Northern Lincolnshire & Goole NHS Foundation Trust

Annual Quality Account

2020/21

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

This year has been the most challenging the NHS has ever faced. In my long career in the health service I have never seen the levels of anxiety and stress which our staff have faced during the coronavirus. Our staff responded magnificently to the challenges put in front of them. Their care and compassion were second to none. To come to work day in and day out – particularly for those staff needing to put on and take off many layers of Personal Protective Equipment (PPE) because of the patients they were caring for – showed extraordinary levels of courage and commitment. Teams representing a variety of roles and disciplines have played an enormous part in keeping our hospitals running through the pandemic. I have said it before, but I mean it: it is humbling being their Chief Executive and a real privilege. Thank you once again to them all.

With our staff facing such unprecedented times we cannot underestimate what impact this has had, and will continue to have, on their health and wellbeing, particularly their mental health. We had already identified staff health and wellbeing as a priority for 2020/21 so in many ways we were ahead of the game and had some support already planned. During the course of the year we added to this support to put together a comprehensive package of help to support our staff and enable them to continue to deliver high quality care to our local population. This will continue to be a key priority for 2021/22.

The pandemic has affected all aspects of how we have provided healthcare. We have continuously had to make risk based decisions to keep people safe which has resulted in services being segregated and reducing the scale of services we could offer due to reduced capacity. This has been complicated further by some of the Trust's ageing estate. This impacted on our improvement ambitions for the year with regards to patient flow through our hospitals. As a consequence I'm sad to report the number of patients waiting more than 12 hours increased although our annual performance for seeing and treating patients in the ED within four hours saw a slight increase to 81% compared to last year.

Our planned care (which means operations or other procedures) numbers were less than planned, due to the national decision to cancel all planned activity. The numbers of COVID-19 patients we were caring for at times, particularly over winter in Scunthorpe, also meant we were unable to bring our theatres back into use as quickly as we would have liked. Taken together these issues have had a significant impact on our waiting lists, as they have for all trusts across England.

To all those patients waiting I send my apologies, we will do everything we can in 2021/22 to improve the position. This will be a key priority for the Trust and we have set ourselves the target of reducing both the number of patients waiting over 52 weeks for elective treatment and those waiting over 104 days for cancer treatment to zero by the end of March 2022.

Despite the challenges we faced, this annual quality account is also an opportunity to reflect on what the Trust has achieved and its progress against quality goals and to the best of my knowledge the information contained within this report is accurate. Work has continued throughout the year to achieve the 'must do' and 'should do' actions identified by the Care Quality Commission (CQC) in their report published in February 2020 following their inspection in September 2019. This is progressing well in most areas.

The Trust has seen a sustained decrease in hospital mortality over the course of the year, now being rated 'as expected'. This is an excellent achievement especially given we were amongst the three worst trusts in England 18 months ago. The following report will provide greater details on this and other achievements.

Our challenge for 2021/22 is to look after our staff and support them as they recover from such an intense year, whilst at the same time doing everything we can to bring down our waiting lists and managing the increased demand we are experiencing for urgent care. That's an incredibly tough balancing act and we need to do that whilst the Trust changes around them – with new buildings, new digital systems, and new ways of working. If anyone can manage to do this, our staff can; they are remarkable. Thanks to them all once again.

Dr Peter Reading,
Chief Executive
08 June 2021

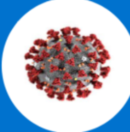
About Northern Lincolnshire and Goole NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust (referred to as 'The Trust' throughout this report) consists of three hospitals and community services in North Lincolnshire and therapy services at all our sites. 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),
- Goole & District Hospital (also referred to as GDH), and
- Community 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**.

A year in numbers 2020/21



1,500
COVID-19 positive patients treated

124,000
Attendances at our emergency departments

11,500+
Coronavirus vaccines administered (1st doses)

40,000+
Operations carried out

350,000+
Outpatient appointments

4,500+
Video consultations

240,000
Attendances at radiology

44+million
Pathology tests

3,700
Babies delivered

£130million
secured in capital funding

250,000+
tasks carried out by porters

640,000+
patient meals prepared

Figures obtained for 1 April 2020 to 31 March 2021. Please note, rounded figures used

Executive summary of key points

6 Quality Priorities for 2020/21:

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

(1) Improve the Trust waiting list;
(Patient Experience)

(2) Reduce mortality rates and strengthen end of life care;
(Clinical Effectiveness)

(3) Improve the management of diabetes;
(Patient Safety)

(4) Improve the effectiveness of cancer pathways;
(Patient Experience & Clinical Effectiveness)

(5) Improve safe flow and discharge through the hospital;
(Patient Safety, Experience & Clinical Effectiveness)

(6) Improve the quality and timeliness of complaints responses using a more individualised approach.
(Patient Experience)

Performance against these quality priorities has been reported within the quality report.

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

Covid-19 Pandemic Response:

The Trust's priorities for 2020/21 were set prior to the onset of the Covid-19 pandemic that had a significant impact on the Trust and the wider NHS.

As such it should be noted:

(1) Responding to the pandemic and its many associated impacts on staff, waiting lists, facilities, etc. was not included among these priorities, and was therefore handled as additional pressure;

(2) The pandemic significantly affected Trust performance against some objectives where key personnel/organisational focus needed to be diverted to pandemic response.

Priority 1 – Patient Experience: Improve the Trust waiting list with a focus on 40 week waits, total list size and out-patient follow-ups:

- The Trust's improvement plans in this area were substantially affected by the NHS wide response to the Covid-19 pandemic which included, during wave 1, a cancellation across the country of all planned activity. This resulted in an unavoidable growth in the waiting list during the course of the pandemic.

- The Trust is currently working hard to recover performance and this is a key priority for the 2021/22 period. Recovery performance to date has shown a strong response when comparing the Trust to regional peers.

- The Trust aimed to reduce the overdue follow up waiting list to below 9,000 by 31 March 2021. This reduced from 31,323 in March 2020 to 21,969 in March 2021. Progress was

affected by COVID-19 which limited follow up patients to be reviewed. The Trust introduced patient initiated follow up during the year to support better management of follow up patients and new referrals.

- Another priority was to have zero patients waiting 52 weeks (or longer). Based on the previous two years delivery the Trust would have achieved this and maintained this performance, however the pandemics impact on elective planned activity resulted in the Trust ending the year with 1,187 patients breaching 52 weeks. Whilst not where the Trust aimed to be, recovery work has supported the Trust compare very favourably to other Trusts within the region similarly impacted.

Priority 2 – Clinical Effectiveness: Reduce mortality rates and strengthen end of life care:

- The Trust has sustained a statistically significant improvement with regards to mortality as measured using the Summary-Hospital Level Mortality Indicator (SHMI). The Trust's SHMI was 106.4 in the March 2021 release which covered the January – December 2020 timeframe. This is within the 'as expected' range and therefore achieves the priority ambition.

- The Trust also achieved its target in increasing the number of deaths that are reviewed by healthcare professionals for learning purposes to support improvement of services.

- Recording of patient observations using NEWS (National Early Warning Score) in line with timescales was also achieved against a target of 85%. This is a significant achievement given the pandemic pressures and the additional time required for Trust staff to don Personal Protective Equipment (PPE).

- The pandemic impacted upon the Trust's plans to improve its ability to report sepsis screening data for improvement and assurance purposes.

Priority 3 – Patient Safety: Improve the management of diabetes:

- Performance against the diabetes quality priority was for the most part achieved, with a monthly audit established for assurance and improvement purposes.

- There have been zero insulin errors resulting in significant harm. 85% Mandatory training for staff in diabetes management has been achieved.

- The audit data has demonstrated that further improvement work is required on ward areas in relation to diabetes. Recording of blood glucose in the Emergency Department has fluctuated for adult and paediatric patients. This therefore will remain as a quality priority for 2021/22 to embed improvements.

Priority 4 – Patient Experience & Clinical Effectiveness: Improve the effectiveness of cancer pathways focussing on time to diagnosis:

- The pandemic has had a significant impact on Trust cancer improvement priorities:

    - Faster diagnosis and patient informed by day 28 was 59.7% compared to the target of 75%.

    - Request to test report turnaround to be no more than 14 days was not achieved with the wait for most cancer diagnostic tests exceeding 14 days.

- To support improvement, the Trust has established the Humber Cancer Board which meets monthly to support the management of Cancer Services across the Humber. The

Group have progressed faster access to diagnostics and earlier treatment in a number of tumour types.

- All cancer MDTs across the Trust have now been combined and through the Humber Cancer Board, work has commenced on combining MDTs across the Humber in a number of tumour sites to improve pathways and access arrangements.

Priority 5 – Patient Safety, Experience & Clinical Effectiveness: Improve safe flow and discharge through the hospital focussing on outliers, late night patient transfers and discharges before noon:

- Despite the pandemic, the Trust has made some significant progress against this quality priority with the average length of stay reducing to below that seen during 2019/20. Complex patients with Covid-19 have prevented this from being reduced further.

- Discharges from hospital with length of stay less than 2 days was 5,953 in March 2020 and 6,578 in March 2021, demonstrating significant improvement in this approach to care.

- Reduction in elective length of stay to less than 2.4 days was achieved during 2020/21 with an elective average length of stay was 2.00, a significant improvement from previous years.

- The Trust embarked on the discharge to assess programme in April 2020. Through this programme, the number of early supported discharges has increased to an achievement of 44% of discharges happening within 7 days against a national ambition of 40%.

- Covid-19 has impacted on the Trust's priority to reduce patients on ward areas outside of the specialty they are being cared under. Percentage of ward outliers was 22.66% in March 2020, this increased to 47.44% in March 2021, however this figure is difficult to report as throughout the year wards changed their classification and clinical patient type due to the need to manage Covid-19 patients. There was also a significant impact on this position related to the overall reduction in beds due to requirements of social distancing and temporary cubicles which were used throughout the COVID-19 pandemic.

Priority 6 – Patient Experience: Improve the quality and timeliness of complaints responses using a more individualised approach:

- Significant improvements have been made with respect of the Trust's processes around the handling and response to complaints.

- All complaints open for more than 120 days have been now closed (at March 2020, there were 97 open).

- There has been a significant reduction in the number of open complaints despite only a slight reduction in the number incoming during the pandemic. There were 219 open in March 2020 compared to just 64 open in March 2021.

- There has been a Trust wide adoption of the new process, with lead investigator roles taking responsibility for investigation within the Division as opposed to central team. This has led to an improvement in both the quality of responses and learning.

Quality Priorities for 2021/22:

Setting quality priorities:

During 2019/20, the Trust reviewed and aligned its five year quality strategy in line with the Trust's strategic direction. The strategy, based upon the National Quality Board's (NQB) *'Shared Commitment to Quality',* sets long term quality objectives linked to the Trust's strategic objectives, the Trust will continue to review and set annual quality priorities.

Priorities for 2021/22 were set in harmony with the Trust's quality strategy longer term objectives. The priorities were also based on a comprehensive programme of consultation which involved the identification and formulation of a 'long-list' of prospective areas for priority focus. This was then consulted on with local residents and service users through the use of a survey made available by the Trust's communications and patient experience teams as well as CCG partners through their social media channels.

This analysis of service user feedback was then used for wider consultation within the Trust and with commissioners which resulted in a short-list of priorities for 2021/22. This was refined further by the Trust's Quality & Safety Committee and Trust Board.

Quality priorities for 2021/22:

Five priorities for 2021/22 have been agreed, these relate to the progress made during the period covered by this quality account:

(1) End of Life and Related Mortality Indicators (n=3)

- Indictors within this area build on the progress made with mortality performance and seek to support further improvement with care planning for patients who are at end of life and require individualised and holistic plans to ensure care is provided in the right care setting.

(2) Deteriorating Patient & Sepsis (n=3)

- These indicators build on the improvements already made in connection with patient observations but aims to focus on improvements in action taken in response to recorded observations.

(3) Increasing medication safety (n=3)

- Medication safety is a new area of focus and links to the Trust's roll out of its Electronic Prescribing and Medicines Administration (EPMA) system to support an understanding of safety gains resulting from this.

(4) Safety of Discharge (n=4)

- These measures focus on the Discharge to Assess project and will enable the Trust to monitor progress with continued improvements in patient flow through the Trust's hospitals.
- Also included are measures linked to specific sub-specialties performance with issuing discharge communications to the patient's GP Practice within defined timescales. This will support and measure improvement plans.

(5) Diabetes Management (n=3)

- These indicators link back to the progress made in 2020/21 and seek to enable continued monitoring to support embedding.

How progress against 2021/22 quality priorities will be monitored and measured:

Progress will be monitored through the Trust's quality section of the Integrated Performance Report. This is a monthly report considered by the Executive-led Quality Governance Group for the oversight of management actions and also by the Non-Executive Director (NED) Chaired Quality & Safety Committee for assurance purposes.

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

Some of the above quality priorities and the underpinning measures to understand progress in each link to Trust performance indicators. In these instances, the Trust's Finance and Performance Committee will primarily oversee progress, with the Quality & Safety Committee seeking assurance on quality outcome measures related to Trust performance.

There are close links established between these oversight arrangements and the monthly performance meetings held with divisions, where divisions will be held to account for their performance.

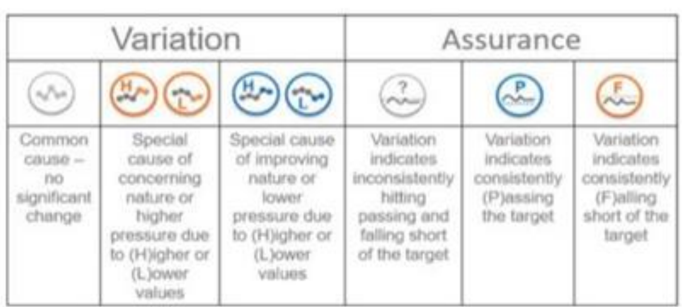
Interpreting the data presented within this report:

The Trust's monthly quality report makes use of Statistical Process Control (SPC) charts wherever possible to support an understanding of what data trends show and what assurance can be gained from these data trends.

The annual quality account aims to provide an easy to digest summary of this performance during the 2020/21 period. To achieve this aim the measures used to focus on the Trust's quality priorities are presented in a table that summarises what the data trends show. This presentation will use the following icons to support interpretation of key points.

Variation - Using SPC methodology, data since April-2017 (or as early as currently available) is fed into SPC charts. If the variation is showing as special cause in the reported month, this is flagged. Orange being negative, and blue being positive.

Assurance – As per above, if the variation in the performance is consistently showing above the target, it will be blue. If orange, it will not meet target without system change. Grey indicates that the target is within the limits of variation.



Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

To further help the reader, a rating is provided within each summary table to demonstrate if the Trust has met the quality priority stated. Supportive narrative will further aid the reader get the sense of the key points.

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 2020/21 quality priorities & quality priorities planning for 2021/22

2.1a: Priority 1: Patient Experience: Improve the Trust waiting list with a focus on 40 week waits, total list size and out-patient follow-ups;

Summary table: Performance during 2020/21:

PATIENT EXPERIENCE:					
QP1: Improve the Trust waiting list with a focus on 40 week waits, total list size and out-patient follow-ups;	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
1a) Reduce delayed transfers of care to 60 (move flow and access)	**8.3**	No data			G
1b) Reduce the overdue follow up waiting list to below 9,000 by 31 March 2021	**21,969**	27,803			R
1c) 52 week waits to be at zero	**1187.0**	1285.0			R
1d) The overall RTT waiting list to be less than it was on 31 January 2020	**28,853**	28,307			R
1e) 50% of out-patient summary letters to be with GPs within 7 days of patient's attendance	**35.00%**	40.00%			R
1f) Reduce the number of face to face follow up appointments by 10%, to support the delivery of an overall reduction by a third by March 2023	**13,657**	11,279			R

Progress Made: (April 2020 – March 2021): During the 2020/21 period, Trust performance has not met the targets set for waiting list improvements as a result of the significant impact, across the NHS, of the Covid-19 pandemic.

- **Reduce delayed transfers of care to 60:**
- The Trust has reduced the number of delayed transfers of care and is currently performing very well compared to other Trust's in the region for the number of patients with a length of stay over 14 days.

- **Reduce the overdue follow up waiting list to below 9,000 by 31 March 2021:**
- The Covid-19 pandemic limited the number of patients who could be seen and followed up. Despite the pandemic the Trust reduced this from 31,323 in March 2020 to 21,969 in March 2021. The Trust also introduced other initiatives to mitigate the quality risks associated with this indicator by introducing patient initiated follow up during the year to support better management of follow up patients and new referrals as well as a move to virtual forms of patient reviews.

- **52 week waits to be at zero:**
- Prior to the pandemic, the Trust were on track to achieve this target, evidenced by a review of the previous two years' worth of data and the improving trend. The pandemic significantly impacted on the Trust's planned activity and limited what the Trust could achieve. As a result the Trust ended the year with 1,187 patients waiting more than 52 weeks. Whilst this is not where the Trust wanted to be, the work during the pandemic to maximise capacity available and the recovery work since the peak of the pandemic places the Trust in a strong position compared to other peer Trusts in the region. This is demonstrated in the chart that follows:

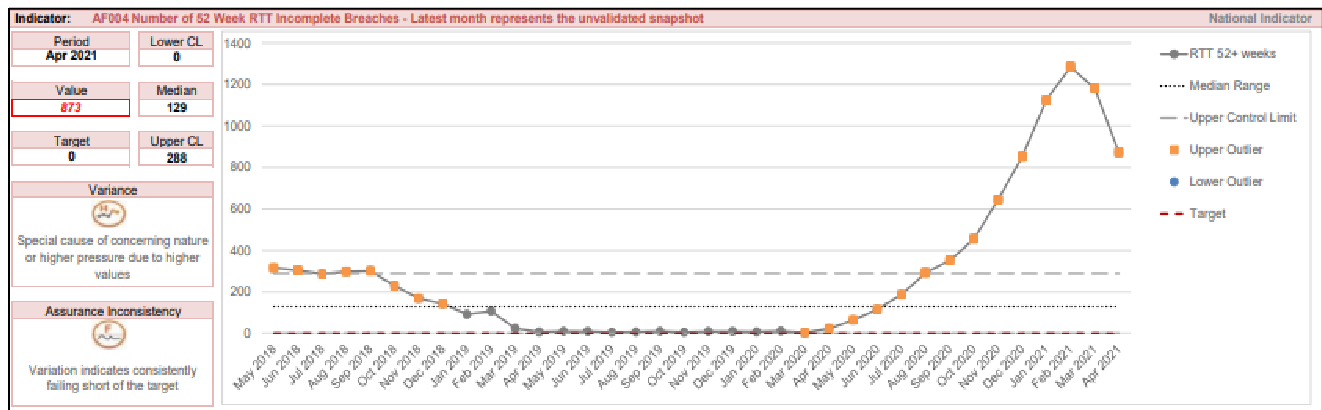


Figure 1: Impact of the Covid-19 pandemic on the Trust's performance with manging patients who are waiting 52 weeks or more

- The chart shows the improvements made in this area during 2019 and the impact of the pandemic on the waiting list position from early 2020. The chart shows the March and April 2021 data that demonstrates the Trust's recovery measures beginning to take effect and reduce the number of patients waiting.

- **The overall waiting list to be less than it was on 31 January 2020:**
- The overall referral to treatment RTT waiting list on 31st January 2020 was 25,227. As a result of the pandemic and its impact on planned activity, the Trust's waiting list grew to 28,853.

- **Reduce the number of face to face appointments:**
- The Trust priority was to move to offer outpatient clinic appointments using different formats other than purely face to face, in person. The pandemic accelerated this enabling the Trust to begin offering more online and telephone appointments. Use during the pandemic of this approach has provided the Trust a strong base to build on to develop further through 2021/22 and beyond.

The Covid-19 pandemic, with the national decision to cancel all planned activity during early 2020, local pressures faced on beds due to surges in activity and staff availability linked to the pandemic significantly impacted on the Trust's ability to focus on these priorities.

During 2021/22 the Trust has listed this as a priority to do everything possible to improve this position as part of the focus on recovery. This key priority for the Trust will include the target of reducing both the number of patients waiting over 52 weeks for elective treatment and those waiting over 104 days for cancer treatment to zero by the end of March 2022.

Progress monitored, measured and reported: Progress with these indicators is monitored within the integrated performance report and is part of the access and flow section that is overseen by the Finance and Performance Committee and the Trust Board.

Relationship to 2021/22 Quality Improvement Priorities: This quality priority has remained the same throughout 2020/21, although significantly impacted upon by the onset of the pandemic. Waiting list indicators no longer feature as quality priorities, but are a part of the Trust's wider priorities to recover following the pandemic.

