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PART 1: Statement on quality from the chief executive of the Northern Lincolnshire and Goole NHS Foundation Trust

The NHS at its inception some 68 years ago was designed to meet three ambitious principles (1) that it meets the needs of everyone, (2) that it is free at the point of delivery and (3) that it is based on clinical need not the ability to pay. Since then, whilst these principles remain, various pressures in the system have needed to be managed. At present one such pressure is financial, affecting the NHS and all public sector services and much effort is invested into getting the best value for money. This leads to a further pressure: financial stability versus the NHS meeting the needs of its customers, meeting the needs of you and I to the standard we expect. What are these needs? These can be broadly categorised into the 3 domains of quality:

- Clinical effectiveness – are we providing the best evidenced based treatments?
- Patient safety – are we ensuring people within health care settings are kept safe?
- Patient experience – was our experience a good one? Where our needs met?

It is my determination that amidst all the pressures of the NHS, that we, Northern Lincolnshire & Goole NHS Foundation Trust (also referred to as ‘the Trust’ throughout the remainder of this report), continue to keep the needs of our service users at the forefront of our thoughts. By doing this we continue in our aspiration to focus on continuous quality improvement.

This annual quality account is just one mechanism we, the Trust, use to measure how we are performing around key quality indicators, that for the most part, we have set ourselves. Within this report the Trust provides an account of some of the work undertaken within the 2015/16 financial year. This provides a small glimpse of the dedication and hard work invested by the many individuals and teams that make the Trust what it is.

You will notice from the contents of this report we have seen continued improvement in connection with quality and innovation and a focus on driving this further. There are some great examples of real achievements the Trust has made working in collaboration with local partners. The development of the Web V system and the use of this to more accurately and efficiently record and communicate key medical and nursing details have already strengthened quality. The new build on the Diana, Princess of Wales site of a purpose built Cardiology unit enables effective treatments in a fantastic environment. The continued work to ensure safe numbers and effective staffing within the organisation, in the backdrop of very acute shortages across the country of staff, again has made great progress. These are just a few of the examples that illustrate our quest together, for continuous quality improvement.

Also contained in this report are areas where we still need to do more. The indicators, many of which are self-selected, are designed to challenge us, not simply to be ticked off as easily achieved. Where we have not yet met our aims, these for the most part will continue to feature for the 2016/17 financial year as targets still to be met. We as a Trust focus on these indicators throughout the year, assessing our progress by means of a monthly board report on the subject of quality which is overseen and scrutinised by our Quality and Patient Experience Committee. This annual quality account then gives us the opportunity to summarise our performance for the last 12 months and as a result of these processes and other assurance mechanisms, to the best of my knowledge the information contained in this document is accurate.

Many more challenges exist and are facing the Trust and the local healthcare community. Despite these challenges, we are determined to continue focussing on quality and ensuring that this commitment illustrates our aspiration to the NHS guiding principle – to meet the needs of our patients, carers and service users.

Chief Executive
About Northern Lincolnshire and Goole NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust (referred to as 'The Trust' throughout this report) consists of three hospitals and community services in North Lincolnshire and therapy services in Northern Lincolnshire. In summary these services are:

- Diana, Princess of Wales Hospital in Grimsby (also referred to as DPoW),
- Scunthorpe General Hospital located in Scunthorpe (also referred to as SGH) and
- Goole District Hospital (also referred to as GDH),
- Community and therapy services in North Lincolnshire.

The Trust was originally established as a combined hospital Trust on April 1, 2001, and achieved Foundation Status on May 1, 2007. It was formed by the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust and operates all NHS hospitals in Scunthorpe, Grimsby and Goole. In April 2011 the Trust became a combined hospital and community services Trust (for North Lincolnshire). As a result of this the name of the Trust, while illustrating the geographical spread of the organisation, was changed during 2013 to reflect the Trust did not just operate hospitals in the region. The Trust is now known as Northern Lincolnshire and Goole NHS Foundation Trust.

Running four services, separated by considerable distances, pose a significant service delivery challenge, but also allow the Trust to serve a wider population. The Trust also provides a range of services delivered outside of hospital settings. Due to these geographical distances a key way the Trust uses to help measure and monitor quality of care is through site by site breakdowns of performance against various measures. You will see this illustrated throughout the following sections of the report.

Our core business can be defined as:

- Delivering a full range of emergency secondary health care services, including intensive and high dependency care
- Maintaining a comprehensive range of planned and unplanned services, in an environment of patient choice and contestability
- Ensuring a full range of secondary care diagnostic services are available locally.

Unplanned services: statistics at a glance – during 2014/15:

- 143,398 people attended one of our Accident & Emergency departments during 2015/16 compared with 144,996 in 14/15 and 137,842 in 13/14.

- Whilst there were slightly less attendances to the Trust’s A&E departments, 30,776 of these were admitted, 181 more patients than during 14/15. This equates to 591 admissions through A&E a week, 84 people a day! Whilst the numbers are increasing, so too is the level of acuity, or the level of dependence on the Trust’s healthcare professionals.

For latest news from Northern Lincolnshire and Goole NHS Foundation Trust visit our website at: www.nlgnhs.uk

Follow the Trust on Twitter: @NHSNLaG
Executive summary of the key points from this year’s Quality Account

The Trust’s Quality Account contains a detailed summary of performance against its quality priorities set for the 2015/16 financial year. This full detail is available within part two of this report. Performance against these indicators and the relationship of these results to next years (2016/17) quality priorities is significant, therefore these two highlights are presented as part of this executive summary.

The Trust's Quality Targets & Priorities – Driving Continuous Improvement

It is worth noting here, that these targets/quality priorities for the most part are not nationally or regionally set, rather they are set locally by the Trust. They are selected as areas of key importance for the Trust to drive and embed continuous quality improvement. These indicators are not chosen for their ease of completion, resulting in a report full of green 'completed' ticks. These indicators are instead quality focussed, aspirational and stretching. As a result, the executive summary that follows, and the greater detail within part two of this report presents progress so far, not always demonstrating that our internal quality targets have been met. Where these have not been met, an explanation and summary of the work underway are presented and for the most part, these targets have been selected to stay within the quality report to drive quality development during 2016/17.

Clinical Effectiveness – performance at a glance 2015/16

The following ‘at a glance’ overview of performance is viewed continually throughout the year, and reviewed within the monthly quality report, as a result these are constantly changing based on the real time nature of these indicators. For full explanation of the data behind these indicators, see section two of this report.

![Quality Indicators at a Glance: Feb-16](image-url)
Comment:

- Mortality indicators have been partially met throughout 2015/16 with the Trust’s ‘official’ SHMI ‘within expected range’ and an improving trend when looking at the HED SHMI over time. Due to the importance of this area, this remains a quality priority for next year’s monitoring in the monthly quality report and the monthly mortality report.

- Compliance with action taken as a result of the National Early Warning Score (NEWS) has exceeded the quality target for a number of months. This indicator was originally chosen as a priority due to its links to the deteriorating patient and mortality indices. Therefore as this has now been embedded it is to be removed from the 16/17 list of quality indicators and replaced instead with another mortality related indicator.

- The identification and care of patients with dementia remains a priority for the Trust. The first element of dementia screening for patients over the age of 75 has been achieved for the last few months, to ensure this is embedded this target will remain. Other related indicators to do with onward referral have been achieved fully consistently for a number of months, therefore these will be removed as quality priorities for 16/17.

- National Institute for Health and Care Excellence (NICE) guidance is another indicator that has not yet been met, despite good progress having been made. This is another indicator that will remain a focal point for the Trust during 16/17.

- Transfer of patients for non-clinical reasons has been an indicator selected to help the Trust focus on the subject of internal transfer and discharge of patients enabling the Trust Board receive regular quality measurement on a number of related data. As such this has aided the Trust’s understanding and will remain a quality priority for 2016/17.

In support of the above commentary, the quality priorities for next year (2016/17 financial year) are illustrated as follows with explanations included. For full detail of how these priorities are set, including consultation with patients and governors, see section 2.1d within this report.

**2016/17 Quality priorities – Clinical Effectiveness**

<table>
<thead>
<tr>
<th>Clinical Effectiveness:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CE1</td>
</tr>
<tr>
<td>Deliver mortality performance within 'expected range' and improving quarter on quarter, until reported SHMI is 95 or better.</td>
</tr>
<tr>
<td>CE2.1</td>
</tr>
<tr>
<td>90% of patients are screened for sepsis on admission/attendance</td>
</tr>
<tr>
<td>CE2.2</td>
</tr>
<tr>
<td>90% of patients with sepsis receive antibiotics within 1 hour of attendance</td>
</tr>
<tr>
<td>CE3</td>
</tr>
<tr>
<td>Dementia – 90 per cent of patients aged 75 and over admitted as an emergency to be asked the dementia case finding question</td>
</tr>
<tr>
<td>CE4.1</td>
</tr>
<tr>
<td>100% of Technology Appraisal Guidelines to be fully compliant within 3 months of publication</td>
</tr>
<tr>
<td>CE4.2</td>
</tr>
<tr>
<td>90% of Clinical Guidelines/NICE Guidelines to be fully compliant within 3 years of publication</td>
</tr>
<tr>
<td>CE5</td>
</tr>
<tr>
<td>Transfer of patients for non-clinical reasons (capacity) to not exceed 10% of the total</td>
</tr>
</tbody>
</table>

(For more information on how these priorities are set, see section 2.1d of this report)
Comment:

- In place of the National Early Warning Score (NEWS) priority is the inclusion of another mortality related indicator, that of screening patients for sepsis and on identification provide timely antibiotics to prevent deterioration. This will enable the Trust Board to receive regular updates from the quality improvement project being undertaken within the Trust looking at sepsis.

- The focus on NICE remains, however the specific nature of the target has been tweaked to ensure compliance with Technology Appraisal Guidance. These are issued by NICE and intended as statutory guidance for all Trusts to comply with.

- During 2015/16 at the mid-year review of the Trust’s quality priorities, the target being aimed for in connection with transfer and discharge had been achieved (number of transfers due for non-clinical (capacity) reasons to not exceed 20% of the total) therefore a stretch target was applied mid-year of not exceeding 10%. This target will continue to be monitored during 16/17.

Patient Safety – performance at a glance 2015/16

(For more information on the detail behind this ‘at a glance’ summary, see section two of this report)

Comment:

- At the mid-year review of quality priorities C difficile incidence target was changed to mirror national guidance that the target (to have no more than 21) was in relation to lapses in care only. Therefore this target has been monitored throughout the rest of 15/16, including the total incidence of C difficile as context. Going into 16/17 this priority area is to remain but a more stretching target is to be monitored to drive continuous quality improvement.
• The acute safety thermometer has not been achieved during 2015/16. From further work to understand this indicator it appears that the acute safety thermometer is being affected by ‘old’ pressure ulcers i.e. those patients presenting from their place of residence with a pre-existing pressure ulcer. As a result this indicator has been a difficult one to use to enable the Acute Trust to focus on continuous improvement. As a result for 16/17 a more acute focussed target has been suggested.

• Nutrition and hydration targets have not yet been embedded; therefore the targets being aimed for are proposed to remain as priorities.

In support of the above commentary, the quality priorities for next year (2016/17 financial year) are illustrated as follows with explanations included. For full detail of how these priorities are set, including consultation with patients and governors, see section 2.1d within this report.

2016/17 Quality priorities – Patient Safety

<table>
<thead>
<tr>
<th>Patient Safety:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PS1</td>
<td>MRSA - 0 MRSA bacteraemia developing after 48 hours into the inpatient stay (hospital acquired).</td>
</tr>
<tr>
<td>PS2</td>
<td>C. Difficile - achieve a level of no more than 10 hospital acquired C. Difficile cases due to a ‘lapse in care’ over the financial year 2016/17.</td>
</tr>
<tr>
<td>PS3</td>
<td>Community Safety Thermometer - provide harm free community care to 95 per cent or more patients - as measured by the Safety Thermometer.</td>
</tr>
<tr>
<td>PS4</td>
<td>Hospital acquired pressure ulcers, specific targets for higher incidence/reporting ward areas to enable further reductions of ‘avoidable’ pressure ulcers over time. The specific target wording and areas of focus are to be agreed during the early part of 16/17 financial year, as part of the monthly quality report.</td>
</tr>
<tr>
<td>PS5</td>
<td>Pressure ulcers - a 50 per cent reduction in avoidable grades 2, 3 and 4 pressure ulcers (as measured via the root cause analysis undertaken for every grade 2, 3 and 4 pressure ulcer).</td>
</tr>
<tr>
<td>PS6</td>
<td>Patient falls - Eliminate all avoidable repeat falls (as measured via the root cause analysis undertaken for every repeat faller).</td>
</tr>
<tr>
<td>PS7.1</td>
<td>Nutrition – 100 per cent of patients the care pathway was followed.</td>
</tr>
<tr>
<td>PS7.2</td>
<td>Nutrition – 100 per cent of patients identified as requiring it will have their food record chart completed accurately and fully in line with the care pathway.</td>
</tr>
<tr>
<td>PS8</td>
<td>Hydration – 100 per cent of patients identified as requiring it will have their fluid management chart completed accurately and fully in line with the care pathway.</td>
</tr>
</tbody>
</table>

(For more information on how these priorities are set, see section 2.1d of this report)

Comment:

• National statutory targets for C difficile for 2016/17 have not yet been published and these will be monitored by the Trust’s Performance reporting mechanisms. To drive forward quality improvement in this area a stretch target of no more than 10 hospital acquired C difficile infections due to a ‘lapse in care’ will be focussed upon.
• Hydration and nutrition, both crucial areas of focus were included last year in the quality indicators, it is proposed to continue to monitor these during 2016/17 until assurance is obtained that these are embedded

• The acute safety thermometer priority has been removed due to this not being a helpful guide as to quality in the acute Trust (impacted upon by ‘old’ pressure ulcers, or those a patient presents with from their places of residence, not generally as a result of any interaction Northern Lincolnshire & Goole NHS Foundation Trust provided services). Therefore the priority for this area is to be set based on pressure ulcers, those acquired in hospital, and to focus on improvement targets for specific ward areas with higher incidences of pressure ulcers reported during 2015/16. The exact methodology to be used and focussed ward areas is to be established and reported on during the early part of the 2016/17 financial year.

Patient Experience – performance at a glance 2015/16

For full explanation of the data behind these indicators, see section two of this report.

(For more information on the detail behind this ‘at a glance’ summary, see section two of this report)

Comment:

• Trust performance with response rates to the national Friends and Family Test has not been within the top 50% of reporting Trusts. Whilst focussing on the response rate is important to ensure the validity of the comments received, this target presently does not reflect on the content of the friends and family tests themselves, therefore not accurately representing how the Trust listens to and acts on this valuable feedback from service users. During 16/17 this target will be refocused to the results from the Friends and Family Test – not simply the response rates

• The various indicators relating to complaints illustrate that the work and focus on this area has resulted in significant improvements in the process measures applied. During 2015/16 the Trust received a CQC visit and an internal audit report, both of which focussed on complaints handling procedures. As a result of this, the subject of complaints will remain a quality priority for 2016/17; however the specific wording and focus of these targets are yet to be set on reflection of CQC/internal audit findings
• One of the quality priorities agreed last year was around pain management. During 2015/16 work has been invested in updating the Nursing Dashboard, the mechanism in place to measure a range of quality indicators, some of which are reported in the monthly quality report, this being one. As a result no data has yet been available for this area, but from April 2016 this information will be included within the monthly quality report.

• The staff morale barometer has been operational during 15/16. From regular reporting of the findings from this barometer, it became clear that response rates were an issue with a small proportion of staff responding. Therefore a number of actions have been taken including simplification of the process. During 2016/17, a refocus of the Trust’s strategy for employee engagement will be undertaken. As a result of this development work, the staff morale barometer process will be placed on hold for the duration of this work. Staff morale will still be assessed but using other evaluation mechanisms.

In support of the above commentary, the quality priorities for next year (2016/17 financial year) are illustrated as follows with explanations included. For full detail of how these priorities are set, including consultation with patients and governors, see section 2.1d within this report.

2016/17 Quality priorities – Patient Experience

<table>
<thead>
<tr>
<th>Patient Experience</th>
<th>98% of feedback from the Friends and Family Test is positive (this will be supported with, for context, response rate information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE1</td>
<td>Re-opened complaints to not exceed 20% of total closed complaints.</td>
</tr>
<tr>
<td>PE2</td>
<td>Complaints: Reduction of complaints relating to communication.</td>
</tr>
<tr>
<td>PE3</td>
<td>90% of patients feel that medical and nursing staff did everything they could to help control pain.</td>
</tr>
<tr>
<td>PE4a</td>
<td>90% of patients received pain relief when they needed it in a timely manner.</td>
</tr>
<tr>
<td>PE4b</td>
<td>Patients should not have more than 2 omitted doses of medications.</td>
</tr>
<tr>
<td>PE4c</td>
<td>90% of patients should have appropriate action taken in relation to any medication omissions.</td>
</tr>
</tbody>
</table>

(For more information on how these priorities are set, see section 2.1d of this report)

Comment:

• The Friends and Family Test indicator will be refocused to examine the feedback from service users instead of being aimed at a quantitative response rate. This will enable greater focus for the Trust on the findings from this.
PART 2: Priorities for improvement, statements of assurance from the Board and reporting against core indicators

2.1 Priorities for improvement: overview of the quality of care against 2015/16 quality priorities

Information reported within Part 2
Due to the timings necessary to compile the Annual Quality Account, the most recent information available presented is not always to the end of the financial year. Despite this at least 12 months trending information is presented where available.

Priorities for improvement
This section of the report highlights progress during 2015/16 towards achieving the Trust’s quality priorities. The quality priorities, and the following report, are divided into three sections:

- 2.1a Clinical effectiveness.
- 2.1b Patient safety.
- 2.1c Patient experience.

During 2015/16 performance against these quality priorities was monitored within the monthly quality report which is presented and reviewed on a monthly basis by the Trust’s Quality and Patient Experience Committee (QPEC) and the Trust Board. In some cases the quality priorities have changed mid-year. Where this is the case, beneath each indicator, the rationale for the change is explained.

In addition to this, to ensure oversight of mortality indicators has led to the creation of the Mortality Performance and Assurance Committee (MPAC). This has meant that whilst the monthly quality report has reported on all quality indicators, including those around mortality, a separate monthly mortality report is also used to monitor performance against a comprehensive range of indicators. This is overseen primarily by the Mortality Performance and Assurance Committee (MPAC), before consideration by the Trust Board.

The targets for 2016/17 are then outlined again in a fourth section of this report:

- Section 2.1d Quality priorities for the 2016/17 financial year.

A note on interpretation of the following information:

Wherever possible throughout this report, unfamiliar terms or acronyms have been explained in the body of the report. Where this has not been possible due to compliance with the national template set for the Trust’s annual quality account submission, every effort has been made to ensure the glossary provides the necessary definition to aid the reader’s interpretation of this information.
Overview of the quality of care against 2015/16 quality priorities:

This Section…

2.1a CLINICAL EFFECTIVENESS (CE)

→ CE1 Mortality
→ CE2 National Early Warning Scores (NEWS)
→ CE3 Dementia
→ CE4 Evidence Based Practice (NICE)
→ CE5 Transfer and Discharge

2.1b Patient Safety (PS)
2.1c Patient Experience (PE)
2.1a CLINICAL EFFECTIVENESS

CE1 – Mortality improvement – Summary Hospital Mortality Indicator (SHMI)

Introduction to mortality data

Mortality – how is it measured?

There are two primary ways to measure mortality, both of which are used by the Trust:

1. Crude mortality – expressed as a percentage, calculated by dividing the number of deaths within the organisation by the number of patients treated,

2. Standardised mortality ratios (SMR). These are statistically calculated mortality ratios that are heavily dependent on the quality of recording and coding data. These are calculated by dividing the number of deaths within the Trust by the expected number of deaths.

This expected level of mortality is based on the documentation and coding of individual, patient specific risk factors (i.e. their diagnosis or reason for admission, their age, existing comorbidities, medical conditions and illnesses). This information is combined with general details relating to their hospital admission (i.e. the type of admission, elective for a planned procedure or an unplanned emergency admission), all of which inform the statistical models calculation of what constitutes expected mortality.

As standardised mortality ratios (SMRs) are statistical calculations, they are expressed in a specific format. Based on the average expected mortality within the UK, an average ‘expected level’ of mortality would be expressed as 100. Therefore an SMR of more than 100 would be considered to be a higher than would be expected compared with the UK average. Conversely, an SMR of less than 100 would be a mortality ratio less than would be expected compared with the UK average.

While ‘100’ is the key numerical value, because of the complex nature of the statistics involved, confidence intervals play a role, meaning that these numerical values are grouped into three categories: “Higher than expected”, “within expected range” and “lower than expected”. These categories are based on mortality performance across the UK, and using this statistical data and the confidence intervals for this information, results in SMRs of both above 100 and below 100 being classified as “within expected range”, therefore the level of 100 does not in isolation determine a Trust’s performance in line with mortality SMRs. For this reason, the Trust looks at SMR data using funnel charts, which illustrate the Trust’s relative position against other UK Trusts and its categorisation.

Standardised Mortality Ratios (SMRs) – which ones are used by the Trust?

There are a number of different standardised mortality ratios (SMR) in use throughout the United Kingdom. Historically, this has made understanding and benchmarking an NHS Trust’s performance against mortality indicators very difficult. As a result the NHS commissioned an ‘official’ standardised mortality ratio called the Summary Hospital Mortality Indicator or SHMI.

As this is the ‘official’ NHS mortality indicator of choice, it is calculated using a strict methodology then ensures all NHS organisations are measured in the same way using the same indicators. As a result of this, it allows NHS organisations to be ranked according to performance. The Summary Hospital Mortality Indicator (SHMI) is therefore designed to bring clarity to quality in this area. However, a crucial element of SHMI, which is not immediately obvious, and therefore can confuse, is that although SHMI has hospital in the title, it is not purely an indicator of in-hospital mortality; it includes community mortality up to 30 days following discharge from hospital. This is the only SMR that includes both in hospital and out of hospital mortality. It can therefore be viewed as a wider healthcare community mortality performance indicator – not solely a reflection of the Trust’s performance.
Another important point to note regarding SHMI is that because it includes community mortality within the indicator, it is based not only on in-hospital recorded data but on information from the Office for National Statistics (ONS). This introduces a significant delay in publishing information on the healthcare community. As a result, when SHMI information is published each quarter, the time frame included within the report is between six and 18 months out of date. To illustrate this, in January 2016, the SHMI was published focusing on the time frame of July 2014 – June 2015. Therefore while the SHMI is a useful tool to aid the Trust’s understanding of this important area, it has struggled to use this effectively in order to monitor ongoing performance due to the significant time lag in reporting.

What is Healthcare Evaluation Data (HED)

As a result of the time lag in reporting of SHMI, the Trust has purchased an additional information toolkit from the University of Birmingham Hospitals NHS Foundation Trust, called Healthcare Evaluation Data (HED).

HED uses the same methodology as the official SHMI, but enables a much more recent timeframe to be reported. The official SHMI publication in January 2016 reported data up to June 2015, the HED information reports data to the end of October 2015. As it is not the official SHMI indicator, it is treated by the Trust as a ‘provisional’ SHMI indication, but from rigorous reconciliation work, it has proved to be an accurate data source that reflects the official SHMI on publication.

As a result of this, the Trust uses both the official SHMI and the HED provisional SHMI indication as markers of performance.

How is mortality performance monitored within the Trust?

The Trust Board monitor performance against mortality indicators through a sub-committee oversight and scrutiny. This sub-committee of the Trust Board is called the Mortality Performance and Assurance Committee (MPAC). It is chaired by the chairman of the Trust Board. The committee oversees all matters relating to mortality. Its primary form of intelligence is the monthly mortality report, which comprehensively presents a range of different mortality performance measures, utilising the official SHMI, the HED provisional information, crude mortality and an overview of mortality using other SMRs.

Now that the key terms of reference have been introduced and explained, the following section looks at how the Trust is performing against these indicators and outlines the work being undertaken to further focus on quality improvement.

A NOTE OF CAUTION: Interpreting Standardised Mortality Ratios:

Standardised mortality ratios (SMRs) must always be interpreted with caution. As these are ratios of actual deaths against expected levels of mortality they are heavily dependent on data and the accuracy of recording.

Interpretation should be likened to that of a smoke alarm, in the same way as the smoke alarm sounding does not mean there is definitely a fire; an SMR indicator of above 100 does not definitely indicate a problem. However, just as it would be unwise to ignore a smoke alarms warning and not investigate, so too is it unwise to ignore an outlying SMR. This is the approach that the Trust takes.
CE1 – Mortality Improvement – Summary Hospital Mortality Indicator (SHMI)

- **TARGET:** Deliver mortality performance (SHMI) within ‘expected range’ and improving quarter on quarter, on a Moving Annual Total (MAT) basis at each quarterly publication date until our reported SHMI is 95 or better.

- **Achievement (July 2014 – June 2015):** Using the official SHMI indicator, the Trust is currently within the ‘expected range’. The next official SHMI publication is due in March 2016 for the period of October 2014 to September 2015.

**The Trust’s official SHMI in national context**

The following chart illustrates the Trust’s most recent SHMI score and ranking in relation to those of all Trusts nationally.

![National SHMI Scores Range: January 2016 Release (covers Jul14 - Jun15 period)](image)

**Source:** Information Services based on the Health and Social Care Information Centre’s data

**Key to abbreviations:**
- SHMI – Summary Hospital Mortality Indicator
- NLAG – Northern Lincolnshire and Goole NHS Foundation Trust

**Comment:**

- The Trust’s SHMI score was 109.7 – ranking 116 out of 136 NHS provider organisations included in the data set. This compares favourably to the Trust’s position last year, when reported in the 2014/15 Quality Account with a score of 109 ranking the Trust as 119 out of the 137 NHS provider organisations.

- This continues to be officially within the “as expected range”.

**The Trust’s Provisional SHMI in National Context**

- Using the HED (Healthcare Evaluation Data) ‘provisional’ SHMI we can now report on more up to date information.

- HED SHMI currently shows data to the end of October 2015. Data in this analysis should be treated as provisional. Whilst from reconciliation work, we know that this data source reflects the ‘official’ SHMI publications, the numerical value of the HED SHMI can be subject to change. This is due to a number of reasons:

  1) The quarterly publication of the ‘official’ indicator provides the HED model with rebased data (representing the national picture/changes) and
2) more complete data is available from hospital episode statistics (HES) data and Office for National Statistics (ONS) each successive month, therefore, both local and national changes (including deaths post hospital discharge) are an emerging picture and become more complete the further away we move from the months covered within the data release.

- Using the provisional data for the twelve months to October 2015, the Trust is ranked as 108 out of the 136 NHS provider organisations included within the mortality data set, with a score of 106.9

- The Trust is within the “as expected range” banding. The following funnel plot graphically represents this.

![Funnel Plot](image)

**Source:** Information Services based on the Healthcare Evaluation Data (HED)

**Key to abbreviations:**
- SHMI – Summary Hospital Mortality Indicator
- NLAG – Northern Lincolnshire and Goole NHS Foundation Trust

**Comment:**

- From the most recent information available, using the HED ‘provisional’ SHMI, the Trust’s ranking remains in the “as expected range”.

- Data in this analysis should be treated as provisional. From reconciliation work, we know that this data source reflects previous SHMI publications.

- For a more detailed overview of the actions having been taken to improve the Trust’s mortality position and those being taken now, see section 2.3a of this report.

**Has the quality indicator been changed during the year from that set in last years (2014/15) Quality Account?** No, there has been no change to this quality priority during the 2015/16 reporting period.

**Rationale for changing this quality priority for 2016/17:** Not all elements of this indicator have at present been met. Therefore no change is going to be made to this indicator and it will continue to be measured during the 2016/17 financial year.
CE2 – National Early Warning Score (NEWS)

Introduction to the National Early Warning Score (NEWS)
When a patient’s condition deteriorates, there are a number of markers that can identify this, and when appropriately monitored, these markers can trigger effective action to prevent further deterioration. These markers are often combined together as a risk calculator. The National Early Warning Score (NEWS) is a nationally developed deteriorating patient score which the Trust has used since November 2012.

