NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Northern Lincolnshire & Goole NHS Foundation Trust

Annual Quality Account

2018/19

CONTENTS

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

In May 2018 Northern Lincolnshire & Goole NHS Foundation Trust (referred to as the Trust throughout this document) received a comprehensive inspection from the Care Quality Commission (CQC). The outcomes of this inspection resulted in our overall rating improving. Importantly for me, as Chief Executive, this demonstrated that the Trust is making progress on its improvement journey.

I am pleased to say that the Trust has made clear improvements in its performance and delivery of high quality services. The Trust's Accident and Emergency teams have demonstrated real resilience despite incredible pressures from an increasing demand on emergency services. Community colleagues within the Trust have supported this with provision of different care models (outside hospital), like the 'virtual ward'. This is where more care is provided in patient's own homes and can support earlier discharge of patients from acute services and work to prevent admission to hospital.

Recognising the particular challenge faced in connection with patients on waiting lists, improved arrangements are now in place and are resulting in reduced numbers, with continuing effort to prioritise those who have waited the longest to make further improvements. Aligned to this is the significant work undertaken during the year to ensure that those patients waiting are assessed for evidence of clinical harm. This has now been built into the established waiting list management arrangements in place, whilst we resolutely continue to focus on reducing the numbers of those patients still further.

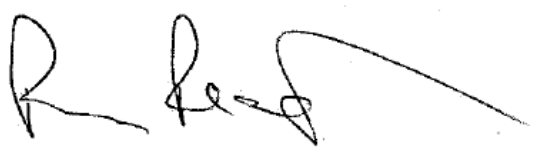
Pressure ulcer incidence has decreased, infection prevention and control indicators demonstrate that hospital acquired infections remain low and the Trust's performance as measured by the Summary-Hospital Level Mortality Indicator (SHMI) has also improved throughout the year. The Trust has continued to focus on quality improvement through the ongoing delivery of its 'Improving Together' programme which is demonstrating further improvements with key projects that underpin clinically effective, safe care resulting in positive experiences.

This annual quality account is designed to outline the Trust's progress against a wide variety of indicators and to the best of my knowledge the information contained within this report is accurate.

Whilst the Trust has made significant progress, there is still much to do. The work to maintain this progress and ambitiously pursue further improvements is underway.

One particular area of focus is staff engagement. The most recent staff survey results from 2018 demonstrate some improvements, but demonstrate this is still a key area. During 2017 and 2018 significant investment into initiatives designed to listen to staff feedback and act on this have been made, with some good results. I am particularly proud of the Trust's Pride and Respect campaign, which has grown in strength during 2018, driven by the organisations workforce to provide our teams of staff with access to additional support where necessary.

The Trust Board and I, continue to focus on effective communication and providing increased visibility to our teams. This has highlighted to us the incredible work achieved on a day to day basis. We remain determined to recognise these efforts and support our teams to get what they need to provide great care, supporting the Trust's ambition to get to good by consistently providing high quality care, with respect and in line with our common values.



Dr Peter Reading,

Chief Executive Officer

25 March 2019

About Northern Lincolnshire and Goole NHS Foundation Trust

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

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

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

Executive summary of key points

5 Quality Priority Themes for 2018/19:

The Trust set out 5 key quality priority themes for focus on within 2018/19, which were:

1. Safety – specific focus on pressure ulcers, recognition of the deteriorating patient and mortality indicators.
2. Safe emergency care – specific focus on access to non-elective care and flow through our hospitals.
3. Safe planned care – specific focus on cancer care, 52 week waits and clinical harm reviews.
4. Safe maternity care.
5. Safe staffing and improved staff engagement.

Understanding Trust performance against these themes has been based on a number of indicators that are reported on within the integrated performance report (or other internal reporting mechanisms) to the Trust's Board. Whilst the quality priority themes have remained the same, some of the indicators used to support understanding of performance against these themes may have changed or been refined during the 2018/19 year.

The executive summary outlines key performance against these quality priority themes. For a more detailed narrative and explanation of performance, see part 2.1 of this report.

The Trust's quality priority themes for 2019/20 are also described within this executive summary, which demonstrate the continued focus on some of the work streams commenced during 2018/19 into next year. More detail is available in part 2.1f.

*****HELP NOTES: How to interpret the summary of performance during 18/19:*****

The reported performance that follows uses a summary table, which is designed to demonstrate, at a glance, performance during 18/19. To help the reader understand this, the following is designed to guide understanding of key points.

THEME 1: SAFETY - Specific focus: Pressure Ulcers, Recognising Deteriorating Patient & Mortality		Most recent data Jan-19		Previous data Dec-18	Trending	Target	Benchmark Data	Source of Target
1.5	MRSA (Hospital acquired) (Year to date: 0)	0	G	0		0	SAME	National
	C Diff: infection rate - lapse in care (Year to date: 5)	0	G	0		20 lapses in care	No benchmark	National
	Gram Negative Blood Stream Infections (GNBI) (Year to date: 62)	4	R	10		52	No benchmark	National

Performance against 2018/19 Quality Priority Themes:

THEME 1: SAFETY – Specific focus on pressure ulcers, recognition of the deteriorating patient and mortality indicators:

	THEME 1: SAFETY - Specific focus: Pressure Ulcers, Recognising Deteriorating Patient & Mortality	Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19	Jan-19				
1.1	Pressure Ulcers per 1,000 bed days (Acute)	Not yet available	1.73		TBD	Work underway to assess Trust benchmarked position with NHSi support	TBC
	Pressure Ulcers: Grade 2 (Acute)	35 R	40		30		Local
	Pressure Ulcers: Grade 3 (Acute)	9 R	15		6		Local
	Pressure Ulcers: Grade 4 (Acute)	0 G	0		0		Local
	Pressure Ulcers - Community (North Lincolnshire)		79		TBD		TBC
		Feb-19	Jan-19				
1.2	Early Warning Score (NEWS) - Recorded on time	75.54% R	73.16%		>90%	No benchmark	Local
		Jan 18-Dec 18	Oct 17 - Sep 18				
1.3a	Summary Hospital-Level Mortality Indicator (SHMI)	112	113		100	SAME (117/130) Jan 18-Dec 18	National
	Position vs peers	As Expected G	Higher than expected		Within expected range		vs. Peer
		Dec-18	Nov-18				
1.3b	Hospital Standardised Mortality Ratio (HSMR)	110 G	110		100	SAME (As Expected)	National
		Mar-19	Feb-19				
1.4	Falls per 1,000 bed days	Not yet available	3.89		TBD	No benchmark	TBC
	Falls: No harm	79 G	74		80	No benchmark	Local
	Falls: Minior harm	37 G	48		40	SAME (65/132) Q2, ST Falls with harm	Local
	Falls: Moderate harm	0 G	2		0		Local
	Falls: Major or catastrophic harm	1 R	0		0		Local
1.5	MRSA (Hospital acquired) (Year to date: 0)	0 G	0		0	SAME	National
	C Diff: infection rate - lapse in care (Year to date: 5)	0 G	0		20 lapses in care	No benchmark	National
	Gram Negative Blood Stream Infections (GNBI) (Year to date: 76)	3 R	6		52	No benchmark	National
1.6	Venous Thromboembolism (VTE) Screening rate (%)	93.70% R	91.40%		95%	AMBER (Safety Thermometer)	National

Key points:

- Overall, during the latter half of 2018/19, improvement has been seen against the quality indicators used to measure this quality priority theme.
- **Pressure ulcer** incidence, within the Trust's acute hospitals has shown significant reductions during the 18/19 period. Work is underway with NHS Improvement to provide greater understanding of the Trust's performance against a benchmark. Whilst this is underway, the Trust has confirmed that it is not an outlier in terms of the number of pressure ulcers reported.
- **Early Warning Scores recorded on time** has shown progress during the year, following the change in systems used to record this, from paper based to electronic recording. Performance at present is static and further work is underway with wards to

improve this area further. The Trust is aware that there are sometimes delays in entering patient observations onto the electronic system on wards, any delays from recording observations and entering these into the electronic system will adversely affect this indicators reported performance.

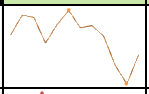
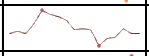
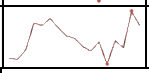
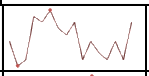
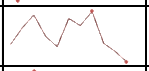
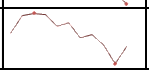
- **Mortality** performance has been measured during 18/19 using the national Summary-Hospital Level Mortality Indicator (SHMI), which includes deaths within the hospital and those within 30 days following hospital discharge, and the Hospital Standardised Mortality Ratio (HSMR). Both indicators are ratios that compare the actual number of deaths to a statistically calculated construct as to what would be expected. This construct is based on the quality of recorded and coded information. The Trust's performance against these indicators during 18/19 has shown improvement, with the 'official' SHMI indicator reducing and the HSMR reducing to demonstrate 'as expected' performance against the national average. The Trust has a strategy on reducing mortality that focusses on 3 specific areas: (1) medical model and improved access and flow around the Trust's hospitals, (2) recognition of the deteriorating patient (linked to the previous indicator assessing early warning scores recorded on time) and (3) learning lessons following retrospective review of deaths in our hospitals. The Trust's strategy closely aligns both Trust and community partners, recognising that these indicators are a reflection on healthcare systems performance, not just hospital provided care. For more information see part 2.1 of this report and later sections detailing mortality performance.

- **Falls** within the Trust have been decreasing as demonstrated by the trending over time.

- **Infection prevention and control indicators,** specifically the number of hospital acquired MRSA and *Clostridium Difficile* infections resulting from a lapse in clinical care, have demonstrated that systems in place are effective. The Trust has not had a Trust apportioned case of MRSA in the last 18 months. Gram Negative Blood Stream Infections (GNBI) is a newly measured indicator during 18/19 and demonstrated a higher than target number of infections. The Trust is working with community partners to reduce the number of patients being admitted to hospital from the community with GNBI aiming for a 50% reduction during 2019/20 in line with national aspirations.

- **Venous Thromboembolism (VTE)** is an indicator demonstrating the percentage of patients admitted who have documented evidence that their risks of acquiring VTE have been assessed, leading to preventative treatment. The Trust's performance during 18/19 has demonstrated improvement towards the 95% target, but performance during December and February has slipped. Work to ensure timely completion of the risk assessment document to evidence this are ongoing.

THEME 2: SAFE EMERGENCY CARE – Specific focus on access to non-elective care and flow through our hospitals

	THEME 2: SAFE EMERGENCY CARE - Specific focus: Access to Non-Elective Care and Flow Through Our Hospitals	Most recent data	Previous data	Trending	Target	Benchmark Data		Source of Target
		Mar-19	Feb-19					
2.1	A&E maximum waiting time of 4 hours from arrival to admission / transfer / discharge - Type 1 (%)	82.2% A	77.6%		90%	AMBER (vs. National)	SAME (vs. Local Peer)	National
2.2	Number of super stranded patients - 21+ days	81 R	82		< 61	No benchmark		National
2.3	Non elective length of stay	4.86 R	5.05		< 4.10	WORSE (4.1 days)		Local
		Feb-19	Jan-19					
2.4	Non elective length of stay - Medicine Division	6.5 R	5.9		< 4.10	WORSE (4.1 days)		Local
2.5	Early Warning Score (NEWS) - Recorded on time in Emergency Department - DPoW	62.3% R	63.87%		>90%	No benchmark		Local
2.6	Early Warning Score (NEWS) - Recorded on time in Emergency Department - SGH	69.0% R	64.64%		>90%	No benchmark		Local

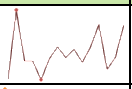
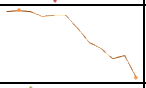
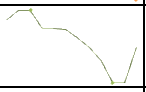
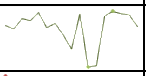
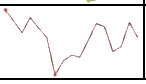
Key points:

- The Trust's performance against the **A&E 4 hour target** has not yet achieved the 90% goal, performance should be considered in the context of a growing demand on the Trust's urgent and emergency care services. When comparing November 2018 to November 2017, the Trust saw, on average, 18 more patients per day. Trust performance has been ahead that of local peer Trusts and has been consistent with the England average. Work continues to improve access and flow processes throughout the Trust's acute hospitals to support the emergency department meeting increasing demands. The Trust's community services have been working closely with colleagues in the acute sector and local authority to support patient flow from hospital and to develop alternatives to admission, supporting patients in their own homes as an alternative to admission where it is safe to do so. They have successfully piloted a new working model, where the patient's own home is used for care delivery, resulting in a 'virtual ward'.

- Patients who have been in hospital for long lengths of stay are referred to as **super stranded**, if in a hospital bed for more than 21 days. NHS Improvement set a target for the trust to achieve 61 days length of stay working as part of its local system. Such long lengths of stay reduce the number of available beds, resulting in increased pressure to urgent and emergency services, which can lead to increased waiting times in A&E. These long lengths of stay also result in poor patient experience and deconditioning of the patient resulting in further support required to enable discharge. Trending data demonstrates reductions during 2018/19. Whilst not yet achieving the target, there have been reductions which support the wider hospitals ability to cope with increased demands.

- Following a switch in the systems used to record and track patient's **early warning score (NEWS)** being recorded on time, performance has seen significant improvement across the Trust. In urgent and emergency care, performance with this indicator has remained static. The Trust is reviewing this data at individual ward and department level and are developing location specific improvement plans. This will continue to feature as a quality priority during 2019/20.

THEME 3: SAFE PLANNED CARE – Specific focus on cancer care, 52 week waits and clinical harm reviews

THEME 3: SAFE PLANNED CARE - Specific focus: Cancer Care, 52 Week Waits and Clinical Harm Reviews		Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19	Feb-19				
3.1	Treatment started within 62 days of urgent GP referral (cancer)	78.9% R	73.2%		85.0%	WORSE vs. Local Peers	National
3.2	Patients on an incomplete referral to treatment pathway waiting > 52 weeks	6 A	110		< 320 & Zero by 31 Mar	No benchmark	National
3.3	Patients on an incomplete RTT pathway: to be less than the Trust's March 2018 reported figure	28,551 G	27,055		< 29,396	WORSE vs. Local Peers	National
3.4	Clinical Harm reviews to be completed (cohort of patients with a due date prior to the 08 Aug 17)	100.0% G	99.0%		100%	No benchmark	Local
3.5	WHO Surgical Safety Checklist (Theatres)	98.7% G	99.5%		> 90%	No benchmark	Local
3.6	Maximum 6-week wait for diagnostic procedures	89.6% R	92.5%		> 99.0%	WORSE 97.6% (Nat), 98.4% (Local)	Local

Key points:

- The Trust have been focussed on delivering significant improvements against the **62 day GP referral to treatment for cancer** during 2018/19. Progress has been made and performance during the year has been improving as measured by this target. In recent months performance against the target has dropped below the trajectory set as there has been prioritisation of those waiting the longest amount of time. This work has reduced the number of patients waiting 62 days or more by 50% with a similar reduction for those waiting between 42-62 days. The Trust's main challenge for cancer pathways is access to diagnostics (endoscopy and CT scan). Both diagnostic areas have received significant funding to increase and renew medical equipment. This has resulted already in a new CT scanner on the DPoW site and the ongoing work to install an additional CT scanner at SGH which has also just become operational during early 2019. In endoscopy new equipment has been purchased which is enabling 7 day working with minimal operational downtime. These efforts will support further improvements against this target. See part 2.1 for more information.

- The **Maximum 6-week wait for diagnostic procedures** is not yet meeting the target set (>99%). This reflects the wider diagnostic challenges the Trust is facing, for which some investment has been successful in CT scanners and in endoscopy. There are still remaining challenges in meeting the demand for diagnostic investigations.

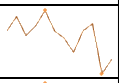
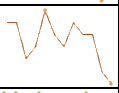
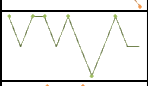
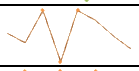
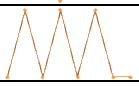
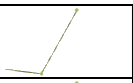
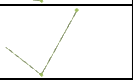
- **Patients on an incomplete referral to treatment (RTT) pathway waiting more than 52 weeks** has seen significant improvement during 2018/19 towards the Trust's quality aim of having zero patients waiting in excess of 52 weeks by the 31 March 2019. At the end of March, the Trust declared just 24 patients waiting more than 52 weeks, due to patient choice. See part 2.1 for further details.

- **Patients on an incomplete referral to treatment (RTT) to be less than the Trust's March 2018 reported figure** is a national target aiming to focus on reducing waiting lists across the NHS. The Trust's has demonstrated a reducing waiting list during the latter

half of the 2018/19 financial year, which is ahead of the Trust's improvement trajectory set and is moving towards the performance of other local providers.

- At the end of 2017/18 it was a key priority for the Trust to establish and embed an effective process to integrate **clinical harm reviews** into the Trust's focus on waiting list improvement. This was initiated and overseen by an external clinical harm review group, chaired by the NHS England Medical Director for the North of England. The principle focus of this groups work was to establish a clinical harm review process for a snapshot of patients who at the 8 August 2017 had waited in excess of 40 weeks for treatment or who were more than 6 months after their due follow-up date, or who had waited more than 104 days on a cancer tracking pathway. The Trust has now assessed and seen all of these patients. Part 2.1 of this report outlines in greater detail the work undertaken to date and that ongoing around clinical harm reviews in conjunction with the aforementioned waiting list improvement initiatives.

THEME 4: SAFE MATERNITY CARE

	THEME 4: SAFE MATERNITY CARE	Most recent data		Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19		Feb-19				
4.1	Ratio of midwives to births - DPoW	Currently not available					No benchmark	Local
4.2	Ratio of midwives to births - SGH	Currently not available					No benchmark	Local
4.3	Where a woman needs an initial CTG, this is commenced within 30 minutes of arrival	91.0%	A	89.0%		100%	No benchmark	Local
4.4	Where a woman in labour has a CTG undertaken fresh eyes reviews should occur at least every 2 hours for the duration of monitoring	93.0%	A	94.0%		100%	No benchmark	Local
4.5	Rolling still birth rate (Year to date: 16)	1		1		TBD	BETTER Rolling 12 month 4.7 per 1,000 births (Nat)	TBC
4.6	1:1 care in labour for women not having a cesarean section	Not yet available		99.50%		TBD	No benchmark	TBC
4.7	Number of Serious Incidents relating to Maternity services (Year to date: 7)	1		1		TBD	No benchmark	TBC
		Q3 18/19		Q2 18/19				
4.8	Antenatal referral for suspected Small for Gestational Age (SGA) or Fetal Growth Restriction (FGR)	62.4%	G	51.6%		>above UK average	BETTER 47.6% (Nat)	National
4.9	Small for Gestational Age (SGA) detected antenatally	53.0%	G	53.0%		>above UK average	BETTER 42.6% (Nat)	National

Key points:

- The **Ratio of midwives to births** data is currently unavailable as this is being validated against standard definitions to ensure accuracy of reporting.

- The Trust chose a priority indicator linked to the commencement of **cardiotocography (CTG)** to ensure that women who needed such investigations had no delays in accessing. This is a key form of monitoring used during pregnancy to monitor fetal well-being and to determine any indications where there is a need for more investigations. Performance has remained above 89% during 2018/19. Linked to this, **fresh eye reviews** are designed to reduce the risk of misinterpretation of a CTG trace. This was found to be effective in reducing the incidence of errors. The Trust has been focussed on ensuring that CTGs are reviewed by more than one person during the period of CTG monitoring, to reduce to the risk of errors and harm to women in the Trust's care. The Trust has maintained consistently high performance, exceeding 93% during 2018/19.

- The proportion of **still births** in the Trust is low and in line with the England average. Whilst public health and social factors affect the risk of still births, the Trust have been focussed on identifying the risk of still birth due to small for gestational age (SGA) and fetal growth restriction (FGR) in the use of **individualised growth charts.** The Trust uses the Perinatal Institute tool for this purpose and is performing above the UK average. Comparing this data with that of other UK centres shows that the Trust is proactively taking action to identify and act on the risk factors for still birth. See part 2.1 for more detailed information on this and the Trust's performance versus the UK average.

THEME 5: SAFE STAFFING, IMPROVED STAFF ENGAGEMENT & THE PATIENT VOICE

	THEME 5: SAFE STAFFING, IMPROVED STAFF ENGAGEMENT & THE PATIENT VOICE	Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19	Feb-19				
5.1	Safer staffing fill rate - registered staff	96.5% G	96.5%		80.0%	No benchmark	Local
5.2	Safer staffing fill rate - carer staff	100.00% G	99.00%		80.0%	No benchmark	Local
5.3	Care hours per patient day	Not yet available	7.3			WORSE 8.0 (Nat)	Local
5.4	Nursing staff vacancy - registered	8.6% A	8.4%		< 6.0%	No benchmark	Local
5.5	Nursing staff vacancy - unregistered	1.5% G	1.8%		< 2.0%	No benchmark	Local
5.6	Medical staff vacancy	14.50% G	14.00%		< 15.0%	No benchmark	Local
5.7	Proportion of temporary staff	8.80%	8.70%		TBD	No benchmark	
5.8	Mixed Sex Accomodation breaches	0 G	36		0	No benchmark	National
		Mar-19	Feb-19				
5.9	Friends and Family Test Results - A&E	75.2% R	73.00%		≥ 95.0%	WORSE 87.1% (Nat), 86.1% (Local)	Local
5.10	Friends and Family Test Results - Inpatient	99.0% G	99.10%		≥ 95.0%	BETTER 95.5% (Nat), 96.3% (Local)	Local
5.11	Friends and Family Test Results - Maternity	100.0% G	100.00%		≥ 95.0%	No benchmark	Local
5.12	Friends and Family Test Results - Community	99.2% G	98.20%		≥ 95.0%	BETTER 96.3% (Nat)	Local
5.13	Complaints - thematic analysis	See narrative					
5.14	Staff engagement: Pride and Respect - the Trust's anti-bullying campaign	See narrative					
5.15	Staff engagement: Listening to Improve	See narrative					
		2018	2017				
5.16	NHS national staff survey - overall engagement	6.5 G	6.4		> 6.4	WORSE 7.0 (Average)	Local
5.17	NHS national staff survey - "I would recommend my organisation as a place to work"	47.3% G	43.0%		> 43.0%	WORSE 62.6% (Average)	Local

Key points:

- **Safer staffing fill rates** is a measure of the extent to which rota hours on ward areas are being filled by registered nurses and midwives and unregistered care staff to enable ongoing monitoring of safe staffing for the Trust and to provide reassurance to local people that wards are safely staffed. The trending data demonstrates an increased fill rate by registered nurses and midwives. Un-registered carer staff shows have also exceeded the target set following a targeted recruitment programme during the latter part of 2018 which has led to a decrease in carer vacancies across the Trust.

- During 2018/19 the Trust set a vacancy target of <6% for registered nurses and <2% for unregistered carer staff. **Registered nursing staff vacancy rates** during the year had been increasing, largely as a result of the Trust rebasing its establishment needs for ward areas (i.e. reviewing the demands on each ward and resetting the number of trained nurses needed on that location) so in effect deciding that more staff were needed, rather than this being solely in relation to nursing staff retention rates. During November 2018 the vacancy rates reduced significantly towards the target. This remains a key priority for the Trust and part 2.1 of this report provides further details as to the work underway to reduce nurse vacancy rates.

- **Medical staff vacancy rate** is another challenge for many Trusts in the NHS. At the beginning of 2018, the Trust set an improvement target to reduce the medical staff vacancy rate to less than 15%. This has been a significant priority for the Trust and a variety of improvements have been undertaken to maximise the Trust's appeal to doctors from other areas to successfully recruit more medical staff, as well as ongoing clinical engagement work to listen to the medical workforce and aid and improve retention rates. The Trust has also invested significantly in improving the experience of rotating junior medical staff, with the opening of a new £16.4 million accommodation complex, called the Roost, on the DPoW site.

- In February 2019 the Trust reduced its Medical vacancy rate to fewer than 14% and has maintained this trajectory to close the 18/19 financial year and thus achieve the target set. This was supported by an above average junior doctor fill rate of 87% in August 2018 which was an improvement of 20% when compared with the previous year. A continued approach to reducing the Trust medical vacancy rate via innovative recruitment methods and meaningful engagement to aid retention, will be an ongoing priority for the Trust to ensure safe staffing. These local efforts have also been supported by the UK Government's lifting of the cap on staff from outside of the EU being able to apply to work in the UK on medical visas earlier during 2018. Included in part 2.1 of this report is an annual update on the work to manage medical staffing rota gaps.

- **Staff engagement, satisfaction and feedback** have been supported during 2018/19 as the Trust continued to focus on a number of work streams designed to improve engagement and support to staff within the organisation. Two specific pieces of work have been used, firstly Listening to Improve which has become a part of the much larger Pride and Respect – the Trust's anti-bullying campaign. Both of these work streams have focussed on listening to staff feedback and initiating actions in response to this feedback. These have resulted in a number of very positive outcomes, however, the Trust recognises that more time is needed to evaluate the outcomes from these programmes and is committed to focus on this as a long-term priority using the latest national staff survey results as a further catalyst for change and improvement. Part 2.1 of this report outlines in greater detail some of the staff engagement work being undertaken and more detail relating to the latest national staff survey findings and also an annual update on the Trust's Speaking Up arrangements.

- The Trust recognises too the importance of the **patient voice and listening to the feedback of patients and service users**. Whilst detailed in the at a glance is key performance against the Friends and Family Test, part 2.1 of this report also outlines greater detail about the work undertaken during 2018 to listen more acutely to patient feedback and some of the improvements made, as well as providing a summary of key feedback received. This section also includes an exciting update on improvements planned during 2019/20 to understand and act on this feedback even more comprehensively.

QUALITY PRIORITY THEMES 2019/20:

The Trust has agreed 5 priority areas for the following year:

1) **Clinical Effectiveness: Mortality reduction:**
   a. Mortality case note review work by clinical staff, key performance indicators;
   b. Patients able to die in their preferred place of death (end of life quality indicator);
   c. Reduction in the Trust's Summary Hospital-Level Mortality Indicator (SHMI).

2) **Patient Safety: Improved management of the deteriorating patient:**
   a. Monitoring and action taken in response to National Early Warning Scores (NEWS);
   b. Compliance with the Sepsis Six care bundle;

3) **Patient Safety: Medication safety**
   a. Reduction in omitted doses;
   b. Reduction in incidents relating to insulin;

4) **Patient Experience: Improved patient flow:**
   a. Embedding the use of the SAFER bundle to improve flow;
   b. Seven day services – improved performance against the priority 4 standards;

5) **Patient Experience: Cancer pathways:**
   a. Increased availability of straight to test diagnostics for suspected cancers;
   b. Improved cancer pathways.

Setting quality priority themes for 2019/20:
Reflecting on the Trust's performance against its quality priority themes set during 2018/19, the Trust's Acting Medical Director commenced a consultation exercise within the Trust that started during November 2018 to determine what the quality priorities for 2019/20 should be to continue the Trust's improvement journey. As a result of this collaborative approach, the first draft contained a wide variety of priority topics. Following subsequent discussion with public and staff governors, who represent the public at the Quality Review Group, following discussion within the Trust with divisions at the Quality Governance Group and also the Non-executive Director chaired Quality & Safety Committee, with CCG representatives present, the Acting Medical Director has facilitated a gradually focussing lens, to ensure the Trust and the Board have clarity on the organisations priorities for quality improvement during 2019/20.

How progress will be monitored and measured:

Performance against these quality priority themes will be monitored through the Trust's Integrated Performance Report by the Quality & Safety Committee for executive understanding of issues and oversight of actions necessary, the Performance Improvement Meetings, the Quality Governance Group and in terms of assurance, the Governors Quality Governance Group with reporting also directly to the Trust Board.

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

2.1 Priorities for improvement: overview of the quality of care against 2018/19 quality priorities & quality priorities planning for 2019/20

2.1a Theme 1: Safety – Specific Focus on Pressure Ulcers, Recognising the Deteriorating Patient and Mortality Indicators

Progress Made: (April 2018 – March 2019): During the 2018/19 period, the Trust's safety indicators (including pressure ulcers, recognising the deteriorating patient and mortality indicators) have demonstrated positive progress against the quality indicators used to measure.

[For at a glance performance against all indicators during 18/19 – see the executive summary]

Specific focus on: Pressure Ulcers:

THEME 1: SAFETY - Specific focus: Pressure Ulcers, Recognising Deteriorating Patient & Mortality		Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19	Feb-19				
1.1	Pressure Ulcers: Grade 2 (Acute)	35 R	40		30	Work underway to assess Trust benchmarked position with NHSi support	Local
	Pressure Ulcers: Grade 3 (Acute)	9 R	15		6		Local
	Pressure Ulcers: Grade 4 (Acute)	0 G	0		0		Local

- **Pressure ulcer** incidence within the Trust's acute hospitals has shown reductions during the 18/19 period, as demonstrated in the chart following (figure 1).

