NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Northern Lincolnshire & Goole NHS Foundation Trust

Annual Quality Account

2022/2023

Kindness · Courage · Respect

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

After two years dominated by responding to the COVID-19 pandemic directly the 2022/23 financial year was a year of coping with the indirect consequences of it. The most obvious impact of the pandemic has been the increase in the number of patients waiting for operations and procedures across the country. At our Trust we saw an increase although it was proportionately lower than many other areas as we did everything we could during the pandemic to keep our operating theatres running. Given this we were asked to provide support to other local hospitals – in particular Hull and, to a lesser extent, York – and take some patients from their waiting lists. This work amounted to several hundred patients.

Another consequence of the pandemic has been the impact it has taken on our staff. After two of the toughest years the NHS has ever faced our staff started the 2022/23 year tired, stressed and facing a difficult year in terms of both their work and the economic climate they were facing. I must report, as I have in my statements in previous Quality Accounts, our staff responded superbly to all the challenges put in front of them throughout the year. Throughout our hospital, community services, pathology services and support functions our teams went above and beyond, again and again, to do everything they could to care for patients and provide services. As in previous years we continued to experience growing demands – for example from patients attending our Emergency Departments (EDs) and in responding to changing guidance and to discharging patients from our wards. And all this in some working environments which are not always the best to work in and in some services where we are carrying more staff vacancies than we would want. Our staff coped incredibly with all this, and more – I want to thank them publicly through this statement for everything they have done in the past year.

Despite the pressures our staff faced and their own levels of tiredness they still managed to achieve some fantastic results. I should start by noting the Trust's continued and sustained performance in its Summary Hospital-level Mortality Indicator (SHMI). The SHMI reports on mortality at trust level across the NHS in England using a standard and transparent methodology and is one of the best overall indicators for the delivery of safe services in hospitals. It is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated. At the time of writing (April 2023) the Trust had a SHMI of 101.35 for the period December 2021 to November 2022. This was in the 'as expected' banding, was a lower score than the previous month (102.79 - 'as expected', November 2021 to October 2022) and the lowest ever SHMI score for the Trust since the figure was first introduced. It is also above the median for all trusts in England, a dramatic improvement on just a few years ago, when the Trust was consistently among the very worst performers in the country. This really is an excellent performance in a key indicator.

Another key indicator of the quality and safety of the services provided by hospitals is the results of a Trust's Care Quality Commission (CQC) inspection. I'm pleased to report the Trust achieved what is necessary to leave the Quality Special Measures it

has been in since 2017 after a CQC inspection in June and July 2022 recognised many improvements in the Trust's hospitals. Published in December 2022, the CQC's report recognises efforts to improve leadership, culture, safety, complaints and to tackle our waiting lists. Inspectors said they saw many good examples of patients receiving compassionate care, with staff ensuring patients' privacy and dignity were maintained and it was evident that staff worked hard to achieve the best possible outcomes for people throughout the services they inspected. The Trust is no longer rated 'Inadequate' for safety in any of its services and has maintained its 'Requires Improvement' rating. Scunthorpe General Hospital and the Diana Princess of Wales Hospital in Grimsby are both rated 'Requires improvement' and Goole and District Hospital is rated 'Good' overall. The Trust's community services were not inspected on this occasion. The CQC grade our services across our three hospitals in 112 'service domains'; we saw improvements across 35 of these 'service domains' and saw a reduced grading in only two. The CQC inspection covers five areas; Safe, Effective, Caring, Responsive and Well Led. At a Trust level Caring is 'Good' across the board and Safe, Effective, Responsive and Well Led are rated 'Requires Improvement'.

The CQC also releases the results of several patient surveys it undertakes throughout the year and we have seen improvement in those scores too. There was improvement in the feedback regarding our maternity services and I was particularly pleased to see the positive changes in our national inpatient results (which surveys patients who have stayed in hospital for one night or more) after the Trust was showing as an outlier in 2019. We have also seen some huge improvements in where we see and treat patients. We invested more than £35 million in the construction of new Emergency Departments in both Grimsby and Scunthorpe. Not only are these units twice the size of those they replace, helping us to meet the growing demand for our care, but our clinical teams have been involved in the design and build from the very beginning. In doing so, they have ensured that everything from the layout of the building to the location of equipment has been designed around what is best for our patients. Work is now underway on the refurbishment of our former Emergency Departments to convert them into Acute Assessment Units and Same Day Emergency Care provision, with both expected to open later in 2023. We also completed a series of smaller schemes, which are providing significant benefits to our patients. These included at Grimsby: a fully upgraded oxygen supply system, replacing the aging structure we previously had in place with a modern system that allows us to provide a consistent strong level of flow across the site; installing state-of-the-art digital X-ray equipment; creating a new lung function testing area; installing a second CT in our new Emergency Department; the demolition and removal of the temporary building which once housed our Critical Care Unit; and improving the safety of all patients, staff, and visitors to the site by installing a new fire alarm system. At Scunthorpe we have undertaken a full refurbishment of Ward 25, which has been transformed into a light and airy space, purpose built to limit the spread of infection; fully refurbished our fluoroscopy facilities and installed new equipment; installed new Maxillio Facial facilities to boost these services; and replicated the mortuary improvement works being done at Grimsby.

So, an incredible year of change and progress at the Trust. Of course, not everything has gone as we would have wanted. Because of our hospitals being so often full, too often patients waited a long time to be seen and treated in our EDs or to be transferred to a ward, and this meant that, with our EDs full, we didn't always have the space in our

EDs to take patients out of ambulances as quickly as we wanted to help the ambulance crews attend other calls. And, despite some great work which you can read about later in the document, we still have much work to do to improve the experience of patients who are reaching the end of their life. An area where we still, sadly, see ratings of 'Inadequate' from the CQC. Improving our end-of-life provision remains a key priority for the Trust in the coming year, as it has been in previous years.

As it has been in previous years our challenge for 2023/24 remains the same: to make sure our staff are able to offer the best possible patient care, by looking after them (our staff) and supporting them as they recover from such an intense few year, whilst at the same time doing everything we can to maintain our waiting lists and managing the increased demand we are experiencing for urgent care. If anyone can manage to do this, our staff can; they are superb and deserve huge credit. Once again, very many thanks to them all.

I can confirm that the Board of Directors has reviewed the 2022/23 Quality Account and can confirm that to the best of my knowledge, the information contained within this report is an accurate and fair account of our performance.

Signature:

Chief Executive and Accountable Officer: Dr Peter Reading
Date: 14 April 2023

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 at all our sites. The Trust provides acute hospital services and community services to a population of more than 450,000 people across North and North East Lincolnshire and East Riding of Yorkshire and has approximately 750 beds across three hospitals. The site locations are:

- Diana, Princess of Wales Hospital in Grimsby (also referred to as DPoW),
- Scunthorpe General Hospital located in Scunthorpe (also referred to as SGH),
- Goole & District Hospital (also referred to as GDH), and
- Community nursing 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 that the Trust did not just operate hospitals in the region. The Trust is now known as **Northern Lincolnshire and Goole NHS Foundation Trust.**

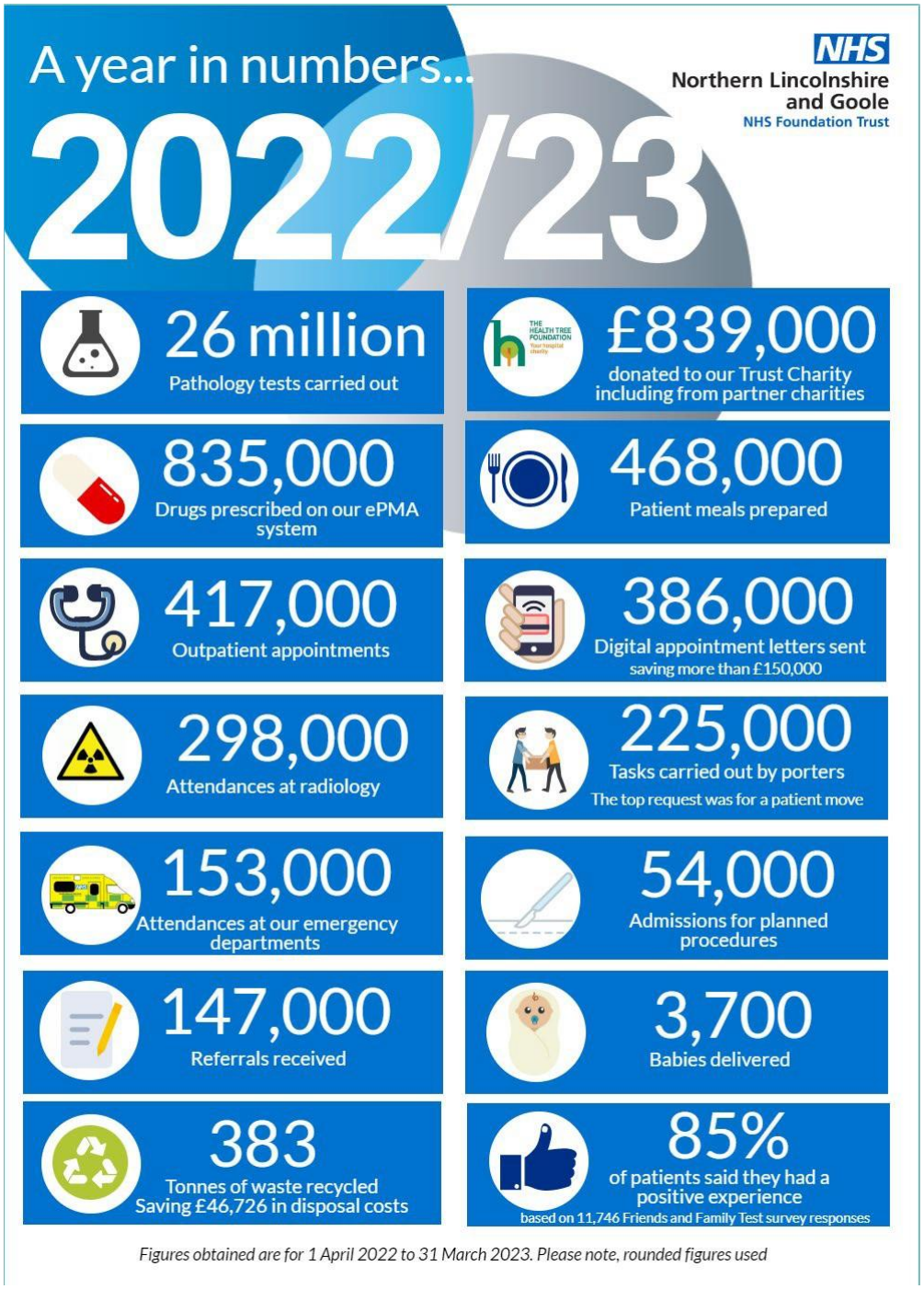


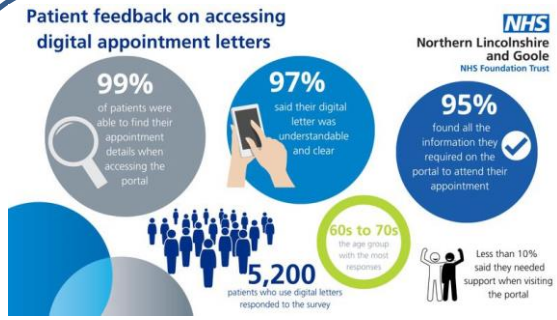
Figure 1: 2022/23 - A year in numbers

Proud Moments of 2022/23

The Trust was proud to be shortlisted as finalists in two categories at the 2022 Health Service Journal (HSJ) Partnership Awards which recognise outstanding contribution to healthcare. Staff have been working hard to get patients who are fit to leave hospital home as soon as possible. The Discharge Improvement Project, which has been a whole system effort across Northern Lincolnshire, has been recognised in the Integrated Care Partnership of the Year category. As a result of our efforts over the last two years the Trust is well under the national average for 'long length of stay' figures which reflect the length of time patients stay in hospital and is one of the best performing trusts in the North. The success of North Lincolnshire's vaccination programme was also recognised in the Covid Vaccination Programme category.

The Trust's latest CQC report showed an improving picture with the Trust no longer rated 'Inadequate' for safety in any of its services and has maintained its 'Requires Improvement' rating. Goole & District Hospital was rated as **Good** overall and the Diagnostic Imaging Core Service was highlighted for 'Outstanding practice'.

The Trust's infection control rates are among the lowest in England.



Our move over to digital appointment letters in Outpatients has been featured in a national digital playbook. The article covers the scope of the project, the functionality and the benefits to patients and staff. It highlights how the Trust have saved £152,000 in the first year, after switching over to digital letters.

The Quality Improvement Showcase launched in Nov 2022 to capture, showcase and celebrate QI initiatives from across the trust. It has over 160 QI projects documented with over 40% showing a measurable improvement with the remainder at various stages of testing and measuring data.

The Showcase allows staff to share their QI journey with others enabling cross divisional learning whilst inspiring and empowering colleagues to undertake their own QI projects.

Proud Moments of 2022/23

April Schwartz Round

Introduction of Schwartz Rounds offering a safe, reflective space for staff to share stories with colleagues about their work and its impact on them. The Rounds increase feelings of compassion towards patients, improve communication, and create more openness to receiving support.

First internationally educated midwives joined the Trust from their home country of Ghana. They will be supported through the Trust's preceptorship programme.

Development of two new EDs and AAUs. This has been supported by a significant national capital investment of £25m.

A range of improvements to clinical and education environments, mammography room at Grimsby and a maxillofacial room, a HYMS room and a fluoroscopy room at Scunthorpe, supported through charitable funding.

Introduction of Maternity triage telephone service. The service, which is for anyone who has medical concerns in pregnancy from 16 weeks onwards, has taken 3,500 calls since it launched on 31 October 2022. It is receiving great feedback and providing an invaluable service. Phase 3, which will see dedicated triage areas for people to attend at Scunthorpe and Grimsby, is coming soon.

We continue to see areas achieve good and outstanding in the 15 steps Programme. This is a continuous audit cycle that allows us to observe the environments from which we deliver care, review our documentation and through patient and staff feedback, highlight good practice and areas for improvement.

Proud Moments of 2022/23

The End of Life team were shortlisted in the Nursing Times Awards for team of the year.

The team, who work across hospitals in Scunthorpe, Grimsby, and Goole, as well as in the North Lincolnshire community, have been recognised for their commitment to improve End of Life care to our patients.

When a patient is near the end of their life, we support them and their loved ones to make it as comfortable as possible in line with their wishes for how they would like to be cared for.

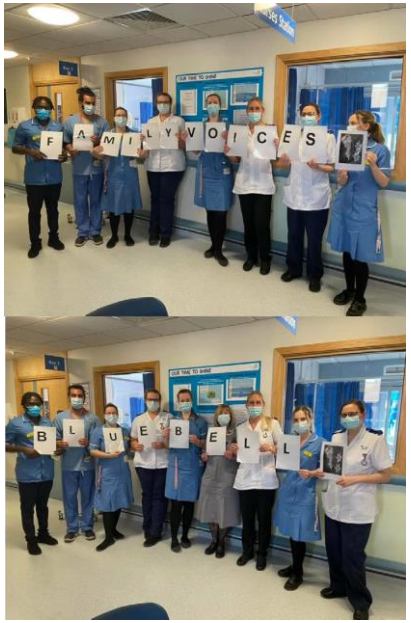
The Bluebell Principles, rolled out across the Trust, focus on better communication with the patients and family, recognising the signs of someone dying and developing individual care plans for each patient to ensure the care we provide is patient-centred, holistic, and consistent.

Sixty-eight End of Life Champions have also been trained to lead on the Bluebell Principles and support colleagues in their areas.

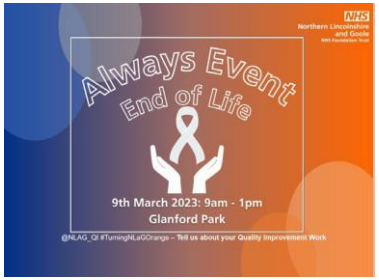
The Bluebell logo has been introduced and will be used in several ways when patients are at the end of their life. A simple Bluebell displayed on the room door of patients who are near the end of their life tells any staff entering the room the person is at the end of their journey with us. Bluebells symbolise humility and kindness, two important qualities to show our patients.

During the pandemic, many of our staff were faced with caring for patients at the end of their lives. Our hope is the Bluebell Principles will support any member of staff privileged enough to care for someone at such an important time of their lives and lead to even better patient care.

The Trust recognises that early recognition of patients at End of Life and support for patients and families goes beyond the End-of-Life team and is everyone's responsibility.



The Trust held an End-of-Life Quality Improvement 'Always' Event in March 2023 which focussed on understanding how we can support recognition and appropriate care planning for people who are approaching End of Life on our wards. Emerging themes and what good looks like will be the focus of our End of Life Quality Priority, Quality Improvement work in 2023/24.



Gareth's Story

Patient stories are recognised as providing valuable awareness and can help inform the Trust about current and ongoing patient experience or patient safety issues, which can generate debate, learning and actions.

Patient stories tend to be both objective and subjective, highlighting what happened and how that made someone feel. Getting the experience of care right is of the upmost importance to the Trust and we want everyone to receive the care and treatment they require, and this means that sometimes we may have to do things a bit differently, to get that same safe care and treatment outcome.

Gareth and his mum wanted to share their positive experience with us, following working with our Learning Disability Nurse Specialist, Emma Watts. Ensuring Gareth received the treatment he needed meant Emma and our staff worked with him, and his mum, over several weeks before his treatment date to ensure his visit went both smoothly and safely.

Gareth sums up his own experience below and details the collaborative approach used in delivering safe, person centred care.

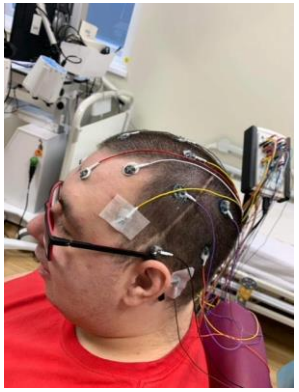
My name is Gareth, I am 28 years old with a learning disability, autism and cerebral palsy. My mum is writing this for me as I don't read or write but can understand what I want and in my own way let her know what I like and what I don't like.

As I have grown older I don't like hospitals, I won't go to appointments or have someone come to my house. But things have changed a little this year and as I had a 'bad toe' that needed surgery, I needed to have it done. With the help and support of Marie my learning disability support worker and Emma the Learning Disability Nurse from hospital as well as the theatre staff and nurses on ward 28 and of course the surgeon the surgery has been completed and all is well.

Marie and Emma worked together with my mum to put together a plan to visit the hospital as a fun trip, have a drink of Dr Pepper and sit in the hospital car park. I did that a few times and I enjoyed the trips out. My mum was included in an MDT on teams with the surgeon and other professionals as my LPA /mum to discuss what was the best plan for me. On the day of the operation I went for my usual trip out to the hospital but this time I had an important job to deliver a letter to Emma inside the hospital, I like helping.

I took the letter with Marie, we all went to sit in the garden where I met some nice nurses who asked me what I liked to eat. "Ham sandwiches and strawberry ice cream" I said. I drank my Dr Pepper but this time it helped me be relaxed and not anxious as I usually was in different places. After a while I went for a ride in a wheelchair to theatre and two nice men helped me on a trolley. I wasn't anxious Marie was there.

I didn't know but my mum was in the car park waiting for me to go to sleep. When I woke up I was on a ward still on the trolley, not a hospital bed as I don't like them. Marie and my mum were there to give me a hug for being so brave. My toe was better. The nurses I had seen in the garden brought ham sandwiches and strawberry ice cream for me. I am so pleased I had my toe made better. Since then I have also been to Grimsby Hospital for an EEG twice.



I can't promise to always go to hospital but they have a plan that's just for me for when I need help to go. My mum isn't as worried now she has support to help me if I am not well. I have even agreed to help Emma with the

garden for learning disabilities and sent ideas for lights and animals to make it nice to visit. I am waiting for Emma to let us know when there is some money to buy the things for the garden.

Thank you for taking the pain away from my bad toe and helping me and my mum to get the help I needed without any extra anxiety and stress.

