NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Northern Lincolnshire & Goole NHS Foundation Trust

Annual Quality Account

2019/20

CONTENTS

PART 1: Statement on quality from the Chief Executive of the Northern Lincolnshire and Goole NHS Foundation Trust 5

About Northern Lincolnshire and Goole NHS Foundation Trust 6

EXECUTIVE SUMMARY OF KEY POINTS 8

PART 2: Priorities for improvement, statements of assurance from the Board and reporting against core indicators 14

2.1 Priorities for improvement: overview of the quality of care against 2019/20 quality priorities & quality priorities planning for 2020/21 14

2.1a Priority 1 – Clinical Effectiveness: Mortality Reduction 14

2.1b Priority 2 – Patient Safety: Improved Management of the Deteriorating Patient 17

2.1c Priority 3 – Patient Safety: Medication Safety 19

2.1d Priority 4 – Patient Experience: Improved Patient Flow 20

2.1e Priority 5 – Patient Experience: Cancer Pathways 24

2.1f Quality Priority Planning for 2020/21 26

PART 2: Priorities for improvement, statements of assurance from the Board and reporting against core indicators 28

2.2 Statements of assurance from the Board 28

2.2a Information on the review of services 28

2.2b Information on participation in clinical audits and national confidential enquires 28

2.2c Information on participation in clinical research 38

2.2d Information on the Trust's use of the CQUIN framework 38

2.2e Information relating to the Trust's registration with the Care Quality Commission 39

2.2f Information on quality of data 42

2.2g Information governance assessment report 42

2.2h Information on payment by results clinical coding audit 42

2.2i Learning from Deaths 42

2.2j Details of ways in which staff can speak up 46

2.2k Annual report on rota gaps and plan for improvement 47

2.3 Reporting against core indicators 48

2.3a Summary Hospital-Level Mortality Indicator (SHMI) 49

2.3b Patient Reported Outcome Measures (PROMS) 52

2.3c Readmissions to hospital 54

2.3d Responsiveness to the Personal needs of patients 55

2.3e Staff recommending Trust as a provider to friends and family 57

2.3f Risk assessed for venous thromboembolism 59

2.3g *Clostridium Difficile* infection reported within the Trust 60

2.3h Patient safety incidents 62

Part 3: Other information and two annexes 65

3.1 Overview of the quality of care offered 2019/20 65

3.2 Performance against relevant indicators and performance thresholds 68

3.3 Information on staff survey report 69

3.4 Information on patient survey report 70

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees 72

Annex 1.1: Statements from Commissioners 72

Annex 1.2: Statement from Healthwatch organisations 74

Annex 1.3: Statement from local council overview and scrutiny committees (OSC) 75

Annex 1.4: Statement from the Trust governors' 76

Annex 1.5: Response from the Trust to stakeholder comments 77

Annex 2: Statement of directors' responsibilities in respect of the Quality Report 78

Annex 3: Independent auditor's report to the Board of Governors on the Annual Quality Report 80

Annex 4: Glossary 81

Annex 5: Mandatory Performance Indicator Definitions 82

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

On a daily basis, as Chief Executive, I see evidence that the Trust is making steady improvements in the way it delivers services to our local residents. Improvements are seen in diagnostics with less delay in imaging and reporting, improving the effectiveness of treatment plans and reducing risks to patient safety. Some of the most vulnerable older people who fracture their hip are receiving surgery in line with nationally agreed best practice timescales, exceeding the targets set and showing significant improvements compared to previous performance and the UK average. These are just two examples of the many instances of improvement I have seen during 2019/20.

These improvements have been made during difficult and challenging circumstances. The Trust's emergency and unplanned services have again faced significant demands. During 2019 over 151,000 people attended our emergency departments, more than 113,000 people were admitted to one of our Trust's hospitals and in excess of 301,000 people attended our radiology departments for imaging.

The Trust's workforce is a critical part of our improvement journey; without their hard work and dedication, none of this would be possible. To invest in our staff and improve their experience, the Pride and Respect initiative has enabled greater focus on supporting staff to care for each other. Over 3,000 colleagues have now received training and 94% of staff accessing more specialised support to deal with specific workplace issues report success at the end of the process. Progress too has been seen in improved medical engagement rates compared to the last assessment in 2017. These important work programmes have been reflected by a general improvement in the results from the latest staff survey. These results, whilst demonstrating our focus on staff experience needs to continue, validates that positive progress is being made.

This annual quality account is an opportunity to outline the Trust's progress against a wide variety of indicators and to the best of my knowledge the information contained within this report is accurate. Whilst strong progress has been made during 2019/20, there is still much more to do.

The latest Care Quality Commission (CQC) visit during September 2019 identified that the Trust's overall rating should remain as 'requires improvement'. Whilst CQC saw and reported improvements since their last visit in 2018, they identified areas where more work was required. We, as an organisation, were disappointed to see that our rating for Safe had deteriorated to inadequate; we are continuing to work to address the challenges, especially in regard to the waiting lists, with detailed ambitions outlined in our 5 year strategy.

Safe staffing on our wards remains a priority. The Trust Management Board has agreed an initial investment of £1.1 million to support the highest risk ward areas. This will support introduction of a new twilight shift for registered nurses to help match activity levels of patient flow into the evening and increased staffing at weekends. A second phase review will be a high priority in 2020/21 business planning. The Trust has further secured investment for additional MRI capacity, which is anticipated as being fully operational in 2021 at Scunthorpe with construction commencing in Grimsby during February 2020. Further investment for CT capacity has also been secured with works starting on the Grimsby site.

2019/20 has seen strong progress being made against our priorities, but there is more to be done in some critical priority areas. This is an exciting time for the Trust with many more improvements planned. The Trust Board and I remain determined; determined to continue to lead; determined to deliver further improvements in local services; and determined to support the Trust make further progress on our improvement journey.

Dr Peter Reading,

Chief Executive Officer

10 March 2020

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**.

2019 in numbers

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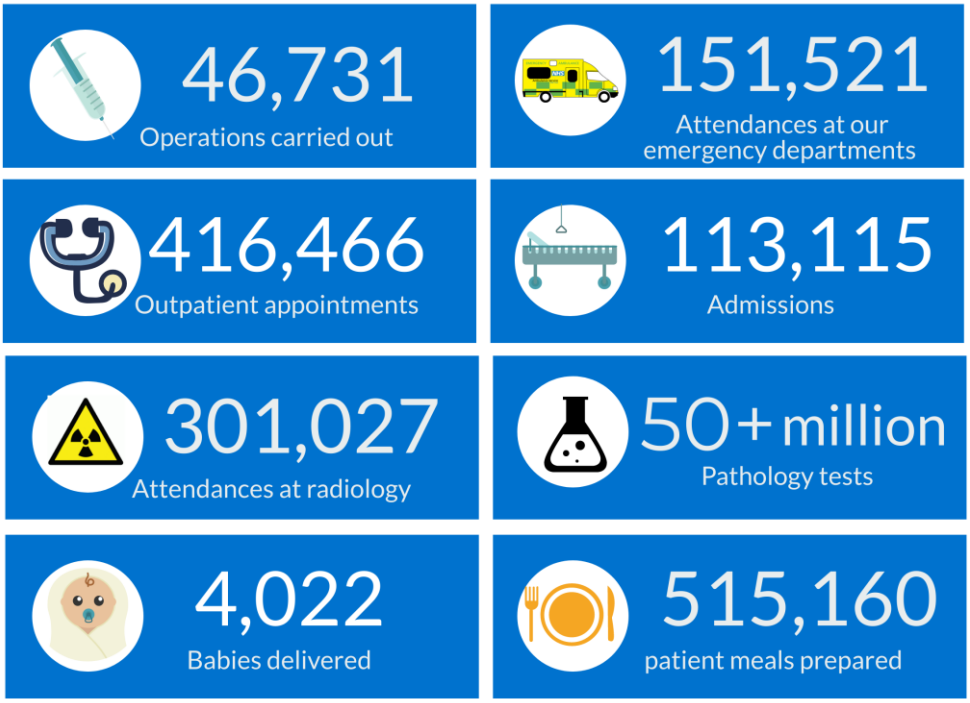


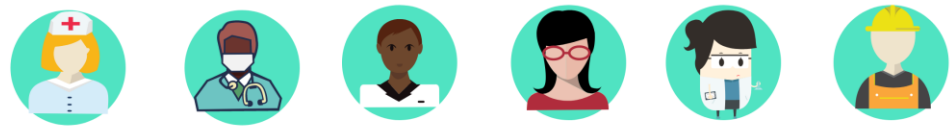
We treated around

TWO THOUSAND

patients every day

We welcomed 850 new staff

including...



109	262	40	181	20	48
Nursing & Midwifery	Medical & Dental	Allied Health Professionals	Admin & Clerical	Healthcare scientists	Estates & Ancillary

£600k+
Donated to our hospital charity

THE HEALTH TREE FOUNDATION
Your hospital charity

Executive summary of key points

5 Quality Priority Themes for 2019/20:

The Trust set out 5 key quality priorities for focus on within 2019/20, which were:

- Priority 1 – Clinical Effectiveness: Mortality reduction
- Priority 2 – Patient Safety: Improved management of the deteriorating patient
- Priority 3 – Patient Safety: Medication safety
- Priority 4 – Patient Experience: Improved patient flow
- Priority 5 – Patient Experience: Cancer pathways

Understanding Trust performance against these themes has been based on a number of indicators that are reported on within the quality section of the Trust's integrated performance report to the Trust's Board.

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.

Priority 1 – Clinical Effectiveness: Mortality reduction

The Summary Hospital-Level Mortality Indicator (SHMI) for the Trust was 117.6 for the period December 2018 – November 2019 which is in the 'higher than expected' bracket.

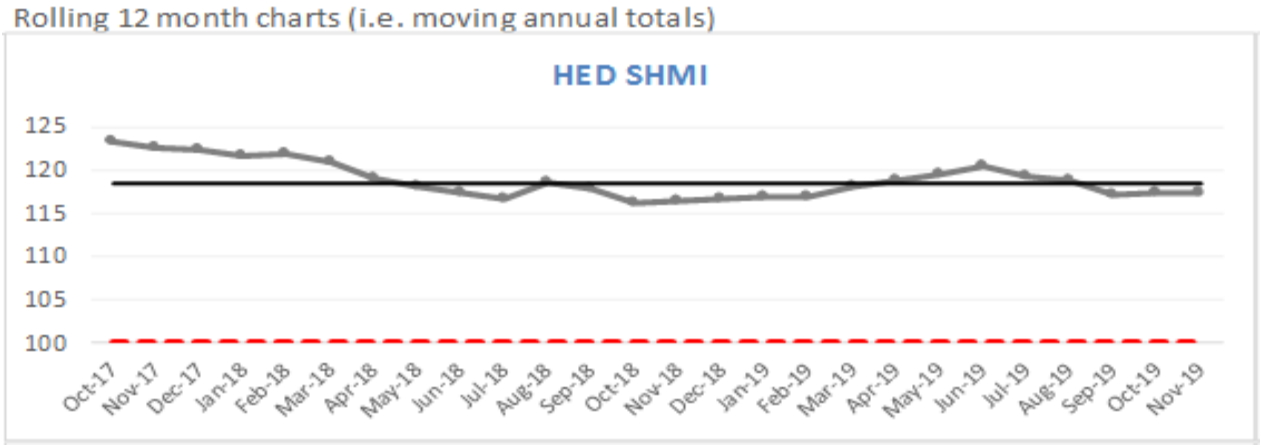


Figure 1: SHMI trending data for the Trust

The SHMI includes deaths within hospital and those within 30 days of discharge and is a summary statistic encompassing the wider healthcare system, not just the hospitals. The SHMI is a statistical calculation of the total number of observed deaths versus the number of 'expected' deaths; the 'expected deaths' component being derived from the recording and coding of risk factor data for admitted patients. The SHMI is reliant on data quality and is recognised as not being a reliable indicator of the quality of care provided.

Actions being taken to improve the SHMI include:

- A review of care quality using a mortality screening tool is undertaken. This aims to increase the proportion of deaths reviewed for quality improvement purposes and supports the Trust's 'learning from deaths' work which is a part of the Trust's mortality improvement strategy.

- Working with primary and community care to improve processes in place for the identification and earlier advanced planning of those patients who are approaching their end of life, recognising that from clinician led reviews, a proportion of patients are being admitted, at end of life, to hospital, when other care settings may have been more appropriate.

- Clinician led validation of data quality: recording and clinical coding of the primary diagnosis being treated; presence of comorbidities and if palliative care was being provided.

Priority 2 – Patient Safety: Improved management of the deteriorating patient

The National Early Warning System (NEWS) scores conducted on time with a 30 minute grace period was 89.51% in March 2020. The chart below shows improvement over time:

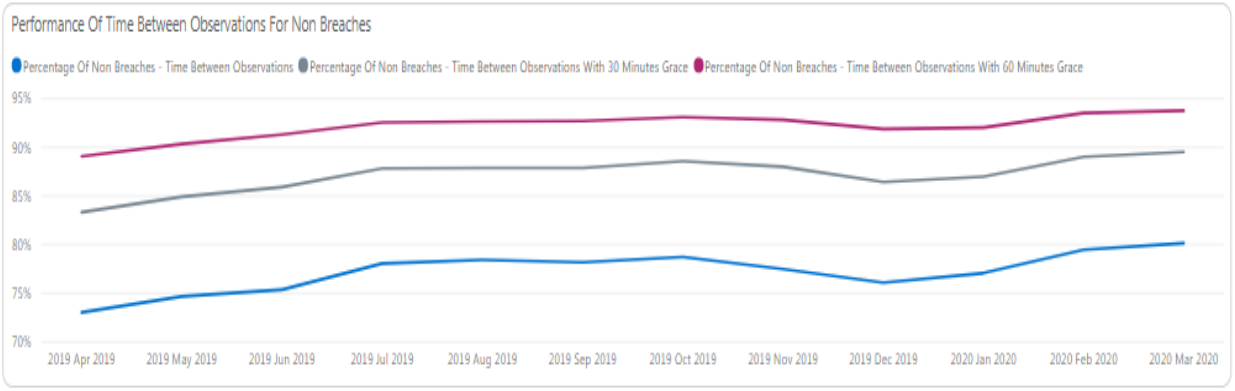


Figure 2: NEWS carried out on time (including 30 min grace period) trending data (grey line)

Audit work undertaken to assess if appropriate action was taken in response to the patient's observations, as guided by the Trust's policy, demonstrates that 80% of patients were escalated appropriately. In the remaining cases the records where unclear as to the clinical situation, whether there were good reasons for non escalation. Work will be undertaken to emphasise the need to document reasons for non-escalation. Further audit work will be undertaken to monitor performance.

