital staff**

Around 200 patients, volunteers and staff members from across the Trust, came together to celebrate at the annual ULHT Staff Awards which recognises and celebrates the dedication and hard work of staff. This year more than 600 nominations were received for staff in a wide range of job roles, all showcasing the fantastic quality of care that is given to patients and colleagues in Lincolnshire's hospital.

At the ceremony, held on Thursday 2nd May 2019 at the EPIC Centre at Lincolnshire Showground, there were 12 award categories including awards for outstanding leader, unsung hero, research and innovation, and great patient experience.


**Freedom to speak up**

In October 2016 the Trust complied with the NHS Contract requirement to nominate a Freedom to Speak Up Guardian. As an organisation, we are committed to investigating and taking appropriate action where concerns are raised with us, and have arrangements, including the Guardian to ensure staff who raise concerns are fully supported to do so. The Trust Freedom to Speak Up Guardian has lead responsibility to ensure that the appropriate handling of concerns is in place and the effectiveness of the local systems is considered by the board. The Trust has a Freedom

to Speak Up Policy which describes the different ways staff can speak up and assures them that staff who speak up will not suffer detriment. The opportunity to feedback is given through a feedback question offered when a speaking up matter is concluded.

**How does the Trust support staff to speak up:**

- Through its Voicing Your Concerns Policy.
- Through the Freedom to Speak Up Guardian.
- Through the 13 Freedom to Speak Up Champions who have been engaged to support speaking up across all staff groups and geographical sites.
- Through the commitment of the Board to champion the importance of raising concerns. The Board receives a quarterly report on speaking up and has completed the self-assessment
- The FTSU Guardian meets regularly with the Trust Chief Executive and Non-Executive Champion for Speaking Up.

**What should staff do if they have a concern:**

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

**Guardians of Safe Working**

All organisations employing 10 or more trainee doctor trainees are required to appoint a Guardian of Safe Working. This principle was agreed as part of the negotiations around the 2016 junior doctor contract. The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by the Trust. The guardian role provides assurance to the employer that issues of compliance with safe working hours will be addressed, as they arise. The Trust has appointed a Guardian of Safe Working, one who has this responsibility for junior doctors employed across the Trust. He is supported by an Human Resources Manager.

The office of the Guardian has established regular pan Trust Junior Doctor Forums that run every 6 weeks. The forums ensure that issues and concerns are highlighted and resolved with

management involvement. This relationship also 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 and Organisational Development Committee, within their reports include details of the numbers of exception report and they draw out themes which we use to improve the experience of junior doctors at the Trust.

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

# PERFORMANCE AGAINST NATIONAL PRIORITIES AND ACCESS STANDARDS

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

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

The national standards are:

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

| Access Key Performance Indicators | | Quarter 1 | | | Quarter 2 | | | Quarter 3 | | | Quarter 4 | | | 2019-20 | 2018-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr 19 | May 19 | Jun 19 | Jul 19 | Aug 19 | Sep 19 | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 | | |
| A&E 4 hours | Actual % | 66.36 | 68.22 | 72.44 | 67.05 | 69.24 | 73.07 | 64.22 | 62.04 | 64.71 | 67.00 | 68.42 | 73.87 | 68.05 | 69.75 |
| | Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| 62 day GP Cancer | Actual Classic % | 77.31 | 65.52 | 79.08 | 73.42 | 65.60 | 72.86 | 65.70 | 65.70 | 63.30 | 54.94 | 67.13 | 77.04 | 68.97 | 73 |
| | Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |
| | Actual Screening % | 100 | 92.11 | 90.16 | 82.10 | 86.57 | 64.52 | 68.10 | 83.33 | 81.10 | 67.57 | 70.59 | 81.4 | 80.63 | 87 |
| | Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| RTT | Actual % | 84.16 | 84.48 | 83.16 | 83.20 | 82.64 | 82.27 | 82.92 | 83.52 | 82.75 | 83.52 | 82.23 | 79.25 | 82.84 | 83.69 |
| | Target | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% |
| 6 week diagnostic | Actual % | 96.71 | 96.03 | 97.09 | 94.53 | 94.15 | 96.59 | 97.65 | 96.55 | 94.13 | 95.35 | 99.08 | 91.94 | 95.82 | 97.53 |
| | Target | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% |
| Clostridioides difficile | Actual | 5 | 4 | 4 | 3 | 6 | 9 | 10 | 10 | 4 | 3 | 4 | 4 | 66 | 57 |
| | Target | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 108 | 59 |
| VTE | Actual % | 96.15 | 97.21 | 96.57 | 97.53 | 97.16 | 96.98 | 97.60 | 97.60 | 97.43 | 97.89 | 98.18 | 96.42 | 97.23 | 96.66 |
| | Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |