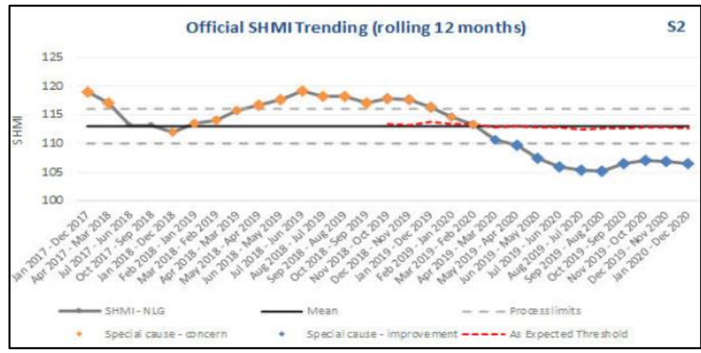
2.1b: Priority 2: Clinical Effectiveness: Reduce mortality rates and strengthen end of life care;

Summary table: Performance during 2020/21:

CLINICAL EFFECTIVENESS:					
QP2: Reduce mortality rates and strengthen end of life care;	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
2a) Reduction in the Trust SHMI to within expected range	**106.4**	106.8			G
2b) Mortality screening: 50% of all deaths	**82.00%**	84.00%			G
2b) Mortality SJR: 100% for those cases identified as requiring SJR	**9.00%**	25.00%			R
2c) a) Adults: Timeliness of observations to 85% within 30 minutes of due time	**90.89%**	88.97%			G
2c) b) Children: PEWS: Observations recorded at least every 4 hours (first 12 hours) to 85%	**85.00%**	88.90%			G
2c) c) Full observations a minimum of 12 hourly & relevant observations as clinically indicated between times to 85%	**92.30%**	100.00%			G
2c) d) New admissions must have all 9 observation parameters (including temperature) recorded and scored at the first assessment to 85%	**80.00%**	80.00%			A
2d) Improve frequency of sepsis screening and robustness of reporting	**No data**	No data			R
2e) Gather patient and carer feedback for end of life care with local hospices	**No data**	No data	-	-	-
2f) 80% of inpatients (exc. maternity) screened for alcohol and tobacco use	**No data**	No data	-	-	-
2g) 90% of inpatients (exc. maternity) receive brief advice on tobacco use if smoke	**No data**	No data	-	-	-

Progress Made: (April 2020 – March 2021): During the 2020/21 period, Trust performance has met the targets set for mortality improvement metrics and partially achieved the other indicators linked to mortality.

- **Reduction of the Trust SHMI to within expected range:**
- The SHMI (Summary Hospital-Level Mortality Indicator) is a statistical calculation of a Trust's hospital associated mortality, including both in-hospital deaths and those occurring within 30 days of discharge. It is based on routine data submissions from the Trust, from hospital coding. Nationally, this data is used to perform the statistical calculation of total deaths expressed against the total number of 'expected deaths' which is derived from the Trust's data recording around admitting diagnosis and their pre-existing co-morbidities amongst other indicators.
- The Trust's performance is shown in the chart and demonstrates statistically significant reductions (improvements) in the Trust SHMI. This is now within the 'as expected' bracket.



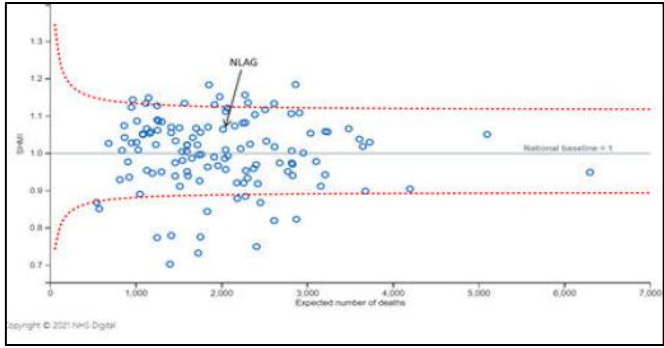


Figure 2: Statistically significant improvement of the Trust's SHMI

- **Learning from deaths – mortality review work:**
- The Trust have met the ambition to review, for learning opportunities, an increased number of deaths, this has been a gradual improvement aim over recent years and during this year the process has been improved to ensure a consistently high proportion of deaths will be 'screened' to identify learning opportunities and where further more detailed reviews are indicated. The second element of this aim was to ensure that all cases requiring more detailed review have this completed within 2 months of the death for more detailed understanding of learning points arising. Due to operational pressures linked to Covid-19 there is a backlog of cases requiring review. These cases are being prioritised as part of the Trust's recovery efforts following the pandemic.

- During 2021/22 the Trust aims to improve the processes in place to support sharing and learning for improvement following completion of mortality reviews.

- **Timeliness of observations:**
- The Trust achieved this target aiming to ensure observations for adults utilising National Early Warning Score (NEWS). This was maintained during the pandemic which is a significant achievement, given the need for staff to don and doff personal protective equipment and the zoning of clinical areas to meet the demands of Covid-19. The chart below summarises this over the year compared to the 85% target.

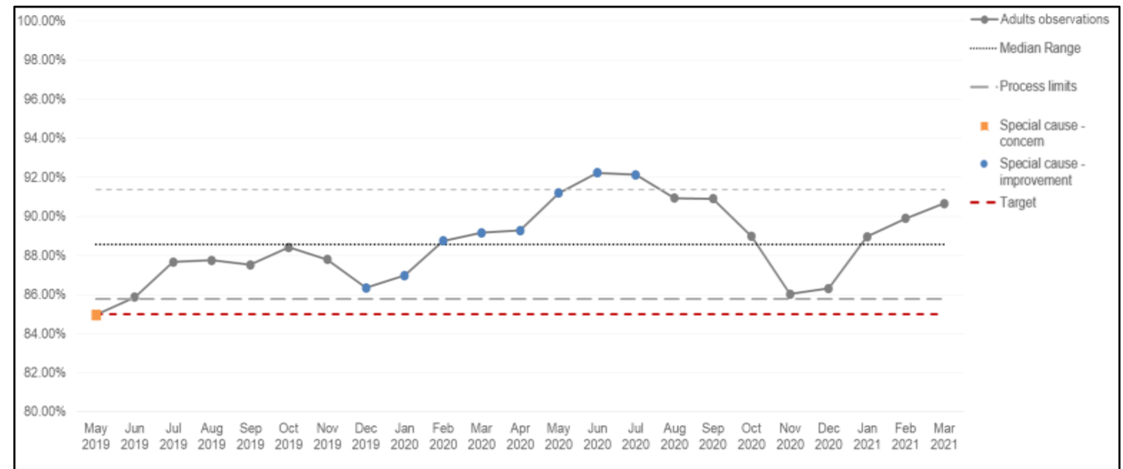


Figure 3: Achievement of the recording of NEWS observations within timescales (including 30 minutes grace)

- **Assurance in connection with Sepsis six:**
- Improvement plans linked to sepsis screening and appropriate treatment were not achieved during the year as a result of the pandemic. This is carried forward as a priority into 2021/22 alongside education and support at ward level and the use of Trust electronic systems to record sepsis screening.

- Other areas within this quality priority were unable to be progressed as a result of Covid-19.

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

Relationship to 2021/22 Quality Improvement Priorities: This quality priority has remained the same throughout 2020/21. Focus on continued improvement around mortality will continue with a focus on end of life and advanced care planning. Sepsis and the deteriorating patient will remain a priority also.

2.1c: Priority 3: Patient Safety: Improve the management of diabetes;

Summary table: Performance during 2020/21:

PATIENT SAFETY:					
QP3: Improve the management of diabetes;	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
3a)i) Improvement in monitoring of blood sugar in patients with diabetes - DPOW	**81.11%**	86.51%			A
3a)ii) Improvement in monitoring of blood sugar in patients with diabetes - SGH	**66.42%**	80.95%			R
3b) Reduction in insulin errors which cause significant harm to less than 5% of overall reported insulin incidents	**0.00%**	0.00%			G
3c) Achieve 85% compliance with role specific mandatory training for diabetes	**85.00%**	85.00%			G
3d) Adults: Blood glucose taken in ECC if NEWs > 1 in 95% of cases	**92.50%**	95.00%			A
3d) Children: Blood glucose taken in ECC if PEWs >1 in 95% of cases	**80.00%**	90.00%			R

Progress Made: (April 2020 – March 2021): This priority for the most part has been met.

- **Improvement monitoring of blood sugar in patients with diabetes:**
- A Monthly audit has been designed and implemented. This has helped to get an understanding of the management of diabetes across ward areas. From this the results indicate additional work still to do to attain and embed the standards. This will be retained as a quality priority for 2021/22.

- **Reduction in insulin errors which cause significant harm:**
- There have been zero insulin medication errors resulting in significant harm.

- **85% compliance with role specific training:**
- 85% compliance with mandatory training for diabetes has been achieved.

- **Blood glucose recording in Emergency Department if NEWS/PEWS >1:**
- Performance against this indicator has fluctuated and has demonstrated that practice is not embedded. This will remain as a quality priority during 2021/22. During 2020/21, the introduction of the Paediatric Emergency Nursing Team into the Emergency Department resulted in paediatric oversight negating the need for blood glucose recording in some instances. The audit is being amended but will continue to ensure there is assurance on practice.

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

Relationship to 2021/22 Quality Improvement Priorities: This quality priority has remained the same throughout 2020/21. Focus on the care of diabetes patients will be included as a quality priority during 2021/22 and expand to include a focus on the use of insulin within the dedicated medication safety quality priority.

2.1d: Priority 4: Patient Experience & Clinical Effectiveness: Improve the effectiveness of cancer pathways focusing on time to diagnosis;

Summary table: Performance during 2020/21:

PATIENT EXPERIENCE & CLINICAL EFFECTIVENESS:					
QP4: Improve the effectiveness of cancer pathways focussing on time to diagnosis;	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
4a) Time to diagnosis and patient informed by day 28 to be at 75%	**59.70%**	65.19%			R
4b) Care of patients with confirmed diagnosis transferred by day 38 to be at 75%	**20.00%**	25.00%			R
4c) Request to test report turnaround to be no more than 14 days in 100% of cases	**84.77%**	84.48%			R
4d) Develop a clear service model and a Trust target to ensure that cancer services are maintained	**No data**	No data	-	-	-
4e) Number of combined site MDTs to be 100%	100.00%	100.00%			G

Progress Made: (April 2020 – March 2021): During the 2020/21 period, Trust performance has not met the targets set for cancer pathway improvements as a result of the significant impact, across the NHS, of the Covid-19 pandemic.

- **Time to diagnosis and patient informed by day 28:**
- Performance against this target was 59.7% in March 2021. This has been severely hampered by the Covid-19 pandemic throughout the year and restrictions affecting planned pathways of care and access to diagnostics.

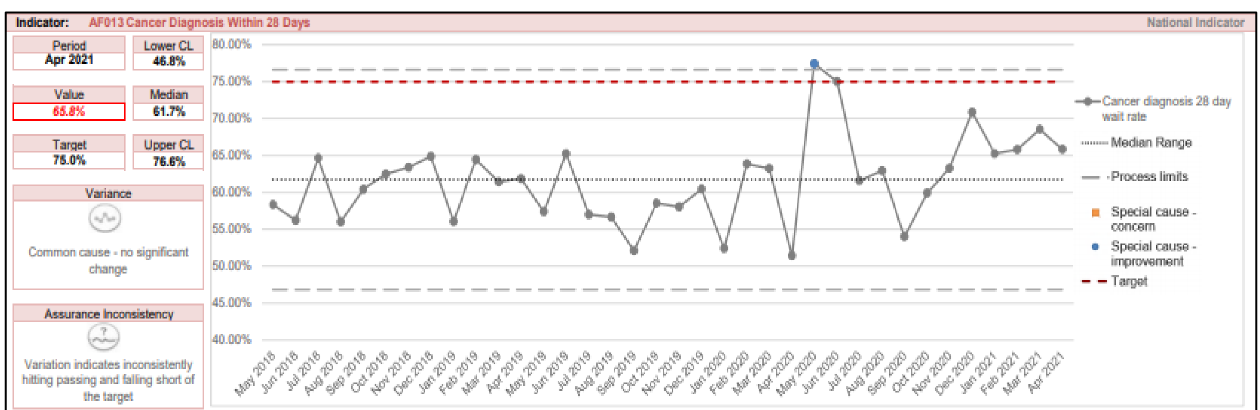


Figure 4: Cancer diagnosis within 28 days

- The chart demonstrates the performance in this area. Despite the pandemic the data for late 2020/early 2021 has been above the median average demonstrating the potential for sustained improvement, although further months data will be needed to determine if this increase is significant.

- **Care of patients with confirmed diagnosis transferred by day 38 to be at 75%:**
- For March 2021 performance was at 20%, but there were only a small number of patients ready to transfer, therefore this percentage should be interpreted with caution. As with all Cancer pathways COVID-19 has had a significant impact.

- **Request to test report turnaround to be no more than 14 days:**
- Due to Covid-19 pressures and the impact of infection prevention and control mitigation on throughput in diagnostics, this target has not been achieved and cancer diagnostic tests waits are greater than 14 days.

- **Develop clear service model and a Trust target to ensure that cancer services are maintained:**
- The Trust has established the Humber Cancer Board which meets monthly to support the management of Cancer Services across the Humber. The Group has progressed the faster access to diagnostics and earlier treatment in a number of tumour types. Unfortunately the progress of these development has been significantly delayed DTC.

- **Number of combined site multi-disciplinary teams to be 100%**
- Despite Covid-19, this target has been achieved with all Trust multidisciplinary teams (MDTs) now combined. Further work is ongoing through the Humber Cancer Board to look at further collaboration with MDTs across the Humber in a number of tumour types.

The Covid-19 pandemic, with the national decision to cancel all planned activity during early 2020, local pressures faced on beds due to surges in activity and staff availability linked to the pandemic significantly impacted on the Trust's ability to focus on these priorities.

During 2021/22 the Trust has listed this as a priority to do everything possible to improve this position as part of the focus on recovery. This key priority for the Trust will include the target of reducing both the number of patients waiting over 52 weeks for elective treatment and those waiting over 104 days for cancer treatment to zero by the end of March 2022.

Progress monitored, measured and reported: Progress with these indicators are monitored within the access and flow section of the integrated performance report and is reported to the Finance and Performance Committee and the Trust Board.

Relationship to 2021/22 Quality Improvement Priorities: The quality priority theme has remained the same throughout 2020/21. Cancer will feature as a priority for the Trust during 2021/22 as part of the post-pandemic recovery work.

2.1e: Priority 5: Patient Safety, Experience & Clinical Effectiveness: Improve safe flow and discharge through the hospital focusing on outliers, late night patient transfers and discharges before noon;

Summary table: Performance during 2020/21:

PATIENT SAFETY; CLINICAL EFFECTIVENESS AND PATIENT EXPERIENCE:					
QP5: Improve safe flow and discharge through the hospital focussing on outliers, late night patient transfers and discharges before noon;	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
5a) Reduction in the average length of stay to less than 4 days	**4.05**	3.99			A
5b) Increase in the zero length of stay to 32%	**28.94%**	29.03%			A
5c) Sustained improvement in the 0 – 1 day length of stay	**6578.0**	No data			G
5d) Reduction in non-elective length of stay to less than 4.1 days	**4.18**	4.18			A
5e) Reduction in elective length of stay to less than 2.4 days	**2.54**	1.91			A
5f) Reduction in the number of medical outliers					
5g) 85% of discharge letters to be completed within 24 hours post discharge	**87.62%**	88.60%			G
5h) Progressive improvement in the number of golden discharges from April 2020 (target: 35%)	**16.8%**	16.2%			R
5i) Increase in A&E performance to 83.5%	**72.2%**	73.3%			R
5j) Reduction of non-emergency patient transfers at night after 10pm by 10% (Target: 48)	**9.84%**	8.5%			R
5k) Reduction in average ward moves for non-elective patients for non-clinical reasons by 7% (Target: 4.6%)	**15.04%**	12.8%			R
5l) Number of early supported discharges to increase by 10%	**No data**	No data	-	-	-
5m) Improvement in the number of patients that have admission prevention services provided by the community services in North and North East Lincolnshire	**No data**	No data	-	-	-
5n) All patients requiring mental health support in ED will be assessed within 4 hours of referral	**No data**	No data	-	-	-
5o) Patient in in-patient wards will be assessed and have a plan in place within 8 hours of referral	**No data**	No data	-	-	-

Progress Made: (April 2020 – March 2021): During the 2020/21 period, Trust performance has made significant progress against these areas, but have been impacted once more by the pandemic.

- **Reduction in the average length of stay to less than 4 days:**
- The average length of stay during the year was 4.06 which is a further reduction on performance during 2019/20. Further improvements were planned, but these were impacted upon by the pandemic and the complexity of caring for some patients affected by Covid-19.

- **Sustained improvement in the 0–1 day length of stay:**
- Patients discharged with a length of stay less than 2 days was 5,953 in March 2020 compared with 6,578 in March 2021. This demonstrates a significant improvement in this approach to care.

- **Increase in the zero length of stay to 32%:**
- The proportion of patients having a zero length of stay was 27.23% which was just short of the target being aimed for. The chart shows the Trust's performance with this:

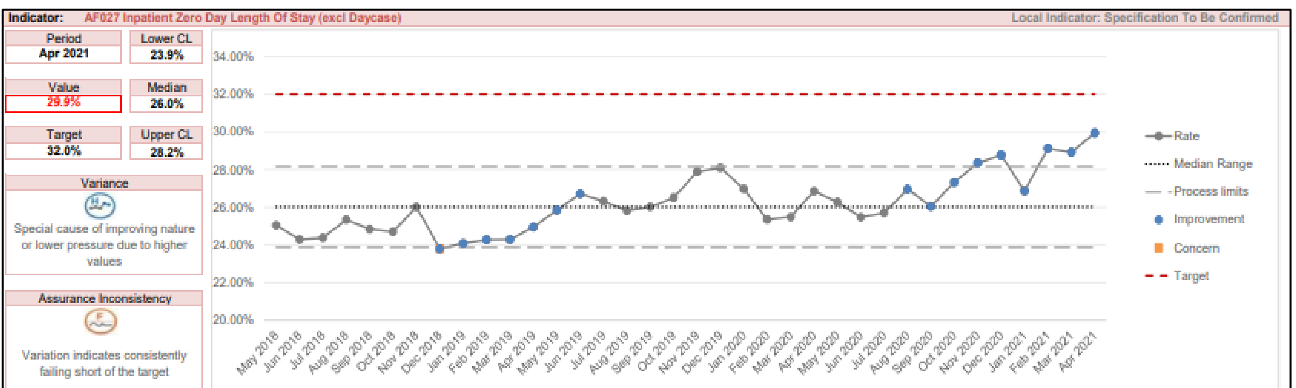


Figure 5: Increase in the zero length of stay

- The chart demonstrates an improving level of performance for patients with a zero day length of stay

- **Reduction in non-elective length of stay to less than 4.1 days:**
- During the year the Trust's non-elective (patients admitted as an emergency or unplanned) average length of stay was 4.22, which was just above the target being aimed for. This again was linked to the care and delivery of treatment to patients affected by Covid-19 requiring more complex input.

- **Reduction in elective length of stay to less than 2.4 days:**
- Patients admitted for planned care had an average length of stay of 2 days which is a significant improvement on previous years performance and has met the quality aim.

- **Reduction in the number of medical outliers:**
- The percentage of patients being cared for on wards outside of the specialty they were being treated under (i.e. a medical patient on a surgical ward) in March 2020 was 23%. This increased to 47% in March 2021. This quality priority was significantly affected by the Trust's response to the pandemic which required segregation and zoning of areas to mitigate infection spread, this has resulted, throughout the year, with wards changing their classification and clinical patient type to manage Covid-19 affected patients. Mitigating actions to support the Trust's response to the pandemic also led to a reduction in beds available due to requirements of social distancing and temporary cubicles which were used throughout the COVID-19 pandemic.

- **85% of discharge letters to be completed within 24 hours post discharge:**
- To support this action further the trust has engaged with clinicians and agreed a new category of letter 'Dictated but not Signed' to reduce the delays to letters being submitted on time.

- **Identify a robust mechanism for recording golden discharges:**
- Despite the pandemic, there was a modest improvement in the number of golden discharges rising from 1,480 in March 2020 to 1,491 in March 2021.

- **Increase in A&E performance to 83.5%:**
- In the early weeks and months of the pandemic the Trust saw a steep fall in the number of patients attending the Emergency Department (EDs), almost certainly due to anxieties related to the coronavirus. As a result, the Trust saw and treated around 25,000 fewer patients in ED compared to last year.

- Towards the end of the year, however, attendance numbers were more or less back to what we would expect and, on some days, even more than that.

