Quality Account 2018-19

Great care, close to home
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Part 1: Statement on quality from the chief executive of Lincolnshire Community Health Services NHS Trust

Lincolnshire Community Health Services NHS Trust (LCHS) provides community healthcare services for the population of Lincolnshire. The trust has an annual turnover of c. £95m, employs c. 2,000 members of staff.

Working in partnership with other health and social care bodies, the trust delivers care in community settings across a range of services including; community nursing and therapy services, end of life care, urgent care, public health and children’s health and social care services; all supporting a shift to care outside of a hospital setting.

In September 2018, LCHS received an overall rating of outstanding from the CQC; with a rating of good for the safe, effective and caring domains and outstanding in the responsive and well-led domains. This rating is something that everyone who works for the trust is extremely proud of and reflects on the incredible amount of work undertaken by LCHS staff.

The entire Trust Board is particularly proud of the culture which the organisation has developed that has facilitated this achievement. LCHS has a strong ethic of valuing, encouraging and developing its staff and this is encapsulated within the LCHS Way. The foundations of the LCHS Way are: we listen, we care, we act and we improve.

The trust builds on these foundations by taking a proactive approach to engaging with its staff and developing its current and future leaders, with the firm belief that motivated and engaged staff directly improve the quality of the care it delivers to patients.

LCHS’s results from the 2018 NHS staff survey were generally positive. There were improved results in eight of the ten themes, a new theme of morale that does not have a comparator from last year and deterioration in one theme, namely; experiencing bullying, harassment or abuse at work. The theme of Safe Environment – Bullying/Harassment is made up of three questions which refer to the public, managers and colleagues.

LCHS is particularly disappointed to see an increase in the number of staff experiencing bullying, harassment or abuse at work. LCHS is committed to an open
and honest culture and takes responsibility to ensure that the concerns of its staff are looked into and staff have access to the support they need.

To facilitate this responsibility, LCHS has appointed a Freedom to Speak Up Guardian. This role means that in addition to other identified ways to raise concerns, staff have access to an independent and impartial source of advice at any stage of raising a concern. Staff will be offered the necessary guidance and support and kept updated as to what is happening with their concern.

The trust wants its staff to feel supported at work and ultimately ensure that it is providing excellent care to its patients and their families.

The trust’s stated purpose is to deliver great care, close to home. This puts it at the heart of the Lincolnshire healthcare economy and it is vital that LCHS’s services continue to be aligned to the needs of the county as a whole.

Although this quality account concentrates on LCHS and the quality of the services it delivers, it is important to stress that LCHS does not exist in a vacuum. The Lincolnshire Sustainability and Transformation Partnership (STP) is a collaboration of provider and commissioner NHS organisations along with Lincolnshire County Council all working together to identify the health and social care needs of the population of Lincolnshire both now and in the future.

The trust prides itself on delivering clinical practice that is safe for patients, effective and delivers a great patient experience. LCHS measures the quality of its services through a series of metrics that are presented on a monthly basis to the LCHS trust board and its assurance committees. Trust Board papers complete with performance reports are available on the LCHS public website here.
Part 2: Priorities for improvement and statements of assurance from the board

This quality account demonstrates the trust’s achievements for the year 2018/19, describes the areas where the LCHS would still like to make improvements and outlines its quality objectives for the coming year.

The quality account priorities for 2018/19 were discussed and agreed with the LCHS Trust Board, Quality and Risk Committee, patients, stakeholders and staff groups. They were chosen in consideration of the national audit recommendations, local prevalence, feedback from Healthwatch Lincolnshire and input from commissioners.

All quality priorities have been monitored throughout the year via the trust’s Quality and Risk Committee, and the LCHS operational plan.

The following section of the quality account describes how the trust performed against each of those quality priorities set. LCHS has made significant progress against the four 2017/18 quality priorities. Two of these have been fully achieved within the last year and whilst the ambitious targets set by the trust have not yet been fully met for the other two priorities work continues to achieve these.

### Priority 1: Leg ulcers

Improving outcomes for patients with leg ulcers

**Senior Lead:** Head of Clinical Services South  
**Progress:** Target achieved fully

**Why did the trust choose this priority?**

Venous leg ulcers are estimated to affect around 1 in 500 people in the UK although they become much more common with age. It is estimated that around 1 in 50 people over the age of 80 has a leg ulcer. Management of leg ulcers represents a major component of the community nursing workload and has a major impact on patient’s lifestyle both psychologically and socially.

**How did the trust plan to address this priority?**

The trust’s aim was to ensure that at least 50% of patients were healed within a 12 week pathway. It planned to achieve this by improving the skills and knowledge of staff to undertake a review of treatment plans and their effectiveness. Self-care was also to be promoted wherever possible through individual management plans.

**How has the trust measured progress?**
Following successful outcomes demonstrated by a pilot scheme in the south of the county it was agreed that a new approach would be adopted across the remaining teams in the south during 2018/19. This included training leg ulcer specialist nurses and timely intervention whereby stockings were prescribed as the first line of compression treatment. This approach guaranteed compression, enabled self-management and improved the quality of life for patients with venous disease. As a result healing rates improved and reoccurrences decreased. At present, 82% of leg ulcer patients treated in this way self-manage and 90% heal in stockings. The trust’s aim was to ensure that at least 50% of patients are healed within a 12 week pathway. During the time period in areas where the new methodology was implemented 53.67% of patients were healed within 12 weeks.

Based on this learning LCHS leg ulcer clinics now offer:

**A full holistic assessment**: including Doppler assessment within the first 2 appointments to establish the cause of the ulcer as soon as possible, so that immediate treatment and/or referral can be instigated.

*(A Doppler assessment is a test that uses high-frequency sound waves to measure the amount of blood flow through the patients arteries and veins)*

**Continuity of care**: the same one or two nurses assess the leg ulcer 100% of the time; this improves healing rates and increases patient satisfaction.

**Value for money**: with the implementation of the two layer compression hosiery system at an early stage costs can be up to five times less than traditional use of bandages.

**Self care**: patients and families/carers have more control over the care of their leg. This has improved patient satisfaction, promoted self-care and reduced leg ulcer re-occurrence rates.

Although healing rates fell slightly in October, the patients who have care delivered through the new clinic model have demonstrated improved healing rates.

**The trust’s ongoing aims**:
Implementation plans are now being activated to spread this model across teams in the north of the county to ensure the model is ultimately delivered countywide. Teams will be trained and supported by the leg ulcer specialist nurses from the south. The trust anticipates that it will take a further year to fully role out this new effective
model of care in order to achieve a 50% increase in healing within 12 weeks across the whole county.

### Priority 2: Falls prevention

To reduce falls with harm rates in our community hospitals

**Senior Lead:** Ward Manager - Skegness Community Hospital  
**Progress – Improvements made, target not fully achieved**

**Why did the trust choose this priority?**  
Community hospitals form part of LCHS’s transitional care pathway. This leads to challenges on hospital wards as the trust cares for people who are in need of rehabilitation relating to falls and are therefore at higher risk of falling upon the ward.

Falls in community hospitals are benchmarked nationally and measured per 1000 occupied bed days (OBD).

**How did the trust plan to address this priority?**  
The trust’s performance for its rate of falls remains positive with achievement being in line with or better than the national average of 7.5 falls per 1000 OBD. Severity of falls are categorised as causing:

- no harm  
- low harm  
- moderate harm  
- severe harm  
- death

The focus of this priority was to reduce the rate of falls which result in harm within the trusts’ community hospitals by 25%.

The trust planned a number of falls prevention initiatives which included establishing patient focus groups and undertaking a review of each hospital by ward. A falls pathway- to encompass environment assessment, prevention, rapid response and rehabilitation to ensure patients only stayed in hospital as long as they needed to. The trust uses patient experience intelligence and lessons learned to improve the ward environment and patient management.
How has the trust measured progress?

The rate of falls by number, severity and ward is monitored on a monthly basis at the Transitional Care and Community Hospital Quality Assurance Group. Work to focus on overall reduction continues and numbers are lower than same time last year however the trust has not yet achieved the target 25% reduction. The impact of falls (harm rates) remains very low and specific actions to reduce the impact of falls remain the trust’s priority. An improvement rate of 21.5% was achieved as part of this initiative.

The way in which staff report falls has been revised so that a greater depth of information is gathered to include the activity at the time of the fall and where the fall occurred. The additional information allows a further thematic review of falls as a whole in order to identify any correlations or patterns. This reporting template also aims to introduce learning through the inclusion of prompts which encourage staff to think about medication reviews, falls care plan reviews, capacity assessments and appropriate patient footwear.

Learning from falls has been implemented in a variety of ways. One example of this is the “Slippers for Trippers” initiative which involves a stock of appropriate footwear being held in the wards for patients who are admitted without appropriate footwear.

A falls therapy activity programme for the patients has also been introduced. This was designed by the therapy team but involves all disciplines of staff on the ward. The weekly programme involves a slightly different element of care each day that staff will focus on with patients. Each Monday the focus is around movement, Tuesday is cognition and dementia, Saturdays and Sundays are weight and nutrition and on Fridays the focus is specifically on falls prevention.

Another common sense initiative which the trust has implemented is the emergency stock of walking aids at all its community hospitals. Sometimes, due to lack of space on patient transport, patients are transferred from an acute hospital setting to an LCHS community hospital without their walking aid which arrives later. The absence of this aid, even for a short time period, can obviously lead to a higher likelihood of the patient falling. In order to address this staff now request the dimensions of the patient’s issued walking aid at the time of referral into the community hospital. A small stock of walking aids is held at each site which enables ward staff to have an appropriately sized walking aid ready in case the patient arrives without their own.
The trust took part in the 2018 National Audit of Inpatient Falls [https://www.hqip.org.uk/wp-content/uploads/2018/02/national-audit-of-inpatient-falls-audit-report-2017.pdf](https://www.hqip.org.uk/wp-content/uploads/2018/02/national-audit-of-inpatient-falls-audit-report-2017.pdf) and the results have been implemented through an action plan that is monitored through the quality assurance group. Part of this includes an audit to evaluate effectiveness of the actions implemented. The trust is also participating in the 2019 National Audit which is taking place between January and June 2019.

**The trust's ongoing aims:**
Work continues to prevent patient falls within our community hospitals.

Further initiatives are being undertaken:

- a programme of training on personalised care planning
- a review of the use, provision and training on falls sensors
- the introduction of an enhanced care policy to support review and falls care planning on admission and during the patient’s stay on the ward
- the revision of the documentation to collect better falls information on referral to the ward
- the introduction of a patient leaflet into the acute trust to give patients and carers a better understanding of the care they will receive when they are transferred into a community hospital ward.

**Priority 3: Pressure Ulcers – Further reducing harm from preventable pressure damage**

**Senior Lead:** Head of Clinical Quality East

**Progress – Improvements made, target not fully achieved**

**Why did the trust choose this priority?**
LCHS continued to see an improvement in the management of pressure ulcers during 2017/18 both in terms of care delivered and accuracy and scrutiny of reporting. The incidence of all pressure ulcers grade 3 and 4 increased slightly from 203 in 2016/17 to 205 within 2017/18. This is within a context of teams needing to respond to the increasing complexity and high levels of frailty in patient groups.
The trust’s focus for 2018/19 has been to take a more holistic approach, exploring all the determinants of frailty, to address the impact of these factors on skin damage both from an educational perspective but also enable individualised plans of care to be implemented to address unique patient need.

LCHS has been working with partners on the prevention on inherited damage. There was a slight reduction in the incidence of grade 3 pressure damage from 194 grade 3 pressure ulcers in 2016/17 to 187 in 2017/18. During the same time period grade 4 damage has risen from 9 in 2016/17 to 18 in 2017/18 however 50% of all damage remains unavoidable. Reductions in the incidence of pressure damage at all grades and specifically in relation to avoidable pressure damage, remains a priority.