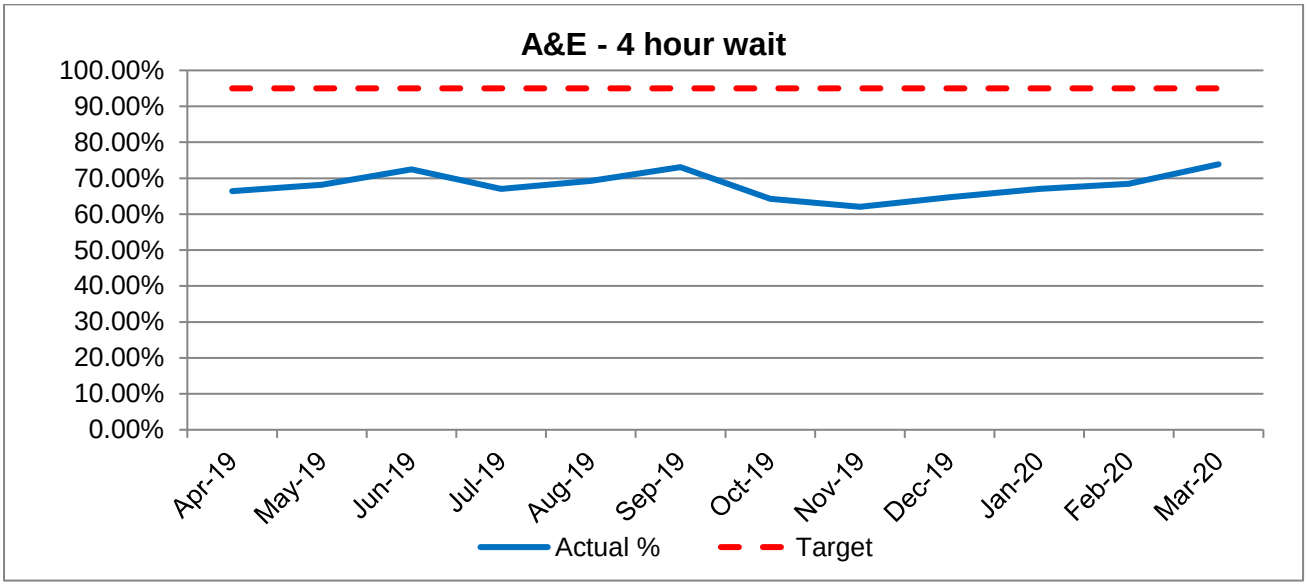
Not Achieved

Achieved

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

The performance for the 4 hour A&E standard for April 2019 – March 2020 was 68.05%.

**A&E 4 hour performance April 19 – March 20**




The performance for the 4 hour A&E standard for 2018-19 was 69.75%.

## Actions undertaken to improve performance

In the early part of 2019-20 the Trust embarked upon the largest improvement programme of its kind in the Trust, an Urgent and Emergency Care Programme (UEC). The Programme consisted of seven work-streams all aimed at improving patient quality, performance and the experience of staff. The work-streams focussed on the emergency pathway from attendance through to discharge and included actions to improve triage, ambulance handover, medical staffing, primary care streaming, ambulatory care, ward processes, discharge and reconfiguration. The model for Improvement used by the UEC Programme is that promoted by the NHS Academy, 'Quality Service Improvement and Redesign' or QSIR. Part of the success of the UEC Programme was that it became an established and recognisable improvement programme within the system. The Emergency Care Intensive Support Team (ECIST) continued to provide support to the Trust throughout the year sharing good practice.

Areas that have seen the greatest improvement and contribution towards achieving improved 4-hour improvement are as follows:

Triage is an assessment that takes place when patients first attend the department to ensure unwell patients are identified sooner. Trusts are expected to perform at 100% against this target and whilst this has fluctuated during the year, by March 2020 Triage was performing at 96%. This is due to there being more trained staff than in the previous year

Another area that has seen significant improvement is primary care streaming. This is a service co-located within the emergency department that reviews patients who do not need to be seen through an emergency pathway. The aim was to achieve 20% of emergency attendances through this stream and this has been successfully delivered through some great partnership working with our community partners Lincolnshire Community Healthcare Services. With out of hours' care included in this metric for primary care streaming, the service has been able to deliver closer to 30%.

