NHS
United Lincolnshire Hospitals
NHS Trust

United Lincolnshire Hospitals NHS Trust Quality Account 2021-22

OUTSTANDING CARE personally DELIVERED

Glossary of Abbreviations

AAA	Aortic Abdominal Aneurysm
A&E	Accident & Emergency
ABG	Arterial Blood Gas
BAME	Black Asian and Minority Ethnic
BAUS	British Association of Urological Surgeons
BCSP	Bowel Cancer Screening Programme
BTS	British Thoracic Society
CAF	Cyber Assessment Framework
CCG	Clinical Commissioning Group(s)
C. diff	Clostridium Difficile
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CT	Computed Tomography
CT/MR	Computed Tomography/Magnetic Resonance (Imaging)
DATIX	Incident Reporting System
DSP Toolkit	Data Security and Protection Toolkit
DVT	Deep Vein Thrombosis
ENT	Ear Nose & Throat
e-BUS	Endobronchial Ultrasound
E. coli	Escherichia coli
ED	Emergency Department
EMAS	East Midlands Ambulance Service
FFP	Foundations for Practice
FFT	Friends and Family Test
GDH	Grantham and District Hospital
GIRFT	Getting It Right First Time
GP	General Practitioner
HEE	Health Education England
HES	Hospital Episode Statistics

HQIP	Health Quality Improvement Partnership
HSMR	Hospital Standardised Mortality Ratio
HVLC	High Volume Low Complexity
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care National Audit and Research Network
IG	Information Governance
IIP	Integrated Improvement Plan
KPI	Key Performance Indicator
LCH	Lincoln County Hospital
LUCADA	Lung Cancer Audit (National)
MBRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MCCD	Medical Certificate of Cause of Death
MDT	Multi-Disciplinary Team
ME	Medical Examiner
MEDP	Midlands Elective Delivery Programme
MEO	Medical Examiner Officer
MI	Myocardial Infarction
MINAP	Myocardial Infarction National Audit Programme
MMAG	Medicines Management Action Group
MorALS	Mortality Assurance and Learning Strategy Group
MQG	Medicines Quality Group
MRSA	Methicillin-Resistant Staphylococcus Aureus
N/A	Not Applicable
NACEL	National Audit Care End of Life
NAIF	National Audit Inpatient Falls
NBCA	National Bowel Cancer Audit
NCEPOD	National Confidential Enquiry into Patient Outcomes and Death
NELA	National Emergency Laparotomy Audit
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Health and Care Excellence
NICOR	National Institute for Cardiovascular Outcomes Research

NIHR	National Institute for Health Research
NIV	Non-Invasive Ventilation
NJR	National Joint Registry
NNAP	National Neonatal Audit Programme
NOD	National Ophthalmology Database
NPCA	National Prostate Cancer Audit
NQB	National Quality Board
NVD	National Vascular Database
O-G	Oesophago-Gastric
OSCE	Objective Structured Clinical Examination
PALS	Patient Advice and Liaison Service
PDSA	Plan Do Study Act
PE	Pulmonary Embolism
PHB	Pilgrim Hospital Boston
PICANet	Paediatric Intensive Care Audit Network
PROMs	Performance Reported Outcome Measures
QGC	Quality Governance Committee
RCEM	Royal College of Emergency Medicine
RCP	Royal College of Physicians
RCPH	Royal College of Paediatricians and Child Health
RSU	Respiratory Support Unit
SDEC	Same Day Emergency Care
SI	Serious Incident
SHMI	Standardised Hospital-Level Mortality Indicator
SHOT	Serious Hazards of Transfusion
SOP	Standard Operating Procedure
SSNAP	Sentinel Stroke National Audit Programme
TARN	Trauma Audit Research Network
TCS	Terms and Conditions of Service
T2RF	Type 2 Respiratory Failure
ULHT	United Lincolnshire Hospitals NHS Trust
VAS	Visual Analogue Scale

VTE	Venous Thromboembolism
WTE	Whole Time Equivalent
7DS	Seven Day Services

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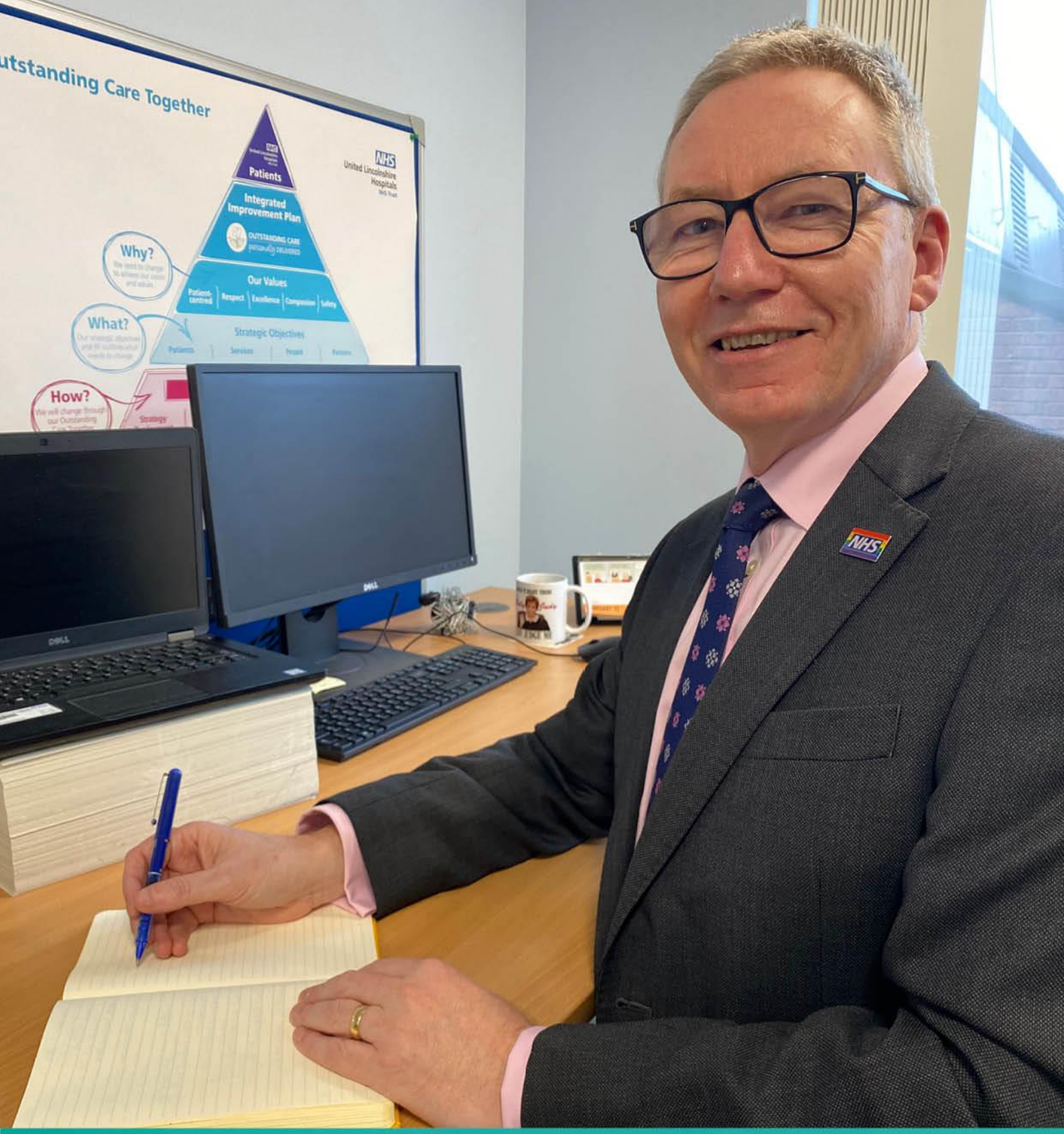


Part 1: Chief Executive's Statement

Welcome to the Quality Accounts for United Lincolnshire Hospitals NHS Trust for 2021/22. This document provides an overview of all of the activity that has been taking place within our hospitals on the quality agenda over the past year.

It has been another incredibly tough year for everyone due to the ongoing COVID-19 pandemic, but we want to say a big thank you to all of our incredible staff, volunteers, patients, and everyone in the community for their ongoing support and co-operation.

Our staff have yet again gone to unprecedented lengths to look after our patients, day in and day out.

As an NHS we have made incredible progress this year in the delivery of the COVID-19 vaccine programme and it has been amazing to see the way teams have pulled together to ensure everyone has been able to receive their vaccines. This includes those vaccinating our NHS and social care colleagues so that they could continue to do their jobs and care for the people of Lincolnshire.

During the year, we continued to monitor and improve the quality of care that we provide, whilst also continuing to deal with unprecedented demands on our services during and as a result of the COVID-19 pandemic.

The organisation has worked together and achieved a number of quality improvements during the challenges of the last year:

- Developing and creating devices in clinical engineering that support patient care
- Mortality rates remain in the expected range.
- The launch of a patient safety and nutrition and hydration campaign.
- Decrease in the number of staff vacancies across the Trust.
- Introduction of robotic surgery.
- Getting it Right First Time project gaining us national recognition for our work in orthopaedics.

We have also had lots of exciting opportunities and ongoing projects to make improvements across our sites:

The transformation of Lincoln County Hospital emergency department is well under way.

- Plans are progressing at speed for the redevelopment of Pilgrim Hospital, Boston emergency department.
- Work has started to install new theatres at Grantham and District Hospital.
- We have also seen lots of new high tech investments over the course of the last year, such as investment in our x-ray and other diagnostic services.

We have also continued to involve our patients in discussions and decision making in the Trust. We launched the Patient Panel in September 2020 that meets every month and in

its first year received presentations and had discussions with over 50 staff on 40 topics. We now have 33 members who meet monthly and are an important collective voice ensuring we seek out, listen to and act upon the views and opinions and suggestions of our patients.

Our latest CQC inspection and report recognised the widespread improvements we made in the quality and safety of our services since the last inspection in 2019.

They commented that this was particularly impressive against the COVID backdrop. Positive comments were also made about the Trust having a strong cohesive team with collective leadership at Board level.

In the report, the CQC particularly applauded the patient-centred care our staff all offer. They said: “without exception, staff 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,” and “from every conversation the inspection teams had with trust staff it was clear that the patient was at the heart of their work.”

As a result of the improvements made, the Trust has also been taken out of special measures. We were placed into special measures (now known as the national Recovery Support Programme) in 2017, following concerns around financial management and quality of care.

Since then, extensive work has taken place to improve both the quality of care that we provide to patients, and financial management within the Trust.

For the year ahead we will continue to focus on the improvements we need to make as part of our Integrated Improvement Plan and sharing what has been done so far.

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.

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

Andrew Morgan,

Chief Executive

Part 2: Deciding our Quality Priorities for 2022-23

In order to determine our quality priorities we have consulted with a number of stakeholders including our Trust Quality Governance Committee (QGC). The QGC on behalf of the Trust 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 the Trust's Integrated Improvement Plan (IIP). 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 following improvement priorities for the Trust have been identified for particular focus in 2022-23. These priorities may be extended over the coming years to ensure they are fully embedded within our organisation. Each 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 - Discharge and Compliance with the SAFER Bundle (Patient Experience)

Why have we selected this Priority?

We are committed to improving discharge and flow across our hospital, working with system colleagues to enhance patient experience, with specific focus on improved discharge processes. This is a strategic priority project within the IIP and is a key driver to the delivery of harm-free, high quality and safe care across the organisation.

The project aims to identify and support the implementation of key improvement opportunities around improving the discharge processes from a variety of sources (e.g. CQC inspection, internal audit, ward reviews, incidents and SIs).

This major project also aims to identify further opportunities to provide harm-free care around improved discharge processes, aligned to National & Local Guidance. These include:

- **Care Closer to Home** – Services delivered as close as possible to people in their own homes.
- **Working together** - Joined up, coordinated services across the system to better meet people's needs and improve their experience of care
- **Prevention** – Move emphasis of the system from treatment to prevention and self-care

- **Person Centred Care** – People should have a choice and control over the way the care is planned and delivered based on what matters to them and their individual strengths and needs

Our Current Status:

As a Trust we have significant delays with discharging our patients. With the introduction of the SAFER Bundle which is similar to a clinical care bundle and has a combined set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients. All patients are seen every day by the medical team and decisions are quickly made with regard to investigations, treatment and plans for discharge or transfer to the most appropriate place.