Monthly manual audits are now undertaken to measure performance against sepsis. The latest data identified that the majority of patients who should have been considered for sepsis screening had appropriate escalation action. Whilst acted upon, there were some cases that did not have a formal screening undertaken, most were in patients where screening was not required, but in about 10% of these, there was no record found for why no formal screening was undertaken.

Actions being taken to improve the care provided to the deteriorating patient include:

- Revising the escalation policy for NEWS.

- Expansion of the Critical Care Outreach team audit work to identify further information and link audit data to incident reporting for further escalation and learning.

- Continue to work towards electronic recording of sepsis performance with links to the NEWS observation data.

Priority 3 – Patient Safety: Medication safety

The Trust's Safer Medication Group monitors internally reported incident data to understand themes and trends in relation to medication safety. This includes work to improve the safety of insulin prescription and administration and identify improvements to reduce the number of omitted doses. Whilst 85 staff have to date received additional training on insulin, further work has been agreed to review and revise the current training available for ward staff on the management of insulin. This will remain a quality priority for 2020/21 as part of the work on improving diabetes management.

The Trust has launched Electronic Prescribing and Medicines Administration (EPMA) at Goole District Hospital during November 2019, and Scunthorpe General Hospital in February 2020. Evaluation of the system implementation has been positive and the learning has been transferred to support the further roll out. The Safer Medication Group has concluded that omitted dose incident data has not been fully representative to inform improvement activities. Work has begun to examine data from the EPMA system to understand the reasons for omitted doses. This will be discussed at the Safer Medication Group and used to inform improvement activity going forward.

Priority 4 – Patient Experience: Improved patient flow

Non-elective length of stay in Medicine has reduced over time but further improvements are required. The Trust is working to deliver on the four priority seven day service indicators and also implement SAFER principles. See section 2.1 for further details.

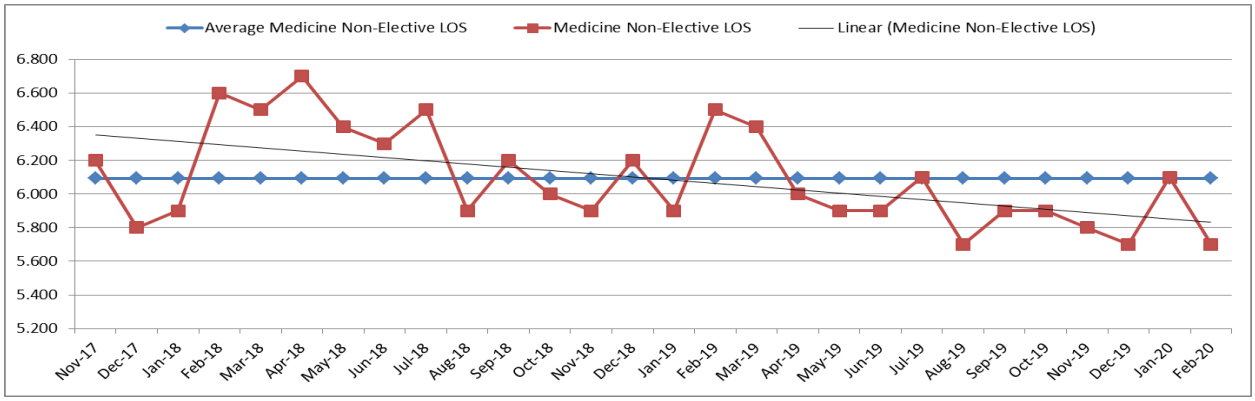


Figure 3: Medicine non-elective length of stay trend

To support further reductions in length of stay and patient flow, the following initiatives have been introduced:

- An Urgent Treatment Centre was introduced at Scunthorpe General Hospital in March 2019 and received formal designation as a UTC in December 2019.
- The unit at Diana, Princess of Wales Hospital commenced in March 2019 and is expected to receive designation in February 2020.
- An Acute Assessment Unit was introduced in Medicine at both Scunthorpe General Hospital and at Diana, Princess of Wales Hospital in November 2019.

- A Multi-agency Discharge Event (MADE) and Perfect Week event in February 2020 was successful in increasing the volume of safe discharges to free up space for those in need of treatment. Lessons are being drawn from that to help shape discharge strategy.

- The Trust has commenced work with NHS Elect to implement Same Day Emergency Care pathways.

Priority 5 – Patient Experience: Cancer pathways

This quality priority has been focussed on improvements in timeliness of cancer pathways specifically with quicker access to diagnostics to achieve a higher proportion receiving a diagnosis within 28 days. The primary focus of this priority was three specific tumour sites: lung; prostate; and colorectal. In lung and prostate, faster diagnosis processes have been implemented which has streamlined pathways, resulting in improvements against this indicator during the year from 45% to 70% in lung, and from 47% to 75% in prostate, in January.

The colorectal cancer pathway remains a significant challenge. The Trust has commenced the implementation of faster access to diagnostics project in colorectal cancer with the expectation that this will be fully implemented in quarter one of 2020. The current dual Multi-Disciplinary Team (MDT) meeting will transition into a single MDT by the end of April 2020. The Trust continues to work across the care system to improve the timescales for Cancer pathways and this will remain as a quality priority during 2020/21.

Whilst the Trust continues to deliver 2 week waits on target, compliance with the 62 day cancer metric remains below target. This reflects capacity shortfalls with the Trust's tertiary cancer provider in Hull also. To improve cancer performance, the following improvements have been made:

- Improvements in first appointment by Day 7 in Breast (96%), Gynaecology (84%), and Urology (64%).

- Improvements in Radiology waiting times (for requests marked 31/62). Request to exam at 8.4 days (CT) and 6.0 (MRI); and Exam to report 3.1 days (CT) and 2.4 days (MRI).

- Haematology strategy developed with Hull University Teaching Hospitals (HUTH).

- Centralisation of oncology clinics In January 2020.

- Joint Cancer Board between Hull University Teaching Hospital (HUTH) and NLAG and an agreed stocktake for Prostate, Lung, Head & Neck, Upper GI pathways undertaken.

QUALITY PRIORITY THEMES 2020/21:

Setting quality priority themes for 2020/21:

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

Following consultation and subsequent setting of the 2020/21 quality priorities, the Trust received the Care Quality Commission's (CQC) inspection report of Trust services in February 2020.

The CQC report identified a number of quality themes requiring further improvement focus. The Trust will prioritise the delivery of these areas for further improvement, and there is a close correlation between the 2020/21 quality priorities and many of the CQC recommendations.

The Trust's local priorities were set following a review of performance during the year and reflection of where further improvement or assurance is needed. The Trust has agreed 5 quality priority areas for 2020/21:

1. Patient Experience: Waiting lists,
2. Clinical Effectiveness: Mortality and End of Life,
3. Patient Safety: Management of Diabetes,
4. Patient Experience & Clinical Effectiveness: Cancer Pathways,
5. Patient Safety, Experience & Clinical Effectiveness: Quality & Timeliness of Safe Flow and Discharge.

These quality priorities, with underpinning metrics, link back to areas from 2019/20 that require continued focus to support continuing improvements, whilst also linking to the CQC identified recommendations.

Examples of this are in relation to end of life services. Whilst this is a theme for improvement identified as part of the Trust's local consultation and setting of quality priorities for 2020/21, this also features as a theme from the CQC inspection. Responsiveness to complaints and patient feedback is also a theme from the CQC inspection which features as a metric within the five local quality priorities.

All improvement actions against all CQC recommendations will be monitored to ensure full oversight and internal assurance. Oversight will be provided by the Trust Management Board, relevant Board sub-committees and Operations Directorate performance meetings held with divisions.

For more details in relation to the Trust's CQC visit please see section 2.2e of this report.

How progress against 2020/21 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

2.1 Priorities for improvement: overview of the quality of care against 2019/20 quality priorities & quality priorities planning for 2020/21

2.1a: Priority 1 – Clinical Effectiveness: Mortality reduction

Progress Made: (April 2019 – March 2020): During the 2019/20 period, Trust performance has not met the target for the Summary-Hospital-Level-Mortality Indicator (SHMI). Progress has been made with embedding improved divisional processes to support more effective learning from deaths. Further work is required to focus on the quality of end of life care.

The SHMI for the Trust was 117.6 for the period December 2018 – November 2019 which is in the 'higher than expected' bracket.

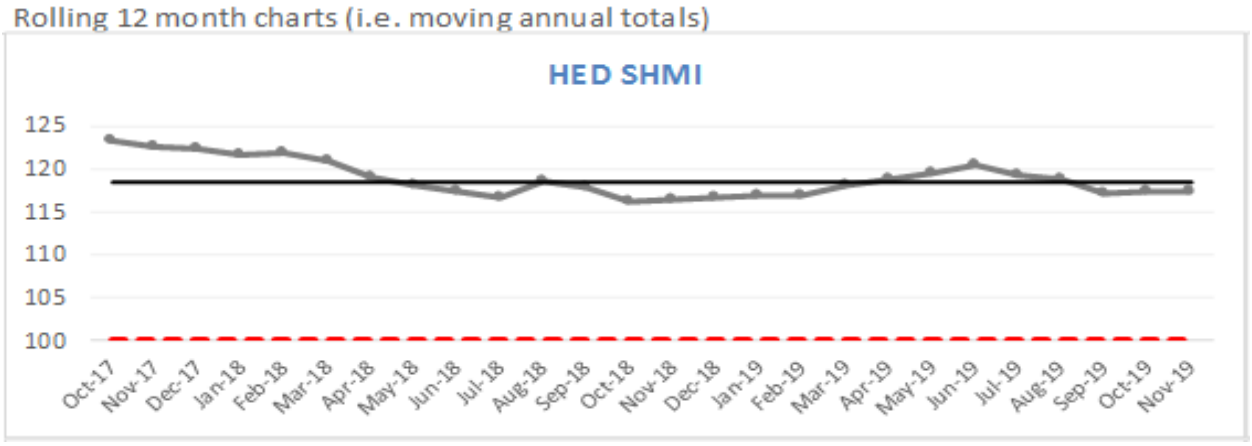


Figure 4: SHMI trending data for the Trust

The Summary Hospital-Level Mortality Indicator (SHMI) includes deaths within the hospital and those within 30 days following hospital discharge. This is a statistically calculated ratio, commonly referred to as a Standardised Mortality Ratio (SMR).

The SHMI ratio compares the actual number of deaths, within 30 days of hospitalisation, to a statistically calculated construct as to what would be 'expected'. This construct is based on the quality of recorded and coded information. National guidance makes clear that SHMI should not be used as an indicator of service quality or be used to compare one Trust against another.

The Trust improved its reporting of mortality data during 2019 to enable greater focus on the component parts of the SHMI indicator. This highlighted that whilst the observed number of deaths showed no significant differences between sites in the statistical model, there is a disparity in the statistically calculated number of 'expected' deaths at the Diana, Princess of Wales Hospital (DPoW), resulting in a lower level of 'expected' deaths compared with Scunthorpe General Hospital (SGH).

The calculation of 'expected' deaths is based on two main elements of data quality. The first is the primary diagnosis the patient is being treated for, based on documentation within the medical record which is then coded. This primary diagnosis has a large bearing on the risk

calculation and is taken from the very first episodes of care, when in many cases a firm diagnosis is still being determined from tests and observations. The second element impacting on the calculation of risk are the secondary diagnoses, or comorbidities, that a patient has already prior to admission and/or those diagnosed whilst in hospital.

Recognising the disparity at DPoW in the 'expected' mortality statistical calculation has led the Trust to compare against other peer sites. This has identified potential data quality improvements in both the recording of the primary diagnosis and in the capture of comorbidity risk factors.

Actions being taken to improve the SHMI include:

- Quality of care reviews have identified a theme relating to some patients being admitted to the acute hospital at end of life where potentially a different place of care may have been more appropriate and the potential for improved end of life care planning. The Trust are working collaboratively with primary and community care to improve pathways of care to improve the identification of end of life and planning.

- The Trust is rolling out a tool that supports patients' create personalised recommendations to aid decision making in the future when they are unable to make or communicate their preferences. This is referred to as the RESPECT tool or Recommended Summary Plan for Emergency Care and Treatment. To support implementation of this tool, which will aid advanced care planning, including consideration of end of life planning, the Trust has funded an educational post to roll-out of the tool across the Trust's hospitals and within the community.

- Clinician-led validation of data quality: recording and clinical coding of the primary diagnosis being treated; presence of comorbidities and if palliative care was being provided in acute medicine, critical care, stroke and cardiology.

- Clinical data improvement project has commenced in February 2020 supporting the Clinical Coding team to strengthen established processes and working more closely with senior clinicians to enhance the recording of clinical codes.

Whilst the SHMI indicator has remained above the target, the Trust's non-elective crude mortality (the simple arithmetic ratio comparing number of deaths to the number of admissions) has improved, and remained lower than historic Trust performance.

During 2019, divisionally-owned processes to support effective learning from deaths have improved. In the division of medicine, where the majority of unplanned or non-elective patients are admitted, monthly meetings in all specialties have been developed to focus on quality and safety, with learning from deaths featuring within these meetings to allow clinicians time to review and reflect on care provided to determine where learning is possible.

The division of surgery has also improved their process of reviewing deaths for learning purposes with the aim that all deaths will be reviewed. In general surgery a weekly meeting has been introduced where all deaths are reviewed to reflect on the care provided. In trauma and orthopaedics a combination of weekly and monthly meetings is being used to review and learn from deaths.

Actions being taken to increase the proportion of deaths reviewed for learning include:

- A new mortality screening tool has been developed to enable a greater proportion of deaths to be reviewed to examine the quality of care. This links to the existing mortality Structured Judgement Review (SJR) work and Serious Incident (SI) investigation process if indicated.

- Collaborative case reviews with primary and community care continue. Increased sharing of issues with primary/community colleagues has commenced to improve feedback and investigation of issues for learning in primary and community care.

For more detailed information regarding the Trust's work on reducing mortality and a focus on end of life care, please refer to part 2.2.