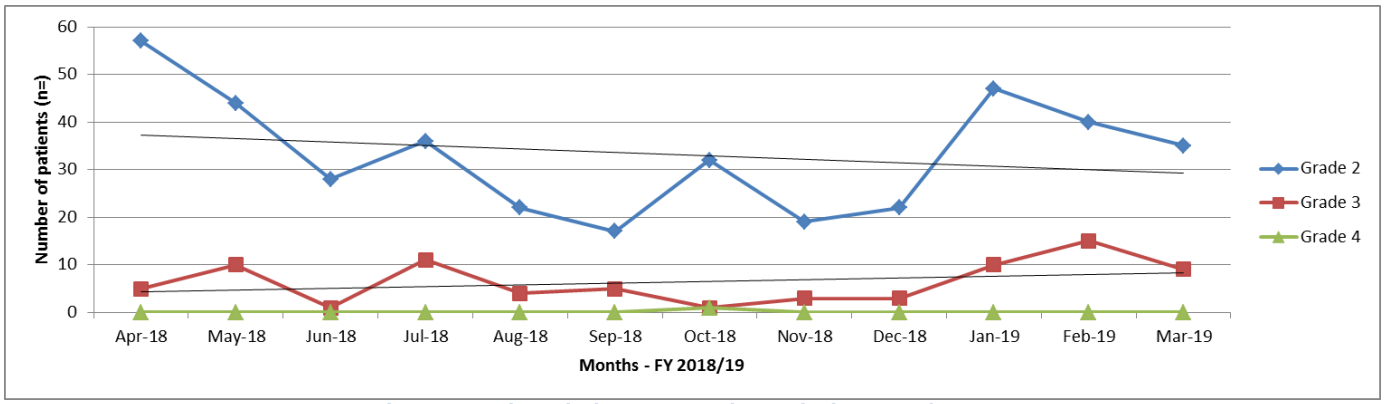


Figure 1: In hospital pressure ulcers during 2018/19

- Figure 1 details all reported acute pressure ulcers, recorded as incidents on the Trust's incident reporting system. The Trust has been working with NHS Improvement (NHSI) to determine comparator data relating to reported pressure ulcers to determine how the Trust compares. This work is still underway at the time of writing this report, but the Trust understands from NHSI that pressure ulcer reporting is not an outlier compared to other Trusts.

- Work to support further improvements in pressure ulcer prevention and management continues including more proactive support from Tissue Viability Nurses working alongside ward staff.

Specific focus on: Recognising the deteriorating patient

THEME 1: SAFETY - Specific focus: Pressure Ulcers, Recognising Deteriorating Patient & Mortality		Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Feb-19	Jan-19				
1.2	Early Warning Score (NEWS) - Recorded on time	75.54% R	73.16%		>90%	No benchmark	Local

- **Early Warning Scores recorded on time** has shown progress during the year, following the change in systems used to record this, from paper based to electronic recording. The benefits of electronic recording are that performance against this indicator measures all admitted patients, not a sample. This information is reported at ward level within a deteriorating patient scorecard, to support wards assess their performance against this indicator in order to support localised improvement plans. The Trust is aware that there are still some data quality issues including some delays in entering details of patient observations onto the electronic system and inconsistent recording of criteria that mean NEWS observations are not appropriate (i.e. end of life care). Any such delays or inconsistencies in entering these into the electronic system will adversely affect this indicators reported performance.

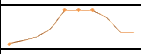
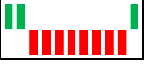
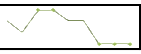
- Using this data, the Trust has identified there are some differences between performance across the Trust's hospital sites. With this data being reported at ward level and provided to individual ward managers and matrons in the deteriorating patient scorecard, this provides localised development and tracking of improvement initiatives. The Deteriorating Patient Group oversees this data and the improvement plan, so that ward specific support is more targeted to areas where performance is below certain thresholds. This group is also looking at data quality issues, IT and equipment problems as well as training needs for clinical staff.

- Focus on this indicator will continue during 2019/20 as this will remain as one of the Trust's 5 quality priorities and will expand to include a focus on the action taken as a result of NEWS observations and monitoring.

- Included in the 19/20 quality priorities is also sepsis pathway adherence. During 18/19 the Trust monitored performance with sepsis by sampling patients admitted or already in hospital with sepsis on a regular basis, using the national CQUIN (Commissioning for Quality and Innovation) indicator. During November 2018, the Trust incorporated within its electronic ward based system, alongside NEWS, an electronic screening tool for sepsis. From this, the Trust is working towards further ward level reporting of performance for all patients. To embed this, during 19/20, this is listed as a distinct quality priority alongside taking appropriate action in response to both NEWS and sepsis.

- The Trust recognises the impact of sepsis on patient outcomes, and this focus is aimed at improving outcomes for our patients.

Specific focus on: Mortality Indicators

	THEME 1: SAFETY - Specific focus: Pressure Ulcers, Recognising Deteriorating Patient & Mortality	Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Jan 18-Dec 18	Oct 17 - Sep 18				
1.3a	Summary Hospital-Level Mortality Indicator (SHMI)	112	113		100	SAME (117/130) Jan 18-Dec 18	National
	Position vs peers	As Expected G	Higher than expected		Within expected range		vs. Peer
		Dec-18	Nov-18				
1.3b	Hospital Standardised Mortality Ratio (HSMR)	110 G	110		100	SAME (As Expected)	National

- **Mortality** performance has been measured during 18/19 using the Summary-Hospital Level Mortality Indicator (SHMI), which includes deaths within the hospital and those within 30 days following hospital discharge, and the Hospital Standardised Mortality Ratio (HSMR). These are both commonly referred to as Standardised Mortality Ratios (SMR).

- Both indicators are ratios that compare the actual number of deaths to a statistically calculated construct as to what would be expected. This construct is based on the quality of recorded and coded information. (It is important to note that national guidance makes clear that these indicators are not to be confused with measures of service quality). The Trust's performance against these indicators during 18/19 has shown some improvement with the 'official' SHMI indicator reducing and the HSMR also showing positive signs of reduction. The Trust's most recent data demonstrates the SHMI as being 'as expected'.

- The Trust also monitors crude mortality (the simple arithmetic ratio comparing number of deaths to the number of admissions) and has seen an improvement on last year. The crude number of deaths for January – December 2018 reduce to 1.43%, from 1.58% (January – December 2017) which is lower than the local peer group (1.52%) the Trust benchmarks performance against.

- For more detailed information regarding the Trust's work on reducing mortality, please refer to part 2.2i.

- Other aspects of the Trust's focus on mortality has been by assessing cardiac arrest rates which are reported at ward level as part of the ward owned deteriorating patient scorecards. This will feature more within the work of the Trust's Mortality Improvement Group.

Specific focus on: Gram Negative Blood Stream Infections (GNBI)

	THEME 1: SAFETY - Specific focus: Pressure Ulcers, Recognising Deteriorating Patient & Mortality	Most recent data		Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19		Jan-19				
1.5	MRSA (Hospital acquired) (Year to date: 0)	0	G	0		0	SAME	National
	C Diff: infection rate - lapse in care (Year to date: 5)	0	G	0		20 lapses in care	No benchmark	National
	Gram Negative Blood Stream Infections (GNBI) (Year to date: 76)	3	R	6		52	No benchmark	National

- **Infection prevention and control indicators,** specifically the number of hospital acquired MRSA, *Clostridium Difficile* infections resulting from a lapse in clinical care have demonstrated during 18/19 effective procedures in place to prevent and control hospital infections. The Trust has met its target of having no more than 20 *C. Difficile* cases resulting from a lapse in care. There has been zero Trust apportioned cases of MRSA in the last 18 months. Gram Negative Blood Stream Infections (GNBI) is a newly measured indicator during 18/19 and has demonstrated a higher than target number of infections.

- Gram Negative Blood Stream Infections (GNBI) are primarily made up of E. coli bacteraemia blood stream infections. The Secretary of State for Health has launched an ambition for healthcare associated blood stream infections to be reduced by 50% by 2021. The majority of such infections occur in the community, prior to a patient being admitted, therefore for any targeted reduction work to be successful; a whole health system approach is needed. During 2018/19 the Trust, along-with local Clinical Commissioning Groups (CCGs), local system partners and specialist teams including those providing continence and care for the elderly, worked together to develop a GNBI reduction plan. This plan has focussed on specific high prevalence areas such as diagnosis and treatment of urinary tract infections, the use of urinary catheters and options for reducing their use in practice when appropriate. This reduction plan is overseen by a Northern Lincolnshire Infection Prevention and Control Group which has been established by the CCG. This multi-agency group will continue work together on a joint approach to achieve a targeted reduction of GNBI in line with the 50% reduction target by 2021.

Patient outcomes: What does this mean for patients accessing Trust services?

Theme 1 – Safety:

- The Trust has improved safety by reducing the number of hospital acquired pressure ulcers;
- The Trust has made safety improvements with the tracking and recording of early warning scores using an electronic system, and plan further improvements during 2019/20, as this will continue to feature as a quality priority;
- The Trust has maintained safety by having had zero MRSA infections, and only a small number of C Diff infections, caused by omissions in clinical practice;
- GNBI infections reported have been above the safety target being aimed for, however, a plan is in place with local health partners to target on patients with this infection in the community, prior to any hospital attendance;
- Screening for VTE has not yet achieved the safety target being aimed for, with an average of 93% of admitted patients having evidence of screening being completed. The Trust are working to improve safety further in this area, ensuring this is reported internally to the Trust Board for assurance that action is being taken.

Progress monitored, measured and reported: Progress with these indicators is monitored within the integrated performance report and as such is reported to the Quality Governance Group, Quality & Safety committee and the Trust Board.

Whilst the quality priority theme has remained the same throughout 2018/19, some of the indicators planned during 18/19 to aid understanding of Trust performance have either not been measured or changed, these include:

- Cardiac arrest indicators – as referred to within the focus on mortality section, these have been reported at ward level and will be used more as part of the Mortality Improvement Group's focus on mortality indices and learning from mortality reviews,
- Appropriate clinical response taken in response to NEWS – as referred to within the focus on deteriorating patient section, during 18/19 the focus has been to embed the use of electronic recording and monitoring of NEWS observations, now these systems are in place, the next phase of the Trust's improvement plan (and therefore a quality priority for 19/20) will be appropriate action taken following NEWS observations,
- Sepsis bundle compliance – as referred to within the focus on mortality section, the Trust has monitored performance against the Commissioning for Quality & Innovation (CQUIN) sepsis scheme, however, this does not provide full assurance as it does not assess all patients admitted neither does it focus on all elements of the sepsis pathway, therefore, this will feature as part of the 19/20 quality priorities to be measured and reported on.

Relationship to 2019/20 Quality Improvement Priorities: The following 18/19 indicators are to remain as quality priorities during 2019/20:

- NEWS – appropriate action taken in response,
- Mortality improvement,
- Sepsis six bundle compliance.

2.1b Theme 2: Safe Emergency Care – Specific focus on access to non-elective care and flow through our hospitals

Progress Made: (April 2018 – March 2019): During the 2018/19 period, the Trust's safety indicators for emergency care have not yet met the performance being aimed for, however, on the whole, these demonstrate improvement over time.

[For at a glance performance against all indicators during 18/19 – see the executive summary]

Specific focus on access to non-elective care and flow through our hospitals:

THEME 2: SAFE EMERGENCY CARE - Specific focus: Access to Non-Elective Care and Flow Through Our Hospitals		Most recent data	Previous data	Trending	Target	Benchmark Data		Source of Target
		Mar-19	Feb-19					
2.1	A&E maximum waiting time of 4 hours from arrival to admission / transfer / discharge - Type 1 (%)	82.2% A	77.6%		90%	AMBER (vs. National)	SAME (vs. Local Peer)	National
2.2	Number of super stranded patients - 21+ days	81 R	82		< 61	No benchmark		National
2.3	Non elective length of stay	4.86 R	5.05		< 4.10	WORSE (4.1 days)		Local
		Feb-19	Jan-19					
2.4	Non elective length of stay - Medicine Division	6.5 R	5.9		< 4.10	WORSE (4.1 days)		Local
2.5	Early Warning Score (NEWS) - Recorded on time in Emergency Department - DPoW	62.3% R	63.87%		>90%	No benchmark		Local
2.6	Early Warning Score (NEWS) - Recorded on time in Emergency Department - SGH	69.0% R	64.64%		>90%	No benchmark		Local

- The Trust's performance against the **A&E 4 hour target** has not yet achieved the 90% target aimed for. However, this performance should be considered in the context of growing demand on the Trust's urgent and emergency care services. When comparing November 2018 to November 2017, the Trust saw on average, 18 more patients per day. Urgent and emergency services in the Trust also came under increased pressure. Despite these challenges, the Trust's performance over time shows an improving trend. When compared nationally, the Trust's performance has been better than the national average, as demonstrated by the following chart, for the period up until January 2019:

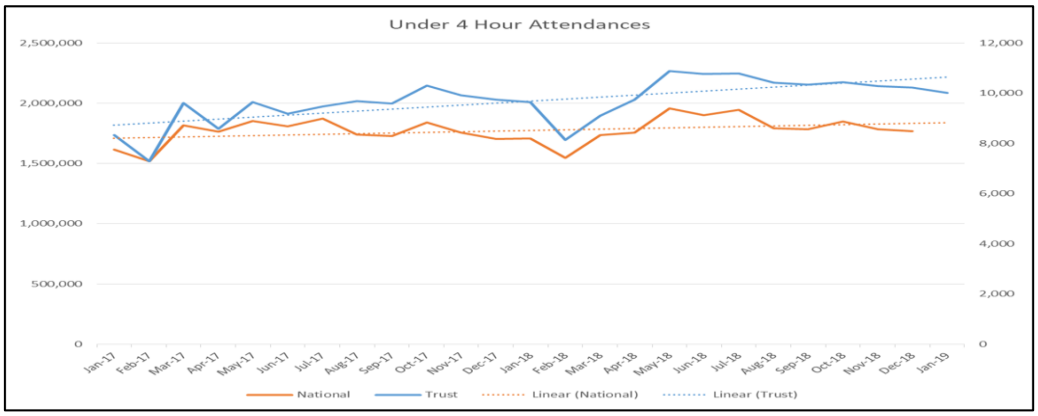


Figure 2: Trust A&E 4 hour target performance (blue line) contrasted against national performance (orange line) up until January 2019 (more recent national data not yet available at time of writing)

- Mitigation of these demands on the service have been planned through increased use of rapid assessments and triage, increased A&E consultant availability until midnight and increased senior nursing cover all shifts until 1am, as well as collaborative work to agree on and trial new multi-disciplinary assessment pathways aimed at improving flow.

- The Trust's community services have been working closely with colleagues in the acute sector and local authority to support patient flow from hospital and to develop alternatives to admission, supporting patients in their own homes as an alternative to admission where it is safe to do so. They have successfully piloted a new working model, where the patient's own home is used for care delivery, resulting in a 'virtual ward'.

- Another related quality indicator linked to flow through the Trust's hospitals is one focussed on those patients who have been in hospital for long lengths of stay. This group of patients are referred to as **super stranded**, if in a hospital bed for more than 21 days. Such long lengths of stay reduce the number of available beds which results on increased pressure in urgent and emergency services, leading to increased waiting times in A&E. The Trust is actively working to reduce the numbers of super stranded patients. At present the target has not yet been met, but the trending chart below demonstrates significant reductions during 2018.

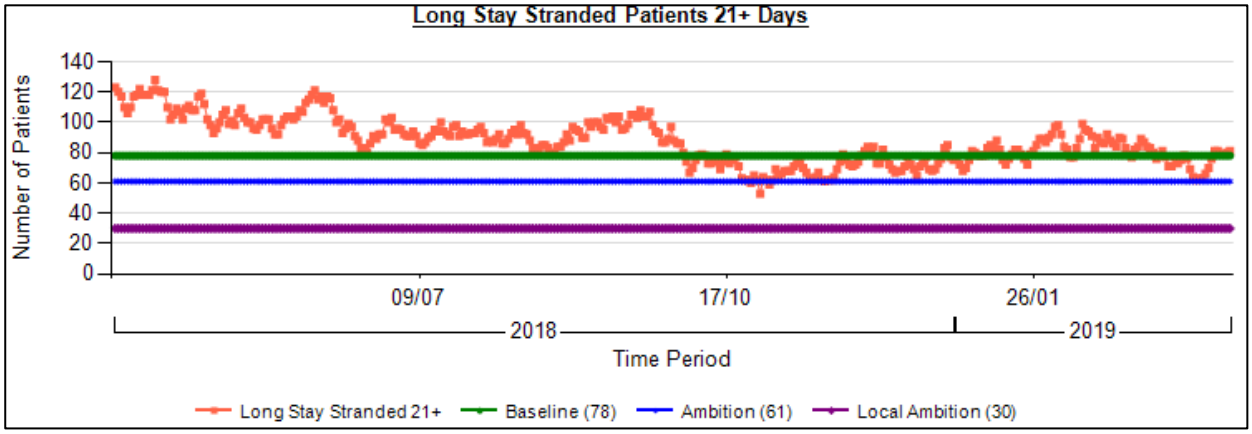


Figure 3: Statistically significant reduction during 2018/19 of the number of patients staying 21 or more days within the Trust's hospitals

- **Non-elective length of stay** is another indicator related to flow. These are not yet meeting the target set, but the trend in Medicine is reducing. A focus on improvements in these areas will mean that patients admitted, as a result of a range of interventions, are staying in hospital for less time, minimising the risk of a loss of independence through immobility for longer than necessary and associated risks of infection.

- These 3 quality indicators have provided the basis for a focus on access and flow through the Trust's hospital services. These are all elements that support the Trust's improvement

journey and are elements of the **SAFER[1] care bundle**. This bundle contains other elements that are designed to support effective throughput, including accessing senior decision making sooner during the admission process, more senior clinician led ward and board rounds and implementation of related seven day service standards. During 2018, the Trust has engaged with an NHS Improvement collaborative project where two of the Trust's wards have worked to implement the SAFER care bundle, with another hospital in Leeds acting as a 'buddy' site for the two hospitals teams to share and learn best practice. The Trust is committed to spread and share this work to many more ward areas. This will be the focus of the 2019/20 quality priority around patient flow.

- **Other emergency department quality indicators** used by the Trust include the Emergency Department safety checklist which is a tool that acts as a reminder for staff to ensure the patients requiring clinical assessment via a 'majors' pathway, receive standardised treatment and care planning. This provides operational benefits, particularly for any staff new to the department, encourages flow through the department, and includes reminders for nutrition and hydration to be assessed. This document is filed within the patient's records to form part of their permanent medical record.

Patient outcomes: What does this mean for patients accessing Trust services?

Patient outcomes: What does this mean for patients accessing Trust services?

Theme 2 – Safe Emergency Care:

- The Trust has performed better than the UK average during the bulk of the year in providing timely emergency treatment through its Emergency Departments, but aims to further improve;
- The number of patients who are in Trust hospital beds for long periods of time has shown positive reductions; this will continue to be a quality priority for 2019/20 and further improvements will be tracked.
- These indicators demonstrate the Trust is making positive progress with ensuring local patients, in a time of emergency, can access appropriate services to receive care and treatment in a timely manner.

Progress monitored, measured and reported: Progress with these indicators are monitored within the integrated performance report and as such is reported to the Quality Governance Group, Quality & Safety committee and the Trust Board. Data from the use of the Emergency Department safety checklist is unable to be reported, as this supports operational care at the point of treatment. Outcome measures from implementation of elements of the SAFER

[1] SAFER Care Bundle consist of the following principles: **S**enior Review before midday, **A**ll patients have an expected date of discharge, **F**low of patients from assessment and admission units as early as possible, **E**arly Discharge before midday and **R**eview by MDT for patients with extended lengths of stay (>7 days).

bundle/Red to Green is reported, but further work during 19/20 will provide further quality reporting with other elements of this bundle.

Relationship to 2019/20 Quality Improvement Priorities: The following 18/19 indicators are to remain quality priorities during 2019/20 to continue the improvement trajectory:

- Compliance with NEWS and the Sepsis Six bundle,
- Access and Flow, linking to the SAFER care bundle.

2.1c Theme 3: Safe Planned Care – Specific focus on cancer care, 52 week waits and clinical harm reviews

Progress Made: (April 2018 – March 2019): During the 2018/19 period, the Trust's performance with these indicators demonstrated positive progress. The Trust recognises there is more to do still, but recognises the improvement journey is underway. The 2019/20 quality priorities demonstrate the Trust's focus on improving key metrics still further.

[For at a glance performance against all indicators during 18/19 – see the executive summary]

Specific focus on cancer care, 52 week waits and clinical harm reviews:

THEME 3: SAFE PLANNED CARE - Specific focus: Cancer Care, 52 Week Waits and Clinical Harm Reviews		Most recent data		Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19		Feb-19				
3.1	Treatment started within 62 days of urgent GP referral (cancer)	78.9%	R	73.2%		85.0%	WORSE vs. Local Peers	National
3.2	Patients on an incomplete referral to treatment pathway waiting > 52 weeks	6	A	110		< 320 & Zero by 31 Mar	No benchmark	National
3.3	Patients on an incomplete RTT pathway: to be less than the Trust's March 2018 reported figure	28,551	G	27,055		< 29,396	WORSE vs. Local Peers	National
3.4	Clinical Harm reviews to be completed (cohort of patients with a due date prior to the 08 Aug 17)	100.0%	G	99.0%		100%	No benchmark	Local
3.5	WHO Surgical Safety Checklist (Theatres)	98.7%	G	99.5%		> 90%	No benchmark	Local
3.6	Maximum 6-week wait for diagnostic procedures	89.6%	R	92.5%		> 99.0%	WORSE 97.6% (Nat), 98.4% (Local)	Local

Specific focus on: Cancer care:

- The Trust has been focussed on delivering significant improvements against the **62 day GP referral to treatment for cancer** during 2018/19. Progress has been made and performance during the year has been improving, however, in recent months performance against the target has dropped below the trajectory set, as demonstrated by the chart below. This deterioration in overall performance is linked to the specific prioritisation of those patients on the waiting list for the longest time and this prioritised approach has led to sustained reductions of patients waiting the longest.

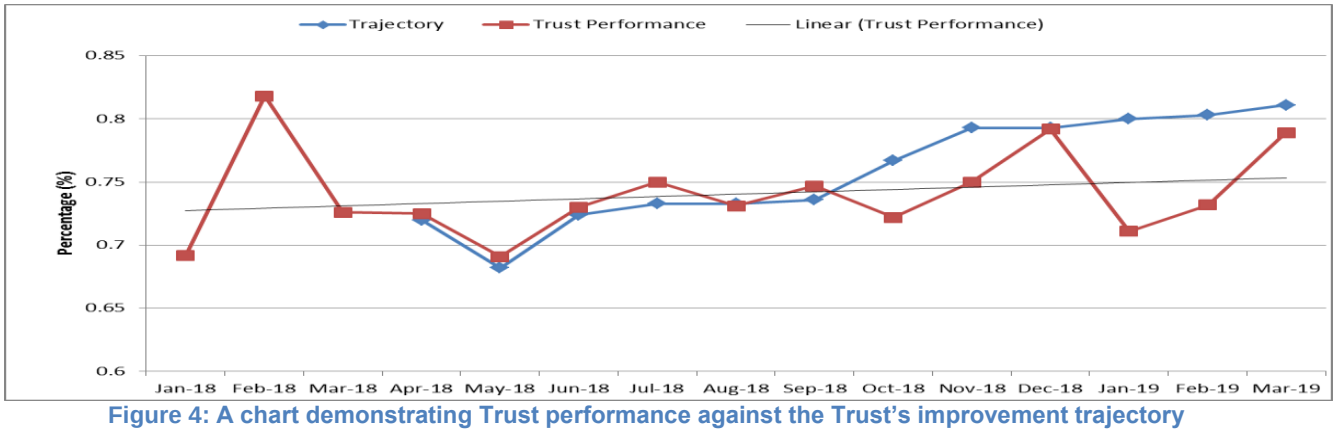


Figure 4: A chart demonstrating Trust performance against the Trust's improvement trajectory

- One of the key challenges for delivery of cancer pathways is access to diagnostics (endoscopy and CT scan). Both diagnostic areas have received significant funding to increase and renew medical equipment. This has resulted already in a new CT scanner on the DPoW site and the ongoing work to install an additional CT scanner at SGH recently becoming operational during April 2019. In endoscopy new endoscopes and equipment have been purchased enabling 7 day working with minimal operational downtime. These efforts will support further improvements against this target. Cancer pathways will remain an area during 2019/20 of focus for the Trust as a quality priority.

Specific focus on: 52 week waits

- **Patients on an incomplete referral to treatment (RTT) pathway waiting more than 52 weeks** have seen significant improvement during 2018/19 towards the Trust's quality aim of having no patients waiting in excess of 52 weeks by the 31 March 2019. This is demonstrated by the following chart which shows that the number of patients on an incomplete pathway has reduced significantly, ahead of the planned improvement trajectory. The Trust, at the end of March 2019, had only 24 patients waiting more than 52 weeks, work will continue to ensure there are zero patients waiting in excess of 52 weeks during 2019 and beyond.

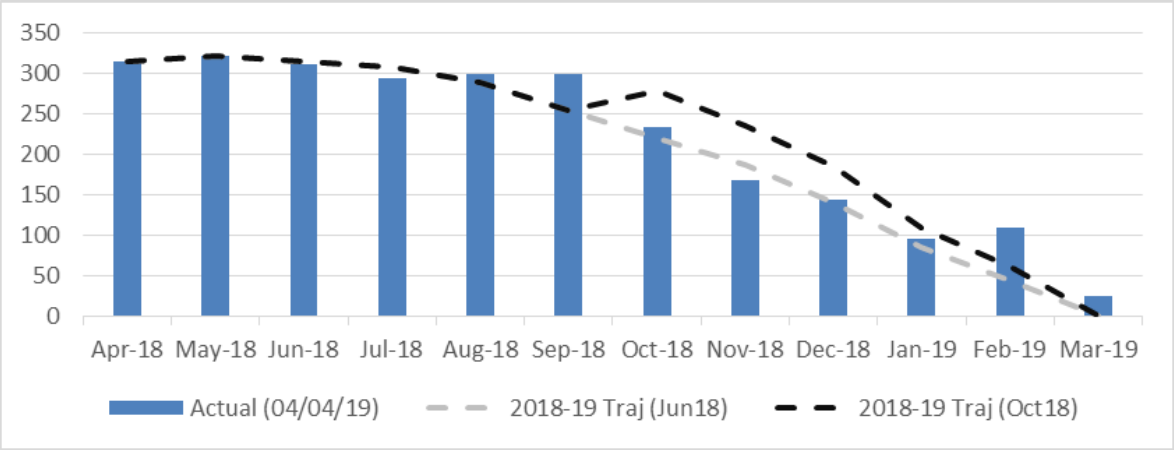


Figure 5: The number of patients on an incomplete pathway waiting more than 52 weeks has been reducing ahead of the planned improvement trajectory during 2018/19.

Specific focus on: Clinical Harm Reviews

- At the end of 2017/18 it was a key priority for the Trust to establish and embed an effective process to integrate **clinical harm reviews** into the Trust's focus on waiting list improvement to determine if any harm has arisen as a result of a delay in waiting for appointments and/or treatment and to take appropriate action for individuals if harm was deemed to have occurred.
- This was initiated and overseen by an external clinical harm review group, chaired by the NHS England Medical Director for the North of England. The principle focus of this groups work was to establish a clinical harm review process for a snapshot of patients who at the 8 August 2017 had waited in excess of 40 weeks for treatment or who were more than 6 months after their due follow-up date or who had waited more than 104 days on a cancer tracking pathway.
- The Trust established a bespoke system to track those patients that met the aforementioned criteria who required clinical review of their records by either a hospital or primary care clinician. If it was not possible to ascertain if any harm had resulted from the retrospective

review of case records, a face to face appointment or telephone appointment was made to review the patient to determine if any harm had resulted.

- During 2018/19 all patients identified within these cohorts have now been reviewed. In some cases, unfortunately, the reviews concluded that harm had occurred and the Trust have been open with these patients and are investigating their care pathways in greater detail as part of a Serious Incident Investigation. As part of this process, duty of candour will be completed, or in other words, the Trust will be open and transparent and apologise to those patients.
- This priority focus on retrospective clinical harm reviews has enabled the Trust to develop ongoing systems to ensure patient safety is a foremost consideration whilst looking at the performance of waiting lists and includes criteria and policy designed to ensure that clinical harm reviews are triggered by certain criteria.

Patient outcomes: What does this mean for patients accessing Trust services?

Patient outcomes: What does this mean for patients accessing Trust services?

Theme 3 – Safe Planned Care:

- The Trust has started to reduce the time taken for patients on a cancer pathway to receive treatment during the year. Specific prioritised attention has been given to those patients waiting the longest on pathways to good effect. Further improvements in waiting times are forecast. Cancer care will remain a quality priority for 2019/20;
- The Trust has reduced the number of patients waiting for more than 52 weeks for treatment following concerted focus to reduce patient waiting. The Trust finished the 2018/19 year with only 24 patients waiting on incomplete pathways for more than 52 weeks, due to patient choice, the Trust aims to have zero during 2019 and beyond;
- Recognising the Trust's challenge around waiting lists and the risk associated, the Trust have completed a large number of clinical harm reviews to provide assurance that waiting lists have not led to patient harm in the main, and where this has been identified, has enabled the Trust to be open with those affected and review individual pathways in greater detail to support a focus on learning. The Trust are working to ensure patient safety by a continued focus on reducing the waiting list first and foremost, as well as establishing clinical harm reviews as standard to assess the risk for harm resulting from waiting.

Progress monitored, measured and reported: Progress with these indicators is monitored within the integrated performance report and as such is reported to the Quality Governance Group, Quality & Safety committee and the Trust Board.