The SAFER Bundle:

S - Senior Review. All patients will have a Consultant Review before midday

A - All patients will have an Expected Discharge Date

F - Flow of patients will commence at the earlier opportunity (by 10am)

E – Early discharge, 33% of our patients will be discharged from inpatient wards before midday. TTO's (medication to take home) for planned discharges should be prescribed and with pharmacy by 3pm the day prior to discharge wherever possible to do so.

R – Review, a weekly systematic review of patients with extended lengths of stay (> 14 days) to identify the issues and actions required to facilitate discharge.

What will success look like?

- SAFER Principles for discharge applied
- Criteria Led Discharge
- Virtual Wards
- Discharge to Assess

How will we monitor progress?

Progress will be monitored through a defined approach of data analysis and review. Key Performance Indicators (KPI) and metrics agreed will be developed into a dashboard,

which will provide a means of tracking progress and trends against the baseline and targets for each of the success measures.

- Improve correlation between plan and actual activity performance
- Increase the number and improve timeliness of Pathway 0 (simple discharges) and Pathway 1 (complex discharges) (vs April 2021)
- Reduce number of patients in hospital beds with criteria to reside metrics

Progress will be monitored by:

Progress will be monitored through our internal improvement governance route along with regular reporting through internal operational and clinical mechanisms. This includes reporting and monitoring via the Trusts Quality Governance Committee.

Priority 2 - Diabetes Management (Clinical Effectiveness)

Why have we selected this Priority?

The management of Diabetic Ketoacidosis (DKA) has been selected as a key improvement area for the Year 3 Integrated Improvement Plan priority to enhance patient safety by learning from reported incidents.

DKA is a complication of diabetes that results from increased levels of a chemical called ketones in the blood. It causes excessive thirst, frequent urination, fatigue, and vomiting.

The project will identify the opportunities for Improvement by learning from reported incidents and identifying themes; which will provide the basis of implementing improvements for our diabetic patients and most specifically the management of patients admitted to acute care with symptoms of DKA.

By identifying themes from our incidents reported for the management of DKA the project will identify opportunities to provide harm-free care and enhance patient experience.

This priority is linked to the Getting It Right First Time (GIRFT) national recommendations and CQC enquiry response.

Our Current Status:

In 2021 the Diabetes Insulin project was undertaken which was a response to the CQC enquiry following a cluster of diabetes related incidents across the Wards and Departments at Boston and Lincoln Hospitals.

This project required a thematic review of all incidents and identified outputs which included:

- **New Insulin Prescription Chart and Pathway**– This has been developed. This includes the full pathway for the patient. This will be incorporated into the ePMA project.
- **Development of Diabetes e-Passport** –Training needs analysis completed. Three modules have been developed; Insulin safety module, DKA Module, Diabetic Emergencies and forms part of core learning. Another model is being developed for the Healthcare Support Worker.
- **Diabetes inclusion in the ward safety huddle** - This is now mandated for discussion at the Safety Huddles on all wards and is part of the matron's audit. (Safety huddles are short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical opportunities to understand what is going on with each patient and anticipate future risks to improve patient safety and care).

- **Diabetes In-reach service** - Fully functioning service at Lincoln and Boston, with a feed to Grantham. Diabetes Nurse led in-reach into ED, supervised by the Consultant of the week.

This priority is aligned with the Improving the Safety of Medicines Management; linking to the Trust's strategic objective of Patients.

What will success look like?

- Full ESR compliance against the e-Learning for Insulin Safety, DKA and Diabetic Emergencies Modules.
- Implementation of the GIRFT recommendations that are applicable to the Trust.
- Reduction in incidents reported for DKA Management.
- Patients with Diabetes are treated on the appropriate ward.
- Implementation of the DKA Project; Pathway implementation of expertly trained Nurses on Diabetes Wards at Lincoln and Boston managing patients with diabetes emergencies.

How will we monitor progress?

This priority will form part of the Integrated Improvement Plan for the Improving the safety of Medicines Management project.

Incident reporting and ESR training compliance will be monitored through Clinical Governance Meeting.

The project will identify Key Performance Indicators to be agreed as part of the Medicines Management Action Group (MMAG). Progress against this will be monitored as part of the Medicines Management Project.

Progress will be monitored by:

- Diabetes Clinical Governance Meeting
- Cardiovascular Performance Review Meeting
- Medicines Management Action Group
- Medicines Management Quality Group
- Patient Safety Group
- Quality Governance Committee

Priority 3 - Improving the Safety of Medicines Management (Patient Safety)

Why have we selected this Priority?

Improving the safety of Medicines Management is a strategic major project within the IIP and is a key driver to the delivery of harm-free care across the organisation.

The project aims to identify and support the implementation of key improvement opportunities around improving the safety of medicines management from a variety of sources (e.g. CQC inspection, internal audit, ward reviews, incidents and Serious Incidents (SIs))

The aims of this major project are aligned with those contained in the 'Developing a safety culture Program'.

This major project also aims to identify further opportunities to provide harm-free care around improving the safety of medicines management. These include:

- Raising the profile of medication safety
- Engaging with our clinical teams more effectively
- Identifying further opportunities for improved medication safety

Our Current Status:

A roadmap has been developed that identifies key areas to address these safety issues and this major project will support and oversee the implementation of these initiatives.

A project team has been identified to align to these key areas and a dedicated Medicines Management Action Group (MMAG) with programme governance will be re-instated in managed and monitor progress.

What will success look like?

- Reduction in avoidable medicines errors reducing serious incidents and improving quality of care
- Improved and enhanced focus on staff training and skill to support improved delivery of quality service, reducing in near misses and wrong drug errors across all Trust services
- Reduced medication wastage will help the trust achieve financial balance.
- Improve education and competency associated with Drug administration and storage

How will we monitor progress?

Progress will be monitored through a defined approach of data analysis and review. Key Performance Indicators (KPI) and metrics agreed as part of the Medicines Management Action Group (MMAG), will be developed into a dashboard, which will provide a means of tracking progress and trends against the baseline and targets for each of the success measures.

Progress will be monitored by:

- The Medicines Management Action Group (MMAG)
- The Medicines Quality Group (MQG)
- Quality Governance Committee

Looking Back: progress made since publication of 2020-21 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.

These were:

1. Improving Respiratory Services
2. Developing a Safety Culture
3. Improving Patient Experience

Introduction

The Quality Account for 2020-21 outlined the Trust's proposed quality improvements for the year ahead (2021-22). These priorities were identified following engagement with patients, the public, staff and external stakeholders. During the year 2021-22 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 2021-22.

The Trust has not fully achieved all its priority ambitions however there is evidential progress in several areas with sustained patient safety improvements. COVID-19 has had an impact on the delivery of our quality account priorities. We set ourselves ambitious targets and have achieved 50% of the individual elements, 3% data was not available, 18% were partly achieved and 29% not achieved. 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. The quality priorities in 2021-22 will become business as usual and will be monitored through our governance processes.

Trust performance

This section provides detail on how the Trust has performed against the three priority ambitions. Results relate to the period 1st April 2021 – 31st March 2022 or the nearest period available. Mechanisms of measurement vary by priority and by the availability of national benchmark.

Benchmark

A Milestone achieved

P Milestone partially achieved

N Milestone not achieved

N/A Milestone not available

Priority 1: Improving Respiratory Services

We said we would:	
Success Measure	**Result**
Non Invasive Ventilation (NIV)	
Total elapsed time from Type 2 Respiratory Failure (T2RF) suspicion to commencement of NIV <120mins	**P**
Start time for NIV <60minutes from Arterial Blood Gas (ABG)	**P**
NIV progress for all patients to be reviewed (once NIV commenced) < 4hours	**P**
Ward Metrics	
20% reduction in falls with moderate / severe harm for respiratory patients	**A**
Zero serious incidents relating to chest drain management	**A**
Zero serious incidents relating to tracheostomy suction management	**A**
Zero moderate and severe harm incidents of pressure damage related to medical devices	**A**
Pleural Procedures	
Zero serious incidents relating to patients with pleural effusions	**A**
100% of pleural procedures to be delivered by appropriately qualified respiratory specialists	**A**
90% of patients to have continuous observations for the first 15 minutes after having received a chest drain	**A**

Zero incidents of pleural procedure room being used inappropriately	**N**

Data Source: Data was sourced from Internal audits and our Internal Incident Reporting System.

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

Commencement of NIV <120mins:
Achievement of this Quality Account Priority was inconsistent and partially met.

Introduced in August 2021, the Acute NIV Audit Tool forms the evidence basis for assessing the Trust's compliance for Acute NIV. Since its adoption the Tool has highlighted the inconsistency in the achievement of the <120min T2RF suspicion to NIV commencement target:

Monthly Plan/Do/Study/Act (PDSA) reviews have been undertaken and these have highlighted minor data capture inaccuracies, which if corrected, will provide the further evidence of the Trust's successful achievement of the target.

These data inaccuracies include:

- Date and time of T2RF suspicion not always recorded accurately by Emergency Department (ED) colleagues;
- Incorrect interpretation of date / time to include within Audit Tool – particularly when T2RF suspicion and NIV treatment commencement goes over the midnight hour;

Seasonal variations in peak site and operational pressures, including COVID wave response have also created an environment, which has contributed towards the inconsistent achievement of the target. For example:

- ED delays in the timely diagnosis and referral of T2RF patients for Acute NIV;
- Delays due to there being no NIV bed available;
- Transfer delays (where a patient's pathway has commenced at Grantham);

Respiratory ward acuity and staffing levels due to COVID wave and peak operational pressures have caused a delay to the timely acceptance and admission of patients to a suitable NIV bed and the commencement of their treatment.

Start time for NIV <60 minutes:
Achievement of this Quality Account Priority was inconsistent and partially met.

In addition to the comments above, there have been specific challenges in successfully evidencing this target. The Acute NIV Audit Tool calculates achievement of the <60min target from the date and time of the last ABG before NIV was commenced.

PDSA reviews have highlighted that clinical teams have, in error, entered the dates and times of other ABG results (i.e. where a patient may have had repeated ABG's performed before a decision to start NIV is made).

The Acute NIV Audit Tool has been refined to support the clinical teams in their data entry (and the selection of the correct ABG date and time), and this has been introduced with supplementary communications and training.

We expect that these refinements will now provide the necessary evidence to confirm that the Trust is consistently achieving this target.

NIV progress for all patients to be reviewed < 4hours:
Achievement of this Quality Account Priority was inconsistent and partially met.

A review of the Acute NIV Standard Operating Procedure (SOP) was conducted as part of the service improvement changes introduced through the Improving Respiratory Services Programme.

The SOP gives clear guidance to the clinical teams involved in the suspicion of T2RF and commencement of Acute NIV. This includes well-defined instruction on the requirements for post NIV review within 4 hours of a patient commencing treatment.

The date and time of the post NIV review is included as a primary data field within the Acute NIV Audit Tool.

Staffing and operational challenges over the last few months of Q4 have unfortunately dropped our achievement of this target.

Zero incidents of pleural procedure room being used inappropriately:
Due to competing site and operational pressures, because of the Trust's required response to COVID and Winter demand, there have been occasions where escalation into the Pleural Procedure rooms on the LCH and PHB sites has been required.

We will avoid future escalations into the pleural room by reviewing the Trust's approach to inpatient flow, and the allocation of beds in times of unprecedented demand.

Priority 2: Developing a Safety Culture

We said we would:	
Success Measure	**Result**
Communication plan and rebranding of safety culture	

Secure funding to enable external support with communication message	**A**
Develop briefing to support procurement process for external support	**A**
Develop dedicated intranet webpage specifically for Safety Culture	**A**
Monthly newsletter developed and circulated through communications and uploaded onto intranet page	**A**
Development of Faculty of Train the Trainers to deliver and roll out training to all staff groups	
There will be an annual plan to deliver one day workshops for all staff groups to enable foundation knowledge in Human Factors	**A**
Two further cohorts of Human Factors Trainers will be completed by Quarter three 2021-2022	**A**
Explore options of system wide approach to develop System Faculty of Trainers	**N**
Safety Culture	
Recruitment into all vacant posts of the Safety Culture team by September 2021	**A**
A programme of enhanced safety visits / safety conversations in Theatres will empower our staff to review and discuss redundant or flawed systems and processes	**A**
Pascal Safety Culture survey will be undertaken in Emergency Areas across the Trust	**A**
All work streams will be aligned through a Patient Safety Framework	**A**
Data Source: Data was sourced from the Patient Safety Improvement Team.	
What we need to do to achieve our success measures?	
Explore options of system wide approach to develop System Faculty of Trainers: Further work required to discuss options of wider health care community of faculty of trainers.	

