NHS
United Lincolnshire Hospitals
NHS Trust

United Lincolnshire Hospitals NHS Trust
Quality Account 2022-23

OUTSTANDING CARE
personally DELIVERED

Glossary of Abbreviations

AAA	Aortic Abdominal Aneurysm
ASR	Acute Service Review
BAME	Black Asian and Minority Ethnic
BAUS	British Association of Urological Surgeons
BTS	British Thoracic Society
C. Diff	Clostridium Difficile
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CT	Computerised Tomography
DATIX	Incident Reporting System
DKA	Diabetic Ketoacidosis
DSP Toolkit	Data Security and Protection Toolkit
DVT	Deep Vein Thrombosis
EBE	Experts by Experience
ED	Emergency Department
ED&I	Equality Diversity & Inclusion
ESR	Electronic Staff Record
FPSG	Falls Prevention Steering Group
FFT	Friends and Family Test
FTSUG	Freedom to Speak Up Guardian
GDH	Grantham and District Hospital
GIM	General Internal Medicine

GIRFT	Getting It Right First Time
HCOP	Healthcare of Older People
HES	Hospital Episode Statistics
HSMR	Hospital Standardised Mortality Ratio
HVLC	High Volume Low Complexity
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care National Audit and Research Network
ICS	Integrated Care System
IG	Information Governance
IIP	Integrated Improvement Plan
JAG	Joint Advisory Group
KPI	Key Performance Indicator
LCH	Lincoln County Hospital
LEDs	Locally Employed Doctors
LUCADA	Lung Cancer Audit (National)
MBRACE	Mothers & Babies: Reducing Risk through Audits and Confidential Enquiries
MCCD	Medical Certificate of Cause of Death
MDT	Multi-Disciplinary Team
ME	Medical Examiner
MEO	Medical Examiner Officer
MI	Myocardial Infarction
MINAP	Myocardial Infarction National Audit Programme
MorALS	Mortality Assurance and Learning Strategy 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
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NICOR	National Institute for Cardiovascular Outcomes Research
NIHR	National Institute for Health Research
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
OBD	Occupied Bed Days
OD	Organisational Development
O-G	Oesophago-Gastric
OSCE	Objective Structured Clinical Examination
PACE	Patient & Carer Experience
PALS	Patient Advice and Liaison Service
PAT	Pets As Therapy
PE	Pulmonary Embolism
PHB	Pilgrim Hospital Boston
PHSO	Parliamentary and Health Service Ombudsman
PIAG	Patient Information Approval Group

PROMs	Performance Reported Outcome Measures
PSIRF	Patient Safety Investigation Response Framework
QGC	Quality Governance Committee
QI	Quality Improvement
RCEM	Royal College of Emergency Medicine
RCP	Royal College of Physicians
RCPH	Royal College of Paediatricians and Child Health
SDEC	Same Day Emergency Care
SHMI	Standardised Hospital-Level Mortality Indicator
SHOT	Serious Hazards of Transfusion
SIG	Skin Integrity Group
SOP	Standard Operating Procedure
SSNAP	Sentinel Stroke National Audit Programme
TARN	Trauma Audit Research Network
TCS	Terms and Conditions of Service
ULHT	United Lincolnshire Hospitals NHS Trust
VTE	Venous Thromboembolism
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
7DS	Seven Day Services

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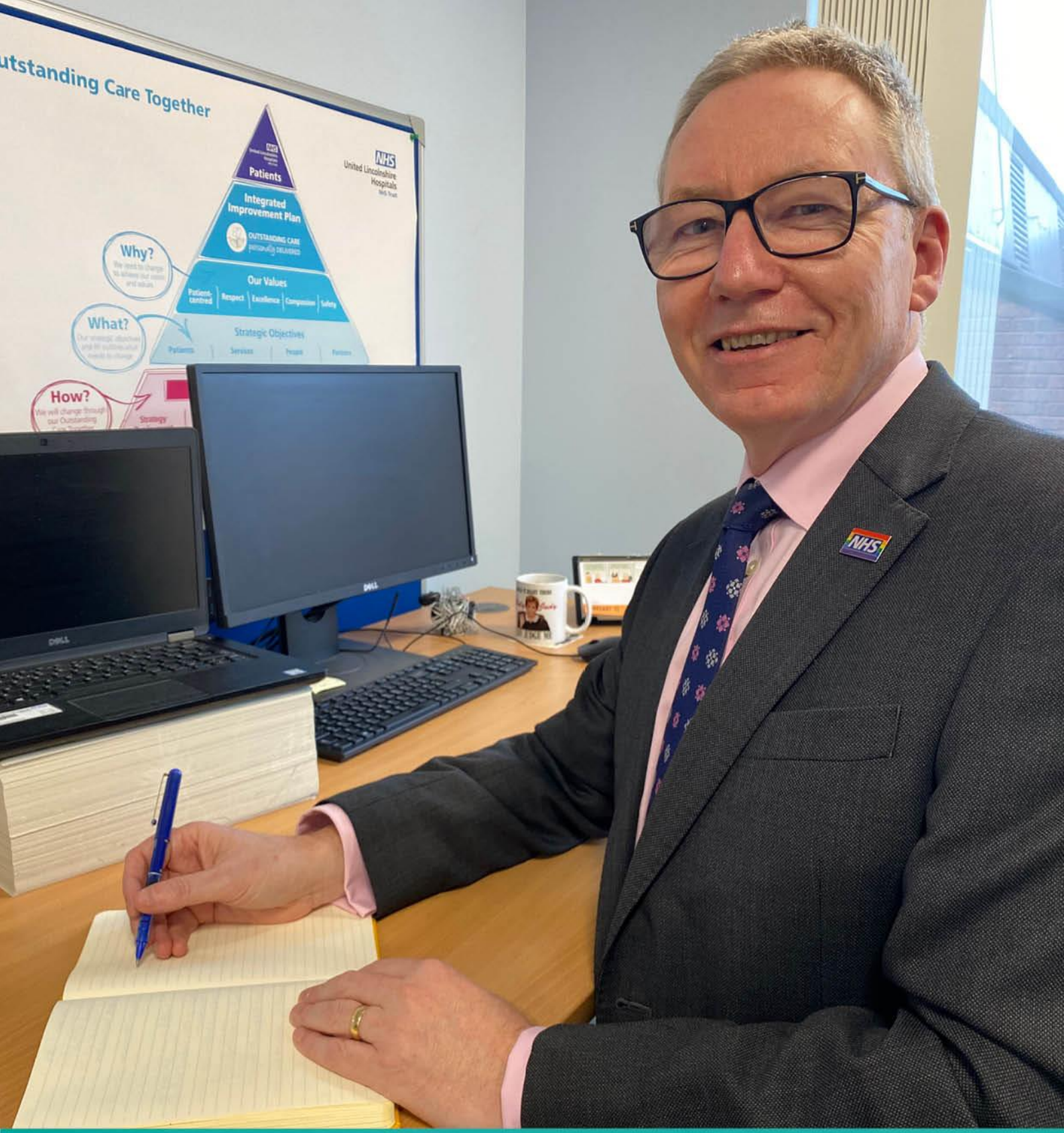


Part 1: Chief Executive's Statement

Welcome to the Quality Account for United Lincolnshire Hospitals NHS Trust for 2022-23. This document provides an overview of all of the activity that has been taking place within our hospitals over the past year, with a focus on improving the quality of care that we provide to our patients.

Once again, we have faced a year with many challenges, including the lasting after effects of the COVID-19 pandemic, tackling a waiting list backlog, unprecedented pressures on urgent and emergency care services and national strike action that has impacted on staffing levels. However, we have also had a year to be proud of, as we have started to see some real movement in many areas of our quality agenda with national recognition of the progress being made. Whilst we acknowledge that there is still more to do, we have some positive momentum to report, and there is a general feeling of optimism within the Trust.

Our staff have yet again gone to unprecedented lengths to look after our patients, day in and day out, and the progress we have made is testament to that dedication.

At the beginning of last year, we heard that many of our Care Quality Commissioner (CQC) ratings across our hospitals had improved following an inspection in October 2021, and that we were being taken out of 'special measures' (now known as the national Recovery Support Programme)

Since that fantastic news, we have demonstrated multiple other achievements, including:

- The removal of all remaining conditions on our CQC registration - the first time there have been none in place for many years.
- Moving out of the Maternity Safety Support Programme.
- Joint Advisory Group (JAG) accreditation achieved for all four of our endoscopy units.
- Huge progress made in reducing our waiting list backlog- with no 104 week waits and nearly eliminating 78 week waits to date.
- Improvements in patient safety indicators around Standardised Hospital-Level Mortality Indicator (SHMI), infection prevention and control, pressure ulcers and medication errors.
- Being rated as one of the most improved trusts in the country in the 2022 NHS Staff Survey- with an improved score around staff believing the care of patients is the organisation's top priority.

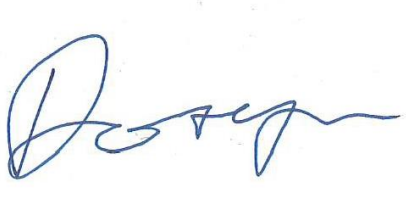
We have also had lots of exciting opportunities and ongoing projects that are making improvements across our sites:

- The transformation of Lincoln County Hospital Emergency Department, with the opening of a £5.6million new resuscitation department.
- The opening of two new £5.3million theatres at Grantham and District Hospital.
- The introduction of robotic assisted surgery into Lincolnshire for the first time.
- Grantham and District Hospital named as one of eight accredited surgical hubs in the country.
- Plans progressing at speed for the redevelopment of Pilgrim Hospital, Boston's new Emergency Department.

We have also continued to involve our patients in discussions and decision making in the Trust, with our successful Patient Panel taking part in regular consultation and discussions about the development and improvement of services.

Next year, we hope to go even further on our quality improvement journey, with lots of exciting plans in the pipeline for new developments, and steady progress being made towards improving other quality indicators for the benefit of our patients.

At the heart of all of this improvement lie our staff, who go above and beyond every day to provide safe and quality care for our patients.



Andrew Morgan,

Chief Executive

Part 2: Deciding our Quality Priorities for 2023-24

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 2023-24. 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 a key component for patient experience.

Priority 1 - Implementation of our ‘you care, we care to call’ programme across 38 wards

Why have we selected this Priority?

This priority is under the Patients Strategic Objective “Enhance patient experience by learning from patient feedback, demonstrating our values and behaviours in the delivery of care with a specific focus on access, flow and discharge of patients”.

The Trust wants to use the implementation of ‘you care, we care to call’, an initiative for proactively calling relatives to update them, to demonstrate how we listen to patients and improve care based on feedback of lived experience, and to ensure we make carers and patients feel valued as partners in care.

Our Current Status:

There are currently 5 wards accredited using ‘you care, we care to call’.

What will success look like?

- 38 wards having the scheme ‘rolled out’ by March 2024.
- Learning, where relevant from the feedback received.
- Improvements made, if required, to processes based on feedback.

How will we monitor progress?

The Improvement Team will collate the information and produce the reports.

The metrics outlined in ‘what success will look like’ above will be used to support tracking and monitoring progress.

Reports will be presented at the Divisional Meetings.

Priority 2 - Improve clinical effectiveness and best practice principles by prioritising Cardiovascular pathways

Why have we selected this Priority?

This priority is under the Patient's Strategic Objective "Enhance clinical effectiveness by ensuring that care delivered to patients is based on evidence base, best practice leading to improved clinical outcomes, ensuring that we prioritise those areas with higher harmful incident rates".

The Trust has had a significant Echocardiography backlog, so by choosing to focus on Cardiovascular pathways it is hoped that this can be improved. In addition, the first Specialty Review completed within the organisation was Cardiology, and also Stroke is a core part of the Acute Service Review (ASR) outputs, with increased Length of Stays.

Echocardiography backlogs have been listed on the Trust Risk Register. In addition, Get it Right First Time (GIRFT) have also been very keen to support a Cardiology Deep Dive.

Our Current Status:

There are 5800 patients on the waiting list for Echocardiography.

Length of Stay for Stroke patients was 16.5 days.

What will success look like?

- Reduced waiting list for Echocardiography with an ambition to have zero patients waiting less than 6 weeks by March 2024.
- Reduced Length of Stay for Stroke patients (reduced to 10 days).

How will we monitor progress?

- The Improvement Team will collate the information and produce the reports.
- Compliance will be presented at relevant Divisional meetings.
- Through the implementation of Cardiology Specialty Review actions, and onward development of their Clinical Strategy (as a result of the Cardiology Specialty Review) there will be a plan outlining improvements needed.

- Stroke Length of Stay will also be monitored through the implementation of the Stroke ASR and reported through the relevant Groups.

Priority 3 - Maximise safety of patients in our care, through learning from incidents

Why have we selected this Priority?

This priority is under the Patients Strategic Objective “Enhance patient safety by learning from incidents, ensuring alignment to those areas highlighted by our Clinical Governance Team throughout the year”.

Some of these areas are priorities outlined in Divisional Integrated Improvement Plans or have seen an increase in the number of incidents causing harm in the specific area, and are aligned to areas which have been highlighted as a Trust priority (Medication Management and Diabetic Ketoacidosis (DKA)).

Our Current Status:

Delayed and omitted medicines can have a significant impact on patients in terms of loss of therapeutic effect and risk of deterioration. Opportunities for medicines to be omitted can occur at many stages of the medicines management pathway. Examples include incomplete medicines reconciliation at points of transfer, errors in the transcription of medication charts, and medicines not administered to patients as prescribed. Delayed and omitted medication has consistently been the most commonly reported medication related incident across the Trust.

NHS organisations have a responsibility to ensure that there are effective systems and processes in place to manage medicines safely. Within ULHT a number of challenges have been identified, from a variety of sources (e.g. CQC inspection, internal audit, ward reviews, incidents and SIs) in respect of some aspects of the Trust's medicines management systems and processes and it has been agreed that these issues need to be addressed as a priority.

Improving the safety of Medicines Management is a major project within the IIP, which has been developed to provide solutions as to how the above-mentioned issues and challenges will be addressed.

What will success look like?

- Reduced incidents resulting in harm relating to medication incidents/omission.

- Reduced incidents resulting in harm relating to Diabetic ketoacidosis (DKA) .
- Reduced incidents resulting in harm which occur in ED.
- Reduction in incidents resulting in harm relating to falls.

How will we monitor progress?

The Improvement Team will collate the information and produce the reports.

The metrics outlined in ‘what success will look like’ above will be used to support tracking and monitoring progress.

A number of improvement work streams are underway and upwardly reported into the Medicines Quality Group on a monthly basis.

Reports will be presented at the Divisional Meetings.

Looking Back: progress made since publication of 2021-22 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. • **Discharge and Compliance with the SAFER Bundle**
2. • **Diabetes Management**
3. • **Improving the Safety of Medicines Management**

Introduction

The Quality Account for 2021-22 outlined the Trust's proposed quality improvements for the year ahead (2022-23). These priorities were identified following engagement with patients, the public, staff and external stakeholders. The priorities have also been aligned with the Trust Integrated Improvement Plan (IIP). During the year 2022-23 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 2022-23.

Trust performance

This section provides detail on how the Trust has performed against the three priority ambitions. Results relate to the period 1st April 2022 – 31st March 2023 or the nearest period available. Mechanisms of measurement vary by priority and by the availability of national benchmark.

Priority 1: Discharge and Compliance with the SAFER Bundle

We said we would:

SAFER Discharge Bundle

The SAFER bundle encourages staff to increase patient flow by carrying out routine multi-disciplinary daily ward board rounds, to cover all patients and explore the reason for delays . Information is captured on the Trusts electronic systems to capture real-time patient data.

Achievements:

- Pilot wards introduced to SAFER bundle – Navenby, Neustadt Welton, Burton and Digby
- All adult in-patient wards across the Trust have been provided a training package which included face to face support, simple user guide and open Teams invite for more help and support
- All wards have been shadowed during ward board rounds
- Standardised Operating Procedure (SOP) has been developed
- Automated compliance audit report developed
- All ward leaders provided with daily updates on the scoring and encouraged to compete with other wards to achieve better results or maintain levels
- Ward Leader released from clinical duties to support with roll out of SAFER bundle across the Trust
- Audit monitoring by Matrons

Criteria Led Discharge

Criteria Led Discharge will help to achieve flow throughout the hospital by clearly defining patients who can potentially be discharged once set parameters have been met.

Achievements:

- Checklist created ready for check and challenge
- Task and finish group set up
- Pilot period agreed for 3 months
- Pilot wards agreed to cover Healthcare of Older People (HCOP) and Diabetes at Lincoln and Pilgrim
- Pilot agreed to cover weekend and out of hours

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?