CE2: National Early Warning Score (NEWS) – appropriate action taken

In 95 per cent of cases with a NEWS score, appropriate action was taken

- **TARGET:** 95 per cent of patients with a NEWS score, an appropriate clinical response were actioned.

- **Achievement (May 2014 – January 2016):** The following chart illustrates that this target has been achieved in the main.

Source: Information services, nursing dashboard

Key to abbreviations: DPoW – Diana, Princess of Wales Hospital
SGH – Scunthorpe General Hospital
GDH – Goole District Hospital

NB: As Trust performance with this indicator has been consistently high, for optimal viewing of this information at individual site level, the above charts axis starts at 90 per cent.

Has the quality indicator been changed during the year from that set in last years (2014/15) Quality Account? No, there has been no change to this quality priority during the 2015/16 reporting period.

Rationale for changing this quality priority for 2016/17: The above chart illustrates that current practice is meeting the quality priority target and has been embedded. Therefore to ensure the Trust’s continuous quality improvement a new area has been identified, relating to sepsis, for the future quality priority.
CE3 – Dementia:

CE3.1: Dementia case screening question

- **TARGET:** 90 per cent of patients aged 75 and over admitted as an emergency to be asked the dementia case finding question.

- **Achievement (April 2014 – January 2016):** The following chart demonstrates that for the last 4 months the Trust has been compliant with this quality priority target and performance has exceeded the 90% target.

![Graph showing compliance percentage]

(Source: NLAG data, intranet, information services team)

**Key to abbreviations:**
- DPoW – Diana, Princess of Wales Hospital
- SGH – Scunthorpe General Hospital

**Comments:**

- Dementia screening has achieved the target of 90% for the fourth consecutive month
- Supporting ongoing focus on this area and providing helpful intelligence to clinical and operational groups is a daily report outlining in ‘real time’ the number of patients eligible for a dementia screening by location. This information is then disseminated to operational colleagues for action and is included within the daily operations centre meetings.
CE3.2 – Further risk assessment as a result of positive screening question

- **TARGET:** 90 per cent of patients scoring positive on the case finding question to have a further risk assessment.

- **Achievement (April 2014 – January 2016):** The following chart demonstrates that this target has been achieved month on month.

Source: NLAG data, intranet, information services team

Key to abbreviations: DPoW – Diana, Princess of Wales Hospital
SGH – Scunthorpe General Hospital

Comments:
- The Trust continues to meet this indicator
CE3.3 – Identified patients at risk to be referred in line with local pathway

- **TARGET:** 90 per cent of the patients identified as requiring referral following risk assessment to be referred in line with local pathway.

- **Achievement (April 2014 – January 2016):** The following chart demonstrates that this target has been achieved month on month.

![Graph showing compliance percentage over time]

**Source:** NLAG data, intranet, information services team

**Key to abbreviations:**
- DPoW – Diana, Princess of Wales Hospital
- SGH – Scunthorpe General Hospital

**Comments:**
- The Trust continues to meet this indicator.

**Has the quality indicator been changed during the year from that set in last year’s (2014/15) Quality Account?** No, there has been no change to this quality priority during the 2015/16 reporting period.

**Rationale for changing this quality priority for 2016/17:** Indicator 3.1 relating to screening patients for dementia will remain a quality priority for 2016/17. The other two elements to dementia have been embedded and will therefore no longer be focussed upon during 16/17.
Introduction to National Institute for Health and Care Excellence (NICE) guidelines
The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. NICE was originally set up in 1999 to reduce variation in the availability and quality of NHS treatments and care.

The Trust’s policy for dealing with NICE guidance is that every guideline released is assessed by the Trust for relevance and then an assessment of how compliant the Trust is with the guideline. If any gaps are found, individual groups use the Trust’s Gap Analysis toolkit as the basis for outlining what action is needed in order to be compliant with NICE issued recommendations. The following section outlines a small glimpse into this process and outlines current levels of declared compliance.

CE4 – Compliance with NICE evidenced based practice:

- **TARGET:** To increase compliance with NICE guidance to 90 per cent by the end of March 2016.
- **Achievement (February 2016):** The Trust has not yet achieved this quality priority, and this will therefore remain as an area of focus during 2016/17 as a quality indicator for oversight by the Trust Board.

Overall Trust Compliance – NICE Technology Appraisal Guidance (TAGs)
As at the 29 February 2016, Trust compliance with those NICE Technology Appraisal Guidelines (TAGs) that had been assessed using the Trust’s Gap Analysis toolkit is as follows:

<table>
<thead>
<tr>
<th>COLOUR</th>
<th>COMPLIANCE STATUS</th>
<th>COMPLIANCE NUMBERS</th>
<th>COMPLIANCE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GREEN</td>
<td>FULL COMPLIANCE</td>
<td>201</td>
<td>94.4%</td>
</tr>
<tr>
<td>AMBER</td>
<td>Partial compliance</td>
<td>3</td>
<td>1.4%</td>
</tr>
<tr>
<td>BLUE</td>
<td>Not yet assessed – OVERDUE</td>
<td>9</td>
<td>4.2%</td>
</tr>
<tr>
<td>RED</td>
<td>Non-Compliant</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>213</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Overall Trust Compliance – All NICE Guidance
As at the 29 February 2016, overall Trust compliance is as follows:

<table>
<thead>
<tr>
<th>COLOUR</th>
<th>COMPLIANCE STATUS</th>
<th>COMPLIANCE NUMBERS</th>
<th>COMPLIANCE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GREEN</td>
<td>FULL COMPLIANCE</td>
<td>381</td>
<td>84.1%</td>
</tr>
<tr>
<td>AMBER</td>
<td>Partial compliance</td>
<td>32</td>
<td>7.1%</td>
</tr>
<tr>
<td>BLUE</td>
<td>Not yet assessed – OVERDUE</td>
<td>38</td>
<td>8.4%</td>
</tr>
<tr>
<td>RED</td>
<td>Non-Compliant</td>
<td>2</td>
<td>0.4%</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>453</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Trust NICE Database

Key to abbreviations:
- Full compliance – fully compliant as declared by teams assessing guideline
- Partial compliance – some elements of the guideline not yet compliant with
- Non-compliant, deviation approved by TG&AC – not compliant with the NICE guideline, and rationale for this presented and approved by the Trust’s Governance and Assurance committee
- Not yet assessed – overdue – compliance not yet assessed and deadline missed
- Non-compliant – fully non-compliant at present with NICE recommendations
Has the quality indicator been changed during the year from that set in last years (2014/15) Quality Account? No, there has been no change to this quality priority during the 2015/16 reporting period.

Rationale for changing this quality priority for 2016/17: As a result of not yet meeting this quality indicator, this will remain an area of focus for 2016/17, however specific wording of the indicator has been amended to monitor compliance with specific types of NICE guidance.

CE5 Transfer and Discharge

- **TARGET**: Transfer of patients for non-clinical reasons (capacity) to not exceed 10% of the total transfers.
- **Achievement (February 2016)**: The Trust has not yet achieved this quality priority, and this will therefore remain as an area of focus during 2016/17 as a quality indicator for oversight by the Trust Board.

The transfer and discharge group continue to focus on this important area. The work as it progresses is captured within the group’s action plan, which sets out the work being done across the Trust in regard to patient flow, including:

- Refining the data compendium to provide information to drive clinical change
- Securing clinical leadership to drive the changes
- Recognising the impact of multi-agency action on realizing discharges
- Opportunities to learn from best practice elsewhere
- Focussing on feedback received from colleagues in primary and community care regarding the quality of discharge communication.

This work is guided by a compendium of data on these various aspects of transfer and discharge, provided by Information Services. The dashboard, providing an at a glance summary of the key data is provided overleaf.
Source: Transfer and Discharge Working Group Report, Trust Information Services
Overview of the quality of care against 2015/16 quality priorities:

2.1a Clinical Effectiveness (CE)

2.1b PATIENT SAFETY (PS)

→ PS1 MRSA Bacteremia Incidence
→ PS2 C Difficile
→ PS3 Safety Thermometer (Community)
→ PS4 Safety Thermometer (Acute)
→ PS5 Falls
→ PS6 Pressure Ulcers
→ PS7 Nutrition
→ PS8 Hydration

2.1c Patient Experience (PE)
2.1b PATIENT SAFETY

PS1 – MRSA bacteraemia incidence

- **TARGET:** 0 MRSA Bacteraemia developing after 48 hours into the inpatient stay (hospital acquired).

- **Achievement (April 2015 – January 2016):** This target has been met with zero MRSA Bacteraemias being reported within this timeframe

![Graph showing Hospital Acquired MRSA Bacteraemias](image)

**Source:** Trust Infection Control Database, Information Services Team

**Key points – previous performance: Hospital acquired MRSA (post 48hrs)**

<table>
<thead>
<tr>
<th>Year</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA Incidence</td>
<td>8</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

**Source:** Trust Infection Control Database, Information Services Team

**Has the quality indicator been changed during the year from that set in last year’s (2014/15) Quality Account?** No, there has been no change to this quality priority during the 2015/16 reporting period.

**Rationale for changing this quality priority for 2016/17:** Due to the important nature of this quality indicator, this will remain a quality priority for 2016/17, and therefore be monitored in the monthly quality report by the Quality and Patient Experience Committee (QPEC) and the Trust Board.

**MEDIA RELEASE: July 2015**

**Work underway to develop services for frail and elderly patients**

A £1.3million investment saw the creation of a new multi-disciplinary team which will focus solely on frail elderly patients being cared for at Scunthorpe General Hospital.

The team is made up of staff from Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), North Lincolnshire Adult Social Care and Rotherham and Doncaster and South Humber NHS Foundation (RDaSH). The new service is being funded through the Government’s Better Care Fund and is being commissioned jointly by North Lincolnshire Clinical Commissioning Group (NLCCCG) and North Lincolnshire Council.

FEAST – frail elderly assessment support team – is located at Scunthorpe hospital and operates between 8am and 10pm seven days a week providing a multi-disciplinary service for elderly patients.

Karen Fanthorpe, deputy chief operating officer at NLaG, said: “This is exciting news for frail and elderly patients, and their families and carers, as they will have rapid access to a dedicated multi-disciplinary team of staff. The aim is to keep people out of hospital if clinically appropriate. If they do need admitting, the team will ensure they are discharged in a timely and effective manner. It will help to prevent unnecessary admissions, and ensure timely and appropriate transfers of care to either a specialist acute elderly care environment, or an alternative community setting when required.”
PS2 – C. Difficile incidence

- **TARGET:** Achieve a level of no more than 21 hospitals acquired C. Difficile cases linked with a lapse in the quality of care, over the financial year 2015/16.

- **Achievement (April 2015 – January 2016):** This target has been met with at present only 7 cases reported as a result of a lapse in care. At the time of writing there were a further 5 cases awaiting review and a judgement as to whether these cases were as a result of a lapse in care. Performance is illustrated in the following chart.

**Source:** Trust Infection Control Database, Information Services Team

**Key to abbreviations:** DIPC review – Director of Infection and Prevention Control (DIPC)

**Comments:**
- A decision as to if this was as a result of a lapse in care (in other words avoidable) is made during the Director of Infection and Prevention Control (DIPC) review of the case. There can be a short delay in undertaking the review. During January there were 4 cases of C. Difficile for which the review is pending. This is illustrated in the above chart.

**For completeness:** All cases of hospital acquired C. Difficile over the financial year 2015/16.

**Trust Performance (April 2015 to date): 24 cases (ALL cases)**
- January 2016: 2 cases reported at Diana Princess of Wales Hospital
- January 2016: 2 cases reported at Scunthorpe General Hospital
- January 2016: 0 cases reported at Goole District Hospital

**Source:** Trust Infection Control Database, Information Services Team

**Key to abbreviations:** DIPC review – Director of Infection and Prevention Control (DIPC)

**Comments:**
- The above chart illustrates the trend since April 2012 for reported hospital acquired Clostridium Difficile cases. The blue line in the chart illustrates all reported infections. Added, for clarity, since April 2015 are those within each month deemed to be as a result of a lapse in the quality of care (or where the DIPC review has not yet been held).
Key points – previous performance: Hospital acquired C Diff (post 48hrs, ALL cases)

<table>
<thead>
<tr>
<th>C Diff Incidence</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>C Diff Incidence</td>
<td>43</td>
<td>41</td>
<td>37</td>
<td>24</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: Trust Infection Control Database, Information Services Team

Comments:
- The above table illustrates the continuous quality improvements made in connection with reduced numbers of hospital acquired c difficile infections.

Has the quality indicator been changed during the year from that set in last year’s (2014/15) Quality Account? At the mid-year review of the quality priorities, based on latest guidance from the Department of Health, the quality priority was amended to more accurately reflect that the specific target of no more than 21 referred to those cases identified as a result of a lapse in care not total numbers of c difficile. For completeness, however, the total number of cases has remained within the monthly quality report for completeness.

Rationale for changing this quality priority for 2016/17: This indicator will remain as a focal point, however to drive further continuous improvement, a reduced threshold of no more than 10 will be aimed for during 2016/17.

PS3 & PS4 – Safety Thermometer

Background to the community safety thermometer

The Trust uses the NHS Safety Thermometer methodology to monitor the incidence of harm as a result of their acute and community care (Community care in North Lincolnshire area only, which became a part of the Trust from April 2011).

The NHS Safety Thermometer provides the ability for ‘a temperature check’ of harm to be recorded. It does this by auditing on a point prevalence basis the care provided to patients on a given date each month. This point prevalence audit provided a ‘snapshot’ view of harm on that given day each month. It focusses on harm in four key areas:

- Pressure ulcers grades 2,3 & 4
- Falls – all falls reported, even if no harm occurred
- Catheter associated UTIs – those treated with antibiotics
- VTE – incidence of new VTEs

The fourth component part of this indicator relating to VTE is not relevant for community and therapy services, but is relevant for the acute safety thermometer.

For further details and methodology used by the Safety Thermometer, see the glossary.
PS3 – Safety Thermometer – Increase in harm free care (Community)

- **TARGET:** Provide harm free community care to 95 per cent or more patients – as measured by the safety thermometer.

- **Achievement (April 2015 – January 2016):** The Trust has generally achieved this target. Since October 2015, the Trust has exceeded this target for 5 consecutive months in a row.

The following table illustrates the total community cumulative percentage of harm free care by month since April 2013.

<table>
<thead>
<tr>
<th>Site</th>
<th>Q1 14/15</th>
<th>Q2 14/15</th>
<th>Q3 14/15</th>
<th>Q4 14/15</th>
<th>Apr 15</th>
<th>May 15</th>
<th>Jun 15</th>
<th>Jul 15</th>
<th>Aug 15</th>
<th>Sep 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Care Total</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
<td>96%</td>
<td>94%</td>
<td>96%</td>
<td>92%</td>
<td>94%</td>
<td>95%</td>
<td>94%</td>
<td>97%</td>
<td>96%</td>
<td>98%</td>
<td>98%</td>
</tr>
</tbody>
</table>

Source: NLAG Safety Thermometer Data, Intranet, Information Services Team

**Key to abbreviations:** Total – average performance within North Lincolnshire community care

**Has the quality indicator been changed during the year from that set in last year’s (2014/15) Quality Account?** No, there has been no change to this quality priority during the 2015/16 reporting period.

**Rationale for changing this quality priority for 2016/17:** As patient safety is such an important indicator to the Trust, this will remain as a quality priority for 2016/17 to ensure that practice has become embedded.

**MEDIA RELEASE: February 2016**

**Community Nurses spend more time with patients thanks to technology**

Community nurses in North Lincolnshire have more time to spend with their patients thanks to a £430k investment.

Northern Lincolnshire and Goole NHS Foundation Trust was successful in a bid for a share of a £35million nursing technology fund.

More than 300 staff who work out in the community visiting patients at home are now equipped with small, lightweight laptops giving them access to patient notes and much more.

It means they can order prescriptions and equipment for patients, update their notes, write up care plans and fill in risk assessments as well as make referrals to other services.

The staff benefiting from the laptops, which have 4G connectivity, include district nurses, community matrons and health visitors.

Tina Dockerty, district nurse in Brigg, said: “We can make better use of our time now and we spend more time with patients, meaning they have more time to ask us any questions. I once ordered some equipment for a patient and before I’d even left the house I received a phone call telling me the equipment would be with the patient the next day so patients are getting a more efficient service.”

June Riley, district nurse, said: “We used to get back to the office at about 3pm and do all our paperwork for all our patients from that day. We can now focus on one patient at a time and get everything done before we visit the next house.”
PS4 Provide harm free acute care to 95% or more patients – as measured by the Open and Honest Initiative

- **TARGET:** Provide harm free acute care to 95 per cent or more patients – as measured by the Open and Honest Initiative.

- **Achievement (April 2015 – January 2016):** From recent monitoring the number of patients who did not experience harms has not met the target set, however it should be noted that this indicator includes elements of practice outside of the Trust’s direct control, specifically for ‘old’ pressure ulcers, or pressure ulcers present prior to a patient’s coming into contact with Northern Lincolnshire & Goole NHS Foundation Trust.

**Key Points: Performance to date – Safety Thermometer:**

- The charts below show the percentage of patients not experiencing any harm.

Source: NLAG NHS Safety Thermometer, as reported within the open and honest initiative, NHS England

**Key to abbreviations:** No harms % - percentage of patients without any ‘new’ harms identified, those identified whilst the patient was in hospital.
Comments:

- The charts above illustrate that whilst 90.5% of patients did not experience any harm (new and old), a proportion of those patients presented to the acute hospital setting with a pre-existing harm i.e. an ‘old’ pressure ulcer, or in other words, a pre-existing pressure ulcer already afflicting them prior to hospital admission.
- The chart on the right hand side illustrates those patients with ‘new’ harms only – those developing at least 72 hours after admission. For January, 95.0% of patients had harm free care.
- The proportion of patients receiving harm free care therefore should be interpreted with caution, recognising that some harm is not preventable by the Trust.

Headline figures – Performance at site level (‘new’ and ‘old’ harms included):

The following chart breaks down the overall ‘headline’ figure to site specific detail. This information is for ‘new’ and ‘old’ harms, reported since October 2013.

Source: NLAG Safety Thermometer Data, as reported within the open and honest initiative, Information Services

Key to abbreviations:  
DPOW – Diana, Princess of Wales Hospital  
SGH – Scunthorpe General Hospital  
Goole – Goole District Hospital  
Any harms – ‘new’ or ‘old’ harms, as defined by NHS Safety Thermometer
To understand harm free care in the Acute Trust, the following site breakdown is presented for the month of February (figures in red illustrate the difference between ‘old’ and ‘new’ harms – where applicable):

<table>
<thead>
<tr>
<th>Location</th>
<th>Pressure Ulcers:</th>
<th>'New' harm free</th>
<th>'Old' harm free</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPoW</td>
<td>97.0%</td>
<td>93.9% (-3.1%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>99.7%</td>
<td>94.2% (-5.5%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>87.0% (-13%)</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**
- The table above illustrate that a proportion of those patients presented to the acute hospital setting with a pre-existing harm i.e. an ‘old’ pressure ulcer, or in other words, a pre-existing pressure ulcer already afflicting them prior to hospital admission. This represents the largest area of harm within the above table.
- The proportion of patients receiving harm free care therefore should be interpreted with caution, recognising that some harm is not preventable by the Trust.

**Action now being taken:**
- For ease of reference regarding the work underway to improve the quality of care for patients with pressure ulcers, please see section PS6 within this report.
MEDIA RELEASE: December 2015

Nurses put through their paces at Care Camp

Newly qualified nurses at local hospitals are being put through their paces in a unique initiative called Care Camp.

Senior nurses at Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) devised the hands-on clinical education programme to ensure staff are all doing things the ‘NLaG way’.

Nurses from overseas are also undergoing the training as an introduction to the way things are done in the UK. So far around 90 members of staff have completed the course.

The two-week intensive course aims to drive up standards at the Trust ensuring the care provided to patients is consistent in quality.

Viv Duncanson, senior infection prevention control nurse at the Trust, was one of the staff members who came up with the idea. She said: “Nurses come to us from all different backgrounds and training and we wanted to find a way to ensure the essential elements of nursing care were consistent regardless of which ward you are on or where the nurse caring for you was trained.”

Topics covered on the course include patient centred care, ward rounds, providing personal care, recognising deteriorating patients and care associated with death and dying.

Paul Kirton-Watson, associate chief nurse for medicine, said the course is particularly beneficial for overseas nurses. He said: “Care Camp is an intensive, practical course which gives staff a good grounding in the way we expect things to be done at our Trust. It also highlights any differences in practices between other countries and the UK.

“It’s a great introduction to the Trust for all our new nurses – which assures us and them that they have the skills and confidence to go out onto the wards.”

The 6 Cs of nursing: compassion, care, communication, competence, commitment and courage, are central to the course as are the Trust’s vision and values of together we care, we respect, we deliver.

Feedback from the course attendees has been very positive. Comments from some of the first Care Camp graduates, who were nurses from overseas, include:

Csongor Varga, from Romania, said: “Care Camp has been very useful, we’ve learned to make sure we pay attention to how the patient feels, and to be very careful with infection control.”

Hunor Seabo, from Romania, said: “We’re all very thankful to be able to work here and will do our best in caring for our patients.”

Janina Lucas Rodriguez, from Spain, said: “Care Camp has given us a really good two weeks of studying and learning. We’re all really looking forward to going on the wards and developing our skills and careers.”
Open and Honest Initiative: Falls & Pressure Ulcers

Key Points: Headline figures – Performance as a Trust (NEW harm only):
The following charts illustrate the number of falls and pressure ulcers, identified from all reported incidents, since October 2013, including the level of harm and the falls rate per 1000 bed days. The chart also illustrates the trend over time.

Falls

Source: NLAG Specific Findings from Open and Honest Initiative, NHS England

Key:
- Moderate – moderate harm resulting from the fall (see glossary for full definition)
- Severe – severe harm resulting from the fall (see glossary for full definition)
- Death – death resulting from the fall
- Falls rate per 1000 bed days – the number of falls expressed as a % rate per 1000 bed days to allow for comparison

Comments:
- The above chart reports the harm classifications following falls, specified by the Open and Honest Initiative, specifically resulting in moderate, severe harm, or harm leading to death
- There was one fall during January 2016 that led to moderate harm. The patient concerned was in an isolation bay close to the nurses’ station due to their infection control status. This prevented the patient being nursed in a bay where they could have been more closely monitored. The patient’s risk of falling was deemed to be low as the patient was settled and not attempting to climb out of bed. Regular care rounds were undertaken and safety rails were in situ.
Pressure Ulcers

Source: NLAG Specific Findings from Open and Honest Initiative, NHS England

Key:
Cumulative number of pressure ulcers (n=) – cumulative numbers of all grades
Hospital acquired grade 2 – grade 2 pressure ulcer (see glossary for full definition)
Hospital acquired grade 3 – grade 3 pressure ulcer (see glossary for full definition)
Hospital acquired grade 4 – grade 4 pressure ulcer (see glossary for full definition)
Rate per 1000 bed days – the number of pressure ulcers expressed as a % rate per 1000 bed days to allow for comparison

Comments:
• The pressure ulcer rate per 1000 bed days demonstrates a continuously improving performance with a decreasing trend for harm from pressure ulcers
• In January the overall number of pressure ulcers was 27 in total. This was comprised of 4 grade 3 and 24 grade 2 pressure ulcers
• 1 grade 4 pressure ulcer was reported. This is the first to be reported since August 2015. This patient was known to the team and had been in to hospital a number of times with pressure damage, this had deteriorated to grade 4 pressure damage. An RCA was undertaken and this was deemed to be unavoidable.

Action now being taken:
• For ease of reference regarding the work underway to improve the quality of care for these patients, please see sections PS5 and PS6 of this report.

Has the quality indicator been changed during the year from that set in last year’s (2014/15) Quality Account? No, there has been no change to this quality priority during the 2015/16 reporting period.

Rationale for changing this quality priority for 2016/17: This indicator assesses not only the care provided by Northern Lincolnshire & Goole NHS Foundation Trust but also the care provided by other organisations, specifically to do with ‘old’ pressure ulcers, or in other words, pressure ulcers present prior to a patient’s contact with the Trust. As a result the Trust has struggled to use this quality priority to guide further improvements (especially when for ‘new’ harms, or those acquired whilst under the Trust’s care the percentage of harm free care routinely exceeds the 95% target). Therefore the proposal has been made to re-focus this on hospital acquired pressure ulcers with the intention of improving quality for specific wards currently reporting higher incidences of pressure ulcers.
PS5 – Patient falls

An introduction

To aid the Trust’s understanding and to guide its approach to reducing patient falls, patients having been identified as having had a repeat fall are assessed using an approved Root Cause Analysis (RCA) process culminating in a meeting with ward staff to determine if the patients fall could have been avoided or not. Using the outcomes of this information, enables us to track progress with avoiding future falls.

PS5 – Patient falls – Eliminate all avoidable repeat fallers

- **TARGET:** Eliminate all avoidable repeat falls as measured via the root cause analysis undertaken for every repeat faller.
- **Achievement (April 2015 – January 2016):** This target has been broadly over the last 12 months. There are a few months where this target has not been met and so the proposal is for this to remain as a quality priority for 2016/17.

The following table provides a summary of performance per month against this target.

<table>
<thead>
<tr>
<th>FY: 13/14</th>
<th>Q1 14/15</th>
<th>Q2 14/15</th>
<th>Q3 14/15</th>
<th>Q4 14/15</th>
<th>Q1 15/16</th>
<th>Jul 15</th>
<th>Aug 15</th>
<th>Sep 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Repeat Fallers</td>
<td>362</td>
<td>56</td>
<td>59</td>
<td>62</td>
<td>48</td>
<td>49</td>
<td>16</td>
<td>13</td>
<td>19</td>
<td>10</td>
<td>16</td>
<td>11</td>
</tr>
<tr>
<td>Avoidable</td>
<td>41</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Unavoidable</td>
<td>321</td>
<td>52</td>
<td>58</td>
<td>60</td>
<td>47</td>
<td>45</td>
<td>16</td>
<td>12</td>
<td>19</td>
<td>10</td>
<td>14</td>
<td>10</td>
</tr>
</tbody>
</table>

Data Source: RCA Records kept by lead Quality Matron

Key to abbreviations: Avoidable – fall deemed to be avoidable as a result of the Root Cause Analysis (RCA)

Unavoidable – fall deemed to be unavoidable

Comments:

- There were zero avoidable repeat falls during January.

Action now being taken:

- Findings of the national audit of inpatient falls are being discussed and as a result, actions will be decided in response by the Trust.
- The substance misuse team will be looking at offering training to our staff regarding falls and the links to those patients who have alcohol dependency.
- Initial discussions held regarding setting up a joint falls prevention working group with community, patient safety fire officers.
- Patient profiles to be reviewed and discussed on particular ward areas that are experiencing higher numbers of falls.
- Quarterly falls prevention meetings dates have been established for 2016.

Has the quality indicator been changed during the year from that set in last year’s (2014/15) Quality Account? No, there has been no change to this quality priority during the 2015/16 reporting period.

Rationale for changing this quality priority for 2016/17: As patient safety is such an important indicator, the Trust will continue to monitor this quality priority monthly within the quality report.
PS6 – Pressure ulcers

An introduction – patient safety – the Trust’s open and honest approach

As part of the Open and Honest dataset, the Trust publishes the number of grade 2, 3 and 4 pressure ulcers and undertake a root cause analysis on all of these. A transparent culture builds public confidence in the nursing care patients receive and ensures organisational accountability for care.

PS6 – Pressure ulcers – 50 per cent reduction in avoidable grade 2, 3 and 4 pressure ulcers

- **TARGET:** Reduction by 50% avoidable grade 2, 3 and 4 pressure ulcers as measured via the root cause analysis undertaken.