Priority 3: Improving Patient Experience

We said we would:	
Success Measure	Result
Improving Communication	
A new training programme will be launched using Objective Structured Clinical Examination (OSCE) style methodology involving our patients as participants and observers	**N**

Staff survey returns will demonstrate an improvement in raising concerns about poor communication	**N/A**
There will be a reduction in communication being cited as a negative factor in Friends and Family Test	**A**
There will be fewer complaints and PALs concerns citing poor communication	**N**
Increasing involvement in decisions and discussion about care and treatment	
The 'What Matters to You' Initiative will be rolled out from the initial 12 forerunner areas	**N**
Complaints and concerns referring to lack of involvement in decisions will reduce	**N**
Introduction of Real Time Surveying which will tell us they feel involved and considered and describe person centred care	**N**
There will be fewer complaints and PALs concerns citing lack of involvement in discussions and decisions about care and treatment	**N**
Improving dignity and respect	
Dignity Pledges launched across the Trust	**N**
We will see a reduction in negative scores and feedback in Friends and Family Test relating to lack of dignity and respect	**A**
Introduction of Real Time Surveying will tell us they were treated with dignity and respect	**N**
Staff will be aware of and follow the principles of the Dignity Pledges (compliance will be seen through a survey)	**N**
Improving engagement and communication with patients and the public	
A diverse Patient Panel will be in place with specialist subgroups including Sensory Impairment, Traveller community, Black, Asian, and Minority Ethnic (BAME) and Eastern European communities	**P**
We will introduce 'Experts by Experience' within a number of specialties to act as expert partners in service development and evaluation	**P**
We will have explored the best way to engage with hard to reach groups, children, young people and their parents / carers	**P**
We will have developed connections with existing groups including: • Maternity Voices Partnership • Neonatal Voices Partnership • Treat Me Well Action Group • Carers Partnership • Cancer Collaborative	**P**

- Stroke Survivors Group

Data Source: Data sourced from the Trust's Internal Incident Reporting System, Friends and Family Test and the national staff survey.

What more do we need to do to achieve our success measures?

A new training programme will be launched:
This was scheduled to commence September 2021 but COVID precautions prevented this from happening. Currently looking for new dates to recommence once face-to-face training is possible again and appropriate venues are available.

There will be fewer complaints and PALS concerns, citing poor communication:
Overall communication as a theme needs continued focus and the position is reflective of the operational pressures services are under particularly in managing the backlog in appointments and staffing capacity on wards. However, there is a notable difference when broken down between complaints and PALS.

- PALS data shows that general communication with patients and relatives or carers is the biggest factor and this primarily relate to being updated and ability to get through to a ward via the phone and get information.
- Complaints data shows that delays feature most.

Actions focus around existing improvement work:

- Communications working group
- Patient Experience training
- Operational pathways for recovery and backlog

The 'What Matters to You' Initiative will be rolled out:

Operational pressures resulted in postponement of planned January 2022 cohort. Currently scoping rescheduled dates.

Complaints and concerns referring to lack of involvement in decisions will reduce:
This work-stream is also related to the objective above relating to fewer complaints and PALS citing poor communication.

Introduction of Real Time Surveying which will tell us they feel involved and considered and describe person centred care:
Although all ready to implement this hasn't been fully launched due to operational pressures and COVID restrictions impacting volunteers. Plans are progressing well to launch mid-April 2022.

There will be fewer complaints and PALS concerns citing lack of involvement in discussions and decisions about care and treatment:

This work-stream is also related to the objective above relating to fewer complaints and PALS citing poor communication.

Dignity Pledges launched across the Trust:
Pledges approved though launch delayed. Planned for April.

Introduction of Real Time Surveying will tell us they were treated with dignity and respect:
This work-stream is also related to the objective above relating to fewer complaints and PALS citing poor communication.

A diverse Patient Panel will be in place with specialist subgroups:
Core panel continues:

In the first year Sept 2020 – Sept 2021:

- 39 topics were discussed presented by 50 members of staff
- Panel member attendance averaged 18 per meeting
- Only one meeting was cancelled
- 4 standalone co-production workshops were held
- 6 members act as links to wider projects feeding in and back to the panel.
- Formal evaluation completed, feedback has been excellent.
- 33 members

Sensory impairment panel working well and has met quarterly.
Initial discussions with Traveller community and links established with in-reach workers.
To establish links with BAME & Eastern European communities.

We will introduce 'Experts by Experience':
Breast Mastalgia Expert Reference Group established – meetings commenced.
Cancer Expert Reference Group currently out to advert for members. First meeting planned for mid-April.
Dementia Carers Expert reference group plans progressing with two scoping meetings held.

We will have explored the best way to engage with hard to reach groups, children, young people and their parents / carers:
Model / framework designed as below. Work now needs to progress to establish links with partners and other agencies and with health inequalities work system wide.

We will have developed connections with existing groups:

- Maternity Voices Partnership – established though needs new contact
- Neonatal Voices Partnership – not yet
- Treat Me Well Action Group – established though national work paused; being re-energised through recent ULHT appointment of Learning Disability Nurse
- Carers Partnership – established and working well including new links with Young Carers.
- Cancer Collaborative – established via Cancer Board
- Stroke Survivors Group – not yet established

Statement of Assurance

Review of services

During 2021-22, the United Lincolnshire Hospitals NHS Trust (ULHT) provided and/or subcontracted 66 relevant health services.

The ULHT has reviewed all the data available to them on the quality of care in 66 of these relevant health services.

The income generated by the NHS services reviewed in 2021-22 represents 93% of the total income generated from the provision of NHS services by the ULHT for 2021-22.

Participation in Clinical Audits

During 2021-22, 42 national clinical audits and 4 national confidential enquiries covered relevant health services that ULHT provides.

During that period ULHT participated in 100% 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 2021-22 are as follows: (see tables below). Action plans are developed to enable the Trust to achieve full compliance.

The national clinical audits and national confidential enquiries that ULHT participated in, and for which data collection was completed during 2021-22, 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.

Due to COVID-19 some national audits were stopped, however, as a Trust we continued to participate in collecting data where possible.

National Audits	ULHT Participation	Reporting Period	Number and % Required
Peri and Neonatal			
Perinatal Mortality Surveillance UK Perinatal Deaths for Births (MBRRACE-UK) Saving Lives Improving Mothers Care Maternal Death and Morbidity	Yes	2019 Published October 2021 Jan 2019-Dec 2019 Published October 2021 2017-2019 Published November 2021	No case ascertainment reported No case ascertainment reported No case ascertainment reported
Neonatal Intensive and Special care (NNAP)	Yes	1st January – 31st December 2020 Published March 2022	100%
Children			
National Children & Young Peoples Asthma Audit	Yes	1st June 2019- 31st January 2020 Report published May 2021	Cases submitted 67 Case ascertainment is not reported

National Audits	ULHT Participation	Reporting Period	Number and % Required
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	1st April 2019 – 31st March 2020 report published June 2021	Cases submitted 274 Case ascertainment is not reported
National Epilepsy 12 Audit	Yes	1st December 2018 – 30th November 2019 Cohort 3 Report published July 2021	124/132 (93.9%)
Acute Care			
National Emergency Laparotomy Audit (NELA)	Yes	1st December 2020 – 30th November 2021 Report awaited	Cases submitted PHB 91 LCH 88
Cardiac Arrest (National Cardiac Arrest Audit) ICNARC	Yes	1st April 2021- 31st December 2021	Case ascertainment is not reported
Intensive Care National Audit Research (ICNARC) COVID-19 process reports	Yes	1st April 2021- 31st September 2021	Cases submitted LCH 402 PHB TBC Case ascertainment is not reported
Pain in Children in EDs (RCEM)	Yes	5th October 2020- 3rd October 2021 Report awaited	Cases submitted ULHT 261 LCH 65 PHB 196
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	17th June 2021 – one day (24 hour survey) Report published October 2022	Case ascertainment is not reported
National Audit Care End Life (NACEL)	Yes	April 2021 – October 2021 Organisation audit, staff survey. Report awaited	Cases submitted LCH 40/40 (100%) PHB 40/40 (100%)
Fracture Neck of Femur ED (RCEM)	Yes	5th October 2020 - 2nd April 2021 Report published March 2022	Cases submitted LCH 96/125 (77%) PHB 118/125 (95%)
Infection Control ED (RCEM)	Yes	5th October 2020 - 2nd April 2021 Report published March 2022	Cases submitted LCH 20/125 (16%) PHB 98/125 (78%)
British Thoracic Society (BTS) Pleural Procedures	Yes	1st April 2021 - 30th June 2021	Not applicable this is a service audit

National Audits	ULHT Participation	Reporting Period	Number and % Required
		Report awaited	
British Thoracic Society (BTS) Outpatient Management of Pulmonary Embolism (PE)	Yes	1st September - 31st October 2021 Organisation Audit Report awaited	Cases submitted 15/15 (100%)
Long Term Conditions			
Diabetes (National Adult Diabetes Audit)	Yes	1st January 2020 - 31st March 2021	Case ascertainment is not reported (data is linked to local CCG)
Diabetes (National Adult Diabetes Inpatient /Survey/ Audit HARMs)	Yes	December 2020 Report published July 2021	Case ascertainment is not reported
National Diabetes in Pregnancy Audit	Yes	1st January 2018 - 31st December 2020 Report published October 2021	Cases submitted ULHT 125 PHB 45 LCH 80
National IBD Registry Ulcerative Colitis & Crohn's Disease	Yes	2021 - 2022	Data submission commenced February 2022
Rheumatoid and Early Inflammatory Arthritis	Yes	June 2021 - March 2022 Report awaited	Cases submitted 18
National Adult Asthma Audit	Yes	1st April 2021 - 30st March 2022 Report awaited	Cases submitted ULHT 159 LCH 69 PHB 90 case ascertainment is not reported
Chronic Obstructive Pulmonary Disease (COPD) Royal College Physicians	Yes	1st April 2021- 30st March 2022 Report awaited	Case ascertainment is not reported
National Diabetes Audit Integrated Specialist Services and Structure Survey	Yes	November 2021 Report awaited	Not applicable refers to the service
Elective Procedures			
BAUS Urology Nephrectomy	Yes	Data collection recommenced once elective surgery resumed following	Case ascertainment is not reported

National Audits	ULHT Participation	Reporting Period	Number and % Required
		NHS England Guidance	
Cardiac Arrhythmia (NICOR)	Yes	April 2019 – March 2020 Report published October 2021	Case ascertainment is not reported
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Yes	1st April 2019 – 31st March 2020 Report published October 2021	Case ascertainment is not reported
National Vascular Registry including NVD -Carotid Interventions Audit)	Yes	1st January 2018-31st December 2020 1st January 2020- 31st December 2020 Report published November 2020	Cases submitted 24 cases Infra-renal AAA, 17 cases Emergency Repair Ruptured AAA 166 cases Lower Limb Bypass, 312 cases Lower Limb Angioplasty, 131 cases Major Limb Amputation 38 cases Carotid Endarterectomy Case ascertainment is not reported
Hip, Knee, Ankle, Elbow and Shoulder Replacements (National Joint Registry)	Yes	1st April 2019 – 1st April 2020 Published February 2022	Cases submitted 1589 (91.32%)
National Elective Surgery Patient Reported Outcome Measures (National PROMs Programme) Overall patient participation rate Participation by each PROM 1.Hip Replacement 2.Knee Replacement	Yes	April 2020 – March 2021 Final report Published February 2022 for patients who completed a pre-op questionnaire	Cases submitted 124/229 (54%) 2020/2021 1. 57, 53.3% 2. 67, 54.9% No post-operative outcomes to report as <30 questionnaires completed
National Ophthalmology Database (NOD) Audit	Yes	Data collection recommenced once elective surgery	Case ascertainment is not reported

National Audits	ULHT Participation	Reporting Period	Number and % Required
		resumed following NHS England Guidance	
Cardiovascular Disease			
Stroke Care (National Sentinel Audit of Stroke) SSNAP	Yes	1st April 2021 – 30th Sept 2021 (includes transfers into ULHT)	Cases submitted 555/517 (107%)
Acute Myocardial Infarction & Other Acute Coronary Syndrome (MINAP)	Yes	1st April 2019 – 31st March 2020. Report published October 2021	Case ascertainment is not reported
Heart Failure	Yes	April 2019- March 2020 Summary Report published October 2021	Case ascertainment is not reported
Cancer			
Prostate Cancer (NPCA)	Yes	1st April 2019 – 31st March 2020 – Report published January 2022	Cases submitted 761 (100%)
National Audit of Breast Cancer in Older Patients	Yes	January 2014- July 2020 (diagnosed during this data period) Report published July 2021	Case ascertainment is not reported
Lung Cancer (LUCADA)	Yes	Patients diagnosed with lung cancer between 1st January 2019 and 31st December 2020 Report published January 2022	Case ascertainment is not reported
Bowel Cancer (NBCA)	Yes	Patients diagnosed between 1st April 2019 and 31st March 2020 Report published February 2022	Cases submitted LCH + GDH 82 (<50%), PHB 164 (>80%)
Oesophago-Gastric Cancer (National O-G Cancer Audit)	Yes	Patients diagnosed between 1st April 2018 and 31st March 2020	Cases submitted