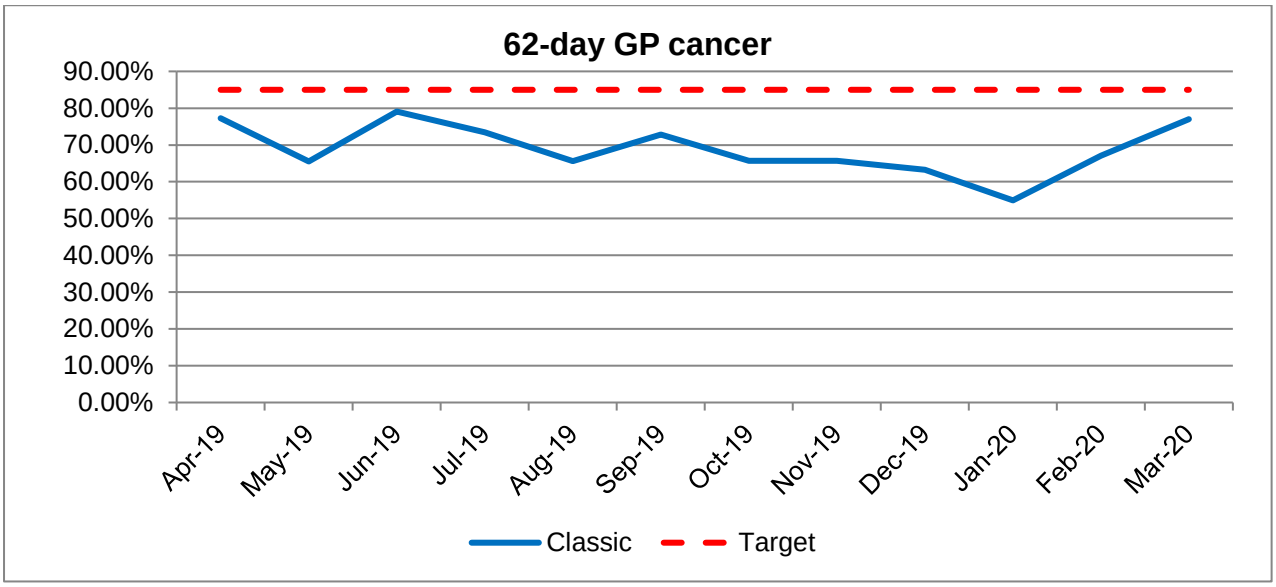
Whilst medical staffing continued to be challenging during the earlier part of the year, demand and capacity modelling and a staffing options appraisal presented to Board later in the year which was approved have enabled further recruitment to take place and a new staffing model to be implemented. This is a significant step towards sustained improvement in emergency care, with the time to first assessment, a well- documented key metric in achieving overall 4-hour performance, beginning to see a month-on-month improvement.

Being able to take handover for patients on ambulances within expected timescales has continued to prove challenging. Whilst some improvement has been seen, this has not been sustained. Delaying an ambulance handover impacts on EMAS's ability to be able to respond to urgent calls within the community, and we are continuing to work with our EMAS partners to look at solutions to improve this metric.

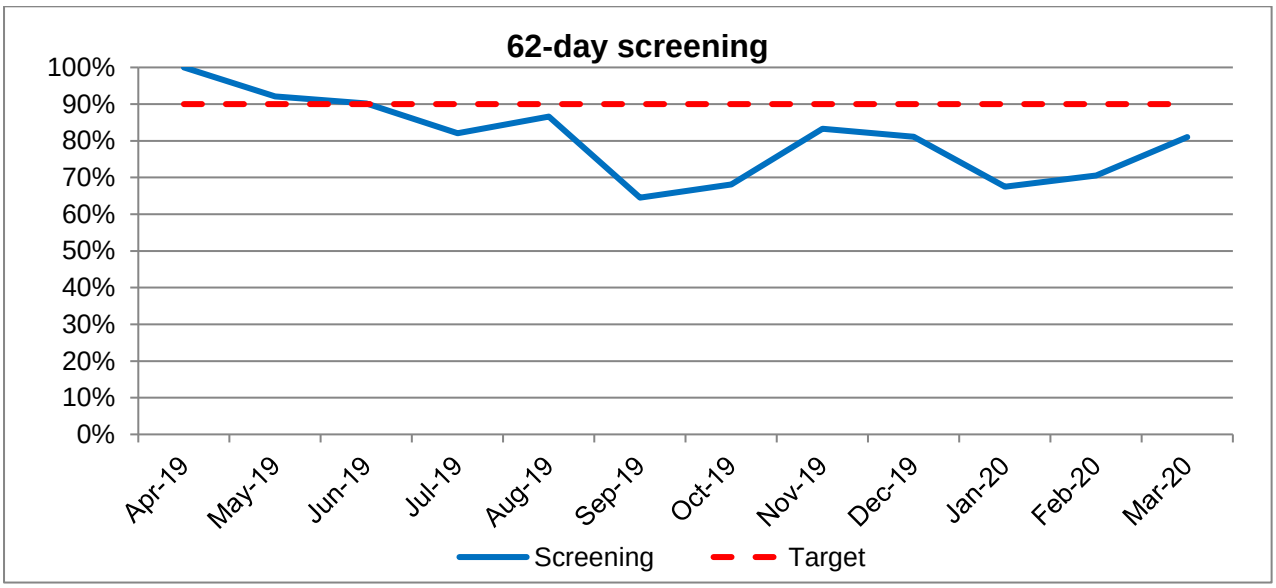
**Cancer 62 day waits**

Performance for 2019-20 has been consistently poor and we have not achieved the national targets which were expected in March 2020.

**Cancer compliance April 2019 – March 2020**




The performance for cancer 62-day classic for 2018-19 was 73%.




The performance for cancer 62-day screening for 2018-19 was 87%.

**Actions undertaken to improve performance**

In December 2019 it was agreed across the system that the Trust would adopt an Improvement Methodology approach to support the Division's to deliver the cancer standards. A more structured, simplified, metric led improvement approach would enable greater transparency of delivery and therefore improve lines of accountability and relations between the commissioners and ULHT.

The improvement approach is to provide a simplified plan, data-driven, and testing areas to ensure optimum pathway improvement. The framework is made up of five key speciality areas and cross-cutting themes with key milestones and metrics attached.