- **Achievement (April 2015 – January 2016):** This target has largely been met during 2015/16; however, to enable the Trust to continue to focus on improved quality for this area of pressure ulcers, this will remain as a quality priority for 2016/17.

Avoidable grade 2, 3 and 4 hospital acquired pressure ulcers – RCA outcomes – 50% reduction in avoidable grade 2, 3 and 4 pressure ulcers

The Trust has actively been focussed on reducing hospital acquired pressure ulcers. The following table focusses on the number of potentially avoidable grade 2, 3 and 4 pressure ulcers. This is first time the root cause analysis work will include grade 2 pressure ulcers as well as previously reported grades 3 and 4. This results in a strengthened quality improvement focussed target.

The information below is taken from records kept by the lead Quality Matron as a result of the RCA work taking place for patients with grades 2, 3 & 4 pressure ulcers.

In order to determine the local target metrics, total numbers of avoidable grade 2, 3 and 4 pressure ulcers were identified for quarter 1, which resulted in 12 that were deemed to be avoidable following the root cause analysis work undertaken. Based on this, setting a 50% reduction target, equates to no more than 6 pressure ulcers per quarter. 6 per quarter, divided by 3 months, equates to no more than 2 avoidable pressure ulcers per reported month.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of Grades 2, 3 &amp; 4 Pressure Ulcers</th>
<th>Avoidable</th>
<th>Unavoidable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 14/15</td>
<td>87</td>
<td>12</td>
<td>75</td>
</tr>
<tr>
<td>Q2 14/15</td>
<td>85</td>
<td>24</td>
<td>61</td>
</tr>
<tr>
<td>Q3 14/15</td>
<td>98</td>
<td>14</td>
<td>69</td>
</tr>
<tr>
<td>Q4 14/15</td>
<td>120</td>
<td>8</td>
<td>78</td>
</tr>
<tr>
<td>Apr 15</td>
<td>24</td>
<td>1</td>
<td>23</td>
</tr>
<tr>
<td>May 15</td>
<td>35</td>
<td>0</td>
<td>35</td>
</tr>
<tr>
<td>Jun 15</td>
<td>22</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>Jul 15</td>
<td>23</td>
<td>1</td>
<td>24</td>
</tr>
<tr>
<td>Aug 15</td>
<td>25</td>
<td>1</td>
<td>24</td>
</tr>
<tr>
<td>Sep 15</td>
<td>16</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Oct 15</td>
<td>20</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Nov 15</td>
<td>29</td>
<td>5</td>
<td>24</td>
</tr>
<tr>
<td>Dec 15</td>
<td>23</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>Jan 16</td>
<td>29</td>
<td>2</td>
<td>27</td>
</tr>
</tbody>
</table>

**Avoidable:**
- 14% Grade 2
- 28% Grade 3
- 14% Grade 4
- 7% Grade 5
- 4% Grade 6
- 0% Grade 7
- 4% Grade 8
- 0% Grade 9

**Unavoidable:**
- 86% Grade 2
- 72% Grade 3
- 70% Grade 4
- 65% Grade 5
- 96% Grade 6
- 100% Grade 7
- 100% Grade 8
- 96% Grade 9
- 100% Grade 10

**Source:** RCA Records kept by lead Quality Matron

**Comments:**
- There were two avoidable Grade 2 pressure ulcers in January both at SGH.
- The number of avoidable pressure ulcers this month equates to the target set.
Has the quality indicator been changed during the year from that set in last year’s (2014/15) Quality Account? No, there has been no change to this quality priority during the 2015/16 reporting period.

Rationale for changing this quality priority for 2016/17: As patient safety is such an important indicator to the Trust, and as this target has not yet been met, the Trust will continue to monitor this within the monthly quality report.

**MEDIA RELEASE: March 2016**

**Phase two of theatres refurbishment scheme underway**

Work has started on phase two of the plan to refurbish the operating theatres at Grimsby’s Diana, Princess of Wales Hospital.

The £1.9million project has seen phase one completed with a new laminar flow ventilation system, new theatres lights and a new digital panel installed in one of the theatres. Laminar flow is a type of system used in mainly implant surgery, such as orthopaedics or breast surgery, to reduce the risk of infection.

The second part of the project will see two trauma and orthopaedic theatres closed for work to begin refurbishing them. Work is expected to be completed in June. Mr Frank Howell, consultant orthopaedic surgeon, said: “This latest phase of works will see two theatres closed and completely refurbished with new ventilation systems installed, new flooring and decoration and new pendants installed, which will contain medical gases and other key equipment. A fire wall is also being installed across the main theatre corridor, as well as a new reception area and new purpose-built storage for orthopaedic equipment.”

**PS7 Nutrition**

**PS7.1 Nutrition – for 100% of patients the Nutrition care pathway was followed**

The Trust uses the Malnutrition Universal Screening Tool (MUST) across all adult in-patient ward areas (excluding maternity, day surgery and investigations unit). The MUST care pathway is screening Tool is used to identify those patients who are at risk of malnutrition and for those at risk, to ensure a management plan is in place for the duration of the patients stay.

The total MUST score for a patient is worked out from their BMI, the amount of unplanned weight loss they may have and the ‘acute disease effect’ (if the patient is acutely ill and there has been or likely to be no nutritional intake for >5 days). The MUST score triggers appropriate action, as described below:

- MUST score of 0: Low risk and require screening weekly.
- MUST score of 1: Moderate risk and require screening weekly, commencement and completion of a food record chart, to be encouraged to have fortified meals from the food menu, offered snacks from the Trust wide snack list.
- MUST score of 2 or more: High risk and require the same management as those patients scoring 1 plus a referral to the dietician for a dietetic review.
PS7.1 – Nutrition – for 100% of patients the Nutrition care pathway was followed

- **TARGET:** In 100% of patients, the nutrition care pathway was followed.

- **Achievement (April 2015 – January 2016):** This target has not yet been met; therefore this target will remain for 2016/17.

The following chart illustrates current levels of compliance with using the care pathway following roll-out of the MUST scoring system in September 2013.

![In 100% of patients the Nutrition care pathway was followed](chart)

**Source:** Information Services, Nursing Dashboard

**Key to abbreviations:**
- Trustwide – Northern Lincolnshire & Goole NHS Foundation Trust overall
- DPoW – Diana, Princess of Wales Hospital
- SGH – Scunthorpe General Hospital
- GDH – Goole District Hospital

**NB:** The above charts axis starts at 80%.

**Comments:**
- Performance against this indicator at all DPOW and SGH has not yet achieved the 100% target set. However as can be seen from the trend line, this is generally improving and so is a positive trend.

**Action now being taken:**
- Focussed work to be undertaken on ensuring protected mealtimes are adhered to and improved use of the salmon pink tray for those patients identified as requiring assistance with eating or drinking or who require monitoring of their nutritional intake.
- Also in support of this is the introduction of a mealtime standard, outlining what is expected of staff at mealtimes. Discussions with the Executive Team have led to the innovation ‘Adopt a Ward’. This initiative is designed to provide greater support and assistance to ward areas, during mealtimes, from other Trust staff adopting a ward and working with the staff on a monthly basis to aid the application of the mealtime standard.
- The electronic nursing documentation development is ongoing and it is planned that all charts will be included within this development which will support the record keeping of the charts and improve compliance.
Has the quality indicator been changed during the year from that set in last year’s (2014/15) Quality Account? No, there has been no change to this quality priority during the 2015/16 reporting period.

Rationale for changing this quality priority for 2016/17: As nutrition and hydration are crucial indicators to the Trust, and as this target has not yet been met, the Trust will continue to monitor this within the monthly quality report.

MEDIA RELEASE: October 2015

Ambulatory service now up and running

A new ambulatory emergency care service is now up and running at Scunthorpe hospital which will assess, treat and discharge patients on the same day.

Patients referred to the unit will be seen by a senior clinician so decisions about their care can be made quickly, preventing where possible the need to admit them to an inpatient bed.

Traditionally acute medical patients are admitted to a hospital ward and assessed by a consultant to decide what diagnostics or treatment they need. Ambulatory care is based on the idea that some medical conditions can be managed in an outpatient setting with the appropriate diagnostic and support services to hand.

Peter Bowker, associate chief operating officer for medicine, said: “Ambulatory care applies to some conditions that can be treated without the need for an overnight stay in hospital. Patients receive the same medical treatment they would previously have received as an inpatient.”

Patients will be referred to the unit either by their GP or staff in the emergency centre at the hospital.

Dr Vijay Singh, consultant acute care physician, said: “The unit is all about ensuring medical patients are managed in the most appropriate way. They will be seen by a senior clinician and decisions made quickly about their care. They will have fast access to diagnostics ensuring treatment can be started immediately, which means they don’t have to stay in hospital overnight.”

Dr Singh added: “It is about trying to reduce the number of medical patients admitted to hospital as low risk patients can be managed as outpatients and discharged back to the comfort of their own home. Ultimately we aim to provide a fast, responsive service that helps patients get home quickly as we know that people would prefer to be in their own homes than in hospital. If the patient requires further treatment they will either be asked to attend the unit the following day or given an outpatient appointment. If the clinician decides they require more intensive treatment they will be admitted to the hospital as an inpatient.”
PS7.2 Nutrition

PS 7.2 continues the nutrition theme, this time focussing on ensuring that those patients who are identified as moderate to high risk (MUST score >1) have a food record chart commenced and completed fully in line with the management plan.

PS7.2 – Nutrition – for 100% of patients the food record chart was completed accurately and fully in line with the care pathway

- **TARGET:** In 100% of patients, the food record chart was completed accurately and fully in line with the care pathway.

- **Achievement (April 2015 – January 2016):** This target has not yet been met; therefore this target will remain for 2016/17.

The following chart illustrates the current compliance with ensuring the food record chart was used fully and appropriately.

![Food Record Chart Compliance Chart]

**Source:** Information Services, Nursing Dashboard

**Key to abbreviations:**
- Trustwide – Northern Lincolnshire & Goole NHS Foundation Trust overall
- DPoW – Diana, Princess of Wales Hospital
- SGH – Scunthorpe General Hospital
- GDH – Goole District Hospital

**NB:** The above charts axis starts at 80%.

**Comments:**
- Compliance reported above is ascertained from examining the documentation completed for those patients at risk who have been commenced on the food record chart. Therefore, not every patient on the ward will be on a food record chart, rather the numbers of patients needing this are very small. The figures presented above, therefore, should be interpreted with caution due to the small numbers represented.

**Action now being taken:**
- The Quality Matrons continue to undertake a more detailed focussed review of nutrition and hydration indicators. This work has included a wider scoping of patients deemed to be at risk and assessment of these patients to determine if the food record chart has been commenced and completed appropriately. Where improvements were felt to be possible, this supportive action has been taken at the time of the Quality Matron visit.
- A recent audit has been undertaken examining performance with certain meal time indicators. The results of this are to be shared with NMAF for discussion and a plan of action to be taken in response.
A pilot project was undertaken on wards 16 and 23 to aid staff awareness and support of patients with nutritional needs by using laminated symbol cards. The results of this pilot have proved its success. The newly appointed Quality Matron will then develop this further and work to spread this innovation.

Has the quality indicator been changed during the year from that set in last year’s (2014/15) Quality Account? No, there has been no change to this quality priority during the 2015/16 reporting period.

Rationale for changing this quality priority for 2016/17: As nutrition and hydration are crucial indicators to the Trust, and as this target has not yet been met, the Trust will continue to monitor this within the monthly quality report.

PS8 Hydration

PS 8 relates to the previous indicators but focusses on the hydration needs of patients admitted to the Trust. Accurate fluid balance monitoring is an essential tool in the early identification of a patient whose condition is deteriorating. Monitoring the hydration status of patients by using fluid management charts is imperative to reducing the risks of dehydration and the associated complications it can bring.

PS8 Hydration – for 100% of patients the fluid management chart was completed accurately and fully in line with the care pathway.

- **TARGET:** In 100% of patients the fluid management chart was completed accurately and fully in line with the care pathway.

- **Achievement (April 2015 – January 2016):** This target has not yet been met; therefore this target will remain for 2016/17.

Source: Information Services, Nursing Dashboard

Key to abbreviations:  
Trustwide – Northern Lincolnshire & Goole NHS Foundation Trust overall  
DPoW – Diana, Princess of Wales Hospital  
SGH – Scunthorpe General Hospital  
GDH – Goole District Hospital

NB: The above charts axis starts at 80%.

Comments:

- Evidence of compliance at SGH has risen to 94%. A similar trend to the documented completion of the food record chart is seen here.
• This is one of the indicators used to identify ward areas needing support meetings with the Deputy Chief Nurse to understand the context and agree actions for improvement. This work continues.

**Action now being taken:**

• Fluid charts are an area that has been included on the electronic nursing document. A roll-out date for this is currently being agreed as a matter of priority.

**Has the quality indicator been changed during the year from that set in last year’s (2014/15) Quality Account?** No, there has been no change to this quality priority during the 2015/16 reporting period.

**Rationale for changing this quality priority for 2016/17:** As nutrition and hydration are crucial indicators to the Trust, and as this target has not yet been met, the Trust will continue to monitor this within the monthly quality report.

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**Update on: The Trust’s Patient Safety Improvement Plan as part of the Sign up to Safety campaign**

Sign up to Safety is a national initiative to help NHS organisations achieve their patient safety aspirations and care for their patients in the safest way possible. The heart of this initiative is the belief that this is locally led, self-directed safety improvement work. The initiative seeks to empower healthcare providers to make any changes they feel necessary in their work to increase patient safety. How has the Trust got involved in this national initiative?

In the spirit of this national initiative recommending locally led patient safety improvement work, the Trust self-selected 5 priority areas on which to focus, these are:

• Falls prevention,
• Pressure ulcer reduction,
• Nutrition and hydration,
• Safe surgery
• Safe maternity care.

For each of these five areas, the Trust has an action plan established to track progress and outline next steps. These are reviewed and updated on a monthly basis. Contained within each action plan is the Sign up to Safety logo to demonstrate the Trust’s commitment to this initiative and to engage and remind those involved in these locally-driven patient safety improvement plans of the initiatives principles and the NHS wide focus on patient safety.

At present, already contained within this report and indeed the monthly quality report, are the overviews of performance and work underway to improve quality for falls, pressure ulcers and nutrition and hydration. This regular update to the Quality, Patient Experience Committee provides assurance to the Board that progress is being made. Additional work is underway for the safe surgery and safe maternity care to ensure that in the same way these areas are able to provide more frequent reporting to the committee to provide that assurance that these areas too are progressing.
Overview of the quality of care against 2015/16 quality priorities:

2.1a Clinical Effectiveness (CE)

2.1b Patient Safety (PS)

This Section…

2.1c PATIENT EXPERIENCE (PE)

→ PE1 Friends & Family Test
→ PE2 Reduction in Re-Opened Complaints
→ PE3 Complaints Action Plans Implemented
→ PE4 Complaints Themes Reduction in Incidence
→ PE5 Pain Management
→ PE6 Staff Satisfaction
2.1c PATIENT EXPERIENCE

PE1 Friends and Family Test – To have a response rate that achieves a response rate in the top 50%.

The Trust have participated in the friends and family test since it was launched across the country. Within 48 hours of receiving care or treatment as an inpatient or visitor to A&E, patients are given the opportunity to answer the following question:

“How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?”

PE1 Friends and Family Test – To have a response rate that achieves a response rate in the top 50%.

- **TARGET:** Have a response rate that achieves a response rate in the top 50%.
- **Achievement (April 2015 – January 2016):** This target has not yet been met.

This target measures the response rate for patient and service user feedback. When comparing the Trust to the national landscape, the following charts illustrate the response rate compared to that of other providers.

**Response Rate: A&E Friends and Family – broken down by site**

![Graph showing A&E Friends and Family response rates by site]

*Source: NHS England, Friends and Family Test Data*

**Comments:**

The Trust ranks 78 out of 141, placed in the bottom 50% of responding organisations.

**Response Rate: Inpatient Friends and Family – broken down by site**

![Graph showing Inpatient Friends and Family response rates by site]

*Source: NHS England, Friends and Family Test Data*

**Key:**
- NLAG Trust – Northern Lincolnshire & Goole NHS Foundation Trust overall
- DPoW – Diana, Princess of Wales Hospital
- SGH – Scunthorpe General Hospital
- National average – the national average response rate
- Bars within graph: Each bar represents NHS organisation participating
The Trust ranks 129 out of 172 Trusts which places the Trust in the bottom 50% of responding organisations.

Feedback from: A&E Friends and Family – broken down by site

Source: NHS England, Friends and Family Test Data

Comments:
A&E feedback for the Trust is 83% which is lower than the national average of 87.4%.

Feedback from: Inpatient Friends and Family – broken down by site

Source: NHS England, Friends and Family Test Data

Key:
- NLAG Trust – Northern Lincolnshire & Goole NHS Foundation Trust overall
- DPoW – Diana, Princess of Wales Hospital
- SGH – Scunthorpe General Hospital
- National average – the national average response rate
- Bars within graph: Each bar represents NHS organisation participating

Comments:
97% recommended the Trust compared to the UK average of 95.6%.


Has the quality indicator been changed during the year from that set in last year’s (2014/15) Quality Account? No, there has been no change to this quality priority during the 2015/16 reporting period.

Rationale for changing this quality priority for 2016/17: The focal point of the Friends and Family test will not be lost in the 16/17 Quality Reporting, however the specific focus will move away from quantitative response rates and move towards the feedback received from patients and service users. The 16/17 quality priority therefore will be focussed on feedback from this national test.
PE2 – Complaints

Introduction

Complaints are a key source of learning for the Trust and as such much work is underway to ensure that the Trust responds to complaints in a constructive and helpful manner therefore answering a patient, relative or carers concerns appropriately. Secondly as a result of the complaint, appropriate action including learning lessons as a result is also of importance to the organisation. As part of this, the following sections relating to complaints are designed to ensure the Trust uses this feedback appropriately.

PE2 – Reduction in Re-opened Complaints

- **TARGET:** Re-opened complaints to not exceed 20% of total closed complaints.

- **Achievement (April 2015 – January 2016):** Broadly speaking this target has been met.

Target setting – Re-opened complaints to not exceed 20% of total closed complaints

- In order to set a useful target for this area, the context of historic performance is needed to be considered. Since May 2014, the number of reopened complaints had been on average 12 per month which exceeded the target being aimed for – a 50% reduction, equating to no more than 2.5 per month. The number of closed complaints had continued to rise and, as a significant proportion of these related to older complaints which made up the ‘backlog’, it was expected that a proportion of those complaints closed would have always been re-opened, as a result of the complainant requiring further assurance.

- To set a numerically based reduction was therefore deemed unrealistic. Instead of a numerical target, a proportional or a percentage target would seem more realistic.

- Accordingly the following chart illustrates the percentage of re-opened complaints.

Data Source: DATIX, Performance Assurance Team

**Key:**

- Re-opened: Complaints that have been resolved which for any number of reasons require further review.

**Comments:**

- The percentage of re-opened complaints is below the 20% target at 10%.

- The above chart illustrates both the percentage re-opened and the numerical equivalent. Both illustrate a downward trend therefore demonstrating a reduction in the numbers of complaints being re-opened. This would imply that complainants’ satisfaction in their complaint handling/response has improved.

- It is worth noting that in an attempt to improve complainants’ satisfaction and improve their feeling of assurance, at the end of each response letter, the complainant is
offered the opportunity of a meeting to discuss the findings. More and more complainants are taking up this opportunity and this has an impact on the numbers of reopened complaints reported in this section of the monthly quality report. As a result of this impact, work is to be invested by the Trust in understanding from peer Trusts how soon they close their complaints. From this benchmarking exercise, the Trust will make a decision as to its own timescales to ensure we are in line with other organisations. Currently complaints are closed as soon as the final response letter is sent. This work is underway and is being discussed by the Trust’s Executive Team.

**Key points: Complaints – contextual information – as at the 17 February 2016:**

![Chart showing complaints resolution from April 2013 to present.]

**Data Source:** DATIX, Performance Assurance Team

**Key:** Percentage of re-opened complaints – the % of complaints that have been re-opened

**Re-opened:** Complaints that have been resolved which for any number of reasons require further review.

**Comments:**

- The above chart illustrates the significant progress made in reducing the net open number of complaints.
- As previously noted, the number of closed complaints has risen during November and December.
- In January, the number of closed complaints fell due to a number of factors including aftermath of Christmas and New Year holidays and the difficulty in booking meetings with complainants during the month. The data for February provides assurance that the number of complaints being closed is continuing to outstrip the number of newly received complaints. This, predictably, is having a positive impact on the number of net open complaints, which has now reduced to 101, the second lowest number reported since April 2013.

**Has the quality indicator been changed during the year from that set in last years (2014/15) Quality Account?** No changes have been made to this indicator during the 15/16 financial year.

**Rationale for changing this quality priority for 2016/17:** The Trust is awaiting the results of their recent CQC inspection and the findings from an internal audit. On receipt of both reports, both of which will focus on complaints handling processes, the Trust may decide to refocus some of the current complaint quality indicators.
PE3 – Complaints – action plans agreed within timescales

- **TARGET:** 90 per cent of action plans following a complaint to be implemented within agreed timescales.
- **Achievement (April 2015 – January 2016):** This quality priority has been achieved and embedded.

The policy for the operational management of this area states that where remedial action is identified, an action plan, which records timescales and responsibilities, will be prepared by the relevant directorate / operational group on the closure of a concern or no later than three months after closure of the complaint and will be monitored regularly by the operational group until fully implemented. Whilst this is not a new requirement, the electronic recording of completed actions on DATIX has not been consistent.

- **Step one of the process:** The table below illustrates the drafting an action plan stage, for those complaints requiring action.

<table>
<thead>
<tr>
<th>Total number closed</th>
<th>Q1 14/15</th>
<th>Q2 14/15</th>
<th>Q2 14/15</th>
<th>Q4 14/15</th>
<th>Q1 15/16</th>
<th>Jul 15</th>
<th>Aug 15</th>
<th>Sep 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
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<tr>
<td>182</td>
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<td>152</td>
<td>151</td>
<td>38</td>
<td>29</td>
<td>39</td>
<td>35</td>
<td>56</td>
<td>47</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total number requiring action plan</th>
<th>Q1 14/15</th>
<th>Q2 14/15</th>
<th>Q2 14/15</th>
<th>Q4 14/15</th>
<th>Q1 15/16</th>
<th>Jul 15</th>
<th>Aug 15</th>
<th>Sep 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>39</td>
<td>53</td>
<td>48</td>
<td>64</td>
<td>11</td>
<td>10</td>
<td>10</td>
<td>22</td>
<td>11</td>
<td>5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Number of action plans drafted | 41       | 39       | 53       | 48       | 64       | 11     | 10     | 10     | 22     | 11     | 5      |

| % action plans drafted by | 100%     | 100%     | 100%     | 100%     | 100%     | 100%   | 100%   | 100%   | 100%   | 100%   | 100%   |

**Data Source:** DATIX, clinical and quality assurance team

**Key:**
- Closed complaint – the number resolved within the month,
- Action plan – a plan to resolve any areas for improvement identified as a result of the complaint,
- Action plans drafted by central team – action plan developed as a result of the complaint,
- % action plans drafted by complaints team – the number of action plans drafted as expressed by a percentage (%).

- **Step two** of the process is implementation by the relevant Directorate / Operational Group of the actions within the agreed 3 month timeframe following closure of a complaint.
- The table below illustrates the number of action plans that required implementation during each month and then illustrates the number of these actually implemented in practice. Due to the aforementioned 3 month timescale, the number eligible for completion each month differs from the number drafted in the same month.

<table>
<thead>
<tr>
<th>Number of action plans requiring implementation</th>
<th>Q1 14/15</th>
<th>Q2 14/15</th>
<th>Q2 14/15</th>
<th>Q4 14/15</th>
<th>Q1 15/16</th>
<th>Jul 15</th>
<th>Aug 15</th>
<th>Sep 15</th>
<th>Oct 15</th>
<th>Nov 15</th>
<th>Dec 15</th>
<th>Jan 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>14</td>
<td>40</td>
<td>32</td>
<td>50</td>
<td>16</td>
<td>20</td>
<td>23</td>
<td>14</td>
<td>10</td>
<td>5</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

| Number of action plans fully implemented | 4        | 0        | 31       | 30       | 48       | 16     | 20     | 23     | 14     | 10     | 5      | 7      |

| % of action plans fully implemented | 9%       | 0%       | 78%      | 94%      | 96%      | 100%   | 100%   | 100%   | 100%   | 100%   | 100%   | 100%   |

**Data Source:** DATIX, clinical and quality assurance team

**Key:**
- Complaint action plans requiring implementation – the number where the action plan deadline agreed ended in this period,
- Action plan fully implemented – the agreed plan is fully implemented as a result of the complaint,
- % action plans fully implemented – the number of action plans implemented as expressed by a percentage (%).

**Has the quality indicator been changed during the year from that set in last year’s (2014/15) Quality Account?** No, there has been no change to this quality priority during the 2015/16 reporting period.

**Rationale for changing this quality priority for 2016/17:** As illustrated above, this quality
priority has been embedded within practice, therefore this indicator will no longer feature as a quality priority for 16/17.

PE4 – Complaints

- **TARGET:** To achieve a 50% reduction in complaints relating to the specific theme of communication (*Reported quarterly*)

- **Achievement (April 2015 – January 2016):** During 2015/16 this target was unable to be measured. From the information recorded on Datix, the theme of communication was not able to identify with any consistency, too much interpretation led to overinflated reporting. As a result, the Trust invested efforts into the data capture mechanism within Datix when a new complaint is first recorded. Using this more reliable data capture process, the plan is for the Trust to monitor the data emerging from this with a view to setting a realistic and useful target around complaints relating to communication as the theme.

PE4 – Complaints

**Target – To achieve a 50% reduction in complaints relating to the specific theme of communication (*Reported quarterly*)**

**Mid-year review of target:**

- This target was designed to aid an improved understanding. However from reviewing the themes to date and reporting these in this report, it has been difficult to ascertain the number of complaints made for the specific reason of poor communication. During the mid-year review of quality priorities the decision was taken to review this target.

- As a result the DATIX system has been refreshed to include additional and more specific categories for complaint themes to be logged at the time the complaint is received. These additional, more specific codes will enable the central complaints handlers to accurately code the exact nature of the communication theme which will enable the Trust to understand this area in much greater detail.

- Over the page, the communication related complaints have been broken down and reported on within this monthly report, now providing 3 months’ worth of data. This data is currently available for the months of November, December and January 2015/16. Using this data and that collated during early 2016, will provide an accurate baseline on which to use to set a more appropriate reduction target for the 2016/17 quality priorities and monitoring of these in this monthly report.

- On the following page this data is presented.

- **NB:** It should be noted that those complaints listed under the ‘open as at…’ table will likely include some data reported in the previous month, as in some cases complaints will remain open overlapping 2 or more reporting month periods, dependant on the nature and complexity of the complaint. Therefore this table should be interpreted with caution.