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

Priority 1 – Clinical Effectiveness: Mortality Reduction:

- Clinician-led validation and the clinical data quality improvement project will support improvements in recording and documentation of medical diagnoses and improve the identification of risk factors that will support improved consideration of treatment options.

- Improved learning from deaths processes will support reflection and consideration of improvements in patient pathways and education to all members of the multi-disciplinary team involved in provision of patient care.

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

Relationship to 2020/21 Quality Improvement Priorities: This quality priority has remained the same throughout 2019/20. Mortality and end of life indicators are to remain as quality priorities during 2020/21.

2.1b: Priority 2 – Patient Safety: Improved management of the deteriorating patient

Progress Made: (April 2019 – March 2020): During the 2019/20 period, the Trust's management of the deteriorating patient demonstrates improvement over time.

The National Early Warning System (NEWS) scores conducted on time with a 30 minute grace period was 89.51% in March 2020. The chart below shows improvement over time:

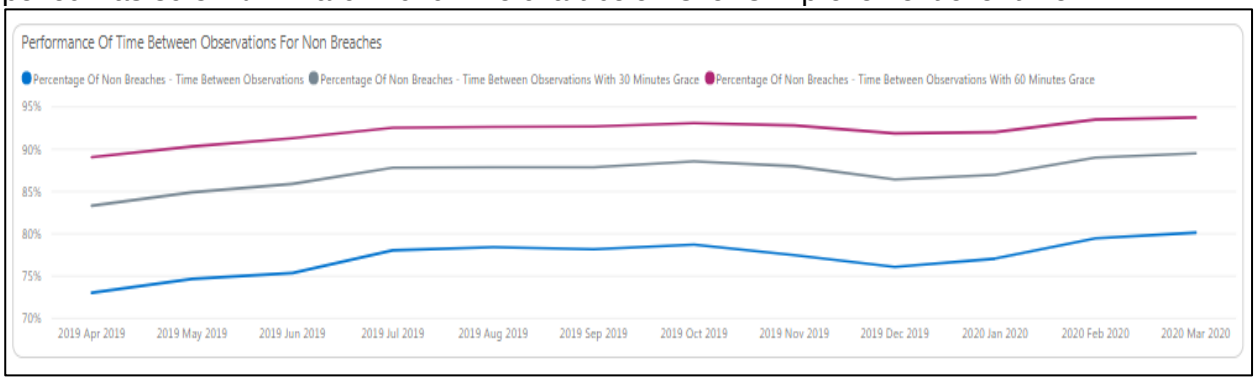


Figure 5 NEWS carried out on time (including 30 min grace period) trending data (grey line)

Action taken in response to NEWS observations is not able to be monitored electronically in the same way, however the Trust's Critical Care Outreach team are undertaking monthly audits to assess if appropriate action was taken in response to the patient's observations, guided by the Trust's policy.

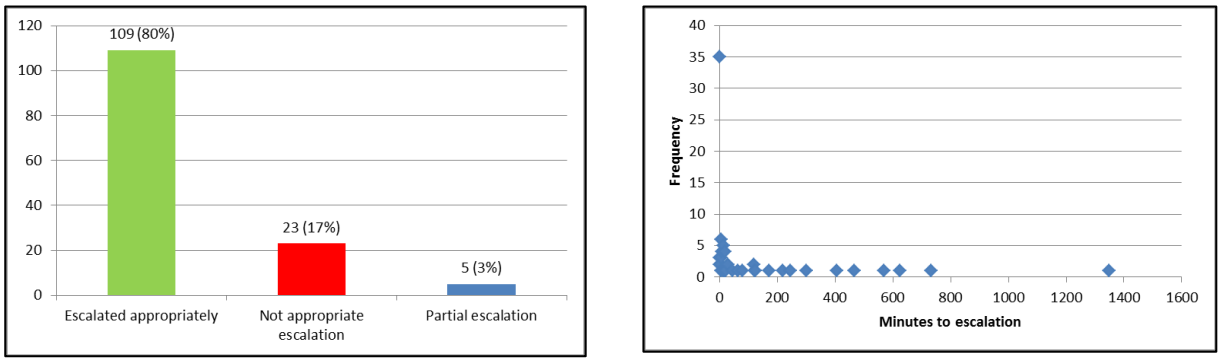


Figure 6: Audit findings from assessment of action taken in response to NEWS

The audit undertaken during December/January identified that 80% of patients were escalated appropriately. In the remaining cases it was not clear from the record what the clinical situation was of the patient. Further audit work will be undertaken during February 2020 to provide further detail with links to the incident reporting mechanism to ensure any issues from the audit are investigated and learnt from.

Sepsis compliance is another area linked to the deteriorating patient improvement work. The Trust has been working to link the NEWS observations and sepsis screening together within its electronic data systems. Whilst this has been successful in the NEWS score, triggering a reminder to ward staff to consider the risk of sepsis and record this electronically to date has not been possible to effectively report outputs from this due to the complexity of the datasets within the electronic system and programming the electronic system to understand when the sepsis elements were required.

Whilst work continues in improving the electronic recording of sepsis, monthly manual audits are being undertaken to measure performance. The latest data identified that the majority of patients who should have been considered for sepsis screening had appropriate escalation action taken. Whilst appropriate escalation action was taken, in some of these cases a formal sepsis screening was not undertaken. Education work continues as part of this project.

Actions being taken to improve the care provided to the deteriorating patient include:

- Revising the escalation policy for NEWS.
- Expansion of the Critical Care Outreach team audit work to identify further information and link audit data to incident reporting for further escalation and learning.
- Continue to work towards electronic recording of sepsis performance with links to the NEWS observation data.

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

Priority 2: Patient Safety: Improved management of the deteriorating patient:

- Improvements in recording of NEWS observations result in increased monitoring and better identification of any signs of deterioration resulting in improved patient safety.
- The trigger on the Trust's electronic systems provides an aide memoir to clinical staff to consider the risk of sepsis and assess this and act appropriately.
- Sepsis audit work demonstrates that the majority of patients are being checked for sepsis as soon as indicated.

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 2019/20 Quality Improvement Priorities: This quality priority has remained the same throughout 2019/20. Focus on the deteriorating patient and sepsis will remain as quality priorities in 2020/21, linked to priority theme 2: Mortality and end of life.

2.1c: Priority 3 – Patient Safety: Medication safety

Progress Made: (April 2019 – March 2020): During the 2019/20 period, the Trust's performance with these indicators could not be fully determined as a result of the data being used to measure these indicators being based on incident reporting data, which is a subjective rather than objective measure.

The Trust's Safer Medication Group monitors internally reported medication incident data to understand themes and trends in relation to medication safety. The following chart provides an overview of omitted doses reported as incidents.

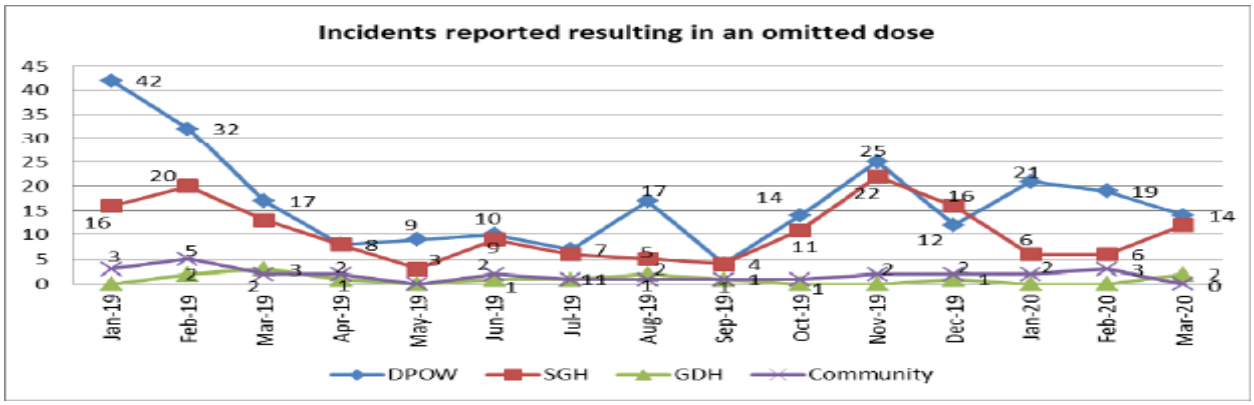


Figure 7: Incident data relating to omitted doses

The Trust has launched Electronic Prescribing and Medicines Administration (EPMA) at Goole District Hospital during November 2019. Evaluation of the system implementation across the 4 wards and Theatre recovery has been positive and the learning transferred to the further roll-out of EPMA. Initial scrutiny of the omitted dose data from EPMA at Goole District Hospital has led the Safer Medications Group to conclude that the omitted doses incident data is not fully representative to inform appropriately targeted improvement activities. It is planned to use data from the EPMA system which will be more robust, timely and enable better understanding of the reasons for omission. A report has been developed in the system from the Goole roll-out and this will be used to inform improvement activity in relation to omitted doses.

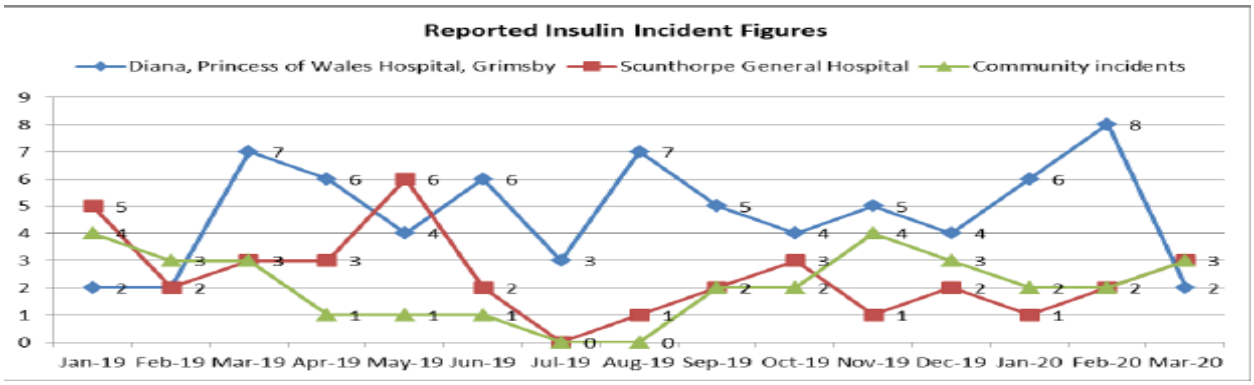


Figure 8: Incident data relating to insulins

Using the reported incidents the Trust has monitored insulin data. The reported data has fluctuated each month with DPoW having a higher incidence of reporting. The majority of incidents relate to the administration of insulin. In response, the current training available for staff in relation to insulin administration has been reviewed and determined to require

improvement to be more accessible to ward staff. Recognising there is more work to do; management of diabetes will be a quality priority for 2020/21.

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

Priority 3 – Patient Safety: Medication safety:

- The Trust's roll out of EPMA will improve the safety of medication prescription and administration whilst providing much greater quality data to understand current practice and focus on improvements.

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 2019/20 Quality Improvement Priorities: This quality priority has remained the same throughout 2019/20. Focus on the care of diabetes patients will be included as a quality priority during 2020/21 to increase the scope of the 2019/20 focus on insulins.

2.1d: Priority 4 – Patient Experience: Improved patient flow

Progress Made: (April 2019 – March 2020): During 2019/20, the Trust has demonstrated progress in the management of flow through its hospitals, but challenges remain and require wider focus across the healthcare system.

The Trust's focus on flow and the SAFER care bundle principles has supported a progressive improvement of the non-elective length of stay within Medicine, with the following chart demonstrating a reduction over time. Whilst positive, further improvements are needed:

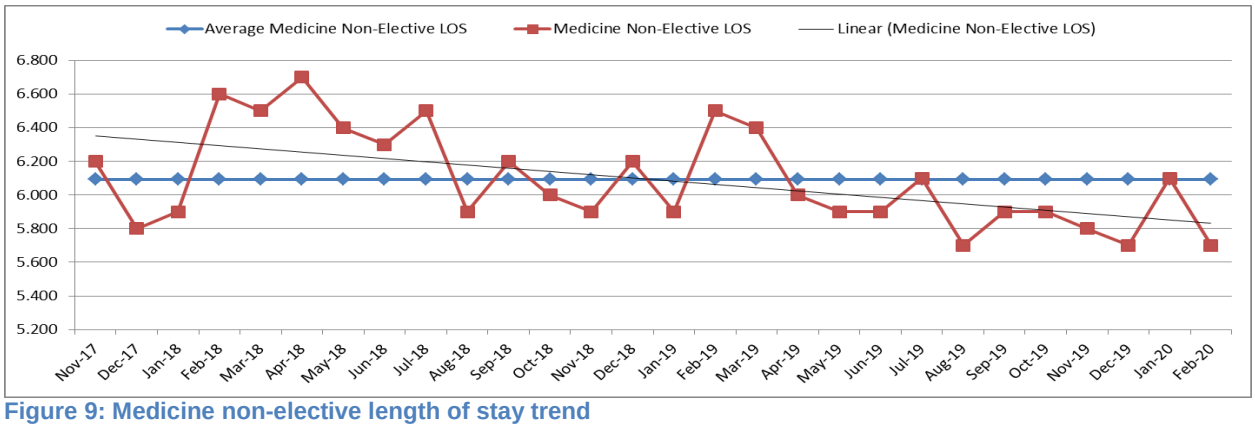


Figure 9: Medicine non-elective length of stay trend

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

To further support the implementation of SAFER principles at ward level additional data has been needed specifically individual ward length of stay and number of discharges before noon on each ward. There has been a gap during the year in being able to provide this ward based data. From February, however, this data has now been made available and will be used to support ward level performance meetings within medicine.

Implementation of priority clinical standards for seven-day services – self assessment:

The Trust is working to meet the requirements for seven day services, specifically, compliance with 4 priority standards. The Trust will not have achieved compliance before April 2020. Key points from the most recently undertaken audit of seven-day services, against these 4 priority standards, are as follows:

Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours from the time of admission to hospital.

From the Trust's audits, there were no gaps in compliance found as a result of the day of the week; weekend admissions had the same access as a patient admitted on a weekday. However, the time of day a patient is admitted was found to significantly impact on compliance with this standard, with those admitted late afternoon or in the evening not always receiving a consultant review within 14 hours. Documentation of all staff present during ward rounds made accurate measurement of this standard a challenge, as it was not always clear from the ward round documentation if a consultant was present, this may have negatively impacted on the Trust's audit results that informed the self-assessment.

Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week [within defined timescales].

Echocardiography is the only diagnostic service not fully accessible seven-days a week; this is due to vacancies within the staff group, a national problem due to a shortage of Cardiac Physiologists, leading the service not being fully established and therefore unable at present to offer this service over a weekend.

Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.

The Trust identified gaps in compliance with this standard as interventional radiology, provided by Hull University Teaching Hospitals (HUTH), is not available out of hours, over the weekends or bank holidays due to very limited number of consultants able to undertake interventions, lack of nursing staff and lack of interventional trained radiographers. Additionally, cardiac pacing is not currently available at the weekend. Options are being explored within the Medicine division.

The Trust is in the process of reviewing with Hull University Teaching Hospitals the service level agreement to determine if a formal agreement is in place regarding provision of services over seven days for both Interventional Radiology and Cardiac Pacing over the weekend.

Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant twice daily. Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patients pathway.

Related to standard 2, documentation within the clinical record of who was present at each ward round made accurate assessment of this standard in the audit difficult. Additionally, in a number

of cases daily ward rounds were undertaken by Senior Registrars rather than the Consultant. Whilst it was acknowledged that in some areas a thorough handover process is in place where the consultant delegates the review, this varied between divisions. These difficulties in measurement prevent the Trust from accurately evidencing compliance with this standard. Once the processes around board rounds and handover are formalised in all areas, this should be easier to evidence.

Following completion of the audit and internal discussion of the results to identify improvements, verbal confirmation from a number of consultants in various specialties outlined the processes in place that ensure patients are virtually reviewed as part of the consultant led board review and/or handover process.

Next steps / improvements planned to improve patient flow and access seven-days:

The gaps identified from the seven-days' audit have been fed back to divisions and is being led corporately by one of the Trust's Deputy Medical Directors and between them and the Chief Operating Officer. Divisions have been requested to include specific detail as to what is required to close the gaps and if required, include within the 2020/21 business planning process. Divisional risk registers will be updated to include any risks arising from this and progress will be overseen by the Quality Governance Group and the performance review process.

To support improved compliance with seven-day service standards, further reduce length of stay and improve patient flow, the following initiatives have been introduced:

- Improved evidence of handover information within the Trust's electronic system to incorporate whether daily consultant review is necessary, has been delegated to a specialty or core trainee doctor, or whether no review was required.

- Seven-day service results are being discussed at handovers/ward huddles to raise awareness of the national requirements.

- An Urgent Treatment Centre was introduced at Scunthorpe General Hospital in March 2019 and received formal designation as a UTC in December 2019.

- The unit at Diana, Princess of Wales Hospital commenced in March 2019 and is expected to receive designation in February 2020.

- An Acute Assessment Unit was introduced in Medicine at both Scunthorpe General Hospital and at Diana, Princess of Wales Hospital in November 2019.

- A 'Multi-agency Discharge Event (MADE) event with Perfect Week was held in February 2020. This enabled significant improvements in safe discharges.

- The Trust has commenced work with NHS Elect to implement Same Day Emergency Care pathways.

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

Priority 4 – Patient Experience: Improved patient flow:

- Improvements in the length of time patients stay in hospital have been seen, meaning that patients are discharged from hospital sooner, improving their experience and minimising the risks of prolonged immobility.

- Whilst there is no significant difference in services and access to essential diagnostics between weekend and weekday, there are still some gaps in compliance with the priority standards linked to the time of day a person is admitted.

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

Relationship to 2020/21 Quality Improvement Priorities: The quality priority theme has remained the same throughout 2019/20. Flow will not be a standalone quality priority for 2020/21 but will have reference to the newly proposed quality priority focussed on waiting lists.

2.1e: Priority 5 – Patient Experience: Cancer pathways

Progress Made: (April 2019 – March 2020): During the 2019/20 period, the Trust's focus on specific cancer pathways and improved timeliness as a result of faster access to diagnostics has demonstrated some improvements, although there are still significant challenges.

A proxy indicator used to determine and measure timeliness of cancer pathways is the proportion of patients (%) diagnosed within 28 days. This helps to understand delays to diagnosis in specific cancer pathways. The following chart demonstrates performance within the four cancer tumour sites of specific focus. For the month of March 2020, the overall Trust performance with this indicator was 62.1%.

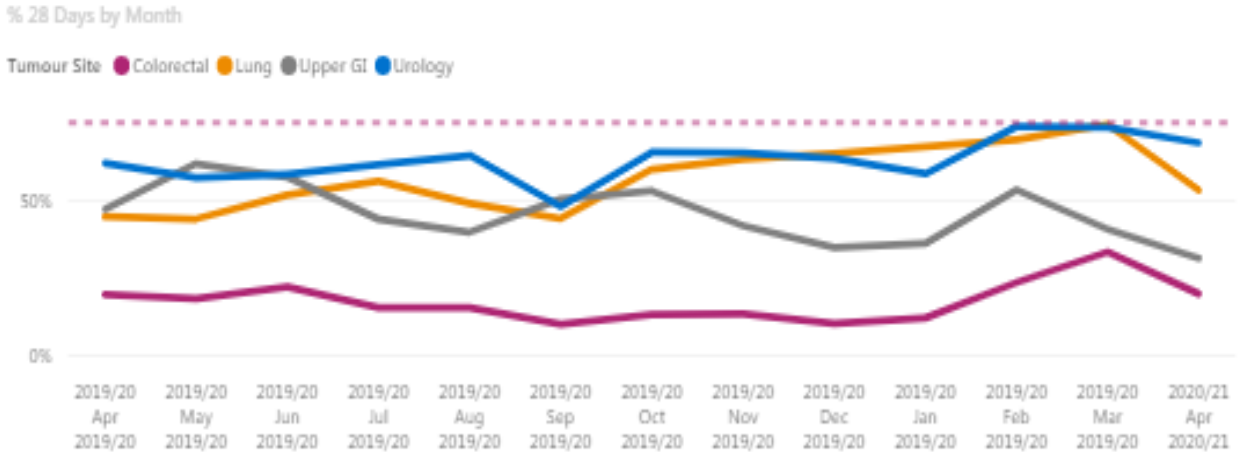


Figure 10: Chart demonstrating the proportion of patients diagnosed within 28 days

The Trust has implemented a faster diagnosis process in urology and lung cancer which has improved access and delivery of care in these specialties.

These changes have supported improvement from 45% to 74.4% in lung cancer. The pathway has also recently been strengthened with the commencement of an Endobronchial Ultrasound (EBUS) service and the centralisation of the two site-based multi-disciplinary team (MDT) meetings into a central MDT enabling improved efficiency and effectiveness through improved membership of the group.

In urology (prostate cancer pathway) the-two stop diagnosis pathway was implemented from mid-September 2019. Performance in March 2020 shows improvement from 47% to 73.5%.

Colorectal pathway remains a significant challenge. Work to commence faster access to diagnostics in colorectal has commenced with the aim of being fully implemented during quarter one of 2020. Improvements are being seen in recent performance.

To improve cancer performance, the following improvements have been made:

- Colorectal '100 day challenge' initiative to commence to provide greater access for patients with non-specific weight loss. This will provide shorter diagnostic and access times to colorectal services. The current dual MDT meeting will also move to a single MDT meeting by the end of April 2020.
- Improvements in first appointment by Day 7 in Breast (96%), Gynaecology (84%), and Urology (64%).

- Improvements in Radiology waiting times (for requests marked 31/62). Request to exam at 8.4 days (CT) and 6.0 (MRI); and Exam to report 3.1 days (CT) and 2.4 days (MRI)
- Haematology strategy developed with Hull.
- Centralisation of oncology clinics: Steering group to oversee the oncology reconfiguration in place (January 2020).
- Joint Cancer Board between HUTH and NLAG – agreed stocktake for Prostate, Lung, Head & Neck, Upper GI pathways undertaken.

Whilst the Trust continues to deliver 2 week waits on target, compliance with the 62 day cancer metric remains below target. This reflects capacity shortfalls with the Trust's tertiary cancer provider in Hull also.

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

Priority 5 – Patient Experience: Cancer pathways:

- Closer working between the Trust and the Tertiary provider of oncology services results in improved use of capacity and reduces the risk to patient safety, following the centralisation of Tertiary provided oncology services in January 2020 onto the DPoW site.
- Improvements in timeliness of pathways and access to diagnostics results in faster diagnosis and commencement of treatment.
- Significant improvements in radiology reporting times further improve patient safety.

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 2020/21 Quality Improvement Priorities: This quality priority theme has remained the same throughout 2019/20. For 2020/21 this area will remain as a quality priority.

2.1f: Quality Priority planning for 2020/21

QUALITY PRIORITY THEMES 2020/21:

The Trust has agreed 5 priority areas for 2020/21:

1. Patient Experience: Waiting lists
2. Clinical Effectiveness: Mortality and End of Life
3. Patient Safety: Management of Diabetes
4. Patient Experience & Clinical Effectiveness: Cancer Pathways
5. Patient Safety, Experience & Clinical Effectiveness: Quality & Timeliness of Safe Flow and Discharge

How the Quality Improvement Priorities are consulted on and agreed:

During 2019/20, the Trust reviewed and re-aligned its five year quality strategy with the Trust's strategic direction over the same time period. The strategy, based upon the National Quality Board's (NQB) *'Shared Commitment to Quality'* outlines that whilst setting long term quality objectives, linked to the Trust's strategic objectives, the Trust will continue to review and set yearly quality priorities.

Following consultation and subsequent setting of the 2020/21 quality priorities, the Trust received the Care Quality Commission's (CQC) inspection report of Trust services in February 2020.

The CQC report identified a number of quality themes requiring further improvement focus. The Trust will prioritise the delivery of these areas for further improvement, and there is a close correlation between the 2020/21 quality priorities and many of the CQC recommendations.

These quality priorities, with underpinning metrics, link back to areas from 2019/20 that require continued focus to support continuing improvements, whilst also linking to the CQC identified recommendations.

Examples of this are in relation to end of life services. Whilst this is a theme for improvement identified as part of the Trust's local consultation and setting of quality priorities for 2020/21, this also features as a theme from the CQC inspection. Responsiveness to complaints and patient feedback is also a theme from the CQC inspection which features as a metric within the five local quality priorities.

All improvement actions against all CQC recommendations will be monitored to ensure full oversight and internal assurance. Oversight will be provided by the Trust Management Board, relevant Board sub-committees and Operations Directorate performance meetings held with divisions.

For more details in relation to the Trust's CQC visit please see section 2.2e of this report.

How progress against 2020/21 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 2019/20 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 2019/20 represents 100% of the total income generated from the provision of relevant health and care services for 2019/20.

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

During 2019/20, 54 national clinical audits and 4 national confidential enquires covered relevant health services that Northern Lincolnshire and Goole NHS Foundation Trust provides.

During that period the Trust participated in 53 or 98% of the national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2019/20 and those in which it participated in are as follows:

NB: The table which follows lists:

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

National Clinical Audits 2019/20

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	Percentage of number required	Action planning
Acute care					
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	Yes	Yes	240	100%	Awaiting publication of results
BAUS Urology Audit - Cystectomy	No	N/A	N/A	N/A	N/A
BAUS Urology Audit - Female Stress Urinary Incontinence	No	N/A	N/A	N/A	N/A
BAUS Urology Audit - Nephrectomy	Yes	Yes	28	Ongoing	Project still underway
BAUS Urology Audit - Percutaneous Nephrolithotomy	Yes	Yes	9	Ongoing	Project still underway
BAUS Urology Audit - Radical Prostatectomy	No	N/A	N/A	N/A	N/A
Care of Children in Emergency Departments	Yes	Yes	195	100%	Awaiting publication of results
Case Mix Programme (CMP)	Yes	Yes	**Total** = 1409 **DPOW ITU** = 344 **DPOW HDU** = 636 **SGH HDU** = 429	100%	Project still underway
Elective Surgery - National PROMs Programme	Yes	Yes	277	Ongoing	Project still underway
Endocrine and Thyroid National Audit	Yes	Yes	61	Ongoing	Project still underway
Falls and Fragility Fractures Audit programme (FFFAP) National Hip Fracture Database (submitted for all)	Yes	Yes	545	100%	Awaiting National Report
Falls and Fragility Fractures Audit programme (FFFAP) Fracture Liaison Service Database	Yes	Yes	885	Ongoing	Awaiting publication of results
Falls and Fragility Fractures Audit programme (FFFAP) National Falls Audit	Yes	Yes	11	92%	Project still underway
Head and Neck Audit (HANA)	No	N/A	N/A	N/A	N/A
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Yes	Yes	340	100%	Project still underway
Major Trauma Audit	Yes	Yes	608	95%	Project still underway

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	Percentage of number required	Action planning
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	Yes	507	100%	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal morbidity & mortality confidential enquiries	Yes	Yes	42	100%	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiry	Yes	Yes	0 Maternal deaths	-	Yes
Mental Health - Care in Emergency Departments	Yes	Yes	194	100%	Awaiting publication of results
Mental Health Care Pathway - CYP Urgent & Emergency Mental Health Care and Intensive Community support	No	N/A	N/A	N/A	N/A
National Asthma and chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Yes	Yes	789	Ongoing	Project still underway
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	302	100%	Awaiting National Report
National Audit of Cardiac Rehabilitation (NACR)	Yes	Yes	732	Ongoing	Report writing/action planning
National Audit of Care at the End of Life (NACEL)	Yes	Yes	40	100%	Report writing/action planning
National Audit of Dementia (Care in general hospitals – Electronic record only)	No	N/A	N/A	N/A	N/A
National Audit of Pulmonary Hypertension (NAPH)	No	N/A	N/A	N/A	N/A
National Audit of Seizure Management in Hospitals (NASH3)	Yes	Yes	60	100%	Awaiting National Report
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Yes	71 (Cohort 1)	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	**Total** = 109 **DPOW** = 63 **SGH** = 46	Ongoing	Project still underway