National Audits	ULHT Participation	Reporting Period	Number and % Required
		Report published December 2021	254/273 (93%) (tumour records submitted)
Trauma			
Hip Fracture (National Hip Fracture Database) National Audit Inpatient Falls (NAIF)	Yes Yes	1st January 2020 – 31st December 2020 Report published December 2021 Facilities Audit completed 31/03/2022	Case ascertainment is not reported Case ascertainment is not reported
Trauma Audit Research Network (TARN) Trauma	Yes	1st January 2021 – 31st December 2022 (TARN data)	Cases submitted PHB 155 (54%), LCH 206 (56%)
Blood Transfusion			
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	April 2021 – March 2022	Cases submitted 20/20 (100%) LCH 8 PHB 11 GDH 1

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

During 2021-22 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			
Dysphagia in People with Parkinson's	Yes	2020/2021 Clinical questionnaire Case note (only one requested) Organisational questionnaire completed Report published August 2021	10/12 (83.3%) 1/1 (100%) 3/3 (100%)
Transition from Child to Adult Health Services	Yes	2021/2022 Clinical questionnaire Organisational questionnaire completed	0/15 (study is open for data submission) 1/1 (100%)
Epilepsy Hospital Attendance	Yes	2021/2022 Clinical questionnaire Organisational questionnaire completed	0/10 (study is open for data submission) 1/1 (100%)
Alcohol Related Liver Disease	Yes	2021/2022 Organisational questionnaire completed	3/3 (100%)

The reports of 20 national clinical audits were reviewed by the provider in 2021-22 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 latest internal report published September 2021 • Procedure to open up blocked heart vessels quickly to restore coronary blood flow latest figure 93% of patients met the door to balloon time of 90 minutes • Prescribing preventative medications above the national average for all eligible patients ULHT has been sustained at 100% • Patient outcomes are good with timely interventions and secondary prevention prescribing, improves patients quality of life • Data validation completed quarterly
Cardiac Arrest	• Education and training around deteriorating patient is on-going • Data validation takes place on a quarterly basis
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 completed 31st December 2021 • NJR Data Quality Provider Award GDH - Audit Period 2020-21
Chronic Obstructive Airways Disease (COPD)	• Data validation process in place • COPD Audit Clerk appointed to Lincoln site
Neonatal National Audit Programme (NNAP)	• Antenatal steroids given to mothers of babies born <34 weeks gestation LCH 91.7%, PHB 91.3% above the national average of 90.8%

National Audit	Headline Results and Actions Taken
	• On time screening of retinopathy of prematurity LCH 100%, PHB 100% above the national average of 95.1%) • Medical follow up at 2 years for babies born <30 weeks LCH 90.9%, PHB 94.7% above the national average of 68.4% • Data validation takes place before data submission
National Emergency Laparotomy Audit (NELA)	• Review of data submissions with Surgeons and Anaesthetists • Validation of data taking place monthly with theatre team

Local Clinical Audit

The reports of 89 local clinical audits were reviewed by the provider in 2021-22 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
Minimum Data Set Completion for CT Reports National Bowel Cancer Screening Programme (BCSP)	• Radiology -all CT reports 100% completion of the minimum data set for CT reporting BCSP
VTE Prophylaxis Audit (NICE)	• General Surgery 100% of cases had a risk assessment completed • 100% of cases were prescribed the appropriate VTE medication where this was applicable to do so
Sepsis Management (NICE)	• General Surgery Sepsis 6 completed within 1 hour 100% • Escaltion to medical staff 100%
Deep Neck Space Infection	• ENT Developed management pathway

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) Clinical Research Network East Midlands. There are plans in place to ensure that high-quality research is a part of the culture of ULHT.

The number of patients receiving relevant health services provided or sub-contracted by ULHT in 2021-22 that were recruited during that period to participate in research approved by a research ethics committee is 1835.

The total number of participants recruited to NIHR portfolio research in 2021-22 was 1,835. These participants were recruited through 39 studies from 13 research specialties including: Gastroenterology, Cancer (including Haematology), Non-malignant Haematology, Cardiovascular, Mental Health, Reproductive Health & Childbirth, Trauma & Emergency, Critical Care, Respiratory Disorders and Infection.

The Trust is delivering trials within a wide variety of specialities, although 2021-22 was challenging as the Research Department continued to respond to the pandemic situation, had reinstated the pre-existing portfolio of trials, whilst feeling the impact of covid-19 isolation protocols on its workforce. The Research and Innovation department is delivering its annual plan and is demonstrating ULHT's commitment to improving the quality of care offered 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.

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 2021-22, the Trust has approved 37 portfolio studies.

The Research and Innovation Department has a three-year strategy in place, which will see the Trust further develop the delivery of research across all four of its clinical divisions.

Use of the Commissioning for Quality and Innovation (CQUIN) Framework

Due to COVID-19, NHS England stated that Trusts do not need to implement CQUIN requirements, carry out CQUIN audits or submit CQUIN performance data. The proposal is to reinstate CQUINs from 1 April 2022.

Care Quality Commission (CQC) Statements

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

The Trust is required to register with the CQC and its current registration status is registered. The Trust has two Section 31 conditions on its registration relating to some aspects of its urgent and emergency care provision. During 2021-22, the Trust demonstrated significant improvements which has resulted in CQC removing the majority of the Section 31 conditions. The Trust continues to focus on delivering further improvements around the two remaining conditions.

ULHT has not participated in any special reviews or investigations by the CQC during the reporting period. The CQC has not taken enforcement action against ULHT during 2021-22.

A number of the Trust's 'core services' were inspected by CQC during an unannounced inspection visit during October 2021. During November, the Trust also engaged with CQC in a 'Well-Led' inspection. The CQC published the inspection report from these visits in February 2022. This identified significant progress had been made with many of the services inspected being rated as 'Good'. CQC observed about the Trust that "without exception the patient is now at the heart of this organisation." As a result of improvements seen, the CQC recommended that the Trust be moved out of the Recovery Support Programme. It has now been confirmed by NHS England and NHS Improvement that we will exit the Recovery Support Programme with immediate effect.

The inspection resulted in the following ratings:

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement Jan 2022	Good Jan 2022	Good Jan 2022	Requires Improvement Jan 2022	Good Jan 2022	Requires Improvement Jan 2022

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
County Hospital Louth	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Lincoln County Hospital	Requires Improvement →← Jan 2022	Good ↑ Jan 2022	Good →← Jan 2022	Requires Improvement →← Jan 2022	Requires Improvement →← Jan 2022	Requires Improvement →← Jan 2022
Pilgrim Hospital	Requires Improvement ↑ Jan 2022	Good ↑ Jan 2022	Good ↑ Jan 2022	Requires Improvement →← Jan 2022	Requires Improvement →← Jan 2022	Requires Improvement →← Jan 2022
Grantham and District Hospital	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Overall trust	Requires Improvement Jan 2022	Good Jan 2022	Good Jan 2022	Requires Improvement Jan 2022	Good Jan 2022	Requires Improvement Jan 2022

CQC further noted that “without exception, staff 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.” The Trust are very pleased to see the inspection teams’ recognition of the improvement efforts made across the Trust.

The Trust’s IIP sets out the strategic direction for the organisation and its planned improvement approach to deliver outstanding care. Continued improvement, as judged by CQC, is a critical component part of this programme of work. The 2022 inspection report testifies to the improvements already made. Building on this, the Trust has refined its process for assurance to oversee delivery of further improvements throughout 2022-23 which is overseen by the Compliance Team. This involves divisional improvement leads working to deliver specific improvements with clear reporting arrangements into Board sub-committees for assurance and the established performance framework for escalation. Regular progress updates from this improvement work will be shared with our teams and with the CQC as part of the Trust’s routine engagement agenda.

Data Quality

NHS Number and General Medical Practice Code Validity

United Lincolnshire Hospitals Trust submitted records during April 2021 to January 2022 at the Month 10 inclusion date to the Secondary Uses service for inclusion in 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:

- 99.91% for admitted patient care (National performance 99.6%);
- 99.96% for outpatient care (National 99.7%);
- 99.61% for accident and emergency care (National 98.9%)

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

- 99.99% for admitted patient care (National performance 99.7%);
- 99.98% for outpatient care (National 99.6%);
- 99.98% for accident and emergency care (National 99.6%).

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 2020-21 was 'standards met'.

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. United Lincolnshire Hospitals NHS Trust will be taking the following actions to improve data quality:

- A wide review of the main Key Performance Indicators (KPIs) that are reported to the Trust Board and Board Committees has been undertaken, including the addition of new metrics for the “Executive Scorecard” and “Divisional Scorecard” that underpins the Integrated Improvement Plan. This will come into effect for April 2022 reporting in May 2022. This involves understanding the metric itself, how it is calculated and assurance around underlying robustness of the metric, data source and collation/publishing.
- The work on the review of metrics last year 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.
- Work was completed to upgrade to the latest version of Careflow (formerly known as Medway). We are also starting to test upgrades to enable our submissions to NHS England to be compliant to CDSv3
- The Clinical Coding department continues to work closely with the 4 Clinical Divisions and Specialty Business Units; we are looking at what improvements can be made, including internal audit and training, and improved engagement with the 4 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 is being reviewed to ensure we support the needs of the Trust. A business case is being developed to support this additional resource requirement.
- We have adopted Microsoft PowerBI as the preferred visualisation tool for the Trust. Ongoing development of the data warehouse, coupled with PowerBI, 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 Apr 21-Jun 21	Qtr 2 Jul 21-Sep 21	Qtr 3 Oct 21-Dec 21	Qtr 4 Jan 22-Mar 22	Comments
Number of patients that have died within ULHT	561	587	737	660	During 2021-22, 2545 of ULHT patients died. This comprised of the following number of deaths which occurred in each quarter of that reporting period:
Number of deaths that have had a case record review/investigation For 2021-22 the reviews and investigations are conducted as one however this will change in the future	559	573	665	585	By March 2022, 2382 case record reviews and investigations have been carried out in relation to 2545 of deaths included above. In 398 of cases a death was subjected to both a case record review and an investigation. This measure illustrates the number of deaths in each quarter for which a case record review or an investigation was carried out. In addition, 187 cases were also discussed within the Governance Meetings.

Measure	Qtr 1 Apr 21-Jun 21	Qtr 2 Jul 21-Sep 21	Qtr 3 Oct 21-Dec 21	Qtr 4 Jan 22-Mar 22	Comments
Number/percentage of deaths that escalated with problems in care In relation to each quarter, this consisted of: 34 representing 6.1% for the first quarter 35 representing 6.1% for the second quarter 31 representing 4.7% for the third quarter 34 representing 5.8% for the fourth quarter	34	35	31	34	134 deaths representing 5.6% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using the grading system that highlights potential areas of concern in care. All cases that are graded 2 and 3 automatically have a Structured Judgement Review completed.

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

During the year a number of case record reviews were conducted. As part of these, issues were highlighted for local reflection and learning, including instances where excellent practice was observed, for example:

During the COVID-19 pandemic visiting was suspended, and there were concerns from bereaved families that communication was sub-optimal as telephone calls were not being answered. A communication working group chaired by the Head of Patient Experience was established to implement numerous strategies to improve communication with their loved ones. An example was a dedicated telephone was launched as a pilot on wards that was to be used for families only.

A review of all patients who died in our hospitals with hospital onset COVID-19 from February 2021 to December 2021 has been completed and learning has been identified.

Description of actions that ULHT have taken in 2021-22, and proposes to take forward in consequence of what the ULHT has learnt

For any death where the Medical Examiners felt there was significant concern, the case was escalated immediately to either the Risk Team as a potential Serious Incident or to the Mortality Team for a Structured Judgement Review (mortality review by the Speciality). Any significant problem of care, whether or not it affected the outcome, was highlighted to the clinical team for discussion and local learning. In addition to promoting reflection and learning by highlighting to governance and clinical teams where care or treatment could potentially have been better, the Medical Examiner also highlighted excellent practice.