**How did the trust plan to address this priority?**

LCHS has embedded into practice a thematic review process as part of the trust’s investigation process. Teams spend an increasing amount of time supporting care of pressure damage patients inherited from other Lincolnshire providers and patients not known to any care services.

LCHS Neighbourhood Teams will continue to be an expert provider of pressure ulcer care within Lincolnshire and support other providers to improve their pressure ulcer management of patients impacting on improved patient outcomes.

The focus has been to further reduce harm from preventable pressure damage by 50%.

**How has the trust measured progress?**

In 2017/ 2018 there were 84 grade 3 and 4 avoidable incidences of pressure damage making the 2018 / 2019 50 % reduction target 42. This highly ambitious target achieved a 38% reduction against the 50% target. The Trust continues to be highly effective in delivery of pressure ulcer management and remains considerably below both national benchmarks for community services and community hospitals.

Pilot sites have seen positive outcomes both in terms of increased staff confidence and competence and a reduction in pressure damage incidence.

Positive practice includes evidence of increased professional curiosity and partnership working. The information and education APP developed as part of the ‘stop the pressure’ initiative [http://nhs.stopthepressure.co.uk/](http://nhs.stopthepressure.co.uk/) has now been downloaded onto staff work mobile phones.
Teams continue to see reductions in incidences of grade 3 and 4 pressure ulcers with a quarterly average number of 15. If LCHS continues to see this rate in Q4 the overall potential reduction for the past year would be 25%. This is behind the target set but significantly lower rates than in prior years.

**The trust’s ongoing aims:**
LCHS will continue to ensure that reductions in the incidence of pressure ulcers grade 3 and 4 are seen consistently across the county. Community teams will participate in county wide pressure thematic review meetings to enable further sharing of good practice and lessons learnt.

### Priority 4: Medicines management – Improving medicines safety for our patients

Senior Lead: Medicines Management Officer & Head of Clinical Quality West

**Progress – Improvements made, target not fully achieved**

**Why did the trust choose this priority?**
Throughout the year 2017 / 2018 there was a reduction in total medicines errors to 204 when compared with the previous year 2016 / 2017 figure of 213.

In total there were 14 harm errors, 190 no harm errors and 156 medicines related incidents across all service areas.

In 2018 – 2019 LCHS’ emphasis has been on delivering improved medicines management standards and addressing the medicines errors that could be eliminated as a result of better checking processes.

Throughout the year 2018 / 2019 there have been a total number of 167 medicines errors. Of these there were 28 low harm errors (requiring additional monitoring) and 139 no harm errors.

There has been a 18% reduction in errors when measured against 2017 / 2018 data in addition to a 16% increase in incidents reported (incidents reported in 2018 / 2019 totaled 525 whilst in 2017/2018 the total incidents reported were 442). This demonstrates an increased level of reporting and vigilance amongst all services.

**How did the trust plan to address this priority?**
The focus has been to improve medicines safety for our patients by 25% against
the base line figure of 204.

Support has been offered through clinical practice, both face to face in the clinical setting and through mandatory training sessions. Peer to peer audit and a quality improvement plan has informed the improvement around standards and medicines safety.

Emphasis has been given to the safe and secure management of controlled drugs. A new process of supply for Out of Hours services has been introduced and monitored closely.

A more robust process for management of medication errors has been implemented with direct support provided to individuals and services. Action plans have been initiated in services and the development of a local link nurse framework has provided more local service level ownership of medicines management.

**How has the trust measured its progress?**

To date this quality priority target has only been partially met. An improvement rate of 19% was achieved against the 25% target.

The quality improvement priorities for the Trust will continue to be reducing patient harm, even though our performance remains to be positive and effective. In 2019 / 20 new and innovative ways of improving medicines and falls management will continue with continued consideration of national learning and new recommended practices and patient feedback on experience.

Specific actions have been put in place to achieve this quality priority target including local medicines training for specific teams and the reintroduction of medicines updates into the staff annual mandatory training programme with particular emphasis given to administration and checking processes.

Medicines management training is undertaken at induction, for new starters and for those returning to practice.

Clinical supervision is being delivered using real time local errors for scenario discussions and peer medicines supervisors have been adopted within one community hospital setting.

There is a continued focus on the promotion of self-care empowering and patients
and carers to learn to safely and effectively administer their own medication where appropriate.

All medicines errors have been triangulated with the ‘Eight rights of medicines administration' which will provide direct impact on support and provision for the next year.

Eight Rights of Medication Administration

1. Right patient
   - Check the name on the order and the patient.
   - Use 2 identifiers.
   - Ask patient to identify himself/herself.
   - When available, use technology (for example, bar-code system).

2. Right medication
   - Check the medication label.
   - Check the order.

3. Right dose
   - Check the order.
   - Confirm appropriateness of the dose using a current drug reference.
   - If necessary, calculate the dose and have another nurse calculate the dose as well.

4. Right route
   - Again, check the order and appropriateness of the route ordered.
   - Confirm that the patient can take or receive the medication by the ordered route.

5. Right time
   - Check the frequency of the ordered medication.
   - Double-check that you are giving the ordered dose at the correct time.
   - Confirm when the last dose was given.

6. Right documentation
   - Document administration AFTER giving the ordered medication.
   - Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that
needed to be checked before giving the drug.

7. Right reason
   - Confirm the rationale for the ordered medication. What is the patient’s history? Why is he/she taking this medication?
   - Revisit the reasons for long-term medication use.

8. Right response
   - Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant?
   - Be sure to document your monitoring of the patient and any other nursing interventions that are applicable.

Mandatory training continues to include a medicines management based on the trends through the year.

Competency packages are now in place with an expectation that these will be completed annually as toolkit for support and reinforcement of good practice.

The trust’s ongoing aims:
This objective will continue to be an area of focus in 2019/20. Monthly thematic reviews have been introduced in order to provide greater understanding / ownership and share learning from errors more widely across the trust.

Medicines management is now a feature within staff mandatory training and training will be based on any trends identified from the previous year’s errors using examples and scenarios as case studies.

‘Champion’ roles are being developed to support the flow of communication of information. LCHS enforces the message that medicines management is everybody’s business however having a ‘champion’ will support the flow of communication and provide a ‘go to’ person within each service for support.

A staff engagement survey has been conducted to better understand the factors that can influence errors. This has resulted in a number of recommendations that will be implemented particularly around the provision of improved training and support. This engagement with staff will be undertaken regularly and evaluated against medication error data.
The use of the ‘8 rights of medicines administration’ a basic aide memoire tool is being continually highlighted through all services. Benchmarking demonstrates that LCHS are a high reporter of incidents with a low rate of errors however it is clear that with increased vigilance that some further errors could be eradicated.

In 2019-20 LCHS will deploy new quality priorities with a different focus. However the 2018-19 priorities will remain key for staff. Work on service improvements in these areas and evaluations of outcomes is ongoing and will continue to support and influence care provision.

### 2.1 2019-20 priorities for improvement

The trust is continually striving to improve the quality of the services it provides and to learn from things that did not go so well. Following engagement with a wide range of stakeholders, including staff, membership and most importantly patients, the LCHS Trust Board has agreed three new quality improvement priorities for 2019/20.

Linking closely with the trust’s strategic objectives, the quality priorities will serve as areas of key focus across LCHS. The priorities are clinically driven and support the three quality domains: Patient Safety, Clinical Effectiveness and Patient Experience. They also align with three of the five the CQC key lines of enquiry: Safe, Effective and Responsive. Progress against these priorities will be reported monthly via the integrated performance report to the trust board.

### Priority 1: Allied Health Professional Services (AHP)

**Outcome Measures** (aim to ensure that all patients admitted onto a community based AHP caseload from April 2019 have mutually agreed outcomes set with their therapist and these are consistently met)

**Senior Lead – head of clinical services AHP’s**

**Why is this a priority?**

It is essential for LCHS to provide high quality safe and personalised care. In order to do this we must be able to measure the impact of the services we provide to ensure we are delivering services that have the best outcomes for patients.

Therapy Outcome Measures (TOMS) is a tool that will enable us to evaluate patient outcomes across five domains – Impairment, participation, activity, wellbeing and carer well-being. Knowledge of how the services and care we deliver impacts on
patients is essential in designing services that best meet the needs of the community and offer value for money, channelling resources into the highest quality and evidence based practise.

Without evidence of our patient outcomes we cannot ensure effective and efficient use of services and we cannot be sure that we are maximising the independence and wellbeing outcomes for all patients. For this reason it is a priority to embed a system of data collection directly related to patient outcomes.

Using TOMS will enable us to benchmark our services against other regions and develop and improve our services appropriately. Having clear, quantifiable data on patient outcomes that can be shared with CQC and commissioners secures the trust’s place as the provider of choice and maps funding directly to the value added for patients. Being able to demonstrate our effectiveness empowers leaders to drive system wide changes and meet the needs of the community.

How will the trust measure this?

TOMS does not set goals that can be achieved/not achieved but provides scores that are a reflection of health and well-being at that point in time

TOMS is designed for baseline and review appointments and without adaptation is difficult to apply to patients that are not reviewed. Capturing outcomes for one-off contacts will require adaptation of the tool which will be best achieved once TOMS is established for those patients for whom the tool more readily applies.

The TOMS systmOne template being implemented by the trust enables the service to separate patients that are expected to deteriorate from those patients that are expected to improve. This is because TOMS scores for certain patient groups are less likely to increase. The trust has set the following target for this quality priority:

- 70% of total patient records audited will have outcome measures documented using service templates based on the Therapy Outcomes Measures (TOMS) evidenced based tool. (All patients will be audited)
- 90% of patients identified as having improvement goals will have increased in score on at least one domain on their TOMs Template at review.
- TOMS data will demonstrate an average improvement in total score at review of 1.5 across all patients at review
- TOMS data will demonstrate an average improvement in total score at review of 2.5 across all patients identified as having improvement goals at review.
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- TOMS data will demonstrate that those patients identified as having maintenance or management of decline goals maintain their baseline TOMS score at review.
- 95% of total patients will have outcome measures documented using service templates based on TOMS or adapted from TOMS

Priority 2: Patients on Macmillan caseload to die in preferred place of death (PPD) as documented on EPaCCS. (Electronic Palliative Care Coordination System)

Senior Lead – matron specialist services

Why is this a priority?
In the last year of life it is important for a patient and those closest to them to have some difficult conversations about their choices and preferences for their care and subsequent death. There is a need for a systematic approach to this; ensuring consistent best practice for patients, families and carers.

How will the trust measure this?
In Lincolnshire the Electronic Palliative Care Coordination System (EPaCCS) template on SystmOne
http://www.eolc.co.uk/uploads/A5-EPaCCS-guidance-V0-3.pdf allows for a coordinated cross organisational approach to documentation of choices and preferences. It allows for evaluation of quality of care by acting as an evidence base for when engaging in difficult conversations and their outcomes. The trust has set the following target for this quality priority:

- 95% patients on Macmillan caseload have an identified place of death documented on EPaCCS.

A monthly joint mortality collaborative is attended by LCHS, ULHT and St Barnabas. This is a committed group established to reduce the summary hospital mortality indicator (SHMI) as it is recognised that there is a risk of elderly patients that are in the last phase of their life being sent to hospital.

A robust process which ensures implementation of the Gold Standards Framework (GSF) will support the LCHS and the wider system in terms of preventing these in
appropriate admissions. The Gold Standards Framework (GSF) is a framework used by health care providers to enable earlier recognition of patients with life-limiting conditions, helping them to plan ahead to live as well as possible right to the end.

Advance care planning, use of ReSPECT and care home education will also in decision making and ensure that end of life patients are not unnecessarily admitted to hospital.

ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person’s care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning.

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**Priority 3: Improving patient access for those with a disability or impairment**

**Senior lead** – Equality & Diversity Manager

**Why is this priority?**

LCHS recognises that every patients accessibility needs are different which is why having detailed, accurate information is so important.

Patient feedback has indicted to the trust that anxiety is already high when accessing health services, particularly for patients with a disability or impairment.

Ensuring that patients can find out how accessible trust sites are before visiting and plan accordingly will provide patients with greater confidence when they need to access LCHS Services.

The introduction of the AccessAble APP across the trust will improve access, help to reduce patient anxiety and improve patient experience overall.

**How will the trust measure this?**

- Q1: Awareness of AccessAble has been rolled out across the trust through internal staff communication channels. This has included a demonstration to trust board and the inclusion of AccessAble information as part of staff
induction and mandatory training. The AccessAble App has been installed all clinical staff work phones and links installed from the LCHS public website

- Q2: Baseline will be established and thereafter monthly reports from AccessAble will provide numbers of times the APP has been downloaded and number of hits of the website thus indicting take up rate.
- A demonstration will be provided at ‘Responsible Together’ in order to further consolidate awareness of AccessAble and reiterate the benefits of promoting its use to LCHS patients.
- Q3: All correspondence to patients will include the AccessAble link.
- Q4: Review of ‘hits’ on the website and App downloads.

Throughout the year continuous patient engagement work will be carried out in order to assess the impact of AccessAble and also better understand patient experience of accessing LCHS services. This will include:

- Working with the AccessAble team in order to gather qualitative data, from those who have used the app, relating to its impact on patient experience.
- Expand the remit of the E&D teams mystery shopper visits to include disabled access, facilities and staff attitude to patients with a disability or impairment.
- Work with the trusts staff and volunteers to better understand experiences and requirements of those with a disability or impairment though staff networks and bespoke focus groups.

The trust wants to ensure that the services it provides and how it provides them is decided with the input and support of all stakeholders. These quality priorities have been chosen as a result of feedback and consultation with those who use, provide, work with and commission services.

Two of the three 2019/20 priorities sit outside mainstream adult community healthcare services (community nursing) but reflect the wide range of healthcare delivered by LCHS by focusing on the trusts therapy and urgent care services. Priority 1 also aims to address the comment made by the CQC during the trusts 2018 well led inspection which was to ensure LCHS continues to raise the profile of its children’s services.

### 2.2 Statements of assurance from the board
Review of services
During 2018-19 Lincolnshire Community Health Services NHS Trust provided and/or sub-contracted 50 relevant health services.

Lincolnshire Community Health Services NHS Trust has reviewed all the data available to them on the quality of care in 50 of these relevant health services.

The income generated by the relevant health services reviewed in 2018-19 represents 100% of the total income generated from the provision of relevant health services by Lincolnshire Community Health Services NHS Trust for 2018-19.

Payment by Results
Lincolnshire Community Health Services NHS Trust was not subject to the Payment by Results (PbR) clinical coding audit during 2018-19 by NHS Improvement as no services are commissioned on a PbR basis.

Participation in clinical audit
To ensure that the services provided by the trust achieve meaningful outcomes for patients and carers, LCHS undertake a range of activities: clinical audit is one. The focus is to ensure that all clinical audit activity results in learning and improvements in care. Participation in clinical audit enables the trust to provide effective, responsive and safe care.

During 2018/19 eight national clinical audits covered the NHS services that LCHS provides. During that period LCHS participated in 100% of the national clinical audits which it was eligible to participate in. The table in Appendix 3 identifies the national clinical audits completed during 2018/19, by service line.

The table shown in Appendix 4 identifies the local clinical audits that were carried out during 2018/19 including the national clinical audits:

National confidential enquiries
None
Local Clinical Audits
All clinical audits that LCHS plans to undertake are registered on the clinical audit registration database. The monitoring of each audit includes results, summary report and action plans. The table in Appendix 5 shows local audits that have been concluded during 2018/19 including the submission of a report and associated action plan. This table does not include audits that will be continued into 2019/20

Participation in clinical research
2157 patients receiving relevant health services provided or sub-contracted by Lincolnshire Community Health Services NHS Trust and the 4 Lincolnshire CCG’s in 2018-19 were recruited during that period to participate in research approved by a research ethics committee.

Proportion of income conditional to Commissioning for Quality and Innovation payments
A proportion of Lincolnshire Community Health Services NHS Trust income in 2018-19 was conditional on achieving quality improvement and innovation goals agreed between Lincolnshire Community Health Services NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018-19 and for the following 12-month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

Care Quality Commission registration
Lincolnshire Community Health Services NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered with no conditions attached to registration.

The trust currently has 20 locations registered with the CQC and is registered to carry out the following activities:
- Personal care
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Surgical procedures
- Family Planning
• Transport services, triage and medical advice provided remotely
• Nursing care

The trust is currently rated as ‘outstanding’ overall and the Care Quality Commission has not taken any enforcement action against Lincolnshire Community Health Services NHS Trust during 2018/19.

Lincolnshire Community Health Services NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period. [http://www.cqc.org.uk/provider/RY5/registration-info](http://www.cqc.org.uk/provider/RY5/registration-info)

**Secondary Uses Service for inclusion in the Hospital Episode Statistics**

Lincolnshire Community Health Services NHS Trust submitted records during 2018-19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics 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:
• 100% for admitted patient care
• 99% for accident and emergency care.

Which included the patient’s valid General Medical Practice Code was:
• 100% for admitted patient care;
• 100% for accident and emergency care.

**Information Governance**

Lincolnshire Community Health Services NHS Trust Information Governance Assessment submission at the end of March 2019 showed 29 of the 32 mandatory assertions as complete. The trust has an improvement plan in place to achieve full compliance and this has been submitted to NHS Digital and approved.

**Payment by Results**

Lincolnshire Community Health Services NHS Trust was not subject to the Payment by Results clinical coding audit during 2018-19 by NHS Improvement.

**Action taken to improve data quality**

Lincolnshire Community Health Services NHS Trust will be taking the following actions to improve data quality:
• teams are responsible for accurate and timely patient record keeping on relevant trust systems
• there will be one agreed version of the truth i.e. indicator source and construct will be clearly defined and consistently applied across formal board and sub committees and trust board
• all KPI achievement reported internally to formal trust board sub-committees and board will be signed-off by the performance team
• all external performance reports will be signed-off by the performance team prior to leaving the organisation

LCHS recognises that it is essential that information which will be used to assure performance is of good quality. Each of the measures is therefore marked on the criteria of timeliness, audit, source/process, validation, completeness and the correct scale or level of detail in a set of data. An indicator can score as insufficient, sufficient or not relevant in each of the areas. These areas make up the sections of the Data Quality Kitemark.

Learning from deaths
During 2018-19, 303 LCHS patients died (these are patients that have died in LCHS community hospitals and the Butterfly Hospice). This comprised the following number of deaths which occurred in each quarter of that reporting period:

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>75</td>
<td>72</td>
<td>79</td>
<td>77</td>
</tr>
</tbody>
</table>

All patient deaths are reviewed. By March 31st 2019, 241 case record reviews had been carried out in relation to the 303 deaths. The remaining 62 cases will be reviewed in Q1 of 2019-2020. There were no instances where circumstances surrounding the patient death suggested that any further investigation was required.

In three cases a death was subjected to both a case record review and a further investigation. This was not because the care was considered suboptimal but to provide the staff involved with a forum to discuss the case in more depth and identify where care delivery could have been better.

0% of the patient deaths during the reporting period are judged to more likely than not to have been due to problems in the care provided to the patient
All reviewed cases have been subject to the following grading system as outlined below. The grading system commences with completion of a Stage 1 template by a clinician in the area in which the patient died. This template is then reviewed by the mortality review group and graded accordingly. Any death which is assessed as falling into either grade 2 or 3 will then be investigated further.

<table>
<thead>
<tr>
<th>Grade 0</th>
<th>Unavoidable death, no suboptimal care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 1</td>
<td>Unavoidable death, suboptimal care but different management would NOT have affected the outcome</td>
</tr>
<tr>
<td>Grade 2</td>
<td>Suboptimal care, but different management <strong>MIGHT</strong> have affected the outcome (possibly avoidable death)</td>
</tr>
<tr>
<td>Grade 3</td>
<td>Suboptimal care, different care <strong>WOULD REASONABLY BE EXPECTED</strong> to have affected the outcome (probable avoidable death)</td>
</tr>
</tbody>
</table>

**LCHS has learnt the following from case record reviews and investigations conducted in relation to patient deaths:**

There continues to be a number of patients that are fast tracked however, due to care packages not being readily available in some areas of the county, patients were not able to die in their preferred place of death.

In terms of documentation there has been an increase in usage of the palliative care and the Electronic Palliative Care Coordination System (EPaCCS) templates following extra training and support provided during 2018-2019.

An audit was undertaken between January-June 2018 and revealed that:

- There were a small number of patients that died within hours of admission and therefore there was not time to instigate a palliative care pathway, however despite this the patients’ needs were met.
- There were two cases where the patient had been admitted for EoL care and then within the mortality review template the narrative suggested that the patient was not EoL and therefore resulted in a lack of instigation of pathway.
- There were no delays once recognition of EoL and withdrawal of treatment to instigation of palliative care template.

It has been demonstrated that some patients have been identified in their end of life (EoL) phase however, this was not imminent and there was no attempt made to discharge the patient to an alternative place of care resulting in some patients...
staying in hospital many weeks before they died. There continues to be a number of patients transferred in from secondary care or home very late on their EoL journey resulting in them dying within a short timeframe after their admission.

**LCHS has taken, or proposes to take, the following actions in consequence of what has been learnt during the reporting period:**

LCHS will continue to identify to commissioners via the CCG representative at Mortality Review Group delayed discharge due to lack of provision of both care packages resulting in patients dying in a place which was not their first place of choice.

With regard to the use of templates the Mortality Review Group will continue to monitor the instigation of templates to ensure that they are being completed as expected. The Mortality Review Group will continue to review length of stay in EoL patients for best use of bed provision, and that patients despite being considered EoL are discharged appropriately.

In terms of late transfer of patients, where the transfer has occurred from the neighbouring acute trust, LCHS continues to highlight these cases at the joint mortality collaborative forum. This forum provides an opportunity for review of these cases in order to improve decision making and ensure patients are transferred earlier. Where it is identified that the late transfer in is from an alternative trust, they will receive feedback via a letter from LCHS outlining concerns.

In addition to reviewing inpatient deaths during 2018/19, where coroner’s enquiries have come onto the organisation with pending inquests these cases have been subject to an investigation to ascertain any root causes and identify lessons learned. One of these cases revealed that when the patient’s carers telephoned the Clinical Assessment Service (CAS) there was no voice recording made of the conversation to support the discussion held to assist decision making process and as a result the importance of using voice recording has been reiterated within the service.

**Freedom to speak up**

Lincolnshire Community Health Services NHS Trust is committed to ensuring the highest standards of service and the highest possible ethical standards. The trust wants staff to feel supported at work and ultimately ensure that LCHS is providing excellent care to patients and their families. The trust recognises that at one time or another staff may have concerns about what is happening at work. Usually these concerns are easily resolved through the line management structure. However when
they are about unlawful conduct, financial malpractice, fraud and corruption, or concerns about the quality of patient care, it can be difficult to know what to do.

In order to support and protect staff in these circumstances LCHS has a comprehensive Speaking Up (Whistle-Blowing) and Speak Up Policy which enables employees to raise concerns at an early stage and in the right way. It also assures employees that any concerns raised will be addressed appropriately. When a member of staff, acting in the public interest, expresses a reasonable concern they will not be penalised in any way. Victimisation by other members of staff towards the employee will not be tolerated under any circumstances. Any such behaviour will be dealt with as a disciplinary offence. The Trust Board is committed to this policy being implemented across the organisation and makes the following assurance to staff.