SAFER Discharge Bundle

- Provide routine checks to validate data
- Sign off SOP from Equality and Diversity lead and Governance route.
- Disseminate SOP to all ward leads
- Temperature check compliance 3,6,9 months to ensure compliance is embedded as business as usual
- Ensure clinical staff are compliant with roles and responsibilities
- Establish read-only access to E-Referrals system to reduce the number of unnecessary escalations for referrals
- Increase utilisation of discharge lounge through Discharge Lounge Sprints

Criteria Led Discharge

- Benchmark data
- Agree checklist for handover at Task and Finish group
- Agree contact group for receipt of handover checklist
- Agree reporting/escalation mechanism
- Disseminate handover checklist
- Review pilot data to assess success/failure/areas for improvement
- Roll out to all wards

Priority 2: Diabetes Management

We said we would:

Compliance against the e-Learning for Insulin Safety, Diabetic Ketoacidosis (DKA) and Diabetic Emergencies Modules

Compliance eLearning:

Month	DKA Compliance %	Diabetic Care Management %	Diabetes Emergencies %
Mar-22	81.54	92	N/A
Apr-22	85.06	93.47	38.95
May-22	87.09	93.5	62.33
Jun-22	88.68	93.87	72.34
Jul-22	89.08	94.13	76.76
Aug-22	88.41	93.71	80.45
Sep-22	87.71	93.21	82.23
Oct-22	89.18	93.76	84.39
Nov-22	88.52	94.33	85.53
Dec-22	88.33	92.44	86.74
Jan-23	89.57	92.63	87.84
Feb-23	89.73	92.71	88.65
Mar-23	88.96	92.24	88.29

The compliance for the three eLearning packages for diabetes highlighted above has demonstrate there has been improvement and the compliance is being maintained, however, there is acknowledgement that we need to increase to 95% and demonstrate the Trust is consistently achieving.

Implementation of the Get it Right First Time (GIRFT) recommendations that are applicable to the Trust

There has been agreement in principle to ring fenced two beds on Navenby and 8a (Diabetes Wards) for management of DKA patients.

The Diabetic Specialist Nurses are providing training to long term agency nurses on the emergenc wards

Reduction in incidents reported for DKA Management

There were 9 DKA incidents reported in 2021/22, in comparison to 7 in 2022/23, a reduction of 2 from the previous year.

Patients with Diabetes are treated on the appropriate ward

Patients with DKA are managed on the admitting ward. Patients admitted to hospital due to a diabetes cause will be cared for on the Diabetes Ward. Patients admitted for another clinical reason but happen to have diabetes will be cared for on the ward that is most appropriate to their admission reason. For patients with diabetes who are not on the diabetes ward but they need support whilst they are an in-patient will have an e-referral made to the diabetes team to review an provide advice.

Implementation of the DKA Project; Pathway implementation of expertly trained Nurses on Diabetes Wards at Lincoln and Boston managing patients with diabetes emergencies

Workshop being set up to agree how the pathway will be implemented which is planned for April 2023. A business case will need developing as there will be additional resources required.

Data Source:

- ESR for core training
- Datix for DKA incidents

What we need to do to achieve our success measures?

ESR Compliance

There is ongoing work by the Diabetic Specialist Nurses in promoting the eLearning, which is monitored by each Division.

Implementation of the DKA Project

A business case will need developing as there are additional staff required to ensure there are specialist Diabetes Nurses on duty 24 hours to provide the specialist advice to staff.

GIRFT Recommendations

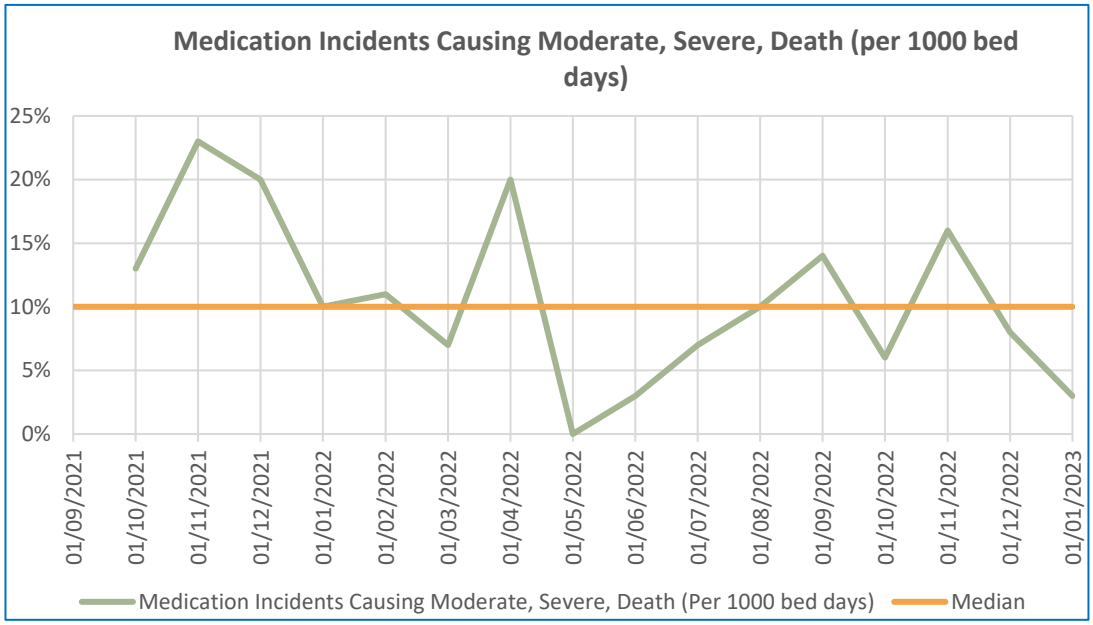
There is a project group being developed to ensure all GIRFT recommendations and best practice are embedded.

Priority 3: Improving the Safety of Medicines Management

We said we would:

Reduce avoidable medicines errors reducing serious incidents and improving quality of care.

ULHT has seen a sustained reduction in reported medication incidents causing moderate, severe harm or death, whilst also seeing a positive, open and honest reporting culture emerging, with an increase in the number of no harm incidents reported. This open and honest reporting culture will allow the Trust to review and understand themes and trends to improve patient and staff experience.



Data source: Jan23 Medication Safety Report

The implementation of the monthly Medicine Quality Group meetings and divisional alignment, has given the Trust greater visibility and accountability for medication incidents and accurate reporting. This platform promotes understanding trends and themes to support continuous learning, which provides a Trust-wide approach for managing medication incidents.

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

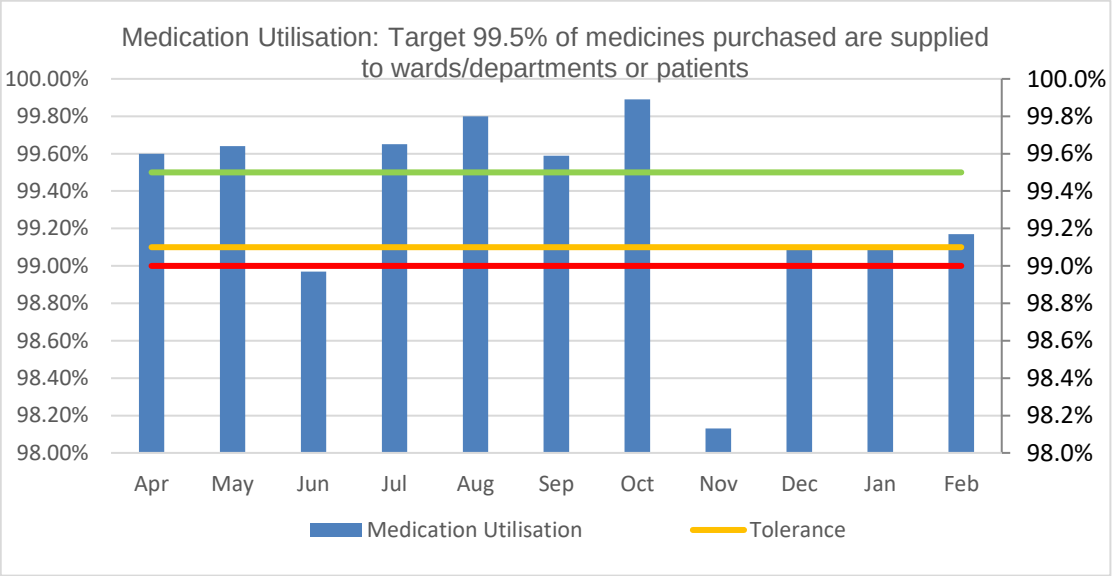
Improve education and competency associated with Drug administration and storage

In September 2022 the Trust held its first ever Medication Safety Event for clinical colleagues to attend. This event provided the opportunity to host workshops on topics such as the “Do not Disturb Campaign” Self-administration of Medication, and Medication Incident reporting. These workshops provided the opportunity for awareness training whilst also providing a platform for collaborative discussions and learning from challenges that our teams identify. Due to the success of this event, the Trust will be moving forward with mid-year, half-day events at Grantham, Lincoln and Boston in April 2023 and a full day event in September 2023. The topics and themes for these events will be identified from the outcome of the incident panels. Attendance at these events has been extended to include Doctors, Nurses, Pharmacy and all other Clinical Support Teams.

A new Drug Administration Programme has been developed to deliver a competency pathway designed for practitioners from adult and paediatric fields, whose role requires the preparation and / or administration of medication. This training programme is currently in the process of the initial review before the governance sign off process can commence, once approved this training package will be hosted on the Trusts Electronic Staff Records platform and will form part of the mandatory training requirements.

Reduced medication wastage will help the Trust achieve financial balance

Due to current constraints within our data and processes, the Trust is currently only able to monitor medication wastage within our pharmacy department. Medication supplied to clinical areas that result in disposal due to temperature excursions, lack of stock rotation is currently unable to be quantified, this is due to the manual process currently in place for returning medication. Therefore, for the Trust to improve visibility and accuracy in reporting all medication wastage, this would require the clinical and pharmacy processes and system for recording medication returns and disposals to be reviewed, to identify what changes would be required for this to be achieved. However, due to current capacity constraints within the Pharmacy Department this has been identified as out of scope at this time.



Data Source:

Pharmacy Audit April 2022-February 2023

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

The temperature-monitoring project linked to this programme of work is currently piloting the Stanley smart thermometers within the maternity and labour Team at Lincoln and Boston, along with a new ways of working booklet which provide greater support for clinical colleagues to achieve compliance with medication temperature monitoring. The next pilot area for the Trust is Theatres at all four sites, this will commence following any changes required to be made based on feedback from the Maternity and Labour teams.

Statement of Assurance

Review of services

During 2022-23, 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 2022-23 represents 89% of the total income generated from the provision of NHS services by the ULHT for 2022-23.

Participation in Clinical Audits

During 2022-23, 46 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 which it was eligible to participate in.

The national clinical audits and national confidential enquiries that ULHT participated in, and for which data collection was completed during 2022-23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audits	ULHT Participation	Reporting Period	Number and % Required
Peri and Neonatal			
UK Perinatal Deaths for Births (MBRRACE-UK)	Yes	January 2020-December 2020 Published October 2022	Case ascertainment is not reported
Saving Lives Improving Mothers Care		2018-2020 Report published November 2022	Case ascertainment is not reported
Maternal, New-born and Infant Care		2018-2020 Report published February 2023	Case ascertainment is not reported
Neonatal Intensive and Special care (NNAP)	Yes	1st January – 31st December 2021 Published November 2022	LCH 42 PHB 24 (100%)
Children			
National Children's & Young Peoples Asthma Audit	Yes	2021- 2022 Report published February 2023	92 Case ascertainment is not reported
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	1st April 2021 - 31st March 2022 Report published March 2023	288 Case ascertainment is not reported
National Epilepsy 12 Audit	Yes	2019 - 2021 Round 3 Cohort 3 Report published July 2022	198/206 (96.1%)

National Audits	ULHT Participation	Reporting Period	Number and % Required
Acute Care			
National Emergency Laparotomy Audit (NELA)	Yes	1st December 2020 - 30th November 2021 Report published February 2023	PHB 90 LCH 87 Case ascertainment is not reported
Cardiac Arrest (National Cardiac Arrest Audit) ICNARC	Yes	1st April 2022 - 31st December 2022	LCH 55 PHB 39 Case ascertainment is not reported
Intensive Care National Audit Research (ICNARC)	Yes	1st April 2022- 31st December 2022	LCH 392 PHB 312 Case ascertainment is not reported
Pain in Children in EDs (RCEM)	Yes	4th October 2021 - 3rd October 2022 Report awaited	LCH 184 PHB 153
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	23rd June 2022 - one day (24hour survey) Report published November 2022	Case ascertainment is not reported
National Audit Care End Life (NACEL)	Yes	April 2022 - October 2022 Organisation audit, staff survey, bereaved relatives/carers survey.	PHB 50/50 (100%) LCH 50/50 (100%)
Consultant Sign Off ED (RCEM)	Yes	1st April 2022 - 3rd October 2022 Report Awaited	LCH 90 PHB 188
Infection Control ED (RCEM)	Yes	4th October 2021 - 3rd October 2022 Report Awaited	LCH 311 PHB 161
British Thoracic Society (BTS) Pleural Procedures	Yes	1st April 2021 - 30th June 2021 Report published August 2022	Not applicable as this is a service audit
British Thoracic Society (BTS) Outpatient Management of Pulmonary Embolism (PE)	Yes	1st September - 31st October 2021	15/15 (100%)

National Audits	ULHT Participation	Reporting Period	Number and % Required
		Organisation Audit Report published October 2022	
Long Term Conditions			
Diabetes (National Adult Diabetes Audit)	Yes	1st January 2021 - 31st March 2022 Report published 8th December 2022	Case ascertainment is not reported (data is linked to local CCG/ICB)
Diabetes (National Adult Diabetes Inpatient /Survey/ Audit HARMs)	Yes	December 2020 Report published July 2021 awaiting further report	Case ascertainment is not recorded
National Diabetes in Pregnancy Audit	Yes	1st January - 31st December 2021-2022 Data submitted Report awaited	Case ascertainment is not yet available
National Adult Asthma Audit	Yes	1st April 2021- 30st March 2022 Report published January 2023	LCH 79 PHB 92 Case ascertainment is not reported
Chronic Obstructive Pulmonary Disease (COPD) Royal College Physicians	Yes	1st April 2021 - 30st March 2022 Report published January 2023	LCH 381 PHB 505 Case ascertainment is not reported
National Audit Dementia R5	Yes	September 2022 - October 2022 Data submitted Report awaited	LCH 79 PBH 56
National Parkinson's Audit	Yes	1st May 2022 - 30th September 2022 Report published March 2023	LCH 20 PHB 20 Case ascertainment is not reported
National Renal Registry	Yes	Data up to 31st December 2020 Report published August 2022	Case ascertainment is not reported

National Audits	ULHT Participation	Reporting Period	Number and % Required
National Diabetes Audit Integrated Specialist Services and Structure Survey	Yes	November 2022 Data submitted Report awaited	Not applicable refers to the service
Elective Procedures			
BAUS Muscle Invasive Bladder Cancer Transurethral Resection Bladder (MITRE)	Yes	1st March 2022 - 30th April 2022 Report published August 2022	Case ascertainment is not reported
BAUS Ureteric Injury	Yes	1st February 2022 - 1st February 2023 Report awaited	Case ascertainment is not reported
Cardiac Arrhythmia (NICOR)	Yes	April 2020 - March 2021 Report published June 2022	Case ascertainment is not reported
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Yes	1st April 2020 - 31st March 2021 Report published June 2022	Case ascertainment is not reported
National Vascular Registry including NVD -Carotid Interventions Audit)	Yes	1st January 2019 - 31st December 2021 1st January 2019 - 31st December 2021 Report published November 2022	41 cases Infra-renal AAA, 9 cases Emergency Repair Ruptured AAA, 141 cases Lower Limb Bypass, 451 Lower Limb Angioplasty, 29 cases Major Limb Amputation 51 cases Carotid Endarterectomy Case ascertainment is not reported
Hip, Knee, Ankle, Elbow and Shoulder Replacements (National Joint Registry) NJR Data Quality Audit	Yes	1st January 2021 - 31st December 2021 Report published November 2022 Published August 2022	GDH 531 PBH 81 LCH 34 Case ascertainment is not reported

National Audits	ULHT Participation	Reporting Period	Number and % Required
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	1st April 2022 - 31st March 2023 Report awaited from NHS Digital	Case ascertainment is not reported
National Ophthalmology Database (NOD) Audit	Yes	1st April 2020 - 31st March 2021 Report published	337 (88.6%)
Cardiovascular Disease			
Stroke Care (National Sentinel Audit of Stroke) SSNAP	Yes	1st April 2021 - 31st March 2022 (includes transfers into ULHT) Routinely Admitting Stroke Unit	997 (>90%)
Acute Myocardial Infarction & Other Acute Coronary Syndrome (MINAP)	Yes	1st April 2020 - 31st March 2021. Report published June 2022	LCH 958 PHB 175 GDH 2 (>90%)
Heart Failure	Yes	April 2020 - March 2021 Report published June 2022	931 Case ascertainment is not reported
Cancer			
Prostate Cancer (NPCA)	Yes	1st April 2020 - 31st March 2021 - Report published January 2023	761 (100%)
National Audit of Breast Cancer in Older Patients	Yes	January 2014 - September 2021 Report published May 2022	218 Case ascertainment is not reported
Lung Cancer (LUCADA)	Yes	Patients diagnosed with lung cancer between 1st January 2020 and 31st December 2021 Report awaited due April 2023	Case ascertainment is not yet reported

National Audits	ULHT Participation	Reporting Period	Number and % Required
Bowel Cancer (NBCA)	Yes	Patients diagnosed between 1st April 2020 and 31st March 2021 Report published January 2023	LCH + GDH 17 (<50%) PHB 135 (>80%)
Oesophago-Gastric Cancer (National O-G Cancer Audit)	Yes	Patients diagnosed between 1st April 2017 and 31st March 2021 Report published January 2023	239 (85-100%)
Trauma			
Hip Fracture (National Hip Fracture Database)	Yes	1st January 2020 - 31st December 2021 Report published November 2022	LCH 454 (94.8%) PHB 352 (103.8%)
National Audit Inpatient Falls (NAIF)	Yes	Report published September 2022	Case ascertainment is not reported
Trauma Audit Research Network (TARN) Trauma	Yes	1st April 2022 - 31st March 2023 (TARN data)	LCH 213 (73%) PHB 212 (62%)
Blood Transfusion			
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	April 2022 – March 2023	21 (100%) PHB 11 LCH 9 GDH 1