Tumour site-specific pathway improvement work streams:
Broken down to detail actions to improve time to diagnosis and actions to improve time to treatment

Cross-cutting work streams, including:

- Operational governance including booking and scheduling
- Oncology
- Diagnostic turnaround – imaging, endoscopy, pathology
- MDT Review and effectiveness
- Tertiary partnerships and collaboration

5 High impact actions were identified, these were identified through monitoring the number of 62 Day patients treated and the number of breaches. Further analysis work for each speciality area is being considered to further scope the service using the NHSI pathway analyser tool as this analysis will look at patients treated in the last 30/ 60 days depending on treatment numbers. The aim of this further analysis work is to support and understand the areas of concern and broaden the deep dive of each specialty areas to ensure they are correct.

The High impact action plans are all uploaded on to Aspyre the Sustainability and Transformation Partnership (STP) Programme and Project planning tool. Each speciality area has a Quality, Service Improvement and Redesign (QSIR) Scoping Brief. Each Speciality area has a project team to support the improvement plan and key metrics.

The 5 areas include;

1. Urology
2. Colorectal
3. Upper Gastrointestinal
4. Lung
5. Gynaecology

For the period of time from January to March 2020 the above areas were scoped and improvement plans were identified and work continued to take place improving aspects of the pathways.

**18 weeks – Referral to Treatment (RTT)**

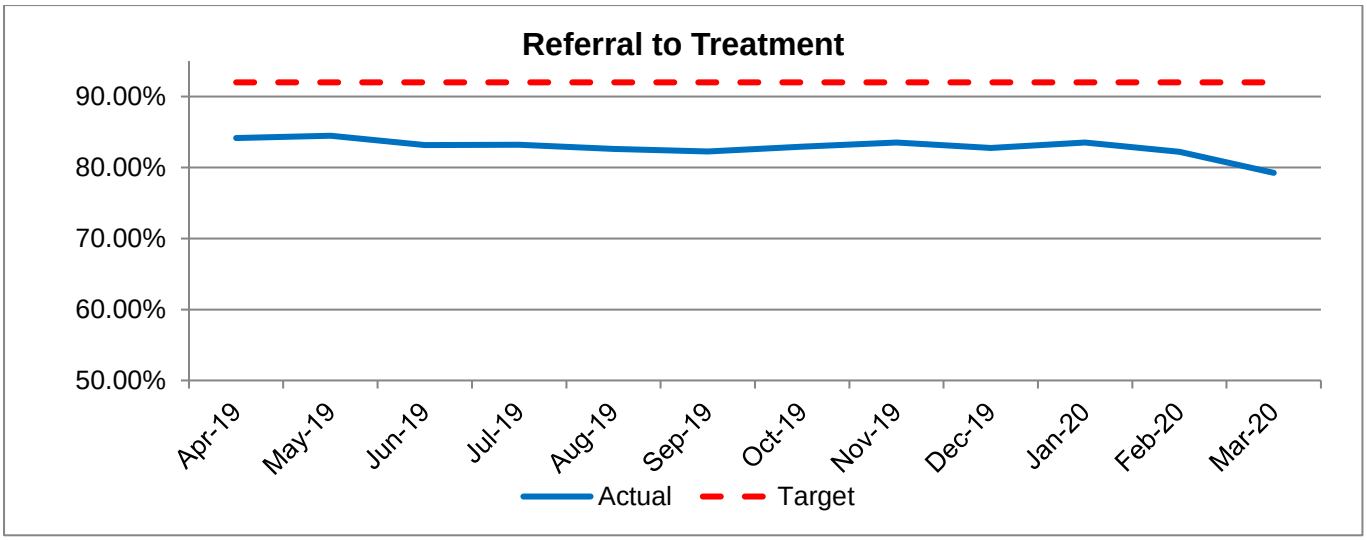
During 2019-20 in addition to the 92% Referral to Treatment (RTT) standard national and regional focus has been on elimination of waits in excess of 52 weeks and reduction of the overall waiting list size.

ULHT RTT performance has maintained an average of just above 83% with variation within control limits.

The Trust had eight RTT 52 week breaches April to September 2019. There were zero 52-week breaches in quarters 3 and 4.

The overall waiting list reduced in size and achieved the agreed target of 37,761 by 31st March 2020.