- To keep people safe, the Trust made changes to the treatment and waiting areas in the Emergency Departments. This along with the mitigating actions taken on wards and the reduction in beds resulted in additional pressures and difficulties in being able to move patients out of the department resulting in longer waiting times. This is demonstrated in the chart below:

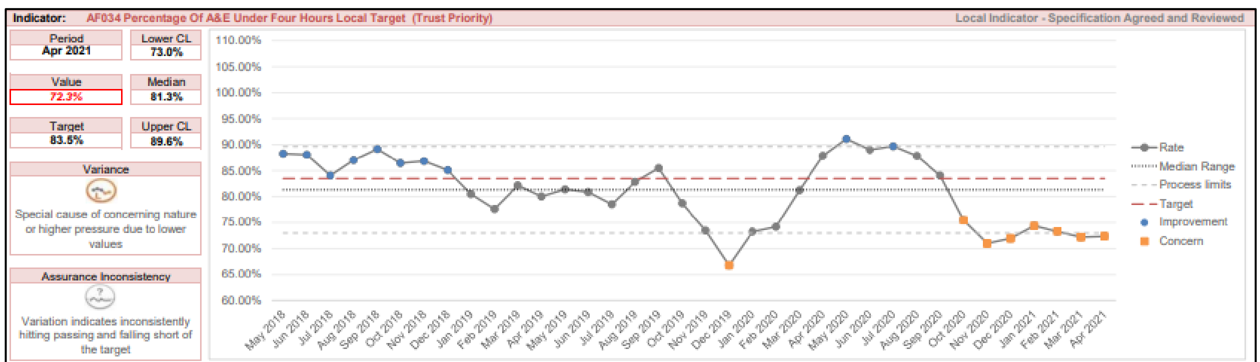


Figure 6: Emergency Department performance with 4-hour standard

- **Number of early supported discharges to increase by 10%:**
- The Trust embarked on the discharge to assess programme in April 2020. Through this programme, the number of early supported discharges has increased to 44% happening within 7 days compared against a national ambition of 40%.

- **Improvement in the number of patients that have admission prevention services provided by the community services in North and North East Lincolnshire:**
- In March 2020 in response to the Covid-19 pandemic response the Community Team added a GP to the single point of access and crisis team. This has resulted in 450 patients in the North Lincolnshire locality being maintained at home rather than attending the Trust's Emergency services.

- **All patients requiring mental health support in ED will be assessed within 4 hours of referral:**
- It has not been possible during the year to collect this data from the Trust's Emergency Department system.

- **Patients admitted will be assessed and have a plan in place within 8 hours of referral:**
- The latest audit of seven day services demonstrated that 60% of patients have a plan in place within 8 hours of admission which rises to 83% within 72hours of admission.

Progress monitored, measured and reported: Progress with these indicators is monitored within the access and flow section of the integrated performance report by the Finance and Performance Committee and the Trust Board.

Relationship to 2021/22 Quality Improvement Priorities: The quality priority theme has remained the same throughout 2020/21. Access and flow will feature as a priority for the Trust during 2021/22 as part of the post-pandemic recovery work and there are links to the discharge to assess project as part of the Trust's 21/22 quality priorities.

2.1f: Priority 6: Patient Experience: Improve the quality and timeliness of complaints responses using a more individualised approach;

Summary table: Performance during 2020/21:

PATIENT EXPERIENCE:					
QP6: Improve the quality and timeliness of complaints responses using a more individualised approach.	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
a) 85% Pals responded to in 5 working days by the 31 January 2021	**56.00%**	55.00%			R
b) 100% of all complaints >120 days on 'old' process pathway to be closed by 31 Jan 2021	**100%**	**100%**			G
c) 100% of all complaints on 'old' process pathway to be closed by 28 Feb 2021	**100%**	**100%**			G
d) 85% of all complaints resolved within timescale by the 31 July 2021	**65.00%**	51.00%			A
e) 85% of reopened complaints resolved within 20 working days by the 30 November 2020 (Quarterly)	50.00%				R
f) 100% Complaints acknowledged within 3 days by the 31 July 2021	100.00%	100.00%			G
g) 100% complainants offered a face to face meeting during initial resolution planning by the 31 Dec 2020 [Amended]	100.00%	100.00%			G
h) 100% of all upheld complaints to have evidence of learning by the 31 October 2020	**85.00%**	83.00%			A
i) 100% formal complaint responses reviewed by Chief Nurses Office by the 31 July 2020 [Amended]	100.00%	100.00%			G
j) 50% reduction in reopened complaints by the 31 January 2021	**No data**	No data	-	-	-

Progress Made: (April 2020 – March 2021): During the 2020/21 period, the Trust has made significant improvement and progress with complaints handling processes.

- 100% of complaints open for 120 days or longer have been now closed. During March 2020 there were 97 such complaints open. The chart below demonstrates the significant improvement.

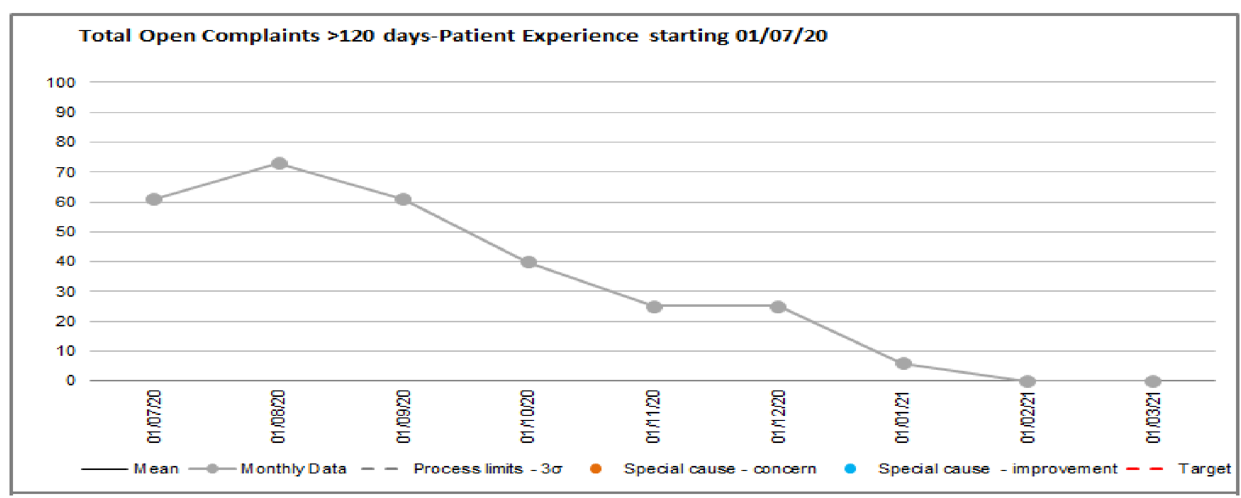


Figure 7: Reduction of the total number of open complaints exceeding 120 days

- There has been a significant reduction in the number of open complaints despite only a slight reduction in the number of incoming complaints during Covid-19. There were 219 open complaints in March 2020 compared with only 64 open complaints in March 2021.

- There has been a Trust-wide adoption of a new process, with lead investigator roles taking responsibility for investigation of complaint concerns. This has supported the quality of responses improving and learning evidenced in responses.

- Complaints resolved within timescales has a target date for achievement outside of the 2020/21 year and is on track for completion by July 2021. The May 21 data demonstrates performance of 73% which is positive.

- The focus on PALs responses will be carried forward into 2021/22 as a priority.

Progress monitored, measured and reported: Progress with these indicators is monitored within the quality section of the integrated performance report by the Quality Governance Group, Quality & Safety Committee and the Trust Board.

Relationship to 2021/22 Quality Improvement Priorities: The quality priority theme has remained the same throughout 2020/21. Given the significant improvements in this area, complaints will not feature as a quality priority during 2021/22. Oversight will remain to ensure improvements are embedded and sustained.

2.1g: Quality Priority planning for 2021/22

The Trust has agreed 5 quality priority areas for 2021/22:

1. End of Life and Related Mortality Indicators
   (Clinical Effectiveness & Patient Experience)

2. Deteriorating Patient & Sepsis
   (Clinical Effectiveness & Patient Safety)

3. Increasing Medication Safety
   (Patient Safety & Patient Experience)

4. Safety of Discharge
   (Clinical Effectiveness, Patient Safety & Patient Experience)

5. Diabetes Management
   (Clinical Effectiveness & Patient Safety)

How these priorities were set:

The quality priorities for 2021/22 were set in harmony with the Trust's quality strategy longer term objectives. The priorities were also based on a comprehensive programme of consultation which involved the identification and formulation of a 'long-list' of prospective areas for priority focus. This was then consulted on with local residents and service users through the use of a survey made available by the Trust's communications and patient experience teams as well as CCG partners through their social media channels.

This analysis of service user feedback was then used for wider consultation within the Trust and with commissioners which resulted in a short-list of priorities for 2021/22. This was refined further by the Trust's Quality & Safety Committee and Trust Board.

How progress against 2021/22 quality priorities will be monitored and measured:

Progress against these quality priorities will be monitored through the Trust's quality section of the Integrated Performance Report. This is a monthly report considered by the Executive-led Quality Governance Group for the oversight of management actions and also by the Non-Executive Director (NED) Chaired Quality & Safety Committee for assurance purposes. Assurance and performance against the Quality Priorities will also be monitored via the Trust Management Board, Quality & Safety Committee, Quality Governance Group and Operations Directorate performance.

Some of the above quality priorities and the underpinning measures to understand progress in each link to Trust performance indicators. In these instances, the Trust's Finance and Performance Committee will primarily oversee progress, with the Quality & Safety Committee seeking assurance on quality outcome measures related to Trust performance.

There are close links established between these oversight arrangements and the monthly performance meetings held with divisions, where divisions will be held to account for their performance.

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 2020/21 the Northern Lincolnshire and Goole NHS Foundation Trust provided and/or subcontracted 7 relevant health 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 2020/21 represents 100% of the total income generated from the provision of relevant health and care services for 2020/21.

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

During 2020/21, 54 national clinical audits and 2 national confidential enquires covered relevant health services that Northern Lincolnshire and Goole NHS Foundation Trust provides.

Due to Covid-19, in March 2020 all Trusts received the following communication:

> *"All national clinical audit, confidential enquiries and national joint registry data collection, including for national VTE risk assessment, can be suspended. Analysis and preparation of current reports can continue at the discretion of the audit provider, where it does not impact front line clinical capacity. Data collection for the child death database and MBRRACE-UK-perinatal surveillance data will continue as this is important in understanding the impact of COVID-19. Participation in NCAPOP and data entry should not impact on front line clinical Covid care".*

Despite this, many of the NCAPOP platforms and web-tools remained open. The Trust participated in 49 or 91% of the national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

NB: *4 national clinical audits were formally suspended by national audit provider, meaning the Trust could not participate.*

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2020/21 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 audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
Antenatal and newborn national audit protocol 2019 to 2022	Yes	Yes	46	100%	Awaiting publication of national report
BAUS Urology Audit – Renal Colic	Yes	Yes	10	100%	Awaiting publication of results
BAUS Urology Audit - Female Stress Urinary Incontinence	No	N/A	N/A	N/A	N/A
BAUS Urology Audit – Cytoreductive Radical Nephrectomy	Yes	Yes	3	100%	Awaiting publication of results
British Spine Registry	No	N/A	N/A	N/A	N/A
Case Mix Programme (CMP)	Yes	Yes	1390	100%	Results published June 2021, Actions to be agreed
Cleft Registry and Audit Network (CRANE)	No	N/A	N/A	N/A	N/A
Elective Surgery - National PROMs Programme	Yes	Yes	468 (79%)	PROMS collections ceased during COVID 19 – Trust continued to submit	Awaiting publication of results
Falls and Fragility Fractures Audit programme (FFFAP) National Hip Fracture Database (submitted for all)	Yes	Yes	585	100%	Awaiting National Report
Falls and Fragility Fractures Audit programme (FFFAP) Fracture Liaison Service Database	Yes	Yes	757	100%	Yes
Falls and Fragility Fractures Audit programme (FFFAP) National Falls Audit	Yes	Yes	6	Ongoing	Project still underway
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Yes	Yes	160 (Cumulative)	100%	Yes
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	Yes	3	100%	Yes
Mandatory Surveillance of HCAI	Yes	Yes	114	100%	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal morbidity & mortality confidential enquiries	Yes	Yes	23	100%	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiry	Yes	Yes	1 Maternal death	100%	Yes

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
National Asthma and chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **Adult COPD**	Yes	Yes	663	65% (On-going)	Yes
National Asthma and chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **Adult Asthma**	Yes	Yes	144	89% (On-going)	Yes
National Asthma and chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **Children and Young People Asthma**	Yes	Yes	57	100%	Awaiting publication of results
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	202	100%	Yes
National Audit of Cardiac Rehabilitation (NACR)	Yes	Yes	775	100%	Report writing/action planning
National Audit of Care at the End of Life (NACEL)	Suspended due to COVID-19	*Local audit undertaken*			
National Audit of Dementia	Suspended Due to COVID-19	*Local audit undertaken*			
National Audit of Pulmonary Hypertension (NAPH)	No	N/A	N/A	N/A	N/A
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Yes	134 (Cohort 2)	100%	Awaiting Publication of Results
National Bariatric Surgery Registry (NBSR)	No	N/A	N/A	N/A	N/A
National Cardiac Arrest Audit (NCAA)	Yes	Yes	113	100%	Project still underway
National Cardiac Audit Programme (NCAP) – Heart Failure	Yes	Yes	831	72% Ongoing	Yes
National Cardiac Audit Programme (NCAP) – MINAP	Yes	Yes	469	48%	Project still underway
National Cardiac Audit Programme (NCAP) – Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	298	Ongoing	Project still underway
National Cardiac Audit Programme (NCAP) – Cardiac Rhythm Management	Yes	Yes	TBC	Ongoing	Project still underway
National Cardiac Audit Programme (NCAP) – Adult Cardiac Surgery	No	N/A	N/A	N/A	N/A

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
National Cardiac Audit Programme (NCAP) – Congenital Heart Disease	No	N/A	N/A	N/A	N/A
National Clinical 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
National Comparative Audit of Blood Transfusion programme - 2020 Audit of the management of perioperative paediatric anaemia	*Suspended due to COVID-19*				
National Diabetes Audit – Core Audit	Yes	Yes	1220	100%	Yes
National Diabetes Audit – Inpatient HARMS	Yes	Yes	15	Ongoing	Yes
National Diabetes Audit – Foot Care	Yes	Yes	184	Ongoing	Project still underway
National Pregnancy in Diabetes (NPID) Audit	Yes	Yes	28	97%	Awaiting Publication of Results
National Early Inflammatory Arthritis Audit (NEIAA)	Communications from BSR - Non mandatory – recommenced April 21 Project still underway				
National Emergency Laparotomy Audit (NELA)	Yes	Yes	287	95%	Awaiting Publication of Results
National Gastro-intestinal Cancer Programme Bowel Cancer (NBOCAP)	Yes	Yes	263	98%	Yes
National Gastro-intestinal Cancer Programme Oesophago-gastric cancer (NOGCA)	Yes	Yes	210	85-100%	Yes
National Joint Registry (NJR)	Yes	Yes	929	96%	Yes
National Lung Cancer Audit (NLCA)	Yes	Yes	342	100%	Yes
National Maternity and Perinatal Audit (NMPA)	*Suspended due to COVID-19*				
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	436	100%	Yes
National Ophthalmology Audit (NOD)	Yes	No	Undertaking local audit as not participating in national audit	N/A	Actions to be agreed
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	229	100%	Awaiting national report
National Prostate Cancer Audit	Yes	Yes	309	100%	Actions to be agreed
National Vascular Registry	No	N/A	N/A	N/A	N/A

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
Neurosurgical National Audit Programme	No	N/A	N/A	N/A	N/A
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	No	N/A	N/A	N/A	N/A
Paediatric Intensive Care Audit Network (PICANet)	No	N/A	N/A	N/A	N/A
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	27	100%	Project still underway
Prescribing Observatory for Mental Health (POMH-UK)	No	N/A	N/A	N/A	N/A
RCEM QIP: Fractured Neck of Femur	Yes	Yes	218	100%	Yes
RCEM QIP: Infection Control	Yes	Yes	291	100%	Yes
RCEM QIP: Pain in Children	Yes	Yes	Extended to cross 2 audit years, ends October 2021		
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	710	100%	Project still underway
Sentinel Stroke National Audit Programme (SSNAP) Early Supported Discharge Data	Yes	Yes	113	100%	Yes
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes	Yes	35	Ongoing	Project still underway
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Yes	48	100%	Yes
Surgical Site Infection Surveillance Service	Yes	Yes	347	100%	Yes
The Trauma Audit & Research Network (TARN)	Yes	Yes	596	96% Ongoing	Yes
UK Cystic Fibrosis Registry	No	N/A	N/A	N/A	N/A
UK Registry of Endocrine and Thyroid National Audit	Yes	Yes	46	84%	Project still underway
UK Renal Registry National Acute Kidney Injury programme	No	N/A	N/A	N/A	N/A

National confidential enquires 2020/21

Confidential enquiry	Eligible for NLAG	NLAG participated	Organisational Questionnaires	Number of cases submitted	% of number required	Action planning
Out of Hospital Cardiac Arrests	Yes	Yes	Yes	10	100%	Yes
Physical Health Care of inpatients in Mental Health Hospitals	No	N/A	N/A	N/A	N/A	N/A
Dysphagia in People with Parkinson's	Yes	Yes	Yes	4	100%	Awaiting national report

A number of published **national** clinical audits were reviewed by the provider in 2020/21 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:

- National Paediatric Diabetes Audit:
  - Regular contact and education with children and young people to encourage and facilitate self-management of diabetes.
  - Monthly data from retinal screening to be reviewed to identify missed appointments and provide further education to children, young people and parents by the Paediatric Diabetes Specialist Nurses.
- National Neonatal Audit Programme:
  - Provide education to parents on reducing environmental factors that could negatively impact upon the infant's ability to regulate their own temperature.
  - Identify and provide consistent discharge advice for parents once correct home room temperature is identified.
- National Pregnancy in Diabetes Audit: Provide educational sessions to the public at Local Diabetes UK groups.

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

- National Emergency Laparotomy Audit:
  - Results of the audit to be displayed on theatre screens to raise staff awareness of performance
  - To highlight the requirement for prompt data collection, as part of the Doctors Induction process in General Surgery.
  - To re-inforce to all anaesthetics trainees that emergency laparotomy's should not be commenced before a consultant is present if the mortality risk is >=5%.
- National Joint Registry: Collation of best practice information shared within the orthopaedic department
- National Paediatric Diabetes Audit: Training to be provided on how to record albuminuria correctly.
- National Pregnancy in Diabetes Audit: communication to be shared amongst the public and primary care practices regarding the availability of pre-conception clinics in the community/GP practices.
- National Neonatal Audit programme:
- Posters to be displayed on the Workstation on Wheels (WOW) stations reminding the team to document if parents are not present at time of the ward round.
- Education to be provided to all NICU / maternity staff on submitting DATIX incidents for low temperature.

- Education to be provided to all NICU / maternity staff regarding the importance of ensuring babies on the Hypoglycaemia pathway have their temperature and room temperature checked when blood glucose noted to be low.
- Display thermoregulation posters in the NICU / Maternity units.
- Educational update to be provided to all NICU / midwifery staff promoting the consideration of how to keep baby warm.
- Raise awareness at daily huddles/clinical audit meeting to ensure that staff:
  - understand the parental consultation (within 24 hours of admission) discussion should be following admission to the unit and any discussions that took place in theatre will not be taken into account
  - understand the importance of welcoming parents to the neonatal unit
  - communicate to parents the value of their presence on the ward round and involve them directly in the ward round

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

- National Pregnancy in Diabetes Audit: Local deep dive review to ascertain indications for the high rates of deliveries of 'large for gestational age babies'.
- National Maternity and Perinatal Audit: Measure local compliance for the use of the new document for babies requiring 'Enhanced Midwifery and/or Transitional Care'.
- National Neonatal Audit programme: Case note review to be undertaken on every baby admitted to NICU at term gestation to identify the reason for admission.
- National Neonatal Audit Programme: Mothers who are breastfeeding with a baby on the neonatal unit to be audited using the UNICEF audit tool (providing their feedback as recommended by NNAP).
- National Bowel Cancer Audit: An audit was undertaken of the Stratified Pathway to provide assurance that patients with bowel cancer are being added to the pathway.
- National Joint Registry: To undertake a local audit of knee arthroplasty infections.
- GIRFT SSI Breast Action re: collating a local list of suspected Breast Surgical Site Infections and collecting data on such cases action – if this has been covered as now under W&C then ignore otherwise ask me for detail.
- National Lung Cancer Audit: Separate deep dive audit undertaken by clinical lead as per National Audit and GIRFT recommendations reviewing cases that fit in to multiple standards/KPI's to review quality of care provided.
- National Audit of Dementia: Local review of delirium screening audit was undertaken despite the Pandemic which evidenced improvement in performance against national standards.
- Core Diabetes Audit: Separate quality priority work doing continuous audit on blood glucose management on the wards and feeding back to wards and Quality and Safety Committee.

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

- TARN Audit: New CT scanner in place from January 2021 to increase capacity and aid compliance with TARN standards.
- National Lung Cancer Audit: Single site MDT put in place to ensure consistent decision making.
- National IBD Audit: Trust Electronic Systems edited to include a module to ensure correct screening investigations and key performance indicators are met prior to commencement of a new biologic drug.
- Fracture Liaison Service Database: Changed the process to request DXA scan (to measure bone density) in the 1st fracture clinic. This sped up the process and improved performance in follow up and commencement of bone therapy.
- National Joint Registry: Data validation via web tool data review system on an ongoing basis.