- **NB:** The table listed under the ‘closed as at…’ includes only those complaints closed, with a communication or values code within that month. Therefore no parallels can be drawn from earlier presented numbers of closed complaints as the analysis of the two data sets are different.
<table>
<thead>
<tr>
<th>Communication Codes</th>
<th>OPEN AS AT</th>
<th>Cumulative (see NB note on previous page)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30-Nov-15</td>
<td>02-Feb-16</td>
</tr>
<tr>
<td>Failure to keep relatives informed</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Communication with relatives/carers</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Communication with patient</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Failure to give adequate discharge advice</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Failure to adhere to open &amp; honest policy</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Inconsistent clinical advice given</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Quality/Content of letters</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Inadequate information provided</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Breakdown in communication between staff</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Failure to communicate test results</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Failure to listen to relatives</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Failure to listen to patient</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Failure to liaise with patient following incident</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Inadequate record keeping</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Communication between medical teams</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Test results</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Information on Condition &amp; Treatment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Values and Behaviours (Staff) Codes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitude of staff - Consultant</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Attitude of Medical Staff</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Breach of Confidentiality by Staff</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Attitude of staff - Nursing</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>20</td>
<td>16</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Communication Codes</th>
<th>CLOSED AS AT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30-Nov-15</td>
</tr>
<tr>
<td>Failure to keep relatives informed</td>
<td>6</td>
</tr>
<tr>
<td>Failure to keep patient informed</td>
<td>3</td>
</tr>
<tr>
<td>Failure to communicate test results</td>
<td>2</td>
</tr>
<tr>
<td>Communication with patient</td>
<td>2</td>
</tr>
<tr>
<td>Contradicting clinical advice</td>
<td>1</td>
</tr>
<tr>
<td>Communication between medical teams</td>
<td>0</td>
</tr>
<tr>
<td>Communication with relatives/carers</td>
<td>0</td>
</tr>
<tr>
<td>Failure to listen to relatives</td>
<td>0</td>
</tr>
<tr>
<td>Information on non-clinical issues</td>
<td>1</td>
</tr>
<tr>
<td>Communication failure between departments</td>
<td>1</td>
</tr>
<tr>
<td>Communication with GP</td>
<td>0</td>
</tr>
<tr>
<td>Attitude of staff - Consultant</td>
<td>0</td>
</tr>
<tr>
<td>Incorrect/no information given</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>16</td>
</tr>
</tbody>
</table>

**Comments:**
- Failure to keep relatives informed remains the number one theme arising from an analysis of those complaints open within these two reporting periods. This is very closely linked to the second row in the table – ‘communication with relatives and carers’.
Has the quality indicator been changed during the year from that set in last year’s (2014/15) Quality Account? Yes, as described above, the target is to be amended on the back of greater specificity from amendments made to the data collection mechanism within the Datix system.

Rationale for changing this quality priority for 2016/17: This indicator will be changed during the early part of 16/17 on the back of greater quality data to ensure the Trust can use this as a meaningful indicator to aid improvements in the area of communication.

PE5 – Pain Management

- **TARGET:** Pain management
- **Achievement (April 2015 – March 2016):** This target has not yet been measured.

Key points – context:

- Following reflections within the ‘patient stories’ presented to QPEC and the Trust Board, management of pain and administration of pain relief were areas felt to require additional scrutiny.
- Guidance on nurse staffing levels included a number of nursing ‘red flags’ to help trigger areas for greater nursing scrutiny/management. Two of these ‘red flags’ related to this area, specifically:
  - Unplanned omission in providing patient medications,
  - Delay of more than 30 minutes in providing pain relief.
- The nursing dashboard process by which levels of nursing quality are measured on a monthly basis, evaluating 10 patients on every ward within the Trust, has been refreshed and is likely to go live during March 2016. The core nursing dashboard will be expanded to include patient experience, community adult and community children dashboards. These will be reviewed at 6 months to determine if they need any further development.
- To ensure the Chief Nurse directorate are focussed on pain management, this refresh includes 4 specific new questions that relate to pain management, these are as follows:
  - **Patient Experience Dashboard:**
    - Did you feel that the medical and nursing staff did everything they could to help control your pain?
    - Did you receive pain relief when you needed it, in a timely way by staff?
  - **Acute Adult Nursing Dashboard:**
    - Are there >2 omitted doses of 1 or more medications?
    - Was the appropriate action taken in relation to the medication omission?
- The findings from these new dashboard questions will be included in the re-launched nursing dashboard questions going lived on the 2nd March 2016.

Has the quality indicator been changed during the year from that set in last year’s (2014/15) Quality Account? No, the quality priority has not changed, work has been invested to ensure this information can be collected and reported to guide future improvements in this area, it is intended that data should be available for this during March 2016.

Rationale for changing this quality priority for 2016/17: No changes are proposed for this indicator.
PE6 – Staff satisfaction: culture change and the morale barometer

- **TARGET:** Staff satisfaction – 2.5% increase in morale / staff satisfaction at each reported morale barometer.

- **Achievement (April 2015 – January 2016):** This indicator has not yet been achieved.

**Key Points – Performance to date:**

**Morale Barometer incorporating the Friends and Family test**

- The ninth Morale Barometer survey took place in September 2015.
- All 6,500 staff were invited to take part and participate in this quarterly survey.

Response rates to date are illustrated in the following table:

<table>
<thead>
<tr>
<th>Date</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov 2011</td>
<td>87</td>
</tr>
<tr>
<td>May 2013</td>
<td>340</td>
</tr>
<tr>
<td>Sept 2013</td>
<td>545</td>
</tr>
<tr>
<td>Jan 2014</td>
<td>356</td>
</tr>
<tr>
<td>Apr 2014</td>
<td>330</td>
</tr>
<tr>
<td>July 2014</td>
<td>496</td>
</tr>
<tr>
<td>Oct 2014</td>
<td>286</td>
</tr>
<tr>
<td>May 2015</td>
<td>321</td>
</tr>
<tr>
<td>Sept 2015</td>
<td>288</td>
</tr>
</tbody>
</table>

Source: Morale Barometer Findings, Directorate of Organisation Development and Workforce

**Actions (all actions link to agreed QPEC MB May 2015 action plan):**

1. OD Team to conduct evaluate of engagement, value, staff voice etc. within AHP staff group and share best practice,

2. OD Team to conduct some all staff Friends and Family Test focus groups to review findings and provide steer to reverse the growing 'unlikely' to recommend the trust as a place to work concerns,

3. Communications and marketing to review and adapt communication channels for ‘all staff’ not just those with PC access,

4. ETD to continue to work regarding improving the PADR experience and effectiveness of PDPs.

**Summary: Measurement of the Quality improvement target around this area**

- To measure this quality improvement target, the key question highlighted on the next page, is used to measure progress in this area. The question asks:

> “How much personal satisfaction do you get from coming to work?”

**Has the quality indicator been changed during the year from that set in last year’s (2014/15) Quality Account?** No, the quality priority has not changed during the 15/16 reporting period.

**Rationale for changing this quality priority for 2016/17:** A lot of work is being planned regarding the engagement of staff. At present staff are being asked for their satisfaction in a number of different ways. As a result of this it has been proposed that we pause the morale barometer for the 16/17 financial year whilst the work behind the scenes is progressed.

The following contains the results of the most recently run morale barometer in Sept 2015 and presents this compared to previous surveys recorded in May.
## Morale Barometer Survey Dashboard - Sept 2015

### Engagement and Workload

<table>
<thead>
<tr>
<th></th>
<th>Total change</th>
<th>Month change</th>
<th>Between survey change</th>
</tr>
</thead>
<tbody>
<tr>
<td>How engaged do you feel at work?</td>
<td>4.1</td>
<td>4.1</td>
<td>4.1</td>
</tr>
<tr>
<td>How engaged do you feel at work?</td>
<td>4.1</td>
<td>4.1</td>
<td>4.1</td>
</tr>
<tr>
<td>How well do you feel your manager/manager is doing?</td>
<td>4.1</td>
<td>4.1</td>
<td>4.1</td>
</tr>
<tr>
<td>How well do you feel your manager/manager is doing?</td>
<td>4.1</td>
<td>4.1</td>
<td>4.1</td>
</tr>
<tr>
<td>How well do you feel your manager/manager is doing?</td>
<td>4.1</td>
<td>4.1</td>
<td>4.1</td>
</tr>
<tr>
<td>How well do you feel your manager/manager is doing?</td>
<td>4.1</td>
<td>4.1</td>
<td>4.1</td>
</tr>
<tr>
<td>How well do you feel your manager/manager is doing?</td>
<td>4.1</td>
<td>4.1</td>
<td>4.1</td>
</tr>
<tr>
<td>How well do you feel your manager/manager is doing?</td>
<td>4.1</td>
<td>4.1</td>
<td>4.1</td>
</tr>
</tbody>
</table>

### Value and Satisfaction

<table>
<thead>
<tr>
<th></th>
<th>Total change</th>
<th>Month change</th>
<th>Between survey change</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often did you receive recognition for your work?</td>
<td>4.7</td>
<td>4.7</td>
<td>4.7</td>
</tr>
<tr>
<td>How often did you receive recognition for your work?</td>
<td>4.7</td>
<td>4.7</td>
<td>4.7</td>
</tr>
<tr>
<td>How often did you receive recognition for your work?</td>
<td>4.7</td>
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<tr>
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<td>4.7</td>
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<tr>
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<td>4.7</td>
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<tr>
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<td>4.7</td>
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<tr>
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<td>4.7</td>
<td>4.7</td>
<td>4.7</td>
</tr>
<tr>
<td>How often did you receive recognition for your work?</td>
<td>4.7</td>
<td>4.7</td>
<td>4.7</td>
</tr>
</tbody>
</table>

### Coaching

<table>
<thead>
<tr>
<th></th>
<th>Total change</th>
<th>Month change</th>
<th>Between survey change</th>
</tr>
</thead>
<tbody>
<tr>
<td>How satisfied are you with the support you have received for your role?</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>How satisfied are you with the support you have received for your role?</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>How satisfied are you with the support you have received for your role?</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>How satisfied are you with the support you have received for your role?</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>How satisfied are you with the support you have received for your role?</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>How satisfied are you with the support you have received for your role?</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>How satisfied are you with the support you have received for your role?</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>How satisfied are you with the support you have received for your role?</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
</tbody>
</table>

### Appraisal and Development

<table>
<thead>
<tr>
<th></th>
<th>Total change</th>
<th>Month change</th>
<th>Between survey change</th>
</tr>
</thead>
<tbody>
<tr>
<td>How well did you find your recent appraisal?</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>How well did you find your recent appraisal?</td>
<td>4.0</td>
<td>4.0</td>
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</tr>
<tr>
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<td>4.0</td>
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<td>4.0</td>
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<tr>
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<td>4.0</td>
<td>4.0</td>
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<tr>
<td>How well did you find your recent appraisal?</td>
<td>4.0</td>
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<tr>
<td>How well did you find your recent appraisal?</td>
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<tr>
<td>How well did you find your recent appraisal?</td>
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<td>4.0</td>
</tr>
<tr>
<td>How well did you find your recent appraisal?</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
</tbody>
</table>

### Scoring Matrix

Scores produced are the mean of all staff groups for each survey. PAQ5 scores are based on those with 12 months service.
2.1d: Quality priorities for 2016/17

Rationale for quality priorities:

The quality priorities for 2016/17 have been identified as a result of the Trust’s concentrated monitoring of the previous year’s priorities and are linked to its continuing focus on ensuring patients and service users are provided with safe and effective care and treatment. A number.

The Trust’s Quality Targets & Priorities – Driving Continuous Improvement

It is worth noting here, that these targets/quality priorities for the most part are not nationally or regionally set, rather they are set locally by the Trust. They are selected as areas of key importance for the Trust to drive and embed continuous quality improvement. These indicators are not chosen for their ease of completion, resulting in a report full of green ‘completed’ ticks. These indicators are instead quality focussed, aspirational and stretching. As a result, the executive summary that follows, and the greater detail within part two of this report presents progress so far, not always demonstrating that our internal quality targets have been met. Where these have not been met, an explanation and summary of the work underway are presented and for the most part, these targets have been selected to stay within the quality report to drive quality development during 2016/17.

of the indicators relate to the Trust’s areas of focus during and throughout 2015/16.

How agreed:

The priorities for 2016/17 have been agreed by the Trust Board and by the Quality and Patient Experience Committee (QPEC). They have been identified via a number of mechanisms including the following:-

• Discussions with the governors,
• Discussions with the commissioners,
• The findings from the national Surveys (out-patient and in-patient),
• The findings from the staff survey,
• Findings from patient satisfactions surveys that are undertaken by the Trust,
• Feedback from patients using the ‘patient story’ video approach (played at QPEC and Trust Board meetings) alongside face to face patient stories,
• The results that are published within our nursing dashboard,
• The data provided by our clinical systems where we are identified as being an outlier
• Information from incidents and complaints,
• Comments received from local Healthwatch organisations as a result of discussions around last year’s Quality Account,
• Feedback received and work undertaken to improve as a result of the various external visits or inspections, now included within the Trust’s Quality Development Plan (QDP),
• As a result of links to other priority Trust areas e.g. Mortality.

Taking into account the wider public views:

The quality indicators are agreed following discussions with governors who represent the interests of their constituents following their election to this role from public members of the Trust. The findings from the in-patient and out-patient surveys are also considered when developing these proposed indicators to take into account the views of the wider public. Feedback and comments from the local overview & scrutiny committees, made up of elected councillors who represent their constituents, is also taken into account when formulating the proposed new quality indicators.
How progress will be monitored and measured:

Progress against these indicators will be reported monthly using the monthly quality report. The indicators include improvement targets to allow for on-going measurement. A selection of methods will be employed to measure this area including statistical process control (SPC) charts, tables and graphs. The Quality and Patient Experience Committee (QPEC) and the Board will receive this report.

To ensure our governors are involved in the Trust’s the monthly quality report features as part of the quarterly Governors Quality Review Group (QRG). This report is also shared with the Trust’s commissioners.

The companion to the monthly quality report is the monthly mortality report, this also features an overview of the organisation’s focus on mortality and provides the Mortality Performance and Assurance Committee (MPAC) and in turn the Trust Board with up to date intelligence charting the Trust’s progress against these quality focussed indicators.

2016/17 Quality priorities:

<table>
<thead>
<tr>
<th>Clinical Effectiveness:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CE1</td>
</tr>
<tr>
<td>CE2.1</td>
</tr>
<tr>
<td>CE2.2</td>
</tr>
<tr>
<td>CE3</td>
</tr>
<tr>
<td>CE4.1</td>
</tr>
<tr>
<td>CE4.2</td>
</tr>
<tr>
<td>CE5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Safety:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS1</td>
</tr>
<tr>
<td>PS2</td>
</tr>
<tr>
<td>PS3</td>
</tr>
<tr>
<td>PS4</td>
</tr>
<tr>
<td>PS5</td>
</tr>
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</table>
### Patient Safety (continued...):

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS6</td>
<td>Pressure ulcers - a 50 per cent reduction in avoidable grades 2, 3 and 4 pressure ulcers (as measured via the root cause analysis undertaken for every grade 2, 3 and 4 pressure ulcer).</td>
</tr>
<tr>
<td>PS7.1</td>
<td>Nutrition – 100 per cent of patients the care pathway was followed.</td>
</tr>
<tr>
<td>PS7.2</td>
<td>Nutrition – 100 per cent of patients identified as requiring it will have their food record chart completed accurately and fully in line with the care pathway.</td>
</tr>
<tr>
<td>PS8</td>
<td>Hydration – 100 per cent of patients identified as requiring it will have their fluid management chart completed accurately and fully in line with the care pathway.</td>
</tr>
</tbody>
</table>

### Patient Experience

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE1</td>
<td>98% of feedback from the Friends and Family Test is positive (this will be supported with, for context, response rate information)</td>
</tr>
<tr>
<td>PE2</td>
<td>Re-opened complaints to not exceed 20% of total closed complaints.</td>
</tr>
<tr>
<td>PE3</td>
<td>Complaints: Reduction of complaints relating to communication.</td>
</tr>
<tr>
<td>PE4a</td>
<td>90% of patients feel that medical and nursing staff did everything they could to help control pain.</td>
</tr>
<tr>
<td>PE4b</td>
<td>90% of patients received pain relief when they needed it in a timely manner.</td>
</tr>
<tr>
<td>PE4c</td>
<td>Patients should not have more than 2 omitted doses of medications.</td>
</tr>
<tr>
<td>PE4d</td>
<td>90% of patients should have appropriate action taken in relation to any medication omissions.</td>
</tr>
</tbody>
</table>

### MEDIA RELEASE: August 2015

**Doors open to new multi-million pound heart unit**

The doors have opened this week to a new £2.48 million cardiology day case unit at Grimsby’s Diana, Princess of Wales Hospital. Work started on the development in November 2014 and this week saw the first patients walk through the doors.

The new unit will see all outpatient and day case cardiology services at the hospital brought together in one place. It is just one of a number of initiatives that is being undertaken as part of the Healthy Lives, Healthy Futures programme of change in North and North East Lincolnshire which aims to deliver better and more efficient health and wellbeing services to people.

During the development a dedicated cardiac catheterisation laboratory has also been built, which will enable the cardiology team to provide state-of-the-art heart services. Associate medical director Mr Oltunde Ashaolu said: “The opening of the new department is incredibly exciting not just for the staff but also our patients as we will be able to offer a much more comprehensive heart service to local people. This will be much better for patients as they will be able to access a greater range of more sophisticated services on their local doorstep in a centralised, dedicated cardiac unit.

“The new unit will provide a cardiac catheter laboratory with a 12-bed day case area where we will carry out angiography work for coronary disease and carry out operations for new pacemakers and other cardiac devices. The unit will allow us access to all the necessary equipment to carry out tests and procedures for inpatients and outpatients in a more timely fashion as well as letting us do more sophisticated procedures.”

The unit has been built in the main outpatient department at the front of the hospital adjacent to the current cardiology outpatient area and has its own entrance to cardiology outpatient and day case services.”
PART 2: Priorities for improvement, statements of assurance from the Board and reporting against core indicators

2.2 Statements of assurance from the Board

2.2a Information on the review of services

During 2015/16 Northern Lincolnshire and Goole NHS Foundation Trust provided and/or sub-contracted 25 relevant health and care services.

Northern Lincolnshire and Goole NHS Foundation Trust has reviewed all the data available to them on the quality of care in 25 of these relevant health and care services.

The income generated by the relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of relevant health and care services by the Trust for 2015/16.

2.2b Information on participation in clinical audits and national confidential enquires

During 2015/16, 39 national clinical audits and 5 national confidential enquires covered relevant health services that Northern Lincolnshire and Goole NHS Foundation Trust provides.

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

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2015/16 and those in which it participated in are as follows:

**NB:** The table which follows lists:
- The name of the national clinical audits and national confidential enquiries listed in HQIP’s quality account resource,
- Which ones the Trust were eligible to participate in,
- The number of cases submitted for each audit against the number required, also expressed as a percentage (%),
- If action planning is taking place or has been completed to improve processes and practice following publication of findings.
<table>
<thead>
<tr>
<th>National clinical audit title</th>
<th>Eligible for NLAG</th>
<th>NLAG participated</th>
<th>Number of cases submitted</th>
<th>% of number required</th>
<th>Action planning</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Mix Programme (CMP)</td>
<td>Yes</td>
<td>Yes</td>
<td>915</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Major Trauma: The Trauma Audit &amp; Research Network (TARN)</td>
<td>Yes</td>
<td>Yes</td>
<td>349/498 (70%)</td>
<td>70%</td>
<td>Awaiting National Report</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>Yes</td>
<td>Yes</td>
<td>152</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>Yes</td>
<td>Yes</td>
<td>617</td>
<td>100%</td>
<td>Awaiting Publication</td>
</tr>
<tr>
<td>Royal College of Emergency Medicine : VTE in patients with lower limb immobilization</td>
<td>Yes</td>
<td>Yes</td>
<td>99</td>
<td>99%</td>
<td>Awaiting Publication of Results</td>
</tr>
<tr>
<td>Royal College of Emergency Medicine : Procedural Sedation</td>
<td>Yes</td>
<td>Yes</td>
<td>100</td>
<td>100%</td>
<td>Awaiting Publication of Results</td>
</tr>
<tr>
<td>British Thoracic Society: Emergency Oxygen</td>
<td>Yes</td>
<td>Yes</td>
<td>593</td>
<td>100%</td>
<td>Underway</td>
</tr>
<tr>
<td><strong>Blood and Transplant</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion programme</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. 2015 Audit of Patient Blood Management in Scheduled Surgery;</td>
<td>Yes</td>
<td>Yes</td>
<td>28/28</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>2. 2015 Audit of the use of blood in Lower GI bleeding;</td>
<td>Yes</td>
<td>Yes</td>
<td>37/50</td>
<td>74%</td>
<td>Awaiting Publication of Results</td>
</tr>
<tr>
<td>3. 2016 Audit of the use of blood in Haematology (submitted for all)</td>
<td>Yes</td>
<td>On-going</td>
<td>27 (DPOW) 6 to submit for SGH&amp; Goole</td>
<td>100%</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel cancer (NBOCAP)</td>
<td>Yes</td>
<td>Yes</td>
<td>236</td>
<td></td>
<td></td>
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<tr>
<td>Head and neck oncology (DAHNO)</td>
<td>Yes</td>
<td>Yes</td>
<td>81 (01/11/2014-31/10/2015)</td>
<td></td>
<td>Awaiting publication for comparison with HES</td>
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<tr>
<td>Lung cancer (NLCA)</td>
<td>Yes</td>
<td>Yes</td>
<td>381</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>276 (2014) 280 (2015)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oesophago-gastric cancer (NAOGC)</td>
<td>Yes</td>
<td>Yes</td>
<td>128</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National clinical audit title</td>
<td>Eligible for NLAG</td>
<td>NLAG participated</td>
<td>Number of cases submitted</td>
<td>% of number required</td>
<td>Action planning</td>
</tr>
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<td>-------------------------------------------------------------------</td>
<td>-------------------</td>
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<td>-------------------------------------</td>
</tr>
<tr>
<td><strong>Heart</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
<td>Yes</td>
<td>Yes</td>
<td>234 (deadline June 2016)</td>
<td>53%</td>
<td>Awaiting National Report</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td>Yes</td>
<td>Yes</td>
<td>322/396</td>
<td>81%</td>
<td>Awaiting Publication</td>
</tr>
<tr>
<td>Congenital Heart Disease (Paediatric cardiac surgery) (CHD)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Coronary Angioplasty/National Audit of PCI</td>
<td>Yes (SGH)</td>
<td>Yes</td>
<td>138 (SGH) up to 31/12/15</td>
<td>100%</td>
<td>Awaiting Publication</td>
</tr>
<tr>
<td>National Adult Cardiac Surgery Audit</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>Yes</td>
<td>Yes</td>
<td>276</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>253/519 (deadline June)</td>
<td>49%</td>
<td>Awaiting National Report (14/15 actions underway)</td>
</tr>
<tr>
<td>National Vascular Registry</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pulmonary Hypertension (Pulmonary Hypertension Audit)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Long term conditions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Kidney Disease in primary care</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Diabetes (Adult)</td>
<td>Yes</td>
<td>Yes</td>
<td>15/16 data to be collected summer 2016</td>
<td>N/A</td>
<td>Underway (14/15)</td>
</tr>
<tr>
<td>Diabetes (Paediatric) (NPDA)</td>
<td>Yes</td>
<td>Yes</td>
<td>240</td>
<td>100%</td>
<td>Awaiting Publication</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) programme – Biologicals Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>60</td>
<td>78%</td>
<td>Awaiting National Report</td>
</tr>
<tr>
<td>Renal replacement therapy (Renal Registry)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Rheumatoid and Early Inflammatory Arthritis</td>
<td>Yes</td>
<td>Yes</td>
<td>13/56</td>
<td>23%</td>
<td>No</td>
</tr>
<tr>
<td>National clinical audit title</td>
<td>Eligible for NLAG</td>
<td>NLAG participated</td>
<td>Number of cases submitted</td>
<td>% of number required</td>
<td>Action planning</td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
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<td>-------------------</td>
<td>---------------------------</td>
<td>----------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>National Pregnancy in Diabetes Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>21</td>
<td>100%</td>
<td>Awaiting publication</td>
</tr>
<tr>
<td>Parkinson’s National Audit</td>
<td>Yes</td>
<td>Yes</td>
<td>70</td>
<td>100%</td>
<td>Awaiting Publication</td>
</tr>
</tbody>
</table>

**Mental health**

| National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) | N/A | N/A | N/A | N/A | N/A |
| Prescribing Observatory for Mental Health (POMH) (Prescribing for substance misuse: Alcohol detoxification) | N/A | N/A | N/A | N/A | N/A |

**Older people**

| Falls and Fragility Fractures Audit Programme (FFFAP) | Yes | Yes | 523 | 100% | Yes |
| National Hip Fracture Database (submitted for all) | Yes | Yes | 54/60 | 100% | Yes |
| National Inpatient Falls Audit | Yes | Yes | Not yet underway | N/A | N/A |
| Sentinel Stroke National Audit Programme (SSNAP) SSNAP Clinical Audit | Yes | Yes | 589/635 (April to Dec 15) | 93% | Yes |

**Other or TBC**

<p>| Nephrectomy Audit (British Association of Urological Surgeons) | Yes | Yes | 9 | 100% | Awaiting Publication |
| Percutaneous Nephrolithotomy (PCNL) (British Association of Urological Surgeons) | Yes | Yes | 13 | 100% | Awaiting Publication |
| Radical Prostatectomy Audit (British Association of Urological Surgeons) | Yes | Yes | 9 | 100% | Awaiting Publication |
| Stress Urinary Incontinence Audit (British Association of Urological Surgeons) | Yes | Yes | 6 | 100% | Awaiting Publication |
| Elective surgery (National PROMs Programme) | Yes | Yes | 1056 | 66% | Yes |
| National Audit of Intermediate Care | N/A | N/A | N/A | N/A | N/A |</p>
<table>
<thead>
<tr>
<th>National clinical audit title</th>
<th>Eligible for NLAG</th>
<th>NLAG participated</th>
<th>Number of cases submitted</th>
<th>% of number required</th>
<th>Action planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women and Children’s</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BTS Paediatric Asthma</td>
<td>Yes</td>
<td>Yes</td>
<td>15</td>
<td>100%</td>
<td>Awaiting Publication</td>
</tr>
<tr>
<td>Royal College of Emergency Medicine : Vital Signs in Children</td>
<td>Yes</td>
<td>Yes</td>
<td>200</td>
<td>100%</td>
<td>Awaiting Publication</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)</td>
<td>Yes</td>
<td>Yes</td>
<td>39</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Perinatal &amp; Infant Death Confidential Survey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal Intensive and Special Care (NNAP)</td>
<td>Yes</td>
<td>Yes</td>
<td>1619</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric Intensive Care Audit Network (PICANet)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total:</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>NLAG Participated in:</td>
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<table>
<thead>
<tr>
<th>Confidential enquiry</th>
<th>Eligible for NLAG</th>
<th>NLAG participated</th>
<th>Organisational Questionnaires</th>
<th>Number of cases submitted</th>
<th>% of number required</th>
<th>Action planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Pancreatitis</td>
<td>Yes</td>
<td>Yes</td>
<td>2</td>
<td>9/9</td>
<td>100%</td>
<td>Awaiting Report</td>
</tr>
<tr>
<td>Mental Health in General Hospitals</td>
<td>Yes</td>
<td>Yes</td>
<td>2</td>
<td>10/10</td>
<td>100%</td>
<td>Awaiting Report</td>
</tr>
<tr>
<td>Non Invasive Ventilation Study</td>
<td>Yes</td>
<td>Yes</td>
<td>2</td>
<td></td>
<td></td>
<td>Awaiting Sample</td>
</tr>
<tr>
<td>Chronic Neurodisability</td>
<td>Yes</td>
<td>Yes</td>
<td>2</td>
<td></td>
<td></td>
<td>Awaiting Sample</td>
</tr>
<tr>
<td>Adolescent Mental Health</td>
<td>Yes</td>
<td>Yes</td>
<td>2</td>
<td></td>
<td></td>
<td>Awaiting Sample</td>
</tr>
<tr>
<td>Total:</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible for NLAG participation:</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The reports of 6 national clinical audits were reviewed by the provider in 2015/16 and the Trust intends to take the following actions to improve the quality of healthcare provided:
Increased information to patients/carers

- (National Audit of Inpatient Falls) Patient information leaflet to be made available to patients as part of the Falls Risk Assessment.
- (RCEM Fitting Child Audit) Ensure patient information leaflet ‘Febrile Convulsions’ is available at both Emergency Departments.
- (IBD Audit) Educate patients that they can request to see the IBD nurse if they are admitted as an inpatient.