PART 2: Priorities for improvement, statements of assurance from the Board and reporting against core indicators

2.1 Quality priority planning for 2023/24

Quality priorities for 2023/24 were developed and set in accordance with the Trust's quality strategy and drawing on triangulated information from a wide range of quantitative and qualitative data sources including complaints, incidents, inquests, litigations, Structured Judgment Reviews (SJRs), clinical audit, risk registers, staff, and patient surveys. A long list of potential quality priority topics was developed and formed the basis of a survey monkey that was shared with all staff, the Trust Governors, stakeholders including Healthwatch, the Integrated Care Board (ICB) and local residents and service users through the Trust's communications and social media channels.

Analysis of the survey feedback was then used for wider consultation within the Trust which resulted in a short-list of quality topics. Building on the momentum and success of the Trust's Quality Improvement team the Trust took the opportunity to implement a new bottom up, Multi-Disciplinary Team (MDT) approach to setting the quality priorities and associated Key Performance Indicators (KPIs) by hosting a one day Quality Improvement quality priorities workshop to ensure engagement with the correct people drawing on feedback from all disciplines to identify what the problem is, what the root cause and drivers are, what needs to change, how the Trust will change it and how the Trust will measure success. This approach will improve Trust wide ownership and engagement and will facilitate coproduction to ensure that the quality priorities and KPIs that are set are Specific Measurable Achievable Relevant Timely (SMART) as well as triangulation with the CQC actions. The workshop took place on the 26 January 2023 and was a positive engaging session with 52% of participants rating the session as excellent and 48% rated it as good. Each topic table produced fishbone diagrams, driver diagrams, measurement plans and project charter documents to help develop the quality priorities. These were refined further by the Trust's Quality & Safety Committee and Trust Board.

5 quality priorities for 2023/24, covering the 3 domains of quality – patient safety, clinical effectiveness, and patient experience were selected:

(1) End of Life: To improve personalised palliative and end of life care to ensure patients are supported to have a good death. *(Clinical effectiveness and patient experience).*

(2) Deteriorating Patient: Improved recognition and responding to the deteriorating patient in patients age 16+. *(Clinical effectiveness and patient safety*).

(3) Sepsis: Improved recognition and responding to sepsis in patients. *(Clinical effectiveness and patient safety).*

(4) Medication safety: To improve the safety of prescribing weight dependent medication to adults. *(Clinical effectiveness and patient safety).*

(5) Mental capacity: Increase the compliance and quality of Mental Capacity Act (MCA) assessments and best interest recording. *(Clinical effectiveness and patient experience).*

Recognising that communication is a key element linked to our workstreams, it will be included within the quality priorities as an associated qualitative KPI where appropriate. Communication is known to be a broadly applicable element of many aspects of how care is provided, so focusing on patient communication for critical phases of care, such as End of Life and managing patients' mental capacity to make decisions are areas where undertaking patient and their carers views through surveys to gain insight into their experiences brings value. We also see that elements of communication between staff can contribute to safe and effective care, so the Trust will explore this through the Deteriorating patient workstream as well.

Progress against the 2023/24 quality priorities will be monitored monthly through a defined approach of data analysis and review in the Quality and Safety section of the Integrated Performance Report (IPR), with overall outcome measures included in the Trust Board IPR. Success will be measured through tracking progress and trends against baseline and targets for each of the quality priorities associated KPIs.

Assurance and performance against the Quality Priorities will also be monitored via the Trust Management Board, Quality & Safety Committee, Quality Governance Group and Divisions monthly performance meetings.

2.2 Looking back on our priorities for improvement in 2022/23

As part of the Trust's annual setting of priorities in 2022/23, the Trust had set 6 quality priorities:

(1) Mortality improvement: Focusing on care at the end of life, we will reduce the number who die within 24 hours of admission and reduce emergency admissions for those in the last 3 months of life.

(2) Deteriorating Patient: In line with the CQUIN to improve safety, we will ensure we observe NEWS2, escalate when it is high, and respond with treatment.

(3) Sepsis: Focus on improving sepsis six screening and the response within 1 hour.

(4) Increasing Medication safety: Improve the recording of patient weights, reduce medication omissions, and improve appropriate antibiotic prescribing.

(5) Friends & family Test and PALS: These are key to patient experience so we will aim to respond to 70% of PALS in 5 days by the end of the year and improve response rates in the Friends and Family test so we better understand what our patients want.

(6) Safety of Discharge: Focusing on seamless safety across organisation boundaries, by improving the timeliness of discharge letters and helping ensure hospital beds are for those who need them by improving the speed of discharge once a patient is well.

The Trust has not fully achieved all its priority ambitions however there is evidential progress in several areas with sustained improvements. The tables and narrative below show a summary of achievement against the key measures of success for each of the quality priorities.

Key	
	Target achieved
	Improvement but below target
	No statistically significant change
	Decline, target not achieved

Mortality Improvement - Summary of milestones achieved, challenges and next steps

Mortality Improvement	Target	Outcome
Reduction in the number of patients dying within 24 hours of admission to hospital	Reducing	Target achieved. The number of patients dying within 24 hours of admission to hospital has decreased year on year from 249 in 2020/21, to 201 in 2021/22 and 193 in 2022/23.
Reduction in the number of emergency admissions for people in the last 3 months of life	Reducing	No statistically significant change. Common cause variation with 181 emergency admissions for people in the last 3 months of life in March 2023 compared to 208 in March 2022 and 202 in March 2021.
Reduction in the out of hospital SHMI to 110	Reducing	No statistically significant change. The out of hospital SHMI rolling 12 month position remains high at 140.1 in August 2022 compared to 138 in April 2022, 125 in April 2021 and 143 in April 2020.

The Trust expanded the Medical Examiner Service in July 2022 to include Scunthorpe General Hospital and all Emergency Department non-coronal deaths providing oversight and scrutiny of the quality of care for patients who die during admission. Case studies have been presented at the Trust's Mortality Improvement Group to share learning and improve quality of care.
The Trust was a pilot site, providing feedback to NHS England, for the new national mortality reporting system SJR plus and was one of the first Trust's in England to successfully transition to the new system in December 2022. This has provided the Trust with improved oversight of high-level mortality information and learning from structured judgement reviews to identify themes and improve quality of care.

The system wide roll out of Electronic Palliative Care Coordination system EPaCCs as the single shared record for preferred place of care and advanced decisions on escalation has progressed during 2022/23 although there were delays experienced in community nursing. Full access to the shared document will see the joint working of all agencies come together to maintain patients care at home where possible. The Trust has been working to promote access to EPaCCs through communication channels on social media and on the Trust's intranet. Respiratory, frailty and paediatric virtual wards were introduced which enhance community services visibility and accessibility at the front door of both hospitals where patients who present as End of Life can be supported to be cared for in their preferred place.

Case reviews of patients who die within 24 hours of admission or who are admitted to hospital in the last 3 months of life have been undertaken alongside community and primary care partners to discuss the quality of care provided, identify gaps in provision of services or pathways that could have enabled patients to die in their preferred place.

The Trust's percentage of deaths reported in the SHMI with palliative care coding continues to be low in comparison to peers and national average. This is linked to gaps in access to a

Palliative care consultant at Grimsby. Appointment of Palliative Care Nurse to focus on advanced care planning in the community was successful but a gap in consultant recruitment remains. Future rounds of Palliative care consultant recruitment are planned.

Care home staff were provided with equipment to undertake basic observations to better inform GPs of the patient's condition to reduce hospital admission. A pilot project was introduced to implement a NEWS2 type system in care homes to help with monitoring of the deteriorating patient. Early identification of palliative care, frailty index and standard palliative resources were rolled out across North East Lincolnshire care homes, with training to upskill staff on palliative management. A community dashboard is in development by NHSE to understand admission reason by care home to allow comparison with Primary Care Network/GP frailty and End of Life rates. This work will be taken forward in 2023/24.

The Divisional Doctors Induction has been updated to include an early introduction to ReSPECT and End of Life and a bespoke training package was developed for ED staff. ReSPECT awareness compliance has also improved however authorship training remains low and will be an area for further improvement work in 2023/24.

A Trustwide Quality Improvement 'Always' Event was held in March 2023 which engaged frontline clinicians in articulating change ideas focussed around:

- The quality of ReSPECT documents which support appropriate ceilings of escalation and preferred place of care.
- Appropriate use of the Last Days of life pathway which underpins evidence-based care.
- Timely recognition of EOL.

The themes and learning identified from this work will be carried forward and developed further in 2023/24 as part of the Trust's End of Life Quality Priority and on-gong quality improvement projects.

Deteriorating Patient - Summary of milestones achieved, challenges and next steps

Deteriorating Patient	Target	Outcome
Percentage of patient observations recorded on time (Adults)	90%	Target achieved for adult observations recorded on time with mean 90.55% and median 90.69%.
Percentage of patient observations recorded on time (Paediatrics)	90%	No statistically significant change for Paediatric observations recorded on time. The target was met or exceeded for 6 out of 12 months and achieved 100% in August 2022. However, overall, no statistically significant difference as remained below target with 75% recorded in March 2023 and April 2022. The mean value was 84.37% and the median was 86.62% over the 12 month period.
Escalation of NEWS in line with policy	No target	No statistically significant change with 3% in February 2023 compared to 0% in April 2022.
Clinical assessment undertaken within 15 minutes of arrival in ED	90%	Whilst the target was not met there was no statistically significant change with 47.4% recorded in March 2023 compared to 44% recorded in April 2022.

The Trust achieved the financially incentivised CQUIN CCG3 recording, escalation and response to NEWS2 for unplanned critical care admissions achieving over 80% in each quarter against a target range of 20 to 60%. The Trust's Critical Care Outreach team keep a record of all patients they review (times of referral, times of review, any areas of good practice). This data is supporting the Quality Improvement team to identify areas for improvements if patients have had delayed escalation.

Wards identified not achieving current target have been supported with focused support from the Deteriorating Educational lead. A standard of the month was introduced and the Paediatric and Neonatal Patient Safety Lead Nurse provides teaching to students about Paediatric Early Warning Score (PEWS) requirements and reinforcement as part of safety huddles. Stop and Check safety huddles were introduced on wards which highlights any patient at risk of deterioration.

Quality improvement work continues and will be carried forward as part of the Deteriorating Patient Quality Priority in 2023/24.

Sepsis - Summary of milestones achieved, challenges and next steps

Sepsis	Target	Outcome
Rate of patients screened for Sepsis	90%	Whilst the target was not met there was improvement from 40% of adults screened in April 2022 to 57.89% screened in February 2023. Similarly, an improvement in paediatric screening from 25.92% in April 2022 to 40% in March 2023.
Rate of patients who had the Sepsis six completed within 1 hour for patients who have a red flag	90%	0% of adults had documented evidence of the Sepsis six being completed within 1 hour. Paediatric patients improved from 21.42% in April 2022 to 42.1% in March 2023.

The Critical Care Outreach Team monitor all escalations into the team and share any good practice and opportunities for learning. Ward spot checks are carried out on all wards by the Educator and Deteriorating Patient/Sepsis nurse. Follow up discussions with staff to check staffs understanding of sepsis has demonstrated improvements. Stop and Check safety huddles continue to highlight any patients requiring a sepsis screening.

Sepsis tool completion is included on Doctors induction and Clinical Leads are supporting conversations with medical staff to promote completion of the Sepsis tools and dispel 'paper exercise' opinion. A booklet for agency/bank staff has been developed so that they are aware of the escalation process.

Escalation either from the healthcare support workers, who undertake patients' observations, to the registered nurses or onward to the Critical Care Outreach team is not electronically documented and so accountability is lacking resulting in missed opportunities for timely treatment. Sepsis screening is optional to complete on Web V rather than automatic or mandatory. Digital solutions have been explored and will be carried forward for discussions in 2023/24.

Adult and paediatric sepsis screening is not recorded electronically in ED. This has proved challenging as Trust wide data reported for sepsis screening via PowerBi does not include

primary sepsis screening in ED. In the interim until we can provide further assurance through robust reporting mechanisms, we are assured that patients are safe and cared for appropriately through triangulation of other robust data sources such as our incidents, claims, complaints, and mortality data. The Trust is not an outlier for Sepsis shock in the SHMI diagnosis group and identification of Sepsis is not a theme from the Medical Examiner case record reviews or Structured Judgement Reviews. Introducing electronic primary sepsis screening in ED will be the focus of work carried forward as part of the Sepsis 2023/24 Quality Priority.

Medication Safety - Summary of milestones achieved, challenges and next steps

Medication Safety	Target	Outcome
Percentage of patients admitted to IAAU with an actual, estimated or patient reported weight recorded on EPMA of WebV	Increasing	No statistically significant change with common cause variations between 61.62% in April 2022 to 70% in March 2023 and peak of 78.57% in May 2022.
Percentage of patients admitted to IAAU with an ACTUAL weight recorded on EPMA or WebV	Increasing	Target achieved. Significant improvement from 13.13% in April 2022 to 56% in March 2023.
Reduction in medication omissions without a valid reason for ward areas using EPMA	Reduction	Target achieved. Sustained low percentage of omissions over the past 16 months and achieved reduction from 1.9% in April 2022 to 1.4% in March 2023 compared to 13% in August 2021.
Reduction in patients prescribed an antibiotic	Reduction	Increase from 40.7% in March 2022 to 65.6% in February 2023. Although this is comparable to 66.4% in June 2021.
Antibiotic prescriptions have evidence of a review within 72 hours	70%	Decline from 69.1% in March 2022 to 48.7% in February 2023. Although the target was exceeded in June 2022 with 72.5% reviewed within 72 hours.

The two new ED builds completed at DPoW and SGH have the facility to weigh patients in ambulance arrivals area to aid compliance with actual weight being documented. The Trust has taken several other steps to improve medication prescribing safety in relation to recording patient's weight including introducing Paracetamol templates on EPMA. The paracetamol templates in the EPMA system have all been restricted and modified to aid the prescriber. Templates were created with the dose and frequency locked down so that the prescriber could not deviate from the BNF dosing for Paracetamol. Multi-route templates with weight-based calculations for the IV doses were then implemented, resulting in the prescriber having to input the patients' weight before the prescription can be added to the drug chart.

Unfortunately, the weight field in the EPMA system cannot be made mandatory, however the way that the multi-route templates have been set up means that it is easier to input the patient's weight (for the dose to be calculated) than it is to override the warnings. Warning notifications have also been added to the templates.

Role specific help buttons have been added to user logins. These include links to guides on the inputting of weights and numerous other guides, help topics and top tips for using the system.

Changes to the EPMA system were made such that the weight now expires in the system after 30 days. If a prescriber tries to use an expired weight, they are informed to update the weight to a current one, this also happens at each subsequent administration. They can override this and continue to use the old weight however the overriding is recorded in the system. A 30-day expiry ensures that weights from previous episodes/visits are expired and prompts staff to update.

Improved communication of system changes via emails, WhatsApp groups and top tip announcements are included on the Trust's intranet site, the HUB. A Medication Safety Newsletter is produced and distributed monthly highlighting the importance of documenting actual patient weight for prescribing.

A new 'weight' button has been added to EPMA to enable easier access to the weight recording page within the system, with the intention of making weight recording easier by all healthcare staff involved in patient care.

A key challenge is that the Trust's electronic patient record system Web V is not linked to the Trust's electronic prescribing system EPMA which prevents sharing of weight data between the two systems. Reporting functionality in EPMA relating to the weight field has also been limited. The next steps are to improve reporting from the EPMA system to improve oversight to enable improvement support to be targeted. The Trust is exploring the possibility of a BOT to overcome cross system data transfer and will be carried forward as part of the 2023/24 Medication Safety Quality Priority.

The Trust continually assesses suitability of new antimicrobials for inclusion to the Trust formulary and is reviewing the indications on EPMA to ensure they are fit for purpose. The Trust facilitates education and training both practically on the wards and in a classroom setting for pharmacists, junior doctors and nurses. The aim is to reduce unnecessary or inappropriate antimicrobial prescribing through an effective stewardship programme and annual strategy plan. Results of audits are shared with relevant governance committees and clinicians to highlight issues around stewardship and prescribing.

The Pharmacy Technician workforce is currently fully established across both main hospital sites. There is work ongoing to upskill the technician workforce to further support the pharmacist teams at both sites. However, Pharmacist staffing levels continue to be challenging with gaps at the SGH site. The Trust has been exploring all options to improve capacity including a recruitment drive, use of locum agencies, relocations packages offered, Star Chamber and shared working with Hull University Teaching Hospitals NHS Trust is being explored.

Friends and Family Test and PALS - Summary of milestones achieved, challenges and next steps

Friends & Family Test and PALS	Target	Outcome
PALS concerns are managed within timescale (5 working days)	70%	No statistically significant change. 62.85% of PALS concerns trust wide were closed within timescale in March 2023 compared to 62.5% in April 2022.
To improve the Friends and Family response rates	Inpatient 40%, ECC 20%, OPD 4%, Community 5%, Day case 25%	Although the FFT response rates for the 5 areas has not increased in line with the ambitious target percentages identified, overall, the Trust FFT response rate has increased by 45.17% with 932 FFT reviews in April 2022 and 1352 FFT reviews in March 2023. The response rate increased by 51% between September 2022 and February 2023 with the introduction of the PALS manager.

The Trust set a target of 60% of PALS concerns managed within timescale (5 working days) for Quarter 1/2, aiming for a stretch target of 70% by Quarter 4. The PALS team have taken a proactive approach to managing PALS concerns which has maintained performance over the past year. Steps taken include:

- Weekly reports sent to Divisional Senior Management Team of current PALS position.
- PALS Team proactive in sending out reminders to Divisions on the date the PALS concern is due.
- Improvement in PALS Team engaging with and offering support to Divisional Teams.
- Improved communication between Wards, Matrons & PALS Team when concerns raised regarding an inpatient for earlier resolution.
- Early escalation to senior leaders/managers if concerns are not being addressed in a timely manner.
- PALS Teams more proactive in supporting Divisions in resolving concerns prior to them being sent to Division.
- Dedicated oversight for a six month period, resulting in interventions in long standing concerns and resolution.
- Monthly updates of Divisional changes distributed within the PALS Team.
- Triangulation of data from FFT/PALS/Insights is captured at Round Table and Nursing Metric Meetings.

The 5 working days target is challenging for complex PALS concerns that have multi team involvement, but do not warrant formal complaint investigation. Increased clinic activity and priorities also impacts the timescales of those concerns that involve clinical and nursing teams. Change of handlers or concerns being sent to incorrect handlers can cause unnecessary delays.

The Trust has taken the following steps to improve Friends and Family Test (FFT) response rates:

- Engagement between the Patient Experience Manager & Department/Ward/Area Managers with individual meetings.
- Development of monthly FFT report for Senior Management Teams.

- Development of monthly feedback reports to each Department/Ward/Area Manager.
- Attendance at Governance and Departmental Meetings.
- Review and amendments to A&E survey.
- Weekly meetings with external provider.

Increased clinic activity and staffing levels means FFT collections and discussions have been challenging. There are limited methodologies for data collection in some areas which will be explored in future. Mandatory verification email address requested on external providers collection site has caused a barrier to patient's/families leaving anonymous feedback. This will be resolved in 2023/24. The Trust will continue to review and explore different collection methodologies and engage with staff and external providers in the future.

Safety of Discharge - Summary of milestones achieved, challenges and next steps

Friends & Family Test and PALS	Target	Outcome
Discharge letter completed within 24 hours of discharge.	85%	Target achieved with an annual mean of 89.42%.
Outpatient Clinic Summary to be sent to the patient's General Practitioner within 7 days of the appointment	50%	Target achieved in most recent months with 70% in March 2023 compared to 30.26% in April 2022.
Improve the proportion of patients discharged before 12 noon	30%	No statistically significant change with 16.56% in March 2023 compared to 18.01% in April 2022 and 16.56% in April 2021.
Improving trend showing a reduction in length of hospital stay 21 days	12%	Fluctuating performance but overall below the national average and the Trust is one of the best performing trusts in the region. Lowest value 7.83% achieved in week commencing 20 June 2022.