- National Emergency Laparotomy Audit: A pre-operative discussion to take place between surgery Consultant and Anaesthetics Consultant for all patients who have a mortality risk of 25% or greater.
- National Bowel Cancer Audit:
    - To document the presence of any stoma and its potential reversibility at the MDT meeting so this information is clearly available to the Clinical Nurse Specialists.
    - To commence a spreadsheet to record cases which have a reversible stoma allowing such cases to be easily identified and highlighted to surgeons 10 months post-operatively.
    - Consider pooling lists of stoma reversals on to one Trust-wide Theatre list at either site if this will increase efficiency.
    - To contact patients at the relevant timeframe point for their stratified pathway review, even if investigations are not available at the time, and then to contact them again with results if necessary.
- National Prostate Cancer Audit: The urology team trialled the use of fusion trans perineal biopsy equipment and is now in the process of purchasing the equipment.
- National Bladder Outflow Obstruction Audit: The urology team are to implement a trial of the use of Greenlight laser equipment.
- National Percutaneous Nephrolithotomy Audit:
    - Junior Doctors to add the patients bone profile to initial blood test.
    - To undertake a trial of Trilogy equipment.
- National Maternity and Perinatal Audit: The Maternity and Neonatal (MatNeo) Safety Improvement Programme to be implemented to include quality improvement work on reducing major PPH rates.
- National Maternity and Perinatal Audit: Introduce Midwifery Enhanced Care model into practice to allow babies (term and late pre-term) who require additional care to be looked after with the mother on a postnatal area by midwives and/or neonatal staff (depending on the area of care at the time).
- National Audit of Care at the End of Life:
    - Standardise the pain assessment tool across the trust.
    - Rollout of RESPECT document and accompanying training.
- National Maternity and Perinatal Audit: OASI bundle to be introduced across the Trust
- MBRRACE-UK Perinatal Mortality Surveillance Report: Better Births initiative to be implemented.
- National Paediatric Diabetes Audit: 'One-stop Service' where patients can have 'catch up' of Annual Review care processes to be introduced.
- National Neonatal Audit Programme:
    - 'Care Plan and Evaluation for Babies who require Additional Care on a Postnatal Area Provided by Midwifery and/or Neonatal Staff' to be introduced for use and used by midwives and/or neonatal staff (depending on the area of care at the time).
    - Introduce new ophthalmology examination sheet for completion by the Ophthalmologists.
    - Babies who require 2 year follow up to be seen in a dedicated consultant led clinic.
    - Record room temperatures (LDRP, Theatre, Transitional Care SGH and Pool rooms) at the beginning of each shift.

A number of **local** clinical audits were reviewed by the provider in 2020/21 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:

- Epilepsy in Pregnancy: Counselling and birth plan documentation to be amended at SGH to ensure women receive the required information for pre/post-natal care.

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

- Intentional Rounding/Patient ID Wristband/Nursing Documentation: Results to be discussed at Patient Safety Days to raise awareness amongst all ward level staff groups regarding the expectation to comply with the clinical audit standards and retrospectively evidencing when a rounding chart is not required.
- Patient ID Wristband: Targeted visits / education to be provided regarding the appropriate use of wristbands to wards with low compliance: C2, Holly, Rainforest, Endoscopy (DPOW), HDU, GNRC).
- Audit of Nutritional Risk Assessment: Education to be provided to Nutrition team and all levels of nursing teams at Nursing Quality & Safety Day.
- Patient ID Wristband: Ongoing surveillance of compliance through the monthly 15 steps assessment with live feedback / action taken to address any issues identified.
- Community Record Keeping: Record keeping workshops to be held to train Audit Champions on good record keeping / inform them what the issues are so they can discuss with their teams and set out the expectations for the role.
- PEWS: SBAR sticker to be re-launched for use on Disney and Rainforest wards.
- PEWS: Discussion amongst medical and nursing staff of the need for documentation of deviation from escalation process.
- Paediatric Sepsis: Continuous education and support for completion of the sepsis screening chart and pathway to be provided at SIP Healthcare Assistant training days.
- Caesarean Section Audit: Provide education to all new doctors rotating into Obstetrics & Gynaecology at doctor's induction on how to complete and work through the Maternity theatre record / working as part of a safe team in theatre.
- Audit of Electronic Discharge Summaries: Discussion at Medical Quality and Safety Meetings and Medicine Audit Meetings to raise awareness of completion of key fields
- Blood Glucose Testing in the ECC: Audits continuously escalated to Governance and Audit Meetings to Raise Awareness, Cases validated by Paediatric Emergency Nurses.
- PEWS in ECC: Escalation/discussion at ECC/A&E Audit meeting regarding the requirements to complete all PEWS parameters in Children.

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

- Assess knowledge of the identification and management of third/fourth degree tears amongst midwifery staff.
- Pre-Assessment Documentation Audit: Following confirmation of improved performance via a re-audit informal spot checks to continue on a local basis to ensure continued compliance.

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

- Intentional Rounding: Introduction of new Patient Safety Nurse with a focus on intentional rounding compliance.
- Nursing Documentation Audit: Adult admission document to be reviewed and updated by Task and Finish Group following introduction of the IAAU model.
- Weighing and Prescribing Audit: Prescription chart to be amended and adopted for use within neonatal services.
- Surgery & Critical Care Documentation Audit: Stamps to be provided to permanent members of the ENT staff to allow then to record their printed name and grade more quickly.
- Oxygen Prescribing in the ECC: Dedicated Oxygen prescribing sections added to ECC/A&E prescription charts to facilitate clear prescribing of oxygen, including target ranges and flow rates.
- Pain scoring in children (ECC/A&E): Added to Symphony chronology and made it a requirement to do pain scoring at streaming.
- Blood glucose testing in the ECC: Added blood glucose to the Acute admissions profile for adults to ensure is undertaken as a matter of course/process.

2.2c Information on participation in clinical research

The research team priorities for 2020/21 have been urgent Public Health studies.

The Trust's main recruitment has been Clinical Characterisation Protocol for Severe Emerging Infection (CCP), RECOVERY and SIREN studies which are all Covid-19 studies. They have all helped to gain knowledge and develop treatments during the pandemic.

The Research team adapted to this sudden change in process well and have been successful in reporting high numbers of trial participants even though the Trusts Covid-19 positive patient numbers were nationally considered low.

The number of patients receiving relevant health services provided or sub-contracted by Northern Lincolnshire and Goole NHS Foundation Trust in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 987.

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

Due to the unprecedented impact on the NHS of Covid-19, the use of the CQUIN framework was paused during 2020/21, therefore, the Trust's income during 2020/21 was not conditional upon achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

The monetary total value for 2019/20 CQUIN indicators was £3,750,766. The Trust received payment for £3,301,539 during 2019/20.

2.2e Information relating to the Trust's registration with the Care Quality Commission

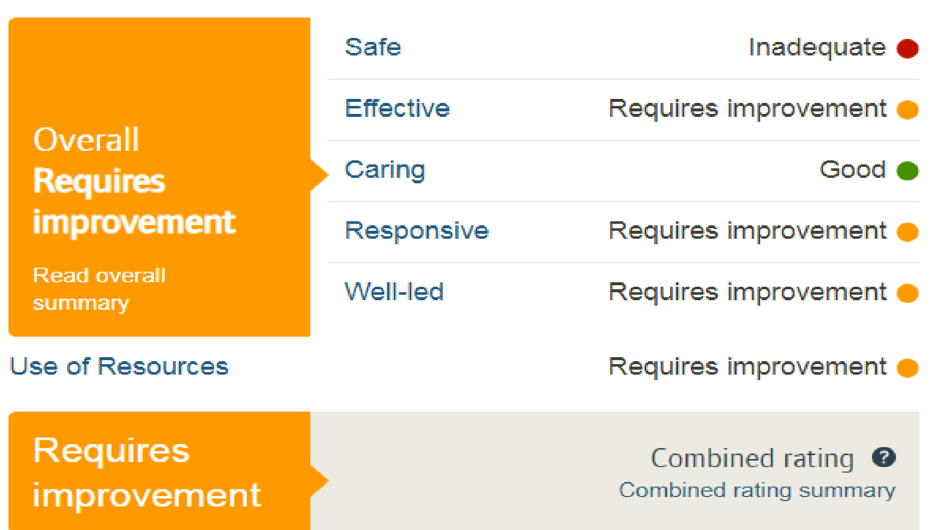
Northern Lincolnshire and Goole NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

The Care Quality Commission has not taken enforcement action against the Trust during 2020/21.

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 September and October 2019 (of which the report was published on the 7 February 2020) the outcome was as follows:



The Care Quality Commission (CQC) last inspected the Trust formally in 2019. Due to the Covid-19 pandemic routine inspections from CQC had been put on hold during the peak of the pandemic. A Transitional Monitoring Approach (TMA) was instead used by the CQC to support providers during the pandemic and using a more 'desktop' style approach, assess if there were risks to patient safety that required further regulatory action.

The Trust was involved in two such instances with CQC to review provision of services, in line with the CQC key lines of enquiry, for infection prevention and control and its provision of Emergency Department services. As a result no further action was required by CQC.

CQC's Transitional Monitoring Approach was not designed to replicate an inspection and has no impact on a providers rating. The Trust therefore has had no ratings review since the 2019 inspection.

Despite the pandemic, the Trust has continued to progress with the CQC improvement programme of work following the last inspection. A monthly report provides detail and assurance on progress.

Some risks arise from this in relation to the effects of the pandemic, these are around:

- Staff compliance with mandatory training which has been impacted by significant difficulties in releasing staff from direct front line care and due to some forms of training requiring practical delivery which was not possible to deliver virtually due to the pandemic;
- Personal Appraisal Development Reviews again impacted upon by staffing challenges linked to the pandemic;
- Diagnostic waiting times, impacted upon by reduced capacity within diagnostics as part of social distancing; increased cleaning and infection prevention and control measures.

The Trust continues to have regular engagement meetings with the CQC and supplies them with regular updates on progress with the plan along with supporting evidence.

2.2f Information on quality of data

Northern Lincolnshire and Goole NHS Foundation Trust submitted records during 2020/21 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:

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

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

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

2.2g Information governance assessment report

Throughout 2019/20 and 2020/21 there have been a number of changes to the reporting of the data and Security Protection Toolkit (DSPT). NHSX recognised that organisations would find it difficult to fully complete the toolkit without impacting on their Covid-19 response. Therefore NHSX took the decision to push back the final deadline from the 31 March 2020 to the 30th September 2020 for the 2019/20 submission. This meant that the Trust were able to continue working on the gaps which had been identified within the improvement plan, reducing the number of actions contained within. The 2019/20 improvement plan has been updated and reviewed a number of times by NHS Digital throughout 2020/21. The 2020/21 Version of the DSPT was launched on the 1st December 2020, with an initial submission date of the 31 March 2021 however this has also been extended to the 30 June 2021. So at the time of compiling this report the Trust has still yet to submit its final response so is not in a position to provide a submission statement.

2.2h 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.

2.2i Learning from Deaths

During 2020/21, 1,830 of Northern Lincolnshire & Goole NHS Foundation Trust’s patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 428 in the first quarter;
- 332 in the second quarter;
- 583 in the third quarter;
- 487 in the fourth quarter

By 20 July 2021, 1,307 case record reviews and 73 investigations have been carried out in relation to 1,830 of the deaths included in item 27.1. In 16 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 280 in the first quarter;
- 156 in the second quarter;
- 497 in the third quarter;
- 447 in the fourth quarter.

1 representing 0.05% of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. *[Definition: using Royal College of Physicians (RCP) question: "Avoidability of Death Judgement Score" for patients with a score of 3 or less – see narrative below for more information].*

In relation to each quarter, this consisted of:

- 1 representing 0.05% for the first quarter;
- 0 representing 0% for the second quarter;
- 0 representing 0% for the third quarter;
- 0 representing 0% for the fourth quarter.

These numbers have been estimated using the Structured Judgement Review (SJR) which includes a 6 factor Likert scale ranging from Score 6: "Definitely Not Avoidable" to Score 1: "Definitely Avoidable". The above number of cases includes all those deaths that were classified as scoring less than or equal to 3 on this 6 factor scale. This assessment is the initial reviewer's evaluation from the retrospective analysis of the medical record. Any case reviews completed that identify that further understanding is needed, are reviewed a second time by the 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 to improve the standard of patient safety and quality of care. The denominator used in the calculation is the total number of deaths during 2020/21.

Summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified during 2020/21;

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 2020/21;

And,

An assessment of the impact of the actions taken by the Trust during 2020/21:

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 reviews as an opportunity to review the quality of care provided to these patients. From these mortality case reviews, the following quality improvement themes and learning lessons have been identified:

Healthcare System Themes:

- Advanced care planning: The Trust's review of mortality within its hospitals or within 30 days of discharge has consistently identified as one of the main themes, advanced care planning to support those patients who are entering the end of life phase of their care. It is likely this contributes to the Trust's higher out-of-hospital SHMI performance.

- In a number of cases reviewers have concluded that greater consideration and planning what happens at end of life could have prevented the patient from being admitted to hospital and could have enabled the patient to die in their own homes with community support in place. In other cases, even when plans are in place, these are not always followed due to a number of reasons, resulting in the patient attending the acute hospital at end of life.

- In such cases, wider community and primary care reviews are undertaken for some of these care episodes to identify cross system learning and sharing. This has supported the development of a community-focussed improvement plan which seeks to focus on and improve elements of care in primary care and support to care and nursing homes to prevent hospital admission. The key actions being taken or planned relate the following areas:

- **RESPECT (Recommendations Summary Plan for Emergency Care and Treatment)** is a document that is designed to facilitate conversations at an early stage between healthcare professionals and patients and their families to ensure the preferences at end of life are at the forefront of the care packages. The RESPECT document is in the process of being rolled out and embedded in community and within the acute Trust. This is a priority project with a project team and dedicated trainer/lead facilitator supporting.

- **Electronic Palliative Care Coordination System or (EPaCCs)** is being rolled out across the wider Humber Coast and Vale Integrated Care System and therefore covers Northern Lincolnshire. EPaCCs is designed to support communication across different care sectors and organisations to support patient choices and preferences at end of life to be delivered on irrespective of which care setting has contact with the patient. This has now been rolled out across the majority of community settings and plans are in place to ensure this is accessible to hospital based clinicians.

- **Primary Care Network (PCNs)** are established in Primary Care and are working to establish support to community providers, especially care homes, and regularly undertake reviews of people to ensure proactive planning in place to prevent access to unplanned services within the acute Trust. Key performance indicators are being established to monitor the impact of this development. The impact of the Covid-19 vaccination rollout has delayed elements of this whilst resource was prioritised.

- **Support to care homes** is a review of training needs and wraparound of other support functions such as pharmacy to support medication reviews. This is designed, along with other initiatives, to support more proactive management of residents health needs and prevent, where possible, access to unplanned services from the ambulance service or the acute Trust.

- The Trust and community partners have also been supported by NHS Improvement / NHS England to review the provision of services at end of life. An audit is underway during April and May to review end of life care delivery from an external team of expert reviewers to identify other areas of end of life care provision that would benefit from further focus.

Learning from deaths within the acute hospitals:

- The Trust's delivery and planning of **end of life (EOL)** services is also an area where action is being taken on the back of themes from mortality and other feedback mechanisms. Whilst the Trust's end of life improvement work interacts closely with the wider systems end of life improvement plans, it also has areas of specific focus. Action at present has been and is being taken to ensure specialist palliative care team provision is supportive by ensuring mandatory training is up to date, effective governance and oversight improvements are enacted. The teams are currently reviewing the documentation and controls in place to support good end of life care provision on hospital wards for those patients who are receiving in-hospital care.

- Use of **do not attempt cardio-pulmonary resuscitation orders (DNaCPR)** has also been a theme identified from either completion of documentation or delays in considering this as part of the patients longer term planning on admission. The Mortality Improvement Group (MIG) requested divisions to assess their performance and processes in place with regard to this and the use of RESPECT during 2020/21. Divisions are in the process of feeding back to the group the specific actions taken to promote early consideration. This has included the use of education and reminders.

- The quality of **documentation and record keeping** remains an area needing further attention and improvement. Education and feedback is provided to clinical staff to help them reflect on the importance of comprehensive record keeping. Completion of specific documents designed to support and guide best practice relating to end of life and sepsis are specific areas of focus by the EOL team and the Deteriorating Patient and Sepsis team. These actions and reminders will remain active actions throughout 2021/22.

- Mortality reviews have also identified general **clinical care management** themes relating to delays in taking action, acknowledging results and undertaking assessments. A theme was identified relating to the management of diabetic ketoacidosis (DKA) which led to a specific review of these cases by the team followed up with education and reminders to department staff.

- **Medication** themes are identified from mortality reviews, these are fed back to the Trust's Safer Medications Group to inform their ongoing oversight of medication safety and action in response to mortality themes alongside other triangulated sources of intelligence overseen by the group.

- **Fluid management** has been identified from the mortality screening process. During 2019/20, additional work was invested into changing the documentation to record this information and to act as a prompt for nursing staff to support improved recording. To ensure themes from mortality are reviewed in the context of wider improvement fluid management has been added to the remit of the Deteriorating Patient and Sepsis group with reporting from mortality reviews into this group.

- During the pandemic **patient flow** was a constant area of focus to prevent and mitigate the spread of Covid-19 within the Trust's hospitals. Actions taken included the zoning of in-hospital locations which, coupled with normal winter pressures, has put a strain on services and the Trust's ability to see and treat patients in the Emergency Department within normal timeframes. The Trust is currently taking action, along with NHS Improvement / NHS England and system partners to embed the Discharge to Assess programme to support effective management of patient flow and reduce bed occupancy and length of stay to mitigate delays in patients being assessed and admitted. This remains an ongoing action planned during 2021/22.

147 case record reviews and 3 investigations completed after 01st April 2020 which related to deaths which took place before the start of the reporting period.

1 representing 0.05% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated based on the number of patients reviewed. Each case was reviewed using the Structured Judgement Review (SJR) which includes a 6 factor Likert scale ranging from Score 6: "Definitely Not Avoidable" to Score 1: "Definitely Avoidable". The above number of cases includes all those deaths that were classified as scoring less than or equal to 3 on this 6 factor scale. This assessment is the initial reviewer's evaluation from the retrospective analysis of the medical record. Any case reviews completed that identify that further understanding is needed, are reviewed a second time by the appropriate specialty clinical lead. This process links into the Trust's Serious Incident Framework. It should be stressed that this data is not a 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 to improve the standard of patient safety and quality of care.

9 representing 0.52% of the patient deaths during 2019/20 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

2.2j Details of ways in which staff can speak up

Annual Update on Speaking Up:

All NHS staff should be able to speak up regarding any concerns they may have in full confidence of not suffering any form of detriment as a result. The Trust is committed to 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 has 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;
    - 'Ask Peter' which provides an anonymous channel to communicate concerns directly to the Chief Executive.

Freedom to Speak Up Guardian:

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

The Guardian role and the Speaking Up process is further promoted through printed and digital materials in the Trust and in the past 12 months there have been several promotional events, and additional magazine features. The Guardian also featured as part of the National 'Speak Up' campaign in October, writing a blog which was shared nationally. The Guardian is now active on social media and regularly uses it as a way of communicating to staff. The Freedom to Speak Up Guardian is accessed via a generic email address and a dedicated mobile telephone number.

The Trust's Freedom to Speak Up Policy and Process and associated procedures supports staff to raise concerns safely without suffering any form of detriment. The Freedom to Speak Up Guardian responds to all concerns raised under this process and follows through each case according to the individual requirements providing regular communications and feedback until the case is concluded. Evaluation feedback from staff raising concerns has shown confidence in the Guardian and the overall process.

The Trust's Freedom to Speak Up Guardian meets monthly with the Chief Executive and Executive Director and bi-monthly with the Trust Chair and Non-Executive Director with specific responsibility for Freedom to Speak Up who provides support to this function. A quarterly Freedom to Speak Up Guardian report is reviewed by the Trust Management Board and the Workforce Sub-committee prior to being presented to the Trust Board by the Freedom to Speak Up Guardian. This ensures the Trust and its board are kept up-to-date on concerns including sufficient details as per the National Guardian's recommendations. An overview of the report is

shared with all staff by quarterly infographics. The Guardian is also sharing information to all Divisions about the number and nature of the concerns raised via the HRBPs. This information now forms part of the PRIM information and can be used in conjunction with other HR intelligence data to highlight potential areas for further analysis.

During 2020/21 there has been a significant increase in concerns raised with 143 cases brought to the Guardian, this compares with 70 the previous year. This is one indication of an improvement in staff feeling more secure in raising concerns. The latest staff survey also shows improvement in staff perception that they will be treated fairly, and that the organisation is moving towards a learning environment.

2.2k Annual report on rota gaps and plan for improvement

The Trust has made significant progress with management of Medical and Dental rotas. The latest data for April 2021 showed a vacancy rate of 15.40%, compared with 12.90% in 2020. This higher vacancy rate is due to an increase in establishment of 37.09 whole time equivalent staff for 2020/21. For trainees, the latest data available is for August 2020, this demonstrated a fill rate of 91.12 % which was an improvement of 3.1% in comparison to the previous year.