Increased awareness and education of staff

- (National Audit of Inpatient Falls) Increase education of health care professionals around ensuring GPs are made aware of patient falls; aware of the requirement for patients to have call bell in sight and in reach; mobility aid in reach and patient wearing safe footwear. Staff should also be reminded on the assessment for visual aids, provision of written information and falls care plan are now part of the Falls Management Plan.
- (National Audit of Inpatient Falls) Data on falls including moderate and severe harm to be reviewed as part of the board-level Falls Prevention Group.
- (National Audit of Inpatient Falls) Information continually updated and displayed on Quality Boards on all wards, trust-wide including falls rates and trends.
- (BTS: Emergency Oxygen Audit) Agree teaching material to support the implementation of a trust-wide E-learning package ‘Oxygen - Test Your Knowledge’ in order to promote consistency and patient safety.
- (SSNAP) Educate stroke responders to ensure all stroke patients are given an NIHSS score.
- (RCEM Fitting Child Audit) Education of staff regarding fitting in children, stressing that blood glucose monitoring should be repeated once patient arrives in the ED and that first fit patients should not be discharged.
- (IBD Audit) Educate relevant staff to ensure that patients receiving corticosteroids are also prescribed vitamin D and calcium, and this to be reinforced at study days.
- (IBD Audit) IBD nurses to arrange for training for nursing staff on wards where most of the IBD patients are located.
- (IBD Audit) IBD nurses to ensure they ask about pain when visiting inpatients on admission.
- (IBD Audit) IBD nurses to discuss medication, self-care and follow-up, potential drug side effects and warning signs to be aware of with patients prior to discharge.

Identified need for further evaluation/patient surveys

- (National Heart Failure Audit) Carry out data validation looking at drugs patients are discharged home with to ensure correct data is entered into the audit.
- (National Heart Failure Audit) Carry out a feasibility study to look at the possibility of rolling out Cardiac Rehabilitation to all patients (to include chair-based exercise for patients with left-sided failure using a DVD).

Changes to service/process

- (National Audit of Inpatient Falls) To introduce AMT as an assessment for cognitive impairment as part of the Falls Risk Assessment, along with Confusion Assessment Method Tool and appropriate Care Plan.
- (National Audit of Inpatient Falls) To add to the initial screening section of the Falls Risk Assessment the following: Patient History of Blackouts / Syncope; Lying and Standing Blood Pressure to be undertaken; requirement for repeat ECG to be considered in the event of a repeat fall; requirement to consider and possibly review night sedation or sedative medication and referrals to Physiotherapy Services.
• (National Heart Failure Audit) Develop and implement a Heart Failure Specialist Nurse Referral Form.
• (BTS: Emergency Oxygen Audit) Oxygen Prescription to be added to the Drug Chart.
• (RCEM Fitting Child Audit) Develop a Trust-wide sticker for recording relevant information when reviewing a fitting child, which includes management of hypoglycaemia and compliance with national guidance.

The reports of 7 local clinical audits were reviewed by the provider in 2015/16 and the Trust intends to take the following actions to improve the quality of healthcare provided:

**Increased awareness and education of staff**

• (Maternity Documentation) awareness surrounding maternity documentation requirements / standards to be included as part of the junior doctor induction programme to raise awareness.
• (Swab second check processes) memo to be sent out to remind staff to complete all parts of the documentation.
• (Goole Midwifery Review) awareness to be raised with staff regarding the necessary requirements in order to meet documentation standards including completion of risk assessment tools and feeding checklists.
• (Health Visitor Guidelines) NICE guidelines to be circulated along with audit results at the Health Visiting Professionals Meeting to raise awareness of the relevant guidelines relating to Feverish Illness and Neonatal Jaundice.
• Driving and Parkinson’s: Increase awareness of the need to record in the notes that patient has been told to inform the DVLA, and creation of a template that includes this information.
• Driving and Epilepsy: Increase awareness of the need to record in the notes that the patient has been told to inform the DVLA, and creation of a template that includes this information.

**Changes to service/process**

• (Swab second check processes) matron to ensure that cotton balls are no longer included within the suturing packs.
• (Caesarean Section) Protocol for intra-operative IV antibiotics to be standardised trust wide (guideline previously had separate instructions for Scunthorpe and Grimsby).

**2.2c Information on participation in clinical research**

The total number of patients receiving relevant health services provided or sub-contracted by Northern Lincolnshire and Goole NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee is not known as this data is not collected. However, those patients recruited to NIHR adopted research studies was 1041 as of end February 2016.

**NB:** It should be noted that all studies opened within the Trust are subject to rigorous governance checks which includes submission to a research ethics committee where required. Thus additional patients will be involved in research studies where by the actual patient accrual is not reported through R&D as a core expectation of the Trust at this time i.e. in house/academic studies that are not NIHR adopted.

The Trust takes part in clinical research, this is because it believes that research is important because it helps to improve healthcare by finding out which treatments work best for patients. It also gives patients the opportunity to access novel and innovative treatments and therapies. Within the department we have adopted the NIHR strapline of ‘Today’s research is Tomorrow’s Treatment’ which captures the essence of what our service is about.
The research and development department offers a central corporate function within the Trust and takes an organisational-level lead in ensuring that research is conducted and managed to high scientific, ethical and financial standards. The R&D function is delivered from two offices based at the Scunthorpe and Grimsby sites and is led and managed by the head of research and professional development supported by a team of 14 Research Nurses, two Data- Coordinators and a Research Governance Manager.

**Within the research and development department, our aims are:**

- To increase the number of research studies open within the Trust, including industry studies that may also generate income. Such income is then re-invested within the Trust in the areas of further research and professional development,
- To increase the number of patients recruited to studies within the Trust thus increasing the opportunities for patients to access new and cutting edge treatments which may not be offered through routine care delivery,
- To improve the time that it takes to open a research study within the Trust.
- To continue working with our research partners in Yorkshire and Humber to deliver the National Institute of Health Research (NIHR) high level objectives

The R&D department are currently supporting a range of research projects. These include,

- National Institute of Health Research (NIHR) Portfolio adopted research,
- Non-Portfolio research,
- Commercially Sponsored studies,
- Academic and In-House research studies,

There are currently 162 Organisational Projects open to recruitment within the Trust, these include

- 27 of these studies are commercial
- 81 are adopted onto the NIHR (National Institute for Health Research) Portfolio.
- 23 studies are commercially adopted portfolio studies.
- 31 account for other studies which are currently open.

**How the research and development team help to deliver research**

The team of nurses, data coordinators help to deliver research within our Trust in the following ways:

- By identifying patients suitable for research studies— involvement is entirely voluntary and never undertaken without formal written consent from the volunteers
- By supporting the investigators in delivering the research studies on a day by day basis, including seeing patients in clinics and at home where required
- Following-up of the patients involved in the studies once the actual treatment stage has been completed – this can be for a number of years in some studies
- Collecting the data that contributes to the results of studies. This then goes onto changing practices and treatments in the future.

**We currently have research Projects open in the following areas:**

<table>
<thead>
<tr>
<th>Oncology</th>
<th>Diabetes</th>
<th>Dermatology</th>
<th>Paediatrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haematology</td>
<td>Gastrointestinal</td>
<td>Rheumatology</td>
<td>Nursing</td>
</tr>
<tr>
<td>Stroke</td>
<td>Obstetrics</td>
<td>ITU</td>
<td>Management</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Gynaecology</td>
<td>Surgery</td>
<td>Neurology</td>
</tr>
</tbody>
</table>
The R&D department is dedicated to supporting and furthering research, development and innovation within the Trust. The department provides assistance and guidance on how to:

- Check whether projects are research, service evaluation or audit
- Help and advice on protocol development, study design, data management and analysis
- Assist in the setup of a study – ensuring that the Trust can deliver the study to time and target
- Coordinate submissions to the Health Research Authority which has replaced the need for us to apply directly to Research Ethics Committee (REC) and Medicines and Healthcare Products Regulatory Agency (MHRA) to facilitate approvals
- Undertake the necessary NHS Trust permission process on behalf of Northern Lincolnshire and Goole NHS Foundation Trust.

We can also provide information about training courses offered by other training providers in the field of health service research, Local and national funding opportunities and research and development publications.

2.2d Information on the Trust’s use of the CQUIN framework

A proportion of Northern Lincolnshire & Goole NHS Foundation Trust’s income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between Northern Lincolnshire & Goole NHS Foundation 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 2015/16 and for the following 12 month period are available electronically at:


The areas of care which were included within the CQUIN scheme for 2015/16 included the following:-

- Acute Kidney Injury
- Sepsis
- Dementia
- Improving Diagnosis & re-attendance rates of patients with Mental Health needs at A&E
- Repatriation of Lincolnshire patients to Louth Community Hospital
- Transfer of clinically appropriate patients from SGH ECC to a suitable community service in the North Lincolnshire area
- Transfer of ERYCCG patients, who are deemed to be clinically suitable, to Goole & District Hospital

The amount of income in 2015/16 which was conditional upon achieving quality improvement and innovation goals was £6.11 million.

The monetary total value for 2015/16 CQUIN indicators was £6.11 million. The Trust are currently in discussions with commissioners regarding the CQUIN financial value that the Trust will receive.
2.2e Information on Never Events

The Trust reported 4 never events during 2015/16. These can be broken down into the following categories, including historical context and related incidents:

<table>
<thead>
<tr>
<th>Category</th>
<th>2015/16</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained Foreign Object</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Ophthalmology – wrong lens inserted</td>
<td>1</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Wrong site nerve block</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**NB:** It should be noted that the never event categories are reviewed annually and therefore are subject to change, making historical comparison difficult.

**Learning derived from incidents:**

- The root causes for the 2015/16 never events related to:
  - Awareness, training and guidance
  - Last minute changes to planned schedules
  - Interruptions during clinical procedures
  - Communication within clinical teams

- As a result of these high-level summary of root causes, the following actions to prevent recurrence have been taken:
  - Increased promotion of guidance in anaesthetic rooms to act as an aide memoire to staff
  - Robust training programme including confirmation of roles and responsibilities for all Theatre personnel to be held
  - Clear allocation of responsibilities for ensuring revised schedules are made available in the event of any last minute changes to plans
  - Consideration and scoping work regarding the use of pre-operative nerve block site marking and keeping interruptions during clinical procedures to a minimum
  - Protocol for procedure to be developed to standardise practice
  - Additions to the induction programme for theatre staff to ensure familiarity of documentation to be used for second checking and competency assessments
  - Audit programme in place to assess progress over time.

**How has learning been shared at all levels of the organisation and externally?**

- These incidents have been brought to the attention of the clinical teams involved
- These never events, along with other learning from incidents and complaints form a core part of the different clinical areas Quality & Safety meetings/sessions enabling senior and junior staff alike to share learning as a result to prevent recurrence
- The investigation and root cause analysis is shared with the various areas management Team to alert them to the issues identified for wider dissemination
2.2f Information relating to the Trust’s registration with the Care Quality Commission

Northern Lincolnshire and Goole NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional. The Trust has no conditions on its registration.

The Care Quality Commission has not taken enforcement action against the Trust during 2015/16.

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

Care Quality Commission (CQC) ratings grid for the Trust

(From their last visit of the Trust in October 2015, of which the report was published in April 2016)

<table>
<thead>
<tr>
<th>Overall rating</th>
<th>Inadequate</th>
<th>Requires improvement</th>
<th>Good</th>
<th>Outstanding</th>
</tr>
</thead>
</table>

How do we plan to address any areas that require improvement?

- During October and November 2015 and January 2016, the Trust received announced and unannounced visits by the CQC. The Trust responded to the initial feedback received in respect of the issues identified including review and follow-up of the backlog of OPD follow-up patients, which the Trust was aware of and already dealing with prior to the CQC inspection, and in respect of the environment in A&E for the management of patients with a mental health problem, and has provided assurances to the CQC on the implementation and delivery of plans to address the issue. The final report of the inspection was published on 15 April 2016. An action plan in response to the additional findings and recommendations is currently being drafted and will be submitted to the CQC by the deadline of 6 May 2016.

- As outlined within the Annual Governance Statement, as at the 31 March 2016, the Trust was not therefore fully compliant with the registration requirements of the Care Quality Commission (CQC). The Trust expects a further re-visit within 6 months.
How is Northern Lincolnshire & Goole NHS FT implementing the duty of candour?

Duty of Candour, or being open with service users when harm is caused as a result of healthcare provision, is now included as a statutory obligation in the NHS standard contract as a result of the Francis report into the failings at Mid Staffordshire. This obligation requires NHS Trusts to ensure that patients and their families are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and are supported to deal with the consequences. The Care Quality Commission (CQC) have also incorporated into their regulations and inspection regime a specific element focussing on duty of candour. How is the Trust working to implement duty of candour in everyday practice?

The Trust has a policy for reference to by all staff to ensure a standardised approach is taken to duty of candour best practice principles. This policy outlines clear responsibilities and accountabilities within the Trust and makes it clear that duty of candour (also referred to as ‘being open’) is not a one-off event, rather it is a process. The policy recognises that being open with patients or their relatives following harm can be very difficult with staff involved feeling cautious for fear of saying the wrong thing, making the situation worse or being blamed for the mistake. With this in mind, the policy attempts to make the process of being open a framework supporting staff and the individual and their relatives involved.

The policy draws from and references the NHS Litigation Authority leaflet on the subject of ‘Apologies and explanations’, published in 2009. As a result the Trust approaches being open with the following key messages for those involved in patient safety incidents:

- **Timeliness:** Initial discussions with the patient and their family should occur as soon as possible after recognition that something has gone wrong.
- **Explanation:** Patients and their families should be provided with a step by step explanation of what happened, that considers their individual needs and is delivered openly.
- **Information:** Patients and their families should receive clear, unambiguous information. They should not receive conflicting information from different members of staff. The use of medical jargon and acronyms, which they may not understand, should be avoided.
- **On-going support:** Patients and their families should be given a single point of contact for any questions or requests they may have. They should also be provided with support in a manner appropriate to their needs. This involves consideration of special circumstances that can include a patient requiring additional support, such as an independent patient advocate or a translator.
- **Confidentiality:** Policies and procedures should give full consideration of, and respect for privacy and confidentiality for the patient, their family and staff.
- **Continuity of care:** Patients are entitled to expect that they will continue to receive all usual treatment and continue to be treated with dignity, respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere.


The above key messages provide a high-level summary of the principles that the Trust adheres to in initiating the being open or duty of candour process. The process then continues for as long as is necessary, taking into account the patient specific factors and the needs of those involved.

The policy on being open also contains guidance for Trust managers to ensure that staff affected or involved in patient safety incidents also have access to support arrangements, recognising that they too are in need of care at such times.
2.2g Information on quality of data

Northern Lincolnshire and Goole NHS Foundation Trust submitted records during 2015/16 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:
  - 96.5 per cent for admitted patient care
  - 99.8 per cent for outpatient care
  - 98.7 per cent for accident and emergency care.

- Which included the patient's valid General Practitioner Registration Code was:
  - 100.0 per cent for admitted patient care
  - 100.0 per cent for outpatient care
  - 100.0 per cent for accident and emergency care.

Northern Lincolnshire & Goole NHS Foundation Trust will be taking the following actions to improve data quality:

- Whilst performance with data quality metrics is already very high, the Trust continues to undertake daily batch tracing of data to the NHS spine to improve and the Data Quality team continue to provide data quality workshops for the benefit of operational staff.

- An internal audit was undertaken in relation to data quality, some of which assessed reporting of indicators around cancer 62 days from referral to treatment. Some of the actions agreed as a result of this include working with GPs to remind them of the Trust’s policy on referrals by fax and raising awareness with staff regarding date stamping referrals on receipt to ensure accurate data quality and reporting.

2.2h Information governance assessment report

The Trust’s information governance assessment report overall score for 2015/16 was 68% and was graded satisfactory.

2.2i Information on payment by results clinical coding audit

The Trust was not subject to the payment by results clinical coding audit during 2015/16 by the Audit Commission.
2.3 Trust performance against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available by the Health and Social Care Information Centre (HSCIC). For each of these indicators, the number, percentage, value, score or rate (as applicable) is reported for at least the last two reporting periods (last two years).

As the information has been made available from the Health and Social Care Information Centre, where possible a comparison has been made for each of the Trust’s indicators with:

a) The national average for the same;

b) Those NHS Trusts and the NHS Foundation Trusts with the highest and lowest of the same.

For each of these indicators, the Trust is required to make an assurance statement in the following format:

The Trust considers that this data is as described for the following reasons [insert reasons].

The Trust [intends to take or has taken] the following actions to improve the [indicator / percentage / score / data / rate / number], and so the quality of its services, by [insert description of actions].

Some of those indicators were not relevant to the Northern Lincolnshire and Goole NHS Foundation Trust; therefore the following indicators reported on are only those relevant to the Trust. This information has been presented as follows in table or graphical format, as most suited to the type of information being presented.
2.3a: Summary Hospital-Level Mortality Indicator (SHMI)

The data made available to the Trust by the Health and Social Care Information Centre with regard to:

a) The value and banding of the summary hospital-level mortality indicator (“SHMI”) for the Trust for the reporting period;

![Diagram]

Source: Health and Social Care Information Centre (HSCIC)

Key to abbreviations: Trust – Northern Lincolnshire and Goole NHS Foundation Trust, UK average – The United Kingdom average, UK best – The lowest SHMI scoring Trust/hospital/unit, UK worst – The highest SHMI scoring Trust/hospital/unit.

Comments:

- The above table illustrates the Trust’s performance against the Summary Hospital Mortality Indicator (SHMI). The SHMI is a Standardised Mortality Ratio (SMR). SHMI is the only SMR to include deaths outside of hospital in the community (within 30 days of hospital discharge). This inclusion of community mortality means the information needed to ascertain this comes from the Office for National Statistics, this results in delay in the reporting of the SHMI. To illustrate the most recently available SHMI reports performance October 2014 to September 2015.

- This delay in reporting makes it difficult for the Trust to continuously in real time monitor this area using SHMI alone, hence why the Trust uses this in collaboration with the ‘provisional SHMI’ indicator from the Healthcare Evaluation Data (HED). Using this ‘provisional indicator’ the Trust has access to more timely information which demonstrates further improvements with mortality performance, illustrated graphically as follows.
Comments:

- The above chart illustrates that the Trust’s mortality performance has improved at pace. Since May 2015 there has been a run of 5 consecutive reducing data points, whilst not a statistically significant trend (a run of 7) this illustrates the improvement is unlikely to be as a result of random (normal) variation and is in fact as a result of improvements made within the healthcare community.

- There has been and are still slight differences between the Trust’s individual hospital sites, and there is a significant difference between the in-hospital element of the SHMI i.e. deaths taking place at the hospital, and the out of hospital part of the indicator, i.e. those deaths that take place within 30 days of discharge home or into the community. Both of these important elements are monitored monthly by the Trust’s mortality report and the Trust’s Mortality Performance and Assurance Committee (MPAC). This committee has membership from general practice and other community services enabling a wider understanding and focus on mortality in and out of hospital.

- While 100 is the national average and is commonly defined as ‘expected’ mortality, it is recognised that this statistical measure is not an absolute indicator of performance. As a result of this, the Health and Social Care Information Centre (HSCIC) publish an organisation’s position nationally, determining the national best and worst, as well as a Trust banding, which illustrates if an organisation is statistically an outlier, using 95 per cent confidence intervals. This banding is illustrated as follows.
<table>
<thead>
<tr>
<th>Publication date</th>
<th>Sample time frame</th>
<th>Trust value</th>
<th>Trust banding</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2011</td>
<td>April 2010 – March 2011</td>
<td>1.14</td>
<td>1</td>
</tr>
<tr>
<td>January 2012</td>
<td>July 2010 – June 2011</td>
<td>1.12</td>
<td>2</td>
</tr>
<tr>
<td>April 2012</td>
<td>October 2010 – September 2011</td>
<td>1.16</td>
<td>1</td>
</tr>
<tr>
<td>July 2012</td>
<td>January 2011 – December 2011</td>
<td>1.16</td>
<td>1</td>
</tr>
<tr>
<td>October 2012</td>
<td>April 2011 – March 2012</td>
<td>1.17</td>
<td>1</td>
</tr>
<tr>
<td>January 2013</td>
<td>July 2011 – June 2012</td>
<td>1.18</td>
<td>1</td>
</tr>
<tr>
<td>April 2013</td>
<td>October 2011 – September 2012</td>
<td>1.15</td>
<td>1</td>
</tr>
<tr>
<td>July 2013</td>
<td>January 2012 – December 2012</td>
<td>1.15</td>
<td>1</td>
</tr>
<tr>
<td>October 2013</td>
<td>April 2012 – March 2013</td>
<td>1.11</td>
<td>2</td>
</tr>
<tr>
<td>January 2014</td>
<td>July 2012 – June 2013</td>
<td>1.09</td>
<td>2</td>
</tr>
<tr>
<td>April 2014</td>
<td>October 2012 – September 2013</td>
<td>1.09</td>
<td>2</td>
</tr>
<tr>
<td>July 2014</td>
<td>January 2013 – December 2013</td>
<td>1.09</td>
<td>2</td>
</tr>
<tr>
<td>October 2014</td>
<td>April 2013 – March 2014</td>
<td>1.08</td>
<td>2</td>
</tr>
<tr>
<td>January 2015</td>
<td>July 2013 – June 2014</td>
<td>1.09</td>
<td>2</td>
</tr>
<tr>
<td>April 2015</td>
<td>October 2013 – September 2014</td>
<td>1.10</td>
<td>2</td>
</tr>
<tr>
<td>October 2015</td>
<td>April 2014 – March 2015</td>
<td>1.11</td>
<td>1</td>
</tr>
<tr>
<td>January 2016</td>
<td>July 2014 – June 2015</td>
<td>1.10</td>
<td>2</td>
</tr>
<tr>
<td>March 2016</td>
<td>October 2014 – September 2015</td>
<td>1.08</td>
<td>2</td>
</tr>
</tbody>
</table>

**Source:** Health and Social Care Information Centre (HSCIC)

**Key to abbreviations:** Trust value – The Trust’s SHMI score, Trust banding – The Trust’s banding – determining if it is an outlier using statistically calculated levels of confidence (95 per cent confidence intervals).

Banding numbers are based on a 95 per cent control limit. The bandings mean:

- 1 – higher than expected,
- 2 – as expected,
- 3 – lower than expected.
b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.

Source: Health and Social Care Information Centre (HSCIC)

Key to abbreviations:
- Trust – Northern Lincolnshire and Goole NHS Foundation Trust,
- UK average – The United Kingdom average,
- UK best – The Trust/hospital/unit reporting highest % levels of palliative care,
- UK worst – The Trust/hospital/unit reporting lowest % levels of palliative care.

Comment:

- The above chart illustrates the percentage of patients with a palliative care code used at either diagnosis or specialty level.

- Palliative care coding is a group of codes used by hospital level coding teams to reflect palliative care treatment of a patient during their hospital stay. Different statistically calculated Standardised Mortality Ratios (SMR) have treated this group of patients differently depending on the indicator. Some previously employed SMR indicators including the Risk Adjusted Mortality Index (RAMI) that the Trust used to use exclude patients with a palliative care code from the mortality indicator. To ensure this was not exploited for minimising an organisation’s mortality, Trusts are required to meet strict rules that govern the use of such codes to only those patients appropriately seen and managed by a specialist palliative care team.

- The SHMI does not exclude this group of patients, rather they are included and the appropriate risk factor for each is statistically determined according to the model. As palliative care coding is a key mortality indicator, the SHMI on publication each quarter include the above breakdown of data for Trusts to see the proportion of palliative care codes being used versus the national average.

- The above charts illustrates the percentage of patients each quarter where palliative care codes have been used in either the patient’s specific diagnosis or at the specialty team level of those caring for the patient. It is noticeable during more recent successive quarters of a gradual decrease in the percentage of palliative care codes being used.
Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust Board, supported by the Mortality Performance Committee, has been focusing on understanding the key factors impacting on mortality. The SHMI indicator includes deaths within 30 days of a patient being discharged from the acute hospital. This detail enables a breakdown of the SHMI between hospital and out of hospital care, as illustrated below.

Source: HED Information, CHKS

Key to abbreviations:
- NLAG Full SHMI – The Trust’s full combined SHMI (including both in-hospital and out of hospital deaths (within 30 days))
- NLAG In-hospital SHMI – The in-hospital death rate
- NLAG Out of hospital SHMI – The out of hospital (within 30 days following discharge) death rate
- National Average – the UK average SHMI score, always represented as 100

- One of the improvement activities has been to use this greater understanding of mortality across the healthcare community to support greater collaborative working with general practice and other community partners.

The Trust has taken the following actions to improve the indicator and percentage in a and b, and so the quality of its services by:

- A detailed board paper is produced on a monthly basis outlining Trust performance across a number of mortality indicators. This report has evolved over time and now includes a dedicated section relating to community/out of hospital mortality to ensure relevance to all involved in overseeing performance in this important area.

- The Trust uses the mortality performance data to focus on more detailed individual case note scrutiny assessing the quality of care provided. This review process is designed to enable healthcare professionals can review the care quality with a view to identifying both areas for improvement work and also lessons to be learnt from excellent quality of care. Using this tool provides the Trust with qualitative information regarding key ‘improvement themes’.
• Using the two aforementioned resources (1) mortality performance data and (2) the quality of care outcomes tool, the Trust has focussed on 6 clinically led improvement projects, including:
  o Gastroenterology,
  o Respiratory,
  o Cardiology,
  o Deteriorating patient/sepsis,
  o End of life/care of the dying,
  o Stroke

• Using the quality of care outcomes review process (a development worked on in collaboration with the Yorkshire & Humber Improvement Academy and recently selected by the Royal College of Physicians as the national review methodology) these 6 clinically led areas are working to identify specialty specific ‘themes’ that require improvement, understand the root causes and using a quality improvement style methodology lead specific improvement activities. These groups are supported and overseen by the Trust’s Mortality Performance Committee which invites each group to report back on a quarterly basis progress having been made or where additional support is required.

2.3b: Patient Reported Outcome Measures (PROMS)
The data made available to the Trust by the Health and Social Care Information Centre with regard to the Trust’s patient reported outcome measures scores for:

a) Groin hernia surgery
b) Varicose vein surgery
c) Hip replacement surgery
d) Knee replacement surgery.

during the reporting period.