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

During 2022-23 hospitals were eligible to enter data in up to four 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			
Epilepsy Hospital Attendance	Yes	2021/2022 Organisational Questionnaire Clinical Questionnaire	 1/1 (100%) 10/10 (100%)
Crohns Disease	Yes	2022/2023 Organisational Questionnaire Clinical Questionnaire	 3/3 (100%) 9/9(100%)
Community Acquired Pneumonia	Yes	2022/2023 Organisational Questionnaire Clinical Questionnaire	 5/5 (100%) 3/3 (100%)
Testicular Torsion	Yes	2022/2023 Organisational Questionnaire Clinical questionnaire	 7/7 (100%) 2/2 (100%)

The reports of eighteen national clinical audits were reviewed by the provider in 2022-23 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 94% 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 quarterly continues to ensure the data submissions are timely and correct.
Sentinel Audit of Stroke (SSNAP)	Data validation takes place on a quarterly basis to ensure timely submissions Stroke group in place to review the stroke service and results from SSNAP to improve
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 2022 NJR Data Quality Provider Award GDH retained for a second year - audit Period 2021-22 Consultant from ULHT appointed to the NJR regional team Orthopaedic surgery hub for hip and knee joint replacements at GDH
Chronic Obstructive Airways Disease (COPD)	Data validation process continues COPD Audit Clerk in place at LCH and PHB to ensure timely data submissions COPD Care Bundle updated July 2022
Neonatal National Audit Programme (NNAP)	On time screening of retinopathy of prematurity LCH 100%, PHB 100% above the national average of 95.4%) Early breast feeding milk feeding for babies born <32 weeks LCH 86.2%, PHB 100% above the national average of 80.5% Data validation takes place before data submission

National Audit	Headline Results and Actions Taken
IBD - Ulcerative Colitis and Crohns Disease	New process implemented to ensure the biologics medicines prescribed are uploaded to the national database Lead IBD nurse oversees this audit
BTS Outpatient Management of Pulmonary Embolism (PE)	Trust PE Guidance updated to include recommendations from national guidance
National Audit Care End of Life (NACEL)	Data review completed for the 2022 audit Data validation in place to review future data submissions Palliative End of Life (PEOL) Group with input from all clinical Divisions
National Emergency Laparotomy Audit (NELA)	Review of data submissions with Surgeons and Anaesthetists Validation of data taking place monthly with theatre team continues to show improvement

Local Clinical Audit

The reports of eighty five local clinical audits were reviewed by the provider in 2022-23 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
Comparison of actual Radiotherapy Late Effects with those predicted in RCR Consent guidelines	Clinician follow-up appointments to discuss late effects from treatment Raise awareness of the Pelvic Late Effects service Posters and communications to other departments to raise awareness of the Late Effects service for patients
Small Bowel Obstruction	General Surgery time to CT scan is 1.7 days compared to 2.2 days nationally 100% MUST completed for all patients Small Bowel Obstruction proforma implemented
Improvement in eDDs (discharge document) Cardiology	Cardiology reduced the time taken to complete an eDD by 50% Implemented a list of the relevant information to be included in the eDD for the patients admitted to Cardiology
Sepsis Care Screening and Bundle (NICE)	A&E achieved >90 % for Adults and Children Regular sepsis teaching is ongoing within the department Mandatory training module implemented by nursing staff
Audit of Diarrhoea and Vomiting (D&V) in Children (NICE)	Symptom onset and duration are recorded in the majority of cases 95% of cases had their weight recorded IV fluids mainly used NG rehydration was not used but is an option Induction guidance on fluid management in children has been produced for all new staff in Paediatrics Management of D&V discussed at staff induction Local guidelines reviewed

Multi-Disciplinary Handover Audit	Obstetrics & Gynaecology handover form not always completed fully, so redesigned the handover form Relevant staff aware of the requirement to complete the form

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. There are plans in place to ensure that high-quality research is a part of the culture of ULHT. Despite this track record and ambitions for the future, 2022-23 has been a challenging year for research delivery, with a drop off in new participants recruited into National Institute for Health Research (NIHR) portfolio adopted research studies.

The number of patients receiving relevant health services provided or sub-contracted by ULHT in 2022-23 that were recruited during that period to participate in research approved by a research ethics committee is 695.

The total number of participants recruited to NIHR portfolio research in 2022-23 was 695. These participants were recruited through 53 studies from 15 research specialties including: Cardiovascular Disease, Health Services Research, Critical Care, Musculoskeletal Disorders, Anaesthesia, Perioperative Medicine and Pain Management, Cancer, Stroke, Trauma and Emergency Care, Ophthalmology, Gastroenterology, Neurological Disorders, Dementias and Neurodegeneration, Dermatology, Renal Disorders and Haematology.

The Research and Innovation department is delivering against its 3 year Research & Innovation strategy, and is developing Trust-wide initiatives to demonstrate its commitment to improving the quality of care and contributing to wider health improvement, through research. 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 being given more opportunities to receive 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 2022-23, the Trust has approved 34 portfolio studies.

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

The CQUIN payment framework is designed to support the cultural change to place quality at the heart of the NHS. CQUIN schemes contain goals for quality and innovation that have been agreed between the Trust and various Commissioning Groups. Listed below are the CQUIN schemes which were agreed with the commissioners for 2022-23. At the time of writing this Quality Account, the Trust is still awaiting the outcome of quarter 4 achievements however we have depicted what we think the Trust will achieve. A summary of the achievements of the CQUIN milestones for 2022-23 are demonstrated below. The Trust is committed to the delivery of CQUINS and recognises these are key to improving patient outcomes and experience.

CQUIN	Quarter 1	Quarter 2	Quarter3	Quarter 4	COMMENTS
CQUIN1 - Flu vaccination for frontline staff Target - 70%-90%	N/A	N/A	N/A	Not Achieved 62%	The Trust achieved 62% There have been numerous initiatives to help increase compliance with flu vaccinations such as flu clinics, peer to peer vaccinations. There has been a decrease nationally on the uptake of flu vaccinations.
CQUIN2 - Appropriate antibiotic prescribing for UTI patients Target - 40-60%	N/A	Achieved 59%	Achieved 54%	Achieved 71%	The Trust has seen an improvement in Q4. To help improve compliance there has been an ongoing education programme.
CQUIN3 - NEWS score and escalation time & response for unplanned critical care admissions Target - 20%-60%	N/A	Achieved 89.13%	Achieved 87.72%	Achieved 77.5%	The Trust has consistently over achieved the target.

CQUIN6 - Anaemia screening and treatment for patients undergoing major elective surgery Target - 45% - 60%	N/A	Achieved 76%	Achieved 86%	Achieved 81%	The Trust has consistently over achieved the target.
CQUIN9 - Cirrhosis & Fibrosis test for alcohol dependent patients Target - 20% - 35%	N/A	Not Achieved 6.38%	Not Achieved 2.12%	Not Achieved 9.6%	The Team have identified they are unable to capture all of the information relating to fibro scans. Information Services have been working with the Team to help improve this data capture.
Specialised CQUIN1 - Achievement of revascularisation standards for lower limb Ischaemia Target - 40% - 60%	N/A < 5 procedures	N/A < 5 procedures	N/A < 5 procedures	Await confirmation	The Improvement Academy are in the process of working with the Vascular Team to review their pathways to help support this CQUIN which has been rolled over to 2023-24
Specialised CQUIN2 – Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery Target - 65% - 75%	N/A	Achieved 81%	N/A	Achieved 78%	The Trust has consistently over achieved the target.
Specialised CQUIN3 – Achieving priority Categorisation (AAA/Cardiac) Target - 74% - 98%	Achieved 100%	Achieved 100%	Achieved 100%	Achieved 100%	The Trust has consistently over achieved the target.

Care Quality Commission (CQC) Statements

The Care Quality Commission has not taken enforcement action against United Lincolnshire Hospitals NHS Trust during 2022-23.

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 no conditions on its registration. 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 2022-23.

During October and November 2021, a number of the Trust's 'core services' were inspected by CQC during an unannounced inspection visit and 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, which has now been enacted.

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

The Trust are very pleased to see the inspection teams' recognition of the improvement efforts made across the Trust and work has continued during 2022-23 to embed further improvements.

During 2022-23, the Trust submitted evidence to CQC which resulted in the remaining two Section 31 conditions on the Trust's registration being removed, resulting in the Trust having unconditional registration with the CQC.

Throughout the year, other actions identified by from the inspection report published in February 2022 have been worked on by divisional teams with upward reporting to established sub-committees of the Board alongside regular updates to CQC as part of the Trust's regular engagement meetings.

Improvements made during 2022-23 include:

- The remaining two Section 31 conditions on the Trust's registration have been removed as a result of the Trust's improvement in the time to first assessment of patients within the Emergency Department, which was ahead of national performance across the UK. Improvements made in the children's areas of the Emergency Department at Lincoln County Hospital have improved the processes in place to see and triage children quickly and more effectively. These improvements resulted in the Trust now having unconditional registration with the CQC.
- The Emergency Department at Lincoln has had significant investment with the completion and opening of a new and expanded resuscitation area. The area has a dedicated bay for paediatric emergencies which is segregated from adult facilities. In addition the number of quiet rooms for patients attending with mental health emergencies has also been expanded providing a safer environment.
- Improved facilities for patients within the Medical Emergency Assessment Unit (MEAU) at Lincoln County Hospital have been completed.
- Within the Pilgrim Emergency Department in Boston, investment has been prioritised in ensuring that one of the rooms within the department is a safe environment for patients attending with mental health emergencies alongside improved processes to safeguard such patients.
- Improved arrangements are in place to ensure that staff within the Emergency Departments receive training and regular updates on procedures required to keep children safe via the Child Protection Information System (CP-IS).

- Revised and improved temperature monitoring arrangements within maternity have been completed enabling more comprehensive ongoing monitoring of temperatures in locations where medicines are stored. This has enabled the team to focus attention on specific locations requiring particular focus. Work is underway to provide further improvements in process within these locations.
- Documentation has been revised to improve the recording and monitoring of nutritional and fluid intake within children's and young person' areas. The impact of this is being monitored.
- The Children's ward at Lincoln County Hospital has had investment to improve the environment for children and their families.

Data Quality

NHS Number and General Medical Practice Code Validity

United Lincolnshire Hospitals Trust submitted records during April 2022 to January 2023 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:
  - 99.88% for admitted patient care (National performance 99.6%)
  - 99.96% for outpatient care (National 99.8%)
  - 99.6% for accident and emergency care (National 95.3%)

- Which included the patient's valid General Medical Practice Code was:
  - 99.98% for admitted patient care (National performance 99.7%)
  - 99.99% for outpatient care (National 99.5%)
  - 99.98% for accident and emergency care (National 98.3%)

Data Security and Protection Toolkit (DSPT)

The DSPT is an annual online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. As data security standards evolve, the requirements of the DSPT are reviewed and updated to ensure they are aligned with current best practice. Organisations with access to NHS patient data must therefore review and submit their annual assessment each year before the deadline.

All organisations that have access to NHS patient information must provide assurances that they have the proper measures in place to ensure that this information is kept safe and secure. Completion of the DSPT is therefore a contractual requirement specified in the NHS England Standard Conditions contract and it remains Department of Health and Social Care policy that all bodies that process NHS patient information for whatever purpose provide assurances via the DSPT.

Completion of the DSPT is also necessary for organisations which use national systems such as NHSmail and the e-referral service.

As a result of the COVID pandemic the DSPT submission deadline was altered to 30th June, this change has been kept in place post COVID.

ULHT's 2021-22 DSPT was submitted as 'approaching standards'. An approaching Standards' assessment, indicates that the Trust have demonstrated good progress but have not yet reached '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 is being undertaken, including the addition of new metrics for the "Executive Scorecard", "Integrated Improvement Plan (IIP) Scorecard" and "Divisional Scorecard" that underpin year 4 of the 5 year Integrated Improvement Plan. This will come into effect for April 2023 reporting in May 2023. 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 over the last couple of years 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 CDSv6.3 and ECDSv3

- The Clinical Coding department continues to work closely with the four 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 four Clinical Divisions.
- An example of this is the “Coding Triangle”, which is a clinician, manager and clinical coder working together on a particular pathway or dataset to ensure that what happens to the patient is recorded accurately by the clinician and interpreted and coded correctly by the Clinical Coder.
- The structure of the Data Quality function and wider Information Services team 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.

Implementation of the National Learning from Deaths guidance is key to the way in which the Trust can maximise the learning opportunities from the review of care delivered to our patients in the days leading up to their death. Improvements as a result of this learning will in turn provide better care for our living patients. To fully support this mortality agenda the Trust has continued to develop the wider mortality systems and processes to enable us to get a clear understanding of the care delivered to patients, their families and loved ones at what is a very emotional and difficult time.

The Trust has an embedded process to screen, review and investigate inpatient deaths. Each Division has an embedded mortality review process to undertake reviews on any death to identify learning. The Mortality Meeting (MorALS) provides Executive-led scrutiny of mortality surveillance to ensure the Trust is driving quality improvement by using a systematic approach to mortality review and learning from death. The Group reports to the Quality Governance Committee and the Trust Board, via a Quarterly Learning from Deaths report.

Measure	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Comments
Number of patients that have died within ULHT	588	628	670	691	During 2022-23, 2577 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	574	626	669	685	By March 2023, 2554 case record reviews and investigations have been carried out in relation to

					2577 of deaths included above. In 601 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, 166 cases were also discussed within the Governance Meetings.
Number/percentage of deaths that escalated with problems in care	28 (4.9%)	31 (5.0%)	16 (2.4%)	29 (4.2%)	104 deaths representing 4.1% 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

ULHT have learnt from case note reviews and from completing in-depth reviews on Dr Foster Diagnosis Alerts. We have disseminated learning on a number of thematic lessons using a modality of communication systems including Patient Safety Briefings, Learning to Improve Newsletters, presentations at meetings and in discussion at Governance Meetings.

- Most mortality reviews that were undertaken identified good care for patients. It was found that a multi-disciplinary team approach to care, with early senior input for patients, and frequent ward rounds was valuable and aided the Junior Doctors in identifying the deteriorating patient earlier. It was also found that this approach ensured that end of life care discussions were held in a timely way, and, if appropriate, Palliative care teams were involved. We are continuing to embed this approach into the care for all patients.
- Communication with families was highlighted as an issue as families. The Patient Experience Lead has completed a review on the communication issues identified and developed key work-streams across the Trust to reduce these issues.
- There is a Palliative End of Life (PEOL) oversight group being initiated which is responsible for supporting improvements through education and learning to recognise when a patient is approaching end of life or palliative.
- Sepsis (potentially life threatening reaction to an infection): compliance with relevant standards (early identification and administration of antibiotics) remains high. Performance in respect of these standards is monitored regularly and reported quarterly to Patient Safety Group.

Description of actions that ULHT have taken in 2022-23, and proposes to take forward in consequence of what the ULHT has learnt

- Reviewing the Mortality Reduction Strategy to ensure it is reflective of current practice.
- Continuing to improve the governance processes around learning from deaths and working closely with other teams e.g. patient safety, complaints, patient experience, to optimise learning opportunities.
- Build on the effectiveness of the Trust's mortality Group (MorALS), widening the remit to include contributions from partner provider organisations to improve the approach to learning from deaths from a system perspective.
- Enhance the skills and training of clinical teams. We will need to ensure that staff reporting deaths have appropriate skills through specialist training and protected time under their contracted hours to review and investigate deaths to a high standard.
- Roll out the structured judgement review tool (proforma used to complete mortality reviews) on Datix Cloud.
- Further support our staff with a series of master classes where experiences and issues are discussed to support continuous improvement.

Assessment of the impact of actions which were taken by ULHT during 2022-23

The benefits of the Medical Examiner (ME) service for the bereaved families cannot be underestimated . 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.

The ME service is rolling out to the community so will be responsible for reviewing all deaths within Lincolnshire.

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	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Comments
Number of reviews/ investigations completed which took place before the start of the reporting period	91	7	2	27	127case record reviews and investigations completed after 31st March 2020 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	85 (93.4%)	7 (100%)	2 (100%)	24 (88.9%)	118 representing 92.9% 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.

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	December 2020-November 2021	December 2021-November 2022
ULHT SHMI / Band	1.0948 / 2	1.0267 / 2
National Average	0.9996	0.9997
Best(B) / Worse(W) National Performance	0.7161 (B) 1.1949 (W)	0.7173 (B) 1.2219 (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	December 2020 - November 2021	December 2021 - November 2022
ULHT %	33%	33%
National Average %	39%	40%
Best(B) / Worse(W) National Performance %	64% (B) 11% (W)	66% (B) 13% (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).

The data is reviewed by the palliative care team, interrogated in line with the key lines of enquiry identified by that team and has reporting and governance arrangements in place.

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

Continually reviewing our mortality processes and reviewing our data.

Working with Dr Foster and the specialist palliative care coding team and by continuing to monitor palliative care coding against national best practice in order to ensure that the number of expected deaths is accurately recorded.