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	Percentage of number required	Action planning
National Cardiac Audit Programme (NCAP) – Heart Failure	Yes	Yes	590	Ongoing	Project still underway
National Cardiac Audit Programme (NCAP) – MINAP	Yes	Yes	262	Ongoing	Project still underway
National Cardiac Audit Programme (NCAP) – Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	380	Ongoing	Project still underway
National Cardiac Audit Programme (NCAP) – Cardiac Rhythm Management	Yes	Yes	507	Ongoing	Project still underway
National Cardiac Audit Programme (NCAP) – Adult Cardiac Surgery	No	N/A	N/A	N/A	N/A
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 Diabetes Audit – Core Audit	Yes	Yes	1274	100%	Awaiting Publication of Results
National Diabetes Audit – Inpatient Audit	Yes	Yes	109	100%	Awaiting Publication of Results
National Diabetes Audit – Inpatient HARMS	Yes	Yes	6	Ongoing	Project still underway
National Diabetes Audit – Foot Care	Yes	Yes	192	Ongoing	Project still underway
National Pregnancy in Diabetes (NPID) Audit	Yes	Yes	25	100%	Awaiting Publication of Results
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	92	Ongoing	Project still underway
National Emergency Laparotomy Audit (NELA)	Yes	Yes	245	98%	Awaiting Publication of Results
National Gastro-intestinal Cancer Programme Bowel Cancer (NBOCAP)	Yes	Yes	294	99%	Actions to be Agreed
National Gastro-intestinal Cancer Programme Oesophago-gastric cancer (NOGCA)	Yes	Yes	110	99%	Actions to be agreed

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	Percentage of number required	Action planning
National Joint Registry (NJR)	Yes	Yes	721 **DPOW** = 341/345 **Goole** = 271/287 **SGH** = 109/136	94%	Awaiting Publication of Results
National Lung Cancer Audit (NLCA)	Yes	Yes	400	100%	Project still underway
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	3958 (Births between 01/04/17 – 31/03/18)	100%	Yes
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	573	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	Data collection underway	Data collection underway	Data collection underway
National Prostate Cancer Audit	Yes	Yes	326	100%	Actions to be agreed
National Smoking Cessation Audit	Yes	Yes	207	100%	Action Plan Monitoring
National Vascular Registry	No	N/A	N/A	N/A	N/A
Neurosurgical National Audit Programme	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	**Total** = 20/29 **DPOW** = 6/12 **SGH** = 14/17	Ongoing	Project still underway
Prescribing Observatory for Mental Health (POMH-UK)	No	N/A	N/A	N/A	N/A
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	532	Ongoing	Project still underway
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes	Yes	51	Ongoing	Project still underway
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Yes	128	100%	Awaiting Publication of Results
Surgical Site Infection Surveillance Service	Yes	Yes	878	100%	Yes

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	Percentage of number required	Action planning
UK Cystic Fibrosis Registry	No	N/A	N/A	N/A	N/A
UK Parkinson's Audit PREMS	Yes	Yes	42	100%	Actions to be agreed
UK Parkinson's Medicine	Yes	Yes	24	100%	
UK Parkinson's Physio and OT	Yes	Yes	14	100%	
UK Parkinson's SLT	Yes	Yes	10	100%	
Sentinel Stroke National Audit Programme (SSNAP) Early Supported Discharge Data	Yes	Yes	Jan – June = 73 Jul – Dec figures not yet published	100%	Awaiting Publication of Results

National confidential enquires 2019/20

Confidential enquiry	Eligible for NLAG	NLAG participated	Organisational Questionnaires	Number of cases submitted	Percentage of number required	Action planning
Out of Hospital Cardiac Arrest	Yes	Yes	2	11	100%	Awaiting publication – due Summer 2020
Dysphagia	Yes	Yes	1	4	100%	Awaiting publication – due Winter 2020
Acute Bowel Obstruction	Yes	Yes	2	11	100%	Partial compliance achieved
Long-term Ventilation	Yes	Yes	1	3	100%	Gap analysis lead assigned
Total:	**4**	**4**				
Eligible for NLAG participation:	**4**					

The reports of national clinical audits were reviewed by the provider in 2019/20 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/families – Summary of some actions taken:

- National Paediatric Diabetes Audit:
  - Booklets/posters will be developed to remind patients of the importance of attending for retinal screening. Verbal reminders will also be given at clinic appointments.

    - All patients to be reviewed at the annual review clinic to allow the dietician to provide information on snacks and healthy eating in families.
    - Families will be advised to download blood glucose meters for weekly use / continuous glucose monitoring.
- National Pregnancy in Diabetes Audit: Media article to be released to reach out to high risk women in the local area regarding the management of diabetes in pregnancy.
- National Neonatal Audit Programme: Multi-disciplinary team to encourage mothers to express breastmilk early after the birth of the baby.
- MBRRACE Saving Lives, Improving Mother's Care: Information to be added to website giving brief advice to women regarding symptoms to be aware of.
- UK Parkinson's Audit: An information pack to be given out to all patients signposting to Parkinsons UK website for more information.
- COPD Audit: COPD poster created for all wards to encourage referral to Respiratory nurse specialists.
- National Bowel Cancer Audit: Undertake promotional activities with the public to promote the bowel cancer screening programme, as well as publicising it to General Practitioners.

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

- National Paediatric Diabetes Audit: Booklets/posters will be developed to remind patients of the importance of attending for retinal screening.
- National Pregnancy in Diabetes Audit: Results to be discussed with GPs and practice nurses to raise awareness and actions required to meet pre-conception care standards.
- National End of Life Audit: Review of end of life training for medical staff and consider if any should be mandatory linking in with ReSPECT document training. Specifically covering: earlier recognition, hydration and nutrition conversations and ceiling of care conversations.
- MBRRACE Saving Lives, Improving Mother's Care:
    - Ensure all relevant staff is aware of the need for consultant review where women attend with suspected placenta accreta.
    - Raise awareness amongst all staff groups that malignancy diagnosed within six months of becoming pregnant is an independent risk factor for VTE and links to Royal College of Obstetricians and Gynaecologists (RCOG) guidance.
- National Dementia Audit: Update dementia training (tier 2 training) to include longer session on delirium.
- SSNAP: Stroke masterclass all day training delivered by stroke lead.
- Falls and Fragility Fractures Audit Programme (FFFAP) National Hip Fracture Database: Anti-coagulation guidelines have been agreed and are in place.
- National Hip Fracture Database (NHFD) 30 Day Mortality:
    - Ongoing monitoring and presentation of performance, best practice tariff compliance, mortality data at the monthly fracture neck of femur business meetings.
    - Fluid balance documentation featured as part of the 15-steps ward accreditation programme and is included as part of the Clinical Sisters education role.
- ICNARC Case Mix Programme:
    - Trust wide guidance for the use of high flow oxygen facilities has been agreed.
    - The Outreach service has combined with the hospital at night service to provide a 24/7 service of skilled staff. Hospital at night staff is working towards a set of core competencies.

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

- National Lung Cancer Audit: Deep dive audit underway to review care pathway for patients not having a pathological diagnosis being made.
- National Audit of Dementia: Local review of delirium screening to be undertaken following implementation of new pathway.
- National Paediatric Diabetes Audit: Questionnaires to be distributed to patients/parents during their waiting time at clinics to allow patient feedback.
- Sentinel Stroke National Audit Programme: Local snapshot review of patients with a long length of stay to be undertaken to identify reasons.
- MBRRACE Saving Lives, Improving Mother's Care: Follow up audit to be undertaken to assess if thromboembolism risk assessment was performed and whether the calculated risk score was correct.
- Elective Surgery National Patient Reported Outcome Measures (PROMS) Programme: A deep dive review of PROMs data undertaken to investigate performance outside the 95% control limits for knee replacement patient reported outcomes.
- NBCA 18 Month Stoma Outlier Alert: The Trust will commission an external review of the service related to stoma formation and reviews.

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

- TARN Audit: CT Capacity increased which will aid compliance with Trauma Audit Research Network (TARN) standards.
- National Lung Cancer Audit: Functionality of Multi-Disciplinary Team (MDT) to be reviewed with the aim of the implementation of single cross site MDT.
- National Heart Failure Audit:
    - One stop clinics and infusion service commenced;
    - Consultant of the week commenced for cardiology, including registrar of the day;
    - Specialist follow up clinics set up – Consultant and Nurse led;
    - Specialist device clinics set up;
    - Heart Failure checklist sticker introduced for use in patient notes to ensure all required aspects of care are given.
- BTS Smoking Cessation: Making every contact count document created to screen for smoking and encourage referral to smoking cessation service.
- SSNAP: Early Supported Discharge guidelines to be amended.
- National Paediatric Diabetes Audit: Use of High HbA1c contract / clinic / early help assessments to be introduced to support patients who require better control.
- National Neonatal Audit Programme:
    - Care bundle to be developed and made available to maternity and neonatal staff for promoting normal temperature after delivery;
    - Sticker to be developed and rolled out for use in maternity services to record when mothers have received dose of antenatal steroids and magnesium sulphate;
    - Retinopathy of Prematurity (ROP) 'screen window' sticker to be developed to be placed on the front of the baby record to inform staff when ROP screening is due.
- National Audit of Care at the End of Life: Consider ways to offer 7 day advice at SGH Palliative Care Services. Roll out pilot of community team offering phone advice.
- MBRRACE Saving Lives, Improving Mother's Care:
    - Adopt the use of the care bundle for suspected placenta accreta when indicated.
    - VTE Assessment form to be re-introduced within gynaecology services to ensure VTE risk is undertaken after miscarriage or ectopic pregnancy to consider if thromboprophylaxis is required.
    - To implement a guideline outlining the correct practice for women presenting with known cardiac issues or symptoms suggesting a potential cardiac problem.

- MBRRACE Mortality Report:
    - PReCePT project to be funded by the LMS for introduction across the trust and to include the following action points:
        - Sticker introduced to act as a prompt/checklist for antenatal steroids/magnesium sulphate to be given for threatened pre-term deliveries
        - All staff to be trained on ensuring steroids & magnesium sulphate are given
    - Better Births initiative will be implemented with funding from the LMS along with introduction of Better Births Teams.
- National Bowel Cancer Audit: The Stratified Pathway Stomas Nurses visit primary care to review patients for potential stoma reversals.
- Falls and Fragility Fractures Audit Programme (FFFAP) National Hip Fracture Database:
    - Prioritisation of fractured neck of femur cases on the trauma lists and the addition of a Saturday list to ensure prompt theatre access.
    - A Best Practice Tariff (BPT) document has been implemented which indicates whether each aspect of the BPT has been achieved.
    - Fractured Neck of Femur Pathway booklet to be implemented which will incorporate all of the documentation from the time of admission to discharge.
- NHFD 30 Day Mortality: Seven day access to Therapy Services is now being provided to enable the patient to be seen the day of or the day after surgery.
- NBCA 18 Month Stoma Outlier Alert: The Stratified Pathway protocol has been implemented and is now embedded for all new patients.
- ICNARC Case Mix Programme: The Outreach Team at SGH put forward a business case for a high flow oxygen facility in designated wards to limit the ICU admissions for level 2 patients. This has now commenced within designated wards.

The reports of local clinical audits were reviewed by the provider in 2019/20 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 to ensure women receive the required information for pre/post-natal care.
- External Cephalic Version (ECV): Video to be produced for pregnant women to inform them of how the ECV procedure is undertaken (including a patient demonstration) and to provide information on the risks and benefits of ECV. Video to be made available on the LMS and NLAG websites.
- Colposcopy: Informative video to be produced and available to patients who are planning on attending for a colposcopy procedure.

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

- Seven Day Services: Raise awareness amongst clinical staff of the importance of accurately recording if the consultant is present during ward rounds.
- Neonatal TPN: Training to be undertaken on the use of the new TPN bags to ensure relevant neonatal staff members are aware how to use them appropriately.
- Maternity Documentation Audit: Raise awareness amongst staff regarding the importance of women who book after 12 weeks of pregnancy to have a dating scan within 2 weeks of booking.
- Community Record Keeping: Nursing and Therapy staff to be made aware of the availability of the ‘Care Summary Record’ on SystmOne to view the patient’s details.

- Deep Dive Review of Major PPH:
    - MatNeo – Multidisciplinary national quality improvement project to commence to allow PROMPT training to be rolled out to all multidisciplinary staff in Maternity Services.
    - Lesson of the week to detail / discussion to take place with clinical staff at ward rounds, huddles stating that PPH proforma should be used when triggered.
- Perineal Trauma Review:
    - OASI care bundle training to be provided to midwives and doctors to aid the identification of third and fourth degree tears.
    - Perineal Trauma Review: Education of the hands on approach will be delivered to midwifery staff.
- Paediatric Documentation Audit:
    - Documentation standards to be added and discussed as part of the induction programme into paediatrics.
    - Paediatric Documentation Audit: Competency training to be provided to both unregistered and registered nursing staff on measuring head circumference.
- NICU Documentation Audit: BADGER system training to be added to the formal induction programme.
- PEWS:
    - Ward Assurance Tool to be completed with feedback to staff on a weekly basis and via the learning lesson handover folder.
    - Discussion of standards at safety huddles to be discussed with nurses/doctors. Also raise awareness of the requirement to document in the medical records where a child refuses to have their blood pressure recorded.
- Gynaecology Swab Check: Swab count training to be included on Doctor's induction to raise awareness of the guidelines relating to colposcopy and hysteroscopy procedures.
- Safe and Secure Audit: Review of processes on the wards/areas to ensure that staff is aware of the Trust policy and procedures relating to medication management.
- Fresh Eyes CTG: Learning lessons newsletter featuring fresh eyes changes to be sent out and displayed in clinical areas.
- Maternity Swab Check Audit: All new doctors starting in the department to be shown the training video on how to complete swab counts and documentation requirements
- Five Steps to Safer Surgery: All new doctors starting in the department to be shown the training video on how to complete the five steps to safer surgery requirements.
- Procedural Sedation in Emergency Department (ED): Checklist fully implemented in both emergency departments.
- COPD patients in ED: Introduced VBG Poster as a guidance on how to screen COPD patients for Acidosis
- S&CC Documentation Audit: The Hospital Liaison Manager for the Medical Defence Union attended the General Surgery Audit Meeting to raise awareness of the issues pertaining to documentation.