The trust set a target of 85% of discharge letters to be completed within 24 hours of discharge. Mid-year a stretch target of 90% was set to drive further improvement. The Trust's performance for the percentage of extended stay patients beyond 21 days is under the national average and one of the best performing Trusts in the region. The Trust has introduced consultant ward rounds on weekends, an electronic handover system and created a 7-day escalation process to address any blockages relating to discharge. Work has been undertaken to ensure patients who require support on discharge are supported by the most relevant team in a timely manner, ensuring they have prompt access to the services they require to enable them to leave a hospital bed. The use of voluntary sector organisations has also been increased to support timely discharge.

Other steps taken to improve performance include:

- 7-day Same Day Emergency Care (SDEC) ward set up.
- Virtual wards for respiratory, frailty and paediatrics established.
- Acute Frailty Assessment service and two integrated hospital discharge Hubs have been established for North Lincolnshire and North East Lincolnshire.
- Outpatient Parenteral Antibiotic Therapy (OPAT) and Home first now implemented.

- Work taking place within care homes to support falls, therapy and training provided within Northern Lincolnshire, SAFE service now operating direct referrals from Urgent Care Service (UCS) and Single Point of Access (SPA) to enable anticipatory/proactive management of frailty.
- Acute and Community joint work group established between Medicine and Community & Therapies.
- Community Response Team GP supporting Category 3 & 5 calls.
- Daily 12 Noon meetings chaired by the site senior team within the operation centre 7 days per week, who work with system partners to have a clear action plan for delayed discharge and escalation plan
- Themes are collated during the week from escalations and fed back to a fortnightly discharge improvement meeting which feeds our improvement plan.
- Multiagency discharge events have been held.
- Early identification of complex discharges prior to having no criteria to reside.
- Pilot for complex discharges and multiple admissions discharge expert panel.

The discharge lounge at SGH is no longer able to facilitate patients with stretchers which has caused flow delays due to a move to allow Ward 18 to be used. The DPoW discharge lounge is being used ad-hoc for inpatient beds which has impacted on discharge times. The Trust is exploring upgrading the discharge lounge capacity and opening hours

2.3 Statements of assurance from the Board

2.3a Information on the review of services

During 2022/23 the Northern Lincolnshire and Goole NHS Foundation Trust provided and/or subcontracted 7 relevant health services. The 7 services are taken from the Trust's standard contract with the ICB as the "categories of service which the Provider is commissioned to provide under this contract". These are:

- A&E Services
- Acute Services
- Cancer Services
- Community Services
- Diagnostic, Screening and/or Pathology Services
- End of Life Care Services
- Urgent Treatment Centre Services

The Trust has reviewed all the data available to them on the quality of care in 7 of these relevant health and care services.

The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health and care services for 2022/23.

2.3b Information on participation in clinical audits and national confidential enquires

During 2022/23, 53 national clinical audits and 10 National Confidential Enquiries into Patient Outcomes and Deaths (NCEPODs) were listed in the Quality Accounts for completion. During 2022/23, 51 national clinical audits and 7 NCEPODs covered relevant health services that Northern Lincolnshire and Goole NHS Foundation Trust provides.

During that period the Trust participated in 50 (98%) of the national clinical audits and 7 (100%) of the NCEPODs. Whilst 2 projects were listed for completion at the beginning of the year, these were delayed by the national audit supplier and will commence in 2023/24. Both audits have been excluded from the Trust's overall participation rate.

Participation did not occur for 1 (2%) national clinical audit; the National Ophthalmology Database Audit as the audit data collection is expected to be via an automated Electronic Patient Record System such as Medisoft that the Trust does not have. Therefore, it was agreed through the Trust's Quality Governance Group not to participate in the audit as diverting clinical resources to collect the vast amount of data required manually would be an adverse risk to the quality of the service. Instead, it was agreed that a local audit project of cataract surgery covering the key standards would be undertaken in its place to allow some level of benchmarking in comparison to the published national audit data.

The tables below list all National Clinical Audits, Clinical Outcome Review Programmes and other national quality improvement programmes which NHS England advise Trusts to Participate in. It also provides a breakdown of those applicable to the Trust and participation details during 2022/23.

Table 1: National Clinical Audits

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
1.	Breast and Cosmetic Implant Registry	✓	✓	20	100%	Report writing/Action planning
2.	Case Mix Programme	✓	✓	1,353	100%	Project still underway
3.	Child Health Clinical Outcome Review Programme	✓	✓	Please refer to Table 2	Please refer to Table 2	Please refer to Table 2
4.	Cleft Registry and Audit Network Database	X	X	N/A	N/A	N/A
5.	Elective Surgery: National PROMs Programme	✓	✓	625	90.1%	Awaiting publication of results
6.	**Emergency Medicine QIPs:**					
	a. Pain in children	✓	✓	166	100%	Action Planning
	b. Assessing for cognitive impairment in older people	✓	N/A	N/A	Commences April 2023	Planning underway
	c. Mental health self-harm	✓	✓	40	On-going	Project still underway
7.	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	✓	✓	169	100%	Awaiting Publication of Results
8.	**Falls and Fragility Fracture Audit Programme:**					

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
	a. Fracture Liaison Service Database	✓	✓	669	On-going	Project still underway
	b. National Audit of Inpatient Falls	✓	✓	6	On-going	Project still underway
	c. National Hip Fracture Database	✓	✓	483	100%	Report writing/Action planning
9.	**Gastro-intestinal Cancer Audit Programme:**					
	a. National Bowel Cancer Audit	✓	✓	273	100%	Awaiting Publication of Results
	b. National Oesophago-gastric Cancer	✓	✓	104	100%	Awaiting Publication of Results
10.	Inflammatory Bowel Disease Audit	✓	✓	522	100%	Action Planning
11.	LeDeR - learning from lives and deaths of people with a learning disability and autistic people	✓	✓	22	100%	Action Planning
12.	**Maternal and Newborn Infant Clinical Outcome Review Programme:**					
	MBRRACE - UK; Saving Lives, Improving Mother care - Maternal mortality surveillance and confidential enquiries	✓	✓	0	100%	Report writing/Action planning
	MBRRACE - UK Perinatal Mortality Surveillance and Confidential Enquiries	✓	✓	8	100%	Report writing/Action planning
13.	Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	✓	✓	Please refer to Table 2	Please refer to Table 2	Please refer to Table 2
14.	Mental Health Clinical Outcome Review Programme	X	X	Please refer to Table 2	Please refer to Table 2	Please refer to Table 2
15.	Muscle Invasive Bladder Cancer Audit	✓	✓	14	100%	Report writing/Action planning
16.	**National Adult Diabetes Audit:**					
	a. National Diabetes Core Audit	✓	✓	1220	100%	Action Planning
	b. National Diabetes Foot Care Audit	✓	✓	157	On-going	Project still underway
	c. National Diabetes Inpatient Safety Audit	✓	✓	9	On-going	Project still underway
	d. National Pregnancy in Diabetes Audit	✓	✓	36	100%	Awaiting Publication of Results
17.	**National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme:**					

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
	a. Adult Asthma Secondary Care	✓	✓	180	On-going	Project still underway
	b. Chronic Obstructive Pulmonary Disease Secondary Care	✓	✓	652	On-going	Project still underway
	c. Paediatric Asthma Secondary Care	✓	✓	31	On-going	Project still underway
	d. Pulmonary Rehabilitation Audit (Primary Care)	X	X	N/A	N/A	N/A
18.	**National Audit of Breast Cancer in Older Patients**	✓	✓	239	100%	Awaiting Publication of Results
19.	**National Audit of Cardiac Rehabilitation**	✓	✓	1074	100%	Report writing/Action planning
20.	**National Audit of Cardiovascular Disease Prevention (Primary Care)**	X	X	N/A	N/A	N/A
21.	**National Audit of Care at the End of Life**	✓	✓	89	100%	Awaiting Publication of Results
22.	**National Audit of Dementia**	✓	✓	80	On-going	Report writing/Action planning
23.	**National Audit of Pulmonary Hypertension**	X	X	N/A	N/A	N/A
24.	**National Bariatric Surgery Registry**	X	X	N/A	N/A	N/A
25.	**National Cardiac Arrest Audit**	✓	✓	73	On-going	Project still underway
26.	**National Cardiac Audit Programme:**					
	a. National Congenital Heart Disease Audit	X	X	N/A	N/A	N/A
	b. Myocardial Ischaemia National Audit Project (MINAP)	✓	✓	267	On-going	Project still underway
	c. National Adult Cardiac Surgery Audit	X	X	N/A	N/A	N/A
	d. National Audit of Cardiac Rhythm Management	✓	✓	273	On-going	Project still underway
	e. National Audit of Percutaneous Coronary Interventions	✓	✓	411	On-going	Project still underway
	f. National Heart Failure Audit	✓	✓	287	On-going	Project still underway
27.	National Child Mortality Database	X	X	N/A	N/A	N/A

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
28.	National Clinical Audit of Psychosis	X	X	N/A	N/A	N/A
29.	National Early Inflammatory Arthritis Audit	✓	✓	28	On-going	Project still underway
30.	National Emergency Laparotomy Audit	✓	✓	200	On-going	Project still underway
31.	National Joint Registry	✓	✓	740	96%	Report writing/Action planning
32.	National Lung Cancer Audit	✓	✓	346	100%	Action Planning
33.	National Maternity and Perinatal Audit	✓	✓	3445	100%	Report writing/Action planning
34.	National Neonatal Audit Programme	✓	✓	657	100%	Awaiting Publication of Results
35.	National Obesity Audit	X	X	N/A	N/A	N/A
36.	National Ophthalmology Database Audit	✓	X*	N/A	N/A	N/A
37.	National Paediatric Diabetes Audit	✓	✓	284	On-going	Project still underway
38.	National Perinatal Mortality Review Tool	✓	✓	8	100%	Action Planning
39.	National Prostate Cancer Audit	✓	✓	294	100%	Awaiting Publication of Results
40.	National Vascular Registry	X	X	N/A	N/A	N/A
41.	Neurosurgical National Audit Programme	X	X	N/A	N/A	N/A
42.	Out-of-Hospital Cardiac Arrest Outcomes	X	X	N/A	N/A	N/A
43.	Paediatric Intensive Care Audit	X	X	N/A	N/A	N/A
44.	Perioperative Quality Improvement Programme	✓	✓	11	55%	Project still underway
45.	**Prescribing Observatory for Mental Health:**					
	a. Improving the quality of valproate prescribing in mental health services	X	X	N/A	N/A	N/A
	b. The use of melatonin	X	X	N/A	N/A	N/A
46.	**Renal Audits:**					
	a. National Acute Kidney Injury Audit	X	X	N/A	N/A	N/A

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
	b. UK Renal Registry Chronic Kidney Disease Audit	X	X	N/A	N/A	N/A
47.	**Respiratory Audits:**					
	a. Adult Respiratory Support Audit	✓	✓	N/A	Commenced March 2023	Project still underway
	b. Smoking Cessation Audit- Maternity and Mental Health Services	✓	N/A	Commences April 2023	Planning underway	N/A
48.	Sentinel Stroke National Audit Programme	✓	✓	242	100%	Report writing/Action planning
49.	Serious Hazards of Transfusion UK National Haemovigilance Scheme	✓	✓	17	100%	Awaiting Publication of Results
50.	Society for Acute Medicine Benchmarking Audit	✓	✓	107	100%	Action Planning
51.	Trauma Audit and Research Network	✓	✓	494	Ongoing	Project still underway
52.	UK Cystic Fibrosis Registry	X	X	N/A	N/A	N/A
53.	UK Parkinson's Audit	✓	✓	60	100%	Awaiting Publication of Results

**Note: The Trust did not participate in the National Ophthalmology Database Audit as this is not a mandated audit and data collection is expected to be via an automated Electronic Patient Record System such as Medisoft that the Trust does not have. Therefore, it was agreed through the Trust's Quality Governance Group not to participate in the audit as diverting clinical resources to collect the vast amount of data required manually would be an adverse risk to the quality of the service. Instead, it was agreed that a local audit project of cataract surgery covering the key standards would be undertaken in its place to allow some level of benchmarking in comparison to the published national audit data.*

Table 2: National Confidential Enquires

Count	Programme / Workstream	Eligible for NLAG	NLAG participated	No. of cases submitted	Participation Rate	Outcome
3.	**Testicular torsion**	✓	✓	7	100%	Awaiting National Report
	Transition from child to adult health services	✓	✓	3	75%	Awaiting National Report
	Juvenile Idiopathic Arthritis	✓	✓	Ongoing		
13.	**Community Acquired Pneumonia**	✓	✓	4	57%	Project still underway
	Chron's Disease	✓	✓	6	75%	Project still underway

Count	Programme / Workstream	Eligible for NLAG	NLAG participated	No. of cases submitted	Participation Rate	Outcome
	End of Life Care	✓	N/A	Commences Spring/Summer 2023	N/A	N/A
	Endometriosis	✓	✓	Ongoing		
	Epilepsy: Hospital Attendance	✓	✓	7	100%	Ongoing
	Physical Health in Mental Health Hospitals	X	X	N/A	N/A	N/A
14.	**Real-time surveillance of patient suicide**	X	X	N/A	N/A	N/A
	Suicide (and homicide) by people under mental health care	X	X	N/A	N/A	N/A

The reports of 30 National clinical audits were reviewed by the provider in 2022/23 and the Trust intends to take the following actions to improve the quality of healthcare provided:

National Audit Programme	Summary of some actions taken
National Neonatal Audit Programme (NNAP)	- Doctors to visit the mother on Maternity Wards where appropriate and within 24 hours of admission to the neonatal unit. - Where parents are unable to be present at ward rounds, ensure contact is made alternatively to provide an update. - Posters to be displayed on nursery doors to ensure parents are aware that they are to be involved and updated in the care of their baby. - PeriPrem passports implemented to ensure standards are being met. - Ensure staff are aware of the importance to utilise the Jitsi Meet App and alternative communication methods to involve parents and update them on their baby within 24 hours of admission. - Safety Huddles (where medical staff are present) to include standards summary of NNAP standards for awareness purposes. - BadgerNet is to be included within the doctor induction training day to raise awareness of the NNAP measures. - The Quarterly dashboards (published by NNAP) are to be presented at the Trust wide Children's service clinical audit meeting to ensure staff are aware of the NNAP standards and any shortfalls in compliance are identified.
National Pregnancy in Diabetes Audit	- Young patients are made aware of the importance of the issues relating to unplanned pregnancy during their appointment in the young adult diabetes clinic. - Patients are offered DESMOND structured education in relation to weight management and diabetes prevention. - Reinforce the benefits of pregnancy preparation by way of a diabetes interface forum with primary care.

National Audit Programme	Summary of some actions taken
	- Local practice nurses to be made aware of the preconception clinic.
Sentinel Stroke National Audit programme (SSNAP)	- Stroke awareness marketing campaign launched to raise awareness of stroke signs and symptoms to aid early recognition/intervention. - Liaise with relevant teams to ensure patient goals are clear.
IBD Registry	- Updated consent process implemented so patients now get up to date information from the registry regarding latest developments in treatment/management of IBD.
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiry – Saving Lives Improving Mothers Care.	- Diagnosis and Treatment of Cancer whilst Pregnant Guidance to be reviewed. A new guideline is being written to ensure women are aware of risks and choices available to them.
National Oesophageal Cancer Audit (NOGCA 2020)	- Contact to be made with Primary Care to raise the consistently above average rate of patients diagnosed with OG Cancer following emergency admission.
National Emergency Laparotomy Audit (NELA) 2021	- Audit Department to pass a list to the Surgery Business Manager of any cases that are in the NELA sample but show as incomplete on NELA webtool. This is to then be raised with the surgeons at the weekly Quality Meeting.
COPD Audit	- Review of COPD cases undertaken identifying an issue with an algorithm which will boost case ascertainment for future publications.
NACAP Children's & Young People Asthma audit	- Discharge Bundle to be raised with all nursing staff and encouraged to compete on WebV. - - Clinical Nurse Specialists are included within the Junior Doctors Induction, to highlight the KPIs. - Review the prescribing of steroids with the Paediatric Emergency Nursing Team to ascertain if this can be included within their roles.
Fracture Liaison Service Database	- Annual review through radiology reports to boost identification of Vertebral Fractures to ensure submission rates are in line with best practice
Elective Surgery: National PROMS Programme	- Deep dive of data carried out to establish if there are any issues that have contributed to the deterioration of patient reported outcomes.
Early Inflammatory Arthritis	- Specific Early Inflammatory Arthritis Clinics to be introduced to provide more clinic time to assess progress and outcomes with regards to Disease Modifying Drugs
Royal College of Emergency Medicine: Pain in Children	- Introduction of mandated field for Pain Scoring on arrival into the ED/ECC electronic systems.
National Audit of Dementia	- Pilot document introduced to aid the completion of Delirium Screening in patients over 65.
National Audit of Breast Cancer in Older People	- To introduce the Fitness assessment form for older patients and ensure this is uploaded to the Somerset system.

The reports of 31 local clinical audits were reviewed by the provider in 2022/23 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Local Audit Topic	Summary of some actions taken
Audit of GI Beed	- Implementation of Glasgow/Blatchford score as a mandated electronic field into ED/ECC Symphony System.
Emergency Department Documentation	- Adoption of stamps by ED/ECC Nursing Staff to improve documentation.
Audit of Weighing Prescribing	- Introduction of Weight Bridges in the ED/ECC to improve the weighing of patients and ensure accuracy of weight dependent drug doses
Cirrhosis Fibrosis CQUIN Audits	- Introduction of new Alcohol Care Team as well as Web V screening and referral tools to ensure best practice pathways are met for this subset of patients to assess kidney health early in the pathway
Local Version of National Ophthalmology Database Audit (NOD)	- Medical Secretaries to highlight any patient who has gone more than 6 months from their pre-operative assessment when they attend for their cataract operation that they need the Visual Acuity check performing prior to the operation.
Paediatric SEPSIS Audit	- The Monthly Dashboard is used to monitor the use of the SEPSIS pathway in children who are admitted, and the results are presented at the Clinical Audit Meeting to raise the importance of adhering to policy.
Paediatric Early Warning Scoring	- The Monthly Dashboard is used to monitor the use of the PEWS Tool and presented at the Clinical Audit Meeting. - Areas of low compliance are displayed as standard of the month in the wards.
Facing the Future Audits	- Paediatric collaborative document (electronic and paper version) to be reviewed to ascertain if additional fields for capturing information can be added.
Audit of Paediatric Documentation Audit:	- The monthly rapid cycle documentation audit is discussed at the Clinical Audit meeting to highlight the standards which consistently have low compliance and to raise the importance of documenting patient height, weight, head circumference and centiles.
Pain Assessment Audit	- Processes surrounding pain scoring within the Trust are to be reviewed as part of a Quality Improvement Project.
Audit of Electronic Discharge Summaries (Surgery)	- Surgery Doctors Induction to include a summary of the standards required when completing Discharge Summary Letters to ensure staff are aware. - Electronic Prescribing system (EPMA) to be linked to Web-V system to pre-populate medication information on the discharge summaries.
ReSPECT Audit	- Development of a continuing 'Lead Educator' post to raise awareness and deliver education regarding the importance of ReSPECT. - Education plan produced and shared at the End-of-Life Operational Group.
Gynaecology Electronic Discharge Summary Audit	- Presenting complaint, to be added as a compulsory field relating to surgical cases. - Consultant job plans to be reviewed to ensure patients have a clinical assessment within 14 hours of admission.
Paediatric Documentation	- Implementation of electronic documentation at DPOW, awaiting role out at SGH.

Local Audit Topic	Summary of some actions taken
Hernia Day Case Rate Audit:	- The General Surgery Business Support Manager has discussed with the relevant administration Teams the importance of categorising Hernia procedures correctly on the booking system, reinforcing that unless stated otherwise by the surgeon or pre-assessment staff then hernia procedures should be day cases. - The General Surgery Management Team to provide data to the clinicians about any Day Case hernia procedure that results in an admission so this can be reviewed for learning points. - Urology clinicians to provide guidance on how best to send patients home with a catheter and place this information in posters on relevant wards. - An audit of the completion of booking forms inputted on to the booking system will be undertaken, to assess whether Day Case/Inpatient bookings matched the resultant procedure.