Workforce and Recruitment meetings are planned to take place regularly (monthly and by exception) with Temporary Staffing as part of the development of the Workforce Resource Centre (WRC) and the groups to identify and plan for vacancies. Vacancies are advertised and active steps taken to follow up any interest in the area. 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 drafted a revised people strategy, overseen by the Workforce Committee. This will lead to a high level delivery plan which will incorporate these roles. ACP roles are currently being developed in the Trust with support from Health Education England, Yorkshire and the Humber.

Rota Co-ordination has improved in 2019, the Trust is in the process of transitioning to an electronic rostering system for greater visibility to identify the workforce needs and 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.

2.2l Summary of Invited Service Reviews during 2020/21

During 2020/21, the Trust commissioned one invited service review. The Trust commissioned the Royal College of Surgeons (RCS) to undertake a review of the Urology surgical service to conduct a clinical record review and external scrutiny of the Urology MDT processes. The invited service review visit was held in November 2020 and the report back to the Trust received in January 2021.

Background:

The Trust made the decision to commission the invited service review following a Never Event occurring within the Surgical Division that, following investigation, identified some potential areas for improvement in the process by which treatment decisions were made.

Terms of Reference for the review:

The review set out with the following objectives:

- Review of relevant documentation that supports treatment decisions being made by the multi-disciplinary team and a consideration from this as to the effectiveness of current processes;

- Team working within the Trust and with the local Tertiary services provider;
- Clinical leadership, timeliness and record keeping.

Summary of conclusions from the review and Trust action in response:

- The review concluded that provision of specific specialist surgery for renal cancer was not sustainable within the Trust alone and closer working was recommended with the local cancer centre and specific and complex types of surgery should be planned alongside the multidisciplinary team at the cancer centre.

- **Trust action taken/in progress:**
  - The Trust is currently looking to recruit additional consultant surgeons with expertise in this area.
  - In line with the Trust's wider plans to support the development of an Integrated Care System, closer working with the cancer centre and looking to develop further joint pathways of care are ongoing.
  - A standard operating procedure has been developed to ensure that patients requiring complex specialist surgery are discussed with the cancer centre to agree treatment plans. This will be written into the wider specialties operational documentation and monitoring/audit arrangements will be developed to track progress.

- The review team did not identify any negative behaviour that could undermine decision-making, or team working in the local MDT. Some improvements were identified though in how the MDT meetings functioned and the governance arrangements.

- **Trust action taken/in progress:**
  - The Trust will ensure that a chair for each multi-disciplinary (MDT) meeting is clearly defined to enable their preparation for the meeting. This will be written into the operational policies the team use.
  - Specific and additional time is to be provided to medical staff within the team to prepare the cases for presentation to the MDT to enable the group to understand key details to help them plan appropriate treatments. This will be also written into operational policies.
  - Work has been completed to make sure the environment and the IT infrastructure is conducive to enable an effective meeting to be held and key decisions made.
  - The MDT business meeting has been reformed resulting in better attendance by the wider team to ensure service improvement discussions can take place. This approach will be documented within operational policies.
  - Plans for future submissions as part of the Quality Surveillance (QST) to include descriptions of compliance with NICE guidance.
  - Work underway to ensure surgeons within the Trust have applied and evidenced their inclusion on the specialist register.

2.3 Reporting against core indicators

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

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:

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

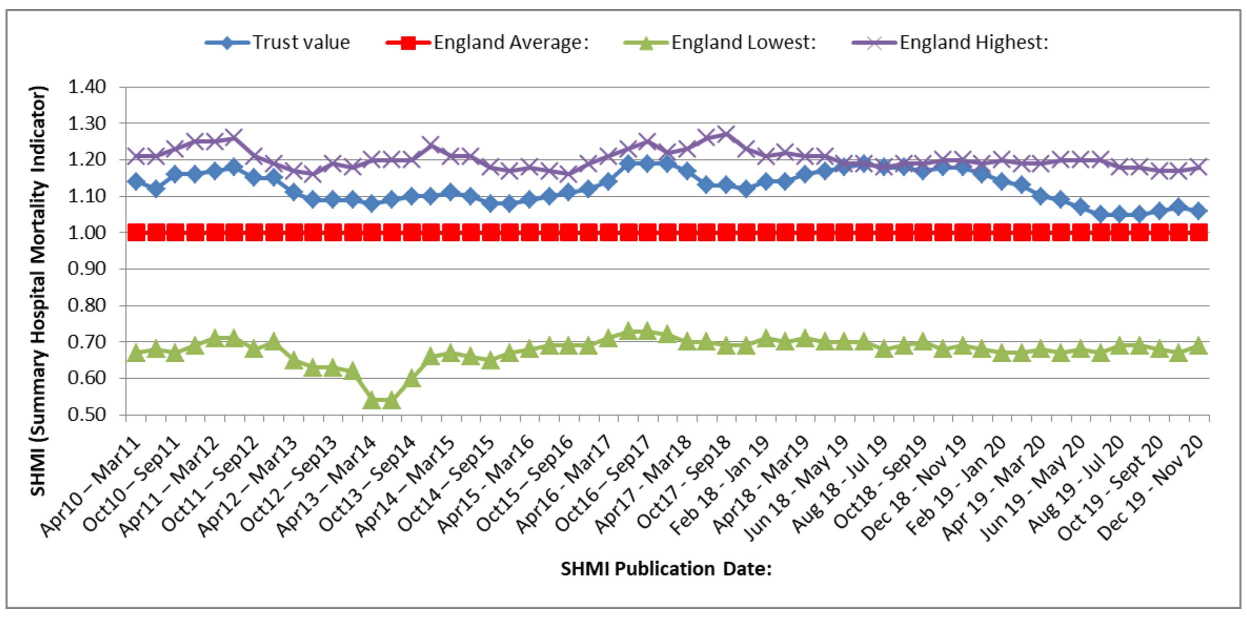


Figure 8: Trust's SHMI score, trended over time

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

NB: It should be noted that from May 2019 the SHMI was released on a monthly basis by NHS Digital, an increase in frequency from the previous quarterly releases.

- The above chart illustrates the Trust's performance against the Summary Hospital Mortality Indicator (SHMI). The SHMI is a Standardised Mortality Ratio (SMR). SHMI is the only SMR to include deaths out-of-hospital (within 30 days of hospital discharge). The SHMI is a measure of observed deaths compared with 'expected deaths', derived statistically from the recording and coding of patient risk factors.

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

- The Trust, as demonstrated in the chart above, has demonstrated statistically significant improvement in the SHMI resulting in the Trust being categorised as having mortality that is 'as expected'.

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

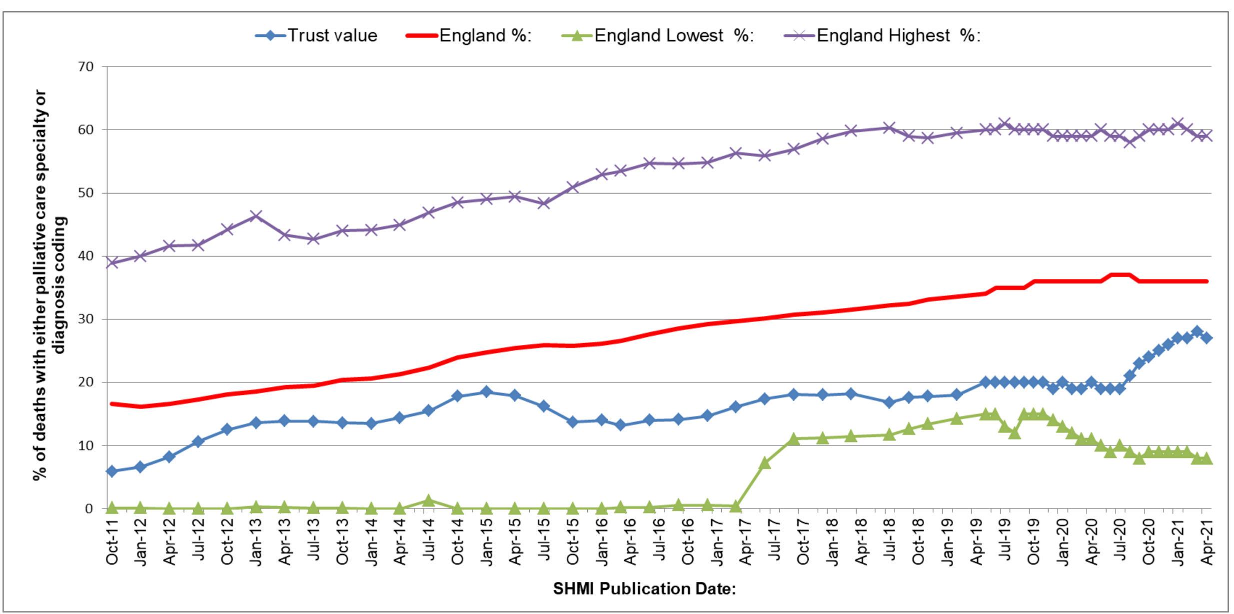


Figure 9: Percentage of patients with a coded palliative care code, compared with other UK Trusts

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

NB: It should be noted that from May 2019 the SHMI was released on a monthly basis by NHS Digital, an increase in frequency from the previous quarterly releases.

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

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

- The chart shows during 2020/21 an increase in the number of patients with a palliative care code. This is as a result of a data quality project undertaken that aimed to ensure processes in place for recording and coding of mortality related data were clinically validated, this resulted in improvements in the quality of captured and coded data relating to mortality. This means that the Trust are better able to make use of mortality data to understand trends and identify any diagnoses groups that have higher levels of mortality that require further review and scrutiny.

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

- During 2020/21 the Trust has been working to implement its Improving Mortality Strategy. Two specific elements of this strategy were with regard to improving the quality and accuracy of the data that underpins statistical mortality calculations like the SHMI and improving the consistency of the learning from deaths programme of work.

- The palliative care level information captured has increased during 2020/21. When this is broken down by hospital site, there is a disparity with SGH having higher levels of palliative care coding than DPoW. This reflects the disparity of consultant-led Palliative

care provision between both hospitals and related CCGs. This likely has an impact on levels of palliative care coding, which then can in turn influence mortality indices such as HSMR. This is currently being reviewed and addressed through collaborative work between primary and secondary care, supported by NHS England / NHS Improvement.

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 quality and accuracy of underpinning data has been improved, along with the Trust's process for processing this data on a monthly basis. This has been as a result of clinician led validation of all mortality data, centralisation of coding to experienced coding team members and increased confidence in obtaining information from the specialist palliative care teams across the Trust. This has resulted in greater confidence in the intelligence derived from mortality data and shown a reduction in mortality outlier notifications for symptoms (i.e. chest infection; pneumonia; acute bronchitis) and a shift to underlying diagnoses alerts (i.e. secondary malignancies; lung cancer) which helps the Trust better understand specific areas requiring Trust and wider system focus.

- Using this data, the Trust at present is an outlier for the SHMI indicator for secondary malignancies and lung cancer. The Trust is working with community partners to review these outlying areas in greater detail.

- As the SHMI includes out-of-hospital deaths (within 30 days of discharge), it can be broken down into in-hospital and out-of-hospital mortality indices. The in-hospital SHMI performance is 'as expected'; however, the out-of-hospital SHMI is significantly higher with a difference of more than 35 points. The Trust's mortality reviews have identified a recurring theme of patients being admitted to hospital at end of life. In some cases, this is the preferred place of death chosen by the individual, however, in other cases, where the acute hospital is not the chosen place of death, clear advanced care plans set with the individual and their family can prevent admission to hospital. Good advanced care planning ensures that symptoms are well managed and planned for. In such cases where an advanced care plan is not in place, admissions to hospital at end of life for symptom support may well have been avoided. Such admissions will contribute to the out-of-hospital SHMI and the disparity currently seen between the in-hospital and out-of-hospital mortality rates.

- The Trust had planned to focus on improved consistency of mortality reviews during 2020/21 with the aim of reviewing 50% of all hospital deaths. The Covid-19 pandemic had a significant impact on many of the Trust's plans for 2020/21. Despite the pandemic, the Trust were able to link the quality of data, clinician led validation sessions with the quality of care screening reviews and have exceeded the target set, reviewing >60% of hospital deaths. This process improvement will continue during 2021/22 with the Trust focussing now on improving the process to support improved learning from these reviews to better support improvement in processes and reflective practice.

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 (no longer a PROM)
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
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
	April 2018 – March 2019	0.483	0.469	0.55	0.33
	April 2019 – March 2020	0.447	0.459	0.54	0.35
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
	April 2018 – March 2019	0.305	0.341	0.410	0.253
	April 2019 – March 2020	0.335	0.335	0.19	0.215

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 3 areas listed above are nationally selected procedures. Varicose vein surgery is not performed by the Trust, therefore no data is available.

- The above tables show the adjusted health gain reported by the patient reported using the EQ-5D index, following their surgery.

- EQ-5D index collates responses given in 5 broad areas (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression) and combines them into a single value.
- The single value scores for the EQ-5D index range is from -0.594 (worse possible health) to 1.0 (full health).

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

- Patient-reported outcomes following primary hip replacement and primary knee replacement surgery remain within the statistically calculated confidence intervals, demonstrating no significantly different performance compared to the UK.

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

- Data made available from the PROMs dataset is presented within the division of surgery to support reflective practice and agreement of actions needed to improve on processes. An overview report is also prepared and presented at the Quality Governance Group and also the Quality & Safety Committee.
- Previously when data concerns have been identified, this has been discussed with Trauma and Orthopaedic Surgeons who have identified areas of improvement and implemented change to address this.
- It is likely that the next annual release of data for PROMs will show an impact from the actions taken during Covid-19 pandemic which will have impacted upon planned surgery provision.

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 30 days of being discharged from a hospital which forms part of the Trust during the reporting period.

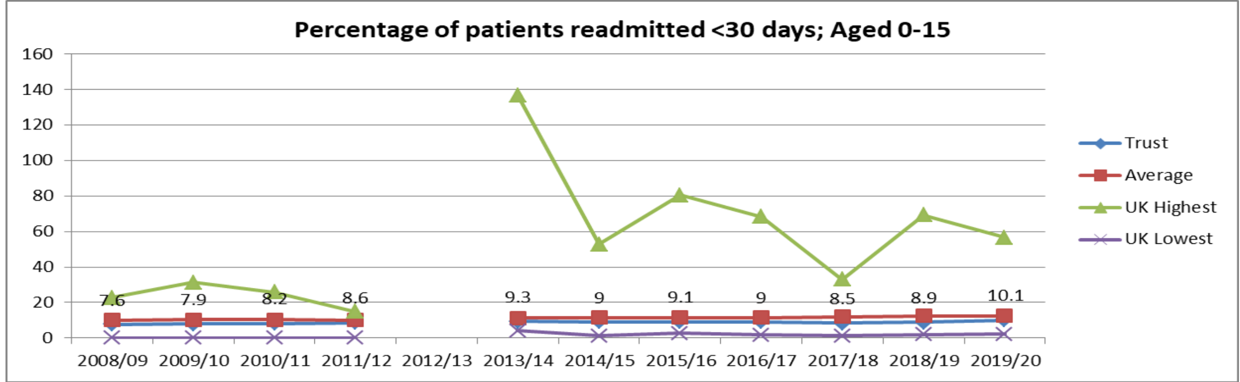


Figure 10: Chart demonstrating % of patients aged 0-15 readmitted within 30 days

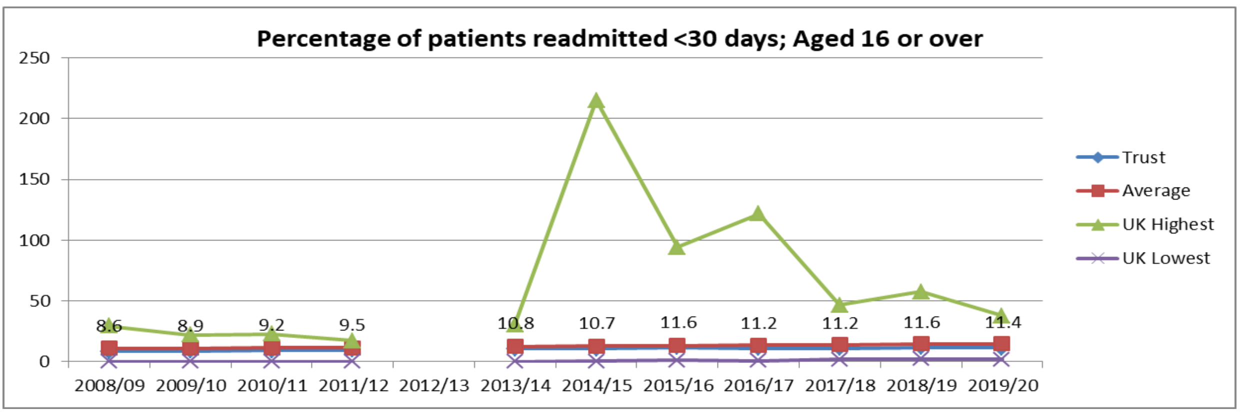


Figure 11: Chart demonstrating % of patients aged 16 or over readmitted within 30 days

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts) [NB: No data is available for the 2012/13 year, hence the gap; the UK highest data should be interpreted with caution as some Trusts with >100% data carry health warnings]

Comment:

- The 2012/13 data was not available hence the gap in the above charts.

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

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

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

- The Trust continues to monitor its readmission rates on a monthly basis (from locally available data) and compares these to the national rates in order to benchmark our performance.

2.3d 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.

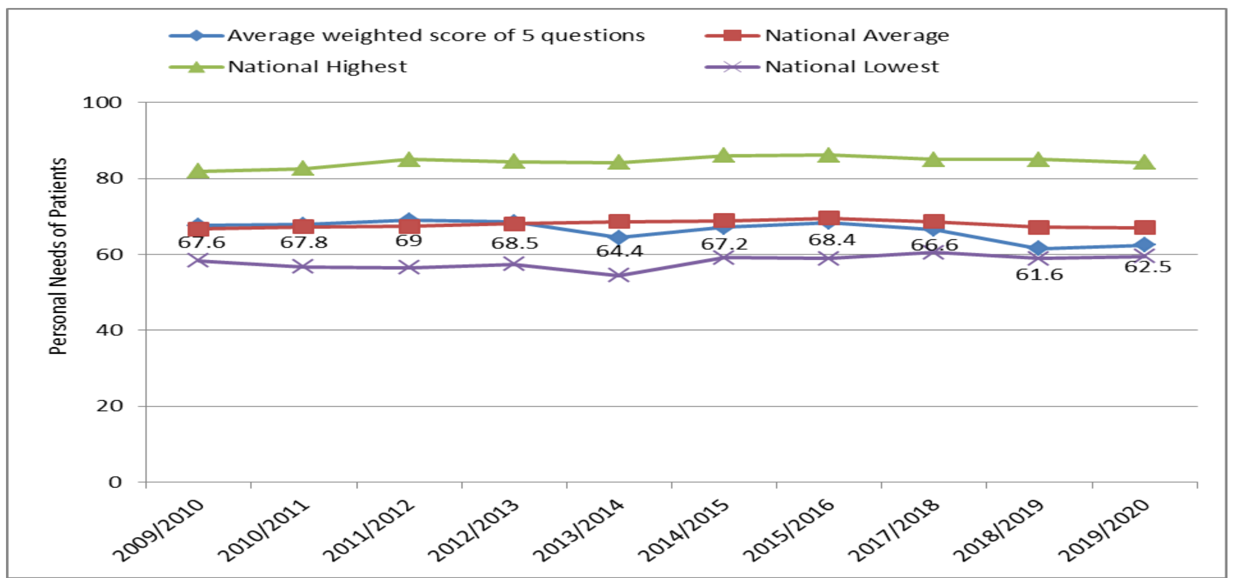


Figure 12: Trust performance with five weighted scores from the national inpatient survey used to determine the Trust's responsiveness to patient's receiving care in its acute services

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.

- Due to the Covid-19 pandemic, the adult inpatient surveys were halted during 2020. These have now resumed, but no further data is yet available, the data presented above therefore is the same referenced to in last year's edition of the Quality Account at the end of 2020.

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

- Due to Covid-19, the surveys that provide this data were halted, and therefore no more recent data is available. The data presented here was the same as reported in the 2019/20 quality account.

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

- The Matron role has been reviewed to allow more dedicated oversight of ward areas, including escalation of any issues. Visitors have a clear point of contact and can discuss any issues if needed.

- Ward based daily huddles also help promotes conversations about safe and effective discharge. Discharge planning continues to be a priority and the Trust is looking at how staff are equipped with key skills to ensure discharge is a unified process with all those involved. Recurring issues involving discharge are to be explored via the Patient Experience Group where appropriate.

- The Trust continues to work towards creating spaces across all ward areas and departments where patients and families can have private conversations. Equally, the Trust is working with teams to involve patients in conversations at the bedside in dignified and respectful ways.