The policy outlines a number of ways in which staff can speak up including through the trusts Freedom to Speak up Guardian:
The Guardian has direct access to the trust board, and the senior leadership team to ensure that all concerns can be actioned at the appropriate level. The Guardian also has direct access to a non-executive director to ensure that concerns regarding board members could be appropriately managed.

All staff are made aware of the Freedom to Speak up Guardian during their induction and through regular mandatory training updates. The trust works hard to ensure the Freedom to Speak up Guardian remains visible and accessible and contact details are promoted regularly to staff through all internal communication channels including staff social media platforms, intranet, team brief, weekly update, service line bulletins and the Chief Executives Friday email. The Freedom to Speak up Guardian regularly attends team meetings and staff engagement events such as ‘Responsible Together’ and the Urgent Care Out of Hours Information and Education events.

The LCHS Freedom to Speak Up Guardian reports regularly into The National Guardian’s Office which is an independent, non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes business as usual. The office is not a regulator, but is sponsored by the CQC, NHS England and NHS Improvement.

LCHS is committed to an open and honest culture and the trust wants to ensure that the concerns of staff are investigated and that staff are offered and have access to the support they need. Feedback is an important part of this culture. The afore
mentioned ‘Speaking Up (Whistle-Blowing) and Speak Up Policy’ outlines the full whistleblowing process which can be seen here.

This includes the trusts commitment to:

- act promptly and notify the member of staff of the action taken
- to keep the individual(s) regularly informed of the process and progress of any investigation and provide feedback to the individual and
- ensure the whistle-blower has access to mediation, mentoring advice and confidential counselling should this type of support be required

2.3 Reporting against core indicators

Since 2012/13 all NHS trusts have been required to report performance against a set of core indicators using data made available to them by the Health and Social Care Information Centre. Many of the core indicators are not relevant to community services. Those that are applicable to us at Lincolnshire Community Health Services NHS Trust are shown in the table below.

<table>
<thead>
<tr>
<th>Prescribed Information</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. 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 family or friends.</td>
<td>76%</td>
<td>85%</td>
<td>85%</td>
</tr>
</tbody>
</table>

LCHS considers that this data is as described for the following reasons:
The drop in 2016/17 was potentially attributable to a number of factors: increased pressure on the NHS, a significant transformation programme across most areas of organisation, a shift in leadership style, contraction of the size of the organisation and much more focus on working more across the system (STP) and the introduction of a new set of organisational values, ‘the LCHS Way’. The improvements in 17/18 were consistent with a large numbers of interventions (listed below). The results for 18/19 are particular pleasing considering the challenging STP environment, but align well with the CQC ‘Outstanding’ report and keep LCHS 4% higher than the Community Trust benchmark.

LCHS has taken actions to improve this percentage score, actively continuing to engage with staff and to build upon our robust staff engagement programme:
Following a reduction in our scores between 2015 and 2016, LCHS embarked on
a clear strategy to improve how it engages with its staff and improve the SFFT score: this included and was not exhaustive to:

- A quarterly meeting with 100 leaders to discuss how to engage with staff
- A new leadership development programme for Band 7+ leaders, with staff engagement central to its core DNA (Responsible Together)
- Leadership development for 1st time and aspiring leaders
- Active/innovative recruitment campaigns to fill vacant posts
- New ways of communicating with staff including social media
- Greater devolvement of budgets and empowerment to managers
- Greater engagement with staff and patients on service re-design
- New ways of staff being able to innovate
- SFFT data being owned at local service line level though the Quality Assurance Managers
- Team Development
- Values Based Recruitment
- Revised Reward and Recognition, informed by staff

In 2019 LCHS is going to calibrate patient and staff FFT data to help us better make the connection between happy staff and happy patients. In addition, from Q4, the trust will also be gathering morale data alongside the SFFT in order to more fully to understand how staff are feeling and respond accordingly.

**Comparative data**

Community Trusts: 18/19 (based on Q1, Q2, Q3) – 81%. LCHS remains 4% higher than the Community Trust benchmark.

<table>
<thead>
<tr>
<th>Prescribed Information</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. <strong>The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.</strong></td>
<td>98.97%</td>
<td>97.76%</td>
<td>100%</td>
</tr>
</tbody>
</table>

LCHS considers that this data is as described because the trust has trained its staff well and has clear clinical policies.

LCHS has taken actions to improve this percentage score and so the quality of its services by the routine reporting through our patient safety thermometer and venous thromboembolism cases to ensure any learning is shared throughout the organisation.
### Prescribed Information

<table>
<thead>
<tr>
<th>25.</th>
<th>The number and where available, rate of patient safety incidents that occurred within the trust during the reporting period. The percentage of such patient safety incidents that resulted in severe harm or death.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016/17</td>
</tr>
<tr>
<td></td>
<td>3349</td>
</tr>
<tr>
<td></td>
<td>0.3%</td>
</tr>
</tbody>
</table>

The NRLS reports are received approximately 5 months after the reporting period. So the second six months in this period are estimated based on the current upload figures to the NRLS.

LCHS considers that this data is as described for the following reasons: LCHS has a culture of high reporting of clinical incidents as reported by the national reporting and learning scheme. There has been a focus during the year on maintaining reporting rates.

LCHS has taken actions to improve this rate and so the quality of its services by developing a supportive reporting culture and ensuring that lessons learned from clinical incidents are shared across the organisation.

**Comparative data:**
The National Reporting and Learning Systems (NRLS) cluster group for NHS community trusts was formed following the formation of new NHS organisations as a result of the transforming community services programme. Due to structural changes within these organisations, many no longer having inpatient services and the provision of diverse services between them mean this cluster cannot be described as a homogenous group. A comparative reporting rate per 1000 bed days is not appropriate within this cluster and comparing organisations based on this rate will be misleading. Therefore no reporting rate will be calculated for this cluster.
Part 3: Core Standards and Metrics

This section of the Quality Account provides trust performance information against quality and performance indicators agreed internally by LCHS and also performance against relevant indicators and performance thresholds set by regulators including NHSI and the CQC.

3.1 Quality of care metrics

Written complaints rate:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Datix</th>
<th>KO41 (submitted to NHS Digital)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>45</td>
<td>46</td>
</tr>
<tr>
<td>Q2</td>
<td>44</td>
<td>45</td>
</tr>
<tr>
<td>Q3</td>
<td>49</td>
<td>49</td>
</tr>
<tr>
<td>Q4</td>
<td>53</td>
<td>53</td>
</tr>
</tbody>
</table>

Staff Friends and Family test (SFFT):

<table>
<thead>
<tr>
<th>2018/19</th>
<th>Care/Treatment of Patients</th>
<th>Place to Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>87%</td>
<td>71%</td>
</tr>
<tr>
<td>Q2</td>
<td>87%</td>
<td>70%</td>
</tr>
<tr>
<td>Q3*</td>
<td>81% (Contained in National Staff Survey 2018 results)</td>
<td>65%</td>
</tr>
<tr>
<td>Q4</td>
<td>85%</td>
<td>65%</td>
</tr>
</tbody>
</table>

*National Staff Survey results for SFFT are historically lower than Q1, Q2 and Q4 by comparison. The table below shows how LCHS is performing on the National stage,
demonstrating how LCHS has improved for the 3rd year in succession (Q21c and Q21d) and are 'above average' when benchmarked against all Community Trusts.

The NHS Staff Survey:
The NHS Staff Survey, which all staff members were invited to complete between October and November 2018, gives an opportunity for everyone to share how they feel about working for the trust. It is independently organised to ensure responses are anonymous on behalf of LCHS by an organisation called the Picker Institute Europe.

The overall response rate in 2019 was 55% - higher than the 53% national average for community trusts but 5% less than we achieved last year. The responses give the trust an important indication of what it feels like to work here and helps leaders to focus their efforts on the areas that need improvement not only for staff but also for our patients and carers.

This year’s results are summarised into 10 new themed areas and we are benchmarked against other community trusts.

The Table below shows how LCHS has performed in the new 10 themes (replaced 32 Key Findings from 2017); better than average in 7, average in 2 and worse than average in 1.
Of the 10 areas, LCHS’s scores have improved in eight areas, with significant improvement in three of those, and have declined in one area (Safe Environment – Bullying/Harassment). The theme of Safe Environment – Bullying/Harassment is made up of three questions which refer to the public, managers and colleagues. The 10th theme of morale is a new theme for 2018 and LCHS is above the average score.

The trust has a ‘best’ score for community trusts in one theme (Appraisals). Within individual questions, staff responses gave us a ‘best’ score compared with other community trusts in six questions, which are listed below as our top scores. LCHS also saw significant year-on-year improvement in the score given for ‘communication between senior management and staff is effective’ and ‘senior managers try to involve staff in important decisions’.

The 2019 results show improvement across a significant number of themes. The trust was disappointed to see an increase in the number of staff experiencing bullying, harassment or abuse at work. This is unacceptable and will not be tolerated at any level. The LCHS Trust Leadership Team has emphasised that any member of staff experiencing these issues to raise them through line managers or through the Freedom to Speak Up Guardian.
Occurrence of any Never Event

Never Events are adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.

A ‘Never Event’ has the potential to cause serious patient harm or death. They provide an essential lever to improve patient safety by learning from events to prevent future harm. LCHS has a strong track record of low levels of ‘Never Events’. There have been no never events recorded at LCHS for the year to date.

Patient safety Alerts not completed by the deadline

In the year to date there have been eight patient safety Alerts issued. LCHS reviews the alerts through the Safeguarding and Patient Safety Group to ascertain if they are relevant to LCHS and, if so, allocate a lead and monitor the action plans to completion.

All the alerts were acknowledged within the 48 hour timescale. Of the eight alerts:

- Three were not relevant and have been closed down within the timescales
- Three have had action plans in place to implement the alert recommendations, the action plans have been monitored and completed and the alerts have been closed within the timescales
- Two have action plans that are being monitored and are within the timescales for closure

Patient Friends and Family Test (FFT)

Friends and Family Test (FFT) responses form an important part of the patient experience intelligence gathered by the trust however within the patient and public involvement (PPI) plan LCHS has implemented a number of methods of engaging with patients in order to supplement this data with a richer patient feedback.

The table below shows the percentage of patients that would currently recommend LCHS services

<table>
<thead>
<tr>
<th>Month</th>
<th>Recommended</th>
<th>No of Responses</th>
<th>Likely</th>
<th>Unlikely</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-18</td>
<td>92%</td>
<td>1274</td>
<td>1171</td>
<td>33</td>
<td>69</td>
</tr>
<tr>
<td>May 18</td>
<td>93%</td>
<td>1441</td>
<td>1346</td>
<td>33</td>
<td>62</td>
</tr>
</tbody>
</table>
FFT response comments are reviewed at service level and triangulated with other sources of patient experience intelligence in order to identify themes and establish actions for improvement. The focus for this year will be to increase FFT response rates by the introduction of SMS automation across additional LCHS services which will allow patient to respond to the FFT survey via text message.

### 3.2 Finance Metrics - Single Oversight Framework

#### Financial Rating

The aim of the ‘Single Oversight Framework’ is to help providers attain, and maintain, CQC ratings of ‘Good’ or ‘Outstanding’. The framework was introduced from 1st October 2016, at which point the Monitor ‘Risk Assessment Framework’ and NHS Trust Development Authority’s ‘Accountability Framework’ ceased to apply.