During the year the Medical Examiner (ME) service was embedded further within the Trust building on the developments in 2019-20 and scrutinised all non-coronial deaths in addition to those referred to the Coroner. The service continued to support accurate and consistent certification of death and to support the bereaved. The Trust has also commenced the introduction of the ME service for Community deaths.

Assessment of the impact of actions which were taken by ULHT during 2021-22

The benefits of the ME service for the bereaved are likely to be the most dramatic. In current practice, relatives of deceased patients rarely get to speak to the clinical team after a patient has died. Within the ME Service, relatives are given a chance to ask a doctor or Medical Examiner Officer (MEO) questions, and often, they want to hear, in simple terms, what really happened.

They fully explain specifically what has been documented on the Medical Certificate of Cause of Death (MCCD), and discuss any issues that arise. This often brings clarity, dissipates doubts, and helps to alleviate negative thoughts and experiences. Providing a voice to the bereaved at this most difficult of times is critically important and rewarding. It allows them to make significant improvements in what happens after death, including spotting concerns sooner.

On a clinical note, the ME service offers greater safeguarding to the public, and uses the independent review of deaths for learning, education, and improvement or the services the Trust provides. They work closely with the Foundation year doctors to improve the quality and consistency of death certification and, in turn, the accuracy of mortality data.

Measure	Qtr 1 Apr 21-Jun 21	Qtr 2 Jul 21-Sep 21	Qtr 3 Oct 21-Dec 21	Qtr 4 Jan 22-Mar 22	Comments
Number of reviews/ investigations completed which took place before the start of the reporting period	19	6	0	1	26 case record reviews and investigations completed after 31st March 2021 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	19	6	0	1	26 representing 100% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the grading system below.

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

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

Measure	Qtr 1 Apr 21-Jun 21	Qtr 2 Jul 21-Sep 21	Qtr 3 Oct 21-Dec 21	Qtr 4 Jan 22-Mar 22	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 2021-22 are judged to be more likely than not to have been due to problems in the care provided to the patient. All are included in the table above.

Reporting Against Core 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	Dec 19 - Nov 20	Nov 20 - Oct 21	ULHT
ULHT SHMI / Band	110.57 / 2	111.23/1	110.57 / 2
National Average	100.19	1.0	100.19
Best(B) / Worse(W) National Performance	69.51(B) 118.69(W)	71.93 (B)/118.60 (W)	69.51(B) 118.69(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	Nov 19 - Oct 20	Dec 19 - Nov 20	Nov 20 - Oct 21
ULHT %	24	24	31
National Average %	36	36	39
Best(B) / Worse(W) National Performance %	59(B) / 8(W)	59(B) / 8(W)	64(B) / 11(W)

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

Information relating to mortality is monitored monthly and used to drive improvements.

The mortality data is provided by an external source (Dr Foster).

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

Launching the Community Medical Examiner Roll Out

Expanding the number of Medical Examiners and Medical Examiner Officers

Implementing Multi-Disciplinary Team approach to reviews

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	2018-19	2019 - 20	2020-21
ULHT EQ:5D index Hip Replacement surgery - (L) Low, (H) High	0.45(L) / 0.46(H)	0.46(L) / 0.47(H)	Insufficient records
National Avg EQ:5D index Hip Replacement surgery - (L) Low, (H) High	0.46(L) / 0.47(H)	0.45(L) / 0.46(H)	0.5
ULHT EQ:5D index Knee Replacement surgery - (L) Low, (H) High	0.32(L) / 0.33(H)	0.32(L) / 0.32(H)	Insufficient records
National Avg EQ:5D index Knee Replacement surgery - (L) Low, (H) High	0.34(L) / 0.34(H)	0.33(L) / 0.34(H)	0.3

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	2018 - 19	2019 - 20	2020 - 21
ULHT VAS index Hip Replacement surgery - (L) Low, (H) High	12.85(L) / 13.16(H)	12.72(L) / 12.83(H)	Insufficient records
National Avg VAS index Hip Replacement surgery - (L) Low, (H) High	14.10(L) / 14.40(H)	14.0(L) / 14.20(H)	14.4
ULHT VAS index Knee Replacement surgery - (L) Low, (H) High	6.04(L) / 6.31(H)	7.38(L) / 7.86(H)	Insufficient records
National Avg VAS index Knee Replacement surgery - (L) Low, (H) High	7.50(L) / 7.60(H)	7.80(L) / 7.0(H)	7.2

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	2018 - 19	2019 - 20	2020 - 21
ULHT Oxford hip surgery score - (L) Low, (H) High	20.83(L) / 21.01(H)	21.61(L) / 22.10(H)	Insufficient records
National Avg Oxford Hip surgery score - (L) Low, (H) High	22.30(L) / 22.70(H)	22.30(L) / 22.70(H)	Not avail
ULHT Oxford Knee surgery score - (L) Low, (H) High	16.48(L) / 16.54(H)	16.7(H) - Low data not available	Insufficient records
National Avg Oxford Knee surgery score - (L) Low, (H) High	17.20(L) / 17.30(H)	17.40(L) / 17.50(H)	16.8

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

The data is taken from NHS Digital PROMs data set.

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

Continually reviewing the data at the Clinical Effectiveness Group quarterly to identify learning and improvements required to increase number.

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	2018 - 19	2019 - 20	2020 - 21
ULHT readmitted within 30 days: 0-15	11.50%	11.40%	13.20%
*National Average: 0-15	N/Av	N/Av	13.49%
Best(B) / Worse(W) National Performance: 0-15	1.8%(B) / 69.2%(W)	2.2%(B) / 56.7(W)	2.8%(B) / 64.4%(W)

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	2018 - 19	2019 - 20	2020 - 21
ULHT readmitted within 30 days: 16+	11.90%	12.20%	13.50%
National Average: 16+	N/Av	N/Av	13.49%
Best(B) / Worse(W) National Performance: 16+	2.1%(B) / 57.5%(W)	1.9%(B) / 37.7%(W)	1%(B) / 161.2%(W)

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 data is consistent with Dr Foster's standardised ratios for re-admissions.

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

Working Group to improve discharge information.

Reviewing and improving the effectiveness of discharge planning.

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	2019 - 20	2020 - 21	2020 - 21
ULHT	61.3	N/Av	N/Av
National Average	67.1	N/Av	N/Av
Best(B) / Worse(W) National Performance	84(B) / 59.5(W)	N/Av	N/Av

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

The data is provided by the national survey contractor.

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

Continuing to promote Friends and Family Test (FFT) using a variety of methods, including face-to-face and innovative technology

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	2019	2020	2021
ULHT Strongly agree(SA) /Agreed (A)	10%(SA) / 40%(A)	9%(SA) / 41%(A)	7.4%(SA) /31.1%(A)
National Average Strongly agree(SA) /Agreed(A)	21%(SA) / 49%(A)	21%(SA) / 52%(A)	17.1(SA) / 42.3%(A)
Best(B) / Worse(W) National Performance	(B) 44%(SA) & 46%(A) (W) 6%(SA) & 45%(A)	(B) 42%(SA) & 50%(A) (W) 9%(SA) & 41%(A)	N/Av

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

The data has been sourced from NHS Digital and compared to published survey results.

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

Creating and Embedding a positive culture with clear visible leadership, clarity of vision and actively promoting behavioural standards for all staff.

Freedom to Speak Up champions available for staff to access.

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	Feb-20	Jan-22	Feb-22
ULHT ED / National Avg/ Best(B)-Worst(W)	82 / 82 / 99(B)-40(W)	81% / 81% / 100%(B) / 56%(W)	78% / 77% / 100%(B) / 29%(W)
ULHT Inpatients/National Avg/ Best(B)-Worst(W)	93 / 96 / 100(B)-73(W)	90% / 94% / 100%(B) / 69%(W)	86% / 94% / 100%(B) / 77%(W)
ULHT Maternity /National Avg/ Best(B)-Worst(W)	97 / 97 / 100(B)-86(W)	98% / 94% / 100%(B) / 63%(W)	N/A* / 91% / 100%(B) / 64%(W)

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

The data has been sourced from NHS Digital and compared to published survey results.

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

Creating and Embedding a positive culture with clear visible leadership, clarity of vision and actively promoting behavioural standards for all staff.

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	Q3 2020 - 21	Q4 2020 - 21	Q1 2021 - 22
ULHT %	97.90%	97.80%	N/A
National Avg %	N/A	N/A	N/A
Best(B) / Worst(W) National Performance %	N/A	N/A	N/A

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

The data has been sourced from NHS Digital and compared to internal data.

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

The Trust is committed to investigating and sharing knowledge in cases where an element of preventability has been found to drive improvement and has a clear governance structure to facilitate this.

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	2018 - 19	2019 - 20	2020 - 21
ULHT	36	25.8	30.9
National Avg	35	37.5	45.6
Best(B)-Worst(W) National Performance	0(B) / 168.3(W)	0(B) / 142.8(W)	0(B) / 140.5(W)

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 18 - Mar 19	Oct 19 - Mar 20	Oct 20 – Mar 21
ULHT %	0.75	0.47	N/A
National Avg %	N/A	N/A	N/A
ULHT Total No of Incidents (T) / Severe or Death (SD)	6,291(T) / 47(SA)	5,914(T) / 33(SD)	N/A

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

The data has been sourced from NHS Digital and compared to internal data.

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

Providing staff training in incident reporting and risk management.

Undertaking comprehensive investigations of and utilising varying forums for learning such as huddles and Trust Communications and Safety Bulletins.

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

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 Test 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 bloodstream 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 ED 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.

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 timeframes.

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: Review 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)

We are moving to a new phase where we have to manage COVID-19 not as a pandemic, but as endemic in our society. This means managing COVID-19 as part of our everyday working processes, in much the same way that we do other seasonal infections such as influenza and norovirus.

As we have moved through the pandemic, national guidance has been published, refined and updated enabling ULHT to respond in an evidence-based manner to change the way we configure our services and ward areas, whilst at the same time keeping staff, patients and visitors safe.

We are extremely proud of the way our staff mobilised to respond to the national crisis, showing dedication, compassion, resilience and innovation to continue to deliver high quality care despite the challenges and pressures we have faced. Everyone working across ULHT has contributed to something extraordinary. Our success has only been possible with close collaboration with our system partners.

Restoring surgical services to pre-pandemic levels

As part of our recovery plan and in line with the national GIRFT (Getting it Right First Time) Programme we are exploring options to reduce wait times for patients needing an operation. The teams within six of our high volume surgical specialties are exploring how as a Trust we can go further and faster to reduce the time patients on our lists wait for their

surgery. Key to this change is exploring what more can be offered by our sites at Grantham and Louth as they offer the additional benefit of capacity that is not affected by the emergency pressures that can affect capacity at Lincoln County and Pilgrim Hospitals. Although, this is only one part of the overall patient pathway, it is important progress as we look to gradually restore our services to pre-pandemic levels.

Get It Right First Time (GIRFT)

Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients in a hospital setting. The programme works by doing in-depth clinically led service reviews across specialties. This involves using data-driven evidence along with input and professional knowledge of senior clinicians to examine how things are currently done and how they could be improved.

The overall aim is to ensure all patients receive quality, timely and effective investigations, treatment and outcomes wherever care is delivered and no matter who delivers that care. The GIRFT focus is to identify and put standard approaches in place across the NHS that improve patient outcomes and patient experience, without the need for major change or added cost. The GIRFT Programme commenced in the Trust in 2015. In response to Covid-19 it was paused and a plan to restart this work is currently under development.

As well as the GIRFT programme, there is also a second National GIRFT programme run by the Regional Midlands Elective Delivery Programme (MEDP) arm of the GIRFT National Programme called the High Volume Low Complexity (HVLC) programme. It is being run across the Lincolnshire Healthcare System, which will form the Integrated Care System from July 2022.

There is a national push to recover non-emergency services following COVID Wave 3 to bring backlog waiting lists down as we return to normal working alongside COVID. The HVLC programme focus is on making improvements initially in six high -volume specialties – ophthalmology, general surgery, trauma and orthopaedics (including spinal surgery), gynaecology, Ear, Nose and Throat (ENT) and urology. The Lincolnshire system are currently working together to deliver the HVLC Programme.