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	2019 - 2020		2020 - 2021	
ULHT EQ:5D index Hip Replacement surgery - (L) Low, (H) High	Pre Op 0.349 (L) 1.0 (H)	Post Op 0.074 (L) 1.0 (H)	Pre Op 0.484 (L) 0.796 (H)	Post Op 0.264 (L) 1.0 (H)
National Avg EQ:5D index Hip Replacement surgery - (L) Low, (H) High	Pre Op 0.594 (L) 1.0 (H)	Post Op 0.594 (L) 1.0 (H)	Pre Op 0.594 (L) 1.0 (H)	Post Op 0.594 (L) 1.0 (H)
ULHT EQ:5D index Knee Replacement surgery - (L) Low, (H) High	Pre Op 0.349 (L) 1.0 (H)	Post Op 0.239 (L) 1.0 (H)	Pre Op 0.074 (L) 0.796 (H)	Post Op 0.516 (L) 1.0 (H)
National Avg EQ:5D index Knee Replacement surgery - (L) Low, (H) High	Pre Op 0.594 (L) 1.0 (H)	Post Op 0.594 (L) 1.0 (H)	Pre Op 0.594 (L) 1.0 (H)	Post Op 0.594 (L) 1.0 (H)

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	2019 - 2020		2020 - 2021	
ULHT VAS index Hip Replacement surgery - (L) Low, (H) High	Pre Op 10 (L) 100 (H)	Post Op 15 (L) 100 (H)	Pre Op 25 (L) 95 (H)	Post Op 51 (L) 95 (H)
National Avg VAS index Hip Replacement surgery - (L) Low, (H) High	Pre Op 0 (L) 100 (H)	Post Op 0 (L) 100	Pre Op 0 (L) 100 (H)	Post Op 0 (L) 100
ULHT VAS index Knee Replacement surgery - (L) Low, (H) High	Pre Op 5 (L) 100 (H)	Post Op 10 (L) 100 (H)	Pre Op 40 (L) 85 (H)	Post Op 35 (L) 99 (H)
National Avg VAS index Knee Replacement surgery - (L) Low, (H) High	Pre Op 0 (L) 100 (H)	Post Op 0 (L) 100 (H)	Pre Op 0 (L) 100 (H)	Post Op 0 (L) 100 (H)

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	2019 - 2020	2020 - 2021
ULHT Oxford hip surgery score - (L) Low, (H) High	0 (L) 48 (H)	3 (L) 48 (H)
National Avg Oxford Hip surgery score - (L) Low, (H) High	0 (L) 48 ((H)	0 (L) 48 ((H)
ULHT Oxford Knee surgery score - (L) Low, (H) High	0 (L) 48 (H)	5 (L) 48 (H)
National Avg Oxford Knee surgery score - (L) Low, (H) High	0 (L) 48 (H)	0 (L) 48 (H)

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

The data is taken from NHS Digital PROMs data set.

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

Continuing to focus on improving participation rates for those surveys which we have responsibility for and by continued oversight of the feedback provided by the elective orthopaedic team.

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	2020 - 2021	2021 - 2022
ULHT readmitted within 30 days: 0-15	13.2%	12.9%
National Average: 0-15	11.9%	12.5%
Best(B) / Worse(W) National Performance: 0-15	2.8% (B) 64.4% (W)	3.3% (B) 46.9% (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	2020 - 2021	2021 - 2022
ULHT readmitted within 30 days: 16+	12.96	11.9
National Average: 16+	15.9	14.7
Best(B) / Worse(W) National Performance: 16+	1.1 (B) 112.9 (W)	2.1 (B) 142.0 (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 to ensure we treat and discharge patients appropriately so that they do not require unplanned readmission, working with partners in the system to address long-standing pressures around demand, capacity and patient flow and working closely with system partners to ensure safe discharge practice.

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	2018 - 2019	2019 - 2020
ULHT	64.6	67.1
National Average	67.2	61.3
Best(B) / Worse(W) National Performance	85.0 (B) 58.9 (W)	84.2 (B) 59.5 (W)

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 collect real-time feedback from patients as part of its inpatient survey, working to increase the FFT response rate this year and expanding the work of the Patient Experience Team.

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	2021	2022
ULHT Strongly agree(SA) /Agreed (A)	43.5%	42.7%
National Average Strongly agree(SA) /Agreed(A)	67.0%	61.9%
Best(B) / Worse(W) National Performance	89.5% (B) 43.5% (W)	86.4% (B) 39.2% (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:

Continuing to encourage participation in this survey and by developing local action plans and responses to the feedback received.

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	Jan - 23	Feb - 23
ULHT ED / National Avg/ Best(B)-Worst(W)	ULHT – 83% National – 83% 100% (B) 43% (W)	ULHT – 78% National – 80% 95% (B) 38% (W)
ULHT Inpatients/National Avg/ Best(B)-Worst(W)	ULHT 91% National – 94% 100% (B) 79% (W)	ULHT – 90% National – 94% 100% (B) 66% (W)
ULHT Maternity /National Avg/ Best(B)-Worst(W)	ULHT – 97% National – 94% 100% (B) 67% (W)	ULHT – 95% National – 93% 100% (B) 69% (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:

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

Domain 5 Treating and caring for people in a safe environment and protecting from avoidable harm

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

Description	2019 - 2020 Quarter 1	20192 - 2020 Quarter 2	2019 - 2020 Quarter 3
ULHT %	97.19%	97.58%	97.93%
National Avg %	95.56%	95.40%	95.25%
Best(B) / Worst(W) National Performance %	100% (B) 69.76% (W)	100% (B) 71.72% (W)	100% (B) 71.59% (W)

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

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

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

Continuing with our VTE programme aims to reduce preventable harm to our patients by promoting timely and accurate VTE risk assessment and ensuring thromboprophylaxis is prescribed accurately and administered effectively when required.

Provide VTE risk assessment data to clinical areas.

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	2019 - 2020	2020 - 2021	2021 - 2022
ULHT	25.80	30.95	24.60
National Avg	37.53	45.62	43.73
Best(B)-Worst(W) National Performance	0 (B) 142.82 (W)	0 (B 140.54 (W)	0 (B) 138.38 (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	October 2018 - March 2019	April 2019 - September 2019	October 2019 - March 2020
ULHT %	27.9% (T) 0.21% (SD)	28.3% (T) 0.11% (SD)	27.5% (T) 0.13% (SD)
National Avg %	47.0% (T) 0.15% (SD)	51.3% (T) 0.15% (SD)	51.5% (T) 0.15% (SD)
ULHT Total No of Incidents (T) / Severe or Death (SD)	6,291 (T) 47 (SD)	6,413 (T) 25 (SD)	5,914 (T) 28 (SD)

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:

Focusing on improving hand hygiene; adopting national and local campaigns including visual prompts.

Training staff on infection prevention and hand hygiene; focusing on high standards of cleanliness, screening of emergency and elective patients and focusing on effective antibiotic stewardship and ensuring that patients are effectively isolated and monitoring and feeding back on cases where inappropriate prescribing is a possible contributory factor.

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.

Integrated Improvement Plan

In 2020, we launched our five-year Integrated Improvement Plan (IIP)- our strategic plan to help us move forward as a Trust and ensure we were focusing on the right things for our patients and our staff.

Our plan recognised the considerable time and effort already taken to address some immediate improvements and urgent quality and safety issues, while supporting our ambitions to move to a more comprehensive and planned approach for the future.

While some of our challenges remain unchanged, including supporting an ageing population in rural and geographically disparate communities, we face significant operational pressures due to increased demand on our services and ongoing recovery from the impact of the COVID-19 pandemic. The organisation also continues to be impacted by workforce challenges, where national staffing shortages contribute to difficulties in recruitment and retention and high agency spend. The introduction of Lincolnshire Integrated Care System (ICS) in July 2022 will have implications for all of our services and provide opportunities to remodel some services, supporting the delivery of care closer to home, improved self-care and the prevention agenda.

We can all help to grow our Trust

By 2025 we want to achieve 'Outstanding Care Personally Delivered' by improving the quality of care and experience for our patients and the wellbeing of our staff

by living our values


Patient centred


Compassion


Respect


Safety


Excellence

and by delivering our strategic objectives

For our patients
High quality, safe and responsive services, shaped by best practice and our wider communities

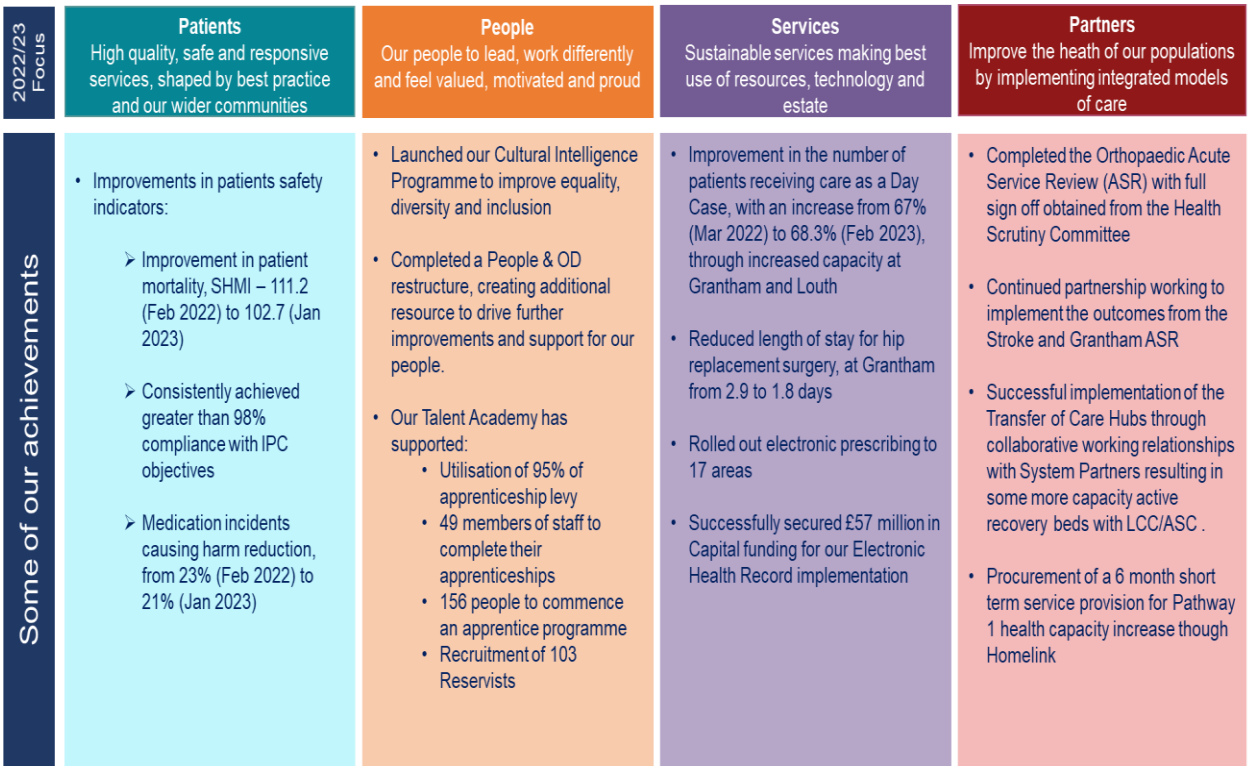
For our people
Our people to lead, work differently and feel valued, motivated and proud

For our services
Sustainable services making best use of resources, technology and estate

For our partners
Improve the health of our populations by implementing integrated models of care

Achievements

2022/23 Focus	Patients High quality, safe and responsive services, shaped by best practice and our wider communities	People Our people to lead, work differently and feel valued, motivated and proud	Services Sustainable services making best use of resources, technology and estate	Partners Improve the heath of our populations by implementing integrated models of care
Some of our achievements	• Developed a new £5.6m Resuscitation department in ED at Lincoln • Safer Maternity Services with removal of all CQC conditions, a move out of Maternity Safety Support Programme and recruitment of 34 additional midwives • Improved patient experience in ED, through reduced waiting times: ➢ Less than 12 hours in ED, aggregated time of arrival, 84.93% (Feb 2022) to 88.25% (Jan 2023) ➢ Number of ambulance handovers delays exceeding 59 minutes, 800 (Feb 2022) to 497 (Jan 2023)	• Increase in overall substantive workforce by more than 1000 WTE • Significant improvements in staff survey results, particularly in: • Feel supported to develop my potential 41% to 50% • Feel organisation respects individual differences 58% to 65% • Satisfied with opportunities for flexible working patterns 45% to 51% • Reduction in staff turnover rates, from 14.7% to 13.6% • Reduced medical vacancies, from 8.88% to 4.72%, recruited over 350 RGN and reduced our support staff vacancies from 13.53% to 7.89%	• Successful in elimination of patients waiting 104 weeks or more • Almost eradicated patients waiting greater than 78 weeks • Invested £5.3 million in two new theatres at Grantham • Awarded Elective Hub accreditation at Grantham, as 1 of only 8 across the country • Provided mutual aid to other Trusts, ensuring equitable access to treatment for patients requiring Urology or Orthopaedic surgery • Reduction in the number of operations cancelled on the day of surgery, 2.9% (July 2022) to 1.28% (Feb 2023)	• Established a Tobacco Cessation Service within the Trust • Developed and introduced a new approach to ULHTs Clinical Service Review process • Continued development of the relationship between the University of Lincoln and ULHT • More than 300 patients seen as a result of our expansion of our virtual ward capacity, supporting reduced waiting times and pressure on emergency services



2022/23 Focus	Patients High quality, safe and responsive services, shaped by best practice and our wider communities	People Our people to lead, work differently and feel valued, motivated and proud	Services Sustainable services making best use of resources, technology and estate	Partners Improve the heath of our populations by implementing integrated models of care
Some of our achievements	• Improvements in patients safety indicators: ➢ Improvement in patient mortality, SHMI – 111.2 (Feb 2022) to 102.7 (Jan 2023) ➢ Consistently achieved greater than 98% compliance with IPC objectives ➢ Medication incidents causing harm reduction, from 23% (Feb 2022) to 21% (Jan 2023)	• Launched our Cultural Intelligence Programme to improve equality, diversity and inclusion • Completed a People & OD restructure, creating additional resource to drive further improvements and support for our people. • Our Talent Academy has supported: • Utilisation of 95% of apprenticeship levy • 49 members of staff to complete their apprenticeships • 156 people to commence an apprentice programme • Recruitment of 103 Reservists	• Improvement in the number of patients receiving care as a Day Case, with an increase from 67% (Mar 2022) to 68.3% (Feb 2023), through increased capacity at Grantham and Louth • Reduced length of stay for hip replacement surgery, at Grantham from 2.9 to 1.8 days • Rolled out electronic prescribing to 17 areas • Successfully secured £57 million in Capital funding for our Electronic Health Record implementation	• Completed the Orthopaedic Acute Service Review (ASR) with full sign off obtained from the Health Scrutiny Committee • Continued partnership working to implement the outcomes from the Stroke and Grantham ASR • Successful implementation of the Transfer of Care Hubs through collaborative working relationships with System Partners resulting in some more capacity active recovery beds with LCC/ASC . • Procurement of a 6 month short term service provision for Pathway 1 health capacity increase though Homelink

Patient Safety Incident Response Framework (PSIRF)

Introducing a fundamental shift in the NHS's approach to responding to patient safety incidents, NHS England has published the new Patient Safety Incident Response Framework (PSIRF).

The framework is a major step towards establishing a safety management system that embeds the key principles of a patient safety culture, introducing a focus on understanding how incidents happen, rather than apportioning blame; allowing for more effective learning, and ultimately safer care for patients.

A key aim of PSIRF is to allow organisations to focus learning response resources on areas where improvement will have the greatest impact. Based on their local incident profile and existing improvement work, organisations will identify areas that will benefit most from patient safety incident response, to create their patient safety incident response policy and plan.

PSIRF removes the requirement that all/only incidents meeting the criteria of a 'serious incident' are investigated. This enables resources to be focused more effectively on the identified areas with the greatest potential for patient safety improvement; and enable

responses to look at incidents that wouldn't have met the serious incident criteria but where important learning can still be gained.

Published alongside the framework, the 'Guide to engaging and involving patients, families and staff following a patient safety incident', also sets out expectations for how those affected by an incident, for example, patients, families and staff, should be treated with compassion and involved in any investigation process.

Organisations are asked to begin a 12-month period of preparation before transitioning to PSIRF from the existing Serious Incident Framework.

Patient Safety Syllabus National Training

The first NHS England/Improvement Patient Safety Strategy was launched at the Patient Safety Congress in July 2019. The Academy of Medical Royal Colleges has worked with colleagues from the University of Warwick to develop the new National Patient Safety syllabus, which was included in the strategy as the basis for education and training throughout the NHS.

This syllabus represents an exciting new approach to patient safety incorporating an emphasis on a proactive approach to identifying risks to safe care and including systems thinking and human factors. This sets the scene for a step change in thinking about patient safety, which will lead to significant gains as it reaches a critical mass of trained practitioners.

Patient safety continues to be a significant issue in healthcare and a focus of both quality improvement and academic research. Though clinicians' training places a strong emphasis on the safety of their individual practice, it is rare that they or anyone else working in the NHS, receive any education in formal safety management or the opportunity to apply those principles, tools and techniques in creating safe systems.

Neither clinical nor non-clinical staff receive training in systems, risk, human factors, or organisational culture.

The Patient Safety Strategy included ambitions to develop training in the fundamentals of patient safety that would be relevant to all NHS staff – clinical and non-clinical.

The syllabus is designed and structured to provide both a technical understanding of safety in complex systems and a suite of tools and approaches that will:

• Build safety for patients.

• Reduce the risks created by systems and practices.

• Develop a genuine culture of patient safety.