The Trust takes part in the annual benchmarking audit that measures performance against the learning disability improvement standards. The improvement standards were launched in 2018 by NHS Improvement to ensure the provision of high quality, personalised and safe care from the NHS for adults and children with learning disabilities and/or autism across England. The NHS Long Term Plan (2019) further pledged that over the next five years, the improvement standards would be implemented by all services funded by the NHS. The improvement standards against which trust performance is measured are respecting and protecting rights, inclusion and engagement, workforce and specialist learning disability services, the first three are universal standards that apply to all NHS trusts, and the fourth is a specialist standard that applies specifically to trusts that provide services commissioned exclusively for people with a learning disability or autism In addition to the data collection by the Vulnerabilities team, 50 staff and 100 patient surveys were sent out that were directly returned to NHSBN. Compliance with these standards demonstrates that a trust has the right pathways and resources in place to deliver high quality patient outcomes that people with a learning disability or autism, their families and carers deserve and expect. The results of the survey were published in November 2022 and the Trust compares favourably to other trusts that took part, for those areas where there is an identified gap the Trust is developing an improvement plan to address these issues.

2.3c Information on participation in clinical research

Clinical research is an essential part of maintaining a culture of continuous improvement. In 2022/2023 there was a reduced focus on COVID-19 public health trials and the Research Team were able to re-commence studies that had been put on hold during the pandemic. The team also commenced a broad range of new clinical research studies, for example, studies relating to, cardiology, urology, dermatology amongst other specialities. The Trust has received several congratulations of achievement from studies relating to how the Trust has conducted the research and the recruitment it has achieved. Whilst undertaking these studies the team are due to, or will achieve close to, the recruitment figure set by the Clinical Research Network.

The number of patients receiving NHS services provided or sub-contracted by Northern Lincolnshire and Goole NHS Foundation Trust in 2022/23 that were recruited during that period (01 April 2022 to 31 March 2023) to participate in research approved by a research ethics committee or Health Research Authority was 1100.

The Trust has 23 studies recruited. 2023/24 will see the team continuing their reduced focus on providing research post COVID public health trials and continue to increase recruitment via a mixture of non COVID commercial/portfolio studies. The recruitment will include focussing on collaborative working with other organisations, to take research out to previously underserved communities in line with the Trust's high level objectives agreed with the Clinical Research Network.

Clinical research has allowed the world's population to gain knowledge and develop treatments and the Trust continue to support this by providing clinical research for our local communities.

2.3 d Information on the Trust's use of the CQUIN framework

The Commissioning for Quality and Innovation (CQUIN) framework is about improving the quality of healthcare. Commissioners reward excellence by linking a proportion of income to the achievement of locally set and agreed improvement goals. These goals are embedded into contracts and are essential for the implementation of National Institute for Health and Care Excellence (NICE) Quality Standards, resulting in improved patient care, experience, and improvements against outcomes.

Use of the CQUIN payment framework

A proportion of the Trust's income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement, or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

For 2022/23 the requirement for national ICB CQUINs was to report on all applicable CQUINs but also choose 5 schemes, for each contract, that would have a financial value attached.

The breakdown of the National CQUIN indicators is based on 1.25% of contract value. Funding was given to the Trust based on the assumption that the Provider would achieve full compliance with the applicable CQUIN Indicators and would therefore earn the full 1.25% value. Due to the contractual arrangements in 2022/23 there was no financial risk to the Trust for non-achievement of the CQUIN.

National CQUIN schemes 2022/23 for ICBs include:

- Staff Flu Vaccinations (Non-financial)
- Appropriate antibiotic prescribing for UTI in adults aged 16+ (Non-financial)
- Recording of NEWS2 score, escalation time and response time for unplanned critical care services (Financial)
- Compliance with timed diagnostic pathways for cancer services (Non-financial)
- Anaemia screening and treatment of all patients undergoing major elective surgery (Financial)
- Timely communications of changed to medicines to community pharmacists via the Discharge Medicines Service (Financial)
- Supporting patients to drink, eat and mobilise after surgery (Financial)

- Cirrhosis and Fibrosis test for alcohol dependent patients (Financial)
- Treatment of community acquired pneumonia in line with BTS care bundle (Non-financial)
- Assessment, diagnosis, and treatment of lower leg wounds (Non-financial)

NHS England Specialised Services (NHSE):
The Trust receives a CQUIN value of 1.25%. The CQUIN payment was based on the block contract value: however, CQUIN is not payable on high-cost drugs, devices, listed procedures identified in the National Payment System and all other expenditure contracted on "pass through" basis.

The NHSE specialised schemes of 2022/23 include:

- Shared Decision Making (SDM) conversations (Financial)

NHSE took a light touch approach to the reporting of CQUINs and agreed that where a provider has engaged and fully participated with the CQUIN schemes but has failed to achieve the requirements fully, due to issues outside of their control (including any future Covid surges) the commissioner would reinvest the CQUIN scheme monies it has recovered with the provider but may identify areas of quality and innovation for the provider to focus the investment on.

The Trust has achieved the highest performance to date with achievement against all the financial incentivised CQUIN, exceeding the maximum targets. For the non-financial CQUIN, the Trust achieved the target for 1 and showed improvement over each quarter for a further 2 CQUINs. The most improvement was seen in the financial incentivised CQUIN **CCG9** Cirrhosis and fibrosis tests for alcohol dependent patients where the Trust achieved 68% in Quarter 4 compared to 11.4% in Quarter 1.

Key	
	Target achieved or exceeded
	Target not achieved but Improvement over full year
	Target not achieved

Indicator	Financial / Non-financial	Min	Max	Q1	Q2	Q3	Q4	Full year performance
CCG1 Flu vaccinations for frontline healthcare workers	Non-financial	**70%**	**90%**	**N/A**	**N/A**	**31%**	**31%**	
CCG2 Appropriate antibiotic prescribing for UTI in adults aged 16+	Non-financial	**40%**	**60%**	**42%**	**43%**	**37%**	**42%**	
CCG3 Recording, escalation and response to NEWS2 for unplanned critical care admissions	Financial	**20%**	**60%**	**85%**	**84%**	**80%**	**96%**	

Indicator	Financial / Non-financial	Min	Max	Q1	Q2	Q3	Q4	Full year performance
CCG4 Compliance with timed diagnostic pathways for cancer services	Non-financial	**55%**	**65%**	**18.35%**	**22.3%**	**18.1%**	**30%**	
CCG5 Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle.	Non-financial	**45%**	**70%**	**16%**	**17%**	**27%**	**17%**	
CCG6 Anaemia screening for those undergoing major elective surgery	Financial	**45%**	**60%**	**86%**	**85%**	**76%**	**92%**	
CCG7 Timely communication of medication changes via discharge medicines IT software	Financial	**0.5%**	**1.5%**	**N/A**	**N.A**	**1.53%**	**1.495%**	
CCG8 Supporting patients to eat drink and mobilise post-surgery	Financial	**60%**	**70%**	**72%**	**78%**	**77%**	**73%**	
CCG9 Cirrhosis and fibrosis tests for alcohol dependent patients	Financial	**20%**	**35%**	**11.4%**	**18.7%**	**67%**	**68%**	
CCG14 Assessment, diagnosis and treatment of lower leg wounds	Non-financial	**25%**	**50%**	**1.63%**	**0**	**10%**	**23%**	
PSS2 Achieving high quality shared decision-making conversations in specific specialised service (Cardiology)	Financial	**Min 65%**	**Max 75%**	**88%**	**92%**	**NA**	**87%**	

2.3e 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 Care Quality Commission has not taken enforcement action against the Trust during 2022/23.

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

Care Quality Commission (CQC) ratings grid for the Trust:

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↑ Nov 2022	Requires Improvement →← Nov 2022	Good →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022

From their last inspection of the Trust in June and July 2022 (of which the report was published on the 2nd December 2022) the outcome was as follows:

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diana Princess of Wales Hospital	Requires Improvement ↑ Nov 2022	Requires Improvement →← Nov 2022	Good →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022
Goole & District Hospital	Good ↑↑ Nov 2022	Good →← Nov 2022	Good →← Nov 2022	Good ↑↑ Nov 2022	Requires Improvement →← Nov 2022	Good ↑ Nov 2022
Scunthorpe General Hospital	Requires Improvement ↑ Nov 2022	Requires Improvement →← Nov 2022	Good →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022
Overall trust	Requires Improvement ↑ Nov 2022	Requires Improvement →← Nov 2022	Good →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022

Several significant improvements were published in the report, including:

- The improvement of Goole District Hospital rating to ‘Good’ overall
- The Trust safety rating improved to ‘Requires improvement’ from ‘Inadequate’.
- Maternity and Surgery Core Surgery ratings increased to ‘Good’ for responsive
- Rating increase to ‘Good’ from ‘Inadequate’ for Outpatients Core Service
- The Diagnostic Imaging Core Service was highlighted for ‘outstanding practice’ and a ratings increase from ‘Inadequate’ to ‘Good’ overall for Goole District Hospital and Scunthorpe General Hospital

The Trust celebrated several positive findings within the report, including no significant concerns around fundamentals of care and no requirement notices were issued. Inspectors also said they saw good examples of patients receiving compassionate care, with staff ensuring patients privacy and dignity were maintained and it was evident staff worked hard to achieve the best possible outcomes for people throughout the services they inspected. The report recognised improvements in leadership, culture, safety, complaints, and the elective backlog along with a commitment to learning and quality improvement highlighted. The report identified improvements to data management as was strengthening of operational financial management and governance arrangements.

The 2022 report had 93 ‘Must do’ and 59 ‘should do’ actions across all three sites, these have been reviewed and incorporated into a robust action plan which the Trust has already made progress with. Initial actions and feedback to the CQC was completed in December 2022 following publication of the report.

During the last year and whilst waiting for the new report, the Trust progressed completion of several actions that were identified as part of the 2019 actions. At the time of publication of the 2022 report, 85% of 2019 actions were rated green or blue meaning they were on target or complete.

Following the latest report, the Trust amended the assurance ratings from blue/green/amber/red to language in line with Recovery Support Programme:

Full assurance	Evidence of embedded and sustained improvement
Significant assurance	Evidence of improvement and the improvements becoming embedded, but yet to be sustained
Moderate assurance	Some evidence of improvement but this has yet to be embedded and sustained
Limited assurance	Limited evidence of improvement and limited evidence of the improvements being embedded or sustained
No assurance	No evidence of improvement

A monthly report provides detail and assurance on progress and is presented at the Trust Management Board and various sub-committees. At the time of writing in March 2023, the Trust had 123 open CQC actions, of those, two were rated full assurance, 23 were rated significant assurance, 52 moderate assurance and 39 rated limited assurance. There are no actions with no assurance and seven to be rated. At the time of publication (June 2023), further progress has been made and the Trust currently has eight rated full assurance, 27 rated significant assurance, 48 rated moderate assurance and 42 rated limited assurance with no actions with no assurance and none awaiting a rating. The Trust continues to have regular engagement meetings with the CQC and provides them with regular updates on progress with the plan along with supporting evidence.

2.3 f Information on quality of data

Northern Lincolnshire and Goole NHS Foundation Trust submitted records during 2022/23 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 (as of April 2023):

- Which included the patient's valid NHS Number was:
  - 99.98 % for admitted patient care
  - 99.97 % for outpatient care
  - 99.57 % for accident and emergency care.

- Which included the patient's valid General Medical Practice Code was:
  - 100 % for admitted patient care

- 100 % for outpatient care
- 100 % for accident and emergency care.

2.3 g Information governance assessment report

The Information Governance Data Security and Protection Toolkit (DSPT) is part of the Department of Health's commitment to ensuring the highest standards of information governance. It allows organisations to measure their compliance against legislation and central guidance and helps identify any areas of partial or non-compliance.

It remains Department of Health and Social Care policy that all organisations that process NHS patient information provides assurance via the IG Toolkit and is fundamental to the secure usage, sharing, transfer, storage, and destruction of data both within the organisation and between external organisations. The submission deadline for the 2022/2023 DSPT Assessment is 30th June 2023.

The 2021/22 Version of the DSPT was released on the 20 July 2021, with an initial baseline assessment date of the 28 February 2022 followed by the final submission of the 30 June 2022. The current status for Northern Lincolnshire and Goole Hospitals NHS Foundation Trust following submission of the 21/22 DSPT is Approaching Standards.

As of March 2023, there were two actions remaining on the improvement plan. Responses to these actions will be captured in the 23/24 return. The remaining actions are as follows:

20/21 DSP ref	2020/21 DSPT Evidence Item Text
3.2.1	Have at least 95% of all staff, completed their annual Data Security Awareness Training?
10.1.1	The organisation has a list of its suppliers that handle personal information, the products and services they deliver, their contact details and the contract duration.

2.3 h Information on payment by results clinical coding audit

Northern Lincolnshire & Goole NHS Foundation Trust was not subject to the payment by results clinical coding audit during the reporting period by the Audit Commission as these no longer take place.

To provide coding quality assurance Northern Lincolnshire & Goole NHS Foundation Trust completed a Trust-wide random sample audit of 200 Finished Consultant Episodes (FCEs - the time a patient spends under the continuous care of one care professional) for the period November 2021 – March 2022 and, in addition, re-commenced regular staff audits in April 2022. These audits were performed by NHS Digital approved auditors based at Hull University Teaching Hospitals as part of the Clinical Coding shared service.

The Trust-wide audit attained the level of standards met, and 77% of staff audits achieved either standards met or standards exceeded, using the Data Security and Protection Toolkit Attainment Levels for Clinical Coding in an Acute Trust to determine the standard achieved (table below). Any below the target of standards met are given additional training and are re-audited within 3 months. The Trust will continue a rolling programme of yearly audits for all Clinical Coding staff throughout 23/24

	Level of Attainment	
	Standards Met	Standards Exceeded
Primary Diagnosis	>=90%	>=95%
Secondary Diagnosis	>=80%	>=90%
Primary Procedures	>=90%	>=95%
Secondary Procedures	>=80%	>=90%

2.3i Learning from Deaths

During 2022/23, 1,648 of Northern Lincolnshire & Goole NHS Foundation Trust's patients died in hospital as an inpatient. In addition to this, 243 deaths occurred in ED or were dead on arrival and there were 6 still births. The inpatient deaths comprised of the following number of deaths which occurred in each quarter of that reporting period:

- 388 in the first quarter
- 341 in the second quarter
- 441 in the third quarter
- 478 in the fourth quarter

As at the 31st March 2023, 1546 have been reviewed by the Medical Examiners, 216 have had a Structured Judgement Review (SJR) and 1 has been subject to a serious incident investigation. In 1 case, a death was subjected to both a SJR and a serious incident investigation. The number of deaths in each quarter for which an SJR or a serious incident investigation was carried out (as of 29 May 2023) was:

- 87 in the first quarter
- 84 in the second quarter
- 44 in the third quarter
- 14 in the fourth quarter

(Note the number of cases in quarter three and four will be less at the time of publication due to a time lag incurred through coding validation and the SJR review process).

3 representing 0.18% of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. [Definition: using Royal College of Physicians (RCP) question: "Avoidability of Death Judgement Score" for patients with a score of 3 or less – see narrative below for more information].

In relation to each quarter, this consisted of:

- 1 representing 0.06% for the first quarter
- 2 representing 0.18% for the second quarter
- 0 representing 0% for the third quarter
- 0 representing 0% for the fourth quarter.

These numbers have been estimated using the SJR which includes a 6 factor Likert scale ranging from Score 6: "Definitely Not Avoidable" to Score 1: "Definitely Avoidable". The above number of cases includes all those deaths that were classified as scoring less than or equal to 3 on this 6 factor scale. This assessment is the initial reviewer's evaluation from the retrospective analysis of the medical record.

Any SJR completed that identifies that further understanding is needed is subject to a second independent review. This process links into the Trust's Serious Incident process. This data is not a measure of deaths that were avoidable, but as an indicator to support local review and learning processes with the aim of helping to improve the standard of patient safety and quality of care.

Summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified during 2022/23

And,

Description of the actions which the Trust has taken and those proposed to be taken as a consequence of what has been learnt during 2022/23

And,

An assessment of the impact of the actions taken by the Trust during 2022/23:

Following on from the success of the introduction of the Medical Examiner Service at the Diana Princess of Wales Hospital site in April 2021 the Trust expanded the service in July 2022 to include Scunthorpe General Hospital and all Emergency Department non-coronal deaths. The service now has full establishment with 1.1 whole time equivalent Medical Examiners comprising of 9 Medical Examiners and 4 full time equivalent Medical Examiner Officers. This is an invaluable service that oversees and scrutinises the quality of care for patients who die during admission. The benefits of the service for the families or carers are likely to be the most impactful as the service provides clarity, dissipates doubts, and helps to alleviate negative thoughts and experiences the families or carers may be experiencing. Providing a voice to the bereaved at this most difficult of times is critically important and rewarding. It allows them to make significant improvements in what happens after death, including identifying areas for improvement as well as highlighting good practice. The service ensures a correct and accurate cause of death is registered and appropriate deaths are referred to the coroner. Representatives from the Medical Examiners attend the Trust's Mortality Improvement Group and share a case review for learning bi-monthly. The Trust has invested in a bespoke module for SystmOne to allow primary care to refer deaths to the Medical Examiner Service for review. This will facilitate more robust scrutiny of community deaths.

In 2021/22 the Trust worked collaboratively with NHS England's Better Tomorrow: Learning from Deaths, Learning for Lives team to pilot the national Mortality Reporting Dashboard and transitioned from paper SJRs to NHS England's electronic SJR system, ORIS. This collaborative working has continued and strengthened in 2022/23 with the Trust invited, by NHS England, to deliver a presentation to Blackpool Teaching Hospitals NHS Foundation Trust as well as presenting at national webinars to share the Trust's experiences of transitioning to the new electronic system. The Trust was also a pilot site, providing feedback to NHS England, for the new national SJR plus system that was developed by NHS England to replace ORIS. The Trust was one of the first in England to successfully transition from ORIS to the new SJR Plus system in December 2022.

The Trust is committed to continuously learning from deaths to improve the quality of care provided to patients, their families, and carers. The following learning themes have been identified in 2022/23:

- Incomplete or poor quality documentation in Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) documents.
- Missed opportunities to discuss DNACPR and ReSPECT documents.
- Missed opportunity for recognition of End of Life (EOL) pathway at earlier stage.
- Lack of anticipatory care planning.

- Mental capacity assessments not completed/poor documentation.

Actions implemented to address areas for improvement include:

- The Divisional Doctors Induction has been updated to include an early introduction to ReSPECT and EOL.
- ReSPECT forms require counter signature by a Consultant.
- A revised last days of Life Document has been produced and has been piloted, with plans to roll out to all wards. It is hoped that the revised version will promote better utilisation. The document review identified a gap in spiritual support to EOL patients and their loved ones. This has led to the development of a small working party and a draft leaflet regarding spirituality is currently in progress.
- Bespoke EOL training package developed for all ED staff.
- EOL Champions in place within ward areas.
- Medical Defence Union representatives have attended Quality and Safety/Audit Meetings to raise awareness of the risks of poor quality documentation.
- The Mental Capacity Act/Deprivation of Liberty Safeguards team have been providing additional training and support to staff to improve compliance and quality of mental capacity assessments and best interest forms. This work will be continued into 2023/24 as part of the Trust's Mental Capacity Quality Priority.
- A Trust wide quality improvement project is underway aiming to deliver a single pain assessment tool which will be used for all patients, including those who are at the end of their life. This is on track to deliver by the end of March 2023.

Building on the success of the Bluebell model introduced on several acute ward areas in 2021/22, the model has been rolled out to all ward areas in 2022/23. The model encourages the discussions and earlier identification of EOL and provides staff with the skills and confidence to identify and discuss patients EOL care needs. The positive impact of implementing this model is demonstrated in staff feedback as well as feedback from families using the Family Voices Diary. The Bluebell project has been instrumental in demonstrating good care as reported in the Trust's CQC report.

Compliance with syringe driver training has significantly improved due to targeted training via in reach onto ward areas where operational pressures inhibit staff from being released to attend classroom or virtual sessions. ReSPECT awareness compliance has also improved however authorship training remains low and will be an area for further improvement work in 2023/24.