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

- Paediatric Early Warning Scores policy updated stating any child with abnormal vital signs (PEWS score 1 or more) will have a blood glucose reading taken.
- Seven Day Services:
    - Formal protocol / Service Level Agreements to be developed detailing arrangements for the provision of out of hours / weekend:
        - Echocardiograph
        - Interventional Radiology
        - Cardiac Pacing

    - WebV handover system to be amended to include a method of recording delegation of consultant reviews.
- Deep Dive Review of Major PPH: Major PPH cases to be discussed as part of the caesarean section review meeting using a merged form.
- Perineal Trauma Review: Introduce the use of epi-scissors to help the prevention of third/fourth degree tears at time of vaginal delivery.
- Perineal Trauma Review: Introduce the OASI bundle into practice to aid the identification and management of third/fourth degree tears.
- Paediatric Documentation Audit: Documentation of weight and height centiles and head circumference to be measured and recorded on admission by nursing staff.
- NICU Documentation Audit: To reduce duplication BADGER system will be utilised to record admission information by clinical / nursing staff rather than the collaborative document. Changes to the collaborative document to be made to mirror BADGER.
- Audit of the use of the new document for babies requiring Enhanced Midwifery and/or Transitional Care: Babies who require additional care to be cared for on the postnatal ward by Midwifery and/or Neonatal Staff rather than admission to NICU/SCBU.
- Safe and Secure Audit: Stanley monitoring system to be rolled out to all the Medication fridges across the Trust so remote monitoring can take place.

2.2c Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Northern Lincolnshire and Goole NHS Foundation Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee 1,035.

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

A proportion of Northern Lincolnshire & Goole NHS Foundation Trust's income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between Northern Lincolnshire & Goole NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2019/20 and for the following 12-month period are available electronically at:

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

The areas of care which were included within the CQUIN scheme for 2019/20 included the following:-

- Antimicrobial Resistance – Lower Urinary Tract Infections in Older People
- Antimicrobial Resistance – Antibiotic Prophylaxis in Colorectal Surgery
- Staff Flu Vaccinations
- Alcohol and Tobacco – Screening
- Alcohol and Tobacco – Tobacco Brief Advice
- Alcohol and Tobacco – Alcohol Brief Advice
- Three high impact actions to prevent Hospital Falls
- Same Day Emergency Care (SDEC) – Pulmonary Embolus

- Same Day Emergency Care (SDEC) – Tachycardia with Atrial Fibrillation
- Same Day Emergency Care (SDEC) – Community Acquired Pneumonia
- Medicines Optimisation & Stewardship
- Armed Forces Covenant

The amount of income in 2019/20 which was conditional upon achieving quality improvement and innovation goals was £3.532 million.

The monetary total value for 2018/19 CQUIN indicators was £6.872 million. The Trust received payment for £5.836 million during 2018/19.

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

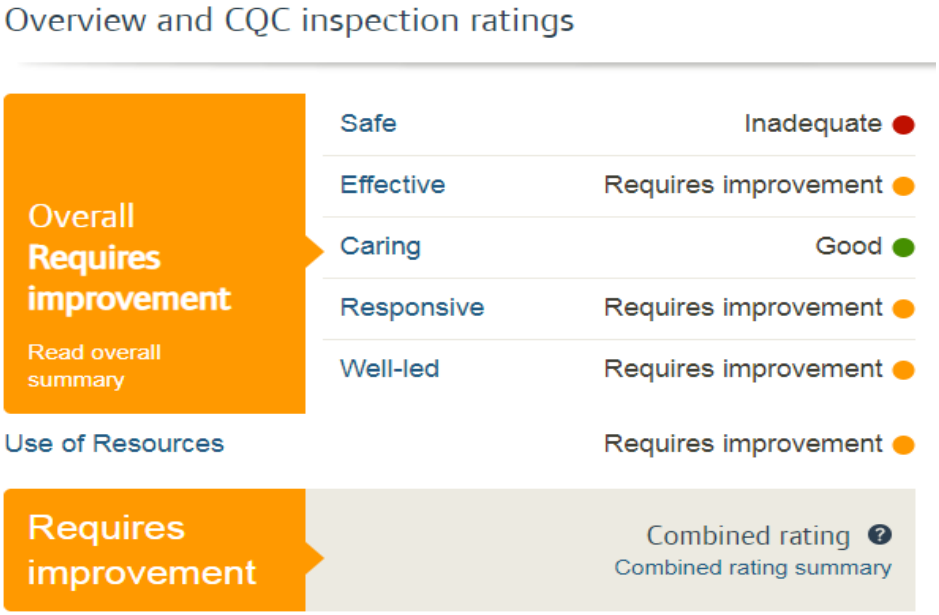
Northern Lincolnshire and Goole NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

The Care Quality Commission has not taken enforcement action against the Trust during 2019/20.

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 latest Care Quality Commission (CQC) visit resulted in the Trusts' overall rating remaining as 'requires improvement'. The Trust was disappointed to see that the rating for Safe had deteriorated to inadequate.

The CQC visit during September and October 2019 identified and recognised many positive changes since their previous visit. Significant progress has been made as part of the Trust's improvement journey.

The CQC report identified specific areas where additional focus is required; a particular concern was raised about the safety of patients subject to long waits. Improvement to waiting lists has been a focus throughout 2019/20 and will continue to be so; featuring the in the quality priorities. Other CQC themes for improvement are included within the Trust's focus on delivery of its quality priorities during 2020/21.

The following section provides, in summary form, the Trust's improvement plans for 2020/21 to support the next phase of improvement work.

Improvement areas of focus during 2020/21:

- Emergency Care Centre:
    - Improved governance and use of information in understanding performance,
    - Ongoing up-skilling of adult registered nurses with paediatric competencies,
    - Adapted ECC paperwork to ensure prompt oxygen to be prescribed appropriately.
- End of Life care:
    - Continued embedding of progress already made in connection with the learning from incident themes and complaints;
    - Continued review of the risk register and those risks linked to end of life care;
    - Improvement actions from baseline audits already completed looking at the quality of end of life care;
    - The Trust recognises that high quality end of life care to be achieved requires health care system wide involvement and is wider than just the Trust. NHS England / Improvement have agreed that a Patient Safety Group meeting will be specifically looking at the provision of EOL care both within the Trust and also across the system.
- Mandatory training and appraisals to include strengthening of divisional arrangements to actively manage mandatory training for clinical staff recognising the challenges in them being released to attend training.
- Complaints process improvements across the Trust and within divisions to better enable effective responsiveness to patients and shared learning from complaints and other feedback received.
- Continued focus on improvements in waiting times in cancer care and with regards to waiting lists and diagnostic reporting.

Progress made already:

- Cancer care:
    - The Trust has implemented a faster diagnosis process in urology and respiratory cancer improving the access and delivery of care in these specialties. The Trust has also now implemented a single cancer Multi-disciplinary Team (MDT) meeting for lung cancer patients. This has led to an improved treatment journey for patients, reducing the duplication of tests and an improvement in referrals to the cancer centre.

- Implementation of faster access to diagnostics in colorectal cancer has commenced with the expectation that during the first quarter of 2020 this will be fully implemented. Work has commenced on a '100 day challenge' considering the route of access for non-specific weight loss. This will provide a shorter diagnostic and access time to colorectal services and reduce the significant number of poor quality referrals into the 2 week wait colorectal service. The Trust is developing the current dual MDT for colorectal into a single MDT by the end of April 2020.

- Waiting lists:
  - Improving the Trust's waiting list position and, in turn, minimising the risk of harm to patients has remained a priority for the Trust and the Trust Board since the 2018 inspection and the Trust is continuing to make progress against all waiting list metrics with significant reductions from 2018 to February 2020; in particular:
    - Patients waiting 52 weeks have reduced from 320 (March 2018) to 4 (February 2020);
    - Patients waiting 40 or more weeks have reduced from 1,503 to 336;
    - Performance with referral to treatment timescales has improved from 66% to 77%;
    - All of these improvements have led to the overall waiting list reducing.
  - Whilst the Trust has demonstrated a systematic approach to mitigating the risks associated with the waiting list position which has resulted in significant improvements, the Trust acknowledges that there is still much more to do, hence the continuing focus on this during 2020/21.

- Diagnostic and Radiology reporting:
  - During 2019/20, the Trust has focussed on improving waiting times linked to diagnostic reporting. This has now been achieved through a variety of improvements including robust arrangements to outsource activity when indicated by time-based triggers, dedicated capacity to effectively oversee monitoring and escalation processes and improved management and oversight of those patients waiting.
  - The Trust has successfully recruited two additional Radiologists, the first has already commenced on an initial 6 month contract with a view to this being extended. A second has accepted a 2 year position and will be joining as soon as overseas' arrangements are made. The Trust has also been successful in securing four Radiologists as part of the Global Fellows' Program and who are due to join the Trust in July 2020 following their induction onto the programme.
  - In order to maximise capacity the Trust has expanded the remit of the reporting radiographer team. This has the benefit of providing additional plain film reporting sessions which enables a release of Radiologist time to support more complex work.

2.2f Information on quality of data

Northern Lincolnshire and Goole NHS Foundation Trust submitted records during 2019/20 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

2019/20 saw the release of the updated 'Beta' Data Security and Protection Toolkit by NHS Digital. This version has seen additional assertions which are heavily weighted towards IT security and Cyber Security functionality. NHS Digital will be allowing the Trust to submit improvement plans against assertions which we are not yet achieving standard met. For the March submission the Trust will be planning to submit a 'Standards not Met (Action Plan Approved)' return. As previously for the 18/19 return the intention is that 'Improvement plans' will be approved by NHS Digital and will be closely monitored by the Trust IG Steering group and NHS Digital to ensure actions are met.

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 2019/20 1,482 of Northern Lincolnshire & Goole NHS Foundation Trust's patients died (this includes patients who died in the Emergency Care Centre). This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 203 in the first quarter;
- 417 in the second quarter;
- 368 in the third quarter;
- 494 in the fourth quarter *[as at the 28 February 2020]*.

At 28 February 2020, 429 case record reviews and 9 investigations (5 undertaken as Serious Incident (SI) investigations; 3 undertaken as Child Death Overview Panels (CDOP) and 1 undertaken as a LEDER (Learning Disability Mortality Review)) have been carried out in relation to 1,482 of the deaths included above.

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

- 66 in the first quarter;
- 151 in the second quarter;
- 161 in the third quarter;
- 107 in the fourth quarter *[as at the 28 February 2020]*

7 representing 0.47% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient *[definition: using Royal College of Physicians (RCP) question: "Avoidability of death judgement score" for patients with a score of 3 or less – see narrative below for more information]*.

In relation to each quarter, this consisted of:

1 representing 0.49% for the first quarter;
1 representing 0.24% for the second quarter;
3 representing 0.82% for the third quarter;
2 representing 0.40% for the fourth quarter.

These numbers have been estimated using the Structured Judgement Review (SJR) which includes a 6 factor Likert scale ranging from "definitely not avoidable" to "definitely avoidable". The above estimate includes all those deaths that were classified as scoring less than or equal to 3 on this 6 factor scale. This assessment is the initial reviewer's assessment from the retrospective assessment of the medical record. Any case reviews completed that identify that further understanding is needed 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 improve quality of care.

7 representing 0.47% of the patient deaths during the reporting period were recorded as a score of 3 meaning "probably avoidable, more than 50-50". All 7 cases were escalated for consideration at the Trust's internal Serious Incident Panel for detailed review. Following presentation at this meeting, 6 did not meet the criteria for being declared as a Serious Incident as there was no evidence of moderate or severe harm resulting from their care within the Trust. In 1 case, the criteria for Serious Incident investigation was met and this is currently subject to a more detailed investigation.

Summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified during 2019/20;

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 2019/20

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 have been identified:

- **End of Life:** One of the biggest themes identified from the learning from deaths reviews has been in relation to potentially avoidable hospital admissions for some

patients at end of life phase of care, where acute hospital admission may not be the best place of care.

- This theme is tested out with community and primary care colleagues who review pathways in community to identify if opportunities for further advanced end of life care planning were potentially missed. This review work has led to the development of a specific out of hospital mortality improvement plan with wide stakeholder involvement.

- In addition to the out of hospital mortality improvement plan, the Trust is also focussing more improvement work on end of life care with business case developments to increase consultant-led palliative care services as well as to improve the documentation and tools available to staff to enable better end of life planning. The Trust is also aiming to launch the RESPECT tool during the early part of 2020/21. RESPECT (Recommended Summary Plan for Emergency Care and Treatment) is a national initiative designed to capture the outcomes following discussion between Health Care Professionals and the patient including resuscitation status. The RESPECT tool then acts as a record communicating recommendations to inform future treatment planning decisions. The Trust is aiming to support the rollout with dedicated training posts to support education for how to make best use of the tool to identify and communicate end of life decisions to all involved or who could be involved in the patients care, including ambulance services.

- Other improvements planned in provision of end of life services include:

    - Look at expansion of Health Care Professionals providing services to cover seven days.

    - Review and benchmarking of service provision against latest National Institute for Health and Care Excellence (NICE) guidance.

    - Regular oversight and review of patient feedback and incident data at team meetings to improve services.

- **Fluid & Electrolytes:** Monitoring and documentation surrounding the use of fluids has been a theme for improvement. During 2019/20 additional work has been invested into changing the documentation to record this information and to act as a prompt for nursing staff to support improved recording. This is also a part of the Nutrition and Hydration improvement group's work which has given a regular update to the Trust's Quality & Safety Committee.

- **Delays:** Delays remain a theme from mortality reviews, often linked to periods of increased demand on Trust services. Whilst this remains a challenge, some good progress has been made in speeding up access to Theatres for vulnerable and frail elderly patients who have broken their hip and require emergency access.

- **Learning from deaths:** Since 2018/19, the Trust has strengthened its mortality review process to support a focus on learning from mortality case reviews, the only way of assessing and quantifying the quality of care provided to patients. An element of this has been the aim of increasing the number of case reviews being undertaken to achieve a minimum 20% of deaths being reviewed.

- In 2018/19, the Trust achieved a review rate of 27.76%, and is currently performing at a review rate of 33% in 2019/20 [as at 28 February 2020].

- The Trust has commenced the use of a mortality screening tool enabling an increased proportion of deaths to be reviewed as well as for more targeted focussed work validating clinical coding.

An assessment of the impact of the actions taken by the Trust during 2019/20:

There has been some positive impact as a result of the actions taken already by the Trust. These are summarised as follows:

- **End of Life:** Whilst there is much more focussed work required by the local healthcare system to improve this area further, there has been improved collaborative review work with the Trust's primary Clinical Commissioning Groups (CCGs) with GP representation to identify specific gaps in current service provision and further opportunities possible. The out of hospital mortality improvement plan will detail specific interventions that will address some of these gaps. There have been a number of specific actions taken to improve care across organisational boundaries including more support to care/residential homes from the Trust and Primary care to improve processes in place. The Trust is also working with wider stakeholders in the local multi-agency end of life group to further improve local services which includes a review of learning from incidents.