Relationship to 2019/20 Quality Improvement Priorities: The following 18/19 indicators are to remain as quality priorities during 2019/20:

- Further focus on improving cancer pathways.

2.1d Theme 4: Safe Maternity Care

Progress Made: (April 2018 – March 2019): During 2018/19, the Trust has demonstrated improved safety in maternity services.

At a glance performance during 18/19:

	THEME 4: SAFE MATERNITY CARE	Most recent data		Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19		Feb-19				
4.1	Ratio of midwives to births - DPoW	Currently not available					No benchmark	Local
4.2	Ratio of midwives to births - SGH	Currently not available					No benchmark	Local
4.3	Where a woman needs an initial CTG, this is commenced within 30 minutes of arrival	91.0%	A	89.0%		100%	No benchmark	Local
4.4	Where a woman in labour has a CTG undertaken fresh eyes reviews should occur at least every 2 hours for the duration of monitoring	93.0%	A	94.0%		100%	No benchmark	Local
4.5	Rolling still birth rate (Year to date: 16)	1		1		TBD	BETTER Rolling 12 month 4.7 per 1,000 births (Nat)	TBC
4.6	1:1 care in labour for women not having a cesarean section	Not yet available		99.50%		TBD	No benchmark	TBC
4.7	Number of Serious Incidents relating to Maternity services (Year to date: 7)	1		1		TBD	No benchmark	TBC
		Q3 18/19		Q2 18/19				
4.8	Antenatal referral for suspected Small for Gestational Age (SGA) or Fetal Growth Restriction (FGR)	62.4%	G	51.6%		>above UK average	BETTER 47.6% (Nat)	National
4.9	Small for Gestational Age (SGA) detected antenatally	53.0%	G	53.0%		>above UK average	BETTER 42.6% (Nat)	National

Key points:

- **Ratio of midwives to births** data is currently being validated to ensure accuracy of reporting, against agreed standard deviations. This will feature when available.

- **Cardiotocography (CTG)** is a key form of monitoring used during pregnancy to monitor fetal well-being and to determine any indications where there is a need for more investigations. The Trust therefore chose this as a priority indicator to ensure that women who needed such investigations had no delays in accessing. The target of 100% of women receiving this within 30 minutes of arrival has not yet been met; however, performance has remained above 89% during 2018/19.

- **Fresh eye reviews** are designed to reduce the risk of misinterpreting a CTG tracing. This was found to be effective in reducing the incidence of errors. The Trust has been focussed on ensuring that CTGs are reviewed by more than one person during the period of CTG monitoring to reduce to the risk of errors and harm to women in the Trust's care. The Trust are not yet achieving the 100% target set, but have maintained consistently high performance exceeding 93% during 2018/19.

- The **still birth** rate in the Trust is low, with a year to date figure of 16. This is in line with the England average. A review of all still births takes place with the intention to identify any improvements possible. Other factors influencing still births are public health differences which play a role. The Trust committed to reducing the risk of still births;

embedding individualised growth charts to support the identification of risks associated with still births.

- **Individualised growth charts** are an important part in identifying the risk of still births related to babies small for gestational age (SGA) or in danger of fetal growth restriction (FGR). As part of this, all pregnant women using the Trust's maternity services have an individualised growth chart generated. The Trust subscribes to, and uses systems supplied by, the Perinatal Institute which is a national not-for-profit organisation set up to enhance the safety and quality of maternity care. Whilst this is a non-mandatory system, the Trust are amongst 86 others in the UK to make use of this (alongside other centres across the world) to support standardising maternity records and fetal growth assessments. This features as part of the Better Birth Scheme and Saving Lives Care Bundle.

- As the growth chart is individualised to the woman, this enables tracking of the woman's pregnancy and supports continuity of care. Further the growth chart helps to identify any deviation from what is considered normal growth trajectory. Any such deviations can then be acted upon using agreed pathways of care referencing the Royal College of Obstetricians and Gynaecologist (RCOG) pathways and Perinatal Institute, including prompt scanning and induction of labour with the intention of preventing still births.

- The use of the Perinatal Institute growth charts also enables the Trust to compare itself with other participating units in the UK. This is available on a quarterly basis and assists understanding how the Trust compares with other units. This is summarised in the table below.

(b) SGA/FGR referral and detection rates[2]

- NB, Quarterly averages are displayed from the end of each quarter

	Q1 Apr-Jun 2018/19						Q2 Jul-Sep 2018/19						Q3 Oct-Dec 2018/19					
	SGA at birth[3]		Antenatal referral for suspected SGA/FGR		SGA detected antenatally[3]		SGA at birth[3]		Antenatal referral for suspected SGA/FGR		SGA detected antenatally[3]		SGA at birth[3]		Antenatal referral for suspected SGA/FGR		SGA detected antenatally[3]	
Hospital / Trust	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Diana, Princess of Wales Hospital	73	13.6	36	49.3	32	43.8	77	13.8	40	51.9	31	40.3	72	12.9	48	66.7	41	56.9
Goole & District Hospital	0	0.0	0	0.0	0	0.0	0	0.0	0	-	0	-	0	0.0	0	0.0	0	0.0
Scunthorpe General Hospital	57	14.1	32	56.1	25	43.9	51	12.8	26	51.0	16	31.4	45	11.3	25	55.6	21	46.7
Northern Lincolnshire & Goole Hospitals NHS Foundation Trust	130	13.8	68	52.3	57	43.8	128	13.4	66	51.6	47	36.7	117	12.2	73	62.4	62	53.0
GUA*		12.1		46.6		41.6		11.8		46.7		41.6		12.1		47.6		42.6

* GUA – GAP User Average – the average rate for all participating Units across the UK

Figure 6: Table summarising the Trust's performance with referral and detection of small for gestational age deviations against normal growth trajectory

- This table demonstrates:

    - **SGA at birth:** The number and percentage in each quarter of small for gestational age babies born compared to the UK average. In each quarter the Trust has a higher number of smaller babies than the UK average, which is linked to public health and social factors.

- **Antenatal referral for suspected SGA/FGR:** This demonstrates that the number and percentage of referrals – in other words the number of cases where the Trust took proactive action based on the individualised growth chart – for suspected SGA/FGR is higher in the Trust compared to the UK average.

- **SGA detected antenatally:** This demonstrates that the detection of babies who are small for gestational age using further imaging and scanning is higher than the UK average during quarter 3, in other words more babies were at risk of SGA than would have been expected, and in these cases further action would be taken including to induce labour to mitigate the risk of a stillbirth.

- Whilst the Trust is performing above the UK average, the Trust is always seeking to improve practice and learn lessons. A benefit of using the National Perinatal Institute methodology is that it enables the Trust to consider, from this data, if more action should have been taken, as part of retrospective reflection and if so, feedback learning from this review to staff involved in care delivery.

- The number of **Serious Incidents relating to maternity services** was also selected as an indicator to help focus on the incidence and learning from these.

- During 2018/19 the Trust had a Care Quality Commission (CQC) inspection of its services (for more details see section 2.2e of this report). The CQC review of the Trust's maternity services reflected the improvements made since their last visit in 2017/18 resulting in Trust maternity services improving to be rated as 'Good', overall. Linked to this, the Trust also received the results from the national Maternity survey which demonstrated high reported levels of patient experience.

- In March 2019 the Trust also received a MARS (Safeguarding Children's Board) Section 11 assurance visit to assess the Trust against its statutory duties outlined in Section 11 of the Children's Act. This visit covered maternity and paediatrics and the results of this assessment were positive demonstrating the Trust is promoting quality and safe care.

Patient outcomes: What does this mean for patients accessing Trust services?

Patient outcomes: What does this mean for patients accessing Trust services?

Theme 4 – Safe Maternity Care:

- The Trust has consistently provided CTG within 30 minutes of arrival to more than 89% of women, where this is required, and has ensured that the results from CTG have been reviewed by a second person. This ensures 'fresh eyes' on cases involving more than 93% of women to reduce the risk of CTG misinterpretation;

- More than 97% of women receive 1:1 care in labour;

- The Trust has a low proportion of still births and has embedded the use of the Perinatal Institute individualised growth charts to proactively identify babies at risk of small for gestational age (SGA) and act accordingly, demonstrating higher than average performance compared to the rest of the UK and at the same time reflecting on a case by case basis to determine what improvements are possible to do more to prevent still births.

Progress monitored, measured and reported: Progress with these indicators are monitored within the integrated performance report, the maternity scorecards and women's & children's audit programme.

Whilst the quality priority theme has remained the same throughout 2018/19, some of the indicators planned during 18/19 to aid understanding of Trust performance have either not been measured or changed, these include:

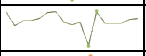
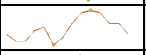
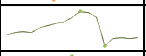
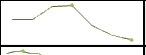
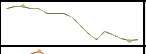
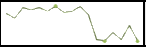
- Average fill rate midwives – this data is superseded by the Trust's focus on ratio of births to midwives, therefore this data has not been used to support an understanding of performance against this quality priority theme,
- Local Safety Standards in Invasive Procedures (LocSSIPs) – these will feature as part of the Trust's ongoing focus, overseen by the Quality & Safety Committee and the Performance Improvement Meetings during 2019/20.

Relationship to 2019/20 Quality Improvement Priorities: Maternity services do not feature within the 2019/20 quality improvement priorities for the Trust. The women's and children's division, however, will continue to focus on these and other quality metrics as part of their business as usual processes, overseen by their clinical governance group, which reports to the Trust's executive led Quality Governance Group. The Trust are proactively planning a suite of indicators to support the Board understand the work needed and progress against the reshaped CNST indicators, these will form the basis of the Women's & Children's Divisional reporting arrangements and will be focussed on patient safety.

2.1e Theme 5: Safe Staffing, Improved Staff Engagement and the Patient Voice

Progress Made: (April 2018 – March 2019): During the 2018/19 period, the Trust's focus on safe staffing has demonstrated considerable progress. Whilst not yet meeting the quality targets set, performance has improved throughout the year.

At a glance performance during 18/19: Safer Staffing

THEME 5: SAFE STAFFING, IMPROVED STAFF ENGAGEMENT & THE PATIENT VOICE		Most recent data		Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19		Feb-19				
5.1	Safer staffing fill rate - registered staff	96.5%	G	96.5%		80.0%	No benchmark	Local
5.2	Safer staffing fill rate - carer staff	100.00%	G	99.00%		80.0%	No benchmark	Local
5.3	Care hours per patient day	Not yet available		7.3			WORSE 8.0 (Nat)	Local
5.4	Nursing staff vacancy - registered	8.6%	A	8.4%		< 6.0%	No benchmark	Local
5.5	Nursing staff vacancy - unregistered	1.5%	G	1.8%		< 2.0%	No benchmark	Local
5.6	Medical staff vacancy	14.50%	G	14.00%		< 15.0%	No benchmark	Local
5.7	Proportion of temporary staff	8.80%		8.70%		TBD	No benchmark	TBC
5.8	Mixed Sex Accomodation breaches	0	G	36		0	No benchmark	National

Key points:

- Persons being admitted to the Trust for acute medical care have a right to ensure their care is provided in a way that protects their rights to privacy and dignity. **Mixed sex accommodation breaches** is an indicator to help the Trust understand how well it is balancing the access and flow pressures in order to provide urgent and emergency care against the rights of patients privacy and dignity. Mixed sex accommodation is particularly challenging to achieve in some of the Trust's small and specialist areas providing high levels of acute care. During 2018/19 the Trust and its commissioners were applying stringent rules to measure and report mixed sex accommodation breaches. Following guidance from NHS England in August, the Trust has agreed with its commissioners that its prior reporting was not in line with other NHS Trusts reporting, resulting in significantly inflated reported data. From September, using the new definitions and agreement for measuring this area has resulted in a significantly lower level of breaches being reported, in line with how this is measured nationally. Monitoring of mixed sex breaches will continue comparing against the agreed target of zero.

- Staffing is a critical component of providing safe, quality care; as such the Trust has focussed on this area throughout 2018/19 with regular updates to the Board. During the year, some significant improvements have been made with a lower turnover rate than reported in the previous 12 months, bringing the Trust in line with other Acute Trusts in the region. Improvements in the retention of medical staff in particular have supported this position. Retention of nursing staff remains a challenge, mainly due to relocation of nurses and retirement.

- Recognising the challenges with nurse staffing, the Board receives a regular report that outlines, in detail, the assurances available to demonstrate the Trust is ensuring the right staff, with the right skills, are in the right place at the right time. **Safer staffing fill rates**

is a measure of the extent to which rota hours on ward areas are being filled by registered nurses and midwives and unregistered care staff to enable ongoing monitoring of safe staffing for the Trust. The Trust is presently reporting performance that exceeds 90%. This demonstrates that the Trust is robustly able to record and manage nursing and midwifery staffing levels on a shift by shift basis.

- Another indicator that enables the Trust to benchmark the provision of registered nursing and midwifery staff alongside care staff is the **Care Hours per Patient Day data or CHPPD.** This is the total hours per day of registered nurses and midwives and care staff divided by the number of patients in the ward or department at 23.59 hours each night, therefore providing an average number of care hours per patient, per day. The overall Trust's Care Hours per Patient Day data is lower than the national average. The Trust, on an ongoing basis, reviews the establishments of staff on each ward (i.e. reviewing the demands on each ward and resetting the number of trained nurses needed on that location). This data will be one of the nursing metrics used to inform these regular establishment reviews. To ensure that staffing establishments on wards are accurate and correct further work is planned to roll out and embed the Safer Nursing Care Tool (SNCT). Whilst the Trust has used this data in the past, it has not been used to support establishment planning. One of the Trust's senior nurses is working on a collaborative programme with NHS Improvement to roll out and embed the use of this data as part of routine establishment review work with the aim of improving still further the focus on safer staffing at individual ward and department level.

- Across the NHS there is a well-publicised shortfall of registered nurses leading to most Trusts having nurse vacancy rates. To support this focus during 2018/19 the Trust set an ambitious vacancy target of <6% for registered nurses and <2% for unregistered carer staff. **Registered nursing staff vacancy rates** are currently above the target set, but have improved from the nursing vacancy rates reported during the early part of 2018. **Unregistered nursing vacancy rates** have reduced significantly from 9.18% in January 2018 to 1.5% in March 2019, therefore this reduction is positive. For both areas, The Trust continue to make use of innovative approaches during 2018/19 to recruit and fill vacancies as well as working hard to retain its existing nursing workforce and build up its internal staff bank to fill any vacancies with other Trust nursing staff who are able to work temporarily to support covering of rotas. Additional work has been completed to recruit to other posts in support of safer care for example additional clinical nurse specialists and preparing to interview newly qualified nurses for additional nursing staff to be appointed and allocated.

- The **Medical staff vacancy rate** has reduced significantly from a vacancy rate of 24% in January 2018 to meeting the Trust's target with a vacancy rate of 14.5% in March 2019. This is demonstrated in the chart that follows.

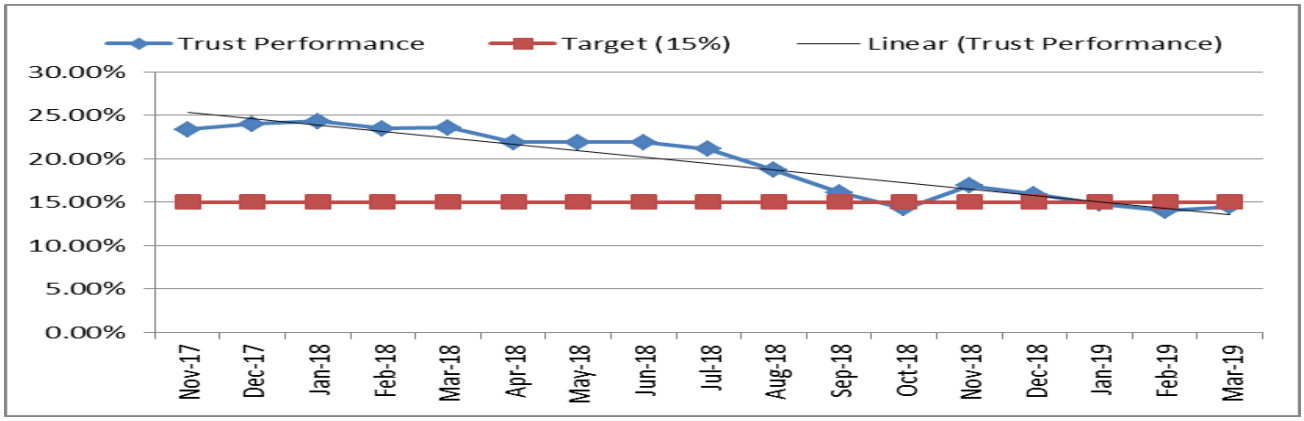


Figure 7: The reduction over 2018/19 of the medical staff vacancy rate

- This has been a significant priority for the Trust and a variety of improvements have been undertaken to maximise the Trust's appeal to doctors from other areas to successfully recruit more medical staff, as well as ongoing clinical engagement work to listen to the medical workforce and aid and improve retention rates.

- In March 2019 the Trust reduced its Medical vacancy rate to 14.5%. This has been supported by an above average junior doctor fill rate of 87% in August 2018 which was an improvement of 20% when compared with the previous year. A continued approach to reducing the Trust medical vacancy rate via innovative recruitment methods and meaningful engagement to aid retention, will be an ongoing priority for the Trust to ensure safe staffing.

- The Trust has ongoing plans to address medical and dental vacancies with 44 doctors waiting to start in the Trust between February and June 2019. Work continues to attract other doctors to the Trust to further recruit and commence them in post to support further reductions of the vacancy rate.

- The Trust has also invested significantly in improving the experience of rotating junior medical staff, with the opening of a new £16.4 million accommodation complex, called the Roost, on the DPoW site.

Annual Update on Rota Gaps:

- The Trust, compared with other Trusts in the Yorkshire and Humber region struggle to attract trainee grade doctors. Geographically the Trust is not well positioned which could contribute to these challenges. Rota gaps are therefore filled by the recruitment of permanent doctors, the use of agency locum and internal locum staff.

- Workforce and Recruitment meetings take place regularly with Medical Staffing and the groups to identify and plan for vacancies. Vacancies are advertised and active steps taken to follow up any interest in the area. Whilst the medical vacancy rate has reduced during 2018/19 staffing levels continue to give cause for concern and more is needed to be done to develop alternatives such as Physician's Associates (PA) and Advanced Clinical Practitioners (ACP). The Trust has developed a robust Workforce Strategy that incorporates these roles and is currently developing ACPs in the Trust with support from Health Education England Yorkshire and the Humber. Rota Co-ordination has improved in 2018 but there is still work to be done. The Trust is continuing its efforts to diversify the clinical workforce and thereby reduce sole reliance on medical staff.

At a glance performance during 18/19: Improved staff and patient engagement

THEME 5: SAFE STAFFING, IMPROVED STAFF ENGAGEMENT & THE PATIENT VOICE		Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19	Feb-19				
5.9	Friends and Family Test Results - A&E	75.2% R	73.00%		≥95.0%	WORSE 87.1% (Nat), 86.1% (Local)	Local
5.10	Friends and Family Test Results - Inpatient	99.0% G	99.10%		≥95.0%	BETTER 95.5% (Nat), 96.3% (Local)	Local
5.11	Friends and Family Test Results - Maternity	100.0% G	100.00%		≥95.0%	No benchmark	Local
5.12	Friends and Family Test Results - Community	99.2% G	98.20%		≥95.0%	BETTER 96.3% (Nat)	Local
5.13	Complaints - thematic analysis	See narrative					
5.14	Staff engagement: Pride and Respect - the Trust's anti-bullying campaign	See narrative					
5.15	Staff engagement: Listening to Improve	See narrative					
		2018	2017				
5.16	NHS national staff survey - overall engagement	6.5 G	6.4		>6.4	WORSE 7.0 (Average)	Local
5.17	NHS national staff survey - "I would recommend my organisation as a place to work"	47.3% G	43.0%		>43.0%	WORSE 62.6% (Average)	Local

- The Trust is working to ensure it has effective systems and processes in place to listen to the voice of the patient. During 2018/19 the Trust listened to patient's feedback from two primary sources: (1) Friends and Family Test results and (2) the feedback to the Trust via complaints, Patient Advice and Liaison Service (PALS) and compliments collated by the Trust's Patient Experience lead nurse. The following provides an update from these and includes exciting developments that will support he Trust hear the patients' voice to a greater degree during 2019/20.

- **Friends and family test and thematic analysis of other forms of patient feedback including complaints** are a way that the Trust understands the experience and voice of the patient. Whilst the friends and family test results demonstrates very high levels of satisfaction in most areas surveyed, the Trust is aware that the response rate is low, meaning that current satisfaction rates may not give the Trust an accurate or reliable indication. To ensure completeness of understanding going forward, the Trust has approved a business case for a new IT system and a dedicated patient experience team. This will enable easier ways for service users to provide feedback and enable greater levels of understanding of the results with interactive dashboards and the ability to design bespoke patient surveys to gain further understanding of the patient voice. This additional resource is being complimented by a review and refocus of the Friends and Family group with increased representation by divisions to work through the themes and understand the actions needed at divisional level to ensure action is taken in response to patient's feedback.

- **Complaints, PALS and compliments** are another source of feedback the Trust monitors and seeks to learn from. During 2018 the management of the central complaints team was moved to sit under the Trust's Patient Experience lead. This has enabled a greater triangulation of patient experience themes and has led to the development of a new patient feedback report which enables key points and feedback to be more widely shared for lessons learning. This increased triangulation of the patient voice and their experience has led to specific themes being identified. Key points identified from the quarter 3 report are summarised in the following infographic.

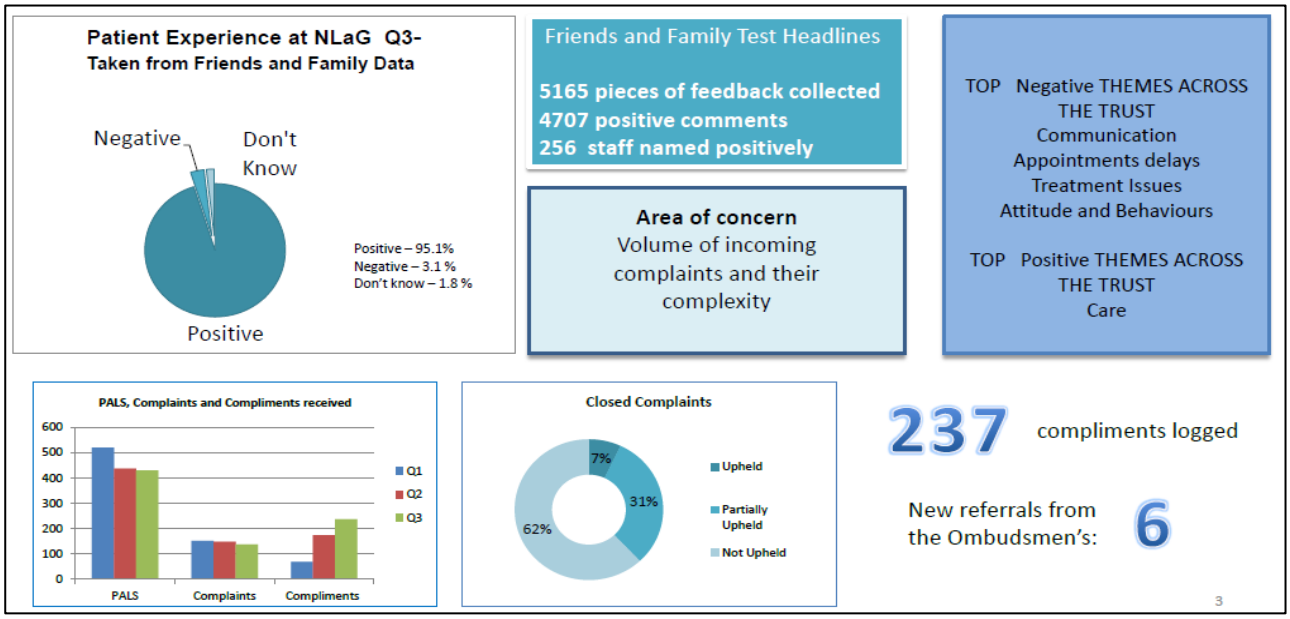


Figure 8: An infographic outlining key points from the quarter 3 patient experience report

- One of the themes identified by the quarter 3 report was in connection with staff communication with patients. This led to a workshop held to understand potential root causes for this theme linking with human factors awareness which will support planning next steps and additional training needs for staff interacting regularly with service users. Other key learning points from the quarter 3 report that have been shared for learning with operational divisions are:
    - More focus required on managing patient expectations and communication of delays/waiting times;
    - Further triangulation on communication, as this overlaps many different services and professionals;
- Actions taken in response to this patient feedback, to date, around these key findings include:
    - Feedback for A&E at Scunthorpe General Hospital related largely to waiting times within the department. This feedback has resulted in the Trust rolling out real time waiting information being displayed in the department to help manage patient expectations better. The greater focus going forward on themes emerging from patient feedback will further support the Trust closing the feedback loop.
    - Revised processes in outpatients where patients are now seen in the examination room to prevent the need for the patient to move to a new location for the procedure.
    - Ophthalmology consultants are kept updated and aware of up to date waiting times to enable them to brief patients to keep them updated and better manage their expectations to prevent anxiety or uncertainty.
    - As referred to already in this report, proactive work in train to reduce radiology delays.

- The Trust is also proactively working to collate compliments and share these in the same way as themes from complaints. Compliments received and shared include:

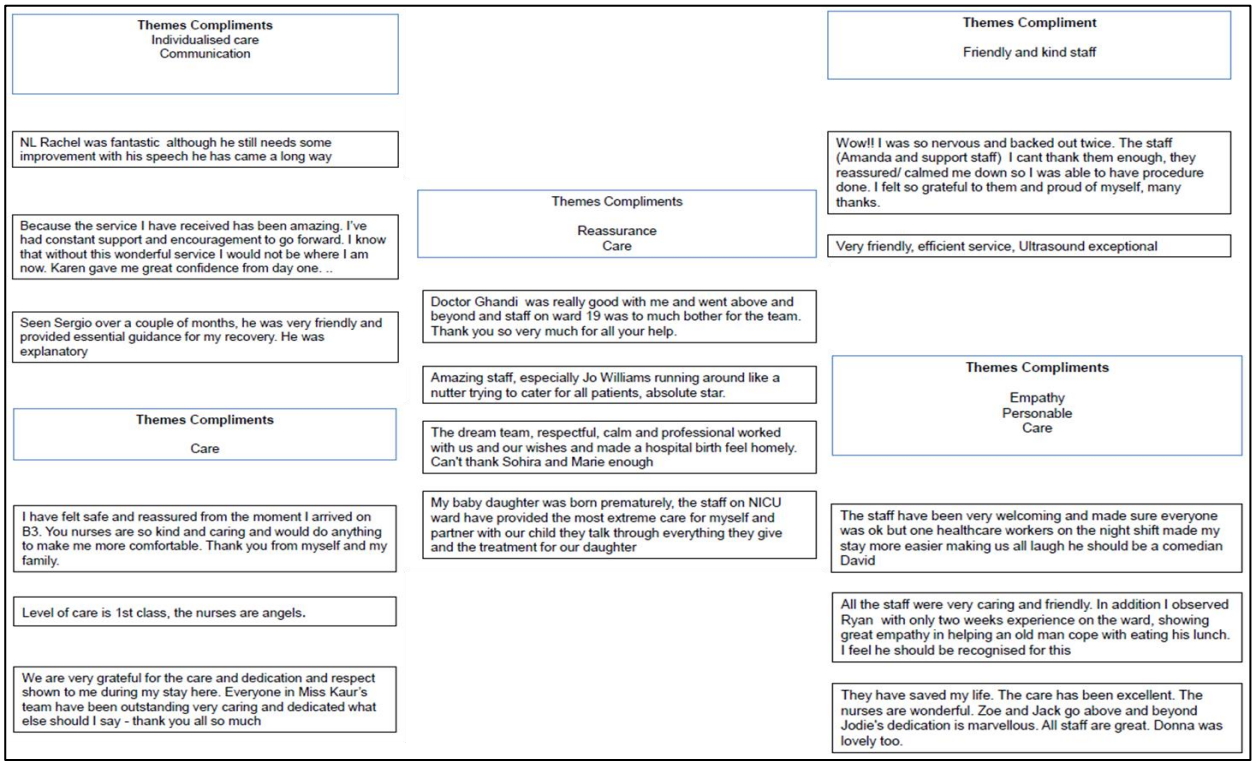


Figure 9 some of the compliment themes and comments received which feature in the patient experience report for quarter 3 and are shared, alongside other feedback, with operational divisions for sharing and learning

- Whilst this feedback is shared with operational divisions, it is also shared with the Trust Board. Another approach taken to listen to the voice of the patient is through the use of patient stories, like the example that follows.