<table>
<thead>
<tr>
<th>Type of surgery</th>
<th>Sample time frame</th>
<th>Trust adjusted average health gain</th>
<th>National average health gain</th>
<th>National highest</th>
<th>National lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groin hernia</td>
<td>April 2010 – March 2011</td>
<td>0.121</td>
<td>0.085</td>
<td>0.156</td>
<td>-0.020</td>
</tr>
<tr>
<td></td>
<td>April 2011 – March 2012</td>
<td>0.084</td>
<td>0.087</td>
<td>0.143</td>
<td>-0.002</td>
</tr>
<tr>
<td></td>
<td>April 2012 – March 2013</td>
<td>0.083</td>
<td>0.085</td>
<td>0.157</td>
<td>0.015</td>
</tr>
<tr>
<td></td>
<td>April 2013 – March 2014</td>
<td>0.051</td>
<td>0.085</td>
<td>0.139</td>
<td>0.008</td>
</tr>
<tr>
<td></td>
<td>April 2014 – March 2015</td>
<td>0.085</td>
<td>0.084</td>
<td>0.154</td>
<td>-0.006</td>
</tr>
<tr>
<td>Varicose vein</td>
<td>April 2010 – March 2011</td>
<td>Not available</td>
<td>0.091</td>
<td>0.155</td>
<td>-0.007</td>
</tr>
<tr>
<td></td>
<td>April 2011 – March 2012</td>
<td></td>
<td>0.094</td>
<td>0.167</td>
<td>0.047</td>
</tr>
<tr>
<td></td>
<td>April 2012 – March 2013</td>
<td></td>
<td>0.093</td>
<td>0.175</td>
<td>0.023</td>
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<tr>
<td></td>
<td>April 2013 – March 2014</td>
<td></td>
<td>0.093</td>
<td>0.150</td>
<td>0.023</td>
</tr>
<tr>
<td></td>
<td>April 2014 – March 2015</td>
<td></td>
<td>0.095</td>
<td>0.154</td>
<td>-0.002</td>
</tr>
<tr>
<td>Type of surgery</td>
<td>Sample time frame</td>
<td>Trust adjusted average health gain</td>
<td>National average health gain</td>
<td>National highest</td>
<td>National lowest</td>
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<tr>
<td>-------------------------</td>
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<td>-----------------------------</td>
<td>------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Hip replacement (Primary)</td>
<td>April 2010 – March 2011</td>
<td>0.438</td>
<td>0.405</td>
<td>0.503</td>
<td>0.264</td>
</tr>
<tr>
<td></td>
<td>April 2011 – March 2012</td>
<td>0.405</td>
<td>0.416</td>
<td>0.532</td>
<td>0.306</td>
</tr>
<tr>
<td></td>
<td>April 2012 – March 2013</td>
<td>0.461</td>
<td>0.438</td>
<td>0.538</td>
<td>0.369</td>
</tr>
<tr>
<td></td>
<td>April 2013 – March 2014</td>
<td>0.426</td>
<td>0.436</td>
<td>0.545</td>
<td>0.342</td>
</tr>
<tr>
<td></td>
<td>April 2014 – March 2015</td>
<td>0.436</td>
<td>0.437</td>
<td>0.524</td>
<td>0.331</td>
</tr>
<tr>
<td>Knee replacement (Primary)</td>
<td>April 2010 – March 2011</td>
<td>0.316</td>
<td>0.299</td>
<td>0.407</td>
<td>0.176</td>
</tr>
<tr>
<td></td>
<td>April 2011 – March 2012</td>
<td>0.317</td>
<td>0.302</td>
<td>0.385</td>
<td>0.180</td>
</tr>
<tr>
<td></td>
<td>April 2012 – March 2013</td>
<td>0.357</td>
<td>0.319</td>
<td>0.409</td>
<td>0.195</td>
</tr>
<tr>
<td></td>
<td>April 2013 – March 2014</td>
<td>0.332</td>
<td>0.323</td>
<td>0.416</td>
<td>0.215</td>
</tr>
<tr>
<td></td>
<td>April 2014 – March 2015</td>
<td>0.339</td>
<td>0.315</td>
<td>0.204</td>
<td>0.418</td>
</tr>
</tbody>
</table>

Source: Health and Social Care Information Centre (HSCIC), Primary data used, EQ-5D Index used

Comment:

- The above table shows the Trust’s reported adjusted health gain, which is a measure of the patient’s own reported outcome following surgery within the Trust.
- The Patient Reported Outcome Measure (PROM)s is a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. The 4 areas listed above are nationally selected procedures of which the Trust has no power to influence. This is illustrated in varicose vein surgery, which the Trust does not provide hence why no data is available.

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

- The Trust monitors its participation rates and response rates in relation to the completion of pre-operative and post-operative PROMs questionnaires. The results for the 14-15 year demonstrate that the Trust was not an outlier for any of the health gain outcomes for any of the procedures.
- Quarterly reports are received from the Health and Social Care Information Centre (HSCIC) that provide progress updates on both the participation rates, and the overall health gain reported by patients. The figures noted above, evidence the positive performance of the Trust during the specific time period.
- NLAG’s headline participation rate of 98.8% was significantly better than the England average of 75.7% and had increased substantially on the Trusts rate for the previous year of 13-14, which was of 80.5%

The Trust has taken the following actions to improve these outcome scores, and so the quality of its services by:

- Presenting the patient level results at the surgery and critical care quality & safety days bi-annually as well discussing at clinical governance group and presenting to clinicians at the general surgery clinical audit meetings. The Trusts access to patient level data enables us to analyse in house and use findings to drive further improvements in patient reported outcomes
- Continuing to review participation rates for each clinical procedure and making improvements in the internal monitoring of pre-operative questionnaire returns to ensure all eligible patients are given the opportunity to participate.
2.3c: Readmissions to hospital

The data made available to the Trust by the Health and Social Care Information Centre with regard to the percentage of patients aged:

a) 0 to 15; and  
b) 16 or over,

Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

<table>
<thead>
<tr>
<th>Age group</th>
<th>Time frame</th>
<th>Trust Emergency readmissions (%)</th>
<th>National re-admissions (%)</th>
<th>National highest (%)</th>
<th>National lowest (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 15</td>
<td>2011/2012</td>
<td>8.56%</td>
<td>10.01%</td>
<td>14.94%</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>2010/2011</td>
<td>8.19%</td>
<td>10.15%</td>
<td>25.80%</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>2009/2010</td>
<td>7.93%</td>
<td>10.18%</td>
<td>31.40%</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>2008/2009</td>
<td>7.59%</td>
<td>10.09%</td>
<td>22.73%</td>
<td>0.00%</td>
</tr>
<tr>
<td>16 or over</td>
<td>2011/2012</td>
<td>9.47%</td>
<td>11.45%</td>
<td>17.15%</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>2010/2011</td>
<td>9.18%</td>
<td>11.42%</td>
<td>22.93%</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>2009/2010</td>
<td>8.92%</td>
<td>11.16%</td>
<td>22.09%</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>2008/2009</td>
<td>8.64%</td>
<td>10.90%</td>
<td>29.42%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Source: Health & Social Care Information Centre (HSCIC)

Comment:

- The above table outlines the percentage rate of emergency re-admissions to the Trust within two primary age groups (1) 0 – 15 years and (2) 16 years or over. The table also provides peer data with which the Trust can benchmark itself. The table illustrates that the rate of emergency re-admissions within the Trust has been consistently lower than that of the national average.

- You will notice the above table does not hold the most recent year’s information. Following consultation with the Health & Social Care Information Centre (HSCIC), this indicator is under review with the next available data planned to be published in August 2016, subject to the review.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has been consistently below the national rates for re-admissions.

The Trust intends to take the following actions to improve these percentages, and so the quality of its services by:

- The Trust continues to monitor its readmission rates on a monthly basis and compares these to the national rates in order to benchmark our performance.
2.3d: Responsiveness to the Personal needs of patients

The data made available to the Trust by the Health and Social Care Information Centre with regard to the Trust’s responsiveness to the personal needs of its patients during the reporting period.

Source: Health and Social Care Information Centre (HSCIC)

Key to abbreviations: Average weighted score of 5 questions – Northern Lincolnshire and Goole NHS Foundation Trust,
National average – The United Kingdom average,
National highest – The Trust/hospital/unit reporting highest scores,
National lowest – The Trust/hospital/unit reporting lowest scores.

Comment:

- The table above highlights the average weighted score for five specific questions. This information is presented in a way that allows comparison to the national average and the best and worst performers within the NHS.
- The above figures are based on the adult inpatient survey, which is completed by a sample of patients aged 16 and over who have been discharged from an acute or specialist trust, with at least one overnight stay. The indicator is a composite, calculated as the average of five survey questions from the inpatient survey. Each question describes a different element of the overarching theme:

  "Responsiveness to patients’ personal needs”.

1. Were you involved as much as you wanted to be in decisions about your care and treatment?
2. Did you find someone on the hospital staff to talk to about your worries and fears?
3. Were you given enough privacy when discussing your condition or treatment?
4. Did a member of staff tell you about medication side effects to watch for when you went home?
5. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. Therefore, this indicator will also take values between 0-100.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust response rates are above the national average at 45%, which builds again on last year’s response rates. Monitoring of the first four questions remains a key area of focus. Our Quality Matron team ask these questions of 10 patients on every inpatient ward, every month. This data is uploaded to our nursing dashboard and is scrutinised by our senior nursing team and actioned accordingly.

The Trust has taken the following actions to improve this data, and so the quality of its services by:

- Ensuring that patients feel part of the decision making process is essential to person centred care and we will continue to monitor and review this on a monthly basis. We are using patient experience stories to highlight the importance of this.

- We always want our patients to feel they can find someone to talk to during their stay and are supporting this by embedding the #Hellomyname is culture throughout the Trust alongside the use of named nurse boards. Through a robust recruitment programme we are establishing a consistent workforce which will work within our Trust Vision and Values framework.

- By providing welcoming patient and visitor rooms within clinical areas we are supporting private areas for conversations, and are committed to supporting this across the Trust.

- We are working closely with our Deputy Chief Pharmacist and Patient Panel to ensure the information regarding medication side effects is given in the right way at the appropriate time. This piece of work will continue until we are confident the process meets our patient needs. This will be monitored via the Patient and Staff Experience Group.

- Our operational matrons continue to support their ward leaders in establishing the good practice of providing patient information leaflets on discharge, this assurance is sought via the monthly Matrons Forum Assurance document.
MEDIA RELEASE: June 2015
Rapid response team to reduce admissions into hospital

A seven day community service in North Lincolnshire is being expanded so people can receive treatment and recover in their own homes rather than being admitted to hospital. The Rapid Assessment Time Limited Service (RATL) will provide a fast community response, seven days a week, twenty four hours a day, to mainly elderly or frail people who are in urgent need of care.

The service is an expansion of the existing unscheduled care team and will see staff responding to the most urgent calls within one hour and preventing hospital admissions where it is safe to do so. Seven additional members of staff are being recruited to the team. Many health problems which might have resulted in an A&E attendance or admission to hospital can be treated successfully in a patient’s own home or care home if they and their carers have the right level of support and advice.

Funded through the Better Care Fund, the £500,000 a year additional investment is a joint initiative between North Lincolnshire Clinical Commissioning Group (CCG) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). Health and social care practitioners, including GPs, ambulance personnel and care homes, will be able to refer to the service via a single point of access. Patients calling 111 may also be directed to the service. The type of patients seen will include patients at the end of life, those who have sustained a fall with no obvious injury and those who are experiencing an acute episode of illness such as chest infections, urinary infections or diarrhoea and vomiting.

The service aims to reduce unnecessary stays in hospital by ensuring people who can be cared for in the community safely will be treated in their own homes or by community teams instead of on a ward.
2.3e: Staff recommending Trust as a provider to friends and family

The data made available to the Trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

![Graph showing staff recommendation trends from 2010 to 2015.]

Source: Health and Social Care Information Centre (HSCIC)

Trust performance – Northern Lincolnshire and Goole NHS Foundation Trust,
National average – The United Kingdom average,
National highest (acute Trusts) – The Trust/hospital/unit reporting highest scores,
National lowest (acute Trusts) – The Trust/hospital/unit reporting lowest scores.

Comment:

- The above table illustrates the percentage of staff answering that they “Agreed” or “strongly agreed” with the question: “If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust”.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- Feedback from staff is that they would recommend the Trust for treatment as they perceive the Trust as providing quality services delivered by dedicated, caring and compassionate staff.
- 86% of staff feel that their role makes a positive difference to patient care with an increase of +5% in year of staff feeling they can make contributions toward improving patient care; 67% of staff in 2015 feel they can contribute toward service improvements.
- Concerns regarding the Friends and Family Test relate to perceptions over staff numbers, in particular the number of registered nurse vacancies. The Trust notes this as both a local and indeed national issue for the NHS as a whole.

The Trust has taken the following actions to improve this percentage, and so the quality of its services by:

- The Deputy Chief Executive Office has constructed and is enacting a significant Friends and Family Test/Staff Survey action plan based on the 32 key findings within the staff survey.
- This action plan aims to increase staff’s ability to influence service developments and importantly seeks to increase the use and impact of patient and service user feedback on Trust developments.
• There are dedicated registered nurse recruitment and retention work streams aligned to the Trusts sustainability plan to focus on the issues relating to attracting future registered nursing workforce and retaining the existing registered nurse workforce.

• The Trust has an increased focus on staff engagement with a new Staff Engagement Strategy pending and a significant number of tailored staff engagement initiatives due to be launched throughout 2016/17.

2.3f: Risk assessed for venous thromboembolism

The data made available to the Trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

The above table illustrates the percentage of patients admitted to the Trust and other NHS acute healthcare providers who were risk assessed for venous thromboembolism (VTE) since quarter two, 2010/11. As illustrated in the above table the Trust has consistently achieved above 90 per cent since quarter four, 2011/12 and is now performing on par with the national average for this indicator.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

• The Trust is striving to oversee compliance with VTE risk assessments and prophylaxis prescribed. This is accomplished through monthly reporting through the Trust’s performance framework. Where possible this overall compliance is broken down to ward and department level to aid continued understanding and improvement.

The Trust has taken the following actions to improve this percentage, and so the quality of its services by:

• The Trust has revamped the risk assessment screening documentation used to assess a patients risk factors and is working to embed this as part of the Trust’s Electronic Patient Record, housed within the Trust’s Web V system. Particular emphasis has been placed on improving VTE risk assessments for patients with lower limb immobility. All of this work is overseen by a Trust lead for VTE and a Thrombosis oversight group.
2.3g: Clostridium Difficile infection reported within the Trust

The data made available to the Trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged two or over during the reporting period.

Source: Health and Social Care Information Centre (HSCIC), Trust apportioned cases

Key to abbreviations: Trust – Northern Lincolnshire and Goole NHS Foundation Trust, National average – The United Kingdom average, National highest – The Trust/hospital/unit reporting highest rates per 100,000 bed days, National lowest – The Trust/hospital/unit reporting lowest rates per 100,000 bed days.

Comment:

- The above table illustrates the rate of C. difficile per 100,000 bed days for specimens taken from patients aged two years and over. The downward trend from the first available data in 2009 is discernible from this table and the Trust compares favourably to the national average for this indicator.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust continues to make significant progress in reducing the number of C Diff cases and remains below the national average. A trend reported previously of cases deemed unavoidable continues to significantly outnumber those cases felt to be at least partially avoidable. Nevertheless, work continues to reduce these still further.

The Trust has taken the following actions to improve this rate, and so the quality of its services by:

- The Trust has an evidence based C. difficile policy and patient care pathway
- Multi-disciplinary team meetings are held for inpatient cases to identify any lessons to be learnt and root cause analysis is conducted for every hospital acquired case and a director of infection prevention and control (DIPC) review is held where there has been a breach in practice or the patient has died
- For each case admitted to hospital, practice is audited by the infection prevention and control team using the Department of Health Saving Lives’ audit tools
- The RCA process is currently being modified to adopt a Post Infection Review process to allow benchmarking with best practice and share lessons learnt in a timely manner.
• Themes learnt from PIR process will be monitored by the Infection Prevention & Control Committee and shared with relevant bodies

• Current C. difficile occurrences will be made more visible on the intranet site to facilitate clinical staff to benchmark performance against peers

• The formation of a HCAI working group to explore all matters pertaining to IPC where relevant lessons and infection cases will be discussed with multidisciplinary teams

• The use of a GDH sticker and actions to be taken has been rolled out to help prevent future CDI cases by streamlining use of broad spectrum antimicrobials

• GPs will be sent a letter to inform them of a patients C. difficile/GDH status again to help reduce the amount of antimicrobial use and prevent future CDI cases

• Existing antimicrobials steering group to produce learning resources for prescribers and non-prescribers on best practice associated with reducing antimicrobial consumption which will assist in reducing CDI incidence

• Implementation of a modified electronic hand hygiene assessment tool to capture compliance with WHO 5 moments. Information to be made available on the intranet so staff can compare performance with peers

• Development and implementation of a rolling programme of antibiotic prescribing audits reviewed by the steering group and the HCAI working group

• Currently exploring the possible use of an app based system to facilitate Junior medical staff with antimicrobial policies

• Undertaking a cultural survey across the trust to establish potential barriers with antimicrobial prescribing and measures to alleviate these.

2.3h: Patient safety incidents
The data made available to the Trust by the Health and Social Care Information Centre with regard to:

a) The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period,

<table>
<thead>
<tr>
<th>Time frame</th>
<th>Trust number of patient safety incidents reported</th>
<th>Trust rate of patient safety incidents reported per 1,000 bed days</th>
<th>Acute – Non-specialist average rate of patient safety incidents per 1,000 bed days</th>
<th>Acute – Non-specialist highest rate per 1,000 bed days</th>
<th>Acute – Non-specialist lowest rate per 1,000 bed days</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2014 – March 2015</td>
<td>5,483</td>
<td>43.2</td>
<td>36.8</td>
<td>82.2</td>
<td>3.6</td>
</tr>
<tr>
<td>April 2014 – September 2014</td>
<td>5,124</td>
<td>41.5</td>
<td>35.0</td>
<td>75.0</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Source: Health and Social Care Information Centre (HSCIC)

NB: Please note the denominator changed in April 2014 to benchmark Trusts safety incidents reported against 1,000 bed days, instead of the previously used comparison rate ‘per 100 admissions’. The classification of Trusts also changed from ‘large acute’, ‘medium acute’, ‘small acute’ and ‘acute teaching’ to simply ‘Acute non-specialist’. As a result of these changes, the previous historic data is not comparable and is therefore not included within this quality account.
Comment:
The above table demonstrates the total number of patient safety incidents and the rate per 1,000 bed days reported within the period of April 2014 – March 2015.

- Northern Lincolnshire and Goole NHS Foundation Trust average rate of patient safety incidents reported is above the average of other acute non-specialist NHS organisations (illustrated in the table above). Within the Trust staff are encouraged to report all incidents. NHS England state “Organisations that report more incidents usually have a better and more effective safety culture. You can’t learn and improve if you don’t know what the problems are”, therefore this number should be seen as encouraging that concerns regarding patient safety are reported for appropriate escalation and investigation and for remedial action to be taken to ensure any concerns are learnt from thus reducing the chance of these incidents replicating themselves and leading to patient harm.

- The Trust is continuing to actively encourage and promote incident reporting, and therefore expects the number of incidents reported to remain high and potentially increase in number in order to continue the work streams focussing on learning from incidents. The emphasis continues on reducing harm from patient safety incidents, the number and percentage in figure b) below demonstrates this.

b) And the number and percentage of such patient safety incidents that resulted in severe harm or death.

<table>
<thead>
<tr>
<th>Time frame</th>
<th>Trust number of patient safety incidents reported involving severe harm or death</th>
<th>Trust rate of patient safety incidents reported involving severe harm per 1,000 bed days</th>
<th>Acute – Non-specialist national average of patient safety incidents reported involving severe harm or death (%)</th>
<th>Acute – Non-specialist national highest rate involving severe harm or death (%)</th>
<th>Acute – Non-specialist national lowest rate involving severe harm or death (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2014 – March 2015</td>
<td>12</td>
<td>0.09</td>
<td>0.19</td>
<td>1.53</td>
<td>0.02</td>
</tr>
<tr>
<td>April 2014 – September 2014</td>
<td>12</td>
<td>0.10</td>
<td>0.19</td>
<td>1.09</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Health and Social Care Information Centre (HSCIC)

NB: Please note the denominator changed in April 2014 to benchmark Trusts safety incidents reported against 1,000 bed days, instead of the previously used comparison rate ‘per 100 admissions’. The classification of Trusts also changed from ‘large acute’, ‘medium acute’, ‘small acute’ and ‘acute teaching’ to simply ‘Acute non-specialist’. As a result of these changes, the previous historic data is not comparable and is therefore not included within this quality account.

Comment:

- The above table demonstrates the total number and rate per 1,000 bed days of patient safety incidents involving severe harm or death reported within the period of April 2014 – March 2015. Northern Lincolnshire and Goole NHS Foundation Trust has a lower than national average of patient safety incidents reported involving severe harm or death.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust undertakes regular analysis of incident data, producing a wide range of monthly, quarterly and annual analysis reports which are shared throughout the organisation via a number of committees/groups/forums. These reports enable aggregate analysis of data, along with analysis of particular hot-spots and trends. The relevant group/committee reviews the reports, and considers recommendations, which look to improving patient safety and addressing known risks identified in these reports.
The Trust has taken the following actions to improve this number and/or rate, and so the quality of its services by:

- A key focus group is the Learning Lessons Review Group. There are a number of multi-disciplinary sub-groups of the Learning Lesson Review Group focussing on prevention initiatives to reduce the harm from patient safety incidents, and also to reduce the number of incidents. These groups are considering issues such as patient misidentification, clinical handover, communication and documentation.

- The Trust Falls Prevention Group is a multidisciplinary group with an ongoing action plan to reduce the risk and preventing harm to patients. A number of initiatives have been introduced and these are having a positive effect on reducing the number of falls and harm to patients. Further initiatives are under consideration to sustain this reduction.

- The Trust have also developed a programme of quality and safety half day sessions that run at least quarterly in each of the Directorate groups. The idea behind these sessions is to enable clinical staff providing the service to be able to have time to present cases of learning for discussion of lessons learnt and to disseminate good practice.
**MEDIA RELEASE: June 2015**

**Hundreds receiving the best treatment for stroke at Scunthorpe Hospital**

In the wake of the national Stroke Association warning of the rise in working-age men and women falling victim to the condition, we re-visit how the centralisation of hyperacute stroke services at Scunthorpe General Hospital is helping patients in North and North East Lincolnshire and hear from one man near Caistor who has written a book of his experience.

More than 300 people were admitted to the hyperacute stroke unit at Scunthorpe hospital during the last financial year. The latest figures from Northern Lincolnshire and Goole NHS Foundation Trust show that from April 2014 to March 2015, a total of 355 people were taken to the unit – 173 were from the North Lincolnshire area with the remaining 182 people from North East Lincolnshire.

The Sentinel Stroke National Audit Programme (SNAP) measures the quality of stroke care provided to patients from when they arrive at hospital to up to six months after their stroke. The Royal College of Physicians compiles the report every quarter and the latest results, based on patients attending hospitals across the region between October and December 2014, puts the Scunthorpe service top of the table for how good it is at treating stroke patients.

The unit was rated ‘A’ on a scale of A to E, the highest out of all 17 stroke units in the Yorkshire and Humber region.

A decision was taken by the Trust in November 2013 to temporarily consolidate hyperacute stroke services on its Scunthorpe site and in doing so provide a service 24 hours a day, seven days a week. In October 2014 this decision was made permanent following public consultation through the Healthy Lives, Healthy Futures review programme, led by the local clinical commissioning groups.

The stroke acute care and rehabilitation service still remains at Grimsby’s Diana, Princess of Wales hospital, and patients from North East Lincolnshire are transferred there as soon as possible after their hyperacute care is completed (mostly within 72 hours). A team of independent external clinical reviewers gave the stroke unit at Scunthorpe hospital a clean bill of health last year. They looked into processes, policies and patient pathways and concluded that the service is safe and sustainable.

The centralisation has enhanced many aspects of the service including thrombolysis treatment – a clot-busting drug that helps to preserve part of the brain affected by the stroke. It means that eligible patients from across the region can receive this drug round-the-clock any day of the week including weekends. Before the centralisation it was only available from 8am to 8pm Monday to Friday.
Part 3: Other information

An overview of the quality of care based on performance in 2015/16 against indicators

3.1 Overview of the quality of care offered 2015/16

Parts 2.1a, 2.1b and 2.1c of this report outlined progress during 2015/16 towards achieving the priorities for this financial year just ended which the Trust set out in its previous Annual Quality Account for 2014/15. The quality priorities in part two were presented in three distinct sections: clinical effectiveness (2.1a), patient safety (2.1b) and patient experience (2.1c).

For these indicators selected by the Trust, the full report, contained within parts 2.1a, 2.1b and 2.1c refer to benchmarked data, where available, to enable performance compared to other providers. References to the data sources used are also stated within these earlier parts of this report and where relevant this includes whether the data is governed by standard national definitions. This information, presented in part two of this report also illustrates historical data for comparison and trending purposes. If the basis for calculating data has changed from that of historical data, this is explained in full detail within section two of this report.

The Trust’s Quality Targets & Priorities – Driving Continuous Improvement

It is worth noting here, that these targets/quality priorities for the most part are not nationally or regionally set, rather they are set locally by the Trust. They are selected as areas of key importance for the Trust to drive and embed continuous quality improvement. These indicators are not chosen for their ease of completion, resulting in a report full of green ‘completed’ ticks. These indicators are instead quality focussed, aspirational and stretching. As a result, the executive summary that follows, and the greater detail within part two of this report presents progress so far, not always demonstrating that our internal quality targets have been met. Where these have not been met, an explanation and summary of the work underway are presented and for the most part, these targets have been selected to stay within the quality report to drive quality development during 2016/17.

During 2015/16 the following quality priorities were monitored by the monthly quality report which was presented and reviewed on a monthly basis by the Trust’s Quality and Patient Experience (QPEC) Committee and the Trust Board. The ‘at a glance’ overview of performance that follows is viewed continually throughout the year, and reviewed within the monthly quality report; as a result these are constantly changing based on the real time nature of these indicators. A summary of the Trust’s performance against these key indicators (outlined within part 2 in full) are summarised below:
## QUALITY INDICATORS AT A GLANCE: Feb-16

### 2015/16 Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Time period / RAG</th>
<th>Comparator</th>
<th>Trends</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLINICAL EFFECTIVENESS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C1</td>
<td>Deliver mortality performance within 'expected range' and improving quarter on quarter, until real reported SHMI is 95 or better</td>
<td>Most recent data</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trends</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>C2</td>
<td>NEWS - Appropriate action taken</td>
<td>Jan-16</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trends</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>C3</td>
<td>3.1) Screened for Dementia</td>
<td>Jan-16</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trends</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td>C4</td>
<td>NICE - Compliance with ALL NICE Guidance</td>
<td>Jan-16</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trends</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>C5</td>
<td>Transfer of patients for non-clinical reasons (capacity to not exceed 10% of the total)</td>
<td>Jan-16</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trends</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td><strong>PATIENT SAFETY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P1</td>
<td>MRSA Bacteremia Incidence</td>
<td>Jan-16</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>P2</td>
<td>C Difficile Incidence (ALL cases)</td>
<td>Jan-16</td>
<td></td>
<td>No more than 21</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous</td>
<td></td>
<td>No more than 21</td>
</tr>
<tr>
<td>P3</td>
<td>C Difficile ('Lapses in care')</td>
<td>Jan-16</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td>P4</td>
<td>Safety Thermometer (Community)</td>
<td>Jan-16</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>P5</td>
<td>Open and Honest Initiative - Harm Free Care - Safety Thermometer ('New' and 'Old')</td>
<td>Jan-16</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>P6</td>
<td>Elimination of Avoidable Repeat Fallers</td>
<td>Jan-16</td>
<td></td>
<td>Eliminate ALL avoidable repeat falls</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous</td>
<td></td>
<td>Eliminate ALL avoidable repeat falls</td>
</tr>
<tr>
<td>P7</td>
<td>Reduction in Number of Avoidable Pressure Ulcers (Grades 2, 3 &amp; 4)</td>
<td>Jan-16</td>
<td></td>
<td>50% reduction (no more than 2 per month)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous</td>
<td></td>
<td>50% reduction (no more than 2 per month)</td>
</tr>
<tr>
<td>P8</td>
<td>Nutrition care pathway was followed</td>
<td>Jan-16</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>P9</td>
<td>The fluid management chart was completed accurately and fully in line with care pathway</td>
<td>Jan-16</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td><strong>PATIENT EXPERIENCE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P10</td>
<td>Response rate to friends and family test within the top 50%</td>
<td>Dec-15</td>
<td>Inpatient</td>
<td>Bottom 50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>R</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Jan-16</td>
<td>Previous</td>
</tr>
<tr>
<td>P11</td>
<td>Re-opened complaints to not exceed 20% of total closed complaints</td>
<td>Jan-16</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td>P12</td>
<td>Complaints - action plans implemented</td>
<td>Q1 15/16</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4 14/15</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td>P13</td>
<td>Complaints - action plans drafted</td>
<td>Q1 15/16</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4 14/15</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Jan-16</td>
<td>Previous</td>
<td></td>
</tr>
<tr>
<td><strong>PATIENT SAFETY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P14</td>
<td>Complaints - 50% reduction in complaints relating to communication</td>
<td>Q1 15/16</td>
<td></td>
<td>To be established</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4 14/15</td>
<td></td>
<td>To be established</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Jan-16</td>
<td>Previous</td>
<td></td>
</tr>
<tr>
<td>P15</td>
<td>Patients feel that medical and nursing staff did everything they could to help control pain</td>
<td>Sep-15</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May-15</td>
<td></td>
<td>90%</td>
</tr>
<tr>
<td>P16</td>
<td>Staff satisfaction - increase in morale/staff satisfaction</td>
<td>Sep-15</td>
<td></td>
<td>1.5% increase (min. 6.6)%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May-15</td>
<td></td>
<td>1.5% increase (min. 6.6)%</td>
</tr>
</tbody>
</table>
3.2 Performance against relevant indicators and performance thresholds

Performance against the relevant indicators and performance thresholds set out in Appendix B of the Compliance Framework.