- **Fluid & Electrolytes:** Progress has been made with this series of actions and this as a theme in mortality reviews has reduced significantly.

- **Delays:** Pathway redesign has led to significant improvements and the Trust is on a par if not exceeding national performance against this as measured in the National Hip Fracture Database. This has resulted in tangible outcome improvements as a result and the reported mortality associated with hip fracture in the elderly has reduced.

- **Learning from Deaths:** Significant progress has been seen in the strengthening of processes to review, discuss and learn from mortality reviews.

134 case record reviews were completed and 2 investigations (undertaken either as a Serious Incident Investigation or Concise SI investigation) completed after 01 April 2019 which related to deaths which took place before the start of the reporting period.

3 representing 0.17% of the patient deaths before the reporting period [1,771 deaths during 01 April 2018 – 31 March 2019], are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Structured Judgement Review (SJR) which includes a 6-factor Likert scale ranging from definitely not avoidable to definitely avoidable. The above estimate includes all those deaths that were classified as scoring less than or equal to 3 on this 6 factor scale. This assessment is the initial reviewer's assessment from the retrospective assessment of the medical record. Any case reviews completed that identify that further understanding is needed is reviewed a second time by another clinician. This process links into the Trust's Serious Incident Framework if necessary. It should be stressed that this data is not a reliable measure of deaths that were avoidable; rather it is designed as an indicator to support local review and learning processes with the aim of helping improve quality of care.

5 representing 0.29% of the patient deaths during the previous reporting period [01 April 2018 – 31 March 2019] 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 and is featured as part of the Pride and Respect training sessions provided to all staff. The Trust has appointed a substantive guardian to focus further on this important role and continue the positive progress made.

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. There has been improvement in the accessibility to the Freedom to Speak Up Guardian via a generic email address and the introduction of the 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 regularly with the Trust Chair and also with the Executive Director and Non-Executive Director with specific responsibility for Freedom to Speak Up who provide 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.

In January 2020 an internal audit review of the Trust's Freedom to Speak Up arrangements reported an outcome of 'significant assurance' in respect of the effectiveness of the systems in place to enable staff to raise concerns and was impressed with the work undertaken in 2019 to develop and enhance the Trust's FTSUG arrangements.

During 2019/20 there has been >30% increase in concerns raised over the past 12 months indicating an improvement in the reporting of concerns' culture.

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 January 2020 showed a vacancy rate of 10.95%, compared with 27% in 2017. For trainees, the latest data available is for August 2019, this demonstrated a fill rate of 88% compared to 67% in 2017.

Workforce and Recruitment meetings take place regularly with Medical Staffing and the groups to identify and plan for vacancies. Vacancies are advertised and active steps taken to follow up any interest in the area. Whilst the medical vacancy rate has reduced during 2019/20 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.

2.3 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;

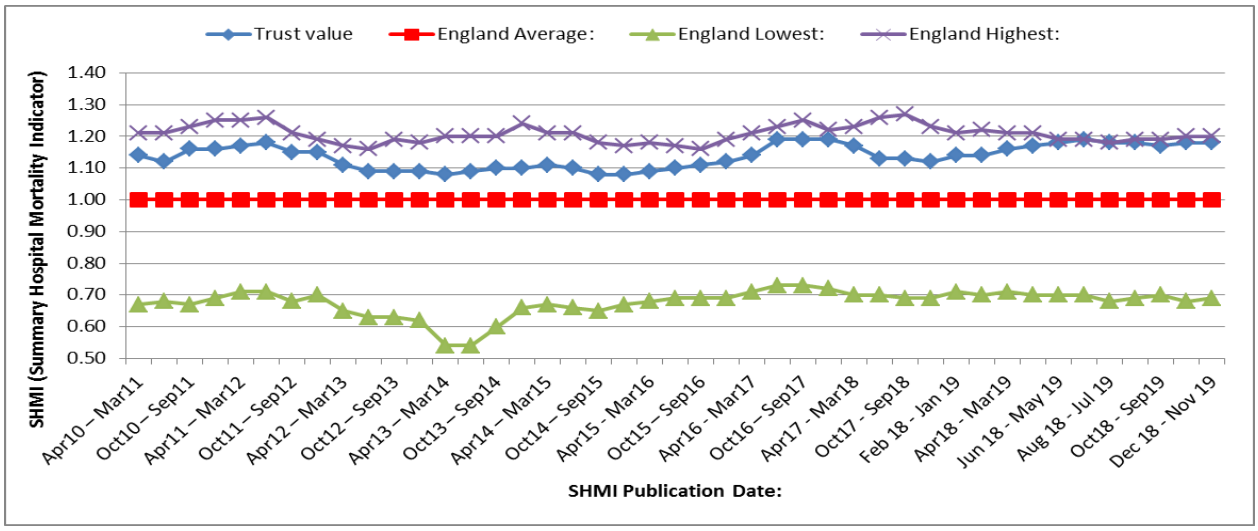


Figure 11: Trust's SHMI score, trended over time

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 outside of hospital in the community (within 30 days of hospital discharge). This inclusion of community mortality means the information needed comes from the Office for National Statistics; this results in delay in the reporting of the SHMI. The Trust is currently within the 'higher than expected' range.

- The SHMI, as referred to in section 2.1 of this report, is a measure of observed deaths, within 30 days following hospitalisation, compared with 'expected deaths', derived statistically from the quality of recording and coding of patient risk factors. SHMI impacting risk factors include the patient's primary diagnosis being treated for during their first episode following admission and any secondary diagnoses or comorbidities the patient already has or that is newly identified as having. SHMI is therefore heavily influenced by data quality.

- 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 and a 'higher than expected' SHMI should not be interpreted as an indicator of bad performance.

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

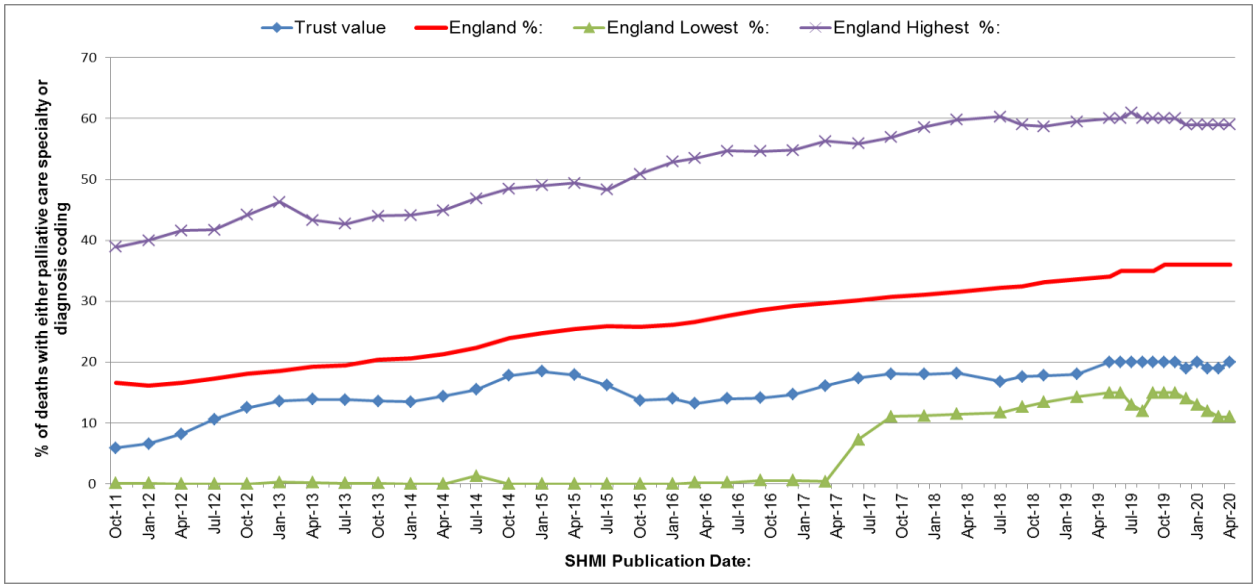


Figure 12: Percentage of patients with a coded palliative care code, compared with other UK Trusts

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

- The SHMI does **not** exclude this group of patients, rather they are included and the appropriate risk factor for each is statistically determined according to the model. Other Standardised Mortality Ratios (SMRs) like the Hospital Standardised Mortality Ratio (HSMR) do actively adjust for palliative care.

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

- During 2019/20 the Trust reviewed its reporting of mortality statistics and made a deliberate change to enable better understanding of the component parts of the SHMI calculation. This in turn highlighted a disparity between the Trust's two main hospitals in the 'expected deaths' statistical construct, which forms the denominator in the calculation of SHMI, whilst the observed deaths showed no significant difference. This has continued to highlight that the number of 'expected deaths' is lower at the Diana, Princess of Wales Hospital. Given the public health challenges in North East Lincolnshire, the lower number of 'expected deaths' informing the SHMI has been identified as requiring further scrutiny of the underpinning data.

- The palliative care level information reflects the differences between the two main hospital sites in provision of consultant led palliative care services. Improvement work within the Trust's End of Life group aims to identify resource to increase the availability and provision of palliative care arrangements at both of the Trust's main hospital sites.

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

- The Trust's Mortality Improvement Group oversees reported mortality performance. On review of the disparity in 'expected deaths' more detailed work has been undertaken to understand potential drivers.

- One element is the accurate recording of risks. From further analysis and benchmarking, the Trust has identified a difference in the Trust's recording of risk factors compared with local peer organisations.

- The Mortality Improvement Group has therefore commissioned a programme of specific clinician-led validation to review and confirm or amend as necessary the quality of data recorded within the medical record that informs the SHMI calculation through accurate clinical coding. This has commenced on the Trust's acute medical admission wards, critical care units, including the high dependency unit, within cardiology and also for patients on the stroke unit. The impact of the clinician-led validation work will be monitored. During January 2020, early findings from the validation work identified that in 36% of cases clinicians identified additional comorbidities or clarified the primary diagnosis being treated. Following validation these changes were made to the hospital coding and will lead to changes in the SHMI risk adjustment.

- Given the time lag in reporting SHMI data, the Trust will be unable to fully evaluate the impact of this work until NHS Digital publishes data encompassing the period of time these changes in practice were implemented and further time will need to pass for the SHMI data (summarising 12 months of data) to fully reflect these changes.

- Whilst the Trust progresses a number of data quality improvements to support accuracy of data, quality of care remains a crucial part of the Trust's mortality improvement programme. This is articulated in the Trust's mortality strategy which includes prioritised quality impacting workstreams supporting (1) improved flow through the Trust's hospitals; (2) end of life improvements and; (3) continued focus on learning from deaths.

- To support the Trust's learning from deaths' process, the Mortality Improvement Group has approved a mortality screening tool that encompasses both a data quality validation tool as well as a quality of care review. This tool is designed to support an increase in the proportion of deaths reviewed in order to increase the identification of learning. The divisionally owned governance arrangements have also been improved during 2019/20 providing greater opportunity and protected time for clinical teams to review and reflect on the learning from mortality reviews. Progress and assurance of these processes in divisions is provided monthly to the Mortality Improvement Group.

- A key quality theme emerging from mortality reviews is the proportion of patients admitted from community at end of life stage where there is a lack of clarity regarding end of life plans. In a number of cases, hospital reviewers have judged admission to the acute hospital as potentially not being the most appropriate place of care for such patients who are at the end of their lives. This is being fed back to community and

primary care colleagues as learning and is reflected in the end of life improvement project work. For further details regarding the end of life improvement work, see the previous section described in 2.2 that updates further on learning from deaths.

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 – see note below)
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
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

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

Comment:

- The Patient Reported Outcome Measure (PROMs) is a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. The 4 areas

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

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

- The above 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 surgery remain within the statistically calculated confidence intervals, demonstrating no significantly different performance compared to the UK.

- Patient-reported outcomes for primary knee replacement is just outside of the 95% statistically calculated intervals and is therefore an outlier.

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.
- The latest data identified that for primary knee replacements; the Trust was outside of the 95% statistically calculated interval and was therefore an outlier. This data has been broken down further to the lowest format and from this the Trust have identified patient's reported outcomes around mobility have deteriorated since the previous PROMs data was released. This has been discussed with Trauma and Orthopaedic Surgeons who have identified areas of improvement and implemented change to address this.

- The deep-dive review of PROMs information also identified some weaknesses in process regarding the provision of pre-surgery PROMS data collection forms to patients which has impacted on a smaller cohort of patients being sampled within this year's dataset. Improvements in this process will also be included in the action plan in response to PROMs that will be developed.

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.