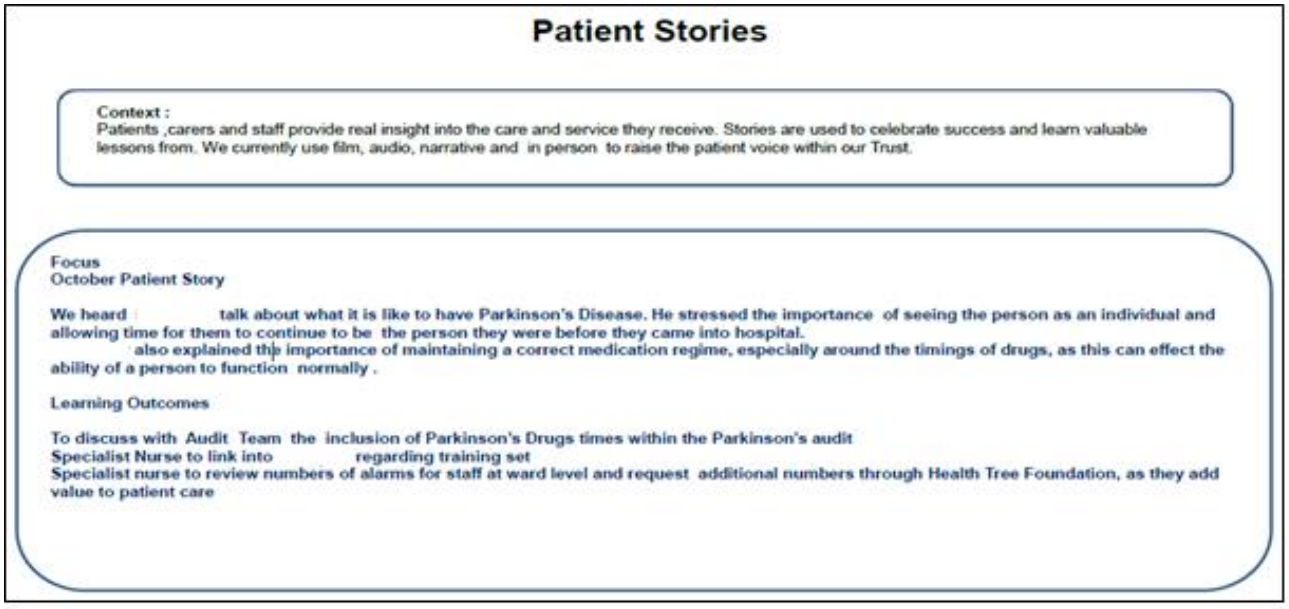


Figure 10 an example of one of the Trust's presented patient stories for understanding of the key issues to the patient and sharing of key learning and summary of actions taken in response

- We recognise that the Team has made some significant changes to the complaints process over this last year, including moving to a co-located model. However there is added focus on the number of complaints outside of our expected timescales, and the senior team are currently working with divisions to understand issues within the current process and work towards addressing these as a priority.

- Timeliness is also an important aspect of acting and responding to patient feedback to support and improve timely resolution of patient feedback via the Patient Advice and Liaison Service (PALS), the central team now work more within divisions, linking in with clinical staff on behalf of the patient to obtain quicker resolution.

- Good progress has been made with the triangulation, understanding and reporting of the patient's voice. The further investment and development of a patient experience team is therefore an exciting step forward and will enable the Trust to develop even further a more rigorous and targeted listening opportunities to understand further patient experience. This will also fundamentally strengthen the ability of the key themes from this feedback to be fed back to operational staff and divisions to support an approach to shared learning for improvement.

- **Staff engagement, satisfaction and feedback** are other important elements that the Trust needs to listen to and act in response. During 2017/18 the National NHS Staff Survey results for the Trust demonstrated a significant challenge for the organisation in terms of doing more to listen and act on feedback from its staff.

- During 2018/19 the Trust used Listening to Improve to help support staff with improvements to in their areas. The Trust has also developed Pride and Respect, the Trust's anti-bullying campaign. Both of these work streams were initiated on the back of staff feedback.

- **Listening to Improve** is about improving the quality and safety of patient care through listening to the Trust's workforce. During 2017/18 the Trust ran a 'pulse check survey' which resulted in 1,114 submissions of feedback. This helped understand the issues that lead to staff feeling less engaged in the Trust. Key issues identified were as follows:

    - 17% day to day frustrations;
    - 19% communications between senior management and staff;
    - 20% communicating goals and priorities.

- Following this listening event, 5 'crowdfixing' events were organised and attended by 315 staff to come together and talk through these issues and seek to identify remedies for some of the frustrations experienced.

- Following these events, a series of clinically prioritised projects were initiated to support improved quality in these areas led on by clinical staff with the aim of improving quality of patient care and responding to themes voiced at the listening or crowdfixing events. The outcomes of these projects were collated and shared widely, examples are shown below.

Figure 11: Examples of the Trust's Listening to Improve projects undertaken on the back of listening to staff feedback and supporting them to act to improve

- Other examples of positive outcomes from this initiative include:
    - **A data analyst forum** has now been established to support increased networking of colleagues doing similar roles and to support personal development as well as improved outcomes at work,
    - Following feedback regarding the **Medical Engineering service** there is now a 24/7 voicemail facility for staff to report faulty equipment,
    - From feedback regarding **wheelchairs**, charitable funds purchased 40 new wheelchairs that are now in use,
    - **Switchboard team's** ability to respond to internal phone calls in a timely manner was improved by now having two dedicated consoles during Monday to Friday 09:00-17:00 hours that enable a focus on internal calls.
- Another example of listening to feedback from staff is the work undertaken by the Trust's Undergraduate team who hold feedback focus groups with the HYMS medical students. Listening to experiences is also obtained following receipt of formal feedback from HYMS and Sheffield Medical Schools via university systems which are communicated back to tutors. These mechanisms allow the Trust to react swiftly to feedback received and act to improve the experience on our placements. Reports are sent to HYMS regularly throughout the year to report how the Trust is responding to feedback and the actions taken in response.

- **Pride and Respect**, the Trust's anti-bullying campaign has seen the recruitment of over 100 Pride and Respect Champions from a variety of different backgrounds, some of whom have further volunteered to help deliver a programme of proactive training comprising of a 2 hour session including training videos designed by the Trust based on specific needs, delivered by actors to support delivery of targeted messages across the organisations staff.

- To date more than 1,000 staff have attended Pride and Respect training sessions, which is a significant achievement as this remains a voluntary (non-mandatory) training session. Training sessions run weekly are trust wide and planned until December 2019. The course has received very positive feedback from participant's evaluation.

- Pride and Respect champions have attended development days and workshops covering issues such as managing conflict. In October 2018 Pride and Respect launched 'Let's talk' service which aims to help staff resolve their relationship problems. This service has helped 44 staff and this includes in-house mediation that is facilitated by champions who have received mediation training. This service is now widely advertised within the Trust for others to benefit from.

- As part of Pride and Respect, 3 leadership conferences have been held, entitled: 'Rebuilding our Organisation through Cultural Change' which have targeted the organisations senior leaders, starting in October 2018 running through to January 2019. Feedback on this 1 day session has been positive.

- The work of the network is overseen by the Pride and Respect Steering Group chaired by one of the Trust's consultants, with vice chair a Nurse educator. Related initiatives include the development of Minority Networks.

- As part of the Pride and Respect Initiatives, the Trust has also made good use of Insights Discovery Training to support staff understand their personal preferred styles, strengths and value they bring to the team. These sessions have been used to support individual sessions, team development sessions through to larger scale department wide initiatives.

- Whilst these initiatives have resulted in a number of very positive outcomes, the Trust recognises that more time is needed to evaluate the outcomes from these programmes and is committed to focus on this as a long-term priority. During this same time, between September and December 2018, the latest National Staff Survey was undertaken; these have been published on the 26 February 2019.

- More than 2,000 staff took part in the survey, equating to a 35% response rate which is an improvement. The results do show improvement across the majority of questions compared to the 2017 survey, but it's clear we still have a lot more work to do. Key points included:

    - 72% of staff surveyed said they were enthusiastic about their job and more of you would recommend the Trust as a place to work and receive treatment.

    - Reading the comments we are starting to see the signs of positive culture change. More staff feel confident about raising concerns and reporting incidents and feel more confident the Trust would act on feedback from staff and patients. Fewer staff are suffering from work related stress compared to the 2017 survey.

    - However the results also highlight that staff morale remains low with concerns around adequate staffing levels, the quality of appraisals and a lack of opportunity for progression.

- The results have been shared widely and each division will be formally looking at their own results. With support from staff from the Trust's Organisational Effectiveness team, each division is developing improvement plans for the specific feedback received broken down to divisional level.
- Since the survey was undertaken, in addition to the Listening into Action and Pride and Respect initiatives, the Trust have taken the following actions:
    - Involved staff in the creation of new Trust values (respect, kindness and courage) and behaviours. We'll be doing much more work to communicate these throughout the year.
    - Launched 'Ask Peter' to give another route for staff to ask questions and to raise concerns, which is proving very popular.
    - Created new ways to celebrate staff achievements e.g. 'Thumbs Up Friday' and 'Team of the Week'.
    - Secured £29million in capital funding to invest in urgent and emergency care and our diagnostic equipment over the next few years.
    - Secured funding to help with the rollout of ePMA (electronic prescribing and medicines administration).
    - Made substantial improvements in mortality rates.
    - Increased the amount of apprenticeships on offer for staff at all levels including trainee nurse associates.
    - Opened a new £16.4 million staff accommodation building, The Roost at Grimsby hospital.
    - Seen big improvements in our vacancy rates for doctors.
- Changing the culture of an organisation is something that takes time, but it's clear from these results that the Trust is starting to head in the right direction.

Further support to patient's mental health alongside their physical health

One in four people in the UK experience a mental health problem each year. Some patients being cared for within the Trust will therefore have both a physical and mental health issue. To care for these patient's needs, the Trust works closely with Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) a mental health provider for North Lincolnshire who provides access, crisis and hospital liaison, including child and adolescent mental health services. These services are complimented by the Local Authority who provides an approved mental health practitioner service. Within North East Lincolnshire, mental health services are provided from NAVIGO, an integrated health and social care provider, providing hospital liaison service, crisis and access services. Lincolnshire Partnership Foundation Trust provides the child and adolescent's mental health services within North East Lincolnshire.

To further support the Trust's focus on mental health care, an interim specialist practitioner for mental health has been appointed, initially on a three month pilot, which started during March 2019. The first month has been used to scope out where there are mental health needs, looking at current pathways, policies and patient flow of a typical patient journey. This has been undertaken working closely with mental health provider colleagues. Current training and education on mental health has also been reviewed as part of this initial review.

Following this initial scoping work, the specialist practitioner will be working closely with colleagues to support and develop plans to improve further service provision and ultimately the patient experience.

In addition, the Trust also employs a specialist perinatal mental health midwife who works closely with midwifery and primary care colleagues. This role is also working alongside both mental health providers to develop emerging perinatal services that cater better for mental health needs during this time.

Support to patients with dementia

We are committed to providing an excellent standard of care for all patients but we know that we need to particularly ensure that those who are vulnerable and frail are getting the best possible care. There are 850,000 people with dementia in the UK, with numbers set to rise to over 1 million by 2025. This will soar to 2 million by 2051. 225,000 will develop dementia this year, that's one person every three minutes (Alzheimer's Society).

The Department of Health (2015) estimated that 25% of hospital beds are occupied with people with dementia. However, informal reports suggest this is a gross underestimate, with some hospitals stating that 40-50% of their patients have dementia (Alzheimer's Society). It is recognised that admission to hospital can have a significant negative impact on the person's physical and mental health and have an emotional impact on carers; therefore, it is important to ensure patients in hospital receive appropriate care and provide support to carers.

Within the Trust, each ward has a link champion as a resource for further information and support. Dementia link sessions continue quarterly being run by the Trust's Dementia Clinical Nurse Specialist team who visit the wards on a daily basis to ensure patients with dementia are receiving the most appropriate care for their individual needs and to support their carers.

Recognition of the need to enhance our healing environment has led to dementia friendly improvements as the Trust refurbishes wards and departments, with consideration to dementia friendly signage and clocks, colour coding in bays to support way finding, plain flooring and furnishings, such as curtains and decorative artwork.

Dementia training is mandatory for all patient-facing staff and the Trust remains consistently high with compliance for both tier one dementia awareness and tier two dementia skills training.

The Trust have successfully introduced a dementia friendly finger food menu this year across all three sites to encourage the maintenance of independence but also to ensure patients with dementia are receiving adequate nutrition whilst they are in hospital.

The Trust has taken part in round 4 of the National Audit of Dementia and improvement plans are in place to ensure we are meeting the standards.

The Trust continues to work with our external partners, including the Alzheimer's Society and the Carers Association who attend our quarterly Dementia Steering Group.

Clinical Leadership development to support improvements in culture and improving quality

During 2018/19, the Trust has reviewed and made changes to strengthen its clinical leadership arrangements to support improvements in both culture and quality and safety. This has been a key priority recognising the importance of these roles. In June 2018 the Trust appointed Divisional Clinical Directors to increase the focus on divisional clinical leadership structures. To support these posts, a consultation has recently concluded that reviewed the role of specialty Clinical Lead across the organisation to ensure these posts had a clearly defined and consistent job description to further support divisional clinical leadership. Now that the consultation has ended, recruitment to these posts will be the next step.

Running in conjunction with this has been work to strengthen nursing leadership with the appointment of two Deputy Chief Nurse Posts. A reorganisation of the matron role has also now been completed, following consultation, resulting in clearly defined and consistent matron and senior nurse roles now in place and being recruited to.

To support this investment in these roles to support improvements in culture, quality and safety, will be comprehensive training and development. Ward leaders have already commenced this training and support, with work underway to develop a leadership programme for the Clinical Lead roles.

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 are committed to ensure 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 have encouraged and supported staff to speak up by instituting a number of 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 and Organisational Effectiveness Directorate;
    - Or by logging an incident on the Trust's incident reporting tool hosted on DATIX.

The Trust's Freedom to Speak Up Guardian presence is communicated to all new starters within the Trust as part of the corporate induction programme, is featured as part of the already referenced Pride and Respect training sessions and the Chief Executive led Senior Leadership Community.

This is further promoted through printed and digital materials including the Trust staff newsletter, posters around the Trust premises and screensavers on desktop computers.

The Trust was visited by the NHS Improvement regional Freedom to Speak Up lead during January 2019 in order to assess the Trust's progress with the implementation of actions following a previous visit by the National Guardian's Office. Whilst recognising there is further work to do, positive feedback on progress was received during the visit, noting specifically that the Pride and Respect Champions who met with the lead exuded passion and commitment and this had reenergised the Trust's approach to this critical aspect of listening to members of staff and promoting further changes in culture. The review also noted the Chief Executive and the Chair's commitment to tackle cultural challenges.

The Trust's current Freedom to Speak Up Guardian reports to the Trust Board on a quarterly basis to ensure the Trust and its board are kept updated and able to continue to support promotion of this function.

Patient outcomes: What does this mean for patients accessing Trust services?

Patient outcomes: What does this mean for patients accessing Trust services?

Theme 5 – Safe Staffing & Improved Staff Engagement:

- The Trust have demonstrated higher levels of registered nursing and midwifery staff and care staff available to cover rota hours on the Trusts wards.
- The Trust are currently below the national average in providing care hours per day but are aiming to improve this by linking this to ongoing ward establishment reviews and therefore more focussed on quality delivery.
- The numbers of vacant nursing and medical staff have reduced, with further improvements planned to ensure safe staffing.
- Patients receiving acute hospital care can be confident that they will not receive care that breaches mixed sex accommodation requirements.
- Feedback from patient experience initiatives is largely positive with a growing number of compliments. Where concerns are raised, the Trust has improved its processes to respond to these in a timely manner and to understand the feedback and work to improve provision of care to improve the patient's experience.
- The Trust is committed to improving engagement with its staff to result in improved staff morale. Whilst there is still further to go, the Trust has demonstrated that the changes made during 2018 have resulted in improvements and that the Trust are moving in the right direction.

Progress monitored, measured and reported: Progress with these indicators are monitored within the integrated performance report and as such is reported to the Quality Governance Group, Quality & Safety committee and the Trust Board.

Whilst the quality priority theme has remained the same throughout 2018/19, some of the indicators planned during 18/19 to aid understanding of Trust performance have either not been measured or changed, these include:

- Wards having had an establishment review, this is an ongoing process and as such was determined to not be a helpful indicator, instead the care hours per patient day, the indicator has been used to link, more firmly, staffing to quality of care,
- Medical fill rate has not been an indicator used, with a focus being on medical staff vacancy rates instead,
- Establishment reviews continue across specialties and will be a useful indicator in support of the focus on reducing the medical staff vacancy rate going forward,
- The total agency spend was not used as an indicator in 2018/19 for quality as there was a focus on having appropriate skills for the patients. Whilst this was not used in this quality setting, it remains within the financial indicators, used to support the Trust's focus on good financial governance.

Relationship to 2019/20 Quality Improvement Priorities: Safe staffing indicators do not feature as part of the Trust's 2019/20 quality priority themes; these will be reported to the Board as performance indicators, monitored in detail for assurance (and recognising the links to quality of care/services) to the workforce sub-committee of the Board.

Patient experience indicators will be featured within the quality priority focussing on flow and cancer pathways. Wider indicators relating to more general experience will feature as part of the Trust's Integrated Performance Report and the Patient Experience report going to Trust Board.

2.1f: Quality Priority planning for 2019/20

QUALITY PRIORITY THEMES 2019/20:

Five priority areas have been set as quality priorities for 2019/20:

1) **Clinical Effectiveness: Mortality reduction:**
   a. Mortality case note review work by clinical staff, key performance indicators;
   b. Patients able to die in their preferred place of death (end of life quality indicator);
   c. Reduction in the Trust's Summary Hospital-Level Mortality Indicator (SHMI).

2) **Patient Safety: Improved management of the deteriorating patient:**
   a. Monitoring and action taken in response to National Early Warning Scores (NEWS);
   b. Compliance with the Sepsis Six care bundle;

3) **Patient Safety: Medication safety**
   a. Reduction in omitted doses;
   b. Reduction in incidents relating to insulin;

4) **Patient Experience: Improved patient flow:**
   a. Embedding the use of the SAFER bundle to improve flow;
   b. Seven day services – improved performance against the priority 4 standards;

5) **Patient Experience: Cancer pathways:**
   a. Increased availability of straight to test diagnostics for suspected cancers;
   b. Improved cancer pathways.

How the Quality Improvement Priorities are consulted on and agreed:

Reflecting on the Trust's performance against its quality priority themes set during 2018/19, the Trust's Acting Medical Director undertook a consultation exercise within the Trust starting November 2018 to determine what the quality priorities for 2019/20 should be to continue the Trust's improvement journey. As a result of this approach, the first draft contained a variety of proposed topics. Following subsequent discussion with public and staff governors, who represent the public at the Quality Review Group, discussion within the Trust with divisions at the Quality Governance Group, and also the Non-executive Director chaired Quality & Safety Committee, with CCG representatives present, the Acting Medical Director facilitated a gradually focussing lens to ensure the Trust and its board have clarity on what the organisations priorities are for quality improvement during 2019/20. The five chosen were agreed through the consultation process, as those which would have the biggest impact on patient outcomes.

The quality indicators discounted as part of this process are no less important, however, the Trust wants to ensure that it prioritises delivery of these five areas as it is recognised that these represent the Trust's highest risks to quality.

Many of those other indicators suggested, but ultimately not included in the above quality priorities for 2019/20, will still feature, either in the Trust's already established Improving Together Programme (i.e. nutrition and hydration), or as part of already established improvement initiatives (i.e. waiting time indicators), or are considered business as usual and have processes in place to report key performance indicators to understand and track quality performance over time (i.e. pressure ulcers and falls). Going forward, the Trust will still make good use of the monthly Integrated Performance Report (IPR) and will continue to report and push improvement on these quality indices. Oversight of the quality priorities will be maintained throughout the year both through performance, within the divisional monthly quality performance reports and through assurance via the Executive led Quality Governance Group and the Non-Executive Director led Quality & Safety Committee. This is a sub-committee of the Board with commissioner representation.

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

2.2 Statements of assurance from the Board

2.2a Information on the review of services

During 2018/19 the Northern Lincolnshire and Goole NHS Foundation Trust provided and/or sub-contracted 7 relevant health and care services.

The Northern Lincolnshire and Goole NHS Foundation 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 2018/19 represents 100% of the total income generated from the provision of relevant health and care services for 2018/19.

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

During 2018/19, 55 national clinical audits and 5 national confidential enquires covered relevant health services that Northern Lincolnshire and Goole NHS Foundation Trust provides.

During that period the Trust participated in 55 or 100% of the national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2018/19 and those in which it participated in are as follows:

NB: The table which follows lists:

- The name of the national clinical audits and national confidential enquiries listed in HQIP's quality account resource,
- Which ones the Trust were eligible to participate in,
- The number of cases submitted for each audit against the number required, also expressed as a percentage (%),
- If action planning is taking place or has been completed to improve processes and practice following publication of findings.

National Clinical Audits 2018/19

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
Acute care					
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	Yes	580	99.5%	Reporting
Case Mix Programme (CMP)	Yes	Yes	866	81%	Project not yet completed
National Emergency Laparotomy Audit (NELA)	Yes	Yes	196	88%	Awaiting Publication of Results
National Joint Registry (NJR)	Yes	Yes	813	92%	Awaiting Publication of Results
Blood and Transplant					
National Comparative Audit of Blood Transfusion programme					
Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	No	N/A	N/A	N/A	N/A
Management of massive haemorrhage	Yes	Yes	5	100%	Awaiting Publication of Results
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	Yes	13	100%	Yes
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	Yes	104	100%	Yes
Cancer					
Lung cancer (NLCA)	Yes	Yes	333	On-going	Yes
Bowel cancer (NBOCAP)	Yes	Yes	243	100%	Project not yet completed
National Audit of Cancer in Older Patients (NABCOP)	Yes	Yes	242	100%	Awaiting National Report
National Prostate Cancer Audit	Yes	Yes	290	100%	Actions to be Agreed
Oesophago-gastric cancer (NAOGC)	Yes	Yes	108	100%	Actions to be agreed

Heart					
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	230	Ongoing	Awaiting Publication of Results
Adult Cardiac Surgery (NICOR)	No	N/A	N/A	N/A	N/A
Cardiac Rhythm Management (CRM)	Yes	Yes	303	Ongoing	Awaiting Publication of Results
Congenital Heart Disease (CHD)	No	N/A	N/A	N/A	N/A
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	294	Ongoing	Awaiting Publication of Results
National Heart Failure Audit	Yes	Yes	238	Ongoing	Awaiting Publication of Results
National Audit of Cardiac Rehabilitation	Yes	Yes	1005	100%	Yes
National Vascular Registry	No	N/A	N/A	N/A	N/A
National Cardiac Arrest Audit (NCAA)	Yes	Yes	148	93%	Project still underway
Long term conditions					
National Diabetes Audit - Adults (National Core Diabetes Audit)	Yes	Yes	1012	100%	Awaiting Publication of Results
National Diabetes Audit – Adults: National Diabetes Foot Care Audit	Yes	Yes	192	100%	Yes
National Diabetes Inpatient Audit – Adults Organisational (NADIA)	Yes	Yes	1	100%	Awaiting Publication of Results
National Diabetes Inpatient HARMS Audit (NADIA HARMS)	Yes	Yes	5	100%	Awaiting Publication of Results
Inflammatory Bowel Disease (IBD) programme – Biologicals Audit	Yes	Yes	293	100%	Awaiting Publication of Results
National COPD Audit	Yes	Yes	697	74%	Yes
National Asthma Audit	Yes	Yes	62	81%	Yes
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	58	Ongoing	Awaiting Publication of Results

Mental health					
Mental Health Clinical Outcome Review Programme (NCISH)	No	N/A	N/A	N/A	N/A
Prescribing Observatory for Mental Health (POMH)	No	N/A	N/A	N/A	N/A
Older people					
Falls and Fragility Fractures Audit Programme (FFFAP) • Fracture Liaison Service Database (FLS-DB)	Yes	Yes	591	100%	Yes
Falls and Fragility Fractures Audit Programme (FFFAP) • National Hip Fracture Database (submitted for all)	Yes	Yes	574	100%	Not yet complete
Sentinel Stroke National Audit Programme (SSNAP) SSNAP Clinical Audit	Yes	Yes	675	100%	Yes
National Audit of Dementia (NAD)	Yes	Yes	100	100%	Yes
National Audit of Intermediate Care	No	N/A	N/A	N/A	N/A
National Audit of care at the End of Life (NACEL)	Yes	Yes	80	100%	Awaiting National Report
Sentinel Stroke National Audit Programme (Post-acute)	Yes	Yes	159 (April-Dec 2018)	100%	Reporting
Other or TBC					
Adult Community Acquired Pneumonia	Yes	Data collection underway	Project still underway	Project still underway	Project still underway
Non-Invasive Ventilation – Adults	Yes	Data collection underway	Project still underway	Project still underway	Project still underway
National Audit of Pulmonary Hypertension	No	N/A	N/A	N/A	N/A
Falls and Fragility Fractures Audit Programme (FFFAP) National Audit of Inpatient Falls	Yes	Data collection underway	Project still underway	Project still underway	Project still underway
National Mortality Case Record Review Programme	Yes	Data collection underway	Project still underway	Project still underway	Project still underway
Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	Project still underway	Project still underway	Project still underway
Feverish Children (care in emergency departments)	Yes	Yes	168	100%	Awaiting Publication of Results
Vital Signs in Adults (care in emergency departments)	Yes	Yes	221	100%	Awaiting Publication of Results

VTE Risk in lower limb immobilisation (care in emergency departments)	Yes	Yes	199	100%	Awaiting Publication of Results
Cystectomy Audit (British Association of Urological Surgeons)	No	N/A	N/A	N/A	N/A
Nephrectomy Audit (British Association of Urological Surgeons)	Yes	Yes	16	36%	Project still underway
Percutaneous Nephrolithotomy (PCNL) (British Association of Urological Surgeons)	Yes	Yes	0	0%	Project still underway
Radical Prostatectomy Audit (British Association of Urological Surgeons)	No	N/A	N/A	N/A	N/A
Female Stress Urinary Incontinence Audit (British Association of Urological Surgeons)	No	N/A	N/A	N/A	N/A
Elective surgery (National PROMs Programme)	Yes	Yes	559	70%	Yes
Surgical Site Infection Surveillance Service	Yes	Yes	248	100%	Not yet complete
National Bariatric Surgery Registry (NBSR)	No	N/A	N/A	N/A	N/A
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	No	N/A	N/A	N/A	N/A
National Neurosurgery Audit Programme	No	N/A	N/A	N/A	N/A
National Ophthalmology Database Audit	Yes	Yes	876	100%	Awaiting Publication of Results
Neurosurgical National Audit Programme	No	N/A	N/A	N/A	N/A
National Audit of Anxiety and Depression	No	N/A	N/A	N/A	N/A
National Clinical Audit of Psychosis	No	N/A	N/A	N/A	N/A
Reducing the impact of serious infections (antimicrobial resistance and sepsis)	Yes	Yes	146	100%	Yes
Seven Day Hospitals Services	Yes	Yes	215	100%	Yes
UK Cystic Fibrosis Registry	No	N/A	N/A	N/A	N/A
Cystectomy Audit (British Association of Urological Surgeons)	No	N/A	N/A	N/A	N/A

Women and Children's					
National Audit of Seizures and Epilepsies in Children & Young People	Yes	Yes	23 SGH 33 DPOW	100%	Currently data collecting
Neonatal Intensive and Special Care (NNAP)	Yes	Yes	594	100%	Awaiting Publication of Results
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	4469 (Births between 01/04/16 – 31/03/17)	100%	Awaiting Publication of Results
National Pregnancy in Diabetes Audit (NPID)	Yes	Yes	41 (delivered in 18/19)	100%	Awaiting national report
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	17/18 203 submitted (18/19 still underway)	100%	Data collection underway
Paediatric Intensive Care (PICAnet)	No	N/A	N/A	N/A	N/A
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK) Perinatal Mortality Surveillance Report (June 2018)	Yes	Yes	48/48	100%	Yes
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK) Saving Lives, Improving Mother's Care (Nov 18)	Yes	Yes	1	100%	Reporting
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK) Breast cancer in Pregnancy (2019)	Yes	Yes	Not yet commenced	N/A	N/A
Total:	**74**				
Eligible for NLAG participation:	**55**				
NLAG Participated in:	**55**				

National confidential enquires 2018/19

Confidential enquiry	Eligible for NLAG	NLAG participated	Organisational Questionnaires	Number of cases submitted	% of number required	Action planning
Acute Heart Failure	Yes	Yes	2/2	10/11	11/11	GAP Analysis underway
Perioperative Diabetes	Yes	Yes	3/3	14/15 Surgical 13/15 Anaesthetist	14/15	GAP Analysis underway
Pulmonary Embolism	Yes	Yes	2/2	8/10	7/10 (8 excluded pts)	Awaiting Report
Bowel Obstruction	Yes	Yes	Not yet sent	1/11 (Recently assigned)	Ongoing Project	Ongoing
Long term ventilation	Yes	Yes	N/A	0/3 (not yet assigned)	Ongoing Project	Ongoing
Total:	**5**	**5**				
Eligible for NLAG participation:	**5**					

The reports of 25 national clinical audits were reviewed by the provider in 2018/19 and the Trust intends to take the following actions to improve the quality of healthcare provided (a sample of the actions agreed are summarised):

Increased information to patients/carers – Summary of some actions taken:

- Feverish Child (Care in Emergency Departments) – An information leaflet for patients will be developed and uploaded to A&E/ECC electronic system for instant printing access.
- VTE Risk in Lower Limb Immobilisation (Care in Emergency Departments) a patient information leaflet was developed and uploaded to the A&E/ECC electronic system.
- National Paediatric Diabetes (2017 cases, published July 2018): At SGH, a dietitian will discuss healthy eating with all families.
- MBRRACE: Perinatal Mortality (published July 2018): All parents of babies who die will be provided with unbiased counselling for post-mortem.