90 Minute Cancer Standard

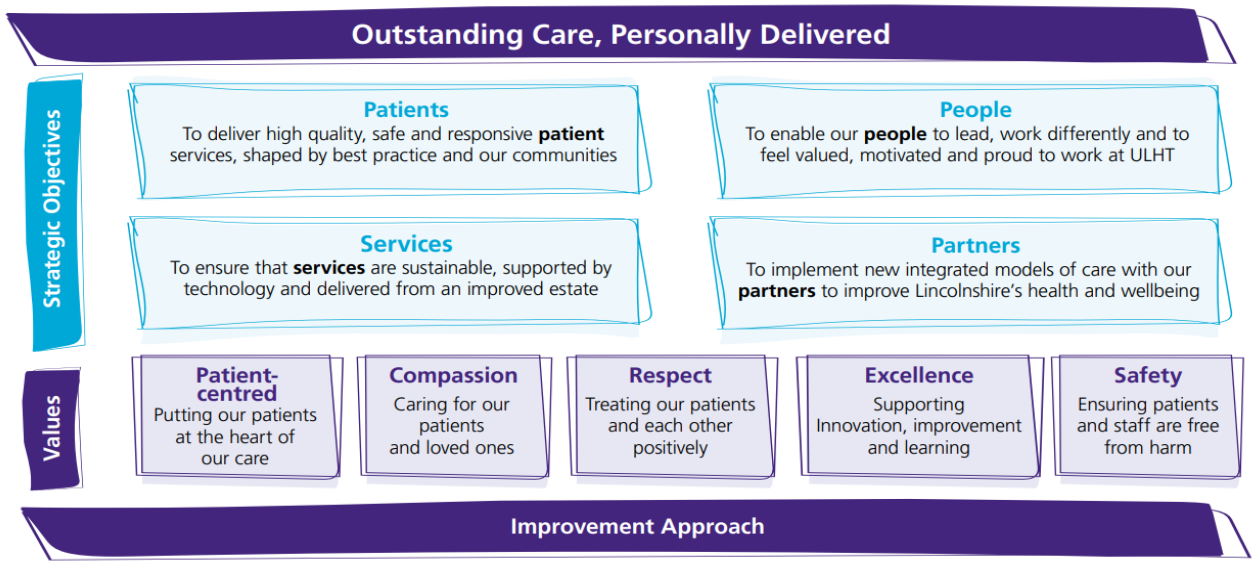
Initially commencing in Colorectal, this has now been rolled out within Urology and Head & Neck. The 90 minute standard is a process the Trust has implemented whereby patients receive a telephone call within 90 minutes following a clinical review of their results, to inform them that they do not have cancer. These ‘good news’ calls provide patients with

immediate reassurance that they do not have cancer and that they will no longer be on the suspected cancer pathway. A letter is also sent in the post to patients at this point to confirm their results in writing and any next steps.

Integrated Improvement Plan (IIP)

Our Integrated Improvement Plan (IIP) describes the Trust's ambition for "outstanding care personally delivered". We will deliver our vision through four strategic objectives that form the basis of our plans over the next 5 years, which covers our patients, services, people and partners. Underpinning the ambition in each of the Strategic Objectives, we have identified key priorities, which will help monitor our progress. Each year detailed actions will be created for the current year priorities, which will form the basis of the Trust's Annual Plan.

The IIP sets out our visions for the future and how we will get there. Our vision to provide 'outstanding care, personally delivered'.



This strategic plan, and the divisional plans which underpin it, mark an important step forward for our Trust. It identifies the key priorities for the Trust over the next five years (2020-2025), ensuring we are focused on the right things for both our patients and our staff. Our Integrated Improvement Plan will be at the centre of all we do supported by our Trust values.

Patient Centred: Putting patients at the heart of our care

Safety: Ensuring patients and staff are free from harm

Excellence: Supporting innovation, improvement and learning

Compassion: Caring for patients and loved ones

Respect: Treating our patients and each other positively

Transformation of Pilgrim Hospital's Emergency Department

In August 2019, the Prime Minister visited Pilgrim Hospital, Boston, where he met staff and announced funding of £21.3 million for the transformation of the emergency department.

Since then, a lot of work has been taking place behind the scenes to finalise the £37.9million design that will not only meet the needs of patients and staff now, but also in the future.

The plans will see the demolition of the existing H-block building and the erection of a two-storey extension with a full refurbishment. It will more than double in size and include state

of the art innovations and infection prevention control measures, have more cubicles to treat patients and a bigger resuscitation zone for the sickest patients.

It will also include a separate area dedicated to providing emergency care for the hospital's youngest patients and their families and have more training rooms for staff.

Transformation of Lincoln County Hospitals' Emergency Department

Work commenced in spring on the new resuscitation zone. The zone will more than quadruple in size and provide twice as many bays for the sickest emergency patients. The new area will be built on top of the current ambulance bay at the hospital.

The first phase of the transformation saw a £3.5 million new Urgent Treatment Centre built alongside the existing A&E department, which has seen and treated thousands of patients since it opened in May last year.

Future phases will include:

- A new paediatrics area with its own dedicated waiting room, treatment cubicles and a sensory area for the youngest patients and their families.
- Additional treatment rooms for mental health patients.
- A new ambulance drop-off and bays created outside the front of the department with entrances directly into the resuscitation and majors areas.
- Additional clinical space, meaning that the emergency department will be able to accept patients from ambulance crews with improved speed and safety.

Specialist Respiratory Unit

Professor Jonathan Van-Tam, the Deputy Chief Medical Officer for England, officially opened the new state-of-the-art £4.5 million unit at Lincoln County Hospital in July 2021. The unit has been designed with 10 side rooms, all equipped with high-tech video technology and monitoring equipment. It means the team will be able to provide patients with non-invasive ventilation and other specialist respiratory treatments.

The unit will also be home to the Captain Sir Tom Moore Pleural Procedure room, which will treat both inpatients and outpatients from across the county who have diseases of the lining of the lung. A second Captain Sir Tom Moore Pleural Procedure room has also been installed and is already being used by patients from across the county at Pilgrim Hospital, Boston.

A&E services reinstated at Grantham and District Hospital

Temporary changes were introduced at the hospital in June 2021, in response to the COVID-19 global pandemic. These saw the urgent care offer at the hospital change, which enabled the Trust to provide chemotherapy sessions, endoscopy, and cancer and other

elective surgeries for patients from across Lincolnshire, in an environment with a minimised risk of possible infection.

These changes were reverted back in June 2021 to an A&E service from 8am – 6pm in conjunction with admitting medical inpatients.

Frailty Service Developments

October 2021 saw the opening of a Frailty Same Day Emergency Care (SDEC) unit within Lincoln County Hospital as part of the NHS mandate for 'Same Day Acute Frailty Services'. This comprised of a 4 chair/bed unit within the current frailty unit (Lancaster Ward).

The vision being that frail patients seen by a senior decision–maker as soon as possible in their journey could avoid unnecessary admission, improve care decisions and outcomes and minimise the time spent in the hospital. To date over 300 patients have gone through the unit.

Along with the Frailty SDEC development the Frailty Team also provide a dedicated telephone support line to provide frailty experience to other health care professionals across the county including GPs, EMAS and Community Teams.

Since January 2022 the team have also been integral to the development of the Frailty Virtual Ward which is a collaboration across all systems in Lincolnshire to provide care closer to home for frail older people and allow them to remain at home while undergoing treatment and monitoring which previously would have required hospital admission. To date there have been just over 100 patients managed as part of the Virtual ward.

Digital Transformation

The Trust is one of 32 NHS organisations to receive support in the second wave of the Digital Aspirants programme, which will see it supported on its transformation journey. The money will be used to develop the Trust's digital strategy and business case to deliver an electronic health record, which will transform how it works to provide outstanding care to Lincolnshire patients.

During the COVID-19 pandemic, health and care organisations have used digital technology to support the delivery of safe, high quality care. In Lincolnshire this has included the use of video and telephone consultations where appropriate to avoid patients having to travel to a local hospital for an appointment.

Plans and funding are also in place around introducing electronic health records and electronic medicines management systems across the Trust, which will help to improve patient experience and safety.

Lincoln Medical School

Eighty students from Lincoln Medical School at the University of Lincoln will have hands-on learning across Lincoln County Hospital and Pilgrim Hospital, Boston, whilst also caring for patients.

The Trust will be providing secondary care clinical placements for medical students, in a collaboration between the University of Lincoln and the University of Nottingham, delivering the University of Nottingham's Medicine and Medicine with Foundation Year degree programmes, enhanced with a Lincolnshire flavour. The initial phase, named Foundations for Practice (FFP), commenced at the end of February 2022.

The first phase of Lincoln students will be training alongside the existing cohort of clinical students from Nottingham's current curriculum. These students will have concluded their training in 2023, after which all student intakes will be from Lincoln Medical School.

It is hoped the new Medical School in Lincoln will address future projected shortages of doctors by offering first class training that will encourage graduates to complete their junior doctor training locally and apply for jobs in the region. The numbers of students coming to Lincolnshire's hospitals will increase over the next two years as part of the planned increase to the government cap on medical school places.

Robotic Assisted Surgery

The Trust has invested more than £3.2 million in a new robotic assisted surgery system that will offer more choice for urology and colorectal cancer patients as they undergo vital treatment.

The system is a computer enhanced surgical robot designed to mimic the surgeon's hand movements, enabling them to perform incredibly delicate procedures through the smallest of incisions.

Currently those patients able to access robotic treatments have to travel outside of Lincolnshire for their care as there has previously been no such system in the county's hospitals.

This robotic system upskills the operating surgeon and allows an advanced minimally invasive approach, which comes with a reduced risk of surgical complications, meaning those having surgery will be expected to go home earlier and have a faster recovery.

As well as delivering benefits to patients, the investment also supports the Trust's longer term vision for improvements outlined in its five-year Integrated Improvement Plan.

Seven-Day Services

The seven-day hospital services (7DS) programme was developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

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 • Standard 5: Diagnostics • Standard 6: Consultant Directed Interventions • 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	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

We continue to face challenges in achieving these standards, however benchmarking across the East Midlands and the country demonstrates 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 weekdays and weekends. There is however clear clinical commitment to move towards seven-day services within our Divisions.

Internal Audit

The Trust participated in 14 internal audits for 2021-22. The 14 internal audits all received significant or partial assurance with improvements required. All 14 reports will have an action plan developed to ensure the recommendations are made and progress will be monitored by the Audit Committee.

The 14 areas that were reviewed by internal audit were:

- Public and Patient Experience (Partial)
- Integrated Improvement Plan CQC Outcomes (Partial)
- Capital Planning (Partial)
- Equality, Diversity and Inclusion (Partial)

- Data Quality of KPIs – 12 Hour Trolley Waits (Partial)
- Recruitment
- Trust Operating Model (Partial)
- Ledger Transfer
- Core Finance Controls in 3 parts (significant, 2 outstanding areas)
- Integrated Improvement Plan CIP
- Infection Prevention and Control
- Data Security and protection Toolkit
- Risk Management (significant)
- Clinical Audit (significant)

Patient Experience

We have understandably had a challenging year; patient experiences have been at the forefront of care and treatment during the pandemic and as we work through our recovery plans. Here are just some of our achievements in the last year.

Patient Engagement

Patient Panel: the panel has only been cancelled once since it first commenced in September 2020 and has welcomed over 70 staff discussing more than 50 topics. We have 33 members and average 17 per monthly meeting and have also held standalone co-production workshops on particular topics such as visiting precautions, dignity pledges and patient moves.

The Sensory Loss sub group of the panel has worked on two projects – the development of bedside symbols and supporting patients with assistance dogs.

The development of Expert Reference groups is progressing well with a well-established Breast Mastalgia Group and an imminent launch of both a Cancer and Dementia Carers Expert Reference Groups. It is hoped that these groups begin to grow specialty based Experts of Experience.

Equality & Inclusion

The IIP ‘Reaching out project’ seeking to make contact with hard to reach communities has had contact with the Traveller Community and early links made with Eastern European communities in the Boston area. This work will continue through the coming months

alongside similar hopes of a link with BAME communities. The Patient Experience Team are members of core Trust groups to ensure equality and inclusion is considered including Safeguarding, mental health and learning disabilities and the Mortality Assurance Learning group.

Communication

We have a wealth of data telling us that communication is a key feature of our patient feedback. We have established a working group with an action plan and a range of projects in place, including keeping in contact with relatives, Objective Structured Clinical Examination (OSCE) training for staff and communication being a core topic within the new Patient Experience training programme.

Helping Dementia Patients in Hospital

Being in hospital is unsettling for all patients, but particularly those with dementia. This is why the Trust has teamed up with local charities to create dementia distraction boxes.