Safety Culture Assessment Survey/PASCAL

Patient safety is about maximising the things that go right and minimising the things that go wrong for people experiencing healthcare. The '*NHS Patient Safety Strategy: safer culture, safer systems, safer patients'* (July 2019) describes a vision of continuously improving safety by building on two foundations: developing a patient safety culture and patient safety system. The NHS aims to:

- Improve its understanding of safety by drawing intelligence from multiple sources of patient safety information (Insight)
- Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (Involvement)
- Design and support programmes that deliver effective and sustainable change in the most important areas (Improvement)

Whilst most care is delivered in a safe and effective way there is a need for us to demonstrate we are delivering care that is the safest, evidence based practice.

Embedding sustained delivery within a safety culture is key to supporting the Trust in achieving the strategic objective it has set for patients which is to '*deliver high quality, safe and responsive patient services, shaped by best practice and our communities'*

Pascal Metrics is a United States based company that provide comparative benchmarking data from a variety of international health care providers which deliver an online survey tool to individual respondents. The Pascal platform can provide an overall analysis based on respondent groups, and summaries analysis of data through report formats.

Pascal Metrics, an independent company, will be running the survey which measures what our staff think about the safety culture across our departments and facilities. When employees feel safe about reporting errors or speaking up when they see a problem, the less likely patients are to experience errors or complications.

ULHT wants to build a stronger culture of safety for the sake of patients and employees, so the participation of all staff, both clinical and non-clinical, is vital. After surveys are

returned, summary reports will be produced so that information can be shared with employees and used to improve safety programs

For the purpose of this survey the Data sets (which correlate to that of the National Staff Survey) cover the following Domains:

- Overall Perception of Patient Safety
- Safety Climate
- Exhaustion/Resilience
- Job Satisfaction
- Team work
- Perceptions of Local Management
- Perceptions of Senior Management
- Non punitive response to errors
- Working Conditions

Currently the Trust has a rolling programme of surveys across the organisation.

Human Factors in Health Care

The Trust continues to roll out the one day Human Factors workshops to all staff within the organisation. The courses allow staff the opportunity to learn about self–awareness and awareness of colleagues, situational awareness, effective leadership and communication - as well as the opportunity to discuss and share personal experiences and ways to reduce error. The Trust now has a Faculty of Trainers that can deliver the training across the organisation.

Human Factors (also called ergonomics) is a discipline that considers both the physical and mental characteristics of people as well as the organisational factors or wider socio-technical system. It is the application of scientific methods to the design and evaluation of tasks, jobs, equipment, environments and systems to make them more compatible with the needs, capabilities and limitations of people. In healthcare Human Factors can improve human performance, optimise well-being, improve both staff and patient safety and experience and improve the overall system performance.

Human Factors, when applied systematically throughout the organisation, has the biggest impact.

Grantham and District Hospital Surgical Hub

Grantham and District Hospital has been named as one of eight surgical hubs nationally to be awarded accreditation for high standards in clinical and operational practice. The hospital is part of a pilot scheme, run by NHS England's Getting It Right First Time (GIRFT) programme in collaboration with the Royal College of Surgeons of England, which assesses hubs against a framework of standards.

Surgical hubs, which are separated from emergency services, are part of plans nationally to increase capacity for elective care with more dedicated operating theatres and beds. The hubs exclusively perform planned surgery and mainly focus on high volume, low complexity (HVLC) surgery across various specialties including ophthalmology, general surgery, orthopaedics, gynaecology, ear nose and throat, and urology.

Within Orthopaedics, the elective hub model supported the reduction of the average length of stay in hospital for patients having a hip replacement from 2.9 to 1.8 days over an 18 month period. Two new theatres were opened at Grantham in November 2022 as part of a £5.3 million investment in services.

Lincoln County Hospital's Emergency Department

The new 2,000 square metre Resuscitation Department (resus) is the area within the Emergency Department where patients will be taken if they need life-saving treatment immediately. It contains eight treatment cubicles, all fitted with patient hoists and the latest equipment needed to provide life-saving support for patients.

The cubicles also have adjoining rooms where staff can safely put on any additional protection to care for patients with infectious conditions, such as flu and COVID-19. They can then safely remove any of the masks, aprons and gloves in the same rooms before returning to areas with other patients and staff.

The new Resus Department also includes a central hub for the team looking after patients, containing monitors and other technology.

One of the new innovations is the fact that ambulance crews will bring patients into the department over a weighbridge, which will enable the Resus Team to work out and administer correct levels of medication to patients more quickly.

There is also a dedicated room where loved ones can spend precious time with those who have passed away in the department.

The new department replaces the existing four resus bays in the hospital's Emergency Department (ED)- doubling the number of cubicles available and with each cubicle over 20% larger than previously.

Directly outside of the unit are the new ambulance bays for the ED, with entrances directly into the resuscitation and majors areas.

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.

Never Events

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

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

The table below details the Never Events that occurred in 2022-23

Never Event	Incident Description	Action Status
Wrong site surgery	Administration of adductor canal block to incorrect leg	All Actions Complete
Wrong site surgery	Incorrect removal of both ovaries. Patient had only consented for unilateral oophorectomy	All Actions Complete
Wrong site surgery	Patient undergoing cystoscopy had a ureteric stent inserted in the wrong side	All Actions Complete
Retained foreign object post procedure	Forceps retained within abdominal cavity following laparotomy	SI investigation ongoing
Wrong site surgery	Error in procedure booking process resulted in a patient undergoing a flexible sigmoidoscopy that was not clinically indicated for them	All Actions Complete

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

- A Safety huddle sheet completed and audited weekly has been developed to strengthen communication within the Team
- All Theatre staff to attend the Human Factors Training
- Amendments have been made to the WHO safety Checklist to include 'Stop Before You Block'

- A patient safety communication bulletin was written and shared with the surgical division trust wide which included ‘stop before you stent, marking the sterile field, speaking up and awareness of the procedure, professional responsibility and accountability and the safeguards in terms of stop and check’
- Theatres to implement a ‘stop and check’ policy for all stent insertions
- The computerised tomography (CT) and /or X-ray images will be available throughout the procedure

Patient Falls

Falls prevention continues to be a key patient safety focus for the organisation. The Trust aims to reduce our rate of avoidable falls and continue our quality improvement journey. Falls amongst inpatients are the most frequently reported safety incident in NHS hospitals with 50% of patients over 80 estimated to fall at least once a year, and 30% of over 65’s. Approximately 30-50% of falls result in some form of injury and fractures occur in 1 to 3% of incidents. Since the start of the COVID 19 pandemic it is now projected that 110,000 more older people will fall annually. Our annual falls numbers have gradually increased between 2020 and 2023, our monthly figures in 2022/2033 are showing fluctuation with no consistent upward or downward trend.

Exercise reduces the rate of falls by 23% and with an extended lockdown period it is also predicted that the COVID 19 pandemic will be followed by a deconditioning pandemic.

Reducing the number of patients who fall in our care and reducing the risk of harm associated with a fall are key quality and safety issues and a priority for improvement for the Trust.

2020-2021

	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Total
1 - No harm	64	98	105	106	109	113	108	136	134	142	107	92	1314
2 - Low Harm	24	35	29	38	41	39	39	34	28	42	35	30	414
3 - Moderate Harm	1	3	2	3	2	2	0	0	2	4	4	1	24
4 - Severe Harm	1	0	0	3	2	0	0	0	0	1	1	1	9
5 - Death	0	0	0	0	0	1	0	0	0	0	0	0	1
Total	90	136	136	150	154	155	147	170	164	189	147	124	1762

2021-2022

	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Total
1 - No harm	89	78	85	108	95	87	106	128	102	114	85	105	1182
2 - Low Harm	30	45	42	54	49	74	58	46	67	71	65	101	702
3 - Moderate Harm	1	0	2	1	2	3	0	2	5	0	2	4	22
4 - Severe Harm	0	0	1	3	1	0	0	1	3	1	0	2	12
5 - Death	0	0	0	0	0	1	0	0	1	1	0	1	4
Total	120	123	130	166	147	165	164	177	178	187	152	213	1922

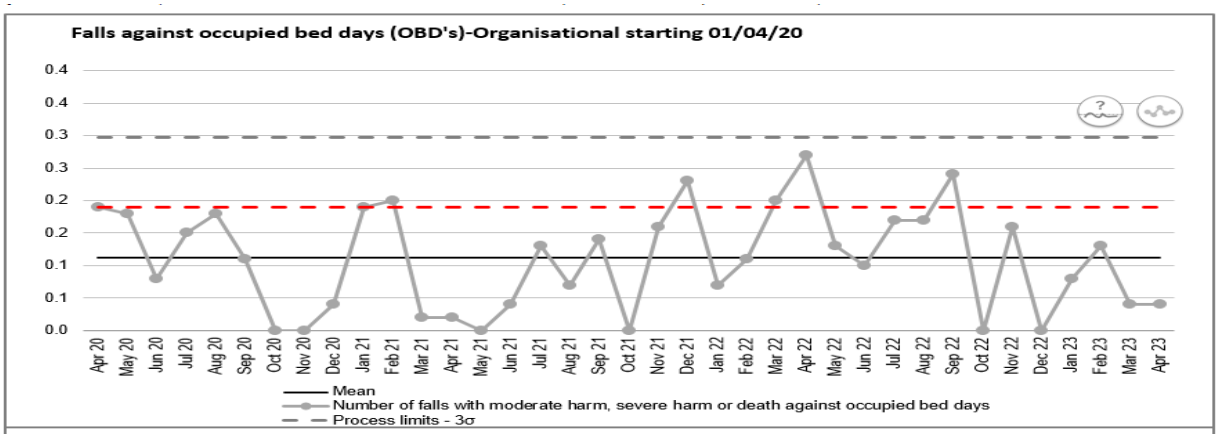
2022-2023

	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total
1 - No harm	103	79	97	88	117	97	107	99	111	96	79	93	1166
2 - Low Harm	80	69	68	64	84	61	66	41	62	54	45	55	749
3 - Moderate Harm	4	2	3	2	0	2	0	1	0	3	0	0	17
4 - Severe Harm	3	2	2	4	3	2	1	4	0	0	3	1	25
5 - Death	1	0	0	0	0	0	0	0	0	0	0	0	1
Total	191	152	170	158	204	162	174	145	173	153	127	149	1958

Reducing avoidable harm from patient falls

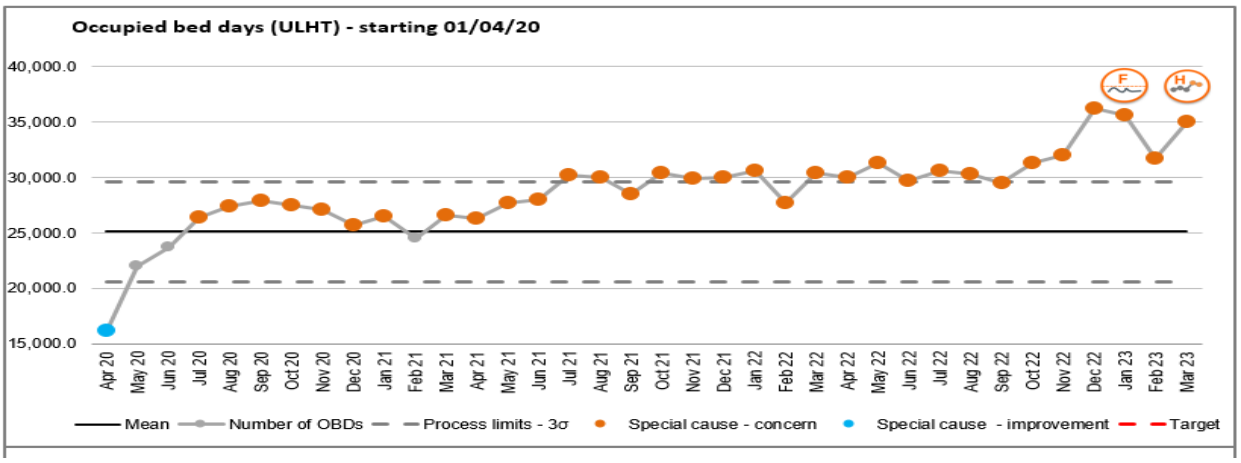
Falls incidents can result in psychological and physical harm, also having a substantial financial impact to the NHS. Falls resulting in harm are more likely to occur in acute Trusts like ours. These incidents may affect patient confidence, and the resulting injuries could mean a longer stay in hospital. In some cases, following a fall, a patient cannot be discharged to their usual place of residence which is a significant life change.

Falls resulting in moderate, severe harm and death April 2020 – March 2023



The national average for falls resulting in moderate, severe harm and death is 0.19. The Trust has been below average for thirty of the thirty six months from 2020 to 2023. The pattern for the data detailed above is very different from the pattern in which our occupied bed days (OBD) rate has changed over the previous 3 years.

The chart below demonstrates a reduced bed occupancy rate at the initial stages of the pandemic in April 2020, then illustrates an increasing trend. The months demonstrating highest OBD's do not have correlating peaks of falls resulting in level 3 harm or above, in fact these months have seen lower figures, illustrating that actions in place across the organisation to mitigate and prevent falls, are positively impacting on the safety of our patients.



Key Achievements

- Falls Prevention and post falls documentation and care is reviewed in the weekly Ward/department Leader's assurance and monthly Matrons audits as a component of the Quality Accreditation Programme. The monthly Quality Metrics review meeting chaired by the Director or Deputy Director of Nursing monitors ward and departments' performance relating to falls.
- As part of the Quality Accreditation programme Harm Free certificates have been introduced to celebrate areas who have periods with no falls related incidents.
- The Falls Prevention Steering Group (FPSG), chaired by the Deputy Director of Nursing continues to meet monthly and is now well established. The group has a multidisciplinary membership and provides oversight, monitoring and accountability of the ongoing improvement work around prevention of falls. Patient stories are regularly shared at FPSG to ensure wider learning.
- The 'Think Yellow Think Falls' message has been introduced across the organisation which has included yellow visual aids such as non-slip socks and yellow blankets to

increase recognition of patients who have been assessed as vulnerable to falling so that anyone entering the ward would know that they may need assistance.

- The ‘Carewatch’ principle has been introduced and promoted across wards and departments. Linking with ‘Think Yellow’ this approach which encourages staff to think differently is often referred to as bay/tag nursing. It is a process to maximise visibility for patients who are at risk of falling and require an enhanced level of observation. Providing care in an identified area of the ward, with a staff member allocated to work within the area at all times who would not leave without passing the responsibility to another member of the multidisciplinary team. It also provides increased visibility of staff for patients.
- The Adult in Patient Risk Assessment booklet has been updated and a new Falls Prevention Daily Assessment document has been introduced across inpatient areas in 2022.The document includes a daily assessment for falls which prompts preventative actions to be implemented and escalation processes to follow.
- A Falls Improvement Teams channel is available to all staff which is regularly updated with educational information and resources. A Lessons Learned from recent falls incidents communication has also been introduced.
- Falls Incident Investigation Support Panel meetings are scheduled weekly to provide a supportive environment to review falls investigations. Panels have representatives from Medical, Therapy, Corporate Nursing and Safeguarding teams who work with clinical staff to explore the reasons why the fall may have occurred, identify learning, and assist in quality improvements to prevent further occurrence.
- Falls Prevention E-learning module has been made available for all staff.
- Successful Trust wide events during ‘Focus on Fundamentals’ Falls Awareness month in July 2022 and Falls Awareness Week in September 2022. This included events linking in with the national campaign, use of Twitter and Trust communications to promote the activities, celebrating success and encouraging staff to have conversations about falls prevention.
- New falls prevention pictorial information resources for patients and staff have been introduced across clinical areas.