Increased awareness and education of staff – Summary of some actions taken:

- Feverish Child (Care in Emergency Department) – A paediatric Sepsis e-learning module is under development and will be made mandatory for clinical staff in relevant areas.
- Care in Emergency Department audits – The audit results have been regularly discussed at team huddles to drive improvements in practice. Posters are displayed in the emergency department reminding staff of national standards and current compliance levels.
- National Audit of Dementia – Delirium training has been incorporated into the dementia training.
- MBRRACE: Perinatal Mortality (published July 2018): Midwives and doctors to be provided with education / training on the following:

- ‘GROW’ Package i.e. undertaking fundal height measurements / plotting fetal grow charts etc.
- Smoking education
- Reducing the stillbirth rate
- How the families feel and how to support them
- SANDS training to be provided on a bi-annual basis.

- National Cardiac Arrest Audit – Implementation of ReSPECT training for (Recommended Summary Plan for Emergency Care and Treatment) for staff has commenced and to be rolled out, including teaching regarding DNACPR.
- NNAP (2016 births, published 2017, action plan put in place during 2018): raise awareness to ensure all midwifery/medical/theatre teams are away of steps to be taken to reduce the chances of babies becoming too cold (i.e. hats ASAP following birth, baby dried immediately after birth, warm towels to be used).

Further evaluation/patient surveys – Summary of some actions taken:

- National Lung Cancer Audit –Deep dive audit underway to ascertain if opportunities were missed/ care pathway would have altered if a pathological diagnosis had been made.
- Procedural Sedation (care in Emergency Departments) –A re-audit is due to take place to test the embedding of changes following introduction of a new checklist.
- National Bowel Cancer Audit – To undertake a review of the cases with a stoma at 18 months.
- National Hip Fracture Database 30 Day Mortality Review – A Trust wide review to be carried out for all 30 day mortality patients with hip fractures for 2017 and 2018.
- NNAP (2016 births, published 2017, action plan put in place during 2018): An audit to be undertaken including all babies admitted to NICU with low temperatures in 2018.

Changes to service/process – Summary of some actions taken:

- National Comparative Audit of Blood Transfusion programme – Blood transfusion Integrated care pathway is currently being amended to incorporate NHSBT recommendations.
- National Audit of Inpatient Falls – A new delirium pathway has been developed to improve assessment and management of patients with delirium.
- National Emergency Laparotomy Audit - Introduction of NELA pathway, which prompts staff to follow guidance such as presence of consultant anaesthetist and surgeon for high risk cases, and prompts documentation of details.
- Falls and Fragility Fractures Audit Programme (FFFAP) National Hip Fracture Database – A business case has been approved for the implementation of 7 day cover for Physiotherapy which would support with the completion of the physiotherapy assessments and therefore enable them to achieve the Best Practice Tariff.
- MBRRACE: Perinatal Mortality (published July 2018): Trust to adopt the National Bereavement Care Pathway paperwork. (NLAG have been a pilot site since April 2018 but paperwork will be rolled out nationally from April 2019.

The reports of 24 local clinical audits were reviewed by the provider in 2018/19 and the Trust intends to take the following actions to improve the quality of healthcare provided (a sample of the actions agreed are summarised):

Increased awareness and education of staff – Summary of some actions taken:

- Medicine documentation audit/Emergency Care Centre documentation audit - Results shared with audit leads and clinicians in all medicine specialities via audit meetings; Business & Governance Meetings. Information Governance responsibilities discussed at ECC/A&E governance to raise awareness of need to have patient identifiable information on each page of the clinical record.
- Medicine documentation audit/Emergency Care Centre documentation audit – Royal College of Physicians standards distributed to all clinicians via and email, distributed at doctor inductions and discussed at Quality & Safety/Audit meetings.
- Audit of ultrasound locating devices for the placing of central vascular catheters: presentation to highlight to Anaesthetists that the central vascular catheter stickers should be used in all cases.
- Newborn Early Warning Trigger and Track (NEWTT): escalation process to be discussed with the nurses/health care assistants to ensure the correct process is always followed.
- Paediatric Early Warning Scores (PEWs): further training with A&E teams to be undertaken at the safety huddles.
- Customised growth charts: training to be undertaken for both hospital sites by an external company and information cascaded where required. E-learning package also be made available.
- Community record keeping audit: Raise awareness amongst staff to ensure patient details are recorded on SystmOne e.g. ethnicity, religion, next of kin details.

Changes to service/process – Summary of some actions taken:

- Diabetes foot risk assessment audit – Capillary blood glucose monitoring documented amended to include recording of date / time of foot risk assessment in order to provide assurance NICE guidelines are met.
- Medicine documentation audit/Emergency Care Centre documentation audit – The Trust's continuation sheets have been updated to include a field to record location of patient, in line with Royal College of Physician's standards.
- Paediatric Early Warning Scores (PEWs): new version of the charts to be implemented with the first row completed as an example of standard of entry.
- Swab checks in maternity: New sticker designed to be used where this is no designated space in the new notes for a swab check (e.g. FBS).

2.2c Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Northern Lincolnshire and Goole NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee 1,453.

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

A proportion of Northern Lincolnshire & Goole NHS Foundation Trust's income in 2018/19 was conditional upon achieving quality improvement and innovation goals agreed between Northern Lincolnshire & Goole NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically at:

https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

The areas of care which were included within the CQUIN scheme for 2018/19 included the following:-

- Improvement of health and wellbeing of NHS staff
- Sepsis
- Improving services for people with mental health needs who present to A&E
- Advice & Guidance
- E-referrals
- Supporting proactive and safe discharge
- Alcohol and tobacco community
- Wound assessment community
- Personalised care community

The amount of income in 2018/19 which was conditional upon achieving quality improvement and innovation goals was £4,997 million.

The monetary total value for 2017/18 CQUIN indicators was £6.427 million. The Trust received payment for £6.370 million during 2017/18.

2.2e 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 2018/19.

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

(From their last visit of the Trust in May 2018, of which the report was published on the 12 September 2018):

The Trust was pleased to receive again the overall rating of Good for caring. The Trust have fully accepted the CQC findings and is using these to inform the Trust's overall improvement programme, some details of which are provided as follows.

Action taken to improve further:

- The Trust's response to the CQC report was to take immediate action on those aspects requiring immediate response. The embedding of other quality improvements, related to the CQC visit's findings, and to other organisational challenges has been addressed by the Trust's Improvement Programme - ***Improving Together.***
- Improving Together focusses on 6 key work streams:
    - Leadership and Culture
    - Quality and Safety
    - Safe Staffing
    - Access and Flow
    - Finance
    - Strategy and Capital
- This programme of work is supported by a dedicated Improvement Team in place to support the project management and delivery of the individual work stream action plans. This is further overseen by the Trust Board and by other external stakeholders. Support

has been provided to the Trust, and gratefully received, from external partners including NHS Improvement and NHS England.

Improvements to date:

- A selection of the changes and improvements made to date is summarised as follows:

    - Increased engagement with our doctors in training and improved training support leading to increase in Deanery fill rate from 68.80% in 2017 to 87.98% in 2018.

    - Turnover rates within the Trust continue to come down with a February 2019 Trust wide figure of 9.56%, a decrease of 1.80% over the last 12 months (11.36%). The Trust wide turnover figure has remained under 10.00% for the past eight months.

    - The development of a Quality Improvement Strategy, endorsed by the Trust Management Board and Trust Board and the introduction of a Quality Improvement Training faculty.

    - The latest staff survey figures for the Trust were released at the end of February 2019. They showed an improvement on many scores and some significant improvement in some areas such as staff feeling confident to raise concerns and overall staff engagement. However the results still show the Trust is some way behind the average and still has much work to do to improve morale and create a more supportive and open culture.

    - A wholesale engagement programme is underway which includes divisions developing and acting on their own individual engagement plans, these will be monitored and the impact measured by an ongoing staff engagement pulse check. The Trust has also agreed to implement the Manchester Patient Safety Framework in the early stages of 2019/2020, this will see staff of all disciplines give their views on patient safety and help identify monitored actions for improvement.

    - An additional 46.75 doctors are now employed at the Trust across a range of specialties.

    - Where agency nurses are required, block booking arrangements are in place so that they can work on a regular ward, thus leading to better patient care and continuity of staff.

    - Nursing staff trained in the use of the Safer Nursing Care Tool to enable us to better identify the correct staffing ratio for wards. This is currently being rolled out at DPOW.

    - The Trust's mortality rate is reducing (particularly at Grimsby) with latest figures showing a SHMI of 113 and work continues to make sure this improvement is sustained.

    - Reducing mortality is one of the Trust's five quality priorities for 2019/20 along with: identifying deteriorating patients; improving patient flow through the hospital (so patients are discharged in a timely way and there are beds available when needed); reducing medication incidents; and improving the time taken to treat patients with cancer.

- A recovery plan for our 52 week wait performance has been developed and this has improved from 320 at 31 March 2018 to 75 as at 3 March 2019 and continues to forecast no patient waiting over 52 weeks at 31 March 2019.

- Reduction in the size of the waiting list by around 3,000 patients.

- A&E performance in terms of A&E has been steady at around 86%. This is despite seeing an increase in the number of people attending A&E (up about 7 per cent compared to 2018).

- The patients from the 2016 backlog have been reviewed and seen where appropriate.

- There has been an overall reduction in our emergency length of stay from 5.3 to 4.8 This has been possible via the introduction of a number of new initiatives including:-

    - Development of Urgent Treatment Centres on both sites aimed at managing the operational 'front door'

    - Frail patients are now being managed as they attend A&E with assessments undertaken and referral on to a dedicated assessment area with the aim of providing the necessary support to facilitate a return home within 12 hours to avoid deconditioning of the patient, where possible.

    - The SAFER project is currently being rolled out across each of the inpatient wards, commencing in Medicine.

    - Introduction of 7 day physiotherapy in orthopaedics in Grimsby which has brought length of stay down (in conjunction with other measures) by 1.5 days.

2.2f Other External Visits and Reviews of Trust Services

Peer Review work during 2018/19

During 2018/19 the Trust continued to progress a number of clinical action plans related to NHS England overseen Peer Reviews. These visits are helpful to provide an external view of the Trust's services and assess where improvements in care are possible.

During 2017/18 the Trust had two peer review visits for the following services:

1. Neonatal Intensive Care Units (NICU) on each of the Trust's two main sites;
2. The Trust's Haemato-Oncology service, based on the Trust's two main hospital sites and including community provision of care.

Areas identified as requiring some improvement work included:

- Increased consultant presence on the neonatal unit at Scunthorpe General Hospital (SGH);
- Review of admissions and re-admission protocols and pathways to the units at both sites;
- Estates improvement work to ensure sufficient space in the unit for cots at both sites;

- Review of practice and use of specific interventions for patients with haematological cancers;
- Strengthening needed of prescribing practices and the move to more electronic prescribing;
- Strengthened governance processes;
- Challenges regarding staffing levels within the haemato/oncology service;
- Improved use of Systematic Anti-Cancer Therapy Dataset (SACT).

During 2018/19, the Trust maintained and updated NHS England on the progress made with the action plans developed following these reviews, with the majority of actions now completed. There are still some actions being worked through, and internally assurance is overseen by the Group Governance arrangements and will be further strengthened by the Quality Governance Group, chaired by the Trust's acting Medical Director.

Peer review visits are linked to the self-assessment declarations the Trust must make to NHS England using the Quality Surveillance Tool (QST) process. This self-assessment is completed for all NHSE specialist commissioned services and some locally commissioned cancer services. The 2018/19 submission has been reviewed by the Trust's commissioners alongside NHS England and a number of areas are required to develop further improvement plans which will be overseen by the Quality Governance Group during 2018/19. The Trust has received notification that a peer review visit will take place during 2019 to assess the Trust's lung cancer service.

The Trust will receive another planned peer review visit in March to review the services in place to provide cervical screening.

Other forms of external visits received by the Trust

The Trust have also received, around the same time as the CQC inspection, during May/June 2018 a review of maternity services led by the Royal College of Obstetricians and Gynaecologists (RCoG). This visit led to a number of recommendations being made. The Trust's response to these recommendations have been developed by the Trust's Women's &

Children's division and the detail of the action plan and progress against this is overseen by their internal governance arrangements. This will also be overseen by the Trust's Quality Governance Group.

2.2g Information on quality of data

Northern Lincolnshire and Goole NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS Number was:

- 99.6 per cent for admitted patient care
- 99.9 per cent for outpatient care
- 99.1 per cent for accident and emergency care.

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

- 99.7 per cent for admitted patient care
- 100.0 per cent for outpatient care
- 100.0 per cent for accident and emergency care.

2.2h Information governance assessment report

2018/2019 saw the release of the new 'Beta' Data Security and Protection Toolkit by NHS Digital. The Trust submitted its annual final submission in line with NHS Digital guidance on the 28th March 2019 as 'Standards not Met (Action Plan Approved)'. The Improvement plan was approved by NHS Digital and will be closely monitored by the Trust IG Steering group and NHS Digital to ensure actions are met within the first two quarters and once all actions have been completed the Trusts final Submission will change to one of 'Standards Met'.

2.2i 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.

2.2j Learning from Deaths

During 2018/19 1,526 of Northern Lincolnshire & Goole NHS Foundation Trust's patients died (this includes patients who died in the A&E department). This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 401 in the first quarter;
- 384 in the second quarter;
- 430 in the third quarter;
- 311 in the fourth quarter *[Jan-Feb 2019]*.

At 22 February 2019, 284 case record reviews and 8 investigations (undertaken as a Serious Incident investigation) have been carried out in relation to 1,526 of the deaths included above.

In 1 case a death was subjected to both a case record review and an investigation (undertaken as a Serious Incident investigation). The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 72 in the first quarter;
- 102 in the second quarter;
- 103 in the third quarter;
- 14 in the fourth quarter (as at the 22 February 2019).

2 representing 0.13% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient *[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:

0 representing 0% for the first quarter;
0 representing 0% for the second quarter;
2 representing 0.13% for the third quarter;
0 representing 0% for the fourth quarter.

These numbers have been estimated using the Structured Judgement Review (SJR) which includes a 6 factor Likert scale ranging from "definitely not avoidable" to "definitely avoidable". The above estimate 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 assessment from the retrospective assessment of the medical record. Any case reviews completed that identify that further understanding is needed is reviewed a second time by the mortality clinical lead or appropriate specialty clinical lead. This process links into the Trust's Serious Incident Framework. 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 improve quality of care.

63 case record reviews and 0 investigations completed after 01 April 2018 which related to deaths which took place before the start of the reporting period.

1 representing 0.23% of the patient deaths before the reporting period [1,557 deaths during 01 April 2017 – 31 March 2018], are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Structured Judgement Review (SJR) which includes a 6 factor Likert scale ranging from definitely not avoidable to definitely avoidable. The above estimate 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 assessment from the retrospective assessment of the medical record. Any case reviews completed that identify that further understanding is needed is reviewed a second time by another clinician. This process links into the Trust's Serious Incident Framework if necessary. It should be stressed that this data is not a reliable measure of deaths that were avoidable; rather it is designed as an indicator to support local review and learning processes with the aim of helping improve quality of care.

1 representing 0.23% of the patient deaths during the previous reporting period [01 April 2017 – 31 March 2018] are judged to be more likely than not to have been due to problems in the care provided to the patient.

For further information relating to mortality improvement work, please see part 2.3a

Summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified during 2018/19;

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 2018/19

The Trust has not found, from the mortality reviews completed, evidence of systematic failings in care delivery leading to 'avoidable' deaths. The Trust views mortality review as an opportunity to review the quality of care provided to these patients. From these mortality SJR case reviews, the following quality improvement themes have been identified:

- Delays in provision of care was identified, relating to a variety of aspects including some delays in specialist review or referral, delay in diagnosis warranting follow-up investigations thereby delaying treatment, delayed review over weekends and delays to Theatre. The Trust is working on flow through its acute hospitals, as detailed earlier within this report. Delays relating to specific interventions are shared with those leading on improvement work around these areas.

- End of life pathway utilisation and management of patients in line with the pathway is an identified theme for improvement. Specific areas identified include the potential to start the end of life pathway sooner to prompt for review of medications and improved communication with families and carers. The Trust's end of life strategy group is aware of these themes and is working with wider stakeholders to improve the quality of care. A regular report containing end of life themes from mortality SJR reviews is received by the group.

- Do Not Attempt Cardio-Pulmonary Resuscitation (DNaCPR) themes have highlighted improvements in considering, discussing and documentation of the decision. The Trust is looking to undertake a more detailed review of this with the Trust's Mortality Clinical Leads.

- Monitoring and documentation surrounding the use of fluids continue to remain a theme for improvement. This has been shared across the trust with targeted learning from themes addressed to areas of concern. Additional work has been invested into changing the documentation to record this information and to act as a prompt for nursing staff to support improved recording. This is also a part of the Nutrition and Hydration improvement group's work. Additionally work has been undertaken during the year to develop an Acute Kidney Injury (AKI) pathway. Work is also currently underway to develop a Hyperkalaemia pathway and revised policy.

- Documentation issues relating to inaccurate death certificate documentation have been identified a theme for improvement in care. Specific recommendations for these to be reviewed and approved by senior clinicians have been made and work is underway in the Trust to initiate the Medical Examiner model within the Trust from April 2019, this role will support a review and completion of death certificates and will standardise the recording processes.

- Community and primary care themes have been identified relating to cases where hospital clinicians have felt the hospital admission was potentially avoidable. The Trust is working collaboratively with NEL CCG colleagues, headed up by their lead GP, to review these cases to identify key lessons for sharing with GPs and community colleagues. Other themes relating to GPs and community care are shared with the intention of developing collaborative improvement plans. The Trust is hoping to establish similar

processes with the Trust's other commissioners and GPs in those geographical localities.

- The Trust have focussed on improving the process by which it undertakes mortality reviews with the intention of strengthening feedback loops of learning for sharing with clinical staff and embedding effective morbidity and mortality (M&M) review meetings. These feature as quality priorities for 2019/20.

An assessment of the impact of the actions taken by the Trust during 2018/19

Whilst many of the actions described are still underway, there has been some positive impact as a result of the actions taken already by the Trust. These are summarised as follows:

a) **Access and flow: Improvements on the Diana, Princess of Wales Hospital site:** linked to the previously described local quality priorities detailed already within this report, the Trust has been working to improve access and flow. During September 2017, Diana, Princes of Wales Hospital implemented an Ambulatory Care model, mirroring this service already available at Scunthorpe General Hospital. Ambulatory care is designed to ensure suitable patients are seen by a senior clinician for access to diagnostics to support quick decision making and the management of the patient as an out-patient or day-case discharging them the same day, thereby reducing the number of patients admitted to hospital, therefore reducing some of the pressure on the hospital's finite number of beds and staffing.

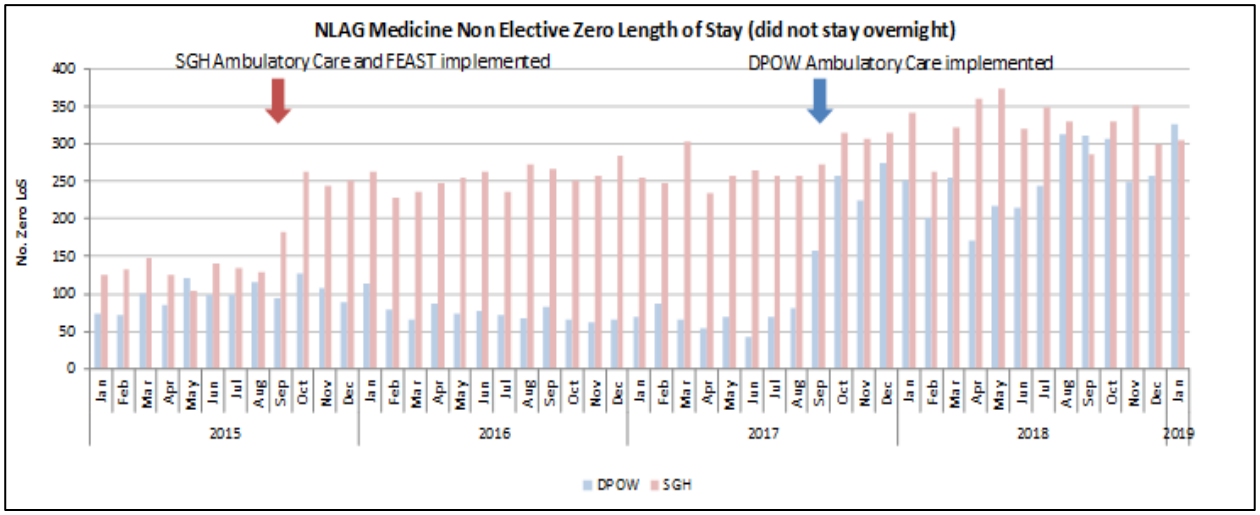


Figure 12 shows the number of patients accessing ambulatory care services with a zero length of stay which demonstrates an increased number of patients not being admitted to hospital

Source: Northern Lincolnshire & Goole NHS Foundation Trust- Information Services (Feb-19)

- The above chart demonstrates that the number of patients being reviewed and discharged from hospital on the same day (or as a 'zero length of stay') has increased significantly since the implementation of the Ambulatory Care services across both sites which has supported management of additional demand on Trust non-elective services.

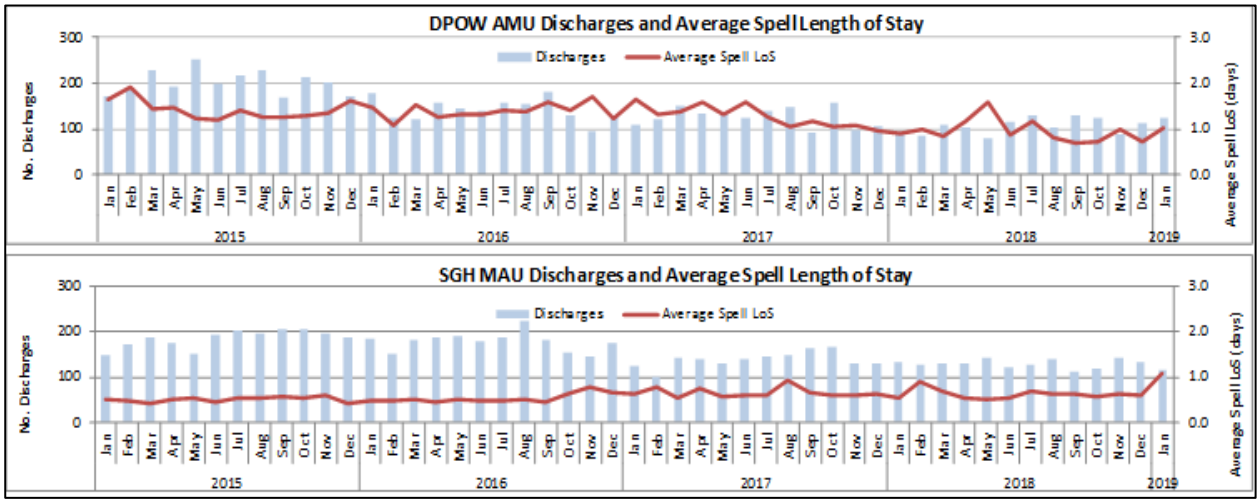


Figure 13 demonstrates the reduction in the average length of stay observed on the Trust's admission units which demonstrates some improvements on the DPoW site. This has moved closer towards the length of stay observed on the SGH site.

Source: Northern Lincolnshire & Goole NHS Foundation Trust- Information Services (Feb-19)

- The above chart again demonstrates that the average length of stay on the admissions ward at DPoW has reduced. This further supports new admissions to be cared for and moved to specialty wards for appropriate clinical management sooner.

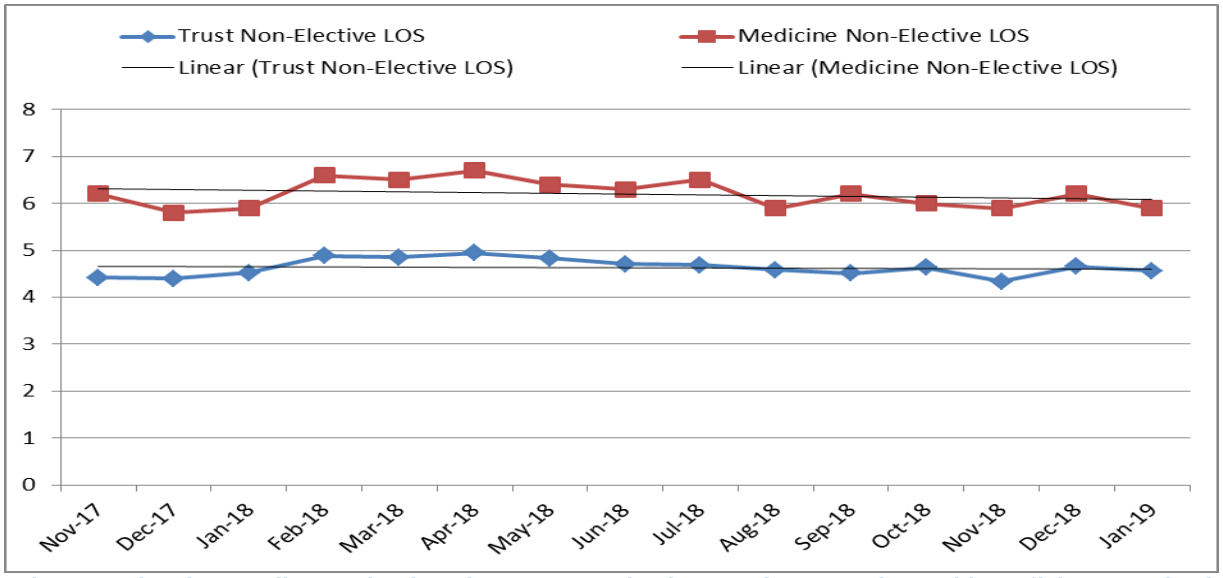


Figure 14 the chart outlines reductions in Trust non-elective LOS in comparison with Medicine non-elective LOS, both demonstrate reducing trends

Source: Northern Lincolnshire & Goole NHS Foundation Trust- Information Services (Feb-19)

- As well as reductions in length of stay on the medical assessment units, the Trust's non-elective length of stay has reduced both for the Trust as a whole and for medicine. This is in the context of increased pressure on Trust services.

- **b) Deteriorating patient:** The Trust's use of the electronic NEWS system to monitor in real time observations being recorded has demonstrated improvements during 2018/19 in recording. Feedback routes have been developed and this data is shared with ward areas using the deteriorating patient ward scorecards. Work continues as part of the Trust's deteriorating patient group to look at individual ward performance and ensure

support arrangements are in place to support ward based and owned improvements in care.

- **c) Recording and coding:** During 2018/19, the Trust have commenced more focussed reviews of data forming the basis of the Standardised Mortality Ratios (SMRs) such as SHMI. Given these indicators provide a statistical construct of the actual mortality compared with the expected mortality, accurate recording is key. The Trusts work to date has been to select diagnostic groups with elevated SHMI scores and undertake a coding audit and a documentation audit to determine if improvements in either coding or recording quality are possible. This work remains underway. A policy has been drafted to support the Trust agree a methodological approach to investigate specific alerts related to SHMI or HSMR.

- More latterly, the Trust, with support from NHS Improvement, has been working with a statistician to explore the statistical data driving the SHMI and HSMR. This work is still underway, but it has enabled some improved understanding regarding hospital site differences. Key findings to date from this action include:

    - Palliative care recording on the two sites is different, mirroring the differences in service provision between the two sites and how palliative care services are delivered. Further work needs to be undertaken to determine if there is scope for improvements in this area.

    - Depth of recording and coding. The statistical data has demonstrated a significant difference on the DPoW site with the attribution of risk which ultimately informs the calculation of the SHMI and HSMR. Whilst public health data demonstrates that there is a higher incidence of premature mortality (<65 years of age) in North East Lincolnshire, the risk factors for mortality, currently being recorded, that informs this risk calculation appear to be potentially underreporting risk compared to SGH which may explain the differences between site based mortality.

    - There is also a disparity in hospital mortality (which is 'as expected') compared with out of hospital mortality which is 'higher than expected'. The ongoing work will seek to understand this in greater detail also.

- **d) Learning from deaths:** The Trust strengthened its processes during 2018/19 to support a focus on learning from mortality case reviews, the only way of assessing and quantifying the quality of care provided to patients. An element of this has been the aim of increasing the number of case reviews being undertaken to achieve a minimum 20% of deaths being reviewed. The Trust are on course to achieve this aim, and then during 2019/20 improve the process still further resulting in more case reviews completed and improved structures in place to ensure these cases are discussed by clinical teams to extract learning to enable this to be widely shared. Some significant steps have been taken already with effective processes being put in place within Cardiology, Haematology and Oncology, Women's & Children's and in development for Acute Medicine. To embed these more effective arrangements across the majority of specialties forms the bases of the quality priorities for 2019/20.