A Trustwide Quality Improvement 'Always' Event was held in March 2023 which engaged frontline clinicians in articulating change ideas focussed around:

- The quality of ReSPECT documents which support appropriate ceilings of escalation and preferred place of care.
- Appropriate use of the Last Days of life pathway which underpins evidence-based care.
- Timely recognition of EOL.

This work will be developed further in 2023/24 as part of the Trust's EOL Quality Priority and on-gong quality improvement projects.

2.3j Details of ways in which staff can speak up

Annual Update on Speaking Up:

All NHS staff should be able to speak up regarding any concerns they may have in full confidence of not suffering any form of detriment as a result. The Trust is committed to ensuring that employees working for the Trust are not only encouraged to do this but are actively supported and guided as to how they can do this, should they feel the need to, whether they are concerned about quality of care, patient safety or bullying and harassment within their workplace.

The Trust has encouraged and supported staff to speak up by instituting several mechanisms for staff to raise concerns, these include:

- Raise concerns with their line manager. If this is not possible for any number of reasons, staff have further established routes in place and available to them to speak up, including:
    - Through the Trust's nominated Freedom to Speak Up Guardian
    - Via the Human Resources Department, a part of the Trust's People Directorate
    - Using 'Shout Out Wednesday' in Family Services to raise any concerns.
    - Logging an incident on the Trust's incident reporting tool hosted on Ulysses
    - Contacting 'Ask Peter' which provides an anonymous channel to communicate concerns directly to the Chief Executive.

Freedom to Speak Up Guardian

The Trust's Freedom to Speak Up Guardian, their role, contact details and the principles of Freedom to Speak Up process is communicated to all new starters within the Trust as part of the corporate induction programme. The Trust's appointment of a substantive guardian in 2020 has led to a significant increase in the number of concerns raised and the role of the Guardian is widely publicised to all. Feedback shows staff would feel safe to speak up again.

The Guardian role and the Speaking Up process is further promoted through printed and digital materials in the Trust and in the past 12 months there have been several promotional events (including a highly publicised campaign for the NGO Speak Up month in October), and additional magazine features. The Guardian is active on social media and regularly uses it as a way of communicating to staff. The Freedom to Speak Up Guardian is accessed via a generic email

address and a dedicated mobile telephone number. Staff can also raise concerns using the Staff App, which gives another portal to access Guardian support.

In February 2023, the Trust formally adopted the Freedom to Speak Up Policy and Process for the NHS, which was developed by the NGO and NHSE with a recommendation that all Trusts adopt it. The Policy has been amended to include relevant Trust contacts. The Freedom to Speak Up Guardian responds to all concerns raised under this process and follows through each case according to the individual requirements providing regular communications and feedback until the case is concluded. Evaluation feedback from staff raising concerns has shown confidence in the Guardian and the overall process.

The Trust's Freedom to Speak Up Guardian meets monthly with the Chief Executive and the Director of People (who is the Executive Sponsor) and bi-monthly with the Trust Chair and Non-Executive Director with specific responsibility for Freedom to Speak Up who provides support to this function. The Freedom to Speak Up Guardian also meets monthly with the Trust Patient Safety Specialist to discuss any concerns raised in relation to Patient Safety. A quarterly Freedom to Speak Up Guardian report is reviewed by the Trust Management Board and the Workforce Sub-committee prior to being presented to the Trust Board by the Freedom to Speak Up Guardian. This ensures the Trust, and its board are kept up to date on concerns including sufficient details as per the National Guardian's recommendations. An overview of the report is shared with all staff by quarterly infographics. The Guardian is also sharing information to all Divisions about the number and nature of the concerns raised via the HR business partners. This information now forms part of the Divisions performance review meetings and information and can be used in conjunction with other HR intelligence data to highlight potential areas for further analysis.

During 2021/22 there was a significant increase in concerns raised with 157 cases brought to the Guardian, and in 2022/23, 220 concerns were brought to the Guardian. The latest staff survey indicates increased confidence in staff being able to raise concerns about anything and an increase that the organisation will address concerns, however there is a decline in staff feeling safe to raise concerns about unsafe clinical practice and that the organisation will address them. Although disappointing, the figure is still in line with national average figures for a Community & Acute Trust and reflects a national trend.

The Freedom To Speak Up Guardian has produced an annual progress report against the Trust's Freedom To Speak Up Strategy 2020-2024 which looked at the objectives set out in the strategy, progress made against them, and if additional actions are required to fulfil them. It is hoped that the majority of objectives set out in the strategy will be met by 2024 and no additional actions were identified at this stage.

2.3 k Information about the Guardian of Safe Working Hours

The 2016 national contract for junior doctors encouraged stronger safeguards to prevent doctors from working excessive hours. With this came the introduction of a 'Guardian of Safe Working Hours' in organisations that employ, or host, NHS doctors and dentists in training to oversee the process of ensuring they do not work excessive hours with inadequate breaks. The contract has stipulations on the length and frequency of shifts as well as rest breaks. Exception reporting is a valuable instrument that provides up to date information regarding pressure points in the system. It ensures safe working hours and improves the morale of doctors in training, the quality of medical training and patient safety. It is also the agreed contractual mechanism for ensuring that trainees are paid for all work done.

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

The safety of patients is a paramount concern for the NHS and for us as a Trust. Staff fatigue is a hazard to both patients and staff. The safeguards for working hours of doctors in training are outlined in the TCS and are designed to ensure that this risk is mitigated, and that this mitigation is assured.

There are no trainees within the Dentistry service at the Trust and so the Annual Report applies only to doctors in training. Fill rates for doctors in training at the Trust continue to be high, over 80%, which has helped with rotas, working hours, and ensuring access to educational opportunities.

The table below, provides a breakdown by specialty of the total number of exception reports received during the period July 2021 to June 2022.

Department	Total number of exceptions submitted
Accident and emergency	1
Acute Medicine	25
Anaesthetics	15
Cardiology	4
Diabetes & endocrinology	3
Gastroenterology	44
General medicine	135
General surgery	29
Geriatric medicine	5
Obstetrics and gynaecology	12
Ophthalmology	1
Paediatrics	3
Respiratory Medicine	2
Rheumatology	2
Trauma & Orthopaedic Surgery	9
Urology	1
Grand Total	**291**

Targeted support is provided to support specialties in reducing exception reporting and provide a good learning environment for the doctors in training. The Trust was granted £60,000 of national funding in 2021 to improve facilities for doctors in training and working in partnership with the doctors this has now been used to upgrade the doctors rest facilities and enhance the doctor's mess. This work has now been completed and upgraded rest areas are available on both sites.

Current numbers of Doctors in training within the trust is as follows (as of 1 January 2023):

Number of Training Posts (WTE)	302.74
Number of Doctors/Dentists in Training (WTE)	262.32
Number of Less than full time (LTFT) Trainees (Headcount)	20
Number of Training post vacancies (WTE)	40.42
Total number of trainees: SGH	155.74
Total number of trainees: DPOW	147
Total number of trainees: GDH	0

Fill rates remain high but this does not always translate in the reduction in need for locums and further work at Directorate level is required to understand the demands for locums, with the aim to reduce the reliance on locum doctors.

There have been 2 fines imposed for breaches of the Doctors in Training Contract. These fines were imposed for doctors missing breaks, and for excessive working hours. This funding has now been spent on wellbeing resources for the doctors, after discussion at the Junior Doctors Forum.

The Guardian of Safe Working attends meetings between the Trust and Health Education England to monitor the learning environment. During the past year these meetings have concentrated on Medicine and Gastroenterology, following concerns raised in the GMC annual trainee survey.

The Guardian of Safe Working holds Junior Doctor Forums (JDF) every month. Issues addressed over the past year have included:

- Rota concerns
- Working conditions
- Continued progression on the Fatigue and Facilities Charter
- Attendance at the JDF

There is now a defined slot at the JDF to discuss quality improvement and there is a dedicated point of contact within the quality improvement office to support the Junior doctors. The Trust continues to see an improvement in engagement with our doctors in training. We will continue to build on this during 2023/24.

Since returning rota coordination management to the divisions in May 2022 there has been an impression of them being more directly responsive to the divisions. Recruitment and training are ongoing in Medicine for Rota Coordinators. Medicine is now engaged in getting all additional hours onto e-Rostering and to getting job plans onto e-Rostering for senior clinicians. This is work in progress that will be completed in 2023/24. This will allow a greater level of visibility across the division of activities undertaken by all clinicians.

2.4 Reporting 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 to the Trust by NHS Digital. However, due to the impact of COVID-19 some national data collection was paused leading to delays in publication. Consequently, to retain consistency and to comply with the national guidance the tables within the report have been populated with the latest published data that is available from NHS Digital. Where appropriate the narrative provides a local update.

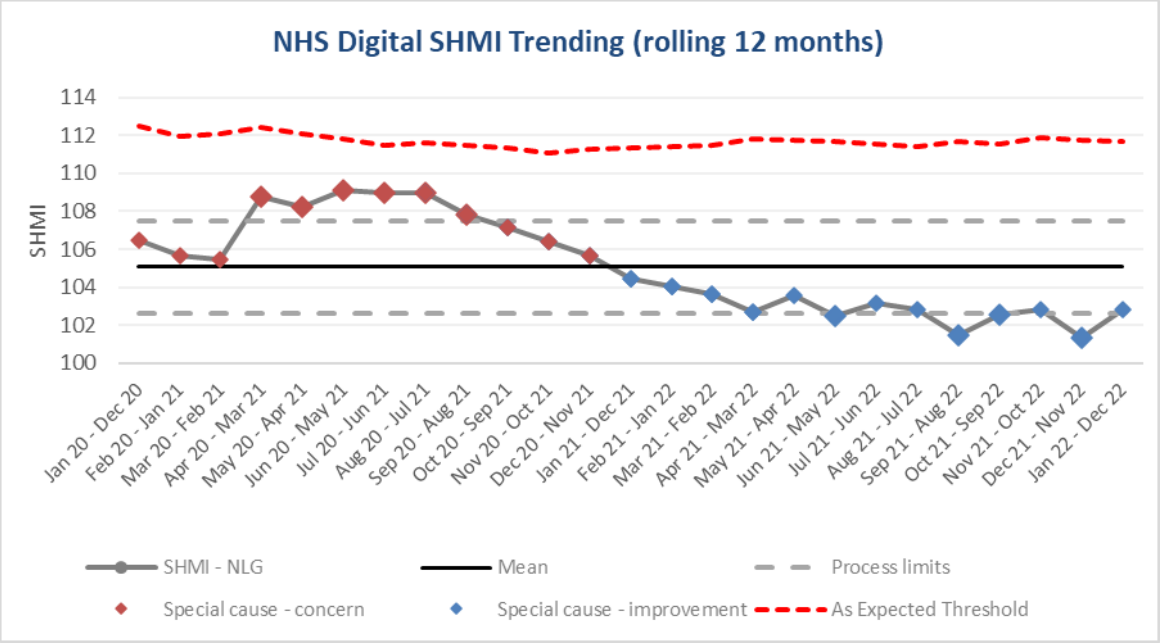
For each indicator, the number, percentage value, score, or rate (as applicable) for the last two reporting periods as well as the lowest and highest values and national average for each indicator for the latest reporting period will be represented in table format below. Some of the mandatory indicators are not relevant to Northern Lincolnshire and Goole NHS Foundation Trust; therefore, the following indicators reported on are only those relevant to the Trust.

2.4a Domain 1 – Preventing people from dying prematurely

Indicator	Trust value Jan 2021 – Dec 2021	Trust value Jan 2022 – Dec 2022	NHS (England) Jan 2022 – Dec 2022	National highest Jan 2022 – Dec 2022	National lowest Jan 2022 – Dec 2022
The value of the SHMI for the Trust for the reporting period*	1.04	1.03	1	1.22	0.71
The banding of the SHMI for the Trust for the reporting period*	2 (as expected)	2 (as expected)	2 (as expected)	1 (higher than expected)	3 (lower than expected)
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period*	23%	23%	40%	65%	12%

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts). *Reporting period January 2021 to December 2022

It should be noted that from May 2019 the SHMI was released on a monthly basis by NHS Digital, an increase in frequency from the previous quarterly releases. All values rounded to 2 decimal places.



- The above chart 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 out-of-hospital (within 30 days of hospital discharge). The SHMI is a measure of observed deaths compared with 'expected deaths', derived statistically from the recording and coding of patient risk factors.

- NHS Digital guidance on SHMI interpretation states that the difference between the number of observed deaths and the number of expected deaths cannot be interpreted as 'avoidable deaths'. The 'expected' number of deaths is not an actual count but is a statistical construct which estimates the number of deaths that may be expected based on the average England figures and the risk characteristics of the Trust's patients. The SHMI is therefore not a direct measure of quality of care.

- The Trust, as demonstrated in the chart above, has demonstrated statistically significant improvement in the SHMI resulting in the Trust being categorised as having mortality that is 'as expected' and has maintained this position over the past two years. The rolling 12 month SHMI value for the Trust for the period December 2021 – November 2022 was 101.35 which is the lowest on record for the Trust.

- Palliative care coding is a group of codes used by hospital coding teams to reflect palliative care treatment of a patient during their hospital stay. There are strict rules that govern the use of such codes to only those patients seen and managed by a specialist palliative care team.

- The SHMI does not exclude or make any adjustments for palliative care. Other Standardised Mortality Ratios (SMRs) like the Hospital Standardised Mortality Ratio (HSMR) adjust for palliative care.

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

- The Trust continue with the processes to improve the quality and accuracy of the data that underpins statistical mortality calculations like the SHMI and improving the consistency of the learning from deaths programme of work.

- Data continues to highlight a difference between hospital sites with SGH having higher levels of palliative care coding than DPoW. This reflects the disparity of consultant-led Palliative care provision between both hospitals. This forms part of the End of Life improvement plan and is being addressed collaboratively between primary and secondary care. Funding has been secured and recruitment of a Palliative Care Consultant at Grimsby will be pursued in 2023/24.

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

- Clinician led coding validation sessions and mortality screening reviews have continued throughout 2022/23. Key learning points around linking acute conditions to underlying problems have also been identified as follows:
  - Clinicians specifying electrolyte disorders or disturbances with the specific disorder, as each have a specific code. If the conditions are not specified only one code will be assigned, for the unspecified issue. If all conditions are specified, e.g. hypokalaemia, hypercalcaemia and hypernatraemia, all can be recorded which will improve the depth of coding and provides greater specificity around the conditions treated.
  - Multi-organ failure is also a 'catch-all' term used by clinicians to describe a patient's deterioration. When the individual organs that are failing are not specified only one ICD-10 code for unspecified multi-organ failure can be assigned. If each organ that has failed, each can be recorded individually (e.g. heart, respiratory, renal, liver). This accurately specifies the conditions that the patient is being treated for and improves depth of coding (Charlson comorbidities) and HRG assignment.
  - Heart failure diagnosed on diagnostic imaging e.g. chest x-ray requires diagnostic confirmation in the body of the medical record. Coders cannot code suggested diagnoses made on radiology reports and require confirmation for the condition to be coded.
- Teaching sessions and case study presentations have been shared at Divisions Quality & Safety meetings to share learning and reduce coding errors.

- The Trust is taking a pro-active approach to monitoring outcome risk of death for each SHMI diagnosis group and undertakes deep dive work with case reviews to learn from any early warning indicators to prevent future outlier alerts.

- The Community and Therapies Division works in partnership with the Northern Lincolnshire EoL Steering group to implement the Sub System EoL Improvement plan which focuses on delivering the National Ambitions for Palliative & End of Life care.

- The Trust is working in collaboration with Lindsey Lodge Hospice in Northern Lincolnshire to embed a single point of access 9am-5pm (7 days a week) where clinicians in the hospital and community can be directed to appropriate specialist palliative care team/professional for Face to face or virtual support. Outside of these hours on call specialist nurses and consultants can be contacted via Northern Lincolnshire Sigle Point of Access for phone or virtual support. This is underpinned by 7 days a week admission to the hospice and 7 day a week access to face to face specialist care nurses and consultants in Northern Lincolnshire. The Northern Lincolnshire Steering group continues to focus on the development of a consistent offer across Northern Lincolnshire, working with CPG and St Andrews Hospice to provide parity.

- The Clinical Coding team receive monthly palliative care contacts extract from North Lincolnshire Community and Therapy Services and North East Lincolnshire Care Plus Group. This is cross referenced against the patient coded data and any omissions are added for data quality purposes.

2.4b Domain 3 – Helping people to recover from episodes of ill health or following injury

Patient Reported Outcome Measures (PROMS)

The data detailed in the table below was made available to the Trust by NHS Digital with regard to the Trust's patient reported outcome measures scores for:

a) Hip replacement surgery
b) Knee replacement surgery
c) Varicose vein surgery *(Not applicable as no longer performed by the Trust)*

The PROMs is a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. The table shows the adjusted health gain reported by the patient reported using the EQ-5D index, following their surgery. EQ-5D index collates responses given in 5 broad areas (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression) and combines them into a single value. The single value scores for the EQ-5D index range is from -0.594 (worse possible health) to 1.0 (full health). As participation is voluntary, patients can choose not to participate in PROMs.

Type of surgery	Sample time frame	Trust adjusted average health gain	National average	National highest	National lowest
Hip replacement (Primary)	April 2019 – March 2020	0.447	0.459	0.539	0.352
	April 2020 – March 2021	0.410	0.472	0.574	0.393
Knee replacement (Primary)	April 2019 – March 2020	0.335	0.335	0.419	0.215
	April 2020 – March 2021	0.334	0.315	0.399	0.181

Source: NHS Digital Quality Account Indicators Portal, Primary data used, EQ-5D Index used (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

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

Patient-reported outcomes following primary hip replacement surgery (published in February 2022) showed a statistical difference to England rates where the Trust had fallen slightly outside the 95% control limit. The Trust scored 0.410, to be within the 95% control limit the Trust would have required a minimum of 0.421. The Trust remains within the 99.8% control limit of 0.392. This alert acts as a 'smoke alarm' and prompts the Trust to investigate processes surrounding primary hip replacement surgery.

The data period of April 2020 – March 2021 was during the peak of the COVID-19 pandemic and this resulted in some activity being cancelled altogether and limited restoration for the remainder of the period, the number of modelled records more than halved from the previous

year. Also, some lower risk patients were transferred to the independent sector which would likely influence the Trust's average patient reported outcomes scores.

Patient-reported outcomes following primary knee replacement surgery remain within the statistically calculated confidence intervals for EQ-5D measures, demonstrating no significantly different performance compared to the UK.

This release of data shows a potential impact from the Covid-19 pandemic which will have impacted upon planned surgery provision.

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

- Data made available from the PROMs dataset is presented within the division of surgery to support reflective practice and agreement of actions required for improvement. A summary report is presented at the Quality Governance Group and also the Quality and Safety Committee.

- Some lower risk patients were transferred to the independent sector to help reduce waiting lists.

- A deep dive investigation was carried out by the Quality and Audit Department and was presented at the Quality and Safety Committee in October 2022. Findings highlighted that although the Trust has fallen outside the 95% control limits for total hip replacements, the data for individual consultants does not highlight any issues that would need further investigation. The health records review further highlighted that over half of the patients for which a worsening in health was recorded had an American Society of Anaesthesiologists (ASA) grade of 3, which is defined as a patient with severe systemic disease. 62% of these patients were clinically classed as obese. This demonstrates that the 21 patients whose health scores deteriorated were high risk patients and may explain why the Trust's overall figures were below the England Average as the Trust does not impose exclusion criteria relating to high BMI and ASA grades.

Patients readmitted to a hospital within 30 days of being discharged

The data made available to the Trust by NHS Digital 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 30 days of being discharged from a hospital during the reporting period.

Indicator	Trust value April 2020 – March 2021	Trust value April 2021 – March 2022	National average	National highest	National lowest
Percentage of patients aged between 0 to 15 readmitted to a hospital within 30 days of being discharged.	9.3	12.4	12.5	3.3	46.9
Percentage of patients aged 16 or over readmitted to a hospital within 30 days of being discharged.	12.7	12.1	14.7	2.1	142

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

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

The Trust is below the England average for readmissions in both age groups. This is borne out by local performance reporting against peer benchmarked data.

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 (from locally available data) and compares these to the national rates in order to benchmark our performance.