Aims for 23/24

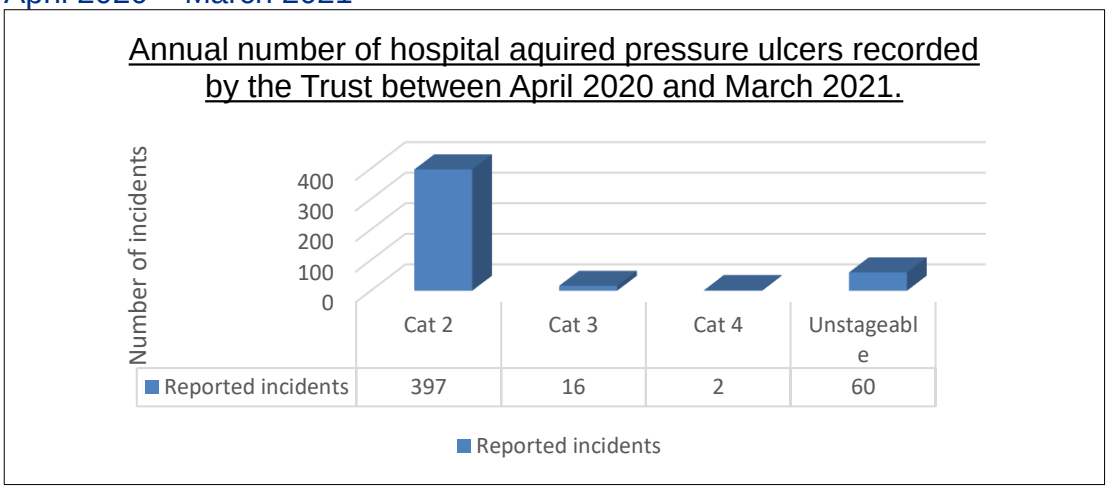
- Continue with our quality improvement work and focus on reducing falls across the organisation
- Continue to embed the new falls documentation across wards

- Prepare to migrate falls prevention investigation processes and learning to the new Patient Safety Incident Reporting Framework
- To further develop falls prevention training and education opportunities
- To develop the role of the Falls Ambassador

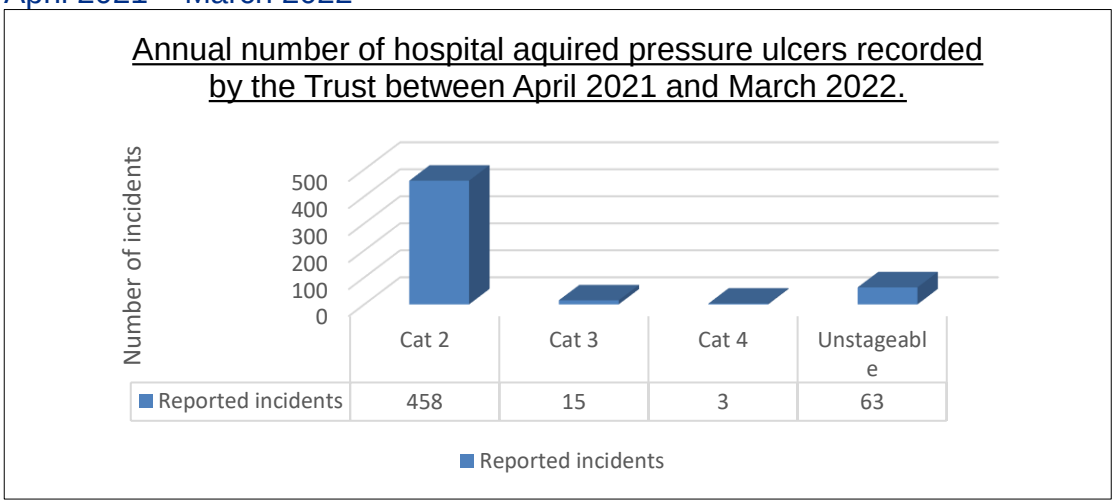
Pressure Ulcers

Pressure ulcer prevention remains a key priority for the organisation. The Trust aims to reduce our rates for hospital acquired pressure ulcers through quality improvement work and continues to focus on education, training and staff awareness. Throughout 2022/23 the number of hospital acquired pressure ulcers increased; this increase correlates with the rise in admissions to hospital and an increase in patient acuity seen as a result of Covid-19 since the first wave in 2020. Pressure ulcer prevention continues to be a patient safety priority and area of focus for the Trust.

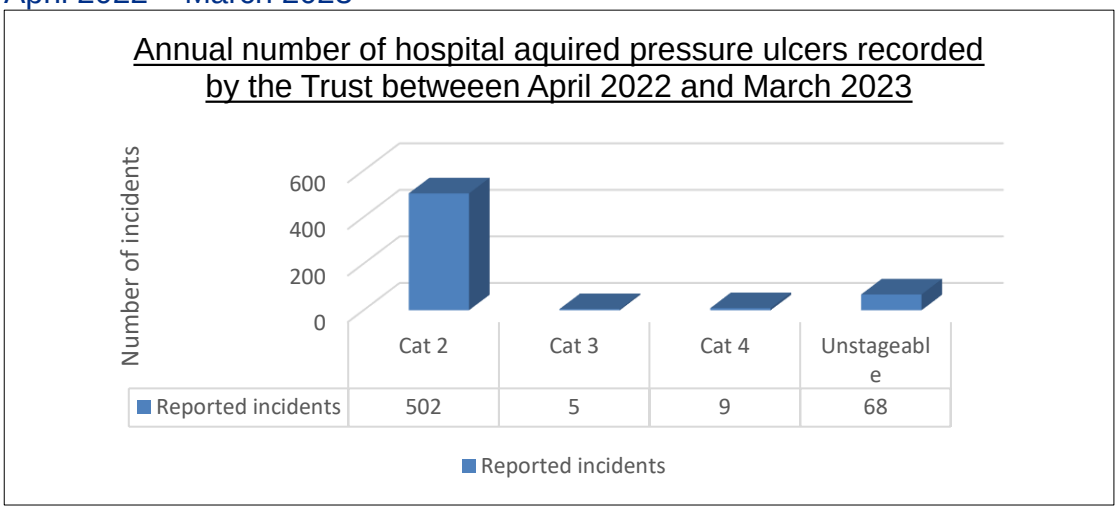
April 2020 – March 2021

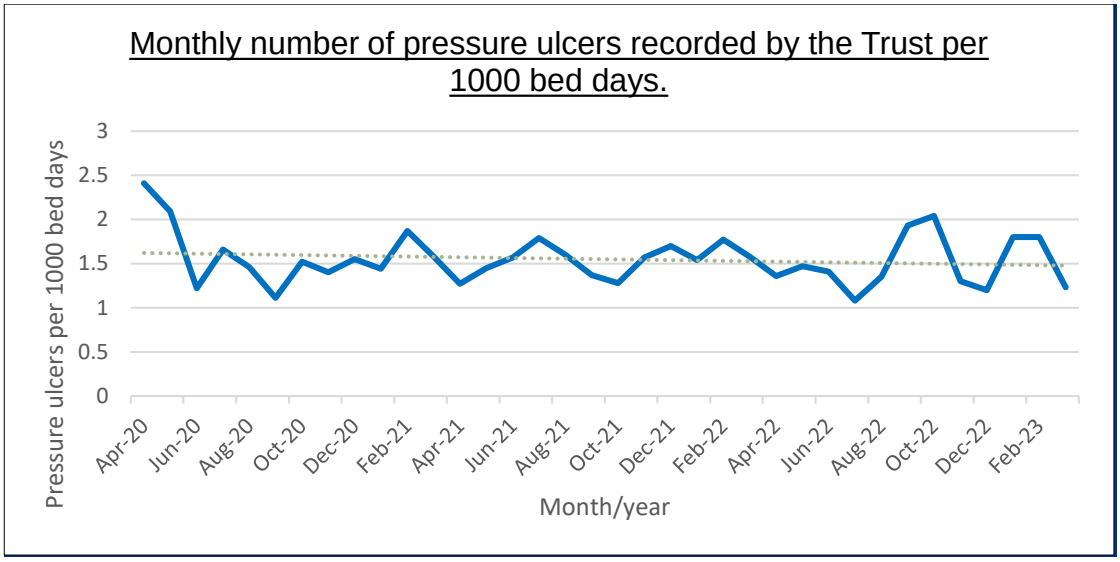


April 2021 – March 2022



April 2022 – March 2023





*Total number of pressure ulcers recorded includes categories 2,3,4 and unstageable combined

During the Covid-19 pandemic clinical priorities impacted on the progress of some of the planned improvement work. During this period there was an increase observed in device related pressure ulcers in patients being cared for in our Intensive Critical Care Units who required specialist positioning, (proning) to support their ability to recover from Covid-19. This mirrored the national pressure ulcer picture for this group of patients.

During the recovery phase of the Covid-19 pandemic we have observed an increase in the number of patients admitted with complex care needs and additional vulnerabilities placing them at an increased risk of developing skin damage.

Key Achievements:

- Skin Integrity documentation and care is reviewed in the weekly Ward/department Leader's assurance and monthly Matrons audits as a component of the Quality

Accreditation Programme. The monthly Quality Metrics review meeting chaired by the Director or Deputy Director of Nursing monitors ward and departments' performance relating to pressure ulcers.

- As part of the Quality Accreditation programme Harm Free certificates have been introduced to celebrate areas who have periods with no pressure ulcer related incidents.
- In line with the National Wound Care Strategy Programme recommendations for best practice, the Trust continues to review and adapt its guidance and practice relating to pressure ulcer prevention and management.
- The Skin Integrity Group (SIG) introduced in 2020, chaired by the Deputy Director of Nursing continues to meet monthly and is now well established. The group has a multidisciplinary membership and provides oversight, monitoring and accountability of the ongoing improvement work around prevention of pressure ulcers. Patient stories are regularly shared at SIG to ensure wider learning.
- A monthly Lessons Learned communication has been introduced and is shared monthly through the SIG and Ward Leader and Matron Forums.
- Successful Trust wide 'Focus on Fundamentals' Tissue Viability month in November 2022. This included events to promote "International Stop the Pressure Day", use of Twitter and Trust communications to promote the activities, celebrating success and encouraging staff to have a conversation about skin integrity. The Quality Matron and Tissue Viability teams facilitated an International Stop the Pressure Day for skin integrity ambassadors and clinical staff. The day included interactive sessions and workshops on the key themes that have been identified from incidents and are focus areas to improve.
- The Adult in Patient Risk Assessment booklet has been updated and a new Pressure Ulcer Prevention Daily Assessment document has been introduced across inpatient areas in 2022. The new documentation includes a more detailed assessment of patient's pressure areas and guides to best practice for those patients at increased risk of developing pressure damage. The new paperwork provides staff with additional prompts including device related and pressure points to assess. The new documentation is supporting staff to perform more comprehensive skin assessments and has led to an improved identification and reporting of skin damage.
- Pressure Ulcer Support Panel meetings are held weekly to provide a supportive environment to review pressure ulcer investigations. Panels have representatives

from Tissue Viability, Corporate Nursing and Safeguarding teams who work with clinical staff to explore the reasons why the pressure ulcer may have developed, identify learning, and assist in quality improvements to prevent further occurrence.

- Mandatory Tissue Viability E-learning training for all staff was implemented in 2021.
- The Tissue Viability Ambassador programme has been relaunched in 2022. The Tissue Viability and Quality Matrons have introduced a competency based training programme for all Tissue Viability Ambassadors which includes dedicated time working with the Tissue Viability team. The aim of the programme is to develop confidence, knowledge and skills and enable individuals to become a proactive and effective resource for cascading learning across their clinical teams. There has been some reduction in pressure ulcer incidents observed on those areas who have undergone the Ambassador training.
- To support clinical teams recognise and appropriately manage different types of skin damage the Tissue Viability team have developed clinical treatment pathways to enhance and deliver timely, appropriate patient care, to prevent further skin deterioration. These are supported with bespoke training to match a clinical areas specific needs.
- The Tissue Viability and Quality Matron team have worked with the Emergency Departments to develop dedicated grab packs for each category of skin damage. These will provide visual aids to support accurate categorisation and appropriate dressings to make it easier for staff to implement care in a timely way.

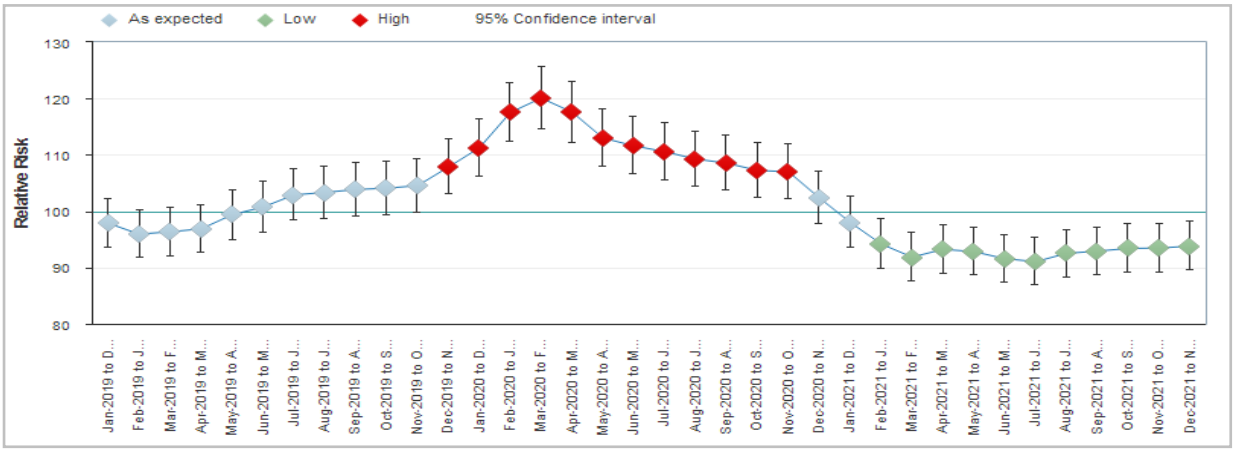
Aims for 23/24

- Continue with our quality improvement work and focus on reducing pressure ulcers across the organisation
- Continue working towards an ambition to eliminate all Category 4 pressure ulcers.
- Continue to embed the new Tissue Viability documentation across wards
- Continue to work collaboratively with Digital Team on improving electronic resources relating to Tissue Viability and Pressure Ulcer Prevention
- Prepare to migrate pressure ulcer prevention investigation processes and learning to the new Patient Safety Incident Reporting Framework

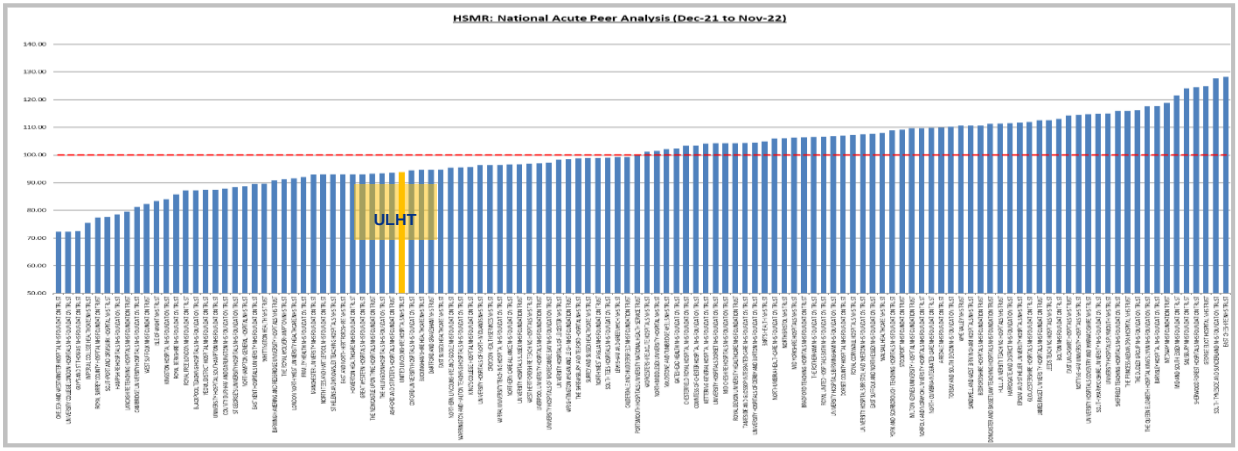
HSMR/SHMI

HSMR is an indicator of healthcare quality that measures the ratio of observed deaths to expected deaths, and whether the number of deaths in hospital is higher or lower than would be expected. At the time of writing the latest HSMR and Standardised Mortality Ratio (SMR) for the Trust relates to the March 2023 Dr Foster report for the time period December 2021 to November 2022. HSMR for the rolling 12-months is 93.79, which places the Trust in the 'Low' banding. As demonstrated on the table below, the Trust's HSMR was elevated during the COVID-19 pandemic, however, the HSMR returned to as expected from January 2021.

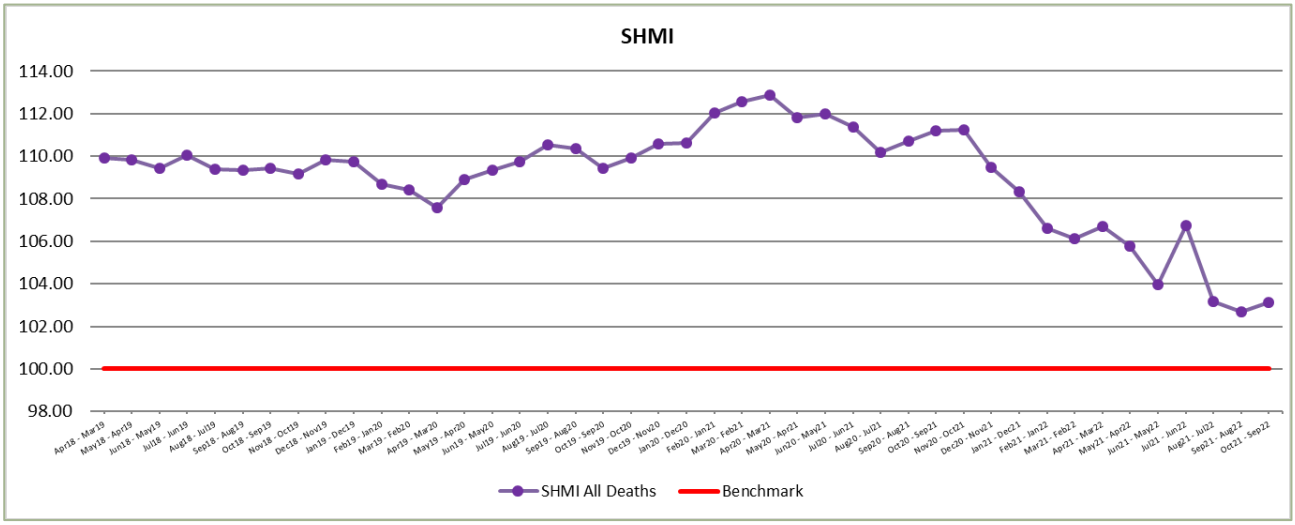
HSMR



The table below depicts ULHT position in comparison to all other Trusts within England.