- Patient information leaflets that provide key information have patient involvement in the process; these are being used to signpost people to additional support. This will be replicated on the Trust's website.

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.

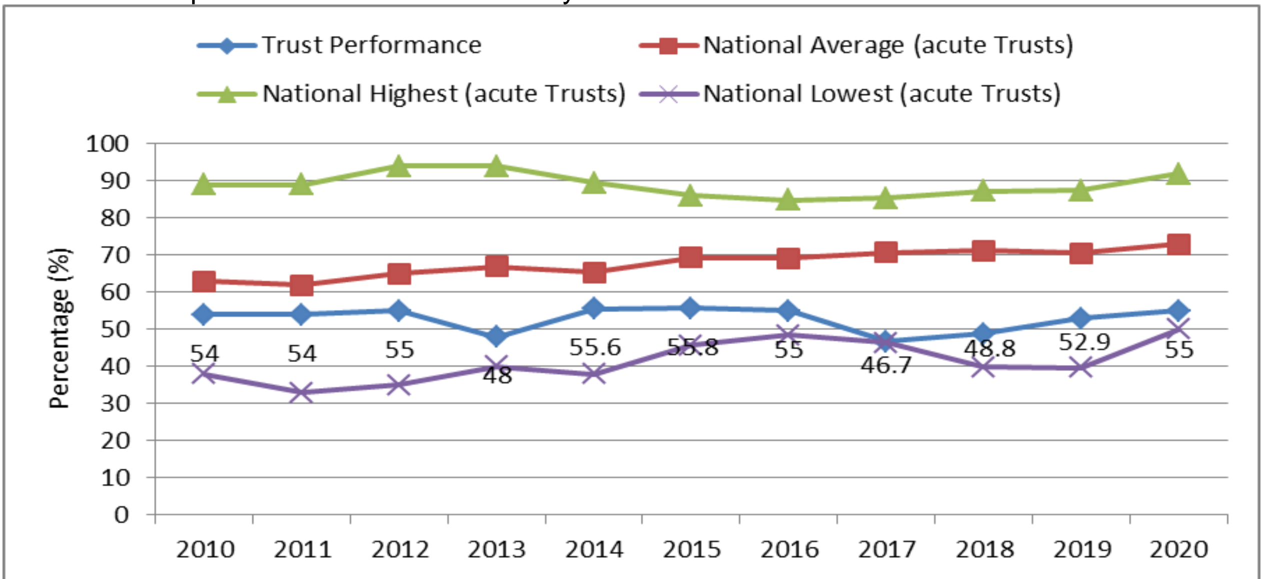
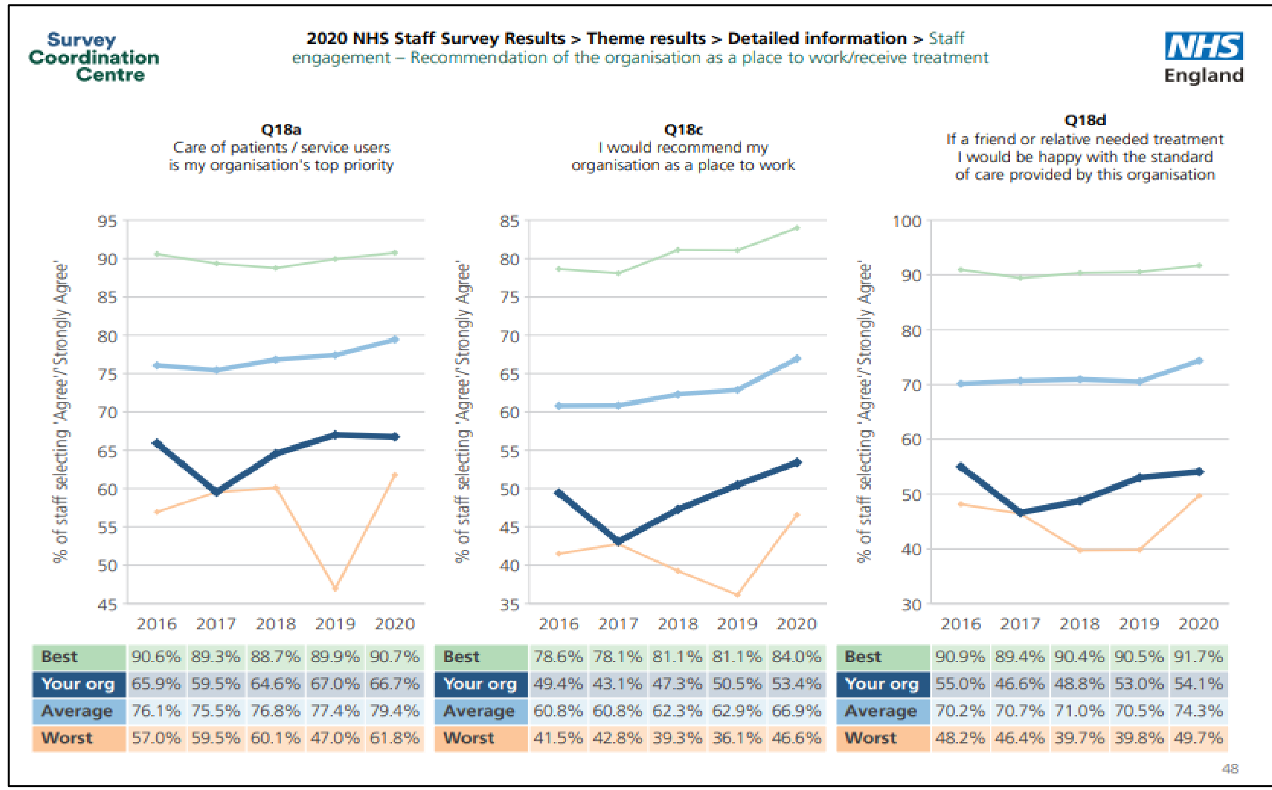


Figure 13: Trust reported performance for staff recommending the Trust as a provider to family and friends

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



Q18a	2016	2017	2018	2019	2020
Best	90.6%	89.3%	88.7%	89.9%	90.7%
Your org	65.9%	59.5%	64.6%	67.0%	66.7%
Average	76.1%	75.5%	76.8%	77.4%	79.4%
Worst	57.0%	59.5%	60.1%	47.0%	61.8%

Q18c	2016	2017	2018	2019	2020
Best	78.6%	78.1%	81.1%	81.1%	84.0%
Your org	49.4%	43.1%	47.3%	50.5%	53.4%
Average	60.8%	60.8%	62.3%	62.9%	66.9%
Worst	41.5%	42.8%	39.3%	36.1%	46.6%

Q18d	2016	2017	2018	2019	2020
Best	90.9%	89.4%	90.4%	90.5%	91.7%
Your org	55.0%	46.6%	48.8%	53.0%	54.1%
Average	70.2%	70.7%	71.0%	70.5%	74.3%
Worst	48.2%	46.4%	39.7%	39.8%	49.7%

Figure 14: Trust reported performance for staff recommending the Trust as a provider to family and friends

Source: NHS Staff Survey Results

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".

- 55% of staff surveyed would recommend the Trust; this is the third consecutive year where an improvement is seen and demonstrates that Trust staff are seeing evidence of improvements. 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 the unprecedented pressures the COVID-19 pandemic brought to the NHS and the Trust we continue to see improvements within the 2020 staff survey when compared against 2019. There are statistically significant improvements against the Health and Wellbeing and Safety Culture domains which reflect the investment in staff and their wellbeing made during 2020. The Trust notes that the Team Working domain shows a statistically significant decline but upon investigation this solely relates to a reduced number of team meetings. It should be noted that within the pandemic staff communications and engagement dramatically increased with alternatives to team meetings being put in place. The Trust considers appropriate measures have been put in place to improve wellbeing and further developments will be supported by the Trust's People Strategy.

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

- For the last two years significant work has gone into transforming the culture and supporting staff on front line services of the Trust, and more latterly significant investment in Health and Wellbeing of staff. The outputs of this work can be seen in the last two staff surveys. Actions already taken include:

    - An investment in staff engagement and a launch of a range of staff recognition schemes.

    - The contracting of two nationally recognised Health and Wellbeing providers to support psychological wellbeing of staff, namely VIVUP and Remploy.

    - The Trust has been awarded two significant funding bids to further bolster its wellbeing offer, including to the funding of Schwartz Rounds/Team Time, Trauma Debriefing and the contracting of the Citizens Advice Bureau to support financial wellbeing.

    - Continued investment into medical staff engagement, and a repeat of the Medical Engagement Scale survey with a marked improvement across the Trust compared to the previous results in 2017.

    - Significant investment has been made in staff engagement to support staff during the pandemic. This has been done via virtual staff briefings using MS Teams, the development and implementation of a new smartphone staff app and the launch of NLaG Staff Facebook account.

    - Investment has been made, to uphold government guidelines, in agile working and risk assessing all staff for health conditions in line with COVID, and from this redeploying staff to keep them safe.

- Successful application for funding from Health Tree Foundation for a full-time Health and Well-Being OD Practitioner due to start in August 2021.

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.

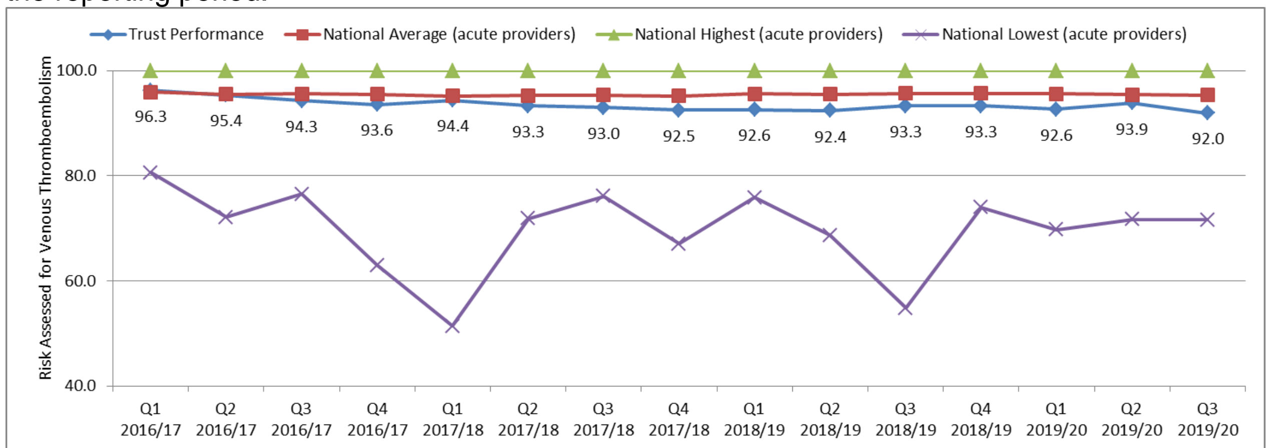


Figure 15: Trust performance for patients risk assessed for venous thromboembolism (VTE)

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, 2016/17. 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:

- The Trust's Quality Governance Group receives a highlight report in relation to VTE screening performance from the Trust's Deputy Medical Director.

- The Trust has rolled out an Electronic Prescribing and Medicines Administration (EPMA) system at Scunthorpe General Hospital and Goole hospital and is partway through implementation of this at Diana, Princess of Wales hospital. This improved system will enable greater controls to be in place supporting improved prescribing that will lead to safety benefits including greater ability to ensure VTE risk has been fully assessed prior to prescribing or administration of medications.

- Two clinical leads have been appointed to focus on further improvement around VTE and this has resulted in some improvement when looking at the April/May 2021 data. Part of their focussed work will be to launch an electronic VTE risk assessment process to support timely completion of the risk assessment process.

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 (hospital onset) amongst patients aged 2 or over during the reporting period.

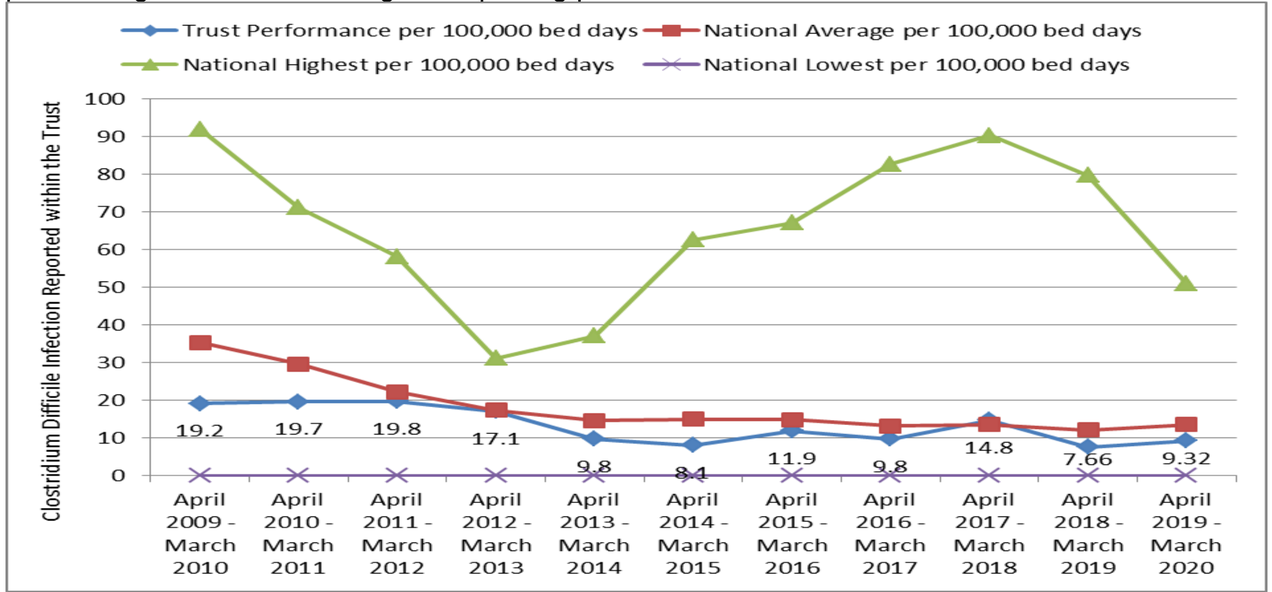


Figure 16: Trust performance for *C difficile* infections reported within the Trust per 100,000 bed days

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

Comment:

- The above table illustrates the rate of *C. difficile* per 100,000 bed days, for the Trust (Hospital onset only), for specimens taken from patients aged two years and over.
- The data shows that the Trust, for the latest reporting period, is beneath the UK average.

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

- The Trust reported 28 healthcare acquired cases to date compared to 38 last year. The definitions for reporting *C. difficile* cases changed in April 2019 meaning cases detected after 2 days would be attributed as Hospital onset as opposed to the previous guidance, which specified 3 days previously. Cases would also be classed as Hospital related if the patient was an in-patient within the previous 4 weeks.

	Hospital onset	Community onset
Diana, Princess of Wales Hospital (DPoW)	11	6
Scunthorpe General Hospital (SGH)	6	5
Goole District Hospital (GDH)	0	0

- The Trust has detected 1 lapse in practice/care associated with non-compliance with Trust antimicrobial guidance or delay in taking samples.

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

- 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 hospital onset cases deemed unavoidable;
- 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 the Post-Infection Review (PIR) process will be monitored by the Infection Prevention & Control Committee and shared with relevant bodies;
- The development of a bespoke IPC WebV module that will alert the IPC team to previous cases of *C. Difficile* infections;
- GPs will be sent an email to inform them of a patient's *C.difficile* / Glutomate Dehydrogenase (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;
- PathLincs antimicrobial formulary reviewed with latest national standards;
- The publication of a new antimicrobial HUB site to make access to content easier for prescribers.

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 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
April 2018 – September 2018	5,806	48.3	44.5	107.4	13.1
October 2018 – March 2019	6,176	50.0	46.6	95.9	16.9
April 2019 – September 2019	7,275	59.2	49.8	103.8	26.3
October 2019 – March 2020	8,105	65.5	50.7	110.2	15.7

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 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
April 2018 – September 2018	21	0.17	0.16	0.54	0.00
October 2018 – March 2019	15	0.13	0.15	0.49	0.01
April 2019 – September 2019	31	0.25	0.16	0.67	0.00
October 2019 – March 2020	20	0.2	0.16	0.5	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:

- 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:

- The Trust continues to monitor the data for understanding of key themes and sharing for learning lessons opportunities.
- The Trust oversees serious incidents (SI) weekly at the SI panel ensuring that appropriate investigation is undertaken in line with agreed timescales.
- The Trust is working towards improving learning in the organisation and has developed a learning strategy.
- The Trust have also introduced a Serious Incident Review Group to look back at older cases to determine if there is anything further we can do to increase safety.

Part 3: Other information

An overview of the quality of care based on performance in 2019/20 against indicators

3.1 Overview of the quality of care offered 2020/21

The Trust set out 6 key quality priorities for focus on within 2020/21, which were:

(1) Improve the Trust waiting list;
(Patient Experience)

(2) Reduce mortality rates and strengthen end of life care;
(Clinical Effectiveness)

(3) Improve the management of diabetes;
(Patient Safety)

(4) Improve the effectiveness of cancer pathways;
(Patient Experience & Clinical Effectiveness)

(5) Improve safe flow and discharge through the hospital;
(Patient Safety, Experience & Clinical Effectiveness)

(6) Improve the quality and timeliness of complaints responses using a more individualised approach.
(Patient Experience)

For a more detailed narrative and explanation of performance, see part 2.1 of this report.

Priority 1 – Improve the Trust waiting list

PATIENT EXPERIENCE:					
QP1: Improve the Trust waiting list with a focus on 40 week waits, total list size and out-patient follow-ups;	Mar-21	Feb-21	SPC Variation	SPC Assurance	RAG
1a) Reduce delayed transfers of care to 60 (move flow and access)	8.3	No data		?	G
1b) Reduce the overdue follow up waiting list to below 9,000 by 31 March 2021	21,969	27,803	L	F	R
1c) 52 week waits to be at zero	1187.0	1285.0	H	F	R
1d) The overall RTT waiting list to be less than it was on 31 January 2020	28,853	28,307	H	F	R
1e) 50% of out-patient summary letters to be with GPs within 7 days of patient's attendance	35.00%	40.00%		F	R
1f) Reduce the number of face to face follow up appointments by 10%, to support the delivery of an overall reduction by a third by March 2023	13,657	11,279	L	P	R

Comments:

- Progress against these priorities have been significantly impacted upon by the Covid-19 pandemic.
- These areas are remaining as key Trust priorities to support recovery actions that have already commenced.

Priority 2 – Reduce mortality rates and strengthen end of life care

CLINICAL EFFECTIVENESS:					
QP2: Reduce mortality rates and strengthen end of life care;	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
2a) Reduction in the Trust SHMI to within expected range	**106.4**	106.8			G
2b) Mortality screening: 50% of all deaths	**82.00%**	84.00%			G
2b) Mortality SJR: 100% for those cases identified as requiring SJR	**9.00%**	25.00%			R
2c) a) Adults: Timeliness of observations to 85% within 30 minutes of due time	**90.89%**	88.97%			G
2c) b) Children: PEWS: Observations recorded at least every 4 hours (first 12 hours) to 85%	**85.00%**	88.90%			G
2c) c) Full observations a minimum of 12 hourly & relevant observations as clinically indicated between times to 85%	**92.30%**	100.00%			G
2c) d) New admissions must have all 9 observation parameters (including temperature) recorded and scored at the first assessment to 85%	**80.00%**	80.00%			A
2d) Improve frequency of sepsis screening and robustness of reporting	**No data**	No data			R
2e) Gather patient and carer feedback for end of life care with local hospices	**No data**	No data	-	-	-
2f) 80% of inpatients (exc. maternity) screened for alcohol and tobacco use	**No data**	No data	-	-	-
2g) 90% of inpatients (exc. maternity) receive brief advice on tobacco use if smoke	**No data**	No data	-	-	-

Comment:

- Significant progress has been made against the Trust's mortality related quality priorities.

Priority 3 – Improve the management of diabetes

PATIENT SAFETY:					
QP3: Improve the management of diabetes;	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
3a)i) Improvement in monitoring of blood sugar in patients with diabetes - DPOW	**81.11%**	86.51%			A
3a)ii) Improvement in monitoring of blood sugar in patients with diabetes - SGH	**66.42%**	80.95%			R
3b) Reduction in insulin errors which cause significant harm to less than 5% of overall reported insulin incidents	**0.00%**	0.00%			G
3c) Achieve 85% compliance with role specific mandatory training for diabetes	**85.00%**	85.00%			G
3d) Adults: Blood glucose taken in ECC if NEWs > 1 in 95% of cases	**92.50%**	95.00%			A
3d) Children: Blood glucose taken in ECC if PEWs >1 in 95% of cases	**80.00%**	90.00%			R

Comment:

- Good progress has been made against these indicators. This will remain as a quality priority for 2021/22 to ensure actions and improvements remain embedded.