**RTT compliance April 2019 – March 2020**




The performance for RTT for 2018-19 was 83.69%

**Actions undertaken to improve performance:**

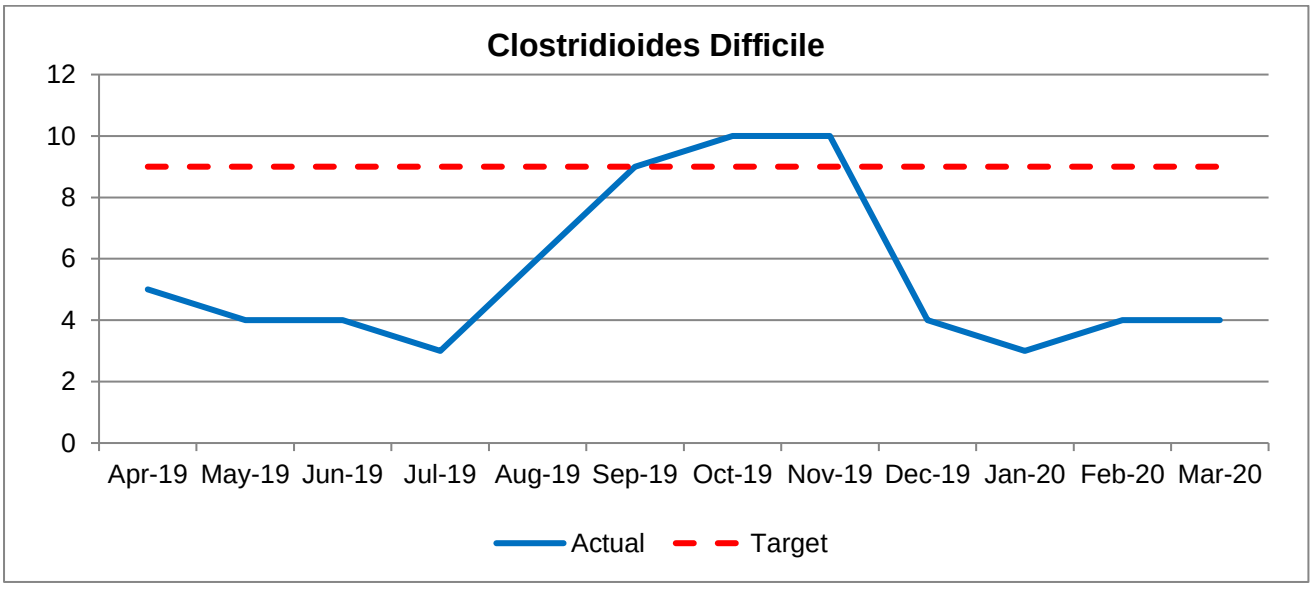
- Deputy Chief Operating Officer post established to lead Planned Care performance improvement
- NHSE/I Intensive Support Team (IST) review and recommendations regarding RTT pathway management embedded
- External validation capacity funded to validate pathways
- System improvement programme focused on challenged specialties, with particular success in neurology

**Clostridioides Difficile Infection**

The acute provider objectives for 2019-20 has been changed to include the two categories:

- Hospital-onset healthcare-associated: cases that are detected in the hospital two or more days after admission
- community onset healthcare-associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks.

**Clostridioides difficile rates April 2019 – March 2020**



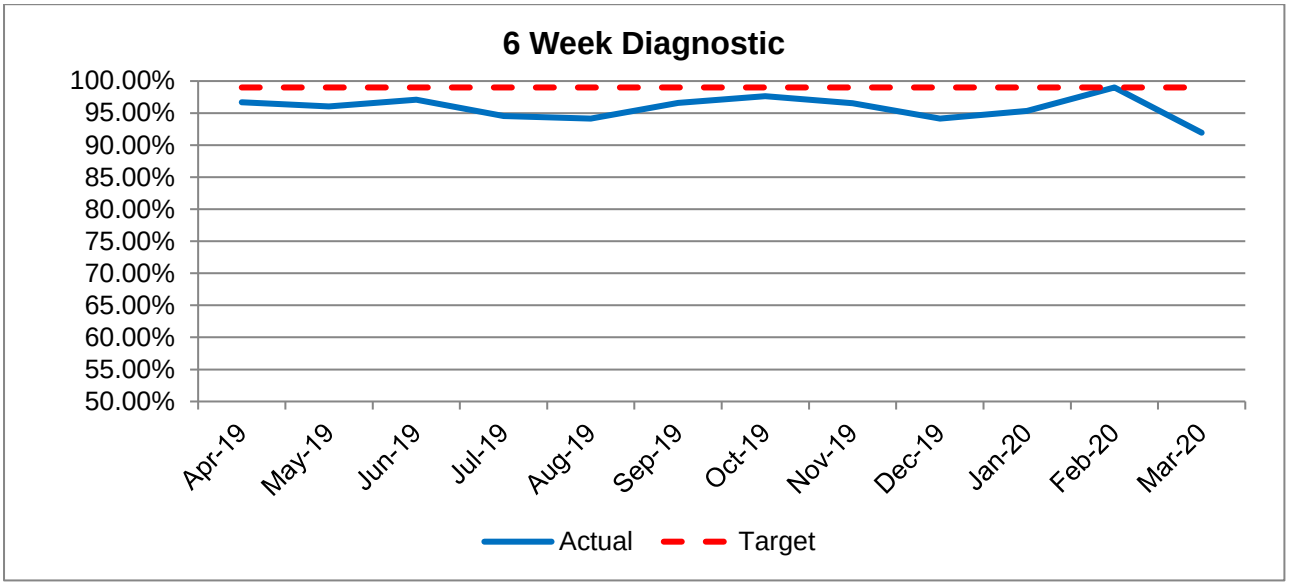

The performance for Clostridioides difficile for 2018-19 was 57 cases.