Every ward that may care for patients with dementia at Lincoln and Boston hospitals now has one of these boxes. They include everything from picture boards to help with communication, to reminiscence themed quizzes and conversation starters, playing cards, dominoes, colouring books, word searches and so much more.

Internal Audit – Patient Experience

Significant assurance was received in the 2021 internal audit in all but two areas assessed as partial. An action plan has almost been fully completed with the only outstanding one being the development of a Patient Experience Activity database, though an interim system has been put in place.

FAB Champions

There are now 83 in place across the Trust and are supported by our Patient Experience Managers with training, support and resources. A monthly #FABFact is sent around that includes ‘grab and go’ resources for staff to implement locally.

Networking

The Patient Experience Team are active members of the NHS Futures Collaborative 'Heads of Patient Experience and have presented and participated in webinars and network meetings gaining insight and inspiration from across the NHS as well as sharing some of our own achievements.

Visiting

Throughout the pandemic visiting systems, procedures and processes have been led by the Patient Experience Team. This has included the development of policies, risk assessments and internal and external communications. Alongside this the team have also led alternatives to visiting such as video calling and letters to a loved one initiatives.

Dignity Pledges

Our feedback data particularly in national surveys shows we need to improve patients experiences in this area and rather than have a dignity policy the Patient Experience Team have worked in partnership with colleagues, patients, patient panel, Healthwatch and CCG colleagues to develop our new Dignity Pledges which are now being launched.

Training

A new training programme has been developed and launched and attendance and early evaluation is excellent. Open sessions are being provided weekly by teams for 2 months and then monthly. The team are willing to attend divisional level forums to deliver and have created a self-study version. In addition night staff have been asked how best to deliver to them and a recorded self-study version is in development.

Complaints

Complaints and enquiries are a key source of feedback for the Trust and inform us about our patients' views regarding the quality of services and care provided. All formal complaints received 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.

The Trust ensures that complainants have the option to have their concerns dealt with informally or formally, via the NHS Complaints Procedure. All complaints, whether formal or informal, are monitored to identify if there are any trends and to provide a consistent approach for patients, carers and the public.

Each complaint is treated individually. Although the issue raised may be similar to others, the circumstances are often different for the individual concerned. The Trust aims to respond to formal complaints within 50 working days, dependent on the complexity and nature of the complaint, and the number of issues raised. If the timescale cannot be achieved, the complainant is informed of when they may expect their response. The Trust has seen a reduction in the number of complaints during the pandemic. A quarterly report is produced and presented the Patient Experience Group and Quality Governance Committee.

Number of complaints received:

	2019-20	2020-21	2021-22
New complaint received	721	555	627

Complaint Processes

The Trust participated in an internal review of their complaints processes. The objective of the review is to provide an independent assessment of the key risks and operational effectiveness of the Trust's arrangements in the management of complaints, and how lessons learned are shared across the organisation to maximise learning. The Trust received partial assurance with improvement required.

The Complaints Team have reviewed and refined their processes and the following changes have been implemented:

- All Complaints staff have attended and passed their accredited training.
- Complaints staff have been aligned to specific Divisions to enable greater shared learning and consistency.
- Divisions are informed of all reopened complaints on a monthly basis so they can review these and identify whether the complaint could have been handled differently in order to resolve this at the first response.
- Patient Stories taken from complaints which have demonstrated learning within the organisation are presented throughout the year to Trust Board.
- All complaint responses are quality assured by a member of the Clinical Governance senior management team prior to Divisional and Trust sign off.

- Divisional Triumvirate approves all complaint responses prior to executive sign off.
- Weekly trackers are sent to each Division detailing their compliance with complaint responses.

Learning from complaints

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. Many of the themes and actions identified from complaints form part of wider programmes of work such as in our IIP.

These are some examples of learning that occurred as a result of complaints:

Seroma drainage

Following a complaint about the current processes for the documentation of seroma drainage, the Matron is in the process of producing a seroma consent form, which outlines expectations, benefits and risks of the procedure. This will also enable clear documentation to be recorded on every visit, keeping the records together and ensuring that the team are able to document any required actions.

Colonoscopy procedure

A complaint was received by a patient who had received a telephone call from a secretary to arrange a colonoscopy procedure. The patient was provided with very little information and was not advised of the urgency and nature of the procedure causing the patient to feel worried and concerned. A leaflet is usually posted with a letter when a date is offered for the procedure to take place. This explains all the necessary information that a patient would need but as this was arranged over the telephone this was never given. The Trust's Lead Colonoscopy Nurse and the Division's Support Manager are developing and implementing a document for the secretaries to refer to when arranging appointments at short notice. This document will provide information for the secretaries to refer to if the patient has any questions and enable them to sign post the patient to relevant websites or advise them of the contact telephone number for the Colonoscopy nursing staff.

Stopping aspirin pre surgery

Following a complaint where a patient had his operation cancelled due to not being advised that that they would be required to stop taking their Aspirin medication, there will be additional training organised for pre-assessment nursing staff regarding the correct information being relayed to patients regarding medication stoppages prior to their procedure taking place.

Nutrition

Following a complaint raised about nutritional monitoring, a training document is being produced that will be shared with staff and copies with will be placed in all staff rest areas so they are accessible at all times.

Transfer of patients with poor mobility

A complaint was raised regarding a patient who had mobility problems and a Sara steady was not available in order to transfer them safely from a wheelchair to the scanner. Radiology have now purchased a Sara Steady to ensure that patients can transfer safely to the scanner and ensure that we maintain their dignity.

Patient Advice and Liaison Service (PALS)

PALS are a first stop service for patients, their families and carers and offers impartial advice and support. The service is confidential and aims to help resolve enquiries and concerns by working in partnership with services to respond as quickly as possible. During 2021-22 PALS dealt with 5,148 contacts.

The majority of PALS contacts related to requests for information about hospital services and putting people in touch with the correct service, department or individual who could help them.

PALS collate all comments, concerns and suggestions made and share this feedback directly with services and departments or by the patient experience feedback mechanisms available throughout the hospital.

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.

The Trust's current Inclusion Strategy is coming to a close at the end of 2021-2022. We are currently consulting on new equality objectives, which will be integrated into our new Inclusion Strategy 2022-2025, which is aligned to the Trust's Integrated Improvement Plan. The new Inclusion Strategy will be published early 2022-2023.

Following a national pause in Public Sector Equality Duty reporting in 2020-2021 due to the initial pandemic response, reporting was reinstated in 2021-2022. The Trust has now fully reinstated all statutory and contractual equality related reporting, which can be accessed on our website: https://www.ulh.nhs.uk/about/equality-diversity/

Freedom to Speak Up

Since 2016, the Trust has complied with the NHS contract requirement to appoint a Freedom to Speak Up Guardian. In 2021, the Trust appointed a full time Freedom to Speak Up Guardian to demonstrate their commitment to supporting and listening to staff who speak up. 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 'Voicing your concerns' which describes the different ways to speak up and who to speak up to, the process including updates and feedback and provides assurance to staff that anyone speaking up with genuine reason will not suffer detriment.

To complete the process, feedback questions are asked to gain assurance that actions have been taken or questions answered and to highlight potential service improvements.

How does the Trust support staff to speak up:

- Voicing Your Concerns Policy
- Freedom to Speak Up Guardian
- 13 Freedom to Speak Up Champions who have been engaged to promote speaking up across all staff groups and signpost to appropriate person or relevant policy
- The commitment of the Board to champion the importance of speaking up.

The Board receives a quarterly report on speaking up and is due to refresh the speaking up self-assessment and complete a development session with NHSE/I and the Freedom to Speak Up Guardian

- The Freedom to Speak Up Guardian meets monthly with the Trust Chief Executive/Chair and bi-monthly with the Non-Executive Champion for Speaking Up
- Mandatory Core Learning for all staff and new starters induction

What should staff do if they have a concern?

- Approach line manager or senior divisional manager
- Contact anyone named in the 'Voicing Your Concerns Policy'
- Contact the Freedom to Speak Up Guardian through the dedicated confidential email address freedomtospeakguardian@ulh.nhs.uk or telephone number 07471110490
- Contact the National Guardians Office

Guardians of Safe Working

The Guardian of Safe Working will support safe care for patients through protection and prevention measures to stop doctors working excessive hours. The Guardian of Safe Working oversees the exception reporting process and has the power to levy financial penalties where safe working hours are breached. The role sits independently from the management structure, and the Guardian is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and / or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe. The Guardian has a permanent 0.6 WTE administrative post to support them in this role.

The Office of the Guardian continues to hold regular Junior Doctor Forums on a two monthly basis and doctors have felt comfortable to raise issues at these meetings, which have been escalated further and addressed by senior management. The Guardian also

continues to hold Educational/ Clinical Supervisor training sessions over Teams; these are well attended and have received excellent feedback. The training sessions are held approximately twice a year (March and September 2022). The purpose of the training sessions is to increase awareness of exception reporting, support the Educational/Clinical Supervisors in the reporting mechanism and gives supervisors an opportunity for any feedback on issues they wish to raise.

The Guardian reports quarterly and annually to the People and Organisational Development Committee meeting. The reports contain the number of exception reports submitted per quarter, split by speciality, grade of doctor and common themes are documented, which can then be used to improve the experience of Junior Doctors within the Trust. Junior doctors are continually encouraged to submit the reports, to help identify where rotas and working patterns differ from those described in a doctor's individual work schedule. The Trust is committed to supporting trainee doctors who raise exception reports and ensuring that they are confident to raise issues where necessary.

The Guardian's Office has produced a new policy on the Process of Exception Reporting and Work Schedule Reviews for Doctors and Dentists in Training (2016 TCS), this is due to go to MSNF in March and be rolled out Trust-wide from April onwards. The purpose of the policy is to provide the process of implementation of Exception Reporting, Work Schedule reviews and Guardian Fines as required in the 2016 Terms and Conditions of Service for Doctors and Dentists in Training and locally employed doctors who raise exception reports and ensuring that they are confident to raise issues when necessary.

The Resourcing Advisors and Strategic Human Resources Business Partners continue to work closely with the Clinical Leads and Managers to understand the resource requirements relating to Doctors in Training within each specialty. This continues to enable a targeted approach to reducing rota gaps through focused recruitment of Locally Employed Doctors. The Resourcing Advisors continue to resource fixed term backfill to rota gaps and the Centralised Medical Agency Team continue to explore temporary staffing solutions as appropriate.

The Trust has recognised the need to invest in the overall experience for our Doctors in Training and a small team has been created as part of the Medical Workforce Team to focus on the rotations throughout the year. This includes close liaison and improved relationships with Health Education England East Midlands (HEEM) to ensure early identification of gaps, to ensure timely receipt of rotas from the Clinical Business Units and to ensure that accurate work schedules are issued in accordance with the Code of Practice. Already this investment has shown improvements with the April 2022 rotation achieving a compliance rate of 97%, which is a significantly improved position on previous rotations.

To further improve the experience of our Doctors in Training and to reduce the reliance on bank and agency staff, the Trust has invested in a rota cell project. This project involves a Trust wide review of rotas for Doctors in Training to ensure delivery of best practice rostering and ongoing compliance with the Junior Doctors' Contract. In addition, the project is focusing on how digital solutions can support the management of rotas and leave. The focus to date has been within the Medicine Division with work being carried out on safe staffing levels as part of the review by the Royal College of Physicians (RCP), the introduction of digital leave requesting and training provided to Rota Co-ordinators. With the new Deputy Director of People & Organisational Development now joining, there has been a requirement to review the project and discussions are ongoing regarding the resourcing requirements to complete the project in Medicine. Once the project is completed in Medicine then this will be rolled out into the other three Divisions.

It's Safe to Say Campaign

As part of the Trust's commitment to patient safety and quality, we have been working behind the scenes to develop our campaign. ***"it's safe to say"***.

We know that historically, our National Staff Surveys, and our internal assessments have indicated that staff do not always feel safe to speak up, or feel supported to raise concerns. Over the past two years the NHS has faced its greatest challenges, however, despite these it is vital that we create a workplace whereby staff feel valued, can speak up be listened to and choose to work safely. A workplace where we protect and care for each other, while we protect and care for each other. It's time for a change, we want to take a fresh look at safety, health and well-being, throughout the Trust, to understand where we are doing well, what our challenges are and what we can do even better.

How it will work:

“It’s safe to say…”

A communications campaign to explain what we are doing and why, to drive momentum for the need to change and to encourage people to get involved.

Focus groups

During November 2021,Culture specialists, Tribe, led a series of focus groups, with a cross-section of our people, to ask:

- How do we manage safety?
- What do we do well?
- What do we need to do better?
- How can we make things safer?