Priority 4 – Improve the effectiveness of cancer pathways

PATIENT EXPERIENCE & CLINICAL EFFECTIVENESS:					
QP4: Improve the effectiveness of cancer pathways focussing on time to diagnosis;	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
4a) Time to diagnosis and patient informed by day 28 to be at 75%	**59.70%**	65.19%			R
4b) Care of patients with confirmed diagnosis transferred by day 38 to be at 75%	**20.00%**	25.00%			R
4c) Request to test report turnaround to be no more than 14 days in 100% of cases	**84.77%**	84.48%			R
4d) Develop a clear service model and a Trust target to ensure that cancer services are maintained	**No data**	No data	-	-	-
4e) Number of combined site MDTs to be 100%	100.00%	100.00%			G

Comments:

- Progress against these priorities have been significantly impacted upon by the Covid-19 pandemic.
- These areas are remaining as key Trust priorities to support recovery actions that have already commenced.

Priority 5 – Improve safe flow and discharge through the hospital

PATIENT SAFETY; CLINICAL EFFECTIVENESS AND PATIENT EXPERIENCE:					
QP5: Improve safe flow and discharge through the hospital focussing on outliers, late night patient transfers and discharges before noon;	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
5a) Reduction in the average length of stay to less than 4 days	**4.05**	3.99			A
5b) Increase in the zero length of stay to 32%	**28.94%**	29.03%			A
5c) Sustained improvement in the 0 – 1 day length of stay	**6578.0**	No data			G
5d) Reduction in non-elective length of stay to less than 4.1 days	**4.18**	4.18			A
5e) Reduction in elective length of stay to less than 2.4 days	**2.54**	1.91			A
5f) Reduction in the number of medical outliers					
5g) 85% of discharge letters to be completed within 24 hours post discharge	**87.62%**	88.60%			G
5h) Progressive improvement in the number of golden discharges from April 2020 (target: 35%)	**16.8%**	16.2%			R
5i) Increase in A&E performance to 83.5%	**72.2%**	73.3%			R
5j) Reduction of non-emergency patient transfers at night after 10pm by 10% (Target: 48)	**9.84%**	8.5%			R
5k) Reduction in average ward moves for non-elective patients for non-clinical reasons by 7% (Target: 4.6%)	**15.04%**	12.8%			R
5l) Number of early supported discharges to increase by 10%	**No data**	No data	-	-	-
5m) Improvement in the number of patients that have admission prevention services provided by the community services in North and North East Lincolnshire	**No data**	No data	-	-	-
5n) All patients requiring mental health support in ED will be assessed within 4 hours of referral	**No data**	No data	-	-	-
5o) Patient in in-patient wards will be assessed and have a plan in place within 8 hours of referral	**No data**	No data	-	-	-

Comment:

- Good progress has been made with a number of these areas, however, the impact of Covid-19 has also impacted on full delivery of these quality priorities.

Priority 6 – Improve the quality and timeliness of complaints responses using a more individualised approach

PATIENT EXPERIENCE:					
QP6: Improve the quality and timeliness of complaints responses using a more individualised approach.	**Mar-21**	**Feb-21**	**SPC Variation**	**SPC Assurance**	**RAG**
a) 85% Pals responded to in 5 working days by the 31 January 2021	**56.00%**	55.00%			R
b) 100% of all complaints >120 days on 'old' process pathway to be closed by 31 Jan 2021	**100%**	**100%**			G
c) 100% of all complaints on 'old' process pathway to be closed by 28 Feb 2021	**100%**	**100%**			G
d) 85% of all complaints resolved within timescale by the 31 July 2021	**65.00%**	51.00%			A
e) 85% of reopened complaints resolved within 20 working days by the 30 November 2020 (Quarterly)	50.00%				R
f) 100% Complaints acknowledged within 3 days by the 31 July 2021	100.00%	100.00%			G
g) 100% complainants offered a face to face meeting during initial resolution planning by the 31 Dec 2020 [Amended]	100.00%	100.00%			G
h) 100% of all upheld complaints to have evidence of learning by the 31 October 2020	**85.00%**	83.00%			A
i) 100% formal complaint responses reviewed by Chief Nurses Office by the 31 July 2020 [Amended]	100.00%	100.00%			G
j) 50% reduction in reopened complaints by the 31 January 2021	**No data**	No data	-	-	-

Comment:

- Significant improvements have been made with respect of the Trust's complaint handling processes and performance during 2020/21.

3.2 Performance against relevant indicators and performance thresholds

Performance against indicators that form the Single Oversight Framework (SOF) are shown as follows for 2020/21.

Indicator	Quarter 1 20/21			Quarter 2 20/21			Quarter 3 20/21			Quarter 4 20/21			20/21 Performance
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	66.7%	60.7%	53.1%	49.1%	55.7%	61.8%	65.2%	66.3%	64.3%	63.4%	63.7%	65.2%	Full Year: 61.43%
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	87.9%	91.1%	89.0%	89.7%	87.8%	84.1%	75.5%	71.0%	71.9%	74.4%	73.3%	72.2%	Full Year: 80.64%
All cancers: 62-day wait for first treatment - GP Referral	69.6%	60.2%	71.2%	83.7%	67.8%	63.1%	70.8%	70.2%	67.6%	70.9%	56.3%	64.0%	Full Year: 67.9%
All cancers: 62-day wait for first treatment - Screening	33.3%	0.0%	100.0%	33.3%	0.0%	100.0%	50.0%	66.7%	42.9%	100.0%	83.3%	84.6%	Full Year: 66.7%
C.difficile: variance from plan [lapses in care] (target 21)	2	4	3	4	3	3	1	2	2	1	1	2	Full year: 28
Maximum 6-week wait for diagnostic procedures	67.3%	65.7%	51.5%	44.0%	48.2%	44.1%	40.1%	40.4%	43.8%	45.3%	38.9%	35.8%	Full Year: 46%
Venous Thromboembolism (VTE) risk assessment	87.6%	88.7%	90.1%	87.7%	85.9%	88.3%	88.2%	84.7%	75.7%	74.6%	76.5%	77.6%	Average 83.8%
Summary Hospital-level Mortality Indicator	110	107	106	105	105	106	107	107	106	*Not yet published*	*Not yet published*	*Not yet published*	Average SHMI for Apr 20 - Dec 20 period: 107

3.3 Information on staff survey report

Summary of performance – NHS staff survey

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

Timeline

Survey Window:	October/November 2020
Embargoed Findings:	Received mid-February 2021
NHSEI Publication:	11 March 2021

Key Facts

Benchmark Comparators:	128 Acute & Acute Community Trusts
Benchmark Response Rate:	45% (-2% on 2019 survey)
NLaG Response Rate:	36% (-3% on 2019 survey)
NLaG Survey Mode:	Paper and Online (2,420 completed)

Staff Survey 2020 findings

In 2020 reports on eleven themes, as below:

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.1	5.8	6.4	5.9	7.4	7.8	9.4	6.4	6.6	6.2
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	2,369	2,380	2,384	2,361	1,926	2,328	2,368	2,373	2,395	2,364

Figure 17: The ten themes now reported in the national staff survey

The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2020 score is significantly higher than last year's, whereas ↓ indicates that the 2020 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.0**	2524	**9.1**	2369	Not significant
Health & wellbeing	**5.6**	2536	**5.8**	2380	↑
Immediate managers †	**6.4**	2537	**6.4**	2384	Not significant
Morale	**5.9**	2493	**5.9**	2361	Not significant
Quality of care	**7.4**	2063	**7.4**	1926	Not significant
Safe environment - Bullying & harassment	**7.8**	2509	**7.8**	2328	Not significant
Safe environment - Violence	**9.5**	2518	**9.4**	2368	Not significant
Safety culture	**6.2**	2509	**6.4**	2373	↑
Staff engagement	**6.6**	2555	**6.6**	2395	Not significant
Team working	**6.4**	2514	**6.2**	2364	↓

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

† The calculation for the immediate managers theme has changed this year due to the omission of one of the questions which previously contributed to the theme. This change has been applied retrospectively so data for 2016-2020 shown in this table are comparable. However, these figures are not directly comparable to the results reported in previous years. For more details please see the technical document.

Figure 18: Key themes from the staff survey

Health and Well-Being (HWB) – Statistical Significant Improvement

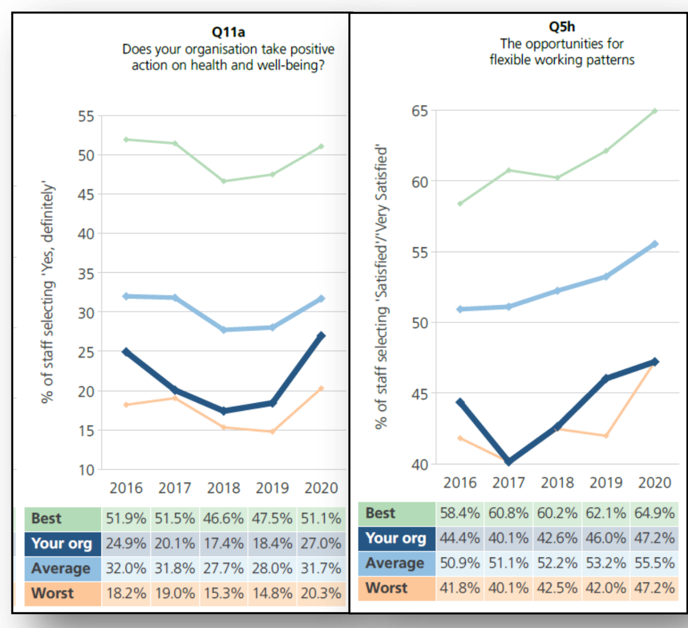
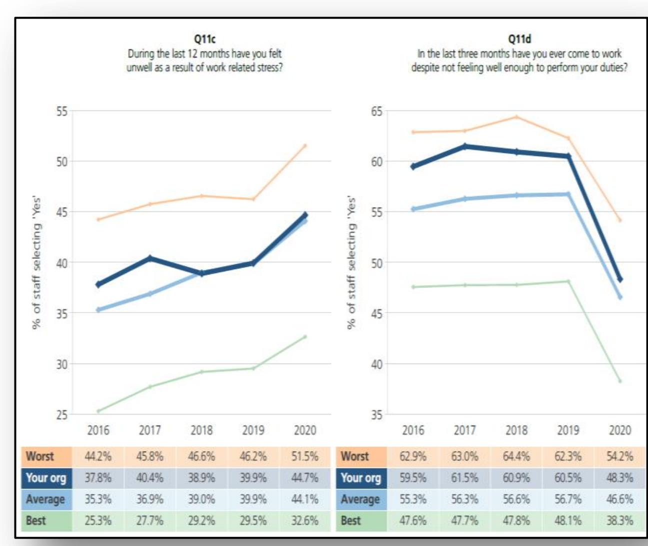


Figure 19: Focus on: Health and Well-being

From the pandemic we can evidence:

- Increased positive action being felt regarding HWB support
- Note: further evidence Q8f with Managers recognised as taking interest in HWB of staff
- The uptake of staff working agilely can be evidenced



Q11c	2016	2017	2018	2019	2020
Worst	44.2%	45.8%	46.6%	46.2%	51.5%
Your org	37.8%	40.4%	38.9%	39.9%	44.7%
Average	35.3%	36.9%	39.0%	39.9%	44.1%
Best	25.3%	27.7%	29.2%	29.5%	32.6%

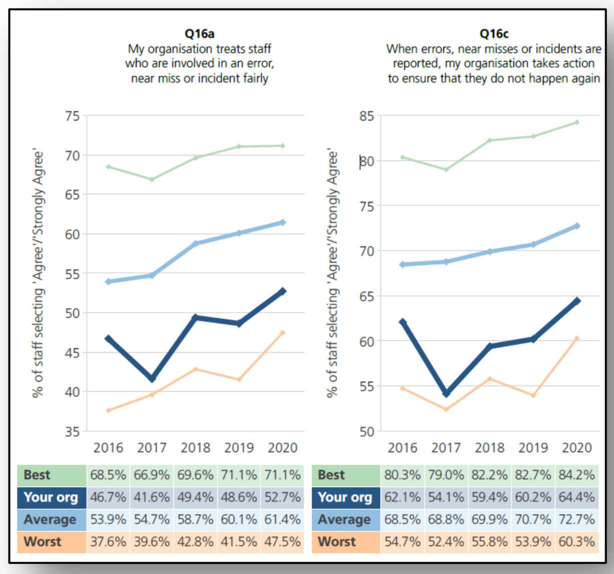
Q11d	2016	2017	2018	2019	2020
Worst	62.9%	63.0%	64.4%	62.3%	54.2%
Your org	59.5%	61.5%	60.9%	60.5%	48.3%
Average	55.3%	56.3%	56.6%	56.7%	46.6%
Best	47.6%	47.7%	47.8%	48.1%	38.3%

Figure 20: Focus on: Health and Well-being

Despite gains further work is still required to:

- Support staff psychological wellbeing. HWB refresh continues, and the Directorate of People and Organisational Effectiveness contracting for Critical Trauma Debriefing and Schwartz Rounds and Team Time.
- Consideration given to supporting staff burnout is required given Q11d and staff continuing to work when unwell (despite c.12% in-year reduction reporting for work while unwell.

Safety Culture (Statistical Significant Improvement)



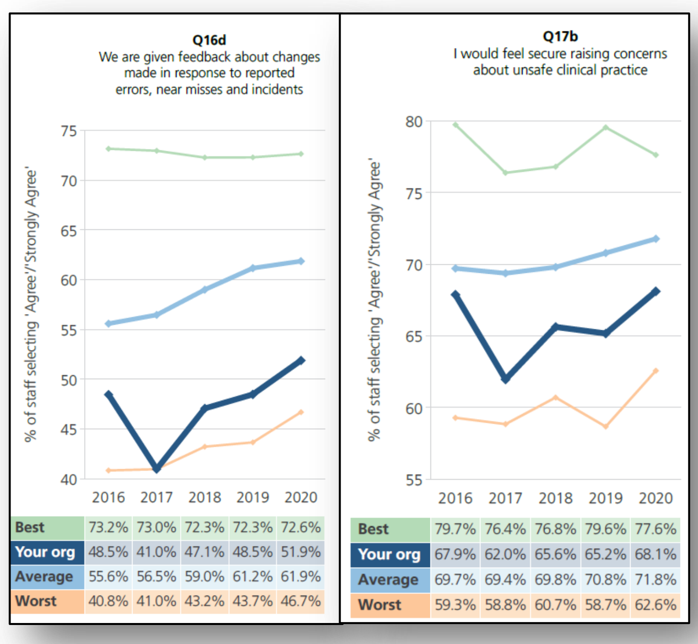
Q16a	2016	2017	2018	2019	2020
Best	68.5%	66.9%	69.6%	71.1%	71.1%
Your org	46.7%	41.6%	49.4%	48.6%	52.7%
Average	53.9%	54.7%	58.7%	60.1%	61.4%
Worst	37.6%	39.6%	42.8%	41.5%	47.5%

Q16c	2016	2017	2018	2019	2020
Best	80.3%	79.0%	82.2%	82.7%	84.2%
Your org	62.1%	54.1%	59.4%	60.2%	64.4%
Average	68.5%	68.8%	69.9%	70.7%	72.7%
Worst	54.7%	52.4%	55.8%	53.9%	60.3%

Since 2017 significant progress has been made relating to:

- Staff perception that they will be treated fairly if they are involved in an incident/near miss (+11%)
- Reassuringly staff continue to report that NLaG takes action to address incidents and avoid them reoccurring (+10%)

Figure 21: Focus on: Safety Culture



Q16d

	2016	2017	2018	2019	2020
Best	73.2%	73.0%	72.3%	72.3%	72.6%
Your org	48.5%	41.0%	47.1%	48.5%	51.9%
Average	55.6%	56.5%	59.0%	61.2%	61.9%
Worst	40.8%	41.0%	43.2%	43.7%	46.7%

Q17b

	2016	2017	2018	2019	2020
Best	79.7%	76.4%	76.8%	79.6%	77.6%
Your org	67.9%	62.0%	65.6%	65.2%	68.1%
Average	69.7%	69.4%	69.8%	70.8%	71.8%
Worst	59.3%	58.8%	60.7%	58.7%	62.6%

Figure 22: Focus on: Safety Culture

Since 2017 significant progress has been made relating to:

- Staffs historic perception that they did not receive feedback to DATI X (+11%)
- Reassuringly staff continue to report a growing sense they are safe and secure in reporting unsafe clinical practice/Freedom To Speak Up (+6%)

Team Working (Statistical Significant Deterioration)

Q4h

	2016	2017	2018	2019	2020
Best	79.6%	81.6%	81.6%	83.4%	81.2%
Your org	71.1%	67.7%	66.6%	67.7%	68.5%
Average	72.9%	72.8%	72.7%	72.3%	71.6%
Worst	65.8%	66.4%	63.6%	63.4%	64.9%

Q4i

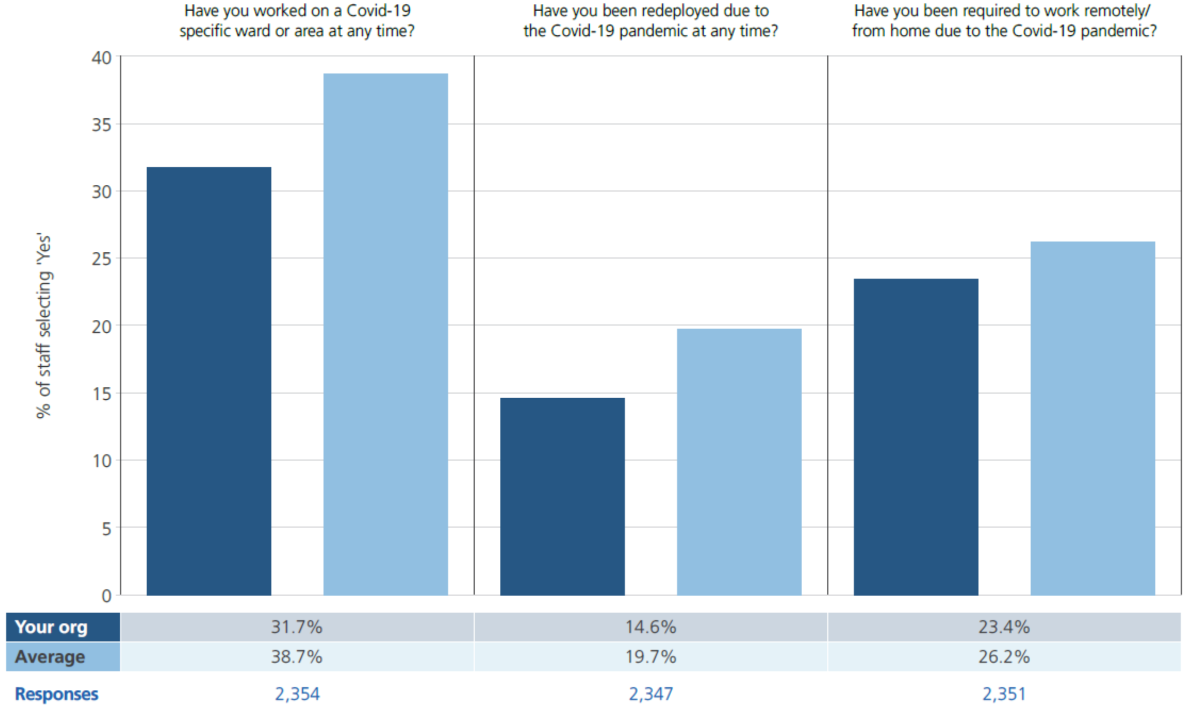
	2016	2017	2018	2019	2020
Best	68.5%	69.4%	69.7%	72.2%	67.2%
Your org	57.5%	53.6%	54.4%	56.6%	51.0%
Average	59.2%	59.7%	59.5%	60.6%	56.7%
Worst	48.2%	49.2%	46.9%	47.8%	46.1%

Figure 23: Focus on: Team Working

Team working theme is derived from only two questions:

- The 'statistically significant deterioration', must relate to a sharp drop in the number of team meetings taking place during 2019/20 due to the pandemic.
- This reduction in meetings has taken place across the NHS – Note the decline across all comparators. Despite this meetings must be reinstated wherever possible to recover the 2019 position.

COVID Questions (*2020 Survey only*)



	Have you worked on a Covid-19 specific ward or area at any time?	Have you been redeployed due to the Covid-19 pandemic at any time?	Have you been required to work remotely/ from home due to the Covid-19 pandemic?
Your org	31.7%	14.6%	23.4%
Average	38.7%	19.7%	26.2%
Responses	2,354	2,347	2,351

Figure 24: Focus on: Understanding impact of Covid-19

Observations:

- Staff survey results are an improvement, but the Trust acknowledges further improvement is possible.
- Whilst this is only one measure it provides the Trust with a very useful benchmark against the rest of the UK.
- Staff survey results are outputs and part of a wider cultural picture of the Trust.
- Some of the indicators within the Staff Survey will be changed (national review).
- Metrics are relevant/useful for the "soft" Workforce metrics as part of our development of Workforce metrics, i.e., engagement and health and wellbeing.