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2.2k Clinical Standards for Seven day Hospital Services

Ten clinical standards for seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. With further input from the AoMRC, four of the ten standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These key standards are:

- Standard 2: Time to first consultant review
- Standard 5: Access to diagnostic tests
- Standard 6: Access to consultant-directed interventions
- Standard 8: Ongoing review by consultant twice daily if high dependency patients, daily for others

The trust is required to be achieving these standards by 2020/2021. More information can be found at: https://improvement.nhs.uk/resources/seven-day-services/.

NHS England are supporting the Trust (and other Acute NHS Trusts) work towards full compliance with the four key standards by 2020. The Trust monitored performance against these standards using a biannual survey as agreed by NHS England. The next planned evaluation of performance against these key standards is scheduled during June 2019 using a new monitoring process. The Trust's lead for this project is the Medical Director with support being provided by the Chief Operating Officer's team and the Quality & Audit teams. As well as the ongoing audit support to the project, action plans are being developed at Divisional level, to implement the programme of work. NHS England continues to provide full support to this project. The findings from the evaluation have been fed back to clinical teams to support ongoing engagement and change management.

This new measurement system replaces the previous self-assessment survey and consists of a standard measurement and reporting template, which all providers of acute services will complete with self-assessments of their delivery of the seven day service clinical standards. The trial run for submission of the Board assurance template was the 28th of February 2019 with the formal submission scheduled for the 28th of June 2019.

2.3 Trust performance against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital.

For each indicator the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods should be presented. In addition, where the required data is made available by NHS Digital, the numbers, percentages, values, scores or rates of each of the NHS Foundation Trust's indicators should be compared with:

a) The national average for the same and

b) Those NHS Trusts and the NHS Foundation Trusts with the highest and lowest of the same, for the reporting period.

This information should be presented in a table or graph (as seems most appropriate).

For each indicator, the Trust will also make an assurance statement in the following form:

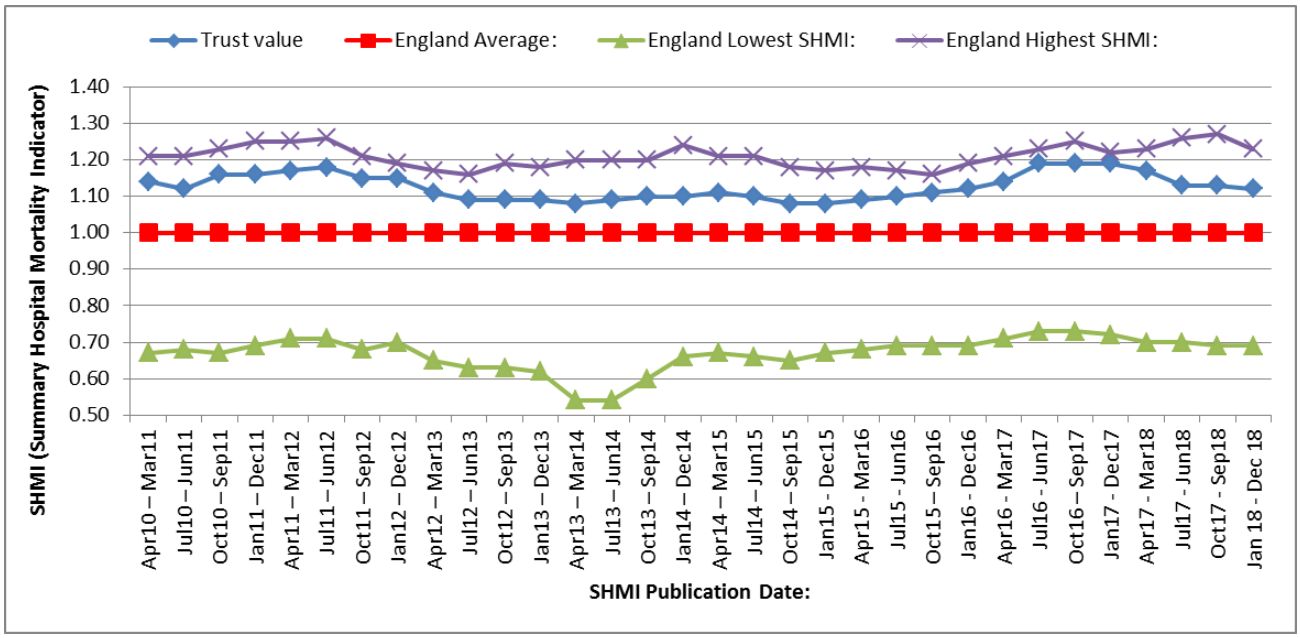
> The Trust considers that this data is as described for the following reasons *[insert reasons]*.
>
> The Trust *[intends to take or has taken]* the following actions to improve the *[indicator / percentage / score / data / rate / number]*, and so the quality of its services, by *[insert descriptions of actions]*.

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.

2.3a Summary Hospital-Level Mortality Indicator (SHMI)

The data made available to the Trust by NHS Digital with regard to:

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



	Oct-11	Jan-12	Apr-12	Jul-12	Oct-12	Jan-13	Apr-13	Jul-13	Oct-13	Jan-14	Apr-14	Jul-14	Oct-14	Jan-15	Apr-15	Jul-15	Oct-15	Jan-16	Mar-16	Jun-16	Sep-16	Dec-16	Mar-17	Jun-17	Sep-17	Dec-17	Mar-18	Jul-18	Sep-18	Nov-18	Feb-19	May-19
NLaG SHMI	1.14	1.12	1.16	1.16	1.17	1.18	1.15	1.15	1.11	1.09	1.09	1.09	1.08	1.09	1.1	1.1	1.11	1.1	1.08	1.08	1.09	1.1	1.11	1.12	1.14	1.19	1.19	1.19	1.17	1.13	1.13	1.12

Figure 15 shows the Trust's SHMI score, trended over time, compared to the absolute UK average (1.00) and highest and lowest reporting Trusts, the chart demonstrates positive progress seen in recent SHMI releases

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

- 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 outside of hospital in the community (within 30 days of hospital discharge). This inclusion of community mortality means the information needed comes from the Office for National Statistics; this results in delay in the reporting of the SHMI. To illustrate the most recently available SHMI reports performance between January 2018 and December 2018 (publication date was May 2019).

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

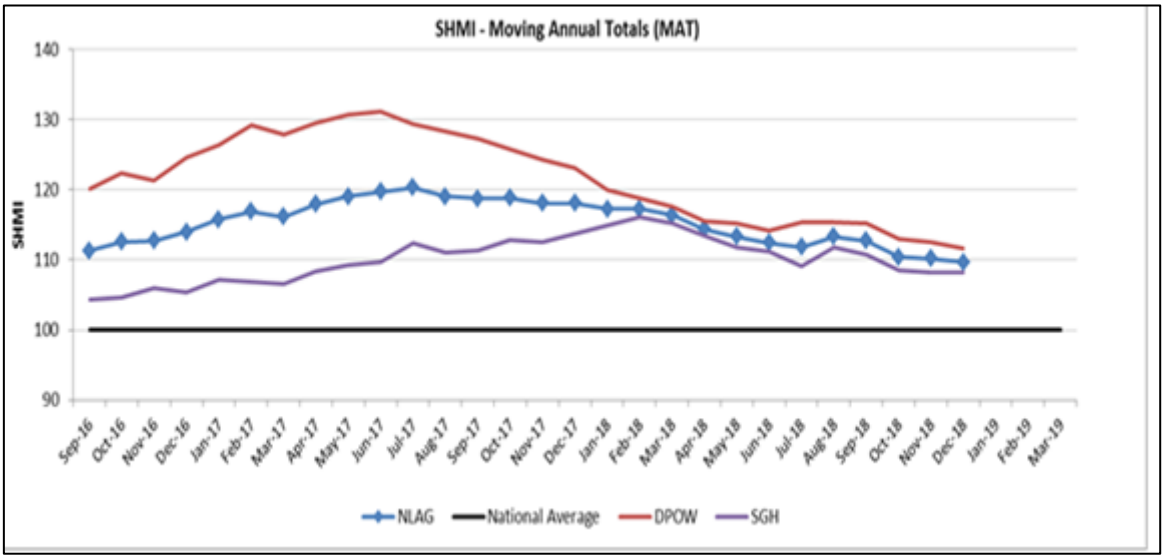


Figure 16 shows the HED SHMI for the Trust and demonstrates the reduction over time of the Trust's SHMI score as well as the individual sites SHMI score, with DPoW being higher overall. The HED data reports up to December 2018

Source: Healthcare Evaluation Data (HED), information services team

- The above chart illustrates that the Trust's HED SHMI provisional mortality performance has continued to reduce.

- The gap between both of the Trust's hospital sites has narrowed displaying a progressive declining trend. As cited previously, from some work being undertaken alongside NHS Improvement, statistical analysis of the SHMI and the principle data feeds has identified a disparity between the recording of 'expected' deaths or the risk factors that are used by the indicator to statistically calculate the 'expected' deaths at DPoW hospital. Given the known public health challenges in North East Lincolnshire, this disparity requires further review as part of the mortality improvement plan.

- Whilst 100 is the national England average and is commonly defined as 'expected' mortality, it is recognised that this statistical measure is not an absolute indicator of performance, rather there is confidence intervals that are classified as being 'as expected'. As a result of this, NHS Digital publish an organisation's position nationally, determining the national lowest and highest, as well as a Trust banding, which illustrates if an organisation is statistically an outlier, using 95 per cent confidence intervals. This is also presented as a funnel chart, as follows.

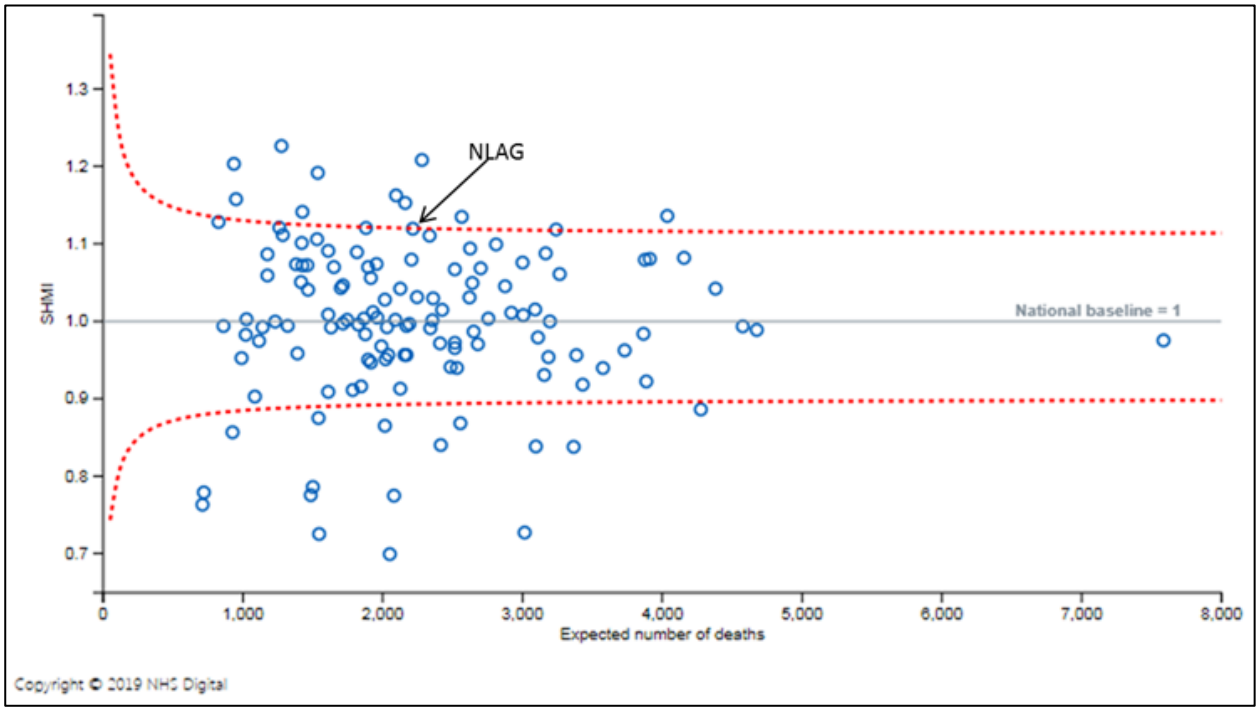


Figure 17 the chart above illustrates the Trust's 'official' SHMI. It is within the 'as expected' range within the funnel plot

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

- The above chart illustrates that the Trust is now within the 'as expected' range for SHMI performance.

c) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.

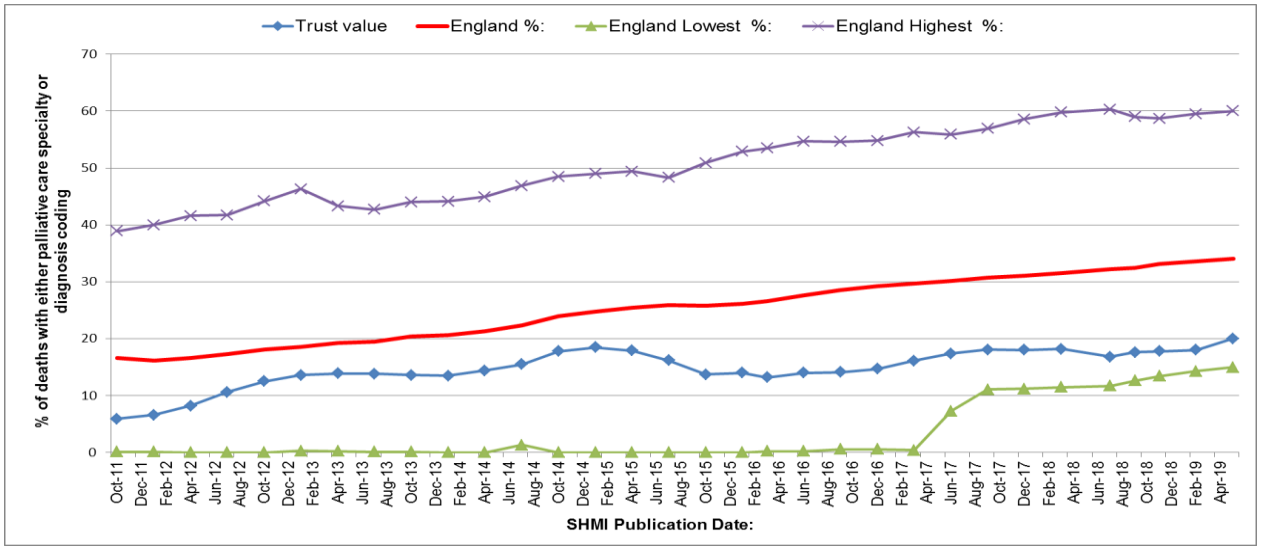


Figure 18 the chart visually illustrates the percentage of patients with a coded palliative care code at either diagnosis or specialty level

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

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

- Palliative care coding is a group of codes used by hospital level coding teams to reflect palliative care treatment of a patient during their hospital stay. To ensure these are not exploited for minimising an organisation's reported standardised mortality ratio, Trusts are required to meet strict rules that govern the use of such codes to only those patients appropriately seen and managed by a specialist palliative care team.

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

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

- The Trust's commissioned review of the data that underpins SHMI has identified a disparity between sites in the use of palliative care codes, which mirrors the differences in service provision recognising there are different models used at the two hospital sites. More work is needed to scope out the need for a change in the service provision and to determine if more consultant palliative care input is needed on the DPoW site.

- It is important to note that SHMI cannot be regarded as a measure of quality, as concluded from research undertaken and published. Quality can only be measured from case note review work, hence the Trust's prioritisation of this as a quality priority during 2019/20.

- The Trust is committed to ensure that mortality case note reviews are undertaken in a steadily increasing proportion of cases and is working to embed effective arrangements within specialties to ensure that case note reviews lead to reflective practice, lessons identified which are shared and used to learn from thereby increasing the quality of services provided, which will impact positively on patient outcomes including mortality. To this end the Trust has established key learning from deaths key performance indicators to support the case note review processes become more effective. Process developments are underway to support this including the introduction of a mortality review e-form.

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:

- The Trust has two mortality clinical leads that are supporting the mortality improvement work. These support and oversee the project work, reporting to the Mortality Improvement Group (MIG) on a monthly basis. This group have approved a number of key documents aimed at supporting further improvement including the learning from deaths policy and a mortality improvement strategy.
- The mortality improvement strategy has been agreed which aims to target 3 specific areas:

    1. Medical model – to focus on improved access and flow around the Trust's hospitals. This is also linked to the quality priorities for 2019/20;

2. Care of the deteriorating Patient – with links to the quality priorities for 2019/20 to support oversight and progress reporting;

3. Care for patients at end of life – overseen by the Trust's EOL strategy group with established links with external stakeholders to the Trust and also with links to the 2019/20 quality priorities. This part of the strategy will closely align the Trust and community partners recognising that these indicators are a reflection on a healthcare systems performance, not just on the hospital provided care;

4. Learning from deaths review work – with links to the quality priorities for 2019/20 to again focus on progress and delivery, with reporting to Board.

- The above strategy also links to the Trust's end of life work, overseen by the Trust's EOL strategy group with established links with external stakeholders to the Trust and also with links to the 2019/20 quality priorities. This is aiming to closely align the Trust and community partners recognising that these indicators are a reflection on a healthcare systems performance, not just on the hospital provided care;

- During 2018/19 the Trust also appointed a dedicated analyst to support the development of the learning from mortality and near misses (incidents) for wider sharing with clinical teams; this focus has helped prioritise improvement work. This support to clinical teams will evolve during 2019/20 as the focus on sharing lessons increases pace.

- The quality priorities for 2019/20, some of which have already been referred to, have significant links to the mortality improvement work programme as well. Deteriorating patient and sepsis quality priority themes will support the Trust's focus going forward.

- The Trust has been supported during 2018/19 by collaborative working with GP, CCG and community partners, this has helped identify key themes for sharing with the wider healthcare system, further close working relationships will remain an ongoing action for the Trust during 2019/20.

2.3b Patient Reported Outcome Measures (PROMS)

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

a) Groin hernia surgery
b) Varicose vein surgery (no longer performed by this Trust)
c) Hip replacement surgery
d) Knee replacement surgery.

During the reporting period.

Type of surgery	Sample time frame	Trust adjusted average health gain	National average health gain	National highest	National lowest
Groin hernia	April 2011 – March 2012	0.084	0.087	0.143	-0.002
	April 2012 – March 2013	0.083	0.085	0.157	0.015
	April 2013 – March 2014	0.051	0.085	0.139	0.008
	April 2014 – March 2015	0.085	0.084	0.154	-0.006
	April 2015 – March 2016	0.128	0.088	No data available	No data available
	April 2016 – March 2017	0.109	0.086	No data available	No data available
	April 2017 – March 2018	No data available	No data available	No data available	No data available
Hip replacement (Primary)	April 2011 – March 2012	0.405	0.416	0.532	0.306
	April 2012 – March 2013	0.461	0.438	0.538	0.369
	April 2013 – March 2014	0.426	0.436	0.545	0.342
	April 2014 – March 2015	0.436	0.437	0.524	0.331
	April 2015 – March 2016	0.485	0.438	No data available	No data available
	April 2016 – March 2017	0.501	0.445	No data available	No data available
	April 2017 – March 2018	0.453	0.468	0.56	0.376
Knee replacement (Primary)	April 2011 – March 2012	0.317	0.302	0.385	0.180
	April 2012 – March 2013	0.357	0.319	0.409	0.195
	April 2013 – March 2014	0.332	0.323	0.416	0.215
	April 2014 – March 2015	0.339	0.315	0.204	0.418
	April 2015 – March 2016	0.349	0.320	No data available	No data available
	April 2016 – March 2017	0.361	0.324	No data available	No data available
	April 2017 – March 2018	0.323	0.338	0.416	0.233

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)

Comment:

- The Patient Reported Outcome Measure (PROMs) is a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. The 4 areas listed above are nationally selected procedures. Varicose vein surgery is not performed by the Trust, therefore no data is available.

- Reporting for groin hernia has been phased off due to the NHS England decision in October 2017 to discontinue the mandatory groin-hernia surgery national PROM collections. The rationale for this decision is that Groin hernia surgery is offered mainly to reduce the risk of requiring emergency surgery, rather than to relieve symptoms, which are often relatively minimal. This, along with the fact that there is no condition-specific PROM for groin-hernia surgery, means that the existing PROM has limited value. The last available data ceased following May 2018.

- The above table shows the Trust's reported adjusted health gain against the EQ-5D index, which is a measure of the patient's own reported outcome following surgery within the Trust.
- 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).

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

- The results for the latest available data release as at February 2019 demonstrates that the Trust was not a statistical outlier for any of the EQ-5D health gain outcomes reported. At the time of writing, groin hernia data is not yet available for the latest period of time (April 2017 – March 2018).
- Quarterly reports are received from NHS Digital that provide progress updates on both the participation rates both pre and post-surgery, and the overall health gain reported by patients.

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

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

2.3c Readmissions to hospital

The data made available to the Trust by 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 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

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

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

Comment:

- There is an ongoing review by NHS Digital of emergency readmissions indicators. This data has not been published since 2014. As part of this review, two indicators will be published during early 2019.

- As there has been no updated information added to the NHS Digital Quality Account indicators site, the Trust cannot provide any further update on this section.

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

- The Trust has been consistently below the national rates for re-admissions, as demonstrated in the locally available data to the Trust.

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.

2.3d Responsiveness to the Personal needs of patients

The data made available to the Trust by NHS Digital with regard to the Trust's responsiveness to the personal needs of its patients during the reporting period.

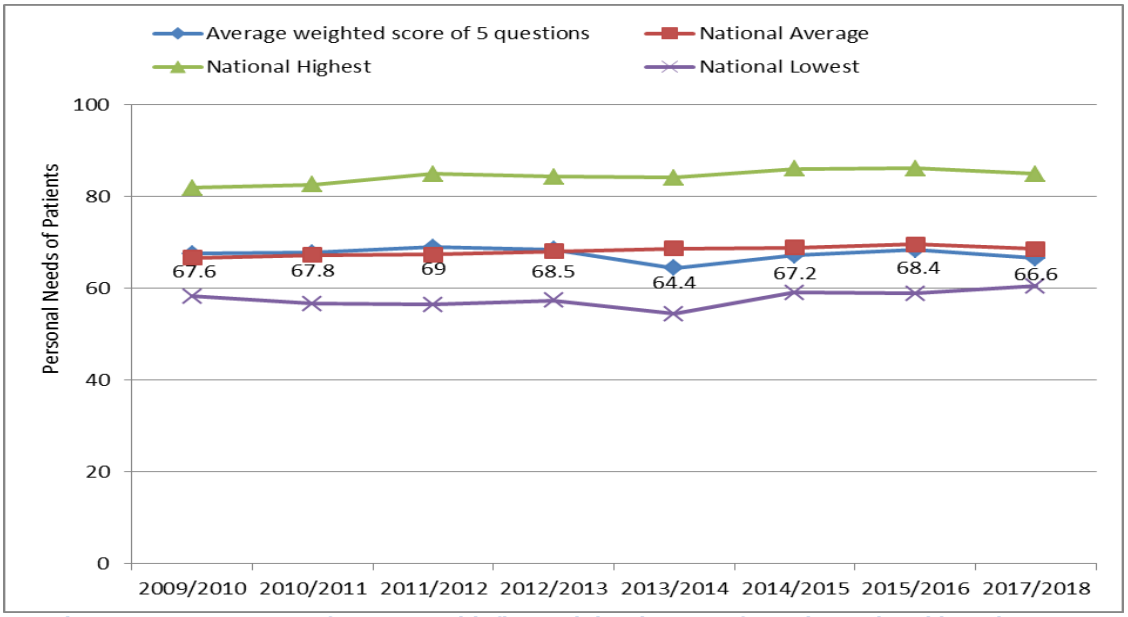


Figure 19 demonstrates Trust performance with five weighted scores from the national inpatient survey used to determine the Trust's responsiveness to patient's receiving care in its acute services

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

Comment:

- The table above highlights the average weighted score for five specific questions. This information is presented in a way that allows comparison to the national average and the highest and lowest performers within the NHS.

- The above figures are based on the adult inpatient survey, which is completed by a sample of patients aged 16 and over who have been discharged from an acute or specialist trust, with at least one overnight stay. The indicator is a composite, calculated as the average of five survey questions from the inpatient survey. Each question describes a different element of the overarching theme:

"*Responsiveness to patients' personal needs".*

1. Were you involved as much as you wanted to be in decisions about your care and treatment?
2. Did you find someone on the hospital staff to talk to about your worries and fears?
3. Were you given enough privacy when discussing your condition or treatment?
4. Did a member of staff tell you about medication side effects to watch for when you went home?
5. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

- Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. Therefore, this indicator will also take values between 0-100.

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

- The Trust results are broadly in line with the national average but it continues to aspire to reach beyond this.

- We know that by developing a positive culture, ensuring the workforce is adequate, competent and empowered will have a natural impact on care and the resulting patient perceptions.

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

- The Trust are focussing staff on “what matters most” to patients and supporting effective communication. By working with staff on projects such as, “what matters to you” bed boards and ALWAYS Events, the emphasis is building a culture of getting staff to re-engage with patients, carers and families to deliver person centred care and quality improvements.

2.3e Staff recommending Trust as a provider to friends and family

The data made available to the Trust 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.

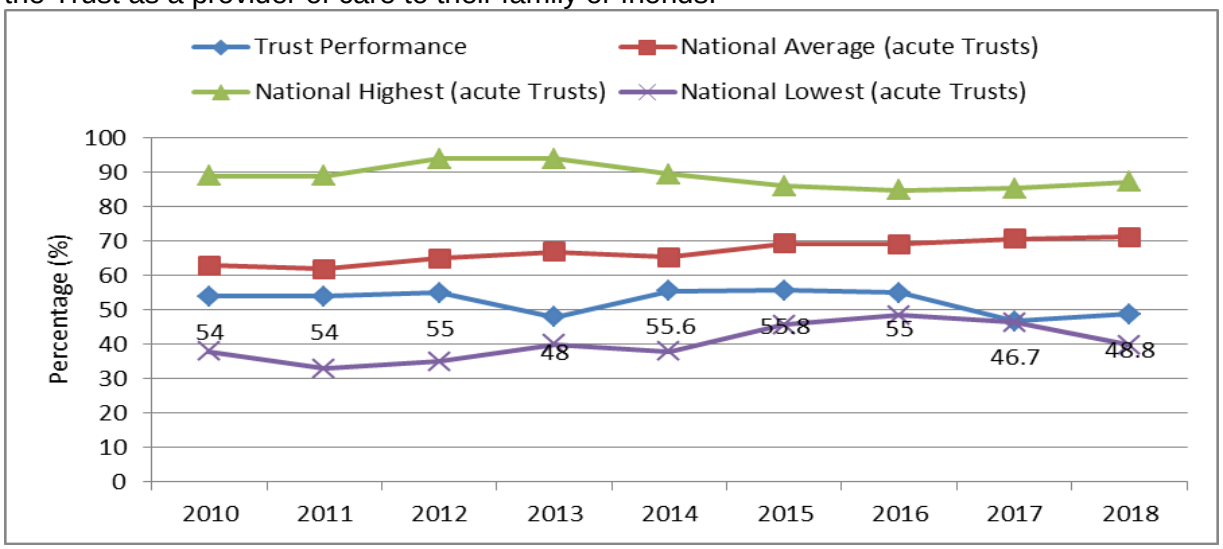


Figure 20 shows the Trust reported performance for staff recommending the Trust as a provider to family and friends

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

Comment:

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

- 49% of staff surveyed would recommend the Trust, which is an improvement from the previous year's survey result and demonstrates that Trust staff are seeing evidence of the improvements being made. The Trust recognises that whilst this is positive, more work is needed to continue improving.

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

- Despite some progress the Trust recognises there is still much more needing to be done to improve the overall score. Reviewing available comments the Trust believes staffs perceptions are built on concerns relating to staffing levels against increased patient activity and concerns over support from senior managers. This is having an adverse effect on workforce morale and their perception over the quality of care offered to patients.

- The Trust have identified these themes prior to the national staff survey being released and has been proactively working throughout 2018/19 to address the themes underpinning these findings.

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

- Prior to release of the NHS staff survey, action had already commenced, with culture being included as a specific and distinct work stream as part of the Trust's Improving Together Programme. Actions already taken include:

    - A key finding from the NHS Staff Survey was in connection with a lack of staff. The Trust continues to use innovative ways to recruit to posts that are challenging to fill. This has included the creation of new roles and the continued expansion of the Trust's apprenticeship programme to home grow future talent. To complement this the Trust continues to focus on the targeted recruitment and retention of staff.

    - The Trust is due to embark on a safety culture diagnosis across its clinical areas using the Manchester Patient Safety Framework tool. Starting in Clinical Support Services and Community and Therapies divisions in April 2019 the tool will be rolled out across all divisions in 2019/20. The output of the tool will allow divisions to create a meaningful action plan which endeavours to place clinical safety central to all the care they provide and their clinical practices.

    - Continued development of 'Pride and Respect (our anti-bullying campaign)' project provides staff and leadership teams with training regarding appropriate behavioural standards (linked to the Trusts values) and access to 'Lets Talk' the Trusts newly launched mediation service.