2.4c Domain 4 – Ensuring people have a positive experience of care

Responsiveness to the Personal needs of patients

The Trust reviews its responsiveness to the needs of patients through monitoring responses to five specific questions:

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?

There has been no new data made available to the Trust by NHS Digital about the Trust's responsiveness to the personal needs of its patients since 2020. Therefore, the table below shows the data up to the most recent entry covering hospital stays between 01 July 2019 to 31 July 2019 (data collected between 01 August 2019 to 31 January 2020). 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.

Indicator	Trust value 2019 - 2020	National average	National lowest	National highest
Responsiveness to inpatients personal needs	62.5	67.1	59.5	84.2

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts).

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

The data is provided by the national survey contractor.

The Trust has continued to take the following actions to improve the quality of its services, represented by this data, by:

Working to ensure that patients can lead decisions in their care management. This is particularly evident in the outpatient transformation work that is ongoing within the Trust. Use of Patient Initiated Follow Up (PIFU) and Patient Knows Best (PKB) are two examples of how patients are encouraged to direct how they are managed according to their health needs.

The Trust continues to gather patient feedback about patient involvement in care and decisions through its monthly INSIGHT survey programme, which supports the national inpatient survey questions, and the 15 Step assurance programme. This feedback provides opportunity for divisions to work closely with areas where feedback indicates further improvement is required. A quality improvement collaborative is in progress focussing on discharge and ensuring patients are involved from the outset and are clear on ongoing care and treatment plans at discharge, including where to seek additional support after leaving hospital. This improvement piece of work also looked at medication at discharge, particularly in the discharge lounge and increased pharmacy support within this.

The most recent national inpatient and maternity surveys both highlighted that patients felt supported by staff, with reference to mental health in pregnancy. This improvement reflects the implementation of the mental health midwifery service. The Trust receives large amounts of positive feedback which references the impact good communication has on patients. Through cultural work, leadership development and training, such as national recognised Sage and Thyme communication workshop, the Trust continues to ensure effective and compassionate communication is a priority.

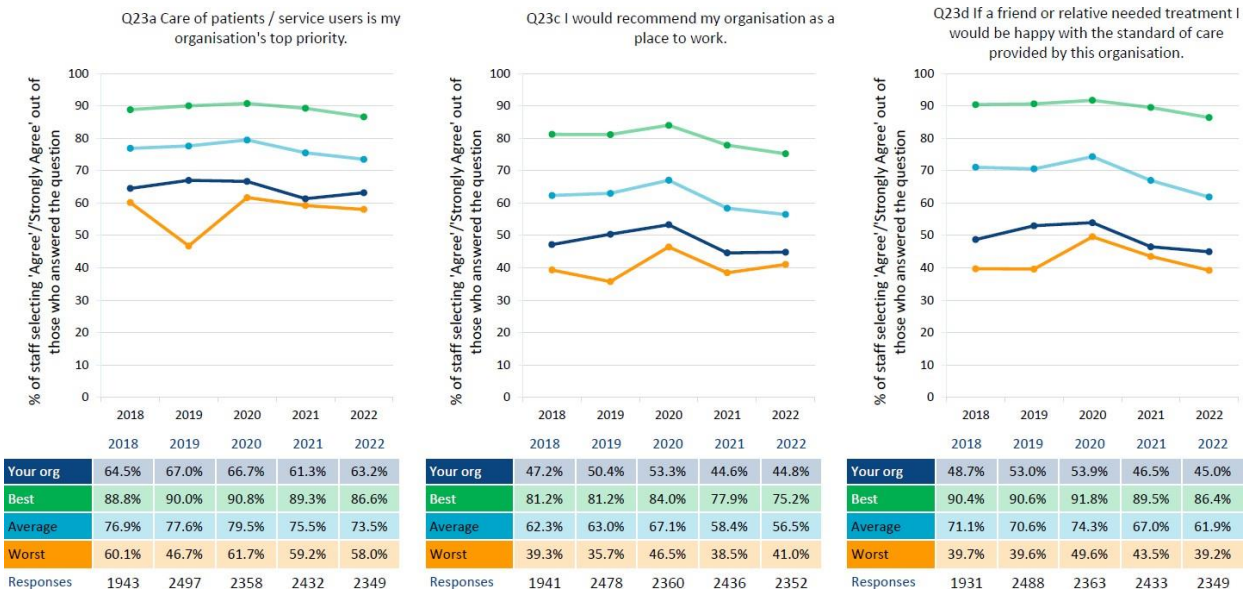
Whilst at times, the patient bedside is the only place to have a clinical conversation, due to the patient's clinical needs, there is further work required to revisit the use of our private spaces. Our charity partner, the Health Tree Foundation, supported a refurbishment programme of quiet rooms across the Trust and a review of this during 2023-24 will help identify the next steps.

The Trust recognises the worry that can arise around care and treatment following discharge. Patient Information leaflets are used within the Trust to provide valuable contact information and signposting. Use of social media platforms and helplines has been successful in our midwifery services, and this should be used to guide other areas wishing to develop this area further. The Trust Patient Advice and Liaison Service (PALS) team always provide a supportive signposting service for patients and families.

Staff recommending Trust as a provider to friends and family

The data made available by NHS Digital with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends is taken from the Trust's NHS Staff Survey Benchmark report 2022 published on 09 March 2023.

Indicator	Trust value 2021	Trust value 2022	National average	National lowest	National highest
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.	46.5%	45%	61.9%	39.2%	86.4%



	2018	2019	2020	2021	2022
Your org	64.5%	67.0%	66.7%	61.3%	63.2%
Best	88.8%	90.0%	90.8%	89.3%	86.6%
Average	76.9%	77.6%	79.5%	75.5%	73.5%
Worst	60.1%	46.7%	61.7%	59.2%	58.0%
Responses	1943	2497	2358	2432	2349

	2018	2019	2020	2021	2022
Your org	47.2%	50.4%	53.3%	44.6%	44.8%
Best	81.2%	81.2%	84.0%	77.9%	75.2%
Average	62.3%	63.0%	67.1%	58.4%	56.5%
Worst	39.3%	35.7%	46.5%	38.5%	41.0%
Responses	1941	2478	2360	2436	2352

	2018	2019	2020	2021	2022
Your org	48.7%	53.0%	53.9%	46.5%	45.0%
Best	90.4%	90.6%	91.8%	89.5%	86.4%
Average	71.1%	70.6%	74.3%	67.0%	61.9%
Worst	39.7%	39.6%	49.6%	43.5%	39.2%
Responses	1931	2488	2363	2433	2349

Source: Northern Lincolnshire and Goole NHS Foundation Trust Staff Survey Benchmark Report 2022

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

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” as published on the Staff Survey Coordination Centre website.

45% of staff surveyed would recommend the Trust (-1.6% since 2021); the reduction in the Trust’s score is not as big a decline compared with other organisations as this trend is system wide across the whole NHS and is likely as a response to the pressures and demands on public health presented post pandemic. It should be noted that the England average reduced from 67% to 61.9% in 2022 (-5.1% since 2001).

The unprecedented pressures and backlog of responses to health concerns and treatment the COVID-19 pandemic created continues to impact on overall staff wellbeing and levels of engagement, resulting in a reduction in most scores in 2022 compared to 2021. The Trust notes that there is much work to do across all staff survey themes. It should be noted that despite these pressures the Trust’s score in relation to “Care of patients/service users is my organisations top priority” improved in 2022 compared to the national trend which saw a decline.

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

For the last three years significant work has gone into transforming the culture and supporting staff on front line services of the Trust. The Trust is taking the following strategic direction to improve our overall scores:

- The implementation of a Leadership Development Strategy focused on increasing line manager core skills, developing a values based leadership programme centred on improving leadership influence on culture and implementation of structured career pathways and education opportunities for clinical and non-clinical staff. As a result of

investment in leadership development the Trust has now piloted the first cohort with community and therapy and looks to run 6 more in 2023 to priority areas and management groups.

- The launch of a cultural transformation programme developed with our staff through the Big conversation of August 2022 to improve employee experience this resulted in high levels of staff engagement and voice: the Trust has since implemented a culture transformation working group and Board. 2023 will see the development of a culture change academy aimed at individuals, teams, leaders and a network of culture change ambassadors.

- Proactive career planning within nursing, including expanding the apprenticeship framework to enrich nursing career opportunities and retain good staff.

- Improved recruitment strategy and actions to become an Employer of Choice.

- implementation of an Equality, Diversity, and Inclusion action plan to strengthen our inclusion, diversity and equity. The Trust has launched 3 staff networks BME, Disability, LGBTQ+ in 2022 and is looking to launch the Women's network in 2023. A provision of educational programmes from 2023 onwards, ran with and through the staff networks, will support a more inclusive and equitable workforce and workplace.

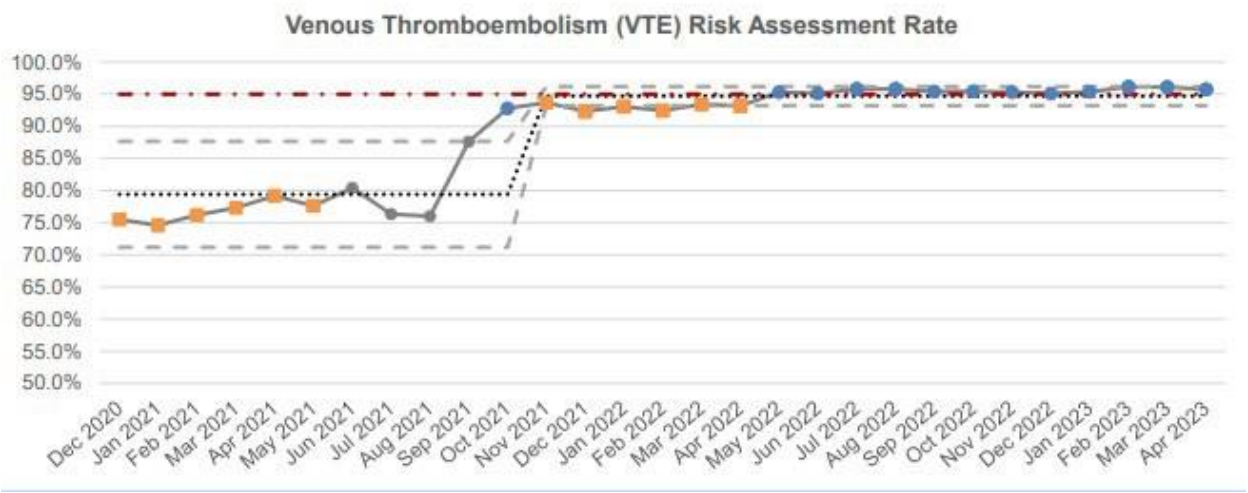
- The Trust has signed up to a two year health and wellbeing plan designed to build on progress made to date and embed effective leadership of our staff's health and wellbeing, introducing Schwartz rounds, growing a network of wellbeing champions and offering training in the field of Mental Health First Aid.

- The Trust aims to further develop this work in 2023 through leadership programme, culture programmes, coaching, mentoring and the development of a culture change academy aimed at individuals, teams, leaders, and a network of culture change transformation.

2.4 d Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

Risk assessed for Venous Thromboembolism (VTE)

The national VTE data collection and publication was paused to release NHS capacity to support the response to the Covid-19 pandemic. National data collection remains paused, so the below data only reflects local Trust performance data.



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

- The Trust reports on and oversees local VTE risk assessment compliance through the Trust's Performance Review meetings and in the Executive Governance reporting mechanisms. Compliance figures are also available at specialty level, allowing targeted support if indicated.

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

- The Trust completed the implementation of an Electronic Prescribing and Medicines Administration (EPMA) system in November 2021. The system is having the desired effect in improving patient safety as built-in controls prompt doctors to undertake full VTE risk assessments in a timely manner, prior to prescribing or administering medications. Since the introduction of the EPMA system VTE risk assessment rate has significantly improved and remained above the Trust's 90% target since May 2022 with a 2023/23 year average of 95.3%.

- The Trust's Quality Governance Group receives a highlight report in relation to VTE screening performance.

Clostridium Difficile infection reported within the Trust

The data made available to the Trust by NHS Digital regarding the rate per 100,000 bed days of cases of Clostridium difficile infection reported within the Trust (hospital onset) amongst patients aged 2 or over is shown in the table below. *(Most recent data published by NHS digital on 29 September 2022).*

Indicator	Trust value 2019/20	Trust value 2020/21	Trust value 2021/22	National average 2021/22	National lowest 2021/22	National highest 2021/22
The rate per 100,000 bed days of cases of C. difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	9.3	7.9	5.1	16.5	0	53.6

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts

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

The data shows that the Trust is beneath the UK average and one of the best performing acute hospitals in the UK which is a major achievement. This level of performance has been maintained in 2022/23.

The definitions for reporting Clostridium difficile cases changed in April 2019 meaning cases detected after 2 days would be attributed as Hospital Onset Healthcare Associated (HOHA) as opposed to the previous guidance, which specified 3 days previously. Cases would also be classed as Community Onset Healthcare Associated (COHA) if the patient was an in-patient within the previous 4 weeks.

Due to success of considerable reduction of cases in previous years, the trajectory for the year 2022 - 2023 of 21 cases was extremely challenging. The Trust had a Clostridium difficile infection objective of no more than 21 cases and ended the year on 24 reported cases combining Hospital-onset healthcare associated and Community-onset healthcare associated cases. There were no significant lapses in practice/care detected from the post infection reviews undertaken. Despite exceeding the threshold, The Trust performed exceptionally well for Clostridium difficile rates for all England acute trusts based on 100,000 bed days and the best performing trust in the region and in the lowest quartile nationally.

The Trust has continued to take the following actions to improve the quality of its services, represented by this data, by:

- Capital and planning teams factored the need to increase isolation capacity in building schemes e.g. Emergency Care Centres and Ward 25.
- The Trust has an evidence-based Clostridium difficile policy and patient treatment care pathway.
- Multi-disciplinary team meetings are held for inpatient cases where required to identify any lessons to be learnt and post-infection review is conducted for hospital onset cases.
- For each case admitted to hospital, practice is audited by the infection prevention and control team based on the Department of Health Saving Lives' audit tools.
- Themes learnt from the Post-Infection Review (PIR) process will be monitored by the Infection Prevention & Control Committee and shared with relevant bodies.
- The development of a bespoke IPC alert that will inform the IPC team to previous cases of Clostridium difficile.
- GPs are sent an email to inform them of a patient's Clostridium difficile status again to help reduce the amount of antimicrobial use and prevent future Clostridium difficile cases; This is now incorporated into the patient discharge letter.
- Development and implementation of a rolling programme of antibiotic prescribing audits reviewed by the Infection Prevention & Control group.
- PathLinks antimicrobial formulary reviewed with latest national standards.

- Updated antimicrobial Trust intranet site, the HUB, to make access to content easier for prescribers.

Patient safety incidents

The data made available to the Trust by NHS Digital represents acute (non specialist) trusts only, which is the Peer Group the Trust is benchmarked against for this indicator. Patient safety incident data is now published annually.

Time frame	Trust number of patient safety incidents reported	Trust rate of patient safety incidents reported per 1,000 bed days	Trust number of patient safety incidents reported involving severe harm or death	Trust rate of patient safety incidents reported involving severe harm or death per 1,000 bed days	Percentage of safety incidents that resulted in severe harm or death	Acute – Non-specialist national average rate of patient safety incidents reported involving severe harm or death per 100,00 population	Acute – Non-specialist national highest rate involving severe harm or death per 1,000 bed days	Acute – Non-specialist national lowest rate involving severe harm or death per 1,000 bed days
October 2019 – March 2020	8,105	65.5	20	0.2	0.25%	0.3	1.95	0.00
April 2020 – September 2020	7,570	79.9	49	0.51	0.65%	Data not available	Data not available	Data not available
October 2020 – March 2021	7,547	69.7	94	0.86	1.25%	Data not available	Data not available	Data not available
April 2021 – March 2022	15,533	72.6	25	0.11	0.16	Data not available	Data not available	Data not available

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts). There have been no new publications of data by NHS digital since February 2021 which covered the reporting period Oct 2019 – March 2020.

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

- Due to Covid-19 and the lack of available data, the national indicators were not updated with new data periods. Therefore, the table has been populated with local data updates from April 2020 onwards from the National Reporting and Learning System.

- The lack of national data prevents the Trust being able to compare rates of patient safety incidents with other non-specialist NHS organisations. However, the Trust monitors and reports on numbers internally.

- The Trust continues to monitor incident rates locally and continues to actively promote and encourage staff to report all incidents as part of an open and transparent culture designed to support learning and improvement, recognising that high levels of reporting indicate a high level of safety awareness.

- The increase in numbers during April 2021 – March 2022 was due to incidents added retrospectively as severe harm/death for each patient who may have acquired COVID in hospital and then required treatment in ITU or who subsequently died with Covid-19. Letters of apology were sent to each patient's family.

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

- The Trust continues to promote high levels of incident reporting, viewing this as a learning opportunity promoting a positive patient safety culture.
- The Trust continues to monitor the data for understanding of key themes and sharing for learning lessons opportunities.
- The Trust oversees Serious Incidents (SI) weekly at the SI panel ensuring that appropriate investigation is undertaken in line with agreed timescales.
- The Trust continually works towards improving learning in the organisation and has a learning strategy in place.
- The Trust have a SI Review Group to look back at older cases to determine if there is anything further that can be done to increase safety.

Part 3: Review of Quality Performance

3.1 Performance against relevant indicators and performance thresholds

Performance against indicators that form the Oversight Framework (not already reported on within this document) are shown as follows for 2022/23.

Indicator	Quarter 1 22/23 (Percentage)			Quarter 2 22/23 (Percentage)			Quarter 3 22/23 (Percentage)			Quarter 4 22/23 (Percentage)			Target	Full year average
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	71.07	71.79	69.49	67.01	66.98	65.97	66.62	65.98	64.46	65.96	66.56	65.55	92%	67.29%
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	58.90	65.50	63.30	62.10	59.10	62.20	61.20	62.30	53.10	57.60	55.80	56.50	95%	59.8%
All cancers: 62-day wait for first treatment from referral/screening	61.30	53.00	52.20	51.10	42.40	49.80	44.70	54.60	62.40	48.90	58.10	47.50	85%	52.17
Maximum 6-week wait for diagnostic procedures	23.80	20.00	24.40	29.80	32.50	31.40	28.40	29.80	38.60	39.20	33.30	34.40	1%	30.47%

3.2 Information on staff survey report

Summary of performance – NHS staff survey

Each year the Trust encourages staff to take part in the national staff survey. The survey results give each health Trust a picture of how its staff think it's performing as an employer and as an organisation.

Timeline

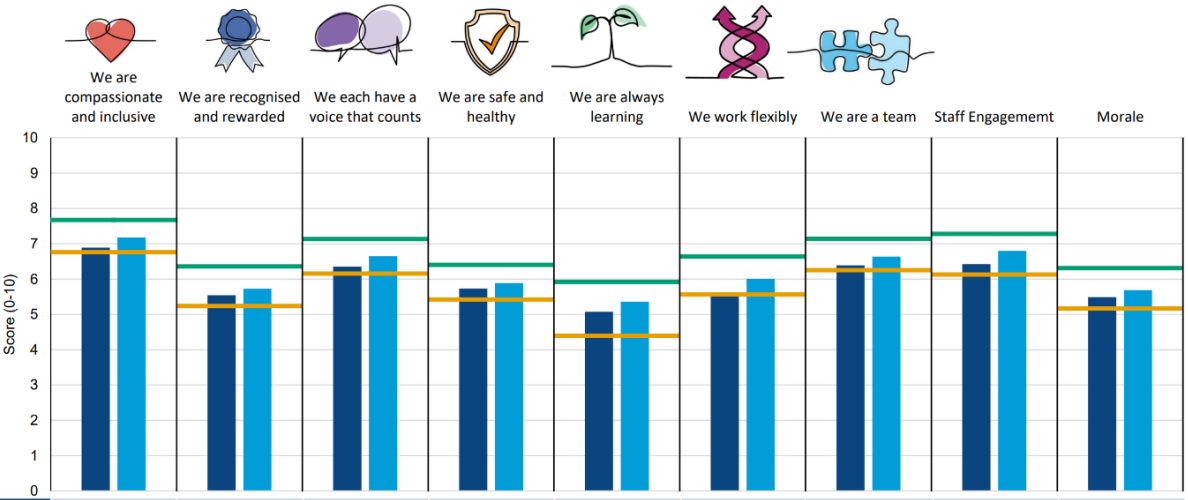
Survey Window: 4th October to 26th November 2022
Embargoed Findings: Received – 24th February 2023
NHSEI Publication: 30th March 2023

Key Facts

Benchmark Comparators: 126 Acute & Acute Community Trusts
Benchmark Response Rate: 46% (+0 % on 2021 survey)
NLaG Response Rate: 36% (-3% on 2021 survey)
NLaG Survey Mode: Online (2,415 completed / -138 on 2021)

Staff Survey 2022 findings

The 2022 survey questions are aligned to the seven themes of the People Promise. Staff Engagement and Morale remain included as in previous years.
The chart below demonstrates Trust results in comparison to peer organisations.