The Trust was under the allocated number for Clostridioides difficile infection.

**6-week wait diagnostic procedures**

This standard covers the top 15 high volume diagnostic tests. The expectation is that, at each month-end, 99% of patients waiting for these tests should have been waiting for less than six weeks.

**6 Week diagnostic compliance April 2019 – March 2020**




The performance for diagnostics for 2018-19 was 97.53%.

In February 2020 the Trust achieved the 99% target, however, due to COVID-19 the performance dropped in March 2020.

**Actions undertaken to improve performance:**

- Cardiac echoes utilised additional capacity to keep breaches to a minimum
- Urodynamics outsourced some of the procedures to the private hospital (BM)I and used the capacity across the Trust and divisions
- Urology utilised additional capacity to bring down their month-end breaches
- Neurophysiology utilised additional capacity and outsourced to reduce their month-end breaches

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# ANNEX 1

OUTSTANDING CARE
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# STAKEHOLDER COMMENTS

## NHS Lincolnshire Clinical Commissioning Group (Lead Commissioner)

NHS Lincolnshire Clinical Commissioning Group (the commissioners) welcomes the opportunity to review and comment on the United Lincolnshire Hospitals NHS Trust (the trust) Annual Quality Account 2019 – 20.

The Quality Account provides very comprehensive information on the quality priorities that the trust has focussed on during the year including delivering a sustained reduction in HSMR (Hospital Standardised Mortality Rate). HSMR compares an organisation's actual number of deaths with their expected number of deaths, the systems implemented for reviewing mortality has enabled the trust to be in the top 25% performing trusts nationally.

Looking forward to the 2020 – 21 Quality Priorities the commissioner is pleased that the approach of maintaining a focus on patient safety is continuing whilst at the same time aligning a number of these priorities to the Lincolnshire System Quality Priorities, these include:

- The safe discharge of patients will enable the trust to support the Emergency Department by improving patient flow throughout the hospital. The trust is regularly delivering care at 92% of hospital capacity and often more than this figure in winter periods, NHSE advises that the optimum is 85%.
- Identification of the need to deliver harm free care in a repeatable way across the trust to all patients but particularly identifying deteriorating patients. The clinical management of sepsis, fluid management, compliance with the World Health Organisations Surgical Safety Checklist and communicating effectively between teams shall have a particular focus.
- Infection Prevention and Control is a building block of good healthcare and the trust is committed to achieving the hygiene code and demonstrating this compliance

The Quality Account has numerous examples of the good work undertaken by the organisation over the past year but the commissioner believes the trust launch of the Single Unified Patient Experience Reporting Board (SUPERB) which triangulates a range of patient experience metrics is particularly noteworthy.

The trust has been subject to two Care Quality Commission inspections over the past year the first inspection rated the organisation as "Requires Improvement" and the second inspection rated the Emergency Department as "Inadequate".

Whilst commissioners' are concerned at these ratings the CCG will continue to support and work with the trust to address the required improvements.

The commissioners would like to thank United Lincolnshire Hospitals NHS Trust who have worked very hard with partners in the Lincolnshire Health System during the COVID-19 pandemic to ensure patients' needs are met in this challenging time.

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

Elizabeth Ball
Associate Director of Nursing & Quality
NHS Lincolnshire Clinical Commissioning Group

## Healthwatch Lincolnshire

**United Lincolnshire Hospital Trust Quality Account Statement 2019/20**

Healthwatch Lincolnshire Quality Account working group: Dean Odell (Contract Coordinator), Maria Prior (Board Chair), Pauline Mountain (Steering Group Chair), Brian Wookey (Trustee), Lyndy Moulder (Trustee).

Healthwatch Lincolnshire would like to thank Bernie Gallen and Sally Seeley 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 where possible, in many cases providing 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.

**Commentary relating to the previous year's Quality Accounts**

Priority 1 – *Patient and Carer Experience*. Friends and Family Test results were not aligned with national averages, but the comments are being used to implement improvements in services. Healthwatch Lincolnshire would encourage the trust to embed a culture of using patient experience to drive improvement.

Priority 2 – *Recommended as a place to work*. We recognise this priority was suspended and superseded by the launch of the Integrated Improvement Plan (IIP).

Priority 3 – *Ensuring Effective Systems for Reviewing Mortality*. This priority was met, and we welcome the initiation of the Mortality Assurance Learning Strategy (MorALS) Group once the Trust begins the recovery stage.

Priority 4 - *Cared For In The Right Place At The Right Time*. Respiratory Patients – This priority met 5 out of the 6 areas. It did not meet the target of Non-Invasive Ventilation (NIV), however, the Trust has included the NIV pathway within this year's priorities and we hope learning from last year has been taken on board.

**Priorities and challenges for the forthcoming year**

**Priority 1 – *Care of Respiratory Patients*.** the current measures of success include the review of a number of processes and clinical pathways. Healthwatch Lincolnshire would like to see the inclusion of more outcome focused measures of success for this priority.