SHMI



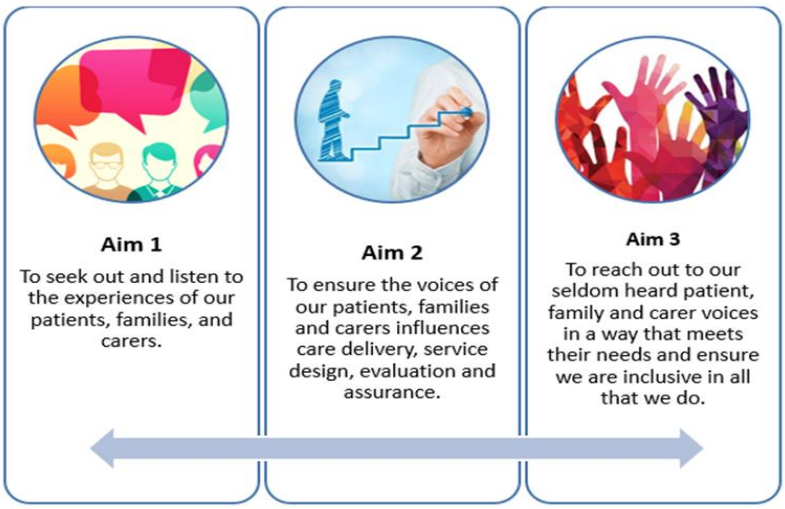
The Mortality Assurance Group (MorALS) meets every month and has oversight of the activities of all mortality review processes across the Trust, including the activities of Learning from Deaths and promoting the learning from mortality reviews. The forum provides an opportunity to discuss any issues arising and to help support the development of learning culture in the organisation in line with our Learning from Deaths policy. The monthly outputs from the Divisions are described in this meeting and the targeted areas for improvement reviewed. The development of this group into something that has greater oversight of the Trust-wide mortality review process has been the focus of our energies. It is also responsible for ensuring ULHT has oversight of the key mortality measures for the Trust and reporting on any concerns arising, which it does via a quarterly report to the Patient Safety Group, Quality Governance Committee and Trust Board.

Patient & Carer Experience (PACE) Plan

A new Patient & Carer Experience (PACE) plan and associated work plan has been introduced in this last year. The aim of this plan is to support our staff and our patients to work together to achieve an outstanding care experience, delivered by compassionate and skilled staff to provide the best possible outcomes for everyone who uses our services. Our key principles in delivering this plan are:

- To listen to our patients, families and carers, including Young Carers
- To put things right if they go wrong
- To use feedback to identify opportunities for quality improvement
- To work in partnership with our patients, families and carers in co-designing services

The plan describes how we will achieve this through three core aims each supported with a detailed work plan; the 'how' of our plan.



PENNA Awards

The Patient Experience Team submitted three entries to the Patient Experience Network National Awards and were on the podium for all three.

Patient Experience Network Annual Awards 2022

WINNER - Martyn Staddon, Data Insight Manager, for the development and implementation of our SUPERB Patient Experience Dashboard. Judges comments included:
The project showed immense leadership from the start. The project is extremely transferable and has demonstrated visible positive outcomes since launching. Brilliant aspiration, well reported - congratulations. So much to love about this - one view, accessed by all, user input.

RUNNER UP - Jennie Negus, Head of Patient Experience, for the development of the ULHT Patient Panel and a number of Expert Reference Groups. Judges comments included:
Thoroughgoing approach to working in partnership with people using the Trust's services, delivering an evident shift from doing to, to doing with. This is how it should be done, I have sat on panels, improvement councils and have worked for the CQC as an Expert by Experience. If any Trust wishes to set up a similar system then in my opinion this is the model to follow.

FINALIST - Sharon Kidd, Patient Experience Manager, for the development of Swan Wedding Boxes. Judges comments included:
Really enjoyed this entry. It gives staff outcomes and sense of closure during managing a very difficult time. Great initiative and as a clinician I can see how this would be a very welcome scheme to support ward teams in arranging end-of-life weddings.

Patient Stories

Each month a digital patient story is presented to Trust Board and these are all now available to all staff within our new Patient Story Library on the intranet. Patient stories are also presented to Patient Experience Group as part of divisional assurance reports and many clinical business units and governance groups have a story to start their meetings.

Patient Panel

The Patient Panel put our patients at the beginning and at the centre, giving them a valued voice in decision-making; engaging and involving from the outset and not just informing them afterwards. They assist us to drive, deliver and demonstrate Trust wide measurable improvement and continuous learning in outcomes, delivery, performance, sustainability and transformation in Patient Experience. The group continues to meet monthly and since its launch in September 2020 has only had to cancel two meetings. Attendance averages at 19 patients per meeting and a recruitment drive in early 2023 has brought 9 new members. Topics discussed continue to be varied and in 2022 – 2023 thirty presentations and discussions have been held.

A story was also presented to Trust Board showcasing the work of the panel.

https://youtu.be/3Md22HH3pU4

Experts by Experience (EBE)

It became evident early on in this project that Divisions and specialties were struggling to host and hold their own Experts by Experience (EBE) despite an acknowledgement of their potential value and worth. As such, the decision was to establish Expert Reference Groups, supported by the Patient Experience Team raising awareness and from where individual EBE may naturally develop.

- Sensory Loss Expert Reference Group with five members, people who live with sight or hearing loss or those who care for and support them. This group has met a number of times and undertaken two co-production production projects.
- Breast Mastalgia Expert Reference Group with six members, functioning more as a task and finish group has been integral in the development and design of a new pathway for patients with breast pain. The group contributed to discussions about the challenges, gave their views and comments and suggestions on pathway design and contributed also to the patient information design and content at the point the new pathway went live.
- Cancer Patients Expert Reference Group with eight members established in partnership with the Lincolnshire Cancer Board. The group meets quarterly and reports upwards to the Lincolnshire Cancer Board.

- Dementia Carers Expert Reference Group with six members held its first ‘getting to know you’ meeting in September and meets alternate months reporting upwards to the Mental Health, Neuro-disability and Dementia Steering Group. In addition, one of the members shared her story as part of the November Trust Board patient story, which is available in our story library here: Story Library (sharepoint.com)
- Improvement Academy Expert Reference Group is a new group launched in March 2023 with 9 members. The group will meet monthly with Quality Improvement (QI) programme participants to hear their project thinking and outlines to ensure consideration of patient’s voices and experiences at the outset. The proposal is that through masterclass engagement methodology our staff will co-design their improvement activities with patients.

Pets As Therapy

The Pets As Therapy (PAT) charity has started to bring its ‘four-legged friends’ to visit hospital patients and staff in Lincolnshire. The charity, which aims to improve health and wellbeing through the visits, brought their dogs onto wards across United Lincolnshire Hospitals NHS Trust.

A labradoodle called Ruby and a terrier called Patrick visited wards at Lincoln County Hospital, Pilgrim Hospital, Boston, and Grantham and District Hospital, cheering up patients and staff. United Lincolnshire Hospitals Charity is funding the visits and hopes to make them a regular occurrence.

Reaching Out to Hard to Reach Communities

Work continues to try and reach out particularly to Eastern European and Black, Asian, and Minority Ethnic (BAME) communities. Working with Healthwatch colleagues to establish contacts suggestions include making connections with local factories to put out flyers or leave surveys in local businesses. Surveys have been translated into other languages and once tested during April will be distributed to local businesses and libraries and other relevant outlets.

Improving Communication

A Communication improvement group was established to lead a number of initiatives to address concerns relating to communication. A comprehensive continuing action plan is in place and achievements include:

- Ward communication folders
- Support for sight & hearing loss patients
- Launch of You Care We Care to Call – an initiative for proactively calling relatives to update them
- Launch of the 'What Matters to You' initiative that encourages asking patients what is most important to them and then working to achieve that
- A new Patient Experience training programme that has a focus on communication skills
- A refresh of the patient experience elements within Junior doctors induction
- Support for the Trauma & Orthopaedics Hearing it My Way OSCE communication training programme
- Development of Ward information tablemats
- Encouraging the use of passwords for family contacts so that key information can safely be given to relatives over the phone

Difficulty getting through to wards by telephone has featured as a significant concern, initially during the pandemic but sadly this continued to be an issue. The "You Care We Care to Call" project, alongside removal of visiting restrictions has improved this to some extent but it is still a problem. We have been working with our telecommunications team to look at functional improvements including the introduction of call queuing and checking of extension numbers. A change to how switchboards function has also been introduced to reduce delays.

National Patient Surveys

All Trusts participate in a programme of surveys run nationally by the CQC. These include inpatients, urgent & emergency care, maternity, children and young people and cancer patients. Whilst we have action plans to address each of these we recognised there were themes across the suite that needed a cross divisional approach to achieve improvements

and have developed an overarching thematic action plan to address this. This is a great example of Trust wide working to improve patient experience.

Patient Information

We have a responsibility to ensure that the information we share with patients is evidence based, up to date and reliable. It is vital that the patient information that we produce meets strict guidelines around accuracy, accessibility and readability and that it is updated when evidence or processes change so that we can be assured that we are doing the best for our patients. It is also important that we make our patient information available in alternative formats, including other languages and accessible formats, wherever we can. A full review and refresh of all our patient information has been taking place and a new group established; the Patient Information Approval Group (PIAG). The group is currently meeting fortnightly and is in the process of reviewing all of our almost 600 existing leaflets as well as considering new ones being submitted and this will take about 6 months to complete reviewing 80 leaflets each month. One of the first things PIAG has done is to look at what information is already ‘out there’. Is there a leaflet or information already available from a reputable body or organisation that we can use? And if so does that information meet our standards in relation to authorship, evidence base, accessibility and that it is reviewed.

Patient Visiting

Through the pandemic restrictions were in place for visiting; these were adapted and amended in line with national guidance and local risk but in September 2022 all restrictions were removed and wards were able to return to pre-COVID arrangements. What became evident however was that approaches to visiting in terms of local discretion and schedules were inconsistent and a full audit was undertaken to understand more. As a result of this a co-design project was launched to consider visiting from both staff and patient perspectives and a new policy has been developed. This standardises visiting times across all our sites and also distinguishes between traditional visitors and carers who need unrestricted access.

Caring for Carers

Having been selected as one of thirteen national pilot sites for the development of a new national Care Partners Policy we have been reviewing and updating how we welcome and involved our carers in our patients care. The review of visiting incorporated a review of how carers are welcomed and a proposal agreed that carers will be welcomed at any time and not be restricted to visiting times. We have updated, rebranded and are relaunching our Carers Badges scheme and have had a particular focus on how we recognise and embrace Young Carers. We have also identified some dedicated space at Pilgrim Hospital to develop a Carers Hub which we plan to open during Carers Week at the beginning of June 2023.

A Caring for Carers story was shown to Trust Board and featured a lady who cared for her mother who had dementia and was a powerful reminder of the importance of recognising carers as expert partners in care.

Caring for carers

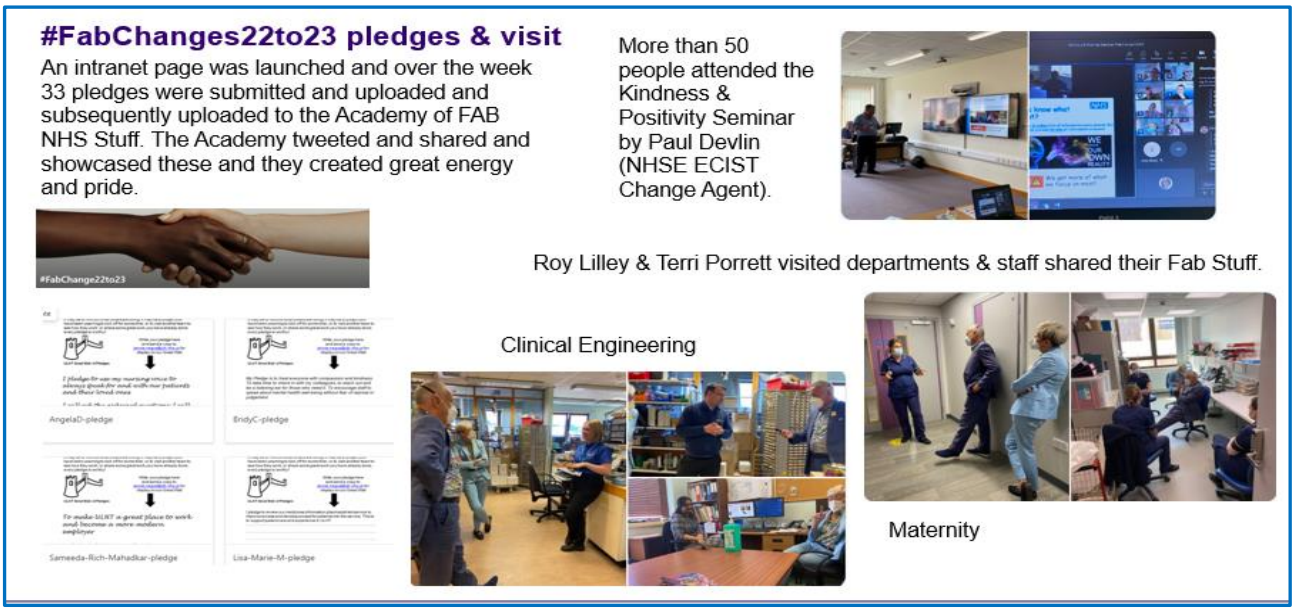
The story tells the reflections of Katherine who is the main carer for her mum who was diagnosed with dementia a few years ago. The story also relates to Caring for carers both adult and young carers and includes all the work that is planned to take place in 2022 to help those who are carers for our patients.

https://youtu.be/9-XPOY4jWoc

Academy of Fabulous NHS Stuff – FAB Change Day 2023

This year '#FabChangeDay' changed to #FabChanges22to23 – so not just one day during the year but supporting and checking in throughout. Mindful of the pressures & challenges of the last two years alongside the challenges that lie ahead, the Academy of FAB NHS Stuff recognised that a focus on a single day once a year not only didn't fit well with QI improvement models but that change doesn't happen overnight. #FabChange22to23 started with pledges and check ins during the coming year to support and champion the delivery of those pledges. The launch took place across the week of 4th July and each day a new FAB message was circulated.

Day 1: Explore the Academy & win a prize	Day 2: book onto our Kindness & Positivity seminar	Day 3: make a pledge	Day 4: meet FABStuff founders Roy Lilley & Terri Porrett at Lincoln	Day 5: sharing your FAB stuff.



Enhancing Patient Experience – Working with ULHT Charity

The Patient Experience Team have spearheaded a monthly programme of activities and events to help alleviate boredom, provide distraction and bring kindness and wellbeing to the fore. Initiatives have included:

- Halloween decorations, treat bags and cupcakes
- A Christmas gift for every patient
- Crosswords, word searches, quizzes and small crafts
- World Cup activities including discovering all about the different countries taking part
- Pets as Therapy visits to all sites
- World Book day – reading to patients

In addition charitable funds have purchased fifty new wheelchairs for volunteers to help with patients coming in to our hospitals, these have tracking devices on so they can be found and returned ready for their next use and a number of other projects are underway including brightening up of ward spaces and the development of the new Carers Hub.

Dignity Pledges

We undertook a review of patient feedback about dignity looking at data from PALs, Friends and Family Test, Care Opinion stories and results from our national surveys. The data reflects that Privacy, Dignity & Respect was an area we needed to improve on. With input from NHS colleagues, our Patient Panel members and external stakeholder Healthwatch, we developed a single poster to reflect our pledges to ensure we achieve outstanding care to all.

Patient Experience Training

A Patient Experience Training programme was launched in the summer of 2022 and approximately 150 staff attended. This is now running monthly and heavily focuses on perceptions, assumptions, expectations and communication skills.

Complaints

Complaints and enquiries are a key source of feedback for the Trust and informs us about our patients' views regarding the quality of services and care provided which enables us to examine our services and make improvements. 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.

A national review of the NHS Complaints Standards has been undertaken by the Parliamentary Health Service Ombudsman (PHSO) on how NHS services should approach complaints handling. The draft Standards were published in 2021 and are being refined and introduced across the NHS in 2022-23. The Trust has reviewed our position against the draft national standards and we have started to make improvements, including a focus on more timely contact by the investigating officer or senior clinicians when a complaint is first received to try and resolve issues more quickly, to improve access to raising a concern, and to improve how learning is disseminated from complaints so actions are not only taken in one team.

To enable the timely resolution of complaints and improve learning, the Trust has introduced an Early Resolution pilot which enables the complainants to receive a telephone call initially to explain the process and if they are happy to proceed. The Early Resolution process enables the complainants to receive a response to their complaint without having to wait for a letter to be generated which enables the complainants to receive the answers to their concerns within 25 days, with the majority being responded to within 7 days. Since the inception for the Early Resolution Team in October 2022, they have responded to 230 complaints. The feedback received has been very complimentary and are very appreciative that they can speak to a person and that they are listening to them and resolving their concerns quickly.

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 complaints within 35 or 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. A quarterly report is produced and presented the Patient Experience Group and Quality Governance Committee.

Number of complaints received:

	2020-21	2021-22	2022-23
New complaint received	555	627	835

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:

- As a result of complaints raised about communication within the orthopaedic team a pilot scheme is being trialled where patients relatives are being called every day to provide them with an update
- The Emergency Department are working closely with the Patient Experience Team to improve communication with relatives
- Clinical Educator for Health Care of Older People (HCOP) is working with staff to build confidence around communication and meaningful updates
- All wards have implemented a communication sheet that is laminated and displayed by the nurses station to capture communication with relatives when visiting is restricted
- Volunteers have been recruited to HCOP, Gastroenterology and Respiratory wards, with a key role to support answering the telephones

Vulnerable Patients

From the investigations of complaints involving patients who have learning disabilities it has highlighted the requirement for further training within the organisation to ensure that we can provide the necessary support to both patients and their family members when there is a need for them to attend our hospitals.