    - The Trust has through extensive staff engagement revised and is about to launched its new values; Respect, Courage, Kindness. Linked to this is a revised behavioural framework designed to complement the Trust's cultural transformation programme

    - The Trust is placing significant emphasis on staff engagement and the benefits of senior leadership teams increasing their level engagement. Divisions are creating bespoke staff engagement plans from which they will review the effectiveness of their staff two-way communication channels and how they provide staff with the means to make service improvement suggestions.

2.3f Risk assessed for venous thromboembolism

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

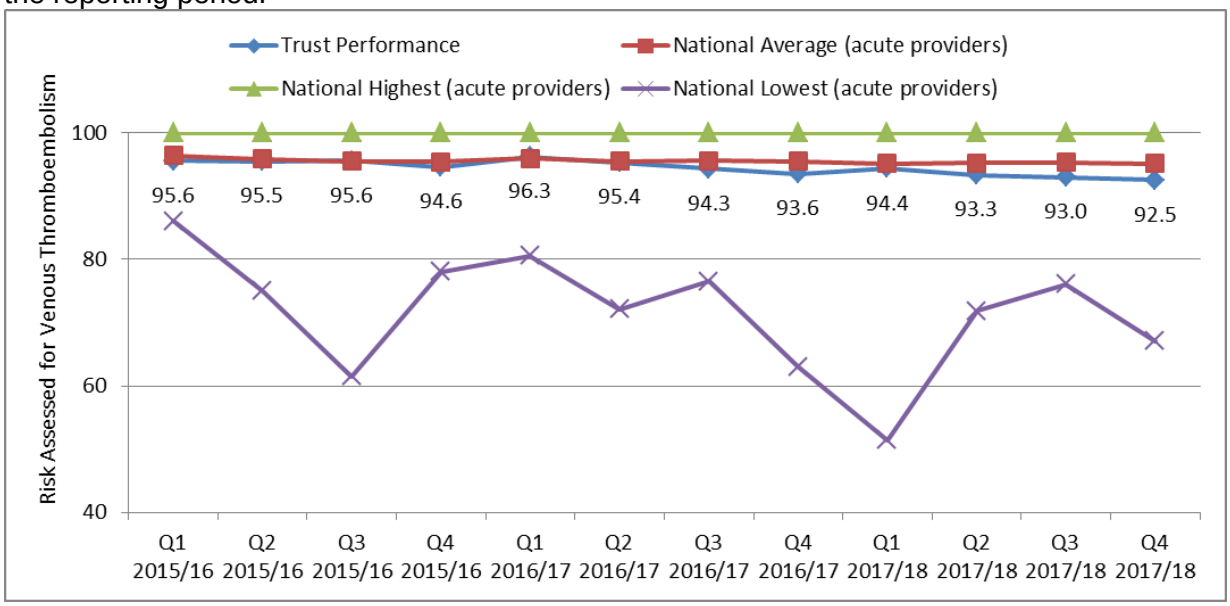


Figure 21 Trust performance for patients risk assessed for venous thromboembolism (VTE)

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

Comment:

- The above table illustrates the percentage of patients admitted to the Trust and other NHS acute healthcare providers who were risk assessed for venous thromboembolism (VTE) since quarter one, 2015/16. The Trust is not at present achieving the 95% target for this area.

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

- The Trust oversees compliance with VTE risk assessments and prophylaxis prescribed through monthly reporting through the Trust's performance framework. Where possible this overall compliance is broken down to ward and department level to aid continued understanding and improvement.

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

- A specific project is underway to work on improving VTE screening performance, being led on by the Trust's Deputy Medical Director.
- The Trust's VTE group has been re-established to focus on this area. The root causes behind why performance reported here is not yet achieving the target, and work to address this will be undertaken overseen by the Trust's Medical Director.
- The Trust has also been successful in their application to be a pilot site for the roll-out of an Electronic Prescribing and Medicines Administration (EPMA) system. As part of this, commencing from April 2019, it is anticipated that greater controls in place to support improved prescribing will lead to safety benefits including greater ability to ensure VTE risk has been fully assessed prior to prescribing or administration of medications.

2.3g *Clostridium Difficile* infection reported within the Trust

The data made available to the Trust by NHS Digital with regard to the rate per 100,000 bed days of cases of *Clostridium difficile* infection reported within the Trust amongst patients aged 2 or over during the reporting period.

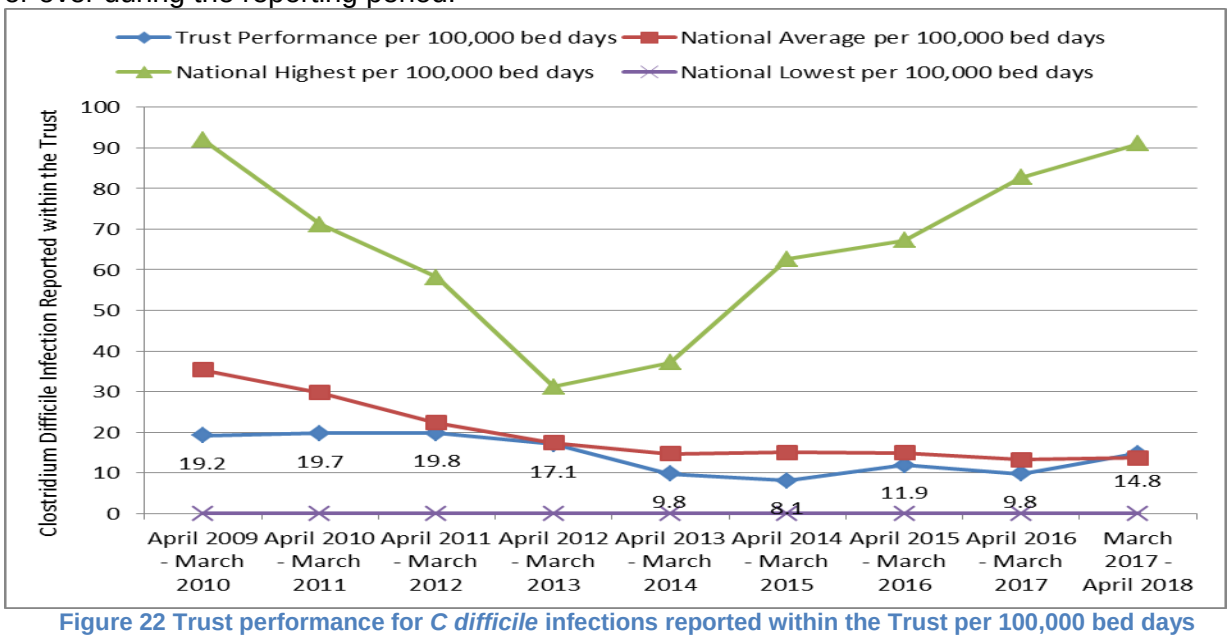


Figure 22 Trust performance for *C difficile* infections reported within the Trust per 100,000 bed days

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

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

Comment:

- The above table illustrates the rate of *C. difficile* per 100,000 bed days, for the Trust (Trust apportioned cases), for specimens taken from patients aged two years and over.

- During 2017/18, the most recent data available, the Trust reported a higher number of *C. difficile* infections than the UK average.

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

- The trust ended the financial year on 37 cases of *C.difficile* toxin positive. The rise in number of cases may be partially attributed to the high level of influenza compared to the previous years, with many patients developing a secondary respiratory bacterial infection necessitating the use of antibiotics. The majority of cases of *C. difficile* infections were detected on the DPOW site as per the previous year.

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

- During 2018/19 the DPoW site has had its medical floor reconfigured and refurbished resulting in a net gain of 20 single rooms which can be used to increased isolation capacity to prevent infection spread. Particular wards with higher incidence of *C. difficile* on the medical floor, as part of this reconfiguration, have had their hand washing

facilities increased significantly resulting in no further cases of *C. difficile* infection on this ward since the improvements were made.

- Capital and planning teams have factored the need to increase isolation capacity into future building schemes.
- The Trust has an evidence based *C. difficile* policy and patient treatment care pathway.
- Multi-disciplinary team meetings are held for inpatient cases to identify any lessons to be learnt and post infection review is conducted for every hospital onset case.
- For each case admitted to hospital, practice is audited by the infection prevention and control team using the Department of Health Saving Lives' audit tools.
- Themes learnt from PIR process will be monitored by the Infection Prevention & Control Committee and shared with relevant bodies.
- The development of a bespoke IPC WebV module that will alert IPC team to previous cases of *C. Difficile* infections readmitted into the trust. The system also should allow the interface with future electronic prescribing software to help identify prescribing habits.
- GPs will be sent an email to inform them of a patients *C.difficile* / GDH status again to help reduce the amount of antimicrobial use and prevent future *C. Difficile* cases.
- Development and implementation of a rolling programme of antibiotic prescribing audits reviewed by the Infection Prevention & Control group.
- The introduction of Ultraviolet non touch decontamination on the DPOW site to enhance deep cleaning process.
- The introduction of biocide impregnated privacy curtains across the Trust.
- A review of impregnated cleaning wipes with a switch to one biocide wipe for cleaning equipment as a standard across the Trust.
- PathLincs antimicrobial formulary reviewed with latest national standards.
- The development and publication of a new antimicrobial HUB site to make access to content easier for prescribers,
- Introduction and review of the cleaning materials used by facilities. This has resulted in a standardisation to one biocide cleaner as a routine across the Trust.

2.3h Patient safety incidents

The data made available to the Trust by NHS Digital with regard to:

a) The number and, where available, rate of patient safety incidents per 1,000 bed days reported within the Trust during the reporting period,

Time frame	Trust number of patient safety incidents reported	Trust rate of patient safety incidents reported per 1,000 bed days	Acute – Non-specialist average rate of patient safety incidents per 1,000 bed days	Acute – Non-specialist highest rate per 1,000 bed days	Acute – Non-specialist lowest rate per 1,000 bed days
April 2014 – September 2014	5,124	41.5	35.9	75.0	0.2
October 2014 – March 2015	5,483	43.2	37.1	82.2	3.6
April 2015 – September 2015	5,570	44.7	39.3	74.7	18.1
October 2015 – March 2016	5,395	42.8	39.6	75.9	14.8
April 2016 – September 2016	5,953	49.5	40.8	71.8	21.1
October 2016 – March 2017	6,536	52.3	41.1	69.0	23.1
April 2017 – September 2017	6,347	52.4	42.8	111.7	23.5
October 2017 – March 2018	5,897	48.0	42.6	124.0	24.2

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

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

- The above table demonstrates the total number of reported patient safety incidents and the rate per 1,000 bed days reported.

- Northern Lincolnshire and Goole NHS Foundation Trust average rate of patient safety incidents reported is above the average of other acute non-specialist NHS organisations. The Trust actively promotes and encourages 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 indicates a high level of safety awareness.

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

Time frame	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	Acute – Non-specialist national average rate of patient safety incidents reported involving severe harm or death per 1,000 bed days	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
April 2014 – September 2014	12	0.10	0.2	1.09	0.00
October 2014 – March 2015	6	0.09	0.2	1.53	0.02
April 2015 – September 2015	6	0.05	0.17	1.12	0.03
October 2015 – March 2016	9	0.07	0.16	0.97	0.00
April 2016 – September 2016	7	0.06	0.16	0.60	0.01
October 2016 – March 2017	21	0.17	0.16	0.53	0.01
April 2017 – September 2017	24	0.20	0.15	0.64	0.00
October 2017 – March 2018	21	0.17	0.15	0.55	0.00

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

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

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

- During 2018/19 the Trust reviewed its incident reporting function which included an updated version of the system and a dedicated analyst was appointed to support interrogation of incident data in greater detail to support a focus on sharing lessons.

- As part of this review in 2018, more stringent oversight arrangements were developed by the central team which included a strengthening of the validation process for any moderate and above incidents reported. Specifically this was around ensuring that incident reporting information was updated for accuracy following this validation and clinical review. It is likely that during 2017/18, whilst validation was undertaken, the master data housed within the Trust's incident reporting system was not updated following the clinical review, resulting in an over reporting of incidents resulting in severe harm or death.

- As a result of the strengthening of central team arrangements during 2018, the Trust would expect the next data download to be in line with the national average. The Trust continues to promote high levels of incident reporting, viewing this as a learning opportunity promoting a positive patient safety culture.

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

- As alluded to already, one of the key actions taken during 2018 was to strengthen the central team validation of moderate and above incidents. This is likely to demonstrate a reduction in the number of incidents reported that lead to serious harm or death.

- Whilst the above action focussed on data quality, the Trust continues to monitor the data for understanding of key themes and sharing for learning lessons opportunities. The Trust has introduced a weekly Serious Incident panel to review incidents which may meet the criteria for requiring a Serious Incident investigation, including those of severe harm or death.

2.3i Information on and learning following Never Events and Serious Incidents

The Trust reported 3 never events during 2018/19. Never Events are considered to be preventable events because there should be robust systems and processes to prevent these. These events are indicative that processes could be strengthened. These can be broken down into the following categories, including historical context and related incidents:

	2014/15	2015/16	2016/17	2017/18	2018/19
Retained Foreign Object	0	2	1	1	1
Wrong implant	0	1	0	1	0
Wrong site nerve block / injection	0	1	1	0	2
Misplaced nasogastric tube	0	0	0	1	0

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

Learning and action taken following Serious Incident / Never Event investigation:

The Trust is committed to learning from errors, to help reduce the risk of future harm. Every Serious Incident investigation, including any Never Event, results in recommendations, actions and learning which the Trust follows to reduce the risk of future events. A brief outline of some key actions and learning following Serious Incidents or Never Events investigations in 2018/19 is provided below:

- **Wrong site nerve block (Never Event):** Work with staff to ensure the '5 Steps to Safer Surgery Policy' is consistently followed, including the 'Stop Before you Block'.
- Ensuring staff changeovers do not occur at critical stages of the patient journey, unless for an emergency, e.g. any section of the WHO Safety Checklist.
- Update the pre-operative checklist with addition of the second nurse check to the pre-theatre checklist within the nursing documentation, and an update of the Pre-Operative Marking Verification Policy.
- Simulation training undertaken and video recorded to embed practice and share the learning trust wide.

- **Retained Surgical Item:** All gynaecological examinations undertaken by nurses and / or medical staff with the use of swabs are to be counted, checked by a second person and documented within the medical records.
- Development of a guideline on counting of swabs, and other accountable items, in gynaecological examinations.
- Study session to highlight the expectations and standards for documentation

- **Pressure ulcers:** Intensive training and support delivered to ward staff by Tissue Viability Nurses working alongside staff for 2 days a week over a 2 month period. Training to focus on pressure area management documentation, including risk assessments, 28 point skin checks and repositioning accurate identification and grading of pressure ulcers.
- Embed into practice Registered Nurses undertaking a daily 1 x 28 point skin assessment.
- Inclusion of pressure ulcer status and actions in all handovers and safety huddles.

- **Medication:** Second checking process checks adhered to on the ward for all patients receiving IV medications, as per Trust policy, to be evaluated by priority Trust Quality and Audit project to test embedding.
- A second check to be introduced whereby two registered nurses confirm and sign that the correct insulin has been given and carried out. Audit to test embedding of practice to be undertaken.
- All Divisions to improve staff compliance in relation to insulin training as agreed at the Trust's Serious Incident Panel.

- **Delayed treatment / follow up in Ophthalmology:** Implementing a process for patients who are prescribed Lucentis who have had their appointment cancelled. These patients to be identified by the Specialty Administration Team, to enable monitoring with spot checks and failsafe's introduced to ensure follow ups requested are acted upon within the pathway timeframes.
- A speciality specific mailbox has been implemented to minimise the risk of human error from urgent emails not being seen or acted upon.
- A refreshed capacity and demand for Ophthalmology using the NHS Intensive Support Team model.
- A clinically developed risk stratification process to be developed to ensure patients are seen in clinical priority order and the development of a robust process to identify time-critical patients.

- **Non-action taken on results:** Handover templates and the safety huddle template modified to include investigations undertaken in order to ensure these are discussed.
- The Head of Radiology to review the process and pathway for communicating abnormal results to inpatient ward areas and implement improvements as appropriate.

Part 3: Other information

An overview of the quality of care based on performance in 2018/19 against indicators

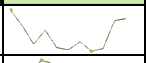
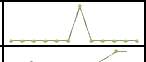
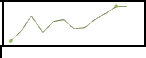
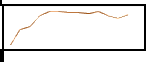
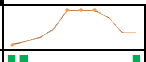
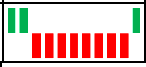
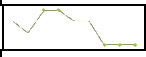
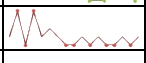
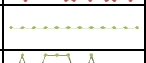
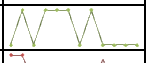
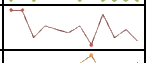
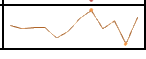
3.1 Overview of the quality of care offered 2018/19

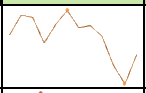
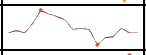
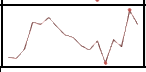
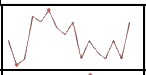
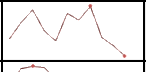
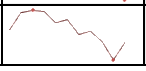
The Trust set out 5 key quality priority themes for focus on within 2018/19, which were:

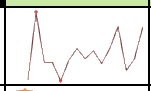
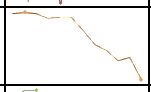
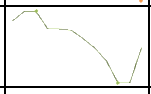
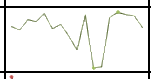
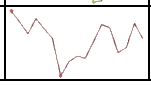
1. Safety – specific focus on pressure ulcers, recognition of the deteriorating patient and mortality indicators.
2. Safe emergency care – specific focus on access to non-elective care and flow through our hospitals.
3. Safe planned care – specific focus on cancer care, 52 week waits and clinical harm reviews.
4. Safe maternity care.
5. Safe staffing, improved staff engagement and patient experience.

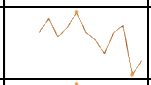
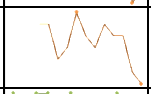
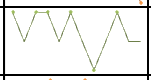
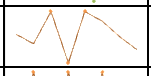
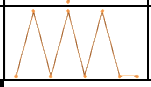
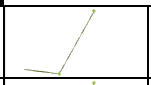
Understanding Trust performance against these themes has been based on a number of indicators that are reported on within the integrated performance report (or other internal reporting mechanisms) to the Trust's Board. Whilst the quality priority themes have remained the same, some of the indicators used to support understanding of performance against these themes may have changed or been refined during the 2018/19 year.

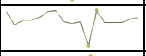
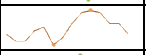
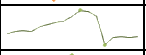
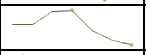
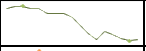
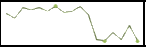
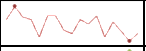
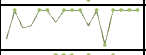
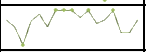
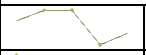
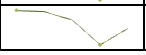
The following outlines, key performance against these quality priority themes. For a more detailed narrative and explanation of performance, see part 2.1 of this report which provides greater detail.

THEME 1: SAFETY - Specific focus: Pressure Ulcers, Recognising Deteriorating Patient & Mortality		Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19	Jan-19				
1.1	Pressure Ulcers per 1,000 bed days (Acute)	Not yet available	1.73		TBD	Work underway to assess Trust benchmarked position with NHSi support	TBC
	Pressure Ulcers: Grade 2 (Acute)	35 R	40		30		Local
	Pressure Ulcers: Grade 3 (Acute)	9 R	15		6		Local
	Pressure Ulcers: Grade 4 (Acute)	0 G	0		0		Local
	Pressure Ulcers - Community (North Lincolnshire)		79		TBD		TBC
		Feb-19	Jan-19				
1.2	Early Warning Score (NEWS) - Recorded on time	75.54% R	73.16%		>90%	No benchmark	Local
		Jan 18-Dec 18	Oct 17 - Sep 18				
1.3a	Summary Hospital-Level Mortality Indicator (SHMI)	112	113		100	SAME (117/130) Jan 18-Dec 18	National
	Position vs peers	As Expected G	Higher than expected		Within expected range		vs. Peer
		Dec-18	Nov-18				
1.3b	Hospital Standardised Mortality Ratio (HSMR)	110 G	110		100	SAME (As Expected)	National
		Mar-19	Feb-19				
1.4	Falls per 1,000 bed days	Not yet available	3.89		TBD	No benchmark	TBC
	Falls: No harm	79 G	74		80	No benchmark	Local
	Falls: Minior harm	37 G	48		40	SAME (65/132) Q2, ST Falls with harm	Local
	Falls: Moderate harm	0 G	2		0		Local
	Falls: Major or catastrophic harm	1 R	0		0		Local
1.5	MRSA (Hospital acquired) (Year to date: 0)	0 G	0		0	SAME	National
	C Diff: infection rate - lapse in care (Year to date: 5)	0 G	0		20 lapses in care	No benchmark	National
	Gram Negative Blood Stream Infections (GNBI) (Year to date: 76)	3 R	6		52	No benchmark	National
1.6	Venous Thromboembolism (VTE) Screening rate (%)	93.70% R	91.40%		95%	AMBER (Safety Thermometer)	National

THEME 2: SAFE EMERGENCY CARE - Specific focus: Access to Non-Elective Care and Flow Through Our Hospitals		Most recent data	Previous data	Trending	Target	Benchmark Data		Source of Target
		Mar-19	Feb-19					
2.1	A&E maximum waiting time of 4 hours from arrival to admission / transfer / discharge - Type 1 (%)	82.2% A	77.6%		90%	AMBER (vs. National)	SAME (vs. Local Peer)	National
2.2	Number of super stranded patients - 21+ days	81 R	82		< 61	No benchmark		National
2.3	Non elective length of stay	4.86 R	5.05		< 4.10	WORSE (4.1 days)		Local
		Feb-19	Jan-19					
2.4	Non elective length of stay - Medicine Division	6.5 R	5.9		< 4.10	WORSE (4.1 days)		Local
2.5	Early Warning Score (NEWS) - Recorded on time in Emergency Department - DPoW	62.3% R	63.87%		>90%	No benchmark		Local
2.6	Early Warning Score (NEWS) - Recorded on time in Emergency Department - SGH	69.0% R	64.64%		>90%	No benchmark		Local

	THEME 3: SAFE PLANNED CARE - Specific focus: Cancer Care, 52 Week Waits and Clinical Harm Reviews	Most recent data		Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19		Feb-19				
3.1	Treatment started within 62 days of urgent GP referral (cancer)	78.9%	R	73.2%		85.0%	WORSE vs. Local Peers	National
3.2	Patients on an incomplete referral to treatment pathway waiting > 52 weeks	6	A	110		< 320 & Zero by 31 Mar	No benchmark	National
3.3	Patients on an incomplete RTT pathway: to be less than the Trust's March 2018 reported figure	28,551	G	27,055		< 29,396	WORSE vs. Local Peers	National
3.4	Clinical Harm reviews to be completed (cohort of patients with a due date prior to the 08 Aug 17)	100.0%	G	99.0%		100%	No benchmark	Local
3.5	WHO Surgical Safety Checklist (Theatres)	98.7%	G	99.5%		> 90%	No benchmark	Local
3.6	Maximum 6-week wait for diagnostic procedures	89.6%	R	92.5%		> 99.0%	WORSE 97.6% (Nat), 98.4% (Local)	Local

	THEME 4: SAFE MATERNITY CARE	Most recent data		Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19		Feb-19				
4.1	Ratio of midwives to births - DPoW	Currently not available					No benchmark	Local
4.2	Ratio of midwives to births - SGH	Currently not available					No benchmark	Local
4.3	Where a woman needs an initial CTG, this is commenced within 30 minutes of arrival	91.0%	A	89.0%		100%	No benchmark	Local
4.4	Where a woman in labour has a CTG undertaken fresh eyes reviews should occur at least every 2 hours for the duration of monitoring	93.0%	A	94.0%		100%	No benchmark	Local
4.5	Rolling still birth rate (Year to date: 16)	1		1		TBD	BETTER Rolling 12 month 4.7 per 1,000 births (Nat)	TBC
4.6	1:1 care in labour for women not having a cesarean section	Not yet available		99.50%		TBD	No benchmark	TBC
4.7	Number of Serious Incidents relating to Maternity services (Year to date: 7)	1		1		TBD	No benchmark	TBC
		Q3 18/19		Q2 18/19				
4.8	Antenatal referral for suspected Small for Gestational Age (SGA) or Fetal Growth Restriction (FGR)	62.4%	G	51.6%		>above UK average	BETTER 47.6% (Nat)	National
4.9	Small for Gestational Age (SGA) detected antenatally	53.0%	G	53.0%		>above UK average	BETTER 42.6% (Nat)	National

THEME 5: SAFE STAFFING, IMPROVED STAFF ENGAGEMENT & THE PATIENT VOICE		Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19	Feb-19				
5.1	Safer staffing fill rate - registered staff	96.5% G	96.5%		80.0%	No benchmark	Local
5.2	Safer staffing fill rate - carer staff	100.00% G	99.00%		80.0%	No benchmark	Local
5.3	Care hours per patient day	Not yet available	7.3			WORSE 8.0 (Nat)	Local
5.4	Nursing staff vacancy - registered	8.6% A	8.4%		< 6.0%	No benchmark	Local
5.5	Nursing staff vacancy - unregistered	1.5% G	1.8%		< 2.0%	No benchmark	Local
5.6	Medical staff vacancy	14.50% G	14.00%		< 15.0%	No benchmark	Local
5.7	Proportion of temporary staff	8.80%	8.70%		TBD	No benchmark	TBC
5.8	Mixed Sex Accomodation breaches	0 G	36		0	No benchmark	National
		Mar-19	Feb-19				
5.9	Friends and Family Test Results - A&E	75.2% R	73.00%		≥ 95.0%	WORSE 87.1% (Nat), 86.1% (Local)	Local
5.10	Friends and Family Test Results - Inpatient	99.0% G	99.10%		≥ 95.0%	BETTER 95.5% (Nat), 96.3% (Local)	Local
5.11	Friends and Family Test Results - Maternity	100.0% G	100.00%		≥ 95.0%	No benchmark	Local
5.12	Friends and Family Test Results - Community	99.2% G	98.20%		≥ 95.0%	BETTER 96.3% (Nat)	Local
5.13	Complaints - thematic analysis	See narrative					
5.14	Staff engagement: Pride and Respect - the Trust's anti-bullying campaign	See narrative					
5.15	Staff engagement: Listening to Improve	See narrative					
		2018	2017				
5.16	NHS national staff survey - overall engagement	6.5 G	6.4		> 6.4	WORSE 7.0 (Average)	Local
5.17	NHS national staff survey - "I would recommend my organisation as a place to work"	47.3% G	43.0%		> 43.0%	WORSE 62.6% (Average)	Local

3.2 Performance against relevant indicators and performance thresholds

Performance against those indicators that form part of appendices 1 and 3 of the Single Oversight Framework (SOF) is presented as follows.

Indicator	Quarter 1 18/19			Quarter 2 18/19			Quarter 3 18/19			Quarter 4 18/19			18/19 Performance
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	67.6%	70.2%	70.7%	71.0%	69.8%	69.3%	71.2%	72.7%	72.7%	73.9%	75.4%	76.1%	Average: 71.6%
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge Ⓐ	85.3%	88.3%	88.1%	84.0%	87.0%	89.2%	86.4%	86.8%	85.1%	80.5%	77.6%	82.2%	Average: 85.0%
All cancers: 62-day wait for first treatment from referral/screening Ⓐ	72.5%	69.1%	73.0%	75.0%	73.1%	74.7%	72.2%	75.0%	79.2%	71.1%	73.2%		Average: 73.5%
C.difficile: variance from plan [lapses in care] (target 21)	0	1	0	1	1	1	0	1	0	0	0	0	5
Maximum 6-week wait for diagnostic procedures	89.6%	82.9%	85.5%	86.6%	86.1%	89.0%	92.3%	91.7%	87.1%	88.0%	92.5%	89.6%	Average: 88.4%
Venous Thromboembolism (VTE) risk assessment	93.0%	92.7%	92.8%	92.8%	91.9%	92.5%	93.6%	94.4%	92.7%	93.4%	91.4%	93.7%	Average: 93.0%
Summary Hospital-level Mortality Indicator Ⓐ	September 2018 Release (Covering Apr 17 - Mar 18 data period): 1.19			November 2018 Release (Covering Jul 17 - Jun 18): 1.13			February 2019 Release (Covering Oct 17 - Sept 18): 1.13			May 2019 Release (Covering Jan 18 - Dec 18): 1.12			Average SHMI for Apr 17 - Dec 18 period: 1.14

This data, for the most part, has formed the basis of the Trust's quality priorities reported during 2018/19. For more detail regarding these see the executive summary and part 2 of this report.

3.3 Information on staff survey report

Summary of performance – NHS staff survey

Each year we encourage our 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.

In 2018, 35% per cent of our staff completed a survey (an increase from 33.6% per cent the previous year).

The survey was open from September to December 2018, and all staff were encouraged to participate. The survey was offered via a mixed mode method; that is staff received either a traditional paper or on-line form depending on their role and access to PC's in their normal day to day activities. The survey was publicised in various internal communications across the organisation, including the staff bi-monthly magazine, weekly team brief, the Hub (intranet), all staff emails and at the chief executive's monthly senior leadership team cascade.

Detailed performance – NHS staff survey

The Trust undertook a census sample survey during 2018, offering 5,820 eligible staff the opportunity to participate. From this 2,020 surveys were completed and returned.