<table>
<thead>
<tr>
<th>PERFORMANCE METRIC</th>
<th>2015/16 QTR 1</th>
<th>2015/16 QTR 2</th>
<th>2015/16 QTR 3</th>
<th>2015/16 QTR 4</th>
<th>Year End Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Infection Control*</td>
<td>G G G G</td>
<td>10.0</td>
<td>21</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2. Referral to Treatment Waiting Times</td>
<td>G G G G</td>
<td>93.6%</td>
<td>92%</td>
<td>92.0%</td>
<td>91.4%</td>
</tr>
<tr>
<td>3. Cancer</td>
<td>G G G G</td>
<td>99.8%</td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>i) 31 day wait for subsequent treatments - Surgery</td>
<td>G G G G</td>
<td>100.0%</td>
<td>94%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>ii) 31 day wait for subsequent treatments - Anti cancer drugs</td>
<td>G G G G</td>
<td>100.0%</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>3. A&amp;E</td>
<td>G G G G</td>
<td>97.6%</td>
<td>93%</td>
<td>97.9%</td>
<td>98.7%</td>
</tr>
<tr>
<td>i) 2 week wait referral to consultation</td>
<td>G G G G</td>
<td>96.0%</td>
<td>93%</td>
<td>95.3%</td>
<td>96.9%</td>
</tr>
<tr>
<td>ii) 2 week wait breast symptomatic referrals</td>
<td>G G G G</td>
<td>97.6%</td>
<td>93%</td>
<td>97.9%</td>
<td>98.7%</td>
</tr>
<tr>
<td>5. Data Completeness Community Services **</td>
<td>G G G G</td>
<td>80.7%</td>
<td>50%</td>
<td>79%</td>
<td>88.4%</td>
</tr>
<tr>
<td>6. Access **</td>
<td>G G G G</td>
<td>Y</td>
<td>Y/N</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

* Quarterly Cumulative figures
** Forecast Position

Comments:

- **Referral to Treatment Waiting Times:** A range of proactive improvement measures have been instigated across the Trust to regularly monitor the performance in this area, including demand and capacity planning by clinical groups. A weekly performance report is scrutinised by the Executive Team and Associated Chief Operating Officers. Capacity has been hindered by a number of factors including the need to cancel surgery due to bed pressures and medical outliers being cared for in surgical wards, the impact of the junior doctors strike action on cancelled appointments and surgery and the impact of the Theatre refurbishment programme at Diana, Princess of Wales Hospital. To mitigate the impact other options have been in place such as the use of St Hughes Private Hospital in Grimsby and the transfer of patient treatment to alternative Trust hospital sites to support planned provision of some surgical procedures.

- **Cancer:** Performance of all cancer performance targets is monitored by the Chief Executive during weekly challenge meetings and the performance data is monitored daily. As a result of this work, key ‘themes’ for patients breaching performance targets have been identified and learning from these themes has been incorporated into a dedicated action plan overseen by the Trust’s Governance & Assurance Committee, a sub-committee of the Board.

- **A&E:** Performance with the 4-hour wait target has been a difficulty faced by NHS Trusts throughout the UK. Locally, due to the number of high dependency patients being seen and limited bed availability has increased the length of time patients are spending in the A&E department. As a result of these challenges the staffing of the Emergency Care Centre is being reviewed, both medical and nursing staffing, and additional consultant physicians have been working additional weekend shifts at both sites to help focus on discharging patients who are safe to leave the hospital. Additional schemes also put into place to help alleviate capacity have included the establishment of an ambulatory care unit, a frail elderly assessment unit, 7 day social work provision, extended discharge lounge working, opening of the Planned Investigations Unit (PIU) and Ward 19 alongside the increased use of Goole.
3.3 Information on staff survey report

Summary of performance – NHS staff survey

The Trust’s staff survey was, as in previous years, offered to a sample group of staff. From this the Trust experienced an increase in participation rates despite an overall national decline in the number of staff submitting completed surveys.

The Trusts 2015 survey results revealed that staffs perception of engagement with them on matters relating to the Trust had increased from 2014 albeit it that the level of engagement falls short of that found in other acute Trusts.

Reviewing the key findings within the survey demonstrates that staffs do report any concerns relating to errors and near misses, they feel the quality on non-mandatory training to be high and compared to other Trusts would less additional paid and unpaid additional hours.

Of concern is that staff, compared to staff in other Trusts, would not recommend the Trust as a place to work or receive treatment or do not perceive that their role makes a difference to patients or service users to the same staff in other Trusts. This needs investigation and incentives putting in place to address these concerns. As a consequence a substantial and detailed action plan has been created and started to be enacted.

Detailed performance – NHS staff survey

The Trust, as in previous years, undertook a sample survey offering 1250 of its c.7000 staff. Despite a national deterioration in the number of staff overall participating in the SS the Trust experienced a 4.1% increase in its return rate.

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>Trust improvement/ deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response rate</td>
<td>Trust 29.6%</td>
<td>National average 44.0%</td>
<td>Trust 33.7%</td>
</tr>
</tbody>
</table>

Source: NHS Staff Survey

Key to abbreviations: Trust – Northern Lincolnshire and Goole NHS Foundation Trust, National average – The United Kingdom average

Staff Survey 2015 findings

Top four ranking scores:

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>Trust improvement/ deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top four ranking scores</td>
<td>Trust 87%</td>
<td>National average 90%</td>
<td>Trust 92%</td>
</tr>
<tr>
<td>Percentage of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>87% 90%</td>
<td>92% 90%</td>
<td>+5%</td>
</tr>
<tr>
<td>Percentage of staff working extra hours</td>
<td>69% 71%</td>
<td>69% 72%</td>
<td>No change</td>
</tr>
<tr>
<td>Quality of non-mandatory training, learning or development</td>
<td>Not available 4.05</td>
<td>Not available 4.03</td>
<td>Not available</td>
</tr>
<tr>
<td>Percentage of staff experiencing discrimination at work in last 12 months</td>
<td>10%</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

**Source:** NHS Staff Survey

**Key to abbreviations:** Trust – Northern Lincolnshire and Goole NHS Foundation Trust, National average – The United Kingdom average

### Bottom four ranking scores:

<table>
<thead>
<tr>
<th>Bottom four ranking scores</th>
<th>2014</th>
<th>2015</th>
<th>Trust improvement/deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff agreeing that their role makes a difference to patients / service</td>
<td>93%</td>
<td>91%</td>
<td>86%</td>
</tr>
<tr>
<td>Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.49</td>
<td>3.67</td>
<td>3.51</td>
</tr>
<tr>
<td>Effective use of patient / service user feedback</td>
<td>3.54</td>
<td>Not available</td>
<td>3.52</td>
</tr>
<tr>
<td>Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>Not available</td>
<td>Not available</td>
<td>44%</td>
</tr>
</tbody>
</table>

**Source:** NHS Staff Survey

**Key to abbreviations:** Trust – Northern Lincolnshire and Goole NHS Foundation Trust, National average – The United Kingdom average

Where data is listed above as ‘not available’ this is due to changes made to the 2014/15 staff survey questionnaire meaning there is no comparable 2013/14 data.

Reviewing the 2014/15 survey highlights that improvements have been made in staff perception that:

- They can contribute towards service improvements at work
- There are improved communications between staff and managers, and
- Importantly staff feel motivated at work

The survey also shows that the number of staff reporting the most recent experience of harassment, bullying or abuse has reduced. This is an area that needs addressing.

The survey also shows that the number of staff reporting concerns relating to harassment, bullying or abuse from other staff members has increased nationally as well as for the Trust. These scores from the staff survey are reproduced below. This is a concern and an area that needs addressing.
<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>Trust improvement/deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF19</td>
<td>Trust</td>
<td>National Average</td>
<td>Trust</td>
</tr>
<tr>
<td>The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months</td>
<td>22%</td>
<td>23%</td>
<td>27%</td>
</tr>
</tbody>
</table>

**Source:** NHS Staff Survey

**Key to abbreviations:** Trust – Northern Lincolnshire and Goole NHS Foundation Trust, National average – The United Kingdom average

Regarding staff perception over equality of career progression staff reported:

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>Trust improvement/deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF27</td>
<td>Trust</td>
<td>National Average</td>
<td>Trust</td>
</tr>
<tr>
<td>The percentage believing that Trust provides equal opportunities for career progression or promotion</td>
<td>87%</td>
<td>87%</td>
<td>88%</td>
</tr>
</tbody>
</table>

**Source:** NHS Staff Survey

**Key to abbreviations:** Trust – Northern Lincolnshire and Goole NHS Foundation Trust, National average – The United Kingdom average

**Action plans to address areas of concerns:**

There is significant read across between the Staff Survey 2015 and the Trusts own Morale Barometer surveys Q3 and Q4 2015/16. As such single action plan be constructed. This will action plan will form a key work stream during 16/17 and will focus on primarily on:

- Staff Voice, engagement and communication
- Staff sense of value, recognition and reward
- Management: staff relationships
- Resilience and change management
- Retention and career development
- Utilisation of patient and service user feedback
- Staff behavioural standards linked to Trust’s vision and values
- Addressing any concerns relating to harassment, violence and aggression shown against NHS staff

**Future priorities and targets**

The above action plan will be linked to the delivery of the People and Organisational Development Strategy deliverables to provide a prioritised and achievable delivery plan. The delivery of this total plan will be monitored and measured by both the Quality and Patient Experience Group and ultimately the Trust Board. The aim of the action plan will be for the Trust to:

- Maintain or improve this position in areas the Trust is above the national average for acute Trusts
- Improve this position in areas the Trust is below or equal the national average for acute Trusts.
3.4 Information on patient survey report

Introduction

The National Inpatient Survey is sent out to 1250 of patients who stayed in our Trust during the month of July 2015. This extensive questionnaire helps provide a more detailed insight into their care received and provides a mechanism by which we can focus our improvement priorities in a patient led way.

Response rate compared with previous year:

<table>
<thead>
<tr>
<th></th>
<th>2014 Trust</th>
<th>National average</th>
<th>2015 Trust</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response rate</td>
<td>51%</td>
<td>45%</td>
<td>45%</td>
<td>45.1%</td>
</tr>
</tbody>
</table>

Source: NHS Patient Survey

Key to abbreviations: Trust – Northern Lincolnshire and Goole NHS Foundation Trust, National average – The United Kingdom average

Comments:

This survey has highlighted the many positive aspects of the patient experience; a summary of this is illustrated as follows:

- Overall: 84% rated care 7+ out of 10.
- Overall: 82% reported respect and dignity.
- Doctors: 81% always had confidence and trust.
- Hospital: 98% room or ward was very/fairly clean.
- Hospital: 96% toilets and bathrooms were very/fairly clean.
- Care: 91% always enough privacy when being examined or treated.

This is excellent and very reassuring that confidence in doctors remains high and has increased since last year’s findings. The cleanliness of our hospitals remains excellent as shown by the patient’s feedback to us.

Based on these results and comparing with the previous year’s survey, the following questions demonstrate the most significant improvements:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital: felt threatened by other patients or visitors</td>
<td>1%</td>
<td>6%</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Nurses: sometimes, rarely or never enough on duty</td>
<td>48%</td>
<td>49%</td>
<td>51%</td>
<td>44%</td>
</tr>
<tr>
<td>Care: more than 5 minutes to answer call button</td>
<td>20%</td>
<td>22%</td>
<td>24%</td>
<td>17%</td>
</tr>
<tr>
<td>Overall: not treated with respect or dignity</td>
<td>24%</td>
<td>28%</td>
<td>24%</td>
<td>18%</td>
</tr>
<tr>
<td>Overall: rated experience as less than 7/10</td>
<td>22%</td>
<td>25%</td>
<td>22%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Source: NHS Patient Survey

NB: Dependant on the question, in some cases, a lower score than last year is a positive result.

Actions to be taken as a result:

Our immediate areas of focus for improvement from this survey are:

- Mixed sex accommodation – We have already established a reviewed assurance procedure which has executive lead, and identified the key problem area and
redesigned the layout.

- Not given any written/printed information about what they should or should not do after leaving hospital – This will be revisited via the Matrons Forum to establish a mechanism of embedding good practice by ward areas on discharge, supported by our well established patient information library.

**Actions for forthcoming year,**

- In conjunction with Picker Institute (a not for profit organisation that makes patient’s views count in healthcare) feedback the results at a forthcoming workshop with feedback to the Patient/Staff Experience Group (PSEG) and QPEC.
- As a result of these comments a comprehensive plan of action will be developed for the forthcoming year. This will help shape improvements and enhance the experience of care.
- The following 12 points are the initial basis of our improvement plan but are not exhaustive at this stage, these initial drivers are based on the questions which are considered most important to our patients and those questions which rated the highest number of respondents:
  - Admission: had to wait a long time to get a bed on ward
  - Hospital: shared sleeping area with opposite sex
  - Hospital: patients using bath or shower area who shared it with opposite sex
  - Doctors: did not always get clear answers to questions
  - Doctors: talked in front of patients as if they were not there
  - Care: staff contradict each other
  - Care: wanted to be involved in decisions
  - Care: did not always have confidence in the decisions made
  - Care: could not always find staff member to discuss concerns with
  - Care: not always enough privacy when discussing condition or treatment
  - Discharge: not given any written/printed information about what they should or should not do after leaving hospital
  - Discharge: not fully told of danger signals to look for
Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Annex 1.1: Statements from Commissioners

Feedback from:
NHS North Lincolnshire Clinical Commissioning Group
East Riding of Yorkshire Clinical Commissioning Group
North East Lincolnshire Clinical Commissioning Group
East Lincolnshire Clinical Commissioning Group

This statement has been prepared in collaboration with North East Lincolnshire CCG (Lead Commissioner), North Lincolnshire CCG, East Riding of Yorkshire CCG and Lincolnshire East CCG.

Commissioners welcome this opportunity to provide feedback to the Trust on the work already undertaken in relation to quality throughout 2015/16, and areas of work identified for further development in 2016/17.

Commissioners remain concerned at the findings detailed within the recent CQC report. Commissioners are keen to see these points woven in to the Trust’s quality agenda for 2016/17.

Positive Assurance

The Quality Account provides Commissioners with a comprehensive overview of progress made and challenges encountered by Northern Lincolnshire & Goole Foundation Trust during 2015/16.

Commissioners note the continued high level of compliance with the National Early Warning Score (NEWS), on-going commitment to the identification and care of patients with dementia, good working practices in relation to screening patients for sepsis and the timely provision of antibiotics to those identified as septic.

In addition to the above, the Trust continues to demonstrate good working practices in relation to the management of pressure ulcers, particularly the focus on specific ward areas to achieve improvement. The impact of this work is reflected in the reduction in the number of serious incidents reported by the Trust that relate to pressure ulcers during 2015/16. The Trust is also recognised (via the National Reporting and Learning System) as being in the top 25 percentile for incident reporting throughout England, this reflects that the Trust continues to adopt a positive culture in the identification and reporting of incidents.

Evidence of the Trusts commitment to improving performance against the quality indicators (some of which are defined above) and improving communication with Commissioners continues to be demonstrated via the NL&G Quality Contract Review (NL&G QCR) meeting. The Trust has been able (via the NL&G QCR meeting) to showcase some of the initiatives that have been developed throughout 2015/16, such as the Care Camp project, national and local recruitment campaigns and developments made to the Trusts complaints process. All of these initiatives provide Commissioners with positive assurance.
Areas Requiring Further Assurance

Commissioners remain concerned with the Trust’s NICE compliance position, the timeliness and the quality of patient discharge information, the impact of the Clinical Administration Review, the staffing position and implementation of the Mixed Sex Accommodation quality measure. Commissioners have also expressed their concern around the Trust’s approach to the care of adults with learning disabilities and the Trusts performance against Nutrition and Hydration targets. Commissioners would also welcome further assurance from the Trust regarding their safeguarding adults and safeguarding children arrangements.

Commissioners welcome the Trusts approach to further developing implementation of the Friends and Family test and proposals to develop further scrutiny of feedback received via the test.

The CQC inspection that was conducted between 13 October 15 and 5 January 16 is briefly acknowledged within the report. Commissioners welcome the areas of focus that were identified as part of the inspection process, these include the following:

- middle grade doctor staffing in the Emergency Department at Grimsby and Scunthorpe sites
- weekend and evening staffing cover
- process for cancelling Ophthalmology appointments
- consistency of leadership and governance arrangements (across all sites)
- Outpatients at Scunthorpe site
- Organisational learning from serious incidents
- provision of learning disability training to relevant staff groups

North East Lincolnshire CCG and associate commissioners recognise the breadth of improvement work the trust is undertaking following the recent CQC inspection and the action plan that has been developed by the Trust to address the areas deemed as requiring improvement.

Commissioners are actively working with the Trust to respond to the actions, where a system wide response is required.

Conclusion

Overall, the Quality Account is well presented and the information included in the report provides a balanced view of the Trusts performance against it quality indicators for 15/16. The Trust has identified action to be taken, and in some cases already taken, in response to the areas of concern highlighted above. Commissioners welcome the Trust’s desire to ensure these actions become embedded into usual practice.

Commissioners note that the Trusts priorities for 2016/17 are similar to those for 2015/16, suggesting that whilst progress has been made in some areas there is room for further improvement.

Finally, we confirm that to the best of our knowledge, the report is a true and accurate reflection of the quality of care delivered by Northern Lincolnshire & Goole Foundation Trust and that the data and information contained in the report is accurate.

Commissioners remain committed to working with the Trust and its regulators to improve the quality of services available for the population of each CCG area in order to improve patient outcomes.
Annex 1.2: Statement from Healthwatch organisations

Feedback from:
North East Lincolnshire Healthwatch
North Lincolnshire Healthwatch
East Riding of Yorkshire Healthwatch
Healthwatch Lincolnshire

Response from the Healthwatch for East Riding of Yorkshire, North Lincolnshire and North East Lincolnshire

Healthwatch East Riding of Yorkshire, Healthwatch Lincolnshire, Healthwatch North Lincolnshire and Healthwatch North East Lincolnshire welcome the opportunity to make a statement on the Quality Account for Northern Lincolnshire and Goole NHS Foundation Trust for 2015/16 and have agreed to provide a joint statement.

Progress on Priorities for 2015/16

We welcome the improvement on many of the quality indicators reported in 2015/16 and decisions to drop indicators where good performance has become embedded with the introduction of new/replacement indicators for 2016/17. Where indicators have been dropped from the account, we would welcome periodic checking and exception reporting to ensure no slippage in these areas.

Clinical Effectiveness

We are pleased that compliance with NICE Guidelines remains a priority in 2016/17 but we are also concerned that the Trust is relaxing its timeframe for full compliance on 90% of NICE Guidance from two to three years from publication when the Trust has reported that 38 items of NICE Guidance are still to be assessed.

Mortality Indicators

We recognise that some progress has been made to return these mortality indicators to ‘within expected range’ but local figures remain at the cusp of that designation and we therefore welcome the work that is now being undertaken with commissioners and other providers to identify issues related to the out of hospital rates that could be better addressed through a collaborative approach. This should include end of life care outside of hospital and other diversion away from hospital.

Patient Experience

We suggested last year that the Friends and Family Test information should include some analysis of the wealth of qualitative data generated from the open question on the FFT test. We believe that a simple step would be to divide response rate data and satisfaction rate data to give a fuller picture on what patients are saying. We would welcome any opportunities to work with the Trust to provide a fuller account of patient experience, whether in general or in specific issue areas.

We continue to hear from patients that are unhappy with the discharge and care planning process. This is partly around perceived delays in discharge but also about support services on return to their local communities with concerns around ‘cross-border communication’ between different providers.

We cannot support your setting 90% targets for pain control and administration of medication (PE4 for 2016/17) and believe these should all be 100%. Acknowledging that around 50% of current complaints relate to communication, we welcome the plan to achieve a 50% reduction in in this type of complaint.
Quality Standards

We highlighted last year that there appears to be no quality standard for percentage of cancelled appointments or length of wait until first appointment. We are also picking up on patients whose cancellation letters arrive after appointment dates, with patients still attending. This can be at significant cost especially to patients in rural areas. We have continued to highlight these issues through our Enter and View activity and dialogue with the Trust and know that similar concerns have now been raised by the Care Quality Commission. We would therefore again ask that consideration is given to developing performance targets in these areas.

Presentation of NLAG Accounts

We welcome the reduction in the size of this year’s Quality Account document from last year and recognise that you have to fulfil the requirements and guidance from the Department of Health and present a wealth of statistical information. However, we still contend that, in this form, it is unlikely to appeal to the public. We would therefore urge that the extraction of a summary into a separate document and compilation of an ‘easy read’ version is actively considered.

Conclusion

Overall, Healthwatch supports the priorities set for 2016/17 across the three areas of clinical effectiveness, patient safety and patient experience. We also have existing opportunities to work with the Trust on quality issues through our Enter and View activity and through involvement in the Quality Review and the Patient and Staff Experience Groups. We therefore look forward to working closely with the Trust in improving the quality of patient experience over the coming year.

Annex 1.3: Statement from local council overview and scrutiny committees (OSC)

Feedback from:
North Lincolnshire Council – Health Scrutiny Panel
Lincolnshire County Council – Health Scrutiny Committee
East Riding of Yorkshire Overview & Scrutiny Committee
North East Lincolnshire Council – Health, Housing and Wellbeing Scrutiny Panel

North Lincolnshire Council – Health Scrutiny Panel’s Quality Accounts comments for Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

North Lincolnshire Council's Health Scrutiny Panel welcomes the opportunity to comment as part of Northern Lincolnshire and Goole NHS Foundation Trust's (NLG) Quality Account. NLG are a key partner and provider of local services, and members have built a valuable working relationship with Trust personnel over many years.

As described during the panel’s 2014/15 submission, members remain concerned regarding the lack of progress on reducing the SHMI rate. Local performance has been largely static now for several years, and the Trust fell briefly into the 'higher than expected' banding throughout the previous year. However, we note and welcome the Trust’s intention to keep this as a priority indicator for the coming year. The panel is, of course, aware of the inexact methodology in this area, the local ‘in-hospital’ and ‘out-of-hospital’ performance, and also that reducing the SHMI rate requires a wide ownership of co-ordinated actions. However, as the key acute provider, and an important community provider, we share NLG’s view that this should remain the highest priority for 2015/16 and beyond. We signal our intent to continue to hold all relevant partners to public account for improvements in this area.
The panel welcomes the clinical effectiveness, patient safety, and patient experience priorities agreed by the Trust and set out within this document. The proposed changes seem largely to be sensible and proportionate, given the Trust’s experiences throughout the year. In particular, we are encouraged to see priorities aimed at improving services for those with sepsis and reducing the transfer of patients for non-clinical reasons, both of which are linked to SHMI performance. However, we believe that the Trust should consider ‘stretching’ their target on re-opening complaints (PE2). A target of 20% when performance is already far exceeding this, seems to the panel to be far from ambitious enough.

As a general point, and acknowledging that the recent CQC reports were published in 2015/16, the panel believes that, in the future, there should be greater alignment of local priorities and action plans arising from inspections.

The panel notes the findings of the 2015 staff survey, as outlined in section 3.3 of the Quality Account. We congratulate the Trust for continuing to be a ‘high reporting’ Trust for errors, near misses and incidents, and we acknowledge recent improvements to staff morale. However, we note with concern the feedback on the number of staff who would recommend the organisation as a place to work or receive treatment, and the worrying and deteriorating performance for staff experiencing harassment, bullying or abuse from colleagues, and the very low number of victims willing to report this. We would expect the Trust to take robust action on improving the situation for staff over the coming months.

As described in previous years’ submissions, the panel continues to note, again with concern, the Trust’s overall performance on staffing issues and the Trust’s financial sustainability. Whilst we recognise that the Healthy Lives, Healthy Futures programme has made substantial progress throughout 2015/16, we share the Trust’s concerns that this is largely yet to have an impact on front-line services. Clearly, we acknowledge that whilst NLG do play a key role within this, this has to be progressed through working with commissioners and other partners. We share NLG’s view that a genuine, sustainable and patient-focussed solution must be delivered in 2016/17 to ensure future sustainability, whilst driving up quality standards and meeting the requirements of the CQC and the regulator.

On work-related issues, the Chief Executive, Deputy Chief Executive, and other key officers pro-actively provide regular, constructive updates to the panel on ongoing and developing activities, answering members’ questions in a frank and open manner. Each contact between the Trust and the panel through the year has been positive and any queries have resulted in a swift and comprehensive response, and we thank the Trust for this.
Presentation and Content
There is comprehensive information throughout the Quality Account and the graphs are clear and easy to understand. The document is cross-referenced and allows readers to take an overview of services or, if they wish, to focus on specific details.

Progress on Priorities for 2015-16
We commend the Trust for clearly indicating whether it has met its targets and for providing this information for each of its three hospital sites. Of particular note is the Trust's progress reducing avoidable pressure ulcers and the number of patients who fall repeatedly and the achievements in significantly reducing MRSA and clostridium difficile. There has also been progress in implementing the NICE guidelines.

We note that the Trust has seen a reduction in the number of complaints that have been reopened, but we would like to see as many complaints as possible resolved in the first instance.

Priorities for 2016-17
We support the Trust's 23 priorities for improvement in 2016-17, and recognise that in most instances these priorities are continuation of previous priorities. This approach is welcomed, particularly in areas where the Trust has not met the previously set targets. We compliment the Trust on its wide consultation that took place prior to the identification of the priorities. This included the public, the Council of Governor and the commissioners.

We believe that the target to screen 90% of patient on admission for sepsis is ambitious, but we look forward to the Trust making progress in this area.

As highlighted above, the continuation of targets to reduce pressure ulcers and prevent patients from falling repeatedly is welcome, as the continued targets for elimination MRSA and clostridium difficile.

We are satisfied that the progress against the priority indicators will be monitored by the Quality and Patient Experience Committee and the Trust Board on a monthly basis.

Never Events
There have been four never events in 2015-16 (there were none in 2014-15). We note the statement by the Trust on its learning from these never events and how this learning is shared with the wider organisation and elsewhere.

Care Quality Commission
We acknowledge that the report by the Care Quality Commission was published at the same time as the draft Quality Account was being prepared. Their specific findings, for example on Scunthorpe General Hospital, will motivate the Trust to pursue further actions in this regard.

Engagement with the Health Scrutiny Committee for Lincolnshire
We note that there has been no direct engagement by the Trust at meetings of the Health Scrutiny Committee for Lincolnshire, and accept that the Trust by necessity has more focus on the health overview and scrutiny committees in North Lincolnshire, North East Lincolnshire and the East Riding of Yorkshire. However, we are grateful for the information updates provided by the Trust. The Health Scrutiny Committee for Lincolnshire would like to explore the possibility of direct engagement in the coming year.

Conclusion
Owing to the timetable set for the receipt of this statement, we were not able to meet a representative of the Trust to provide direct feedback on the content of this Quality Account.