Feedback

We are now planning a seris of feedback events to our staff.

This will help us understand the behaviours that will make all the difference.

Programme roll-out

A programme to address the areas where we can make improvements.

This will include training for leaders and the workforce, as well as supporting tools and communications to help us drive our vision, so that everyone working here feels valued, respected, challenged, satisfied and, above all, safe.

Annex 1: Stakeholder Comments

NHS Lincolnshire Clinical Commissioning Group (Lead Commissioner)

NHS Lincolnshire Clinical Commissioning Group

United Lincolnshire Hospital Trust Quality Account Statement 2021/22

NHS Lincolnshire Clinical Commissioning Group (the commissioners) have welcomed the opportunity to review and comment on the United Lincolnshire Hospital NHS Trust (the Trust) Annual Quality Account 2021/22. The Quality Account for the Trust provides a comprehensive summary of the key quality priorities that were focussed on during the past year.

The areas that were focused on were identified as priorities through engagement with patients, public, staff and system partners. The key areas were: Improving Respiratory Services; Developing a Safety Culture; Improving Patient Experience.

The Trust has been transparent and open with their achievements against the ambitious targets that were set and they have identified that they have only fully achieved 50% of the individual elements. However, we are fully aware that all NHS providers faced huge challenge from their response to the COVID 19 Pandemic and the Trust were no different and this would have significantly affected their ability to meet their objectives. The Trust have identified what else they need to do in these priority areas to fully meet the objectives set and these are set out clearly in the Quality Account and we welcome that this work will continue into this fiscal year.

We were delighted to see the improvements identified by the Care Quality Commission (CQC) following their unannounced inspection in 2021 and subsequent Well Led inspection. This allowed the Trust to move out of the Recovery Support Programme and will enable the Trust to focus on their improvement journey. The commissioners are fully sighted on the CQC action plan and the progress that is reported into the Quality Governance Committee and we recognise the significant effort that the Trust and all its staff have put into this.

The commissioners were pleased to see the Medical Examiner role continue to be embedded within the Trust and the impact of the actions are clearly articulated within the

Quality Accounts. We hope that the introduction of this role in the community will also help identify any possible learning from patients that have been discharged from hospital but sadly die within 30 days of discharge.

The commissioners have noted that four new quality priorities have identified for the coming year 2022/23. These are:

Priority 1 Discharge and Compliance with the SAFER Bundle (Patient Experience).

Priority 2 Diabetes Management (Clinical Effectiveness)

Priority 3 Improving the Safety of Medicines Management (Patient Safety)

Clear rational has been given for why these are the selected priorities, and they align with the Trust's Integrated Improvement Plan. As commissioners we support these as they are well aligned to the priorities for the Lincolnshire system.

We are pleased to see that the Trust have recognised within the Quality Account the way that staff responded and mobilised to respond to the COVID 19 Pandemic. ULHT were a key system partner during this time and demonstrated excellent system wide working. The Trust recognise that they have much work to do in order to restore services and address backlogs that have occurred in common with services across the country and commissioners and system partners will continue to support them with this.

There are some key exciting programmes of work planned for the coming year including the continuing transformation of the Pilgrim and Lincoln Hospital Emergency Departments as a result of significant investment. Demand on urgent and emergency care services continue to rise and both departments will be able to increase capacity in state of the art new facilities which will vastly improve the patient experience.

The commissioners feel that there has been a missed opportunity to demonstrate the work that they have done around Children and Young People and the response to the recommendations set out in the Ockenden Review of Maternity Services at Shrewsbury and Telford NHS Trust but recognise that these areas are significant priorities for the Trust.

The commissioners would like to thank united Lincolnshire Hospitals NHS Trust who have worked with system partners during the COVID-19 pandemic to ensure patients' needs are

met and they have provided their services safely and effectively in what was certainly the most challenging period in NHS history.

As an Integrated Care Board, we look 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.

Terry Vine, Deputy Director of Nursing and Quality, NHS Lincolnshire CCG

United Lincolnshire Hospital Trust Quality Account Statement 2021/22

Healthwatch Lincolnshire share all relevant patient experiences we receive with ULHT. Over the last year we have experienced delays in receiving these responses, in some cases it was over 6 months before we received an answer. These 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.

Overall, the report is comprehensive and very informative. It was felt that it maybe better to move the glossary of terms at the front to the back, starting a report with three pages of this is quite off putting, this said the list of terms was welcomed.

Commentary relating to the previous year's Quality Accounts.

The inclusion of the benchmark ratings for whether priority actions have been met, partially met etc was very useful. Sadly, where the first two priorities showed real performance against actions, the one area that hasn't and is particularly disappointing is Improving Patient Experience. This priority showed most results as not achieved or only partially achieved, this really demonstrates lack of commitment to include patients at the heart of service design, decision making and most importantly person-centered care. Which also reflect our experience of ULHT failing to respond to our monthly patient experience report. Listening, learning, and including patients in their healthcare journey is essential and as a result it was felt that ULHT should include this again as a priority for 2022/23.

From last year's Healthwatch quality account statement we said: As an organisation who provide ULHT with much patient insight we would welcome the inclusion of a 'You said – We did' style public communication, so patients can understand the improvements made, and that their feedback is taken on board and actioned.

As Healthwatch we will continue to provide patient insight to assist with improvements across ULHT and would still like to understand more how this is being used to provide improvements and change for patients and service users as mentioned last year.

Priorities and challenges for the forthcoming year 2022/23

We would like to highlight that we found this year's Quality Account Priorities easy to read and it was very useful as a watchdog organisation that the sections What will success look like? and How will we monitor progress? have been included this allows us to hold ULHT to account and monitor progress throughout the year.

Priority 1 – Discharge and Compliance with SAFER bundle is an excellent area to focus on, knowing that this continues to be a significant issue within the system, and it was good to see the inclusion of how ULHT are working towards a more joined up approach. We are about to plan a piece of work to reinstate our Enter and Views visit with a plan to have discharge as a theme and therefore will be looking to work in a collaborate way with the trust.

Priority 2 - Diabetes Management - we support the inclusion of this priority to enhance patient safety by learning from reported incidents.

Priority 3 - Improving the Safety of Medicines Management -This is an absolute essential priority as it is linked to previous failings by the Trust and the impact of this on patients is significant

Healthwatch Lincolnshire, in our Watchdog role, plan to benchmark your 2022/23 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.

Healthwatch Themes and Trends for ULHT – The last 12 months

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

ULHT Patient Experiences Summary – April 2021 – April 2022

Important to note - we heard several positive experiences of attending A&E at all hospitals in the trust and the quality of care provided whilst in hospital. Many patients acknowledge and appreciate the pressures on the NHS.

Concerns:

- Widespread concern, but especially prevalent in the east of the county (Mablethorpe and Louth) and in Grantham, around the growing population of the county but a perceived reduction in hospital services, with services being more centralised and specialist care often being provided out of county individuals feel the impact (both economically and emotionally) of travelling for services is not acknowledged.
- Patients concerned around the closure of Grantham A&E and the impact having to travel to a hospital further afield in the case of an emergency will have on their health. The lack of clarity of where residents in Grantham need to go in such cases is causing confusion and distress
- Patients are concerned about the impact long waits for operations and specialist appointments and cancellations will have on their health

Finally, poor communication was a common issue and related to the following:

- Between hospitals, other services and patients
- Medical records not being shared between services (or the length of time it takes for the information to be shared), resulting in treatment delays
- Difficult to keep in contact with relatives in hospital and get updates on their condition
- Difficult to get through to hospital departments on the phone – e.g. to cancel an appointment – individuals are passed from department to department spending often over an hour trying to get through

Finally, we continue to see our relationship with ULHT develop positively and look forward to continued engagement with the Trust in the coming year.

Statement on United Lincolnshire Hospitals NHS Trust's Quality Account for 2021/22

This statement has been prepared by the Health Scrutiny Committee for Lincolnshire, which is grateful for the opportunity to review the Trust's draft quality account.

Progress on Priorities for Improvement for 2021-22

- *Priority 1 – Improving Respiratory Services* – The Committee is pleased to note the progress with this priority, where seven out of the ten milestones have been achieved, with the remaining three milestones partially achieved. The Committee welcomes the opening of the specialist respiratory centre at Lincoln County Hospital in July 2021, as a significant benefit for patients.

- *Priority 2 – Developing a Safety Culture* – The Committee welcomes the achievement of all ten of the milestones for this priority.

- *Priority 3 – Improving Patient Experience* – The Committee accepts that there has been less progress with this priority, as several of the milestones have relied on face-to-face communication, which was constrained by the pandemic's infection control measures. The Committee understands that work on meeting these milestones will continue in the coming months. The Committee would like to stress the importance of enabling staff to provide feedback to their managers on issues, and the reinstatement of the staff survey will assist in this. Patients will always benefit from a culture that supports candour and transparency.

Priorities for Improvement for 2022/23

The Committee supports the selection of the three priorities for improvement for 2022/23 and the following comments are put forward on each priority:

- *Priority 1 – Discharge and Compliance with the SAFER Bundle* – We passed comments on the need for explanation of SAFER, and pathways 0 and 1.

  A key concern for Committee, as raised by the CQC, are ambulance handover delays at emergency departments. The Committee understands that improvements to discharge arrangements, including compliance with the SAFER bundle, will improve 'patient flow' through all the Trust's hospitals. Releasing beds in a timely way will allow patients in emergency departments to be admitted to wards, which would in turn allow patients to be transferred from ambulances to the emergency department. The Committee will be seeking information on progress during the coming year.

- *Priority 2 – Diabetes Management* – The Committee recognises the importance of this priority, which arose from a CQC enquiry on a cluster of diabetes-related incidents at Pilgrim and Lincoln County Hospitals and looks forward to progress being made in the coming year.

- *Priority 3 – Medicines Management* – As noted below, improvements to the management of medicines, were part of the Trust's response to the CQC's 2022 inspection. The Committee looks forward to progress with this priority.

Care Quality Commission Inspection and Integrated Improvement Plan

The Committee has welcomed the positive report from the CQC in February 2022 and is aware that the Trust has incorporated the findings into a programme of improvement work. This references into existing improvement activity within the Trust's Integrated Improvement Plan (IIP).

National Clinical Audits

The Committee understands that details of clinical audits are a requirement in a quality account, although these audits became voluntary in many instances as a result of the pressures of the pandemic. As the Trust decided to participate in as many audits as possible, we suggest that this approach is explained, together with the reason why some of the clinical audit figures, for example on infection control, were low because these teams were directly responding to the pandemic.

Review Quality Performance

In addition to the specialist respiratory unit stated above, the Committee welcomes the inclusion in the *Review Quality Performance* chapter, the benefits to patients and staff arising from:

- the significant capital investment at the emergency departments at Lincoln County and Pilgrim Hospitals;
- robotic-assisted surgery, particularly for urology and colorectal cancer patients; and
- the placements of students from the Lincoln Medical School on the Trust's wards as part of the *Foundations for Practice* programme.

The Committee also looks forward to further progress with digital transformation, in particular electronic health records.

Engagement with the Health Scrutiny Committee for Lincolnshire

During 2021-22, engagement with the Health Scrutiny Committee for Lincolnshire has continued, with representatives of the Trust attending for various items at six of the nine meetings of the Committee which have taken place during the year.

The Committee is also grateful to the Trust's Assistant Director of Clinical Governance and the Trust's Head of Clinical Governance, Complaints and Effectiveness for attending the meeting of the Committee's working group, which considered this document on behalf of the Committee. This provided an opportunity for both immediate explanations and direct feedback.

We look forward to continued engagement with the Trust's managers, and where appropriate clinicians, in the coming year.

Presentation of the Document

We are pleased to see a well presented and easy-to-read document. For example, there is a clear indication as to whether the success measures for the actions supporting each

priority from last year have been achieved; and there is a glossary at the beginning to enable the public to understand the abbreviations used.

Conclusion

The Committee is grateful for the opportunity to make a statement on the draft Quality Account. The Committee looks forward to the Trust's progress with the three priorities in the coming year and will continue to seek to engage the Trust at its meetings.

Annex 2: Statement of Directors' Responsibilities

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011, 2012 and 2017 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

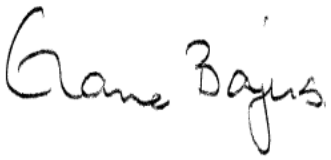
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

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

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

Andrew Morgan

Chief Executive Officer



Elaine Baylis

Chair, Trust Board