	2018		2017		Trust improvement/ deterioration
Response rate	**Trust**	**National average**	**Trust**	**National average**	
	35%	**44%**	**33.6%**	**45.5%**	1.4% improvement

Source: NHS Staff Survey

Staff Survey 2018 findings

In 2018 the staff survey nationally moved away from reporting 33 key findings, from which the top five and bottom five ranked scores were listed. Instead the staff survey now reports ten themes, as below:

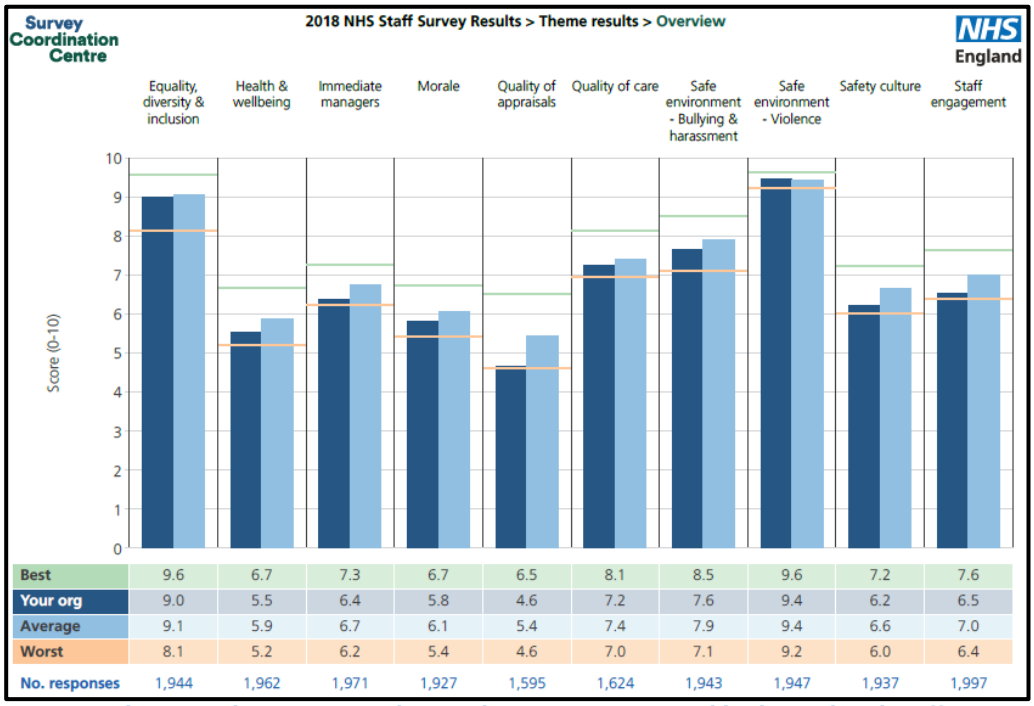


Figure 23 demonstrates the ten themes now reported in the national staff survey

Future priorities and targets

The Trust recognises that its greatest asset are its staff. As such the Trust's Improving Together plan contains numerous staff focused work streams, including (but not limited to):

- Continuing the Pride and Respect culture transformation work, including the delivery of behavioural standards training to all staff
- A review and redrafting of the Trust value statements with ratification by Trust Board in Q3 2018/19. The new values – Respect, Courage, Kindness – have an associated behavioural framework and are due to be formally launched Trust wide in Q1 19/20,
- The profile and importance of staff engagement has grown significantly over the last 12 months with all divisions being challenged by the CEO to create and deliver a bespoke staff engagement plan,
- The Trusts apprenticeship programme continues to grow in scope and credibility with national recognition for the work undertaken locally,
- To continued review of workshop establishments to enable the introduction of new roles such as Advanced Clinical Practitioners to support services and the medical rotas,
- An extensive and targeted recruitment programme supported by a tailored Staff Retention Strategy and a wide range of retention deliverables,
- The emerging recognition that quality improvement, coupled with a collaborative leadership style, will support the continuous service improvement agenda, provide staff with the mechanism to bring their service improvement ideas on line and provide alternative management practices based on QI methodologies and statistical performance analysis

The above work streams performance and outputs are monitored through the Trusts Improving Together Oversight Committees and Improving Together Board. These work streams will positively contribute to overcoming staffs concerns within the 2018 staff survey.

Importantly though the Trust continues to recognise the need for positive organisational culture change and the above programme of work illustrate the ongoing determination to rebuild the Trust, improve the working lives for staff and in doing so to improve the quality of care and patient experience. It is therefore pleasing to see that although the majority of the Trust's staff survey results are below the national average there is positive movement in the vast majority of the individual question scores.

To continue this direction of travel the Trust, rather than embarking on a multi-stranded transactional action plan, is intending to invest in two main work streams which very much build on the above work:

- **Staff Survey Work stream 1:** The continued corporate focus on staff engagement, including investing heavily in increasing staff voice to improve clinical/non-clinical services. To build on 2017/18 progress this work stream will now be linked to the quality improvement work to provide staff and leadership teams with the skills and QI methodologies to take staffs service improvement ideas forward.
- **Staff Survey Work stream 2:** Invest in Divisional Staff Survey Action Teams. Each Divisional leadership team, supported by their HR Business Partner and the Organisational Development Team, to work in partnership with their own staff, to jointly

agree between themselves a maximum of three areas from within the survey that they want to improve within their area of work.

The above two work streams will be monitored through the 'Leadership and Culture' Improving Together work stream. Additionally progress reports will be presented at the Trust Management Board and Trust Board itself. The staff survey transformational work streams commence April 2019. The measure of success will be taken from quarterly pulse check surveys aligned to staff survey key finding and ultimately by the findings within the 2019 staff survey report.

3.4 Information on patient survey report

Introduction

The National Inpatient Survey for 2018 was sent out to 1250 of patients who stayed in our Trust, 45% choose to respond. This extensive questionnaire helps provide a more detailed insight into their care received and provides a mechanism by which we can focus our improvement priorities in a patient led way.

Response rate compared with previous year:

	2018		2017	
Response rate	Trust	National average	**Trust**	**National Average**
	45%	43%	**41.1%**	**38.3%**

Source: NHS Patient Survey

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

These are the highlighted areas where we performed higher than the 77 Trusts we were benchmarked against and also the areas where we can focus our attention for improvement during the coming year.

	Top 5 scores (compared to average)
87%	Q21+. Hospital: got enough help from staff to eat meals
97%	Q20. Hospital: offered a choice of food
61%	Q50. Discharge: was not delayed
98%	Q72+. Overall: well looked after by non-clinical hospital staff
60%	Q19+. Hospital: food was very good or good

	Bottom 5 scores (compared to average)
61%	Q6. Planned admission: was admitted as soon as necessary
53%	Q56. Discharge: patients given written/printed information about what they should or should not do after leaving hospital
55%	Q9. Admission: did not have to wait long time to get to bed on ward
55%	Q60+. Discharge: told of danger signals to look for
48%	Q58+. Discharge: told side-effects of medications

	Most improved from last survey
87%	Q21+. Hospital: got enough help from staff to eat meals
55%	Q9. Admission: did not have to wait long time to get to bed on ward
81%	Q61+. Discharge: family or home situation considered
61%	Q50. Discharge: was not delayed
11%	Q52. Discharge: delayed by no longer than 1 hour

	Least improved from last survey
15%	Q71. Overall: received information explaining how to complain
61%	Q6. Planned admission: was admitted as soon as necessary
68%	Q63. Discharge: told who to contact if worried
11%	Q70. Overall: asked to give views on quality of care
60%	Q19+. Hospital: food was very good or good

Actions to be taken as a result:

Divisional action plans will be created and the Patient Experience Group will monitor this over the coming year. The Patient Experience team will also be looking at improving engagement with the national inpatient survey results as an ongoing piece of work.

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

Annex 1.1: Statements from Commissioners

Feedback from:
This statement has been prepared in collaboration with the following Clinical Commissioning Groups:

- **North East Lincolnshire CCG,**
- **North Lincolnshire CCG,**
- **East Riding of Yorkshire CCG,**
- **Lincolnshire East CCG.**

This statement has been prepared in collaboration with the following Clinical Commissioning Groups; North East Lincolnshire; North Lincolnshire; Lincolnshire East and East Riding of Yorkshire.

We commend Northern Lincolnshire and Goole NHS Trust on achieving an improved overall CQC inspection rating in 2018, moving the rating from Inadequate to Requires Improvement. Whilst this is a significant achievement commissioners recognise the importance that the Trust maintain a continued focus on their improvement journey to achieve good quality care.

There are specific areas to celebrate with the Trust from their achievements in 2018/19. The focused improvement work around the acute hospital pressure ulcer care, a reduction in the medical vacancy, the move from a Requires Improvement CQC rating in maternity to Good and the activity in the Pride and Respect work streams are extremely positive. The Trust has strengthened its clinical leadership to support improvements in both culture and quality and safety and commissioners welcome this approach. Commissioners acknowledge the work the Trust is undertaking in addressing the nurse vacancy rates. This is a national challenge and commissioners welcome the innovative approaches the Trust is involved in to address the vacancy rates. Commissioners recognise the significant achievement of the Trust in having no 52 week breaches at the close of the financial year.

The annual staff survey saw improvement across the majority of questions but the response rate, which had improved from the previous year, remained low and below the national average. Although the position indicates that the Trusts Improving Together Plan to engage staff and support workforce is having an impact on culture the importance of continuing the work stream to influence further progression next year in these areas is clear, as is a focus on improving the staff survey response rate as it is below national average.

Whilst Commissioners acknowledge the progress and improvement against the Trust Improving Together Plan, there remain a number of areas where we would like to see a significant change in the pace, scale of improvement or maintaining the improved position in the coming year. Commissioners are keen to see improvement expedited or maintained in the management of the deteriorating patient, Trust mortality, diagnostics, complaints management and management of waiting lists. We are continuing to work closely with the Trust to support improvement and seek assurance in this regard. We acknowledge the work to improve the Trust's Serious Incident Process and how the Trust learns when things go wrong. We are keen to see this work come into fruition in 2019/20.

The Trusts quality priorities for 2019/20 are welcomed by commissioners. It is recognised that the focused areas for improvement in clinical quality have the potential to have a significant

impact on improving safety, effectiveness and experience. Whilst we recognise that some Trust priorities from 2018/19 have continued into 2019/20 we are keen to observe pace and achievements in these areas. In general the priorities of the Trust reflect those of the local and national health and social care systems in improving; the general quality of healthcare services; flow through the system; cancer outcomes and the provision of safe care.

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

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

Commissioners remain committed to working with the Trust and its regulators to improve the quality and safety of services available for the population of each CCG area in order to improve patient outcomes.

Annex 1.2: Statement from Healthwatch organisations

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

healthwatch North Lincolnshire healthwatch North East Lincolnshire healthwatch East Riding of Yorkshire

Statement on North Lincolnshire and Goole NHS Foundation Trust Quality Account for 2018/2019

Healthwatch North Lincolnshire, Healthwatch North East 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 North and North East Lincolnshire Healthwatch and Healthwatch East Riding of Yorkshire.

We acknowledge that the trust has made some improvements in 2018-2019, in many of the indicators within the document, however more needs to be done to ensure that Northern Lincolnshire and Goole NHS Foundation Trust continue to improve against national standards.
It is encouraging to see improvements in staffing and vacancy rates have decreased; and all 3 Healthwatch are pleased to see the trust taking a more innovative approach to attract new medical and nursing staff as well as addressing retention of the Trust's existing Workforce.
However, continued improvement is still needed in improving staff morale and we would hope to see improvements in this area in 2019-2020.

We recognise the concerted effort to continue to improve the quality and safety of services within the trust and we look forward in continuing to work more closely with Northern Lincolnshire and Goole NHS Foundation Trust in the future and seeing how their new priorities are developed

Healthwatch Lincolnshire

Healthwatch Lincolnshire believe NLAG priorities set out in your Quality Account cover many important healthcare needs at this time.

However from a Lincolnshire patient perspective, where referrals are made for our counties patients into NLAG services, over the past year we have received from patients and carers, a mix of both positive and negative comments. Some of the negative comments link to the need for better communications between in and out of county services where patients are accessing cross border services. In addition, we are acutely aware of the fragility of services at both ULHT and NLAG and welcome proactive approaches to continual open dialogue between the Trusts and other healthcare services. We believe it is important to also highlight positive comments which include patient views that your staff are caring and compassionate.

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

Feedback from:
North Lincolnshire Council – Health Scrutiny Panel's Quality Accounts comments for Northern Lincolnshire and Goole NHS Foundation Trust

North Lincolnshire Council's Health Scrutiny Panel welcomes the opportunity to comment as part of Northern Lincolnshire and Goole NHS Foundation Trust's (NLG) Quality Account. NLG are a key partner and provider of local services, and members have built a valuable working relationship with Trust personnel over many years. Our day-to-day contact with the Trust is always handled in a timely, professional manner, and NLG representatives have always expressed a willingness to provide information and assist with specific issues. The panel would wish to pass on our sincere appreciation for this.

For a number of years, the panel has used this opportunity to raise serious concerns about the Trust's overall performance in many areas and its future sustainability. However, whilst the Trust acknowledges that there is obviously much work still to do, the panel is genuinely glad to see some signs of recovery in 2018/19. Most apparently, this is shown in the September 2018 CQC rating of 'Requires Improvement' from the previous 'Inadequate'. The CQC's report on the Trust also shows noticeable improvements in many areas of operation, and trends on issues previously of concern such as 52-week referrals are particularly encouraging.

Similarly, the panel notes the small but consistent improvements on many indicators in the Annual Staff Survey, particularly around safety culture, support from management, and providing a safe environment for staff. However, whilst the panel notes the improvement in the number of staff who report that they would be happy for a friend or relative to receive care at NLG, the panel remains concerned that the Trust still performs well below the national average.

The panel's main contact with the Trust in 2017/18 has unfortunately focussed on a number of administrative problems that were identified. Most notably, the Trust reported errors around some 4,584 discharge summary letters not being sent to GPs and some 188 letters reporting

the results of cervical screening being missed. Naturally, the panel finds this very concerning, particularly where they could negatively impact on the health and wellbeing of patients. The panel also received updates in 2018/19 regarding the 'missed referrals' Serious Incident (SI) which was referenced in our comments from 2017/18. Whilst the panel welcomes the fact that NLG is a high-SI-reporting Trust, of course we remain concerned about the instances of patients coming to harm (page 28), or the two cases referred to on page 62 where patients have died, "more likely than not… due to problems in the care provided to the patient". The panel has therefore asked the Trust for a detailed briefing on SIs in summer 2019.

As described during each of the panel's submissions since 2014/15, and prior to this, set out in the panel's June 2013 scrutiny report on this subject, members remain concerned that the Trust's SHMI rate remains in the 'higher than expected' banding. Whilst the panel notes the downward trend, members have long advocated for a genuine whole-system approach to reducing mortality which aims to overcome operational and organisational boundaries.

The panel generally welcomes the quality priorities agreed by the Trust and set out within the Quality Account. In particular, the panel fully supports the prioritisation given to improving patient experience, clinical effectiveness and patient safety. Despite this, the panel notes the performance on staff recommending the Trust as a place to work, safer staffing fill rate, and medical staff vacancies, and believes that challenging targets for these important indicators should be set for 2019/20. In particular, the panel believes that, whilst the recent improvements should be welcomed, the target for staff recommending the Trust as a place to work should be set at least to match the national mean.

In summary, the panel welcomes the improvements on many issues in the previous 12 months, but shares the Trust's view that there is much more to do.

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

Owing to the upcoming local and parish elections, and the period of purdah immediately preceding the elections, East Riding of Yorkshire Council's Health, Care and Wellbeing Overview and Scrutiny Sub-Committee has declined to comment on this year's Quality Accounts.

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

The North East Lincolnshire Council Health and Adult Social Care scrutiny panel has continued to observe the progress being made by NLaG (the Trust) through regular reports and by stakeholder attendance of the Council of Governors.

Panel members have commented on more than one occasion on the progress being made in delivering efficiency and more importantly cultural change within the Trust. We were pleased to note the improvement in the CQC rating but remain aware that there is still much to do, particularly in relation to future sustainability and the Trusts role within the greater STP. It is important to all residents of North East Lincolnshire that there is an acute hospital within the borough.

We note the progress made in filling vacancies, especially within nursing, but remain concerned about the high vacancy levels generally and particularly for doctors. We believe that the newly opened accommodation block will help to attract more candidates.

We have noted the progress in addressing waiting lists, but remain concerned that patients are still waiting too long to be appointed.

Cultural changes that the Trust aspires to are noteworthy, as is the progress being made, but the concerns of highly pressured staff remain THE challenge, and the scrutiny panel will turn its focus more towards this in the coming years.

We welcome the publication of the Quality Account and appreciate the vast amount of detail contained herein. This is a high quality, plain English, and well-illustrated report which clearly delivers an open and transparent account of the Trusts journey.

Lincolnshire – Health Scrutiny Committee for Lincolnshire

The Health Scrutiny Committee for Lincolnshire is grateful for the Trust sharing its draft Quality Account for 2018/19 and recognises the Trust's provision of acute hospital services for significant number of residents in the northern part of the county. For this year, the Committee is focusing on the quality accounts of two other local trusts.

Annex 1.4: Statement from the Trust governors'

Feedback from:
The Trust's Lead Governor

The Council of Governors is very appreciative of the progress the Trust has made throughout the year whilst dealing with the unenviable position of being in double special measures. The emphasis has been on working towards improving on 5 quality priority themes with indicators to measure performance against each one.

Trust progress is regularly presented to the Board, relevant committees and the Council of Governors by means of the Integrated Performance Report. Governors are now attending some of the key committee meetings in addition to holding their own sub-committees such as the Governor Assurance Group and the Quality Review Group, which assist in reassuring the Council that it has an accurate and current understanding of Trust progress.

The Council is encouraged to note that during the year 2018/19 there has been a great deal of improvement in the area of staff engagement. Staff have more opportunities to comment on issues through various initiatives such as Listening to Improve, Pride and Respect and the 'Ask Peter' Chief Executive question sessions. There has been better retention of medical staff with a lower staff turnover rate than the previous account. The new £16.4 million staff accommodation block has been opened on the Diana Princess of Wales Hospital site which should assist in encouraging new staff to come to the area. There have also been great improvements in patient experience with emphasis being on reducing the 52 week waiting list and prioritising patients on cancer pathways waiting the longest time.

The Quality Account is very well presented and reflects the hard work done by the Board and all staff to help improve the staff and patient experience. The layout is easy to follow as each of the 5 themes is explained below the relevant data in a series of key points. Each theme also lists the patient outcomes in easy bullet points displayed in a green box.

Governors are encouraged to see the Quality Priorities for 2019/20 are set to further improve the patient experience and their safety.

Annex 1.5: Response from the Trust to stakeholder comments

The Trust is grateful for the comments from stakeholder comments and is pleased that the Trust's progress on its improvement journey has been acknowledged. The Trust will continue during 2019/20, using its quality priorities, to focus on further improvements. No changes have been made following feedback from stakeholders.

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 Improvement 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 2018/19 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 2018 to the 7 May 2019
    - Papers relating to quality reported to the board over the period April 2018 to 7 May 2019
    - Feedback from commissioners dated 25 April 2019
    - Feedback from governors dated 02 May 2019
    - Feedback from Local Healthwatch organisations dated 15 April 2019 and 24 April 2019
    - Feedback from Overview and Scrutiny Committees dated 1 April 2019, 16 April 2019, 16 April 2019 and 26 April 2019
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 17 May 2019
    - Latest national patient survey 2019
    - Latest national staff survey 2019
    - The head of internal audit's annual opinion of the trust's control environment dated 09 May 2019
    - CQC inspection report dated 12 September 2018.
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate; except in the case of waiting list information, where the Trust's internal scrutiny and review has identified that reported waiting list data did not provide a true picture of performance;
- 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 majority of data underpinning the measures of performance reported in the Quality Report are robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review. From these internal controls and scrutiny and review of data during 2018/19, the Trust determined that the waiting list data did not provide a true picture of the Trust's waiting list position. The directors are confident that the extent of the data quality issues are being understood and a robust and reliable plan of action is in place to ensure the required data quality standards and prescribed definitions for waiting list data are adhered to and are assured that progress in this area will be reported to directors of the board; and
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality 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

21/5/2019 ..... Date ..... Chair

21.5.19 Date ..... Chief Executive

Annex 3: Independent auditor's report to the Board of Governors on the Annual Quality Report

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

We have been engaged by the Council of Governors of Northern Lincolnshire and Goole NHS Foundation Trust to perform an independent assurance engagement in respect of Northern Lincolnshire and Goole NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to our limited assurance conclusion (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor (operating as NHS Improvement) ("NHSI"):

Specified Indicators	*Specified indicators criteria* (exact page number if possible, or title of section where criteria can be found)
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge	See Section 2.1b 'Theme 2: Safe Emergency Care – Specific focus on access to non-elective care and flow through our hospitals' (Pages 22-25) and Annex 5: Mandatory Performance Indicator Definitions (Page 108-109)
Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	See Section 2.1c 'Theme 3: Safe Planned Care – Specific focus on cancer care, 52 week waits and clinical harm reviews' (Pages 26-28) and Annex 5: Mandatory Performance Indicator Definitions (Page 109)

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the 'Detailed requirements for quality reports 2018/19' issued by NHSI. The Directors are also responsible for the conformity of the specified indicators criteria with the assessment criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19' issued by NHSI and for reporting the specified indicators in accordance with those criteria, as referred to on the pages of the Quality Report listed above.

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

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the 'Detailed requirements for quality reports 2018/19';
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the 'Detailed requirements for quality reports 2018/19'; and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the financial year, April 2018 and up to the date of signing the limited assurance report ("the period");
- Papers relating to quality reported to the Board over the period;
- Feedback from the Commissioners (North East Lincolnshire CCG, North Lincolnshire CCG, East Riding of Yorkshire CCG and Lincolnshire East CCG) dated 25/04/2019;
- Feedback from Governors dated 02/05/2019;
- Feedback from local Healthwatch organisations Healthwatch North Lincolnshire, Healthwatch North East Lincolnshire, Healthwatch East Riding of Yorkshire dated 15/04/2019 and Healthwatch Lincolnshire dated 24/04/2019;
- Feedback from the Overview and Scrutiny Committee's dated 01/04/2019 (North Lincolnshire Council – Health Scrutiny Panel), 16/04/2019 (East Riding of Yorkshire Council – Health, Care and Wellbeing Overview and Scrutiny Sub-Committee & North East Lincolnshire Council – Health, Housing and Wellbeing Scrutiny Panel) and 26/04/2019 (Lincolnshire – Health Scrutiny Committee for Lincolnshire)
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 17/05/2019;
- The latest national patient survey dated January 2019;
- The latest national staff survey dated January 2019;
- Care Quality Commission inspection report, dated 12/09/2018; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 09/05/2019.

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

Our Independence and Quality Control

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

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of Northern Lincolnshire and Goole NHS Foundation Trust as a body, to assist the Council of Governors in reporting Northern Lincolnshire and Goole NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Northern Lincolnshire and Goole NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- reviewing the content of the Quality Report against the requirements of the FT ARM and the 'Detailed requirements for quality reports 2018/19';
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis, of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the FT ARM and 'Detailed requirements for quality reports 2018/19'.

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

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

Basis for Disclaimer of Conclusion – patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

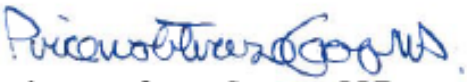
No supporting clinical documentation was available for patients to support the time of admission, transfer or discharge (clock stop) within the tested sample. As a result, we have been unable to obtain evidence for the waiting period from arrival to admission, transfer or discharge reported across the year.

Conclusion (including disclaimer of conclusion on patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge)

Because the data required to support the indicator is not available, as described in the Basis for Disclaimer of Conclusion paragraph, we have not been able to form a conclusion on the patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge indicator.

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2019:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the 'Detailed requirements for quality reports 2018/19';
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The indicator 'Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer' has not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19'.



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29th May 2019

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

Annex 4: Glossary

Acuity: Defined as the severity of a patient's condition (physical or psychological) and the intensity and complexity of care and corresponding workload required by a patient/group of patients) on the Trust's healthcare professionals.

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.

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

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

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

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

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.

Healthcare Evaluation Data (HED)

- As a result of the time lag in reporting of SHMI, the Trust has purchased an additional information toolkit from the University of Birmingham Hospitals NHS Foundation Trust, called Healthcare Evaluation Data (HED).
- HED uses the same methodology as the official SHMI, but enables a much more recent timeframe to be reported. The official SHMI publication in January 2016 reported data up to June 2015, the HED information reports data to the end of October 2015. As it is not the official SHMI indicator, it is treated by the Trust as a 'provisional' SHMI indication, but from rigorous reconciliation work, it has proved to be an accurate data source that reflects the official SHMI on publication.
- As a result of this, the Trust uses both the official SHMI and the HED provisional SHMI indication as markers of performance.

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".

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

The Trust uses *The Menu Card Survey* which helps the Trust understand patient experience and is attached to inpatients' menu cards. It measures the patients' experience in real time.

Rate per 1000 bed days: So we can know if we are improving even if the number of patients we are caring for goes up or down, we also calculate an average called 'rate per 1,000 occupied bed days'. This allows us to compare our improvement over time, but cannot be used to compare us with other hospitals, as their staff may report in different ways, and their patients may be more or less vulnerable than our patients.

Readmission Rate (RA): This measure shows the percentage of patients who were readmitted to hospital as an emergency within one month of being discharged. It can serve as an indicator of the quality of care provided and post-discharge follow up. A low readmission rate is an indicator of the quality of care in that it reflects a healthy care balance. Where rates are low, patients do not have to come back to the Trust for care of the same complaint. Conversely, a high readmission rate potentially signals that an organisation is releasing patients home too soon or otherwise not addressing all elements of their clinical condition.

SAFER Care Bundle consist of the following principles: **S**enior Review before midday, **A**ll patients have an expected date of discharge, **F**low of patients from assessment and admission units as early as possible, **E**arly Discharge before midday and **R**eview by MDT for patients with extended lengths of stay (>7 days).

Stranded patients are those in hospital for 7 or more days.

Super stranded patients are those in hospital for more than 21 days.

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 5: Mandatory Performance Indicator Definitions

The following indicators:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge,
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers,
- Summary Hospital-level Mortality Indicator (SHMI).

Have been subject to external audit in line with the following criteria:

Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge:

Source of indicator definition and detailed guidance

The indicator is defined in the technical definitions that accompany Everyone counts: planning for patients 2014/15 - 2018/19 at https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf.

Detailed rules and guidance for measuring A&E attendances and emergency admissions are at https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf.

Additional information:

Paragraph 6.8 of the NHS England guidance referred to above gives further guidance on inclusion of a type 3 unit in reported performance:

> *We are an acute trust. Can we record attendances at a nearby type 3 unit in our return?*
>
> *Such attendances can be recorded by the trust in the following circumstances.*

a) *The trust is clinically responsible for the service. This will typically mean that the service is operated and managed by the trust, with the majority of staff being employees of the trust. A trust should not assume responsibility for reporting activity for an operation if the trust's involvement is limited to clinical governance.*

b) *The service is run by an IS provider on the same site as a type 1 unit run by the trust. This would need to be agreed by the parties involved, and only one organisation should report the activity.*

Where an NHS foundation trust has applied criterion (b) and is including type 3 activity run by another provider on the trust site as part of its reported performance, this will therefore be part of the population of data subject to assurance work.

In rare circumstances there may be challenges in arranging for the auditor to have access to the third party data. In this scenario the NHS foundation trust may present an extra indicator in the quality report which only relates to its own activity and have this reported indicator be subject to the limited assurance opinion.

Numerator

The total number of patients who have a total time in A&E of four hours or less from arrival to admission, transfer or discharge. Calculated as:

(Total number of unplanned A&E attendances) – (Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge)

Denominator

The total number of unplanned A&E attendances

Accountability
Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution measures).

Indicator format

Reported as a percentage

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

Detailed descriptor[2]

PHQ03: Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

Data definition

All cancer two-month urgent referral to treatment wait

Numerator

Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Denominator

Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Accountability

Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution measures).

[2] Cancer referral to treatment period start date is the date the acute provider receives an urgent (two-week wait priority) referral for suspected cancer from a GP and treatment start date is the date first definitive treatment starts if the patient is subsequently diagnosed. For further detail refer to technical guidance at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131880

Summary Hospital-level Mortality Indicator (SHMI)

The SHMI is not calculated by trusts; it is provided by NHS Digital. As explained in NHS Digital's guidance (https://files.digital.nhs.uk/73/EB4673/SHMI%20FAQs.pdf), the indicator is computed by NHS Digital using information provided by the trust and other information. The assurance work performed need only concentrate on the information provided by the trust which is used in computing the indicator. We recommend that the auditor makes the scope of work clear in the governors' report. The auditor's work should focus on the trust's Secondary Uses Service (SUS) data submissions, and the information used from that in the computation of observed deaths and expected deaths.

More information on the data specification can be found at:
https://files.digital.nhs.uk/3F/80BAA0/SHMI%20specification.pdf.

Page 9 of this document lists the Hospital Episode Statistics (HES) data fields taken from SUS data used to compute the SHMI. Only a subset of these are expected to be included in sample testing performed by the auditor:

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