The framework is used to identify NHS providers’ potential support needs and to segment trusts according to the level of support required, with signposting and offer (or mandate) of tailored support as appropriate. This segmentation is informed by data monitoring and judgement of providers’ circumstances against five themes, however only three of the themes have indicators relating to LCHS (Leadership and Improvement, Quality of Care and Finance and Use of Resources). Each of the themes has trigger points, which impact on the segmentation of the trust. NHSI publish segmentation outcomes on a monthly basis (see most recently published performance below), and have consistently assessed the trust as 1 – “no evident concerns”. As such, review meetings with NHSI are held on a quarterly basis.

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun 18</td>
<td>96%</td>
<td>1404</td>
<td>1341</td>
<td>26</td>
<td>37</td>
</tr>
<tr>
<td>Jul-18</td>
<td>96%</td>
<td>1443</td>
<td>1383</td>
<td>22</td>
<td>38</td>
</tr>
<tr>
<td>Aug-18</td>
<td>96%</td>
<td>1133</td>
<td>1083</td>
<td>24</td>
<td>26</td>
</tr>
<tr>
<td>Sept-18</td>
<td>95%</td>
<td>1152</td>
<td>1091</td>
<td>26</td>
<td>35</td>
</tr>
<tr>
<td>Oct-18</td>
<td>94%</td>
<td>1400</td>
<td>1322</td>
<td>39</td>
<td>39</td>
</tr>
<tr>
<td>Nov-18</td>
<td>96%</td>
<td>1210</td>
<td>1161</td>
<td>21</td>
<td>28</td>
</tr>
<tr>
<td>Dec-18</td>
<td>96%</td>
<td>972</td>
<td>930</td>
<td>19</td>
<td>23</td>
</tr>
<tr>
<td>Jan – 19</td>
<td>94%</td>
<td>1361</td>
<td>1284</td>
<td>19</td>
<td>58</td>
</tr>
<tr>
<td>Feb –19</td>
<td>94%</td>
<td>971</td>
<td>912</td>
<td>23</td>
<td>36</td>
</tr>
<tr>
<td>Mar -19</td>
<td>96%</td>
<td>1135</td>
<td>1084</td>
<td>25</td>
<td>26</td>
</tr>
</tbody>
</table>
Of the 226 trusts operating under the framework, the overview of segmentation by type is as below (as at 09 April 2019); Lincolnshire Community Health Services NHS Trust is one of only 41 trusts in segment 1.

<table>
<thead>
<tr>
<th>Segment</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>13</td>
<td>63</td>
<td>54</td>
<td>17</td>
<td>147</td>
</tr>
<tr>
<td>Ambulance</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Care Trust</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Community</td>
<td>9</td>
<td>8</td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>Mental Health and Learning Disability</td>
<td>17</td>
<td>27</td>
<td>3</td>
<td>1</td>
<td>48</td>
</tr>
<tr>
<td>Grand Total</td>
<td>41</td>
<td>107</td>
<td>59</td>
<td>19</td>
<td>226</td>
</tr>
</tbody>
</table>

3.3 Operational Performance Metrics:

A&E Maximum waiting time
The trust is required to achieve a target of 95% of urgent care attendances where the service user was admitted, transferred or discharged within 4 hours of their arrival at an urgent care department. The Trust consistently achieves the 95% target.

3.4 Organisational health indicators:

Staff Sickness
Sickness absence across the organisation continued to increase during the months of December and January, although February has decreased to 4.88%. Short term sickness remained above the 1% target during this quarter; with long term absence also being above the 3% target in December but reducing below this in January and February.

Anxiety, stress and depression remains the top reason for long term sickness and is consistently within the top 3 reasons for short term sickness absence. Following a review of the BUPA Healthy Minds service, the contract for the Employee
Assistance Programme (EAP) has been renewed for a further 12 months, up to 1st November 2020.

The Workforce team continue to work collaboratively with Heads of Service, Matrons and Clinical Team Leaders, to support managing sickness absence, through monitoring of trends and regular discussion. Additional training is being provided to leaders in relation to attendance management where development gaps are identified. Return to work completion rates, whilst improving, remain an area requiring further improvement.

**Staff turnover**

The graph above shows the total staff turnover and staff turnover excluding TUPE. Rolling 12-monthly turnover decreased from 11.7% in January 2019 to 11.5% in February 2019.
Proportion of temporary staff

![Proportion of Temporary Staffing Costs](image)

The trust is required to ensure that temporary staffing costs do not exceed 5%. This information includes spend on agency and bank staffing but excludes any external medical staffing figures. February has seen a 2.6% increase to 5.8% which is slightly above target, due to a reclassification of external staffing as agency. Continued monitoring is taking place to ensure that staffing costs stay below the 5% target.

3.5 Additional quality and performance information:
In addition part 3 of the LCHS quality account provides greater detail in relation to:
- Duty of Candour
- Patient Experience - Patient and Public Involvement
- Care Quality Commission (CQC)
- Sustainability and Transformation Partnership (STP)
- Quality and Risk Board Assurance Group

LCHS has an established a performance management framework which includes a monthly integrated performance report to the Trust Board. The content of the integrated performance report is reviewed and approved each year by the quality and risk committee and the finance, performance & investments committee on behalf of the Trust Board. This includes all regulator targets as defined within the well-led framework, plus locally agreed indicators. The performance report for the 2018/19 reporting period can be found in the LCHS Annual Report 2018/19 [https://www.lincolnshirecommunityhealthservices.nhs.uk/about-us/our-publications/annual-reports](https://www.lincolnshirecommunityhealthservices.nhs.uk/about-us/our-publications/annual-reports)
Duty of Candour – Open and Honest Care Policy

The NHS Constitution for England 2009 states:
“The NHS also commits when mistakes happen to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively”

Lincolnshire Community Health Services NHS Trust is committed to the provision of high quality health care. As part of this objective, the trust has a duty to limit the potential impact of clinical and non-clinical risks and put in place robust and transparent systems to make sure that all incidents which might cause actual or potential harm to patients, visitors and staff are identified, investigated and rectified, with lessons learnt identified.

The effects of harming a patient can be widespread and can have devastating emotional and physical consequences for patients, their families and carers as well as being distressing for the professionals involved. LCHS promotes a culture of openness which recognises that truthfulness is a prerequisite to improving the safety of patients, staff and visitors as well as the quality of healthcare systems. This involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment, wherever they have received care from the trust. It also involves apologising and explaining to staff or visitors who have suffered harm. It encompasses communication between healthcare organisations, healthcare teams and/or their carers, staff and visitors and makes sure that openness, honesty and timeliness underpins responses to such incidents.

The trust implements an ‘Open and Honest Care’ policy which provides a best practice framework to create an environment where patients, their families and carers, healthcare professionals and managers all feel supported when care goes wrong and have the confidence to act appropriately.

To communicate this framework to patients and the public LCHS has developed a duty of candour patient information leaflet which outlines the trust’s commitment to provide open and honest care.

For more information on the trust’s open and honest care policy click the link here

Patient Experience

LCHS is committed to being responsive to the needs and wishes of the Lincolnshire population, all of whom will use its services at some point in their lives. Under the
objective of providing high quality, safe personalised care the trusts aim is to deliver service improvement that stems from feedback from partners, patients and carers.

2018-19 has seen a concerted effort to ensure that PPI adds value and is meaningful with the Quality, Equality & Diversity (E&D) and Engagement Teams working in collaboration to achieve this. The establishment of a sub group which meets monthly to focus on patient experience has proved invaluable allowing the opportunity to triangulate patient intelligence and design an approach to PPI which is consistent across LCHS and yet allows for the diversity of the very different services the trust provides.

Listening to and learning from our patients has been reinforced as a priority at service line level and there is a renewed understanding of the value of PPI and this was reflected in the recent CQC feedback:

“The trust had a structured and systematic approach to engaging with staff patients, relatives, carers and stakeholders. Services were developed with full participation of those who use them, staff and external partners, as equal partners.”

LCHS has developed a robust patient and public involvement programme which includes a range of proactive activity based on patient experience intelligence gathered to date and the space and flexibility to include additional reactive activities throughout the year. PPI highlights from 2018-19 and key priorities for the coming year 2019-20 are outlined for each service line below;

**Urgent Care (UC)**

**2018 - 19 Achievements:** Patient intelligence suggested that access to UC could be an issue for patients particularly within the Eastern European community. In response to this the service worked in collaboration with the E&D Team to develop and undertake language and communication access visits. These ‘mystery shopper style’ visits have been delivered across urgent care sites and have tested the service’s ability to communicate with patients who do not use English as their first language. As a result of this work significant improvements have been made with regard to signage to assist patients in accessing translation services when booking in at reception and the education of front line staff on how to access translation services.
In addition to this equality and diversity champions have been identified at a number of urgent care sites and much work has been done by the E&D team in engaging with Eastern European communities about appropriate use of urgent care services.

**2019-20 Priorities:** “Staff attitude & behaviour” has been a theme identified this year from the UC Family and Friends Test (FFT) detractors. Over the next year a key area of focus for the service will be to compare staff and patient FFT results, highlight any areas of patient dissatisfaction that correlate with low morale in the workforce and undertake work to address this.

**Integrated Community Teams, Allied Health Professionals and Specialist Services including the Lincolnshire Integrated Sexual Health Service (LISH)**

**2018 - 19 Achievements:** Although FFT returns have increased significantly this year in community services this method of capturing feedback still only reaches a small percentage of patients. Therefore the above services take a very proactive approach to gathering patient intelligence. 15 steps has been an important PPI tool this year with 8 visits taking place across a wide range of services. In addition the services have gathered intelligence using a range of patient experience interviews and satisfaction surveys:

Whilst much of the feedback gathered was positive this activity enabled the services to share good practice across the organisation as a whole. Using an ‘experience based co design’ (EBCD) approach to patient interviews, which allows patients to share their stories rather than answering prescriptive questions, meant that the quality team identified some small improvements that made a big difference to patient experience. One example of this was that cardiac rehab patients would like relatives/carers to be more involved in their recovery programme. Patient feedback relating to this service is predominately positive and it is unlikely that this feedback would have been picked up through other methods of gathering patient experience. The service has since reviewed the new patient invitation and this now encourages a partner/relative/friend/carer to attend weekly with the patient.

**2019 - 20 Priorities:**
Patient satisfaction surveys will be undertaken across the 12 integrated care teams. Questions will be developed based on the intelligence gathered through 2018 - 19 PPI work and enable the service to drill deeper in specific areas. The Lincolnshire Integrated Sexual Health (LISH) service plans to undertake a bespoke piece of PPI activity to assess how patients are finding access to the service. This will follow up
on concerns that were raised in 2018 - 19 and establish whether the subsequent actions taken have successfully addressed the issue.

**Community Hospitals**

**2018-19 Achievements:** As with the other community services the Community Hospitals also take a proactive approach to gathering patient intelligence and testing out subsequent improvements.

A key achievement this year was the re design of Scarbrough Ward at Skegness Hospital to ensure it was dementia friendly. This was done in partnership and co-produced with patient, carers, LCHS staff and other health professionals.

Scarborough ward had a PLACE (patient led assessment of the care environment) audit undertaken by a team including volunteers, service users and members of the public. The audit findings reported that the environment failed to meet the needs of patients with dementia. This led to a service transformation and redesign.

A wide range of stakeholders including the carers and families of LCHS patients were interviewed. This provided data and insight from multiple areas and involved those who deliver the service as well as those in receipt of care on the ward. Members of the multi-disciplinary team (MDT) including a social worker, nurse, mental health nurse, administrator, physiotherapist, occupational therapist and student nurse were also asked to feed in their views and suggestions which added professional insight. Engagement with stakeholders continued whilst changes to the ward were being made. Families, carers, patients and staff were involved at every step of the project which allowed the service to continuously test whether the redesign was meeting needs and improving patient experience.