**Priority 2 – *Safe discharge of our patients*.** Over the last few years Healthwatch Lincolnshire has highlighted safe discharge as an area of concern and we are aware that this is something ULHT have been working on improving for some time but with limited effect. Improved system working across health and social will be required to meet this priority. Healthwatch as a national network are looking to focus some work into hospital discharge this year, and as the local Healthwatch we will feed information gathered into this initiative both locally and nationally.

**Priority 3 – *Care of the deteriorating patient*.** We welcome the recognition that the current care is sub-optimal but there is little detail around how this will be achieved in practice.

**Priority 4 – *Delivering harm free care*.** Considering the high number of Never Events in 2019/20, we welcome the inclusion of this priority. However, there is not much evidence as to how success will be achieved. We would also urge the Trust to include zero Never Events as a desired outcome for this priority in these Quality Accounts. We would also encourage the inclusion of 'always' events, things that should always be done 100% of the time.

**Priority 5 - *Infection Prevention and Control*.** There are 150 items on IPC list. Have we assurances that there will be compliance for each one? We welcome the inclusion of your action plan with monthly milestones.

Healthwatch Lincolnshire, in our Watchdog role, plan to benchmark your five 2020/21 priorities during the coming year against patient and carer feedback. As part of this process we will be inviting ULHT to provide periodic performance updates against them. We believe this approach will help to bring more relevance and support to our involvement in responding to future Quality Accounts.

We welcome the various work streams and priorities for 2020/21 and see the potential for much improved partner working across many of the priorities, including 'Safe Discharge of Patients' and increasing implementation of the ReSPECT process. We strongly believe that partnership working with other providers such as patient transport, primary care and care homes can only improve the quality of care for patients across the whole of health and social care.

**Healthwatch Themes and Trends for ULHT – The last 12 months**

The sentiments below are shared to give example of service-related comments.

- General lack of communications in relation to: -
  - Appointments being cancelled without reason
  - Results not being sent to patients GP surgeries, either in a timely manner or at all, patients having to chase these
  - Medication changes not being sent to GP surgeries, resulting in delays in patients getting new medication
  - Lack of communication between departments (information not passed on resulting in anxiety for patients/families)

- Patients told us about their mixed experiences with A&E, many commented they felt they were treated with respect and found the staff most helpful, however others experienced the opposite.

- There were also several comments that stated patients felt well cared for during their stay in a ULHT hospital in different departments.

- During the COVID-19 outbreak many patients felt there could be more information provided around their appointments being cancelled. Patients understand the necessity for this but feel they have been left with little or no further communication. A helpline would be useful for each speciality so patients could make contact should they need any advice or guidance in their situation.

Healthwatch Lincolnshire appreciates and supports the honesty in the Quality Accounts where the Trust identifies there is still much more work that needs to be done as they remain in quality and financial special measures. Healthwatch Lincolnshire continue to have concerns around cancer services and A& E performance. Healthwatch Lincolnshire is here to support these improvements with the inclusion of learning from patient experience.

Finally, we consider our relationship with ULHT is very positive and look forward to continued engagement with the Trust in the coming year.

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

**Statement on United Lincolnshire Hospitals NHS Trust's *Quality Account* for 2019/20**

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

Covid-19

The impact of covid-19 on the whole Trust is of course unprecedented, although the peak of activity was after the end of the quality account year. The Committee would like to record its thanks to all the staff, who have continued to provide services during the most challenging period in the history of the NHS. The Trust is to be commended in ensuring that stocks of personal protective equipment have remained available for staff during the pandemic.

Progress on Priorities for Improvement for 2019-20

The Committee welcomes the Trust's progress on the four priorities for improvement for 2019-20, which are considered in turn: -

- *Priority 1 – Patient and Care Experience* – Six of the seven actions have been achieved, which is welcome and the continued work to improve patient feedback data is noted.
- *Priority 2 – Organisation as a Place to Work and be Treated* – All actions have been achieved, which is commended, and the consolidation of this work in the integrated improvement plan is noted.
- *Priority 3 – Effective Systems for Reviewing Mortality* – All actions have been again been achieved. The planned launch of the mortality assurance learning strategy group during the Trust's recovery phase is noted.
- *Priority 4 – Improving Care and Treatment for Respiratory Patients* – Five of the six actions have been achieved and the inclusion of the non-invasive ventilation pathway in the 2020-21 priorities is supported.

Priorities for Improvement for 2020-2021

We support the selection of the five priorities for 2020/21.

- *Priority 1 – Care of Respiratory Patients* – The Committee understands this priority applies to all patients, including those affected by covid-19 and will build in previous work in response to the *Getting It Right First Time* improvements.
- *Priority 2 – Safe Patient Discharge* – The rationale for focusing on the safe discharge of patients, including improving 'patient flow' through the hospitals, is accepted, and progress on this priority would be welcome.
- *Priority 3 - Care of the Deteriorating Patient* - Prompt diagnosis and treatment of sepsis is key to delivering improved care for patients in this category.
- *Priority 4 – Harm Free Care* – Ten 'never events' during 2019-20 is much higher than usual, so all actions to eliminate never events are a key priority.
- *Priority 5 – Infection Prevention and Control* – Improving compliance against the hygiene code is supported.