Whilst we currently have a specialist Learning Disability Nurse, who provides support and guidance to staff, to ensure that our patients with learning disabilities receive care tailored to their needs, it has been identified that further training is required to support staff.

As a result of a complaint received by the Trust, The Matron for the Emergency Department (ED) and Same Day Emergency Care (SDEC) are participating in a new focus group, which will look at the care of vulnerable patients in the Trust, including those with learning disabilities. The focus group is being led by the Trust's Safeguarding Lead and it will involve formulating training, to ensure that our staff have the knowledge and skills to care for and support our most vulnerable patients.

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 2022-23 PALS dealt with 4906 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

United Lincolnshire Hospitals NHS Trust recognises that everyone is different, and values the unique contribution that individual experiences, knowledge and skills make in delivering quality healthcare and fulfilling the NHS People Promise.

We continue to promote equality and challenge discrimination in all service provision, recognising and meeting the needs of the diverse communities we serve.

We continue to work towards providing an environment in which people want to work and recommend the Trust as an employer, and to fulfil the NHS People Promise. We are also committed to enabling each member of staff to achieve their full potential in an environment characterised by dignity and mutual respect. Our 2022 National Staff Survey data reflects our progress with this.

We do not tolerate unlawful discrimination, victimisation, bullying or harassment based on age, disability, gender reassignment and gender identity, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex or sexual orientation. Any action found to be in breach of any of these will be addressed in accordance with the Trust's policies and procedures.

The Trust's current Equality Objectives, which are aligned to the Trust's Integrated Improvement Plan are published on the Trust's internet at: Our equality objectives - United Lincolnshire Hospitals (ulh.nhs.uk)

The Trust fully-reinstated all Public Sector Equality Duty and National Health Service England (NHSE) mandatory reporting and action planning in 2022, and these are published on the Trust's internet at: Equality, diversity and inclusion - United Lincolnshire Hospitals (ulh.nhs.uk) under the relevant report heading.

The Trust has an active governance and assurance route for Equality Diversity & Inclusion (EDI), through EDI Operational Group, Patient Experience Group (Patient Equalities), upwards to People and Organisational Development (OD) Committee, and for all statutory and mandatory reporting and action-planning, these are approved by the Trust Board. Externally, the Senior Equality & Human Rights Manager (Arden & GEM CSU) reviews this work and provides external assurance, through the Lincolnshire Integrated Care Board (ICB) Equality & Human Rights Forum, with no issues or concerns raised at last review, October 2022.

Also, the Workforce Race Equality Standard (WRES) is assured nationally by NHSE national WRES team. The Trust's action planning based on our October 2022 submission is rated as "Good".

Freedom to Speak Up

Since 2016, the Trust has complied with the NHS contract requirement to appoint a Freedom to Speak Up Guardian (FTSUG). 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 incorporated the new national NHSE/I Freedom to Speak Up policy into it's local 'Voicing your concerns' policy, which describes the different ways to speak up and who to speak up to, the process and an appendix, which provides assurance to staff that anyone speaking up with genuine reason should not suffer detriment/disadvantageous behaviour and the process to follow. To complete the Speak Up process, feedback questions are asked to gain assurance that actions have been taken or questions answered and to highlight any potential service improvements.

A database and dashboard has been produced for intelligence, to capture metrics, including: number of cases, thematic information, who is speaking up and protected characteristics. The database will measure all open cases, feedback and follow up from closure of a case over a 12 month period to establish any detriment/disadvantageous behaviour.

Drop in sessions and twilight shifts have been organised to capture staff across all sites, covering day and night staff.

Speak Up, Listen Up and Follow Up training has been approved as core learning for two years and to be included on all new starters induction.

The Chair, Chief Executive, Directors and Non-Executive Directors attended the FTSU board development session and self-assessment to ensure any gaps were actioned.

How does the Trust support staff to speak up:

- Voicing Your Concerns Policy
- Freedom to Speak Up Guardian
- 25 Freedom to Speak Up Champions from across different staff groups and staff networks, who have been engaged to promote speaking up and signpost to the 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 has completed the speaking up self-assessment
    - The Non-Executive Champion for FTSU completed the National Guardians Office training development session
- The Freedom to Speak Up Guardian meets monthly with the Trust Chief Executive/Chair and 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 their line manager or senior divisional manager or any appropriate 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 a Freedom to Speak Up Champion
- Contact the Non-Executive Director for Freedom to Speak Up
- 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 / update sessions over Teams; these are well attended and have received excellent feedback. The training sessions are held approximately twice a year (March / April and September / October). The purpose of these sessions is to increase awareness of exception reporting, support the Educational/Clinical Supervisors in the reporting mechanism and give supervisors opportunity to feedback on issues they may have.

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 the issue, such as working hours, work pattern, educational and patient safety. 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 the 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 policy on the Process of Exception Reporting and Work Schedule Reviews for Doctors and Dentists in Training (2016 TCS), which has been

approved by the Trust Board. The purpose of the policy is to provide guidance about the process of implementation of outcome 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. The same policy is applicable to the exception reports raised by the Locally Employed Doctors so as to make them feel confident to raise issues when necessary.

The Resourcing Advisors and the newly formed Medical Recruitment Team 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. In addition the Medical Workforce Team continue to work closely with Health Education England East Midlands (now NHS England) 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.

A Medical Workforce Project was established last year. This group oversees key projects relating to the medical workforce including right sizing of rotas and the implementation of the HealthMedics digital rostering and leave system. In August the Trust went live with the HealthMedics system for annual leave for all doctors including junior doctors. This has enabled greater visibility of leave bookings and removed the need for manual systems and spreadsheets.

Part of the project is focused on reviewing the junior doctor rotas and the initial phase of this work has been in Medicine. Work has been carried out on safe staffing levels using the methodology in the Royal College of Physicians Safe Staffing Report. Significant progress has been made in respect of the General Internal Medicine (GIM) rota at Lincoln County Hospital for junior doctors with a newly designed rota implemented at the start of the April rotation. This new rota provides enhanced safety and quality benefits, including greater continuity of care to our patients and increased workforce satisfaction and work life balance. A key element of the introduction of the improved rota has been the recruitment of additional Locally Employed Doctors. The move to HealthMedics has also delivered significant benefits for this group of doctors which has resulted in the removal of spreadsheets for medical rotas and is the first step towards standardisation across the Trust.

The project team have also developed a new model for Pilgrim Hospital, Boston (PHB) GIM rota, Grantham Medical rota and Lincoln and Pilgrim Emergency Department rotas.

These rotas are currently progressing through the appropriate governance arrangements with an expected implementation date of August 2023 in line with the August rotation.

Annex 1: Stakeholder Comments

NHS Lincolnshire Integrated Care Board

NHS Lincolnshire Integrated Care Board (ICB) is pleased to review and provide feedback on the United Lincolnshire Hospital NHS Trust (the Trust) Annual Quality Account 2022/23. The Quality Account provides a comprehensive summary of the Trust's key quality priorities.

The ICB acknowledges the progress made by the Trust in implementing last year's quality priorities and welcomes their commitment to continue meeting these objectives throughout this year.

This year's Quality Account highlights valuable objectives and accomplishments, including improvements following the Care Quality Commission's (CQC) inspection in 2021. The Trust has no further CQC conditions to meet and has moreover reported significant achievements, as emphasised in the statements from the Trust's Chief Executive and the CQC. The ICB particularly notes the CQC's positive observations and the outcomes of the NHS Staff Survey report in 2022, which reflect the Trust's dedication to prioritising patient care.

The ICB also acknowledges the achievements outlined in the Trust's Integrated Improvement Plan, while recognising the ongoing challenges faced by the Trust, such as those related to older and rural populations, staff shortages, and the ongoing effects of the COVID-19 pandemic in relation to recovery of services.

Furthermore, the ICB commends the Trust's commitment to learning from patients' deaths and applying learning from these difficult experiences to drive future improvements in high-quality care. The ICB is also particularly encouraged by progress made in patient safety incident management via development of the Patient Safety Incident Response Framework (PSIRF). The focus on learning from incidents, engaging with patients and families and optimising resource allocation demonstrates its positive approach.

The ICB also appreciates the Trust's efforts to engage with communities prone to inequitable contact and experiences with healthcare services. However, the ICB acknowledges that there is still work to be done in this area, recognising that this is a collaborative undertaking with partnering multi-sector organisations. The ICB further commends the Trust's Equality, Diversity and Inclusion statement, especially their commitment to the Public Sector Equality Duty, the establishment of a Patient Experience Group, and the 'Good' action planning in line with the Workforce Race Equality Standard.

With regard to Urgent and Emergency Care, the ICB joins the Trust in celebrating the Grantham and District Hospital Surgical Hub's recognition for maintaining high standards in clinical and operational practice. Additionally, the ICB acknowledges the substantial improvements at Lincoln County Hospital's new Resuscitation Department, which enhances staff effectiveness and patients' experiences.

Looking ahead to 2023/24, the ICB notes three new quality priorities identified by the Trust. These are the implementation of the 'you care we care to call' program across 38 wards to enhance patient experience; improving clinical effectiveness and best practice principles by prioritising cardiovascular pathways; and maximising patient safety through learning from patient safety incidents. The ICB supports these priorities, as they align with the ambitions of the Lincolnshire Integrated System.

The ICB expresses gratitude to United Lincolnshire Hospitals NHS Trust for their unwavering dedication within the Trust and with partnering services to meet patients' needs and provide safe and effective healthcare services during one of the most challenging periods in the history of the NHS.

As an Integrated Care Board, we eagerly anticipate working alongside the Trust in the coming year, as they endeavour to achieve optimal quality of services, health outcomes and parallel patient and public experiences.

Yours sincerely,

Vanessa Wort
Associate Director of Nursing & Quality
NHS Lincolnshire ICB

United Lincolnshire Hospital Trust Quality Account Statement 2022/23

Healthwatch Lincolnshire share all relevant patient experiences with ULHT and thank you for responding within 20 working days. Your responses are shared in turn with the patient, carer or service user who raised the issue, in many cases this provides them with a level of closure they may not otherwise receive. We believe learning through patient feedback and experiences is an essential part of any service improvement.

Overall, the report is comprehensive and very informative.

Commentary relating to the previous year's Quality Accounts

We acknowledge the work ULHT have achieved over the past 12 months to improve overall performance and to achieve the previous years priorities. We would like to thank the ULHT team for their hard work and dedication in achieving this, we appreciate the challenges and work being done to improve patient and staff experience,

Priorities and challenges for the forthcoming year 2023/24

Priority 1 – Implementation of our 'you care, we care to call' programme across 38 wards With Communication being one of the biggest concerns we hear from patients we believe patients, carers, family and friends will benefit from this initiative.

Priority 2 - Improve clinical effectiveness and best practice principles by prioritising Cardiovascular pathways - we support the inclusion of this priority to improve clinical effectiveness, patient and service user input will be needed to evaluate their experiences which was not directly mentioned in the QA.

Priority 3 - - Maximise safety of patients in our care, through learning from incidents -This is an absolute essential priority, in relation to medications we have heard form both

service users and staff that medications is often a reason for delayed discharge, and we would expect to see an improve in this area as a result of this priority focus.

Healthwatch Themes and Trends for ULHT – The last 12 months

Many of the comments we received from patients relating to ULHT were very specific to each individual case, all of which have already been shared with ULHT. However, poor communication continues to be an issue repeatedly raised by patients.

Patients shared their struggles of trying to contact a variety of different hospital departments with appointment queries or trying to find out how relatives were. Additionally, patients raised their concerns about poor communication between professionals both within and across services and to patients.

Patients also shared experiences of where they felt they had been dismissed and not listened to as well as cases where their medical history e.g. (test results) had not been shared between services. There were also instances where patients had been told that someone would contact them either via phone or post about test results, a referral or follow-up appointment but these patients had not heard anything for months. The latter often caused additional stress with patients worrying whether or not they were still on waiting lists or if they had been discharged from a service.

Similarly, patients shared their concerns around waiting times for diagnostics, tests, treatments and follow-ups and the poor communication during this time. Many appreciated the pressures on the NHS at the moment but were, especially in suspected cancer cases, concerned about the impact waiting times would have on their prognosis. It was unclear in these cases whether patients have been given any information on how to wait well or if such information had been given but was ineffective in helping individuals manage their symptoms or relieve some of their anxieties.

For patients who had been referred or received treatment at services out of the county, communication appeared to be especially poor. These individuals often appeared to feel that no one services really took accountability/responsibility for their care, instead their concerns were passed from service to service with no answer.

There was, however, many comments praising the breast cancer screening service. Staff were praised for being friendly, welcoming and informative.

Statement on United Lincolnshire Hospitals NHS

Trust's *Quality Account* for 2023/24

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

Progress on Priorities for Improvement for 2022-23

- *Priority 1 – Discharge and Compliance with the SAFER Bundle* – The Committee is pleased to note the progress with this priority. Assurance has been received that discharge plans are being followed and delays are still anticipated where cases are more complex. In addition, checklists are being monitored, whilst pilot data is being reviewed to assess overall effectiveness and areas for improvement.

- *Priority 2 – Diabetes Management* – The Committee welcomes the improvements following the implementation of the three eLearning packages and recognises that the Electronic Staff Record (ESR) compliance monitoring and the rollout of the diabetic ketoacidosis project is ongoing.

- *Priority 3 – Medicines Management* – The Committee accepts the increase in reporting of incidents as a positive step in line with the open and transparent culture being nurtured and demonstrated. The Committee is pleased to note that the new drug administration programme (for adult and paediatric) is currently going through final governance processes before the training package is rolled out on the ESR platform.

Priorities for Improvement for 2023/24

The Committee supports the selection of the three priorities for improvement for 2023/24, which remain patient-centred and seek to enhance their experience, to optimise clinical effectiveness and incorporate learning from incidents. The following comments are put forward by the Committee on each priority:

- *Priority 1 – Implementation of our 'you care, we care to call' programme across 38 wards.* The Committee acknowledges the efforts to proactively engage with patients and families in breaking communication barriers. The Committee welcomes the activity in addressing communication issues as a result of complaints raised previously as well as the training and support offered to staff to improve their communication skills both face to face and over the telephone.

- *Priority 2 – Improve clinical effectiveness and best practice principles by prioritising Cardiovascular pathways* – The Committee looks forward to progress with this priority, acknowledging the efforts towards reducing waiting lists and backlogs.

  The Committee also notes that arrangements are in hand in reducing those slipping from the 78 week wait category to the 104 week wait category. Assurance has been given that work is underway that mitigate the risk of patients moving to the 104 week wait category. The Trust has assured the Committee that medical examiners are scrutinising deaths in hospitals and in the community, with the latter increasing as part of a UK wide phenomenon, whilst efforts are made to collaborate with GPs in communities looking at inpatient and outpatient deaths for themes and trends.

- *Priority 3 – Maximise safety of patients in our care, through learning from incidents* – The Committee recognises the importance of this priority and notes that there is need to ensure that incidents resulting in harm relating to falls as notably, annual falls numbers related to severe harm have increased between 2020-2023. Assurance has been received that efforts are made in preventative activity, however, as has been explained, the human factors need to be understood. Recognition of high-risk cases and appropriate escalation (adequate staff support and close monitoring) is the focus of the Trust for this priority.

The Committee also notes the increase of Never Events and requests assurances that proactive steps are taken in reviewing cases, decoding commonalities, and educating staff.

Other Achievements During 2023/24

The Committee welcomes the following achievements during 2023/24:

- opening two new theatres at Grantham and District Hospital;
- managing patient waiting lists, so that in advance of the national deadline of 31 March 2023 no patients were waiting more than 104 weeks;
- opening a new emergency department, including a resuscitation unit at Lincoln County Hospital; and
- a reduction in hospital mortality rates, as measured by the standardised hospital mortality indicator.

Finally, the Committee is pleased to hear that improvements have been made and would be maintained in improving staff communications and cultivating a culture of openness and trust. Assurances have been received that staff complaints are addressed through a different process to the patient complaints process, that staff are confident to make complaints and that the "it is safe to say" campaign that aims to raise awareness and nurture a positive culture is being re-launched.

Care Quality Commission Inspection and Integrated Improvement Plan

The Committee has welcomed the positive report from the CQC, and the Trust being rated as one of the most improved trusts in the country in 2022 and the recognition of the Trust's efforts to embed further improvements during 2022-23. Following the January 2022 inspection, the Trust moved out of the Recovery Support Programme and the Section 31 conditions on the Trust's registration were removed; overall recommendations have evidently been incorporated into a programme of improvement work. The Committee notes the achievements made through the Trust's Integrated Improvement Plan (IIP) which was launched in 2020 and ongoing for a period of five years.

The Committee is looking forward to seeing how inherent issues with staff retention and recruitment would be addressed.

Engagement with the Health Scrutiny Committee for Lincolnshire

During 2022-23, engagement with the Health Scrutiny Committee for Lincolnshire has continued, with representatives of the Trust attending for various items at four of the eleven meetings of the Committee which have taken place during the year. 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 have been achieved; colour coding helps to identify aspects pertinent to the same category in reporting achievement; and there is a glossary at the beginning to enable the public to understand the abbreviations. The Committee is pleased to see the section on *Performance Against Core Indicators* clearly presented, with national comparators. ESR was missing from the list of abbreviations in the draft and there was reassurance it would be included in the final version.

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).

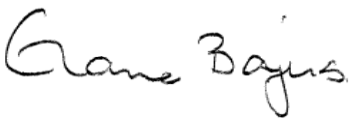
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- 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