**2019 – 20 Priorities:** A variety of activities are planned for the forthcoming year:

- Patient satisfaction surveys across wards and outpatients to allow benchmarking
- 15 steps visits with particular focus on areas where changes to service delivery are planned or have been implemented (e.g.) County Hospital Louth
- Exploring innovative/effective ways in which to gather patient experience within Assertive In Reach (AIR) team and transitional care beds.
- Working with patients to improve patient literature
- Working with the families of patients in community hospitals on the use of technology to aid communication
PPI remains a priority for the trust and our on-going aims include:

- Encouraging and supporting greater use of the ‘Experience based design’ approach to involvement and introducing the concept of ‘Always Events’ to services.
- Analysis of Patient FFT and Staff FFT side by side to identify correlations

To ensure the patient voice is heard and considered at all levels of the trust LCHS has a Patient, Public, Staff and Stakeholder Engagement Group (PPSSEG). The group is appointed by the leadership team and chaired by the director of operations AHPs & nursing in order to seek assurance on trust activity in terms of patient, public, staff and stakeholder engagement. PPSSEG has implemented and monitors this activity through the Stakeholder Engagement and Involvement Workplan. PPSSEG reports into the Quality and Risk Committee on a monthly basis to demonstrate effective internal control.

Stakeholder Engagement:
In addition to the aforementioned activity to involve patients much work has taken place during 2018 to further embed engagement / consultation with wider stakeholders as part of service development and change. Some examples of this include;

- Development of the trusts 2018/19 quality priorities
- Changes to location of service delivery due to the estates rationalisation programme
- Stakeholder engagement to support growth of the wider neighbourhood working network
- Involvement in system wide engagement to support STP Acute Services Review consultation
- Support to the CCG led engagement around reconfiguration of inpatient services at County Hospital Louth.

The trust has this year demonstrated consistent compliance with its statutory duty to engage/consult but also a commitment to the best practice approach of continuous engagement. This was reflected in the CQC feedback:

“There were consistently high levels of constructive engagement with staff, people who use services and external stakeholders. The chief executive and chair were proactively working to collaborate and build relationships with external partners.”

There is still work to do in this area and the year ahead will see a continued focus on the following:
Quality Account 2018-19

- ‘Closing the loop’ by revisiting patient experience once quality improvements have been made
- Increased patient and public involvement and representation at all levels of the trust.
- Identifying opportunities for co-production
- Further embedding a business as usual approach to involving patients and carers in service delivery changes or new service models
- Support of engagement/consultation requirements within STP work streams

Care Quality Commission (CQC)

As a result of the last CQC inspection, Lincolnshire Community Health Services (NHS) Trust currently has a rating of “Outstanding” overall.

The CQC undertook an inspection at the trust between 18th and 20th June 2018, focusing on community health inpatient services, community health services for Adults, community health services for children, young people and families, and urgent care services. In addition, and as a routine part of all inspections, the CQC also inspected the trust against the well led element of organisational management between 10th and 12th July 2018.

The CQC published their inspection report on 27th September 2018, awarding the trust with an overall “Outstanding” rating. The report confirmed the individual ratings for those services inspected under the five domains, as follows:

- **Safe** – Good
- **Effective** – Good
- **Caring** – Good
• **Responsive** – Outstanding
• **Well Led** - Outstanding

A summary of the report found that there were examples of “outstanding” practice across all five core services inspected and throughout the overall management of the trust.

The report highlighted numerous “outstanding” practices including an innovative approach to risk management at a corporate level, a highly innovative and responsive service overview of operational levels across the trust and wider system via the trust operations centre, effective and responsive use of technology for patients through the use of an automated phone system for patients requesting unscheduled visits, and development of real time, fast and effective innovations in partnerships with the acute sector to reduce winter pressures.

Whilst the CQC found no actions that the trust MUST take to improve, they have made some recommendations on a number of areas which the trust should take to further improve their services and work towards achieving an ‘Outstanding’ rating in all of the five overall domains. An action plan has been developed to work towards achieving these recommendations.

More information and the full CQC report can be found through the following link - [https://www.cqc.org.uk/provider/RY5](https://www.cqc.org.uk/provider/RY5)

**Sustainability and Transformation Partnership (STP)**

The commissioning and provider NHS organisations in Lincolnshire including LCHS have committed to:

• system working, with common purpose, standards and outcomes.
• the delivery of the single system plan for the benefit of the Lincolnshire population.
• applying all the collective resources to deliver better outcomes, while living within the funds available across the system.

In summer 2018 Lincolnshire’s commissioner and provider organisations worked together as STP to undertake an engagement exercise designed to help inform the ongoing process of developing healthcare services in Lincolnshire.

The information gathered informed the emerging options contained in the county’s Acute Service Review about the hospital services in Lincolnshire. The full report can be found at [https://www.lincolnshire.nhs.uk/together/july-2018-engagement-events](https://www.lincolnshire.nhs.uk/together/july-2018-engagement-events)
March 2019 saw the launch of the ‘Healthy Conversation 2019’ campaign. The campaign focuses upon what change is needed and why; the importance of patients, public, and staff’s views, and the services the health system expect to be discussing this year. These include:

- prevention and self-care
- integrated community care including general practice
- mental health and learning disabilities
- acute services

Further engagement and involvement activities are scheduled to continue the ‘Healthy Conversation 2019’ throughout the year for more information or to share your views visit https://www.lincolnshire.nhs.uk/healthy-conversation

**Quality and Risk Committee**

The trust’s Quality and Risk Committee has the responsibility for leadership and strategic development, implementation, and oversight of the risk register and its impact on clinical delivery. It also oversees clinical governance with a key focus on quality of clinical care across the whole trust and actions taken to share standards, guidance and best practice and ensure that lessons learned are embedded. This includes ensuring actions are taken to address issues of poor quality, safety and performance. It monitors progress on delivery of the Clinical Strategy taking regular updates from key service lines.

The committee has met monthly during the year with 100% attendance from non-executive directors. The meeting in February 2019 was utilised for a committee development session to improve overall performance. The committee, its business and its effectiveness was reviewed by external auditors and achieved a rating of significant assurance.

There have been a number of achievements over the past year including the achievement of an overall ‘Outstanding’ rating from the Care Quality Commission. Focus for the coming year will be reflected in the trust’s quality account priorities as outlined earlier in this quality account.
Appendices
Appendix 1: Statements from Health Scrutiny Committee for Lincolnshire, Lincolnshire West CCG and Healthwatch Lincolnshire

The Health Scrutiny Committee for Lincolnshire is grateful for the Trust sharing its draft Quality Account for 2018/19 and recognises the Trust's provision of community health services for Lincolnshire residents. The Committee acknowledges the Trust's rating of 'outstanding' by the Care Quality Commission in the last year. For 2018-19, the Committee is focusing on the quality accounts of two other NHS providers.

Healthwatch Lincolnshire Quality Account Working Group: Sarah Fletcher (CEO), John Bains (Board Chair), Clive Green (Trustee), David Gaskell (Trustee) Maria Prior (Trustee), Nicola Clarke (Partnership & Development Manager), Julie Evans (Signpost Officer)

Healthwatch Lincolnshire would like to thank Sarah McKown, Janice Wiseman and Heather Emmerson for presenting the LCHS Quality Account and meeting with our representatives. We acknowledge the work LCHS has done over the past 12 months to improve the overall performance. On behalf of patients, carers and families, we would like to thank your staff for their hard work and dedication in achieving this.

We very much appreciate that the Trust responds to concerns and information shared by Healthwatch Lincolnshire and look forward to building upon this relationship in the future. We would like to identify within this statement the recognition by LCHS of what we do as a Healthwatch locally, and specifically for us to have involvement in the collective stroke patient and carer work to look at the patient pathway and also our involvement in the independent evaluation of patient views and experiences of the Johnson GP Practice (previously Pennygate GP Practice) for and on behalf of LCHS.
Healthwatch Lincolnshire welcomes the inclusion of Trust work into the Lincolnshire system and how this has been embedded within the Trust Aims and Objectives. We also recognise and welcome the joint system CQUIN approach. As part of this we would anticipate that all opportunities to work collaboratively will be maximised including the use of the Care Portal, and that it will become a mandatory tool and not continue to be an untapped resource for the county.

Healthwatch Lincolnshire acknowledges the broad remit of LCHS, and changing services over recent years including the 0-19 service. We are also aware of how the Trust supports the whole system during times of clinical and seasonal spikes including out of hours, the clinical assessment service, weekends and bank holidays. Healthwatch asked and felt reassured that capacity for LCHS is currently manageable, but we would ask that the capacity within the Trust is reviewed regularly to ensure that where CAS, out of hours GP Practice caretaking exists, it continues to be achievable.

Quality Accounts are an important way for local NHS services to report on quality and show improvements in services they provide to local communities and stakeholders. With this in mind Healthwatch made a number of comments around style and language within the report for consideration. We hope that the Trust will consider our comments on some areas of ambiguity around the detail for the priorities. By this we mean specifically what do LCHS constitute as success, as well as other areas highlighted of clinical audit, learning from deaths and awareness of a bullying, harassment and abuse concern. We would also recommend that the report includes more graphical representation of the detail for the reader to easily understand.

We have noted the Outstanding CQC rating for the Trust and the number of Awards that the Trust are accredited with which is a testament to sharing their successes.

We heard that whilst complaints are meeting the standards, the focus for the Trust is related to quality of response rather than speed and that this will remain a priority area going forward.

Commentary relating to the previous year’s Quality Accounts

We noted that both the leg ulcer and falls with harm priorities for 2018/19 were achieved, along with an overall decrease in the number of falls.

The Pressure Ulcers stretch target of 50% was not achieved. However we heard the benefits of this stretch from work around the 100 day pressure ulcer challenge, which assured that whilst the target had not been achieved, learning had occurred.

Medicines Management was set as a priority even though the Trust does not have any major issues and are not an outlier on medicines management. It was noted that the communication of medication management is an issue for the Trust which requires recognition and continued attention. Healthwatch appreciates the wide range of incidents currently classified and recorded as medication errors. We ask
that greater consideration is given to how they are described in the report, in order to more accurately reflect the potential level of harm from different types of error.

Priorities and challenges for the forthcoming year

Allied Health Professions: Therapy Services, when asked why this was chosen for 2019/20 we heard that the service hasn’t been previously prioritised but is a significant service covering both adults and children. We were pleased to hear that the focus of the priority will be about putting the patient at the centre of the therapy services.

Macmillan patients on end of life caseload to die in preferred place of death. We were reassured to understand that this priority is around continued communication with patients and families around place of death and being able to document and respond to any changes in that preference, taking learning from the patients as to the reason for changes which will enhance service and patient understanding.

Improving access for patients with sensory and physical impairment

The Trust is encouraging patients to use AccessAble to support their use and access to health facilities. Healthwatch were encouraged to hear that the LCHS Board were asking for more substance within this priority in terms of checking the impact with a focus on experience as well as metrics. We suggest that LCHS work more closely with those VCS organisations that work with directly with patients with physical and sensory impairment.

Themes and Trends Healthwatch have heard over the last 12 months

The following highlights some of themes that we hear on a regular basis from patients, carers, families and we would ask the Trust to continue to review and address what their customers are telling them.

- Community Paediatrics are taking too long to get children and their families into the system.
- Ulcer clinics are good once patients are in service, however again patients are telling us it takes too long to get into the service.
- Lymphoedema clinic at Skegness has been held up as a shining light for service delivery.
- The Pennygate transfer to LCHS was positively received by patients.
- Community nursing is good when received, although again time between referral and receiving care can be lengthy.
- The Louth Community and surrounding areas still feel nervous about the future of Louth hospital services.
NHS Lincolnshire West Clinical Commissioning Group (the commissioners) welcomes the opportunity to review and comment on the Lincolnshire Community Health Services NHS Trust (the trust) Annual Quality Account 2018 – 19.