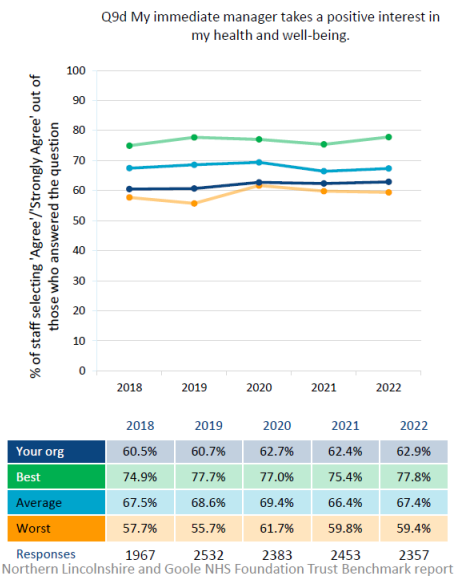
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	6.9	5.5	6.4	5.7	5.1	5.6	6.4	6.4	5.5
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	2359	2359	2345	2355	2283	2352	2357	2359	2358

Health and Well-Being

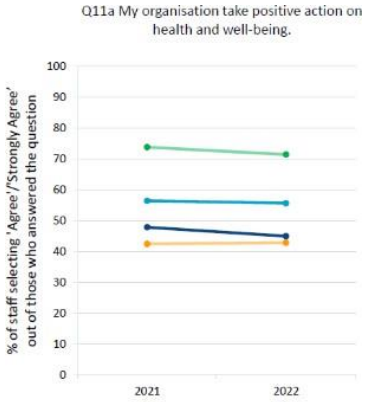
Since last year the Trust can evidence:

- Increased positive action being taken regarding health and wellbeing support
- The uptake of staff working agilely can be evidenced.

Note: Q11a with Trust taking positive action towards Health and Wellbeing is not felt by the respondents yet Q9d respondents felt immediate managers take an interest in health and wellbeing.



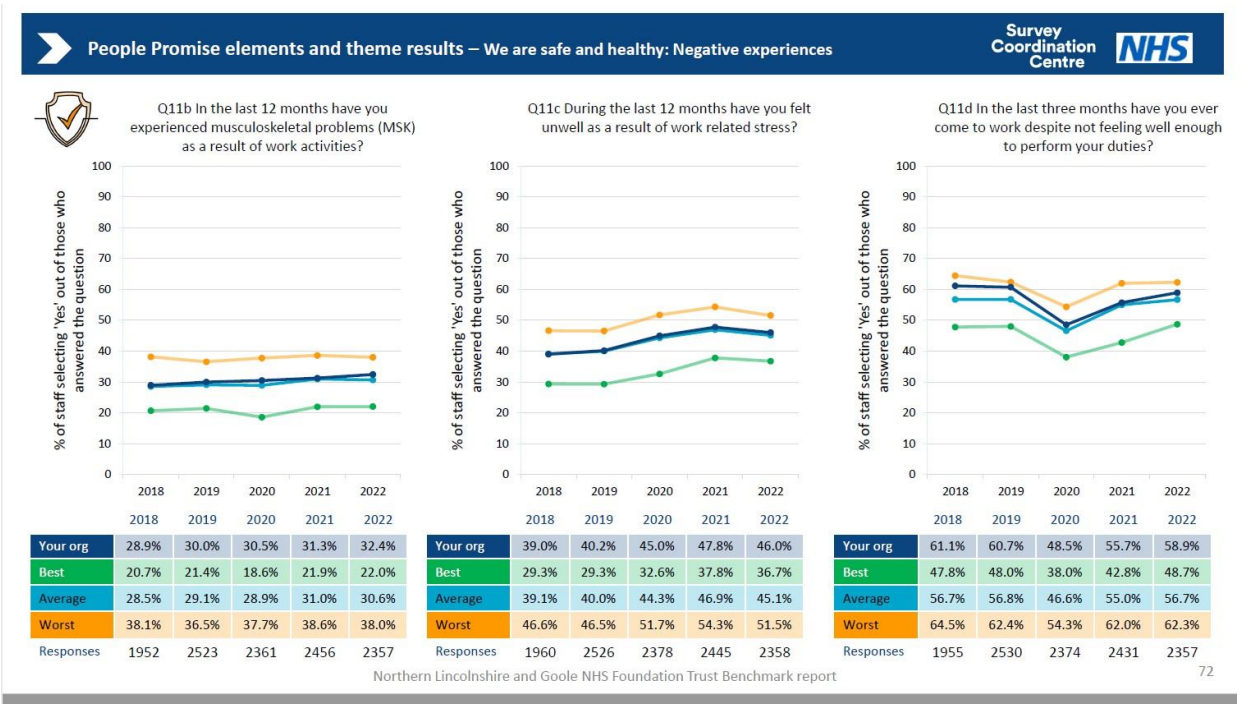
	2018	2019	2020	2021	2022
Your org	60.5%	60.7%	62.7%	62.4%	62.9%
Best	74.9%	77.7%	77.0%	75.4%	77.8%
Average	67.5%	68.6%	69.4%	66.4%	67.4%
Worst	57.7%	55.7%	61.7%	59.8%	59.4%
Responses	1967	2532	2383	2453	2357



	2021	2022
Your org	47.8%	44.9%
Best	73.8%	71.4%
Average	56.4%	55.6%
Worst	42.4%	42.8%
Responses	2426	2306

Northern Lincolnshire and Goole NHS Foundation Trust Benchmark report

The Trust has retained a fairly consistent score on the value managers placed on staff health and wellbeing. This is largely due to a comprehensive and proactive pandemic response action plan implemented in 2020 and retained and enhanced in 2021/2 to support managers and staff through the challenges of the pandemic.



	2018	2019	2020	2021	2022
Your org	28.9%	30.0%	30.5%	31.3%	32.4%
Best	20.7%	21.4%	18.6%	21.9%	22.0%
Average	28.5%	29.1%	28.9%	31.0%	30.6%
Worst	38.1%	36.5%	37.7%	38.6%	38.0%
Responses	1952	2523	2361	2456	2357

	2018	2019	2020	2021	2022
Your org	39.0%	40.2%	45.0%	47.8%	46.0%
Best	29.3%	29.3%	32.6%	37.8%	36.7%
Average	39.1%	40.0%	44.3%	46.9%	45.1%
Worst	46.6%	46.5%	51.7%	54.3%	51.5%
Responses	1960	2526	2378	2445	2358

	2018	2019	2020	2021	2022
Your org	61.1%	60.7%	48.5%	55.7%	58.9%
Best	47.8%	48.0%	38.0%	42.8%	48.7%
Average	56.7%	56.8%	46.6%	55.0%	56.7%
Worst	64.5%	62.4%	54.3%	62.0%	62.3%
Responses	1955	2530	2374	2431	2357

Northern Lincolnshire and Goole NHS Foundation Trust Benchmark report 72

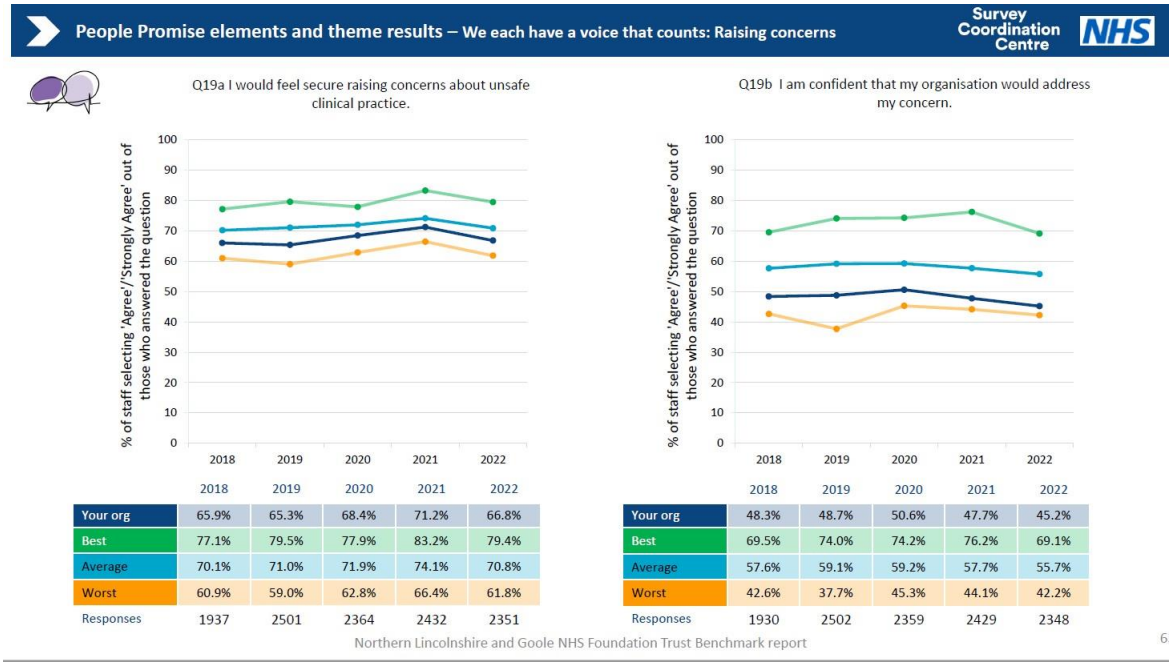
The Trust are committed to further work on health and wellbeing, as set out in our forthcoming two year health and wellbeing plan, and our Trust's recent participation in the NHSE Health and Wellbeing Trailblazer Pilot. The Trust was noted for its strategic perspective in the pilot, focusing on long term improvement of staff wellbeing and line manager capability to proactively support their staff. Further work is mapped to strengthen this including:

- The support of staff psychological wellbeing with skills training and sessions in CISM training, further funding of clinical psychologists, the introduction of Schwartz Rounds

and a series of pop up wellbeing Hubs planned for 2022/23 to continue well into 2023/24.

- Consideration given to supporting staff burnout is required given Q11d and staff continuing to work when unwell is increasing.

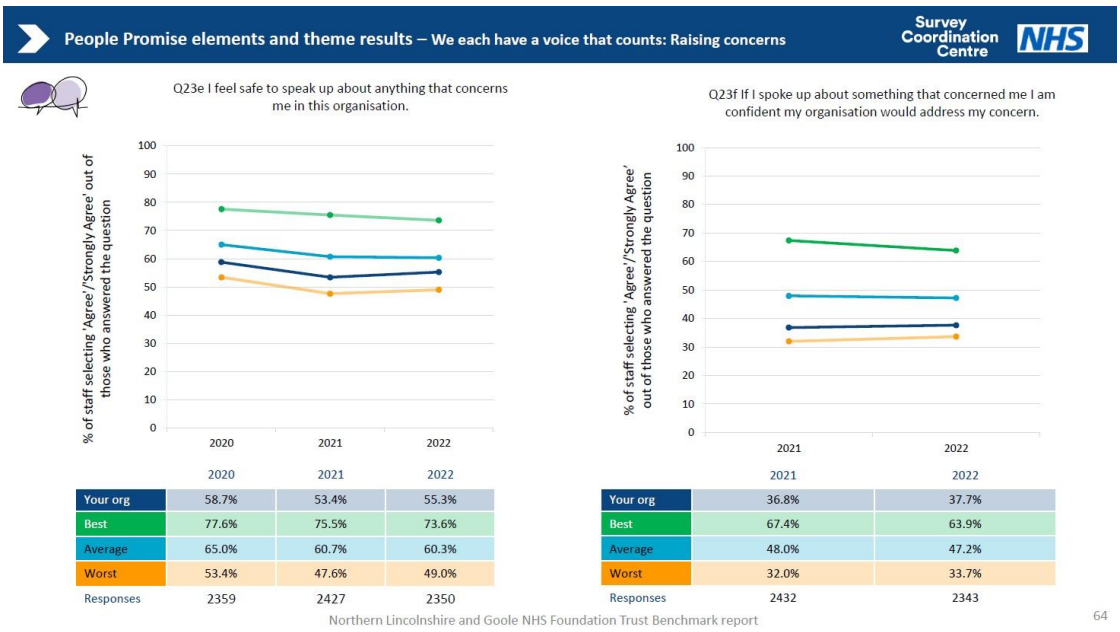
Safety Culture



	2018	2019	2020	2021	2022
Your org	65.9%	65.3%	68.4%	71.2%	66.8%
Best	77.1%	79.5%	77.9%	83.2%	79.4%
Average	70.1%	71.0%	71.9%	74.1%	70.8%
Worst	60.9%	59.0%	62.8%	66.4%	61.8%
Responses	1937	2501	2364	2432	2351

	2018	2019	2020	2021	2022
Your org	48.3%	48.7%	50.6%	47.7%	45.2%
Best	69.5%	74.0%	74.2%	76.2%	69.1%
Average	57.6%	59.1%	59.2%	57.7%	55.7%
Worst	42.6%	37.7%	45.3%	44.1%	42.2%
Responses	1930	2502	2359	2429	2348

Since 2018 significant progress has been made relating to staff feeling secure raising concerns about unsafe clinical practice (+8.9% since 2017 in 2021). However, we see an increase in loss of confidence in raising concerns and addressing these since last year (-4.4% for Q19a and -2.5% for Q19b)

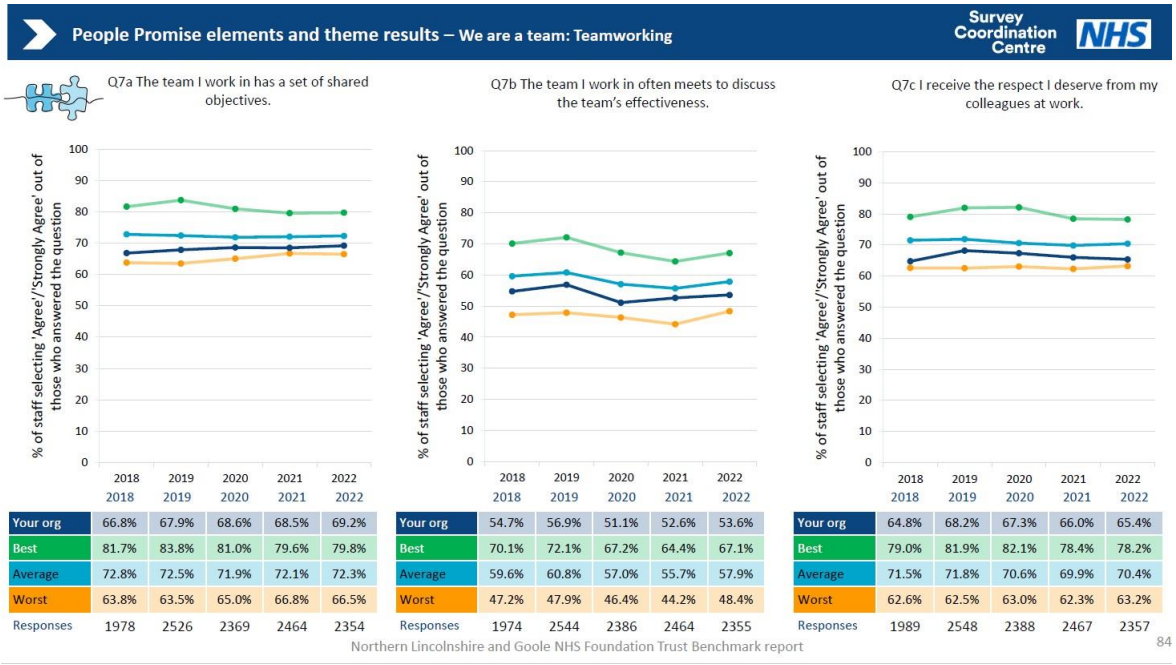


	2020	2021	2022
Your org	58.7%	53.4%	55.3%
Best	77.6%	75.5%	73.6%
Average	65.0%	60.7%	60.3%
Worst	53.4%	47.6%	49.0%
Responses	2359	2427	2350

	2021	2022
Your org	36.8%	37.7%
Best	67.4%	63.9%
Average	48.0%	47.2%
Worst	32.0%	33.7%
Responses	2432	2343

Whereas 2021/22 saw a decrease in staff feeling they are able to speak up about anything that concerns them in the organisation there has been a marked improvement with the introduction of our Freedom To Speak Up Guardian and the Trust taking a proactive approach to improve on this as part of the Culture Transformation programme and Just and Learning Culture.

Team Working



We see a small uplift in scores since last year as an indication that some small improvements have been made and felt by our staff. In addition to the Trusts approving the Leadership Development Strategy last year more Teamworking and Line management skills are required to achieve high levels of staff engagement. Our forthcoming core leadership skills programme of work will support improvement in this theme.

Next Steps:

Begin delivery on revised cultural and leadership objectives aligned to Trust priorities and the Leadership Development Strategy. These are overseen by the Culture Transformation Board and the Workforce Committee.

3.3 Information on patient survey report

The national survey programme provides a year-on-year review of person-centred validated questions and responses. This data allows the Trust to monitor internal progress and benchmarking. During 2022/23 the Trust implemented a comprehensive action plan based on the 2021 national inpatient survey (2022 survey results are still being collated nationally), of which the headlines are detailed below.

The 2021 National Adult Inpatient Survey shows a significant internal improvement for Northern Lincolnshire and Goole NHS Foundation Trust, compared to the 2020 survey results from its survey provider, Picker.

All trusts then have their dated weighted and represented by the CQC. The demographical data indicates most people surveyed were over 66 years of age and had a long-term condition.

On release of the CQC data the Trust is rated in the same mid-range as the other 134 acute trusts surveyed for 46 of the questions asked. It also highlighted significant internal improvement in 5 questions, as shown below:

Q39. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?
Q10. If you brought medication with you to hospital, were you able to take it when you needed to?
Q49. During your hospital stay, were you ever asked to give your views on the quality of your care?
Q42. Before you left hospital, did you know what would happen next with your care?
Q29. Do you think the hospital staff did everything they could to help control your pain?

There has been an organisational quality improvement pain collaborative which has clearly impacted on the patient experience, reflected in the question responses, which provides added assurance to existing monitoring.

The celebration of improvements is shared across the Trust and the whole survey has been reviewed and discussed to determine the proposed improvement actions.

The areas for improvement from the CQC survey, as shown below, have

Where patient experience is best

- ✓ Quality of food: patients describing the hospital food as good
- ✓ Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital
- ✓ Taking medication: patients being able to take medication they brought to hospital when needed
- ✓ Help with eating: patients being given enough help from staff to eat meals, if needed
- ✓ Dietary needs or requirements: patients being offered food that met any dietary needs or requirements they had

Where patient experience could improve

- ○ Waiting to get to a bed: patients feeling that they waited the right amount of time to get to a bed on a ward after they arrived at the hospital
- ○ Equipment and adaptations in the home: hospital staff discussing if any equipment or home adaptations were needed when leaving hospital
- ○ Changing wards during the night: staff explaining the reason for patients needing to change wards during the night
- ○ Information about medicines to take at home: patients being given information about medicines they were to take at home
- ○ After the operation or procedure: patients being given an explanation from staff of how their operation or procedure went

The survey is shared divisionally, and any actions are designed collaboratively, following discussions around existing quality improvement pathways. This method avoids unnecessary duplication of actions, the overarching action is owned divisionally and monitored every quarter through the Trust's Patient Experience Group. Actions fall under the 4 main headings:

- Person centred care
- Information
- Environment and Facilities
- Discharge

This year's priorities are based on survey results, exiting quality improvement work streams and triangulation of other patient experience data. An example of this is, whilst medications at discharge featured on the CQC report as below the expected range, internally there has been no significant decline in scores and discharge is already a quality improvement priority.