The Health Scrutiny Committee for Lincolnshire looks forward to the Trust making progress across all its priorities, as well as meeting the requirements of the Care Quality Commission, so that services to patients in Lincolnshire continue to improve.
East Riding of Yorkshire Council – Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

Response to Northern Lincolnshire and Goole NHS Foundation Trust

Draft Quality Accounts 2015/16

Northern Lincolnshire and Goole NHS Foundation Trust has engaged with the Council’s Health, Care and Wellbeing Overview and Scrutiny Sub-Committee throughout its work programme 2015/16. This has included monitoring performance against the Trust’s current priorities and previous CQC inspection outcomes. The Sub-Committee also welcomed the opportunity to participate and comment on the development of the 2015/16 Quality Accounts, particularly through the Trust’s attendance at a recent scrutiny meeting to present the draft Quality Accounts to members.

The Draft Quality Accounts are highly detailed in the information, data and evidence set out and whilst some of this may at times be a bit overbearing, the Sub-committee nevertheless welcome the Trust’s open and transparent approach taken in the draft Quality Accounts.

Whilst the Sub-Committee understand the findings of the recent CQC inspection and the Trust’s proposed response and action plan to this, cannot be included at this time in this year’s Quality Accounts, it is hoped that the Trust’s response to improve its rating of ‘requires improvement’ forms the bedrock off all its work for the coming year.

Aside from the recent inspection findings, the Sub-committee welcome the priorities set for 2016/17 and feel these have been carefully considered and hope the Trust can meet these priorities in forthcoming year.

North East Lincolnshire Council – Health Scrutiny Panel’s Quality Accounts comments for Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

The Health Scrutiny Committee for North East Lincolnshire recognises the importance of services provided by the Trust to the residents of North East Lincolnshire. Unfortunately, the Health Panel is unable to make a statement on the Quality Account for 2015/16, but will continue to work with the Trust and looks forward to participating in the Quality Account process in future years.

Annex 1.4: Statement from the Trust governors’

Thank you for providing us with the 2015/16 Annual Quality Account. Governors are kept informed of progress during the year through their receipt and scrutiny of the monthly Quality Report at the Governor chaired Quality Review Group and so we were pleased to see an amalgamation of the previous 12 months performance against quality priorities. The report contains detailed explanations of key targets and terminologies used within the Quality account.

Governors, via the Quality Review Group and the regular Council of Governor meetings, look forward to further closer working and seeking necessary assurances that the Trust is continuing to focus on and improve quality of services during 2016/17.
Annex 2: Statement of directors’ responsibilities in respect of the Quality Report

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

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance;

- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2015 to March 2016 (the period);
  - Draft Board minutes from the meeting on 29 April 2016;
  - Papers relating to Quality reported to the board over the period April 2015 to March 2016;
  - Feedback from commissioners; NELCCG, NLCCG, ERYCCG and Lincolnshire East CCG for 2015/16 dated 04 May 2016;
  - Feedback from governors dated 29 April 2016;
  - Feedback from Local Healthwatch organisations; Healthwatch North Lincolnshire, Healthwatch North East Lincolnshire, Healthwatch Lincolnshire and Healthwatch East Riding of Yorkshire dated 05 May 2016;
  - The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 for Q1 – Q3 and Trust’s Quality Report to the Board, dated 29 April 2016;
  - The 2015 national patient survey;
  - The 2015 national staff survey;
  - The Head of Internal Audit’s annual opinion over the trust’s control environment dated 27 April 2016.

- The Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered;

- The performance information reported in the Quality Report is reliable and accurate;

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

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
• The Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the Board

NB: sign and date in any colour ink except black

........................................ Date ........................................ Chairman

........................................ Date ........................................ Chief Executive
Annex 3: Independent auditor’s report to the Board of Governors on the Annual Quality Report

Independent Auditors’ Limited Assurance Report to the Council of Governors of North Lincolnshire and Goole NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of North Lincolnshire and Goole NHS Foundation Trust to perform an independent assurance engagement in respect of North Lincolnshire and Goole NHS Foundation Trust’s Quality Report for the year ended 31 March 2016 (the ‘Quality Report’) and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance (the “specified indicators”) marked with the symbol ▲ in the Quality Report, consist of the following national priority indicators as mandated by Monitor:

<table>
<thead>
<tr>
<th>Specified Indicators</th>
<th>Specified indicators criteria</th>
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<tbody>
<tr>
<td>Percentage of incomplete pathways within 18 weeks for</td>
<td>Criteria can be found on page 101 of the 15/16 Quality Report</td>
</tr>
<tr>
<td>patients on incomplete pathways.</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients with a total time in A&amp;E of four</td>
<td>Criteria can be found on page 102 of the 15/16 Quality Report</td>
</tr>
<tr>
<td>hours or less from arrival to admission, transfer or</td>
<td></td>
</tr>
<tr>
<td>discharge.</td>
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</table>

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the “Criteria”). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual (“FT ARM”) and the “Detailed requirements for quality reports 2015/16” issued by the Independent Regulator of NHS Foundation Trusts (“Monitor”).

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the “Detailed requirements for quality reports 2015/16”;
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the NHS Foundation Trust Annual Reporting Manual (“FT ARM”) and the “2015/16 Detailed guidance for external assurance on quality reports”.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the “Detailed requirements for quality reports 2015/16; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the financial year, April 2015 and up to March 2016 (the period);
- Draft Board minutes from the meeting on 26 April 2016;
- Papers relating to quality report reported to the Board over the period April 2015 to the date of signing this limited assurance report;
• Feedback from the Commissioners NELCGG, NLCCG, ERYCCG, Lincolnshire East CCG for 2015/16 dated 4 May 2016;
• Feedback from Governors dated 29 April 2016;
• Feedback from Local Healthwatch organisations Healthwatch North Lincolnshire, Healthwatch North East Lincolnshire, Healthwatch Lincolnshire and Healthwatch East Riding of Yorkshire dated 5 May 2016;
• The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, for Q1 – Q3 and Trust’s Quality Report to the Board, dated 29 April 2016;
• The national and local patient survey dated 2015;
• The national and local staff survey dated 2015; and
• The Head of Internal Audit’s annual opinion over the Trust’s control environment dated 27 April 2016.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the “documents”). Our responsibilities do not extend to any other information.

Our Independence and Quality Control

We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics [, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour]. We apply International Standard on Quality Control (UK & Ireland) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of North Lincolnshire and Goole NHS Foundation Trust as a body, to assist the Council of Governors in reporting North Lincolnshire and Goole NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and North Lincolnshire and Goole NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- reviewing the content of the Quality Report against the requirements of the FT ARM and “Detailed requirements for quality reports 2015/16”;
- reviewing the Quality Report for consistency against the documents specified above;
• obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
• based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
• making enquiries of relevant management, personnel and, where relevant, third parties;
• considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
• performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
• reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM the "Detailed requirements for quality reports 2015/16 and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by North Lincolnshire and Goole NHS Foundation Trust.

Basis for Disclaimer of Conclusion – Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways.

The Trust reports monthly to Monitor on the Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways indicator, based on the waiting time of each patient who has been referred to a consultant but whose treatment is yet to start.

The 18 week indicator is calculated each month based on a snapshot of incomplete pathways and reported through the Unify2 portal. The data reported is subsequently updated for any identified errors through a monthly validation process. However, the data is reviewed and corrected only on a sample basis and the correction to pathways resulting from validation are not used to recalculate the performance for the year. The Foundation Trust was not able to provide final accurate and complete data to check the waiting period from referral to treatment reported across the year.
Conclusion (including disclaimer of conclusion on Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways.)

In our opinion, because of the significance of the matters described in the Basis for Disclaimer of Conclusion paragraph, we are not able to form a conclusion on the Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways.indicator.

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2016:

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the “Detailed requirements for quality reports 2015/16”;
- The Quality Report is not consistent in all material respects with the documents specified above; and
- the ‘Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge’ indicator has not been prepared in all material respects in accordance with the Criteria set out in the NHS Foundation Trust Annual Reporting Manual (“FT ARM”) and the “Detailed guidance for external assurance on quality reports 2015/16”.

PricewaterhouseCoopers LLP
Benson House, 33 Wellington Street, Leeds, LS1 4JP
26 May 2016

The maintenance and integrity of the North Lincolnshire and Goole NHS Foundation Trust’s website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.
Annex 4: Glossary

**Benchmark Peer Group:** Calderdale and Huddersfield NHS Foundation Trust, Chesterfield & North Derbyshire Royal Hospital NHS Trust, Countess of Chester NHS Foundation Trust, County Durham and Darlington NHS Foundation Trust, Doncaster and Bassetlaw Hospitals NHS Trust, North Cumbria University Hospitals NHS Trust, North Tees & Hartlepool NHS Trust, Rotherham NHS Foundation Trust, Royal Bolton Hospital NHS Foundation Trust, The Pennine Acute Hospitals NHS Trust, University Hospitals of Morecambe Bay NHS Trust

**Clostridium Difficile – Guidance from Monitor, received during 2015:** As part of the Trust’s obligations to monitor, we are performance managed against this target of “no more than 21 hospital acquired cases”. However, when understanding their guidance to Trusts, this is no more than 21 cases “due to a lapse in care” or in other words, potentially preventable cases. An extract from Monitor’s guidance is reported as follows:

“For 2014/15, organisations will be encouraged to assess each CDI case they identify to determine whether the case was linked with a lapse in the quality of care provided to patients. This will increase the organisation’s understanding of the quality of the care they are providing and highlight areas where care could be improved. Where CDI cases are not linked with identifiable lapses in care, it is proposed that those cases are not considered when contractual sanctions are being calculated.”

As a result of this, the Quality report now contains an analysis of both ALL cases of hospital acquired CDiff alongside those classed as ‘preventable’ (or in other words lapses in care).

**Commissioning for Quality & Innovation Framework (CQUIN):** The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers’ income to the achievement of local quality improvement goals. Since the first year of the CQUIN framework (2009/10), many CQUIN schemes have been developed and agreed. This is a developmental process for everyone and you are encouraged to share your schemes (and any supporting information on the process you used) to meet the requirement for transparency and support improvement in schemes over time.

**Common Cause Variation:** an inherent part of the process, stable and “in control”. We can make predictions about the future behaviour of the process within limits. When a system is stable, displaying only common cause variation, only a change in the system will have an impact.

**Complaints:** The NHS Complaints Regulations (England) 2009 require that an offer to discuss the complaint with the complainant is made on receipt of all complaints; the discussion to include the response period (the period within which the investigation is likely to be completed and when the response is likely to be sent to the complainant). The requirement is to investigate the complaint in an appropriate manner, to resolve it speedily and efficiently and to keep the complainant informed as to progress. The response should be within 6 months or a longer period if agreed with the complainant before the expiry of that period.

The Complaints Regulations permit extensions to the agreed timescale where this becomes necessary and in agreement with the complainant. The Trust (as outlined within the Policy for the Management of Complaints) expects that any delay to the agreed response time is communicated to the complainant, the reasons explained and an extension agreed.

In respect of monitoring, the Regulations require (amongst other points) that the Trust maintain a record of the response periods and any amendment of that period and whether the response was sent to the complainant within the period or any amendment of that period.

**KEY DEFINITIONS TO INTERPRET COMPLAINTS DATA:**

- **NEW:** The number of new complaints received in a month regardless of whether or not they were resolved within that month.
- **CLOSED:** The number of complaints that were resolved within a month regardless of whether they were received within the month or resolved within agreed timescale.
- **NET OPEN:** The total number of complaints currently open; includes new complaints and those unresolved from previous month(s). This includes open ‘on hold’. This includes re-opened complaints.
- **RE-OPENED:** Complaints that have been resolved which for any number of reasons require further review.

**Control Limits:** indicate the range of plausible variation within a process. They provide an additional tool for detecting special cause variation. A stable process will operate within the range set by the upper and lower control limits which are determined mathematically (3 standard deviations above and below the mean). These consist of an upper control limit, a lower control limit and a mean (average).

**Crude Mortality Rate:** The crude mortality rate is based on actual numbers. Unlike Standardised Mortality Ratios (SMRs) i.e. SHMI and HSMR which features adjustment based on population demographics and related mortality expectations. Crude mortality is calculated by using as the numerator the number of patients who have died divided by the denominator which in this case is the total population. Times this figure by 100, equals the crude mortality percentage (%).

**Dementia – methodology for determining compliance with Quality Target:**

**CE3.1 – Dementia Screening:** All patients who are admitted to the Trust as an emergency admission who are aged 75 or over should have an initial screening for dementia. The screening consists of the patient being asked:

“Have you been more forgetful in the last 12 months to the extent that it has significantly affected your daily life?”

Patients who already have a diagnosis of dementia or who have a clinical diagnosis of delirium do not require screening. In the national guidance regarding calculating compliance, these two groups of patients are included in the numerator as patients who are determined to have had a dementia screening.

**CE3.2 – Further risk assessment.**

All patients admitted aged 75 and above, who have scored positively on the case finding question, or who have a clinical diagnosis of delirium and who do not fall into exemption categories should then receive a more detailed diagnostic assessment using the 6 item Cognitive Impairment Test (6CIT).
Positive feedback defined as the percentage of patients/service users answering ‘extremely likely’ and ‘likely’ or negative. There is also an opportunity to elaborate on the reasons for their answer and all feedback will be encouraged whether positive or of a lack of due care.

Friends and Family Test – Methodology: The Trust introduced the new friends and family test in April 2014, when it was launched across the country. Within 48 hours of receiving care or treatment as an inpatient or visitor to A&E, patients are given the opportunity to answer the following question:

“How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?”

Service users are then asked to answer how likely or unlikely along a six-point scale they would answer the above question. There is also an opportunity to elaborate on the reasons for their answer and all feedback will be encouraged whether positive or negative.

‘Positive feedback’ defined as the percentage of patients/service users answering ‘extremely likely’ and ‘likely’

H.E.D. – Health Evaluation Data: The official national data publications are released quarterly, six months after the event. The Trust therefore reports its performance to its Board every month using provisional data published by the University of Birmingham through its Hospital Evaluation Data system (HED). This is normally three months behind the current position, and has been validated as virtually identical to the official published data.

HED SHMI – Numerical value – interpret with caution: HED SHMI is referred to within this report as a ‘provisional’ indicator and should be interpreted with caution. Sometimes within this report, the numerical value of the HED SHMI is sometimes observed as changing over subsequent month’s reports, for the same time frame. The reason for this is multi-faceted and is explained as follows:

1. SHMI modelling information is released on a quarterly basis, alongside the ‘official’ SHMI publication. The official SHMI essentially readjusts the HED ‘provisional’ indicator so it’s in line with the ‘official’ data/statistical modelling. This modelling data when available following the publication of the ‘official’ SHMI will readjust the HED data so it is line with the official statistic. It could be reasoned from this therefore, that the further away from the quarterly release of the official data, the more scope there is for HED to be different to the next/future ‘official’ SHMI publication. When we say different, the actual difference is usually small, less than a point.
2. Hospital Episode Statistics (HES) and Office for National Statistics (ONS) data is being added to as more and more data (data completeness) becomes available. Simply put each monthly HED data includes more complete information from Trust data sources and community data (the 30 day deaths, post discharge) than the information available for the previous month. Not all deaths are reported in a timely manner, so the monthly data going into HED for the month of February, let’s say as an example, could be added to – in terms of completeness – in future monthly releases. That means that the HED data for the Trust – but most importantly – the Trust’s peers, the rest of the UK, is always being added to. HED is vulnerable to these changes as it reports a period in time much sooner to that reported by the ‘official’ SHMI. The ‘official’ SHMI looks at data 6-18 months old, so in terms of data completeness is more stable and therefore reliable.
3. All Trusts can resubmit data for previous months (during a specified window of opportunity). This can be for small data corrections or specific pieces of work to cleanse/validate data.

HED SHMI is still a useful indicator; these factors need to be borne in mind when using the information for comparing progress made with the improvement agenda.

MUST – Malnutrition Universal Screening Tool: The total MUST score for a patient is worked out from their BMI, the amount of unplanned weight loss they may have and the ‘acute disease effect’ (if the patient is acutely ill and there has been or likely to be no nutritional intake for >5 days). The MUST score triggers appropriate action, as described below:

- MUST score of 0: Low risk and require screening weekly,
- MUST score of 1: Moderate risk and require screening weekly, commencement and completion of a food record chart, to be encouraged to have fortified meals from the food menu, offered snacks from the Trust wide snack list.
- MUST score of 2 or more: High risk and require the same management as those patients scoring 1 plus a referral to the dietician for a dietetic review.

Patient Experience: This Trust has set the goal of being the hospital of choice for our local patients. Being the hospital of choice is a far different thing than being the hospital of convenience, proximity or default. We measure patient experience using methodologies employed by the NHS National Patient Experience Survey against two key indicators to help us determine that our hospitals are the ones our patients would choose if the practical factors were removed.

The Trust uses The Menu Card Survey which asks five questions relating to patient experience and is attached to inpatients’ menu cards. It measures the patients’ experience in real time. The questions asked are all derived from questions that feature in all National Patient Surveys.

The scores depicted in the graphs reflect an absolute figure generated by this methodology (in short – high score is good, 100%
would be the maximum achievable score).

**Pressure Ulcer: Definition of Avoidable and Unavoidable Pressure Ulcer**

The Department of Health (DH) has been asked to clarify what an avoidable pressure ulcer is in regards the nurse sensitive outcome indicators. The DH researched the availability of definitions, finding that there are a limited number of definitions in existence to draw from.

The Wound, Ostomy and Continence Nurses Society of the US have produced a position paper which points to a clear definition of “avoidable” pressure ulcer (WOCNS) March 2009. However, the DH are using a modified version of the Avoidable d

**AVOIDABLE PRESSURE ULCER:**

“ Avoidable” means that the person receiving care developed a pressure ulcer and the provider of care did not do ONE of the following:

- Evaluate the person’s clinical condition and pressure ulcer risk factors
- Plan and implement interventions that are consistent with the persons needs and goals and recognised standards of practice within the Trust
- Monitor and evaluate the impact of the interventions
- Revised the interventions as appropriate

**UNAVOIDABLE PRESSURE ULCER:**

“Unavoidable” means that the person receiving care developed a pressure ulcer even though the provider of the care had done ALL of the following

- Evaluated the persons clinical condition and pressure ulcer risk factors
- Planned and implemented interventions that are consistent with the persons needs and goals and recognised standards of practice within the Trust
- Monitored and evaluated the impact of the interventions
- Revised the interventions as appropriate
- The individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence and this was documented.

**Pressure ulcer gradings from the European Pressure Ulcer Advisory Panel (EPUAP):**

**Category/Grade 1: Non-blanchable redness of intact skin**

Intact skin with non-blanchable erythema of a localized area usually over a bony prominence. Discoloration of the skin, warmth, edema, hardness or pain may also be present. Darkly pigmented skin may not have visible blanching.

**Further description:** The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate “at risk” persons.

**Category/Grade 2: Partial thickness skin loss or blister**

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister.

**Further description:** Presents as a shiny or dry shallow ulcer without slough or bruising. This category/stage should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.

**Category/Grade 3: Full thickness skin loss (fat visible)**

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Some slough may be present. May include undermining and tunnelling.

**Further description:** The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

**Category/Grade 4: Full thickness tissue loss (muscle/bone visible)**

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often include undermining and tunnelling.

**Further description:** The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable.

**Rate per 1000 bed days:** So we can know if we are improving even if the number of patients we are caring for goes up or down, we also calculate an average called ‘rate per 1,000 occupied bed days’. This allows us to compare our improvement over time, but cannot be used to compare us with other hospitals, as their staff may report in different ways, and their patients may be more or less vulnerable than our patients.

**Readmission Rate (RA):** This measure shows the percentage of patients who were readmitted to hospital as an emergency within one month of being discharged. It can serve as an indicator of the quality of care provided and post-discharge follow up. A low readmission rate is an indicator of the quality of care that it reflects a healthy care balance. Where rates are low, patients are not having to come back to the Trust for care of the same complaint. Conversely, a high readmission rate potentially signals that an organisation is releasing patients home too soon or otherwise not addressing all elements of their clinical condition.

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Together we care, we respect, we deliver
Safety Thermometer methodology:
The NHS Safety Thermometer provides the ability for ‘a temperature check’ of harm to be recorded. It did this by auditing on a point prevalence basis the care provided to patients on a given date each month. This point prevalence audit provided a ‘snapshot’ view of harm on that given day each month. It focusses on harm in four key areas:

- Pressure ulcers grades 2, 3 & 4
- Falls – all falls reported, even if no harm occurred
- Catheter associated UTIs – those treated with antibiotics
- VTE – risk assessment, prophylaxis and treatment of DVT or PE

Harm:
- **Catastrophic harm:** Any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care.
- **Severe harm:** Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.
- **Moderate harm:** Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care. Locally defined as extending stay or care requirements by more than 15 days; Short-term harm requiring further treatment or procedure extending stay or care requirements by 8 - 15 days
- **Low harm:** Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care. Locally defined as requiring observation or minor treatment, with an extended stay or care requirement ranging from 1 – 7 days
- **None/ ‘Near Miss’ (Harm):** No obvious harm/injury, Minimal impact/no service disruption.

Harm Free Care:
- Safety Thermometer enables the calculation of the proportion of patients who received harm free care. This is calculated by dividing the number of patients receiving harm free care (as the numerator) by the total number of patients surveyed (the denominator).
- Patients with more than one of the harms listed, will not be classified as harm free care and are thus not counted in the numerator. Patients recorded as having multiple harms are removed from the numerator in the same way as those with only one harm.

Proportion of patients with ‘harm free’ care:
- Those patients without any documented evidence of a pressure ulcer (any origin, category 2-4), harm from a fall in care in the last 72 hours, a urinary infection (in patients with a urinary catheter) or a new VTE (treatment started after admission).

Proportion of patients with ‘harm free’ care – new harms only:
- Those patients without any documented evidence of a new pressure ulcer (developed at least 72 hours after admission to this care setting, category 2-4), harm from a fall in care in the last 72 hours, a new urinary infection in patients with a urinary catheter which has developed since admission to this care setting, or a new VTE (treatment started after admission).

Community Safety Thermometer: VTE is not relevant as an indicator. In community practice, patients are not routinely risk assessed for VTE and any concerns regarding a patient in this matter would be referred to the patient’s GP or to the acute Trust via A&E attendance. In the same way, prophylaxis, unless prescribed by a doctor, would not routinely be commenced by community staff. Due to these differences, the individual elements of this indicator have been classed as not applicable to the community care safety thermometer results. As a result, VTE is not included in the following section pertaining to community care Safety Thermometer results.

Sigma: A sigma value is a description of how far a sample or point of data is away from its mean, expressed in standard deviations usually with the Greek letter σ or lower case s. A data point with a higher sigma value will have a higher standard deviation, meaning it is further away from the mean.

Summary Hospital Mortality Indicator (SHMI): The SHMI is the NHS ‘official’ Standardised Mortality Ratio (SMR). It is a method of comparing mortality levels in different years, or between different hospitals. As a result, the SHMI is used as a performance tool to rank NHS organisations within a league table. The ratio is calculated by using as a numerator the number of deaths divided by the denominator, in this case, the number of ‘expected’ deaths, multiplied conventionally by 100. Thus, if mortality levels are higher in the population being studied than would be expected, the SHMI will be greater than 100. This methodology allows comparison between outcomes achieved in different trusts, and facilitates benchmarking. The outcomes of the SHMI are reported in three bandings: (1) higher than expected, (2) as expected and (3) lower than expected. The SHMI includes not only in-hospital deaths, but also includes deaths within the community, occurring within 30 days of hospital discharge. As a result, it is dependant not only on in-hospital coded information, but also on Public Health data, this results in a delay in reporting. As a consequence, the quarterly data published by the Health and Social Care Information Centre reports on historic information ranging from 18 months to 6 months. To illustrate this point, the SHMI Information release in April 2015 reports performance from October 2013 – September 2014.
**Special Cause Variation:** the pattern of variation is due to irregular or unnatural causes. Unexpected or unplanned events (such as extreme weather) can result in special cause variation. Systems which display special cause variation are said to be unstable and unpredictable. When systems display special cause variation, the process needs sorting out to stabilise it. This is most commonly reported using two types of special cause variation, trends and outliers. If a trend, the process has changed in someway and we need to understand and adopt if the change is beneficial or act if the change is a deterioration. The outlier is a one-off condition which should not result in a process change. These must be understood and dealt with on their own (i.e. response to a major incident).

Identifying Special Cause Variation – agreed rules:

- Any point outside of the control limits,
- A run of 7 points all above or below the central line, or all increasing / decreasing,
- Any unusual patterns or trends within the control limits,
- The proportion of points within the middle 1/3 of the region between the control limits differs from 2/3.

**Standard Deviation:** Standard deviation is a widely used measurement of variability or diversity used in statistics and probability theory. It shows how much variation or “dispersion” there is from the “average” (mean, or expected/budgeted value). A low standard deviation indicates that the data points tend to be very close to the mean, whereas high standard deviation indicates that the data are spread out over a large range of values.

### Annex 5: Mandatory Performance Indicator Definitions

The following indicators:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period,
- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer and discharge,
- Data completeness community services, treatment activity.

Have been subject to external audit in line with the following criteria:

**Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways:**

**Source of indicator definition and detailed guidance**


**Detailed descriptor**

E.B.3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period

**Numerator**

The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks

**Denominator**

The total number of patients on an incomplete pathway at the end of the reporting period

**Accountability**


**Indicator format**

Reported as
• Detailed descriptor: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period;
• Numerator: The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks;
• Denominator: The total number of patients on an incomplete pathway at the end of the reporting period.
• Accountability: Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wp-content/uploads/2013/125yr-strat-plann-guid-wa.pdf
• Indicator format: Reported as a percentage.
• This indicator has been tested by external auditors and includes the full population.

**Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge**

*Source of indicator definition and detailed guidance*

The indicator is defined within the technical definitions that accompany *Everyone counts: planning for patients 2014/15 - 2018/19* and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf.


*Additional information*

This indicator is as required to be reported by the *Risk Assessment Framework*:

• A&E four-hour wait: waiting time is assessed on a provider basis, aggregated across all sites: no activity from off-site partner organisations should be included. The four-hour waiting time indicator applies to minor injury units/walk-in centres.

Paragraph 6.8 of the NHS England guidance referred to above gives further guidance on inclusion of a type 3 unit in reported performance:

• *We are an acute trust. Can we record attendances at a nearby type 3 unit in our return?*
• *Such attendances can be recorded by the trust in the following circumstances.*

  a) *The trust is clinically responsible for the service. This will typically mean that the service is operated and managed by the trust, with the majority of staff being employees of the trust. A trust should not assume responsibility for reporting activity for an operation if the trust’s involvement is limited to clinical governance.*

  b) *The service is run by an IS provider on the same site as a type 1 unit run by the trust. This would need to be agreed by the parties involved, and only one organisation should report the activity.*

Where an NHS foundation trust has applied criterion (b) and is including type 3 activity run by another provider on the trust site as part of its reported performance, this will therefore be part of the population of data subject to assurance work.

In rare circumstances there may be challenges in arranging for the auditor to have access to the third party data in these cases. In this scenario the NHS foundation trust may present an additional indicator in the quality report which only relates to its own activity and have this reported indicator be subject to the limited assurance opinion.

*Numerator*

*The total number of patients who have a total time in A&E of four hours or less from arrival to admission, transfer or discharge. Calculated as:*
(Total number of unplanned A&E attendances) – (Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge)

**Denominator**
The total number of unplanned A&E attendances

**Accountability**

**Indicator format**
Reported as a percentage
This indicator has been tested by external auditors and includes the full population.

**Data completeness community services, treatment activity.**

The data completeness report shows the number of patients that have been registered onto SystemOne Units per month. Of these registered patients how many have had an open referral recorded against them.

Theoretically all patients that are registered onto SystemOne, should have an open referral recorded at the same time as they are registered, therefore for data completeness we would expect this to be 100%.

A report is available which shows how many patients are registered during the month, and how many of these also had an open referral recorded, to ensure data completeness. Failure to record an open referral results in the episode being unable to be used for contracting and finance purposes.

As SystemOne is a live system, historic information is not stored, so in order to audit this process the Trust relies on assessing the previous month's extract of data for completeness analysis purposes.