The Quality Account provides comprehensive information on the Quality Priorities (QPs) that the trust has focussed on during the year. The commissioner is a little concerned that the four QPs have not achieved the goals set by the trust at the start of the year although it is recognised that the reduction targets were very aspirational. However there has been good work undertaken in a number of these areas particularly medicines management and the prevention of falls. The commissioner is pleased to note that the work above is to continue into 2019 – 20 to build upon the improvements made.

Looking forward to the 2019 – 20 Quality Priorities the commissioner supports the quality priorities chosen particularly the End of Life Pathway for cancer patients. The commissioner recognises that the above is initially to be a pilot project and would urge the trust to consider a county wide roll out to support this particular patient group and their families with this valuable clinical work.

The Quality Account has numerous examples of very positive work undertaken by the trust over the past year to improve quality, but the commissioner believes the following items are of particular note:

- The Care Quality Commission Inspection rated the organisation as Outstanding with all organisational level domains as Good with the Well Led (Leadership) and Responsive (meeting patient’s needs) domains individually rated as Outstanding
- The Staff Survey has a number of very good results with the trust at the or above the national average for eight out of ten areas

The staff survey identifies an increase in staff experiencing bullying, harassment or abuse at work over the last year, the commissioner is concerned at this and will be seeking assurance over the coming year as to how the trust will address this important issue.

The commissioner can confirm that up to the end of quarter three the trust has achieved 19% out of the possible 35% to date of the Commissioning for Quality & Innovation (CQUIN) schemes which are designed to improve the quality and safety of services for patients. This provides the commissioner with a moderate (or partial) level of assurance.
The commissioner cannot confirm the final quarter 4 CQUIN position at this moment as the joint commissioner and trust review, verification and approval process is scheduled for June 2019 although the commissioner will be expecting a greater level of achievement from the trust.

The commissioner believes that both the audit and patient complaints information presented within the quality account would benefit from a greater level of detail to demonstrate the recommendations and changes to clinical practice. It is recognised that the trust is undertaking some good work in these areas and this will no doubt be reflected in the clinical audits undertaken and complaints responses presented within the trust.

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

The commissioner can confirm that this draft Quality Account has been critically appraised against the 2010 Quality Account Regulations and subsequent additions to the regulations in 2017, 2018 and 2019. The results of this appraisal have been issued separately to the trust.

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

Wendy Martin
Executive Nurse
NHS Lincolnshire West Clinical Commissioning Group
Appendix 2: Statement of directors’ responsibilities for the quality account.

The trusts directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. In preparing this Quality Account, LCHS directors have taken steps to satisfy themselves that:

- the content of the quality account meets the requirements set out in the NHSI detailed requirement for quality reports 2018/19 and supporting guidance
- the content of the quality account is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to March 2019
  - board papers relating to quality for the period April 2018 to March 2019
  - feedback from commissioners dated 29 May 2019
  - feedback from local Healthwatch organisations dated 18 May 2019
  - the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2019
  - the latest national staff survey dated Jan 2019
  - the Head of Internal Audit’s annual opinion of the trust’s control environment – Significant Assurance
  - CQC inspection report dated 27 September 2018
- the quality account presents a balanced picture of the NHS trust’s performance over the period covered
- the performance information reported in the quality account is reliable and accurate
- the data underpinning the measures of performance reported in the quality account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the quality account has been prepared in accordance with NHS Improvement’s annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality account.
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality account.

By order of the board

27th June 2019 .............................................................Chair

27th June 2019 .............................................................Chief Executive

Appendix: 3 National clinical audits 2018/19

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<th>Sexual Health Service</th>
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<td>Oxygen Use</td>
<td>BHIVA National Clinical Audit 2018: Monitoring of Adults with HIV aged 50 and over</td>
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<td>National Audit of Care at the End of Life</td>
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Appendix: 4 Local Clinical Audits 2018/19

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<th>Community Hospitals</th>
<th>Sexual Health Service</th>
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<tr>
<td>CS-1: Community Hospitals/Butterfly Quality Audit Tool: in and out patient areas</td>
<td>CS-2: Inpatient/outpatient areas - Quality Audit Tool e.g. Podiatry, Leg Ulcer Clinic, SH</td>
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<td>CS-3: Operating Theatres - Quality Audit Tool</td>
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<td>CC-8: Hii MRSA pathway</td>
<td>Medicine Audit formulary</td>
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<td>Community, specialist nurses and allied health</td>
<td>Use of Intra-Uterine Systems (IUS) in Sexual Health</td>
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<td>BASHH 2018: Audit of HIV Partner Notification (PN)</td>
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<td>Professionals hand hygiene compliance audit</td>
<td>BHIVA National Clinical Audit 2018: Monitoring of Adults with HIV aged 50 and over</td>
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<tr>
<td>Chart Checker Audit - community hospitals/butterfly hospice only (including antibiotic review)</td>
<td>BHIVA National Clinical Audit 2018: Monitoring of Adults with HIV aged 50 and over</td>
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<td>Wound Packing Audit</td>
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<td>Community Surgical Scheme. Hernia Service. Patient Satisfaction. Assessment Templates Completions</td>
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<td>Record Keeping</td>
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<td>Take 5 Audit Skegness Hospital wards Falls Audit</td>
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<td>Servicing and Maintenance Audits (Beds)</td>
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<td>Ward Quality and Transitional Beds</td>
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<td>Record Keeping</td>
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<td>Wound photography audit</td>
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<td>Controlled Drugs Audit</td>
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<td>Controlled Drug Self Audit</td>
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<td>Treatment Room audit</td>
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<td>Oxygen use</td>
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<td>Cold Chain fridge audit</td>
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| Urgent Care | Adult Therapy Services |
| Management of Patients who present with Burns | CS-2: Inpatient/outpatient areas – Quality Audit Tool |
| Antibiotics that should and should not be prescribed | Take 5 audit |
| CS-4: Minor injuries/ UCC/MIIU inpatient and outpatient areas - Quality Audit Tool | Notes Audit for AQP MSK Physiotherapy Service |
| CS-5: OOHS: Quality Audit Tool: in and out patient areas | Ward Quality/ Transitional Beds |
| Hand Hygiene | SSNAP |
| Management of Sore Throat in Urgent Care Assessment, Diagnosis and Treatment of Suspected Venous Thromboembolism (VTE) | Record Keeping |
| OOH Treatment Room audit | Electronic Discharge documentation receipt with referral |
| OOH Controlled Drug audit | Dysphagia Trained Nurses Scheme 1 April 2017-31st March 2018 |
| OOH Medicines Management Divisional Quality Review | Reducing the length of waiting times and the number of patients waiting for community therapy. Hand Hygiene |
| Children and Young People within Urgent Care OOH Cold Chain audit | |
| CAS ED Disposition audit | |
| Reducing OOHs visits to problematic catheters | |
| Record Keeping | |
| CAS Clinical Audit | |
| Practitioner Performance Notes audit | |
| Otitis Media | |
### UCSS Live audit at Pilgrim Hospital
- Audit of sepsis screening in patients admitted to hospital by the OOH Service
- Audit following implementation of Hyperkalaemia Algorithm
- VTE assessment in patients over 60 who had POP applied by an Urgent Care Centre
- Urgent Care Safeguarding Adults and Children Audit
- Safeguarding across Urgent Care
- Child protection or child in need where domestic abuse/parental mental health/parental drug and alcohol use all in place
- CAS/Patient Safety Alerts Audits
- Antimicrobial audit
- Oxygen Use

### Children’s Services
- Review Appointment Audit
- To ensure compliance with Cerebral Palsy Integrated Pathway
- Quality & Timeliness of LAC Initial Health Assessments
- Record Keeping

### Specialist Services
- CS-2: Inpatient/outpatient areas – Quality Audit Tool
- National Audit of Care at the End of Life (NACEL)
- Use of Palliative Care Templates in the EoL period in Community Hospitals and the Butterfly Hospice
- National Audit of Inpatient Falls
- National COPD audit Pulmonary Rehabilitation
- Continence Service Audit of Community Nursing Caseloads
- Diabetes – HbA1c Outcomes
- SSNAP Record Keeping
- National Asthma & COPD Audit Programme: Pulmonary Rehabilitation (PR) Clinical Audit
- Take 5 Audit Skegness Hospital Wards Falls audit
- Audit of preferred place of death and actual place of death
- Audit of Palliative Care to Learn Programme
- Hand Hygiene
- Treatment Room
- PGD

### Transitional Care
- National Audit of Intermediate Care
- Electronic Discharge Documentation receipt with referral.

### Safeguarding
- Response to the protection of older children
- Child protection of child in need where domestic abuse/parental mental health/parental drug and alcohol use all in place
- Safeguarding across OOHs settings
- Safeguarding across Minor Injury Unit settings
- Safeguarding across Urgent Care
- Performance on LAC assessments
### Appendix 5: Local and National Clinical Audits – Actions & Outcomes