Care Quality Commission

The Care Quality Commission (CQC) suspended most of its inspection activities in March 2020 and it is not yet known when these will fully resume. There are some outstanding actions for the Trust from previous CQC reports, and again the Committee is unsure when the CQC will begin its follow-up activities. As noted previously, poor CQC ratings can impacts on staff morale; and recruitment and retention. The Trust's continued status of being in special measures for its care, as well as for its finances, will be considered by the Committee in the coming year, as part of updates on the Trust's progress with its integrated improvement plan.

Reducing Harm from Pressure Ulcers

The Committee congratulates the Trust on the significant reductions in the number of category three and four pressure ulcers, with only one of the latter recorded during 2019/20.

Engagement with the Health Scrutiny Committee for Lincolnshire

During 2019-20, frequent engagement with the Health Scrutiny Committee for Lincolnshire has continued. This has included during the summer of 2019 attendance by clinicians at the Committee as part of the presentations on the *Healthy Conversation 2019* engagement exercise, which provided the Committee with a deeper understanding of the rationale for each preferred option.

We look forward to continued engagement with the Trust's senior managers in the coming year. This will be particularly important as the Trust, together with the rest of the local NHS, balances the challenges of responding to covid-19 with restoring care and treatment to non-covid-19 patients.

Workforce Challenges

The Committee understands that recruiting and retaining staff is continuing to be an issue for the Trust. There are also challenges with the staff being transferred from one hospital to another to support the restoration of services. Communication with staff is paramount so that they are involved in developments, whether long term or temporary.

Grantham Accident and Emergency

The closure of Grantham A&E overnight from August 2016 has been a longstanding concern for the Committee. During the last year, the Committee has sought information on the impact of this continued closure on the waiting times at other A&Es, for example at Lincoln County Hospital, as this will need to be taken into account in the eventual consultation on its future.

Although outside the quality account year, the conversion of Grantham A&E into an urgent treatment centre in June 2020 on a 'temporary' basis has led to further concern. The Committee's position is that consultation on the long term future of Grantham A&E should take place as soon as possible.

Presentation of the Document

We are again pleased to see a clear indication as to whether the success measures for each action supporting each priority have been achieved. We also welcomed the opportunity to provide direct feedback on the presentation of information in the draft quality account, particularly on how the priorities for 2020/21 are set out.

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 five quality improvement priorities in the coming year and will continue to seek to engage the Trust at its meetings.

## Explanation of changes from stakeholder feedback

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

No changes required

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

Respiratory priority: Outcome measures have been included within this priority.

Care of the deteriorating patient: Greater detail has been added to this priority.

Delivering harm free care priority – there was a request to have zero surgical Never Events which has been included.

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

The Committee requested design changes to the 2020-2021 priorities which were made.

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# ANNEX 2

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# STATEMENT OF DIRECTORS' RESPONSIBILITIES

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

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

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

- The content of the quality account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019-20 and supporting guidance; Detailed requirements for quality account 2019-20;

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

- Board minutes for the financial year, April 2019 and up to 4th June 2020 ("the period");

- Papers relating to quality reported to the Board over the period April 2019 to the date of signing this statement;

- Feedback from the Commissioners Lincolnshire East Clinical Commissioning Group on behalf of the Lincolnshire Federated Quality Function dated 9th July 2020;

- Feedback from local Healthwatch organisations Healthwatch Lincolnshire dated 24th July 2020;

- Feedback from the Overview and Scrutiny Committee, Lincolnshire County Council Health Scrutiny Committee dated 14th July 2020

- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2018-19;

- The latest national patient survey, CQC Survey Coordination Centre Maternity Care Pathway Reports: antenatal care, dated January 2019;

- The latest national patient survey, CQC Survey Coordination Centre Maternity Care Pathway Reports: labour and birth, dated 2019;

- The latest national patient survey, CQC Survey Coordination Centre Maternity Care Pathway Reports: postnatal care, dated 2019;

- The latest national patient survey, CQC Survey Coordination Centre Patient Survey Report, dated 2019;

- NHS England National Cancer Patient Experience Survey, published 25th June 2020;

- The latest national and staff survey, Survey Coordination Centre, United Lincolnshire Hospitals NHS Trust, NHS Staff Survey Benchmark Report dated 2019;

- Care Quality Commission inspection, CQC Pilgrim Hospital Quality Report, Inspection dated 17th October 2019.

- Care Quality Commission United Lincolnshire Hospitals NHS Trust Inspection Report, dated 17th October 2019;

- The Head of Internal Audit's draft annual opinion over the Trust's control environment dated 16th June 2020; and

- Minutes of the Quality Governance Committee Meetings May & September 2020;

- The quality account presents a balanced picture of the NHS Trust's performance over the period covered;

- The performance information reported in the quality account is reliable and accurate;

- There are proper internal controls over the collection and reporting of the measures of performance included in the quality account, and these controls are subject to review to confirm that they are working effectively in practice;

- The data underpinning the measures of performance reported in the quality account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

- The quality account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality account.

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

By order of the board

Andrew Morgan

.....
Chief Executive Officer

Elaine Baylis

.....
Chair, Trust Board