Priorities are also based on which questions mattered most to patients, using the Picker Institutes research-based analysis during review.

Therefore, survey actions are now in place and being monitored around key areas:

- Did not have to wait long time to get to bed on ward
- Not prevented from sleeping
- Explained well how procedure had gone
- Family or home situation considered at discharge

Due to the time span of national surveys, they are, in effect, always year behind by the time results are analysed and shared, the Trust conducts its own ongoing inpatient survey programme. The INSIGHTS local survey programme surveys 10 patients on each adult inpatient ward monthly and monitors this feedback. It remains the Trust's commitment to listen and act on patient feedback and prioritise actions that matter to patients most.

3.4 Quality Improvement Journey

The Quality Improvement (QI) program for the trust has continued to develop in year with 656 staff trained in QI methodologies by the QI Academy during 22/23, including 327 Foundation Level Doctors from across the Integrated Care System at Applying QI level, where they are able to apply their QI skills by delivering a Quality Improvement Project (QIP). 23 Trust staff (and 1 Integrated Care Board staff member) have been trained in Leading & Coaching QI, enabling staff to not only enact their QI skills but lead larger programmes of change. A further 50 Trust staff undertook Applying QI level training with 37 either completing a QIP or in the process of doing so.

In addition, the Trust has run several trust wide QI collaborative events with measurable outcomes involving 38 wards from across the trust. These include the Safe and Secure medications QI collaborative which focused on increasing the compliance of the Safe and Secure Medications audit from a baseline 71.30% compliance to achieving the target of 85% compliance across all inpatient wards at the Trust. An ongoing QI Collaborative commissioned in year focused on the improvement of Pain Assessment and Reassessment, with the 5 pilot wards Increasing the number of electronic pain assessments completed from 497 in March 2022 to 3584 in March 2023. An 'Always' Event was also held during March 2023 to engage clinical colleagues, patients, and families to start a QI programme focusing on the trust End of Life pathways. This work will continue throughout 2023.

The Quality Improvement Showcase launched in Nov 2022 to capture, showcase, and celebrate QI initiatives from across the trust has over 160 QI project documented with over 40% showing a measurable improvement with the remainder at various stages of testing and measuring data.

The Trust will continue to build on its strong QI foundations to deliver outstanding quality of care to our patients in 2023/24.

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Annex 1.1: Statements from Commissioners

Feedback from:
Humber and North Yorkshire Integrated Care Board (ICB)
Lincolnshire ICB

This statement has been produced by Humber and North Yorkshire Integrated Care Board (ICB) and includes the reflections of Lincolnshire Integrated Care Board.

The 2022/2023 financial year has been particularly challenging for our health and care system. The Trust has accomplished significant advancements and sustained improvements within the year whilst also being open to opportunities to support the wider healthcare system. The ICB is delighted that the hard work and efforts of the Trust have been formally recognised in their latest CQC inspection and NLaG has moved out of the Recovery Support Programme formally known as Special Measures. The Humber and North Yorkshire Integrated Care Board would like to thank the Trust and all Staff working within the organisation for their significant contribution to supporting the health and care of our population.

The ICB would particularly like to recognise the sustained improvement of the Summary Hospital-level Mortality Indicator (SHMI). An indicator which demonstrates the efforts of the Trust within the organisation and that of the collaboration with health and care partners outside of the Trust to drive system improvement in this area. Additionally, other achievements of the Trust throughout 2022/2023 are highly commended, specifically the vast number of quality improvement initiatives undertaken throughout the year, the establishment of the Maternity Triage Telephone system, the excellent work around the personalisation agenda which is reflected in Gareth's story and the exceptional achievement of the Trust with regards to having some of the lowest Infection Control rates in the country.

The ICB are supportive of the Trust's Quality Priorities for 2023/24, recognising the need to continue to embed the excellent work commenced during 2022/2023 for some areas and the additionality of new quality priorities including End of Life and Mental Capacity which are fundamental to ensuring high quality care for all. With the development of more complex patient pathways, effective communication is key across health and care partners to ensure patient safety and the ICB is reassured that there will also be a specific focus on communication.

We will continue to support the Trust on its improvement journey and will be actively contributing to this by facilitating system health and care innovations within the local health and care system which will impact the quality of our health and care pathways. The two places in Northern Lincolnshire have prioritised Quality Improvement activity to support development in system flow and the quality of care in hospital avoidance and supported discharge. Support into and around care homes is the focus of North and North East Lincolnshire Health and Care Partnerships.

Once again we would like to commend all staff and the Trust on their hard work, resilience and achievements this financial year.

Annex 1.2: Statement from Healthwatch organisations

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

Healthwatch North East Lincolnshire
Suite 4 Alexandra Business Centre
Fisherman's Wharf
Grimsby
DN31 1UL

18.5.23

Dr Peter Reading
Chief Executive
Northern Lincolnshire & Goole NHS Foundation Trust

Dear Dr Peter Reading

Healthwatch response to the Annual Quality Accounts 2022/23

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

The three local Healthwatch organisations recognise that the Quality Account report is a useful tool in ensuring that NHS healthcare providers are accountable to patients and the public about the quality of service they provide. The following is the joint response from Healthwatch North East Lincolnshire, Healthwatch North Lincolnshire and Healthwatch East Riding of Yorkshire.

The summary clearly sets out what you have achieved during 2022/23 against your 6 priority areas and what still needs working on and where progress has been made. The Trust has also clearly indicated what the priorities will be for 2023/24 and how you hope to achieve them.

Here at Healthwatch we are pleased to hear that the Northern Lincolnshire & Goole NHS Foundation Trust achieved the targets that were necessary to leave the Quality Special Measures after your CQC inspections, these inspections have also shown that through the hard work you and your staff have put in during 2022/23 that your overall CQC rating has gone from 'Inadequate' to 'Requires Improvement'.

The highlight for patients across Northern Lincolnshire has been the opening of the 2 new Emergency Departments, with further developments consisting of Acute Assessment Units and Same Day Emergency Care Provision.

We at Healthwatch are pleased to see the personal account and the impact you have made to an individual with support from staff the young man received the treatment he needed in a caring and compassionate way and the difference this had made to him and his family.

In 2021/22 you reported that you intended to improve the figure for patients being discharged before 12pm. 2022/23 there has still been no statistical change to your position, we at Healthwatch would hope that during 2023/24, with new initiatives being in place that these figures improve. We are aware that you are often reliant on outside agencies to support you and to work collaboratively for the patient and that sometimes things are outside of your control, however improvement in this area is paramount for the wellbeing of patients.

Healthwatch is also pleased to see that the Friends and Family Test has resumed after being paused due to the Covid-19 pandemic, the Trust had set targets to increase the response rates, these may not have been achieved but plans are in place to continue with this action. Healthwatch offers support in this area, if you require it.

The Trusts work and future planning with regards End of Life is welcomed. During 2022/23 we are aware that you have started to roll out the Electronic Palliative care Coordination System (EPaCCs) and this should enable patient's wishes and feelings to written in one place, this will improve their journey and the care they receive. There is still progress to be made in the area of End of Life but the Trust has a clear plan in place to achieve the goals set out.

We would like to thank all of your staff for the hard work they have put in during 2022/23 to achieve a better CQC rating and for the developments that are happening within the Trust. We have still been in Covid-19 recovery, however you have continued to make improvements and to recognise were you still need to make progress.

Yours sincerely,

Tracy Slattery	Jennifer Allen	Cheryl Howley
Delivery Manager	Delivery Manager	Delivery Manager
Healthwatch North East Lincolnshire	Healthwatch North Lincolnshire	Healthwatch East Riding of Yorkshire

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

Feedback from:
Lincolnshire – Health Scrutiny Committee for Lincolnshire

Introduction

The Health Scrutiny Committee for Lincolnshire is grateful to representatives from the Trust for presenting its draft quality account and enabling the representatives from the Committee to receive answers to their questions on its content.

Presentation and Clarity of the Quality Account

The Committee believes that the quality account is clearly presented, for example, progress on each of the metrics for the previous year's quality priorities is clearly indicated by colour-coding. The Committee notes that the glossary of terms was included in the draft quality account, and this would be expanded in the final version to cover the acronyms throughout the quality account.

Priorities for Improvement

Progress in 2022/2023

The Committee notes that improvements were made across the metrics for the six priorities for improvement, except antibiotic prescribing, where it was explained to representatives of the Committee that setting targets for reducing antibiotic prescribing may not always be appropriate. The following specific comments are recorded on three of the priorities:

- Priority 1 *(Mortality Improvement)* – Improvements in the Summary Hospital-level Mortality Indicator [SHMI] are particularly welcomed, as are the year on year reductions in the number of patients dying within 24 hours of admission.

- Priority 3 (*Sepsis*) – Although the targets were not met, the Committee accepts that there have been improvements in the percentage of patients screened for sepsis. The Committee looks forward to further improvements as this priority has been carried forward into 2023/24.

- Priority 6 (*Safety of Discharge*) - The Committee supports the contribution of weekend consultant ward rounds to enable the timely discharge of patients, thereby avoiding discharge peaks on Monday mornings.

Priorities for 2023/2024

The Committee supports the five quality priorities selected for 2023/2024, three of which are continuations of actions taken during 2022/23. The Committee looks forward to progress across all five priorities, including the two new priorities (*Improving End of Life and Palliative Care*; and *Increasing the Quality of Mental Capacity Act Compliance*). It was confirmed to the representatives of the Committee that all five priorities were selected with the involvement of patients and staff.

Achievements During 2022/23

The Committee welcomes the following achievements during 2022-23:

- external recognition of the Trust's end of life team and the training of 68 bluebell end of life champions;
- external recognition of the discharge improvement project;
- the development of two new emergency departments and adult assessment units in Grimsby and Scunthorpe; and
- the introduction of the maternity triage system.

Support for Patients with Mental Health Needs

The Committee is grateful for the representatives of the Trust who presented the quality account for outlining the Trust's support for patients needing mental health support, which include some 'in-reach' services provided by the two local mental health providers, as well as access to support from these providers outside the hospital setting. The Committee stresses the importance of mental health support, particularly in emergency departments, as these are places where patients go, when mental health crisis services are not available.

Staff Wellbeing

The number of staff recommending the Trust as a provider to their friends and family had fallen in 2022, and notes that this is likely as a result of staff fatigue and demands on them following the pandemic. Representatives of the Committee were reassured that staff wellbeing was important: the "Ask Peter" initiative, and the *Freedom to Speak Up Guardian* were key elements in valuing staff involvement and supporting their welfare. The Committee was pleased that a higher percentage of exit interviews were being conducted, so that the Trust could learn from staff leaving the service.

Engagement with the Committee

As the Trust engages regularly with three other health overview and scrutiny committees representing the local authority areas where its main sites are located, engagement with the Health Scrutiny Committee for Lincolnshire has previously been limited. The Committee is mindful that the Humber Acute Services Review, with its possible changes to the acute hospitals in Grimsby and Scunthorpe, will affect Lincolnshire patients, and as a result the Committee believes that its engagement with either the Trust or its commissioners is likely to increase.

Conclusion

The Committee is grateful for the opportunity of making a statement on the Trust's quality account for 2022/2023 and looks forward to the Trust continuing with its progress on its standards of care and continuing to provide the acute hospitals of choice for a significant number of patients in the administrative county of Lincolnshire.

Feedback from:
East Riding of Yorkshire Council – Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

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 2022/23.

The Sub-Committee welcomes the quality priorities set for 2022/23 and feel these have been carefully considered and hopes the Trust can meet these priorities in forthcoming year and that these will help to improve the overall performance of the Trust.
Comments:

- Elective Waiting – In February 2023, the Sub-Committee were presented with a breakdown of NLaG's elective waiting backlog and note that the CQC identified an improvement. A continued commitment to reducing the backlog would be greatly supported by the Sub-Committee.

- Workforce – An approach to address staffing challenges is vital to future proof service delivery. Following on from its consideration of the health care workforce in November 2022, and the continued references throughout the year, the Sub-Committee are pleased to see that activity has been identified for upskilling pharmacists. Opportunities to improve the career prospects of staff, including career planning within nursing, is a positive step towards recruiting and retaining staff.

- Co-production - In preparation for quality priority planning for 2023/24, the Sub-Committee appreciate the engagement with service users as a means to co-produce areas of improvement.

Feedback from:
North Lincolnshire Council – Health Scrutiny Panel

North Lincolnshire Council's Health, Integration and Performance Scrutiny Panel note and welcome the Trust's Quality Account document, including the priorities for the forthcoming year. The Scrutiny Panel intends to work closely with the Trust throughout 2023/24 to discuss services for local patients and residents, to robustly scrutinise forthcoming proposals around acute care, and to hold local decision makers to account.

Feedback from:
North East Lincolnshire Council – Health, Housing and Wellbeing Scrutiny Panel

No feedback was received for inclusion in the Trust's quality account.

Annex 1.4: Statement from the Trust governors'

The Council of Governors is pleased to have been given the opportunity to comment on the Trust's Quality Account for 2022/23. Despite the Covid pandemic aftermath, this demonstrates a continuation in the significant quality improvements that have been achieved over recent years through the herculean efforts of NLaG staff at all levels of the organisation. It was particularly gratifying that these measurable improvements were reflected in the Care Quality Commission's latest inspection report and the subsequent removal of the Trust from Quality Special Measures or the Recovery Support Programme as it is now known.

Throughout the year governors have continued to prioritise seeking robust assurance regarding the quality and safety of all hospital and community services provided by the Trust in the context of our duty to hold Non-Executive Directors (NEDs) to account for the performance of the Trust Board. We receive regular reports at Council of Governors meetings on progress in implementing the Trust's quality priorities. We are represented at meetings of the Quality & Safety Committee in an observer capacity and the NED chair makes herself available to brief bi-monthly Governor Assurance Group meetings on committee highlights and to answer our searching questions.

Governors are pleased to see the progress that has been made against many of the Trust's 2022/23 quality priorities. Maintenance of a consistent downward in-hospital mortality trajectory has been particularly impressive although more work is required with integrated care system place partners to drive improvements to out of hospital mortality rates. It is also pleasing to see the improvements that have been achieved in the discharge process through much more timely despatch of discharge letters and outpatient clinic summaries to GPs.

The Council of Governors supports the five quality priorities identified for 2023/24. We were pleased that feedback was sought from Trust members and service users in identifying quality improvement areas. It is clearly right that priority is being given to improving palliative and end of life care. This is the one area of NLaG service provision still rated 'inadequate' by the Care Quality Commission, although bringing about the necessary improvements will require concerted action by all system partners. Governors were initially disappointed that communication improvement was not identified as a standalone quality priority as poor communication is too often at the heart of quality lapses. We have since been reassured that communication key performance indicators will be developed for each of the agreed quality priority areas.

Annex 1.5: Response from the Trust to stakeholder comments

The Trust are grateful to stakeholders for their views and comments on the Quality Account for the period 2022/23.

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.

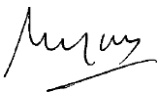
NHS England has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality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

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

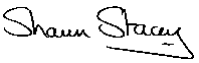
- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2022/23 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2022 to March 2023
    - Papers relating to quality reported to the board over the period April 2022 to March 2023
    - Feedback from commissioners
    - Feedback from governors
    - Feedback from Local Healthwatch organisations
    - Feedback from Overview and Scrutiny Committees
    - Latest national inpatient survey 2021
    - Latest national staff survey 2023
    - CQC inspection report published 2 December 2022
- 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 routinely quality checked to ensure it 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 routinely quality checked to ensure it is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The Quality Report has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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



22 June 2023
…… Date.....Chair



22 June 2023
…… Date.....Interim Chief Executive

Annex 3: Glossary

Ceiling of Care: The course of treatment considered to be the predetermined highest level of intervention deemed appropriate by a medical team, aligning with patient and family wishes, values and beliefs. These crucial early decisions aim to improve the quality of care for patients in whom they are deemed appropriate.

Clostridium Difficile (C. Difficile): A species of bacteria of the genus Clostridium that causes severe diarrhoea and other intestinal disease when competing bacteria in the gut flora are wiped out by antibiotics.

CQUIN or Commissioning for Quality & Innovation Framework: 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.

Deteriorating Patient: Sometimes, the health of a patient in hospital may get worse suddenly. There are certain times when this is more likely, for example following an emergency admission to hospital, after surgery and after leaving critical care. However, it can happen at any stage of an illness. It increases the patient's risk of needing to stay longer in hospital, not recovering fully or dying. Monitoring patients regularly while they are in hospital and taking action if they show signs of becoming worse can help avoid serious problems.

Electronic Palliative Care Coordination system EPaCCs: Single shared record for preferred place of care and advanced decisions.

EPMA stands for Electronic Prescribing and Medicines Administration and is the digital prescribing system used by Medics and Pharmacists at the Trust.

Family and Friends Test (FFT): From April 2013, all patients will be asked a simple question to identify if they would recommend a particular A&E department or ward to their friends and family. The results of this friends and family test will be used to improve the experience of patients by providing timely feedback alongside other sources of patient feedback.

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.

Mortality Data: - 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) and 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. The absolute average mortality for the UK is expressed as a level of 100.

Whilst '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". The statistically calculated confidence intervals for this information results in SMRs of both above 100 and below 100 being classified as "within expected range".

Summary Hospital-level Mortality Indicator (SHMI): The SHMI is a measure of deaths following hospital treatment based on all conditions, which occur in or out of hospital within 30 days following discharge from a hospital admission. It is reported at Trust level across the NHS in England using standard methodology.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD): NCEPOD promote improvements in healthcare and support hospitals and doctors to ensure that the highest possible quality of safe patient care is delivered. NCEPOD use critical senior and appropriately chosen specialists to critically examine what has actually happened to the patients.

National Early Warning Score (NEWS2): Nationally defined way of monitoring patients' observations to determine if there are signs of deterioration over time. Sometimes referred to as Early Warning Scores each Trust will have an agreed policy to act on NEWS scores escalating care were appropriate. In some cases, NEWS escalation will not occur, for example when a patient is receiving end of life care, such decisions will be agreed with patients and their families.

Patient Advice & Liaison Service (PALS): The PALS service offers confidential advice, support and information on health-related **matters. They provide a point of contact for patients, their families and their carers.**

Patient Reported Outcome Measures (PROMS): Patient Reported Outcome Measures are questionnaires that ask patients about their health before and after an operation. This helps to measure the results or outcome of the operation from the patient's point of view. This outcome is known as the 'health gain'. All NHS patients undergoing planned hip replacement, knee replacement, varicose vein or groin hernia surgery procedures are invited to fill in PROMs questionnaires.

A Recommended Summary Plan for Emergency Care and Treatment (ReSPECT): Provides a summary for a person's clinical care and treatment in a future emergency in which they do not have capacity to make or express choices.

Same Day Emergency Care (SDEC): Same Day Emergency Care is one of the many ways the Trust is working to provide the right care, in the right place, at the right time for patients. It aims to benefit both patients and the healthcare system by reducing waiting times and unnecessary hospital admissions.

Sepsis: A medical condition that is characterised by a whole body inflammatory state and the presence of a known infection.

Venous Thromboembolism (VTE): VTE is a condition in which a blood clot (thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called deep vein thrombosis. The thrombus may dislodge from its site of origin to travel in the blood – a phenomenon called embolism.

VTE encompasses a range of clinical presentations. Venous thrombosis is often asymptomatic; less frequently it causes pain and swelling in the leg. Part or all of the thrombus can come free and travel to the lung as a potentially fatal pulmonary embolism. Symptomatic venous thrombosis carries a considerable burden of morbidity, including long-term morbidity because of chronic venous insufficiency. This in turn can cause venous ulceration and development of a post-thrombotic limb (characterised by chronic pain, swelling and skin changes).

Annex 4: Mandatory Performance Indicator Definitions

No external audit of indicators included in the report has been required as part of the 2022/23 Quality Account reporting process, this follows national guidance received to all NHS Trusts.

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