<table>
<thead>
<tr>
<th>Audit name</th>
<th>Audit scope</th>
<th>Key successes</th>
<th>Key actions following the audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS-2: Inpatient/outpatient areas – Quality Audit Tool e.g. Podiatry, Leg Ulcer Clinic/SH</td>
<td>Infection Prevention &amp; Control</td>
<td>Audits submitted quarterly. Areas of non-compliance addressed and monitored at local governance meetings.</td>
<td>Action plans monitored through local governance. Facilities issues addressed with LCHS Estates.</td>
</tr>
<tr>
<td>CC-4: Peripheral vascular devices IPS RIT</td>
<td>Infection Prevention &amp; Control</td>
<td>Due to the low numbers of PVD throughout the organisation, IP Team monitor compliance during clinical visits.</td>
<td>Action plans resulting monitored through local governance.</td>
</tr>
<tr>
<td>CC-7: HII Clostridium difficile pathway</td>
<td>Infection Prevention &amp; Control</td>
<td>Due to the low numbers of cases, C.diff pathway is monitored through</td>
<td>Action plans are monitored through local governance</td>
</tr>
<tr>
<td>Audit name</td>
<td>Audit scope</td>
<td>Key successes</td>
<td>Key actions following the audit</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>CC-8: HII MRSA pathway</td>
<td>Infection Prevention &amp; Control</td>
<td>Due to the low numbers of cases MRSA pathway is monitored by IP Team through daily surveillance</td>
<td>Action plans monitored through local governance.</td>
</tr>
<tr>
<td>Community, specialist nurses and allied health professionals hand hygiene</td>
<td>Infection Prevention &amp; Control</td>
<td>Measures have been addressed to provide that assurance.</td>
<td>Hand hygiene audits demonstrate compliance for this period. Areas that have been requested to submit hand hygiene audits, have submitted at least one hand hygiene audit this quarter, as requested. CQC assessment identified gaps in the assurance of hand hygiene compliance in the community setting. Measures have been addressed to provide that assurance.</td>
</tr>
<tr>
<td>BASHH 2018: Audit of HIV Partner Notification (PN)</td>
<td>LISH</td>
<td>50.1% of individuals initially testing negative for HIV were re-tested at 3-6 weeks, as were 24.1% of those not tested initially. Follow-up HIV testing rates were higher at clinics with policies supporting this.</td>
<td>All services to ensure that contact action is completed for all patients. Caution is required with the contact attendance as reported by the patient. Consideration should be given to early follow-up HIV testing to diagnose seroconversion.</td>
</tr>
<tr>
<td>BHIVA National Clinical Audit 2018: Monitoring of adults with HIV aged 50 and over</td>
<td>LISH</td>
<td>National audit</td>
<td>National audit awaiting report</td>
</tr>
<tr>
<td>Management of Sore Throat in Urgent Care</td>
<td>Urgent Care</td>
<td>An adequate assessment of patients under 5 years presenting with acute sore throat is being carried out across all OOH bases Advice on self care and adequate safety net advice is being provided consistently across all sites</td>
<td>The findings of this audit will be shared with Clinicians via the monthly Clinical Bulletin A summary of the NICE Guidance will be included within the March Clinical Bulletin with advice on use of FeverPAIN or Centor scoring system when assessing patients who present with acute sore throat</td>
</tr>
<tr>
<td>Audit name</td>
<td>Audit scope</td>
<td>Key successes</td>
<td>Key actions following the audit</td>
</tr>
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<td>------------------------------------------------</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Use of delayed prescription of antibiotics was not found at any of the OOH sites.</td>
<td>Audi...</td>
<td>Use of delayed prescription of antibiotics was not found at any of the OOH sites.</td>
<td>An update on NG 84 will be presented at the next Urgent Care GP engagement event. A further audit of the management of patients presenting with acute sore throat will be undertaken in November 2018.</td>
</tr>
<tr>
<td>There were no cases of inappropriate referral to hospital or home management.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioner Performance Notes audit</td>
<td>Urgent Care</td>
<td>Annual audit for assurance that record keeping is of an appropriate standard.</td>
<td>Issues addressed with individual practitioners. For 2019/20 this audit will take place quarterly to ensure that any areas for improvement are continually addressed.</td>
</tr>
<tr>
<td>VTE assessment in patients over 60 who had POP applied by an Urgent Care Centre</td>
<td>Urgent Care</td>
<td>To provide assurance that patients within a defined criteria are treated as per the revised Standard Operating Procedure.</td>
<td>The revised SOPs have been circulated. As a result of the initial audit Pop-up template to be devised for SystmOne. Audit to be repeated monthly, splints to be included in cases reviewed as well as plasters. Practice will be addressed with individuals. Link to VTE audit included in the new Adult Clinical Audit template.</td>
</tr>
<tr>
<td>Diabetes – HbA1c Outcomes</td>
<td>Specialist Services</td>
<td>S1 data from Oct 2018 on active caseload is available showing change in HbA1C % improved, deteriorated and stayed the same.</td>
<td>Diabetes – HbA1c Outcomes</td>
</tr>
<tr>
<td>Audit of preferred place of death and actual place of death</td>
<td>Specialist Services</td>
<td>Audited 63 expected deaths in JULY 2018 to see if preferred place of death acheived. Currently repeating audit to include expected deaths on ICT caseloads.</td>
<td>More training is needed for staff regards to completing EPaCCs and recognising patients who are appropriate for this. Next years audit will include the RESPECT and well as DNACPR forms to capture the</td>
</tr>
<tr>
<td>Audit name</td>
<td>Audit scope</td>
<td>Key successes</td>
<td>Key actions following the audit</td>
</tr>
<tr>
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</tr>
</tbody>
</table>
| Audit of Palliative Care to Learn Programme | Specialist Services | Audit report previously sent Feb 2019 Resent 15.05.15  
Change of plan from auditing care to learn programme as insufficient data available.  
Audit replaced with a snapshot of palliative care knowledge and confidence at a LCHS base. | Include both classroom based and ‘on the job learning’ would be welcomed by the workforce.  
The programme should aim to deliver the palliative pathway at its core in order to upskill the workforce and increase confidence and skill in the deliverance of palliative care.  
Have a ‘tool kit’ of resources that we can tailor to an ICT teams individual needs.  
This audit aligns with the current Macmillan prioritisation matrix in that education, reduction of inappropriate referrals, promotion of EpACCs and greater reach and influence. |
| National Audit of Care at the End of Life (NACEL) | Specialist Services | LCHS scored above national average for quality of governance, and benchmarked well nationally in communication with the dying person. | LCHS will contribute to 2019-20 audits.  
Improvements made to mortality review process. |
<p>| Safeguarding across OOHs, UC and MIU settings | Safeguarding | Key successes: this audit is completed quarterly and monitored through the quality governance meeting, areas of non-compliance are identified which informs safeguarding team visits and supervision, as well enabling clinical leaders to address this in their take 5 practitioner audits. | Key actions: This audit is conducted quarterly and the results are scrutinised in the quality and audit group (Urgent care) and are discussed and monitored through the quality governance meetings. |
| Controlled Drugs Audit           | Medicines Management | Audit submitted quarterly. Areas of non-compliance addressed | Action plans monitored through local governance groups. Reported through DTC and SG&amp;PS |</p>
<table>
<thead>
<tr>
<th>Audit name</th>
<th>Audit scope</th>
<th>Key successes</th>
<th>Key actions following the audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily Controlled Daily Check</td>
<td>Medicines Management</td>
<td>Daily checks are recorded within the service area.</td>
<td>Monitored as part of quarterly CD audit. Actions included within quarterly action plan. Any anomalies highlighted on the daily checks are reported via the incident reporting system.</td>
</tr>
<tr>
<td>Chart Checker Audit</td>
<td>Medicines Management</td>
<td>Completed monthly by pharmacy team. Areas of non compliance highlighted to service local governance groups</td>
<td>To be Action plans monitored through local governance groups. Reported through DTC and SG&amp;PS</td>
</tr>
<tr>
<td>Pharmacist Interventions</td>
<td>Medicines Management</td>
<td>Action plans monitored through local governance groups. Reported through DTC and SG&amp;PS</td>
<td>Action plans monitored through local governance groups. Reported through DTC and SG&amp;PS</td>
</tr>
<tr>
<td>Treatment Room audit</td>
<td>Medicines Management</td>
<td>Completed monthly by Urgent Care services. Reported through UC quality and Risk group</td>
<td>Reported through local governance groups, DTC and SG&amp;PS</td>
</tr>
<tr>
<td>Cold Chain fridge audit</td>
<td>Medicines Management</td>
<td>Completely monthly by all services</td>
<td>Reported through local governance groups, DTC and SG&amp;PS</td>
</tr>
<tr>
<td>Daily Fridge temperature monitoring</td>
<td>Medicines Management</td>
<td>Monitored daily by individual services. Any anomalies escalated and reported through datix system</td>
<td>Monitored as part of monthly datix reporting and quarterly safe and secure medicines audit.</td>
</tr>
<tr>
<td>Daily room temperature monitoring</td>
<td>Medicines Management</td>
<td>Monitored daily by individual services. Any anomalies escalated and reported through datix system</td>
<td>Monitored as part of monthly datix reporting and quarterly safe and secure medicines audit.</td>
</tr>
<tr>
<td>Antimicrobial audit</td>
<td>Medicines Management</td>
<td>Data monitored quarterly.</td>
<td>Shared through local governance groups, DTC and medical leads meeting.</td>
</tr>
<tr>
<td>Safe and Secure handling of medicines</td>
<td>Medicines Management</td>
<td>Quarterly monitoring by MM team. Reported through local governance groups</td>
<td>Audit and action plans shared through local governance groups, DTC and SG&amp;PS</td>
</tr>
<tr>
<td>PGD</td>
<td>Medicines Management</td>
<td>Standardised process of PGD development. PGDs audited at time of renewal to establish</td>
<td>PGDs reviewed, process of rationalisation and standardisation. DTC taken role of PGD</td>
</tr>
<tr>
<td>Audit name</td>
<td>Audit scope</td>
<td>Key successes</td>
<td>Key actions following the audit</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>clinical need. PGD data to be monitored quarterly to establish clinical application.</td>
<td>approval group – monitoring / developing.</td>
</tr>
</tbody>
</table>

**Glossary:**

<table>
<thead>
<tr>
<th>Abbreviation or Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIR</td>
<td>Assertive In Reach</td>
</tr>
<tr>
<td>BME</td>
<td>Black and Ethnic Minorities</td>
</tr>
<tr>
<td>Carers</td>
<td>Relatives or friends who voluntarily look after individuals who are sick, disabled, vulnerable or frail.</td>
</tr>
<tr>
<td>CAS</td>
<td>Clinical Assessment Service</td>
</tr>
<tr>
<td>C-Diff</td>
<td>Clostridium Difficile</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Groups</td>
</tr>
<tr>
<td>Grade 3-4 pressure ulcers</td>
<td>Classification of pressure ulcer severity as defined by the European Pressure Ulcer Advisory Panel and recommended for use by the National Institute for Health and Care Excellence.</td>
</tr>
<tr>
<td>Doppler Assessment</td>
<td>A test that uses high-frequency sound waves to measure the amount of blood flow through the patients arteries and veins</td>
</tr>
<tr>
<td>E Coli</td>
<td>A bacterium commonly found in the intestines of humans and other animals, some strains of which can cause severe food poisoning.</td>
</tr>
<tr>
<td>E&amp;D</td>
<td>Equality and Diversity</td>
</tr>
<tr>
<td>EPACCS</td>
<td>Electronic Palliative Care Coordination System</td>
</tr>
<tr>
<td>FFT</td>
<td>Friends and Family Test</td>
</tr>
<tr>
<td>GDPR</td>
<td>General Data Protection Regulation</td>
</tr>
<tr>
<td>IMT</td>
<td>Information Management &amp; Technology</td>
</tr>
<tr>
<td>IG</td>
<td>Information Governance</td>
</tr>
<tr>
<td>LCHS</td>
<td>Lincolnshire Community Health Services NHS Trust</td>
</tr>
<tr>
<td>MDT</td>
<td>Multi-disciplinary team</td>
</tr>
<tr>
<td>MRSA</td>
<td>Methicillin-resistant Staphylococcus aureus</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>MSSA</td>
<td>Methicillin-sensitive Staphylococcus aureus</td>
</tr>
<tr>
<td>NEWS</td>
<td>National Early Warning Score - Determines the degree of illness of a patient and prompts critical care intervention</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NHSI</td>
<td>NHS Improvement</td>
</tr>
<tr>
<td>NICE</td>
<td>The National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>NRLS</td>
<td>National Reporting and Learning Systems</td>
</tr>
<tr>
<td>OOH</td>
<td>Out of Hours - Primary care service operating out of normal general practice working hours.</td>
</tr>
<tr>
<td>PALs</td>
<td>Patient Advice and Liaison Service</td>
</tr>
<tr>
<td>PbR</td>
<td>Payment by Results</td>
</tr>
<tr>
<td>PLACE</td>
<td>Patient led assessment of the care environment</td>
</tr>
<tr>
<td>PPI</td>
<td>Patient and Public Involvement</td>
</tr>
<tr>
<td>PPSSEG</td>
<td>Patient, public, staff and stakeholder engagement group</td>
</tr>
<tr>
<td>Safety Thermometer</td>
<td>Collects information on four harms: pressure ulcers, harm from falls, urine infection (in patients with a urinary catheter) and new VTE.</td>
</tr>
<tr>
<td>SI</td>
<td>Serious Incident</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability and Transformation Partnership</td>
</tr>
<tr>
<td>SystmOne (S1)</td>
<td>A centrally hosted clinical computer system used by healthcare professionals in the UK.</td>
</tr>
<tr>
<td>TOMS</td>
<td>Therapy outcome measures</td>
</tr>
<tr>
<td>ULHT</td>
<td>United Lincolnshire Hospital Trust</td>
</tr>
<tr>
<td>VTE</td>
<td>Venous thromboembolism</td>
</tr>
<tr>
<td>WRES</td>
<td>Workforce Race Equality Standard</td>
</tr>
</tbody>
</table>

**Contact details**

We welcome your comments about our Quality Account. Please contact us using the details below:

Telephone: 01522 309751  
Email: Ichsecomms@lincs-chs.nhs.uk  
Visit: [https://www.lincolnshirecommunityhealthservices.nhs.uk/contact-us/get-involved](https://www.lincolnshirecommunityhealthservices.nhs.uk/contact-us/get-involved)  
Twitter: @lincscommhealth  
Facebook: lincscommhealth
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