Proposed – Next Steps

- Communications to the workforce with an emphasis on improvements, i.e. safety culture and Health and Wellbeing (tie HWB in with the refresh relaunch) and acknowledgement of areas for improvement – Team Work.
- Identify any areas of immediate concern and address or continue if already underway, highlight this to staff.
- Distribution of the results to Executive Directorates and teams, to focus on any areas that need immediate attention and below Trust benchmark: Directorates with support from Human Resource Business Partners.
- Development of a Culture Steering Group – to undertake a diagnostic of "current state of play" with Trust culture (this will bring together all known evidence hard and soft, including staff survey).
- In line with the NHS People and People Strategy and Trust priorities – identify areas of improvement and build "one plan" to address (so focus on doing the right things, not just chasing staff survey results). This will include leadership development.

3.4 Information on patient survey report

Due to the Covid-19 pandemic, the National Inpatient Survey for 2020 was put on hold. As such there is no new information to report as part of the Quality Account for 2020/21.

The Trust has launched its own local inpatient programme which intended to run monthly, surveying ten patients on every adult inpatient ward. This ran successfully over two separate occasions but due to the priorities of the Covid 19 pandemic was stood down. It is planned to restart in quarter one of 2021/22.

The patient experience team actively worked on ward areas with patients during Covid 19, gathering direct feedback and intelligence. Aspects of this were received through the Patient Experience Group (in its weekly Covid 19 format) to initiate actions, monitored through its action log.

We continued to review feedback reviews shared on social media platforms, Care Opinion and through our partners at the CCG and Healthwatch.

Our Emergency Care Centres continued to send out SMS messages, despite the national pause of the Friends and Family Test and gathered hundreds of pieces of feedback, with high percentages of recommending our service.

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

Annex 1.1: Statements from Commissioners

Feedback from:
North East Lincolnshire CCG

North Lincolnshire CCG

Lincolnshire CCG

East Riding of Yorkshire CCG

Commissioners recognise this statement is written following an unprecedented year in health care, and would like to take this opportunity to thank all staff at Northern Lincolnshire and Goole NHS Foundation Trust for their hard work and dedication during the COVID19 pandemic.

Whilst the Trusts CQC rating has remained as 'Requires Improvement', Commissioners would like to acknowledge progress has been made against some elements of the CQC action plan despite the on-going pandemic.

We fully support the quality priorities identified by the Trust for the next financial year and would like to reiterate our commitment to supporting system quality improvement, recognising that improvement in these areas is likely to have not only a positive impact on patients but also on the wider systems health and care providers. It is also acknowledged that some quality priorities identified in 2020/2021 such as, sepsis and diabetes require some further embedding and improvements and have been transferred over into the 2021/2022 priorities.

We recognise the significant improvements that have been made in reducing the Summary Hospital Level Mortality Indicator (SHMI) to within the "as expected range", and the work led by the Trust in relation to improvements in End of Life Care.

Commissioners note the significant improvements that have been made in the response time for complaints and welcome the new process that has been established at the Trust with lead investigators taking responsibility for the investigations.

Through the last year the Trust have clearly invested in staff health and wellbeing and this has been reflected by the staff with the improved score seen within the staff survey regarding this. Additionally the staff survey highlighted improvements in relation to staff feeling there is a good safety culture which is positive to hear. Good quality cancer services and performance remains a commissioning priority and it is positive to see Cancer Pathways as a continued area of focus and the establishment of the Humber Cancer Board is a significant step forward, recognising the impact the COVID-19 pandemic has had on this.

We acknowledge the challenges experienced by the Trust in relation to delivery of some NHS Constitution Targets such as waiting times and A&E performance which have been exacerbated by the COVID-19 pandemic both locally and nationally. Commissioners continue to monitor the delivery of these closely and look forward to working with the Trust over the next year in achieving these.

Commissioners would like to take this opportunity to reiterate our commitment to working with and supporting the Trust's continued improvement journey.

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.

Annex 1.2: Statement from Healthwatch organisations

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

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

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

The summary clearly sets out what you have achieved during 2020/21 against your 6 priority areas and what still needs working on, in the forth coming year. Here at Healthwatch we are aware that the COVID-19 Pandemic has had a major impact on the NHS and what you hoped to achieve, especially the waiting lists, but we are aware that a recovery plan is in place to achieve the position that you hoped for at the end of 2020/21 and that these priorities are to be carried forward into 2021/22.

Even though during 2020/21 the National Inpatient Survey was put on hold due to COVID-19, your patient experience team continued to work with patients on the ward and collect feedback directly from patients on their experiences of their hospital stay. This feedback has resulted in actions that your Trust has taken on board and for which you are monitoring through your action logs. Patient experiences are important for your NHS Trust to learn from and Healthwatch would like to commend you on gathering feedback from patients, even though there was a national pause on the Friends and Family Test, you continued to send out SMS messages to encourage people to share feedback with yourselves. This shows a commitment to the importance of patient feedback to yourselves and to making improvements.

Improvements have been made within the time complaints are open for and this is partly due to you adopting new processes within the Trust. The Trust has seen a reduction in the elective length of stay for patients, we would like to highlight this as a good piece of work. This is not just ‘Good Practice’ as far as the patient is concerned but enables the hospitals to treat more patients as the flow of patients improves. Improvements have been made in the management of diabetes and we are glad to hear there have been zero insulin errors resulting in significant harm.

Cancer targets are still a priority area for yourselves, work with community partners should continue to ensure these targets are met over the coming year. The Humber Cancer Board will help improve the current position to enable patients to access diagnostics and treatment faster. We are aware this is an issue across the Humber and it is a positive step to be part of a network that will improve pathways for patients.

The Quality Priorities that the Trust have set out for 2021/22 are clearly understandable and how you intend to measure your progress against the targets. Alongside this, the data presented is easily understandable and the use of RAG rating (colour coding) your performance measures gives an instant visual indication of your current position.

During the COVID-19 Pandemic you have adapted your services to accommodate the new regulations and your staff have maintained the level of service expected of the NHS and continued to work under extreme circumstances. A priority for yourselves has been to ensure

that your staff have shielded and isolated, when they needed to and here at Healthwatch we are aware that this has put pressure on you but the well-being of staff was prioritised.
We would like to thank all of your staff for the hard work they have put in during these unprecedented times.

Feedback from:
Healthwatch Lincolnshire

Summary
Healthwatch Lincolnshire would like to thank North Lincolnshire and Goole Trust for the opportunity to comment on their most recent Quality Account for 2020/21.

Healthwatch Lincolnshire acknowledge the work Northern Lincolnshire and Goole Trust have done over the past 12 months to improve performance and in particular the role they have played in supporting the NHS and our patients during the COVID-19 pandemic. On behalf of patients, carers, and service users, we would like to thank Northern Lincolnshire and Goole Trust for their hard work and dedication in achieving this.

We welcome opportunities like this to review and be part of commentary on the delivery of services. During the last 12 months, Healthwatch Lincolnshire have received very little feedback in relation to Northern Lincolnshire and Goole Trust. We would welcome the opportunity to work more closely with Northern Lincolnshire and Goole Trust to improve the level of engagement and feedback we hear from patients using the services.

Commentary relating to the previous year's Quality Accounts
Patient Experience: Improve the Trust waiting list with a focus on 40 week waits, total list size and out-patient follow-ups. As a Healthwatch over the last 12 month we have continually heard from patients about long waiting lists, despite this not being a set priority for the quality account 2021-22 we do acknowledge that this will be a focus for the 2021-22 year as part of the trusts wider organisational priorities, to reduce long waiters significantly to pre-covid levels. This is one of patient's biggest concerns and we advocate better communication with patients and their families in relation to waiting times and the trusts recovery plan.

Priorities and challenges for the forthcoming year
We welcome the various work streams and priorities for 2022/22. As Healthwatch Lincolnshire we encourage the promotion of the patient voice and experience in delivery of your services, we would also be an advocate to looking at not just the patient voice but that also of the carer,
Finally, we look forward to continued engagement with the Trust in the coming year.

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

Feedback from:
North Lincolnshire Council – Health Scrutiny Panel:

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.

Naturally, we echo the Chief Executive's comments in his foreword about the unprecedented challenges that the Covid-19 pandemic has brought to the staff at NLG, his concerns for their

health and wellbeing, and the ongoing and planned work to support them. We very much welcome these statements, and would wish to put on record our sincere appreciation for all of the staff's invaluable, selfless and humbling contributions to their patients' wellbeing.

We acknowledge that these unprecedented circumstances have led to a marked deterioration in many areas of the Trust's performance. We are aware of the recovery efforts that are underway, and note the challenging targets the Trust has set itself around 52+ week waiters, cancer care, and other elective work for the coming twelve months.

Due to the circumstances, we intend to provide a limited response in 2020/21, with an anticipated much fuller reply in 2021/22.

We have long held concerns around a number of specialties at NLG, and about the corporate ability to improve as a Trust. However, we have detected signs of progress in recent years, as identified at the last CQC inspection, and it was hugely disappointing that the pandemic necessarily impacted upon that trajectory. Despite this, there are areas that have continued to improve, including the SHMI mortality rates and some of the key NHS survey results, which have concerned the scrutiny panel for more than a decade. We do not intend to comment on other indicators, due to the context of the pandemic.

The panel intends to meet regularly throughout the coming 12 months with Trust representatives, commissioners, and other interested parties, to discuss in detail both the clinical recovery, and how services are likely to be stabilised, then improved, in the coming years. We are naturally keen to represent the views of our residents in these discussions to ensure they meet both the clinical, and the social, needs of patients. We particularly look forward to discussions with providers and commissioners alike, to ensure that the delivery of core services remains within the North Lincolnshire area, in line with the stated aim of North Lincolnshire CCG, unless there is a clear, unequivocal, and publicly supported rationale not to.

It would be remiss of us not to note and reflect upon the many deaths of patients in the last year where Covid-19 was a causal or contributing factor. Each of these people's lives should be celebrated and remembered, and we welcome the steps that the Trust, families and loved ones, and others are taking to ensure this occurs.

Finally, on work-related issues, Trust representatives have been very open to work with the panel and other scrutiny colleagues for many years, most recently on oncology and the Humber Acute Services Review. We believe that this is clear evidence that the Trust has a genuine desire to improve services through working more co-operatively with partners. Finally, any day-to-day queries have always resulted in a swift and comprehensive response, and we thank the Trust for this.

Feedback from:
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 through regular reports and attendance at panel meetings. The panel appreciated and noted the impact of the Covid-19 pandemic on the Trust's ability to deliver against all six quality priorities.

Concerns were raised over the Trust's waiting list time scales and the panel sought assurance from the trust that whilst this had been adversely impacted on by the pandemic the trusts focus on recovery was the number one priority. The panel was reassured that the trust had a good handle on the safety element and prioritisation of patients and that recovery had started and good progress was being made.

It was positive for the panel to hear that the hospital flow and discharge improvement work had reduced the length of unnecessary stay within the hospital that was freeing up space on the wards and enabled patients to return home where safe to do so. The panel felt it was extremely important because the best outcomes for patients were often as a result of recuperating in their own homes.

The panel welcomed and the five priorities for 2021/22 set out within the Quality Account and that the improvements made from the CQC inspection feedback were embedded and making a difference for patients and staff whilst remaining cautious that as winter approached the pressure on services would increase.

Feedback from:
Lincolnshire – Health Scrutiny Committee for Lincolnshire:

The Health Scrutiny Committee for Lincolnshire is grateful to Northern Lincolnshire and Goole NHS Foundation Trust for sharing its draft quality account for 2020/21 and recognises the Trust's continued provision of acute hospital services to residents in the north of the administrative county of Lincolnshire, in particular to those residents in Louth, Mablethorpe and the surrounding areas.

The Committee would like to record its gratitude for all the staff at the Trust for continuing to respond to the Covid-19 pandemic and at the same time maintaining and restoring other health care services during the last year.

While the Committee is focusing on the detail of the quality accounts of two other local NHS trusts for 2020/21, it is pleased to note the five priorities for improvement for 2021/22 and the Trust's arrangements to monitor progress with these priorities.

The Committee recognises that engagement between the Trust and health overview and scrutiny committees is usually focused on those committees in North Lincolnshire, North East Lincolnshire and the East Riding of Yorkshire. However, there may be opportunities at a later date for engagement to take place between the Health Scrutiny Committee for Lincolnshire and the Trust.

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

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

Annex 1.4: Statement from the Trust governors'

Feedback from:
The Trust's Lead Governor

The Council of Governors is pleased to have the opportunity to comment on the 2020/21 Quality Account which demonstrates that significant quality improvements have been achieved despite the extraordinary challenges posed by the coronavirus pandemic. We would like to place on record our appreciation of the incredible commitment made by Trust staff to the delivery of high quality patient care in the most difficult of circumstances.

Throughout the year governors have continued to prioritise seeking robust assurance regarding the quality and safety of services provided to patients, specifically in the context of our duty to hold Non Executive Directors (NEDs) to account for the performance of the Trust Board. We receive regular reports at Council of Governors meetings on progress against the Trust's quality priorities, we are represented in an observer capacity at meetings of the Quality & Safety

Committee and the NED committee chair makes himself available to answer searching questions at Governor Assurance Group meetings.

Although the Trust remains in quality special measures, governors are greatly encouraged by the progress that has been achieved in addressing the 'must do' and 'should do' recommendations made by the Care Quality Commission following its 2019 inspection. Perhaps most pleasing has been the consistent downward trajectory in hospital mortality which was one of the 2020/21 quality priorities. Despite coronavirus constraints it is good to see that progress has also been made against most of the other priorities. Inevitably the pandemic has severely impacted the length of waiting lists, but governors are reassured by the robust risk stratification measures that have been put in place to ensure that treatment delays do not result in patient harm.

The Council of Governors supports the five quality priorities agreed for 2021/22. Governors were consulted in the process of determining these priorities and we were pleased that the Trust also sought service user feedback in identifying a shortlist of potential quality improvement areas. Governors will continue to support the Trust as 'critical friends' in delivering quality improvements over the coming year during the course of which we hope that the tremendous efforts of Trust staff will be rewarded by the lifting of quality special measures.

Annex 1.5: Response from the Trust to stakeholder comments

The Trust are grateful to stakeholders for their views and comments on the Quality Account for the period 2020/21.

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 2020/21 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 2020 to March 2021
    - Papers relating to quality reported to the board over the period April 2020 to March 2021
    - Feedback from commissioners dated 28 June 2021
    - Feedback from governors dated 30 June 2021
    - Feedback from Local Healthwatch organisations dated 02 July and 14 July 2021
    - Feedback from Overview and Scrutiny Committees dated 24 June; 01 July and 16 July 2021
    - The trust's draft complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2021
    - Latest national inpatient survey 2019
    - Latest national staff survey 2021
    - The head of internal audit's annual opinion of the trust's control environment dated May 2021
    - CQC inspection report dated 7 February 2020.
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the quality report is routinely quality checked to ensure it is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the quality report is routinely quality checked to ensure it is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;
- The Quality Report has been prepared in accordance with NHS 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

...20/07/2021 Date .... Chair

2.8.21........ Date .... Chief Executive

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

Due to the Covid-19 pandemic, no independent auditor's report has been required as part of the 2020/21 Quality Account reporting process, this follows national guidance received to all NHS Trusts.

Annex 4: Glossary

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.

Harm:

- **Catastrophic harm:** Any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care.
- **Severe harm:** Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.
- **Moderate harm:** Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care. Locally defined as extending stay or care requirements by more than 15 days; Short-term harm requiring further treatment or procedure extending stay or care requirements by 8 - 15 days
- **Low harm:** Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care. Locally defined as requiring observation or minor treatment, with an extended stay or care requirement ranging from 1 – 7 days
- **None/ 'Near Miss' (Harm):** No obvious harm/injury, Minimal impact/no service disruption.

Mortality Data: - How is it measured?

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

1. Crude mortality – expressed as a percentage, calculated by dividing the number of deaths within the organisation by the number of patients treated,
2. Standardised mortality ratios (SMR). These are statistically calculated mortality ratios that are heavily dependent on the quality of recording and coding data. These are calculated by dividing the number of deaths within the Trust by the expected number of deaths. This expected level of mortality is based on the documentation and coding of individual, patient specific risk factors (i.e. their diagnosis or reason for admission, their age, existing comorbidities, medical conditions and illnesses) and combined with general details relating to their hospital admission (i.e. the type of admission, elective for a planned procedure or an unplanned emergency admission), all of which inform the statistical models calculation of what constitutes expected mortality.

As standardised mortality ratios (SMRs) are statistical calculations, they are expressed in a specific format. The absolute average mortality for the UK is expressed as a level of 100.

Whilst '100' is the key numerical value, because of the complex nature of the statistics involved, confidence intervals play a role, meaning that these numerical values are grouped into three categories: "Higher than expected", "within expected range" and "lower than expected". The statistically calculated confidence intervals for this information results in SMRs of both above 100 and below 100 being classified as "within expected range".

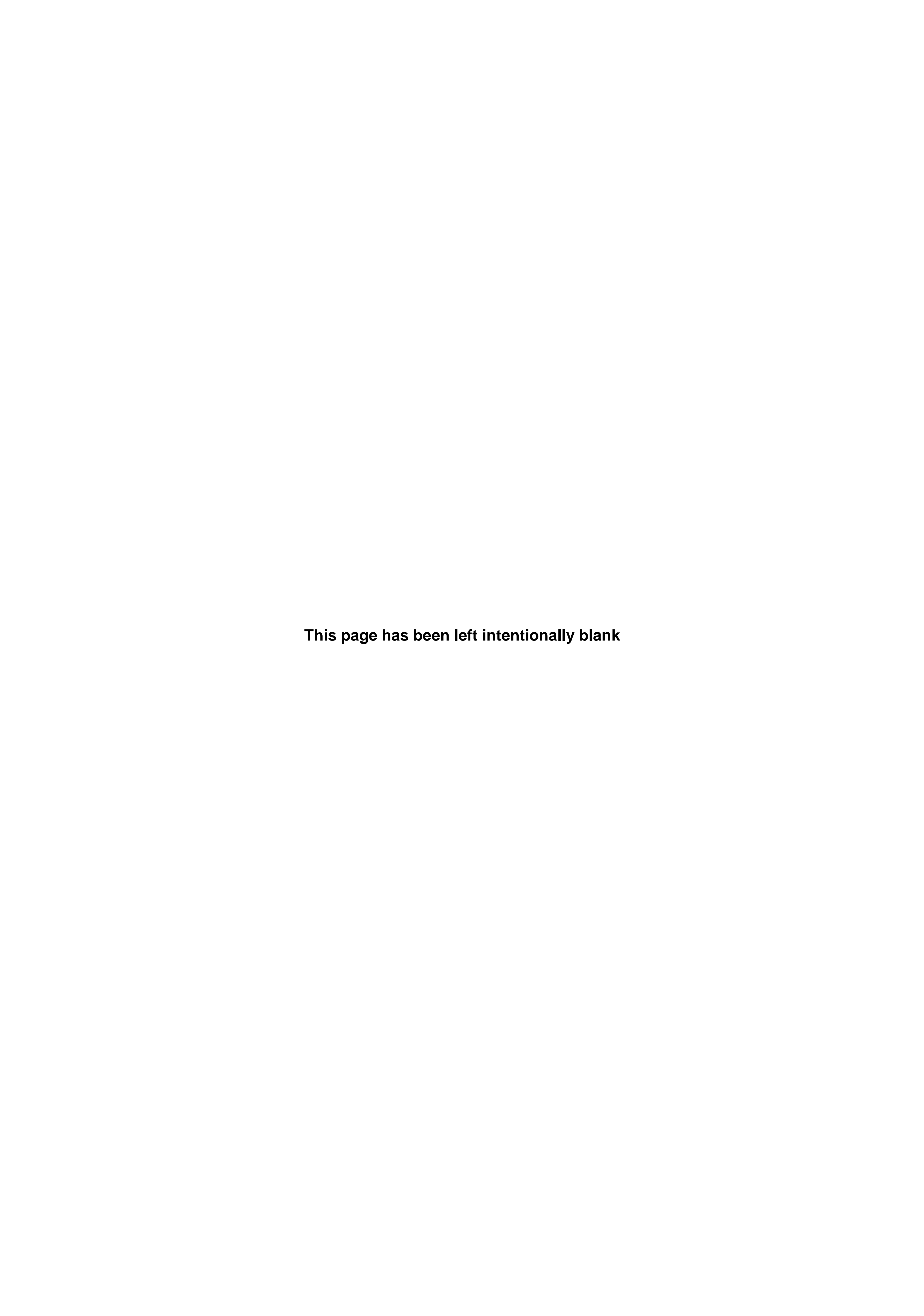
NEWS stands for the National Early Warning Score which is a nationally defined way of monitoring patients' observations to determine if there are signs of deterioration over time. Sometimes referred to as Early Warning Scores each Trust will have an agreed policy to act on NEWS scores escalating care 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.

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

Due to the Covid-19 pandemic, no external audit of indicators included in the report has been required as part of the 2020/21 Quality Account reporting process, this follows national guidance received to all NHS Trusts.



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