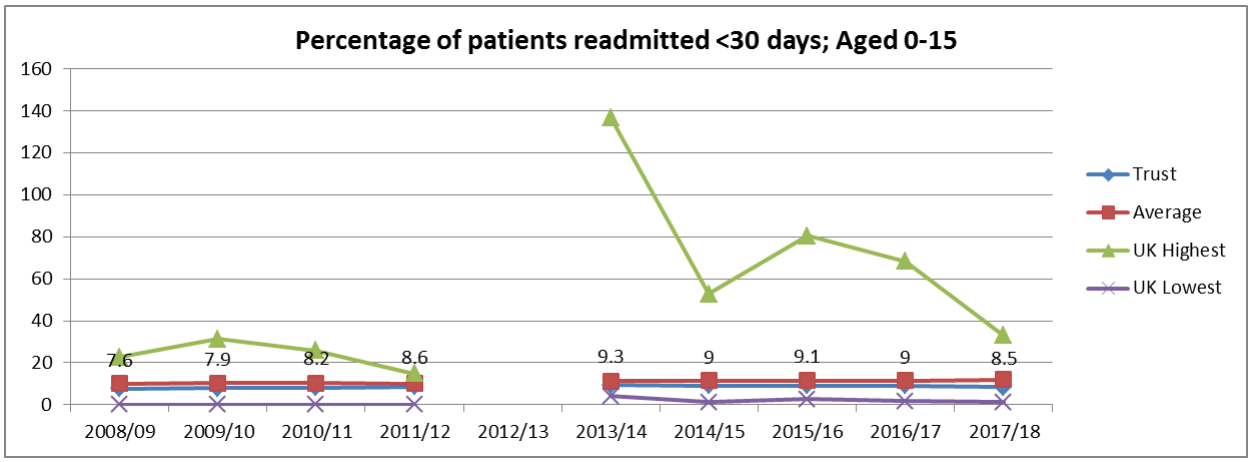


Figure 13: Chart demonstrating % of patients aged 0-15 readmitted within 30 days

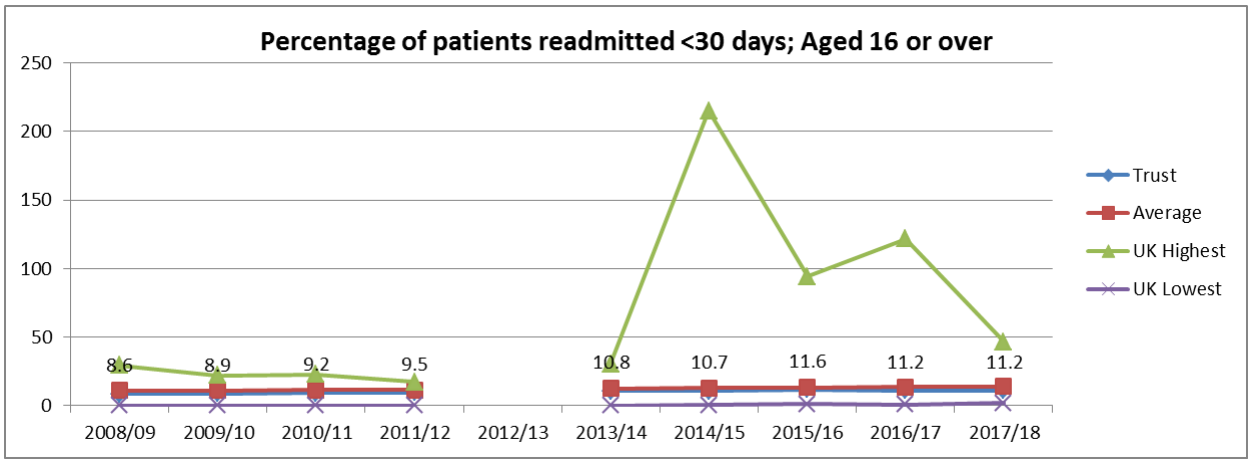


Figure 14: Chart demonstrating % of patients aged 16 or over readmitted within 30 days

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:

- There has been an ongoing review by NHS Digital of this indicator which has prevented the Trust from accessing latest data over the last two quality account reporting periods. The data has now been reviewed and was released again during 2019. 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.

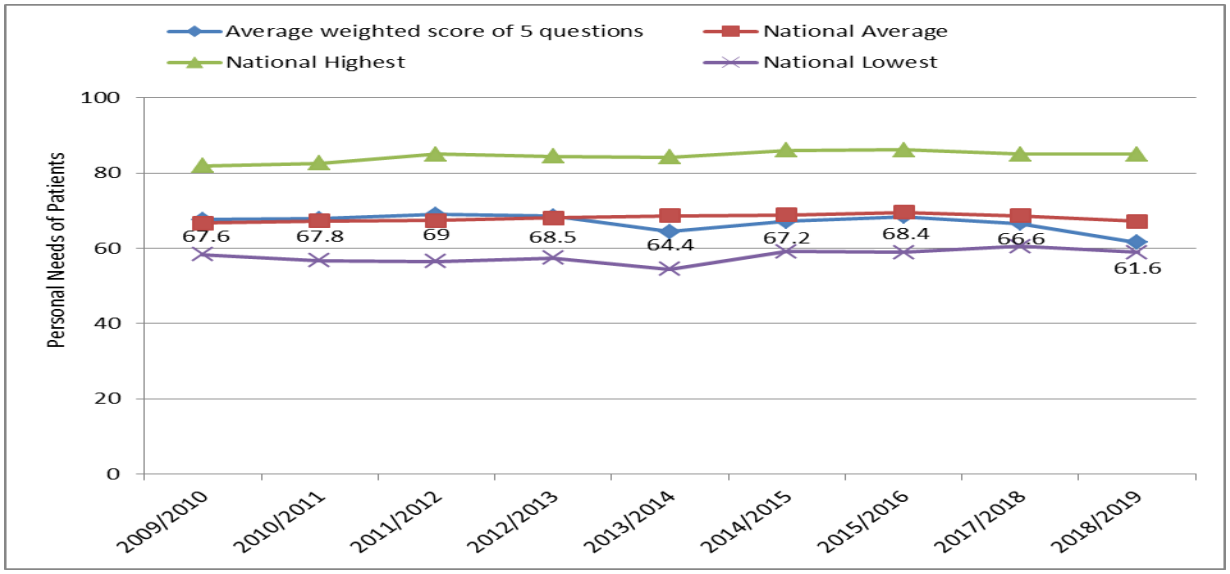


Figure 15: Trust performance with five weighted scores from the national inpatient survey used to determine the Trust's responsiveness to patient's receiving care in its acute services

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

Comment:

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

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

"*Responsiveness to patients' personal needs".*

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

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

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

- The Trust results are marginally lower than the national average but it remains committed to look at the specific areas highlighted in these responses to improve patient feedback.

- The experience of care is a high priority for the Trust and focus is being given to these results through divisional actions and quarterly oversight at the Patient Experience Group. This will be further supported by the launch of a rolling inpatient survey programme to provide near real time feedback. This will use key areas from the adult national inpatient survey to shape its questioning. This is a more responsive methodology to create improvements and encourage staff engagement in the process.

- Recruitment and retention of skilled and compassionate staff continues to be a key focus which will support a more stable work force to deliver consistent, safe and person centred care.

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 promote 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.

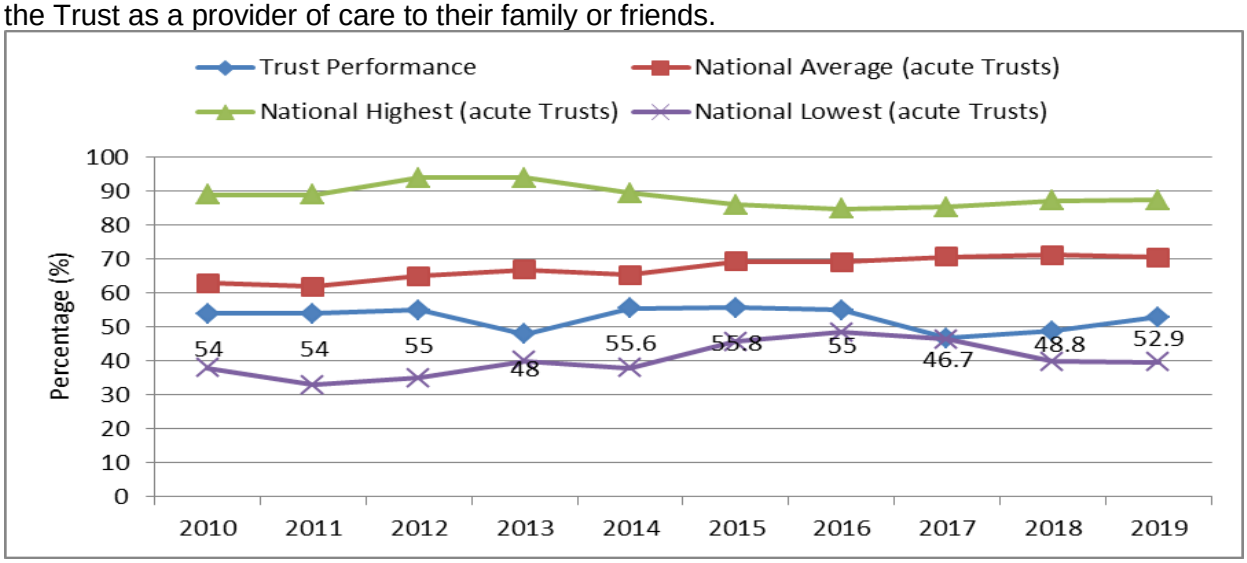


Figure 16: Trust reported performance for staff recommending the Trust as a provider to family and friends

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

Comment:

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

- 53% of staff surveyed would recommend the Trust, this is the second 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:

- The Trust continues to see improvements within the 2019 staff survey which, when reviewing the statistically significant improvements, builds a picture of staff who feel an improvement in staff numbers, feel more engaged, have better access to the equipment they need and have overall a better experience at work. Furthermore staff's overall perception regarding the quality of care provided by the Trust has significantly increased, with patients seen as the main Trust priority. These factors, amongst the other improvements seen in the national staff survey, are demonstrating staff are now increasingly recommending the Trust as place to receive treatment and/or to work.

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. The outputs of this work can be seen in the last two staff surveys. Actions already taken include:

    - A review of, and increase in, the nursing establishment numbers to bolster the number of staff on wards and in patient clinics;

    - Financial investment into procuring additional levels of equipment, such as patient hoists and ward-based mobile computers for wards;

    - The continued exploration of new roles, such as ACPs and Clinical Sisters, to support the development of services and staff's skills and competence, and provide career opportunities for staff;

    - The continued investment and success of the Trust's apprenticeship programme;

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

    - 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;

    - Investment into Quality Improvement (QI) with four QI trainers now supporting the training of clinical and non-clinical staff, and providing QI expertise into both Improving Together and non-Improving Together improvement projects;

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

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.

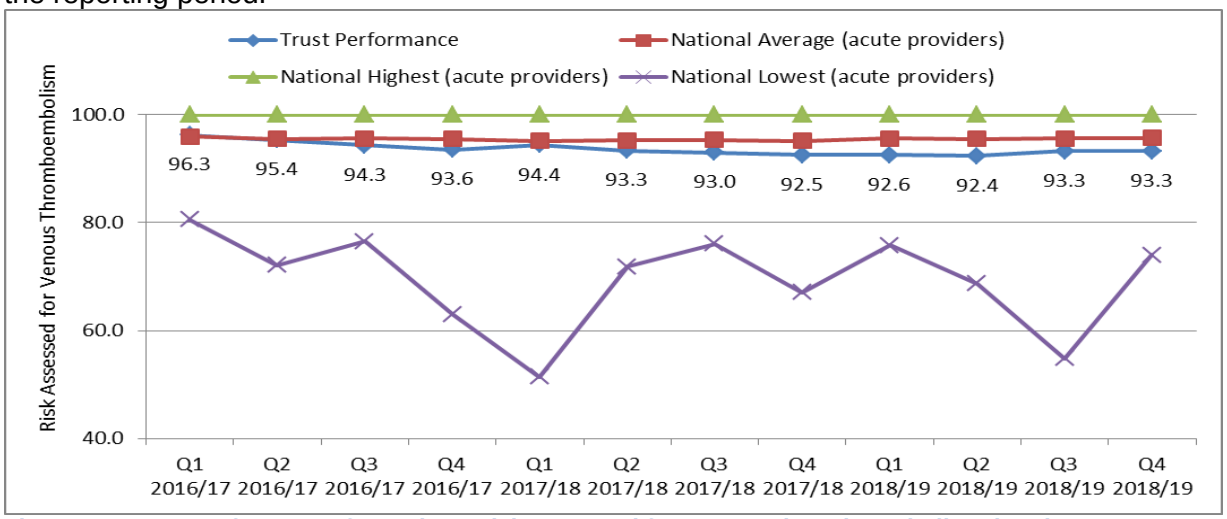


Figure 17: Trust performance for patients risk assessed for venous thromboembolism (VTE)

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 a VTE group which reviews performance and practice in relation to venous thromboembolism.
- The Trust has rolled out an Electronic Prescribing and Medicines Administration (EPMA) system at Goole hospital and is partway through implementation of this at Scunthorpe hospital; with plans for go live at Diana, Princess of Wales Hospital in place. 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.

2.3g *Clostridium Difficile* infection reported within the Trust

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

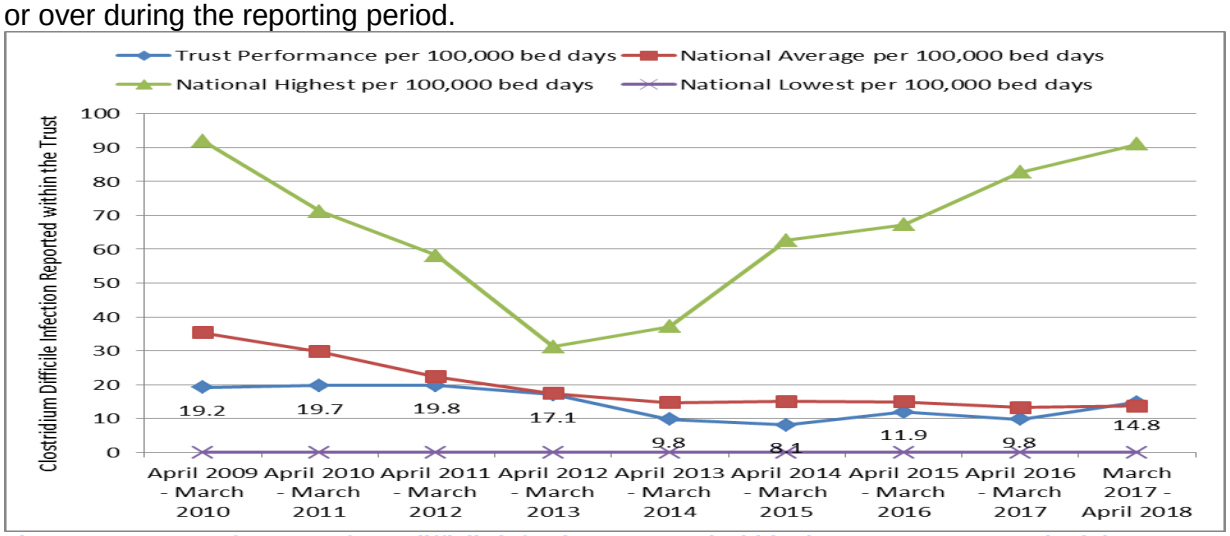


Figure 18: Trust performance for *C difficile* infections reported within the Trust per 100,000 bed days

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

Comment:

- The above table illustrates the rate of *C. difficile* per 100,000 bed days, for the Trust (Trust apportioned cases), for specimens taken from patients aged two years and over.
- An update for the 2018-2019 time frame is not available to the Trust for inclusion in the chart above.
- The most recent available data to the Trust is that made available from the Public Health England 'Fingertips', for the period December 2019. This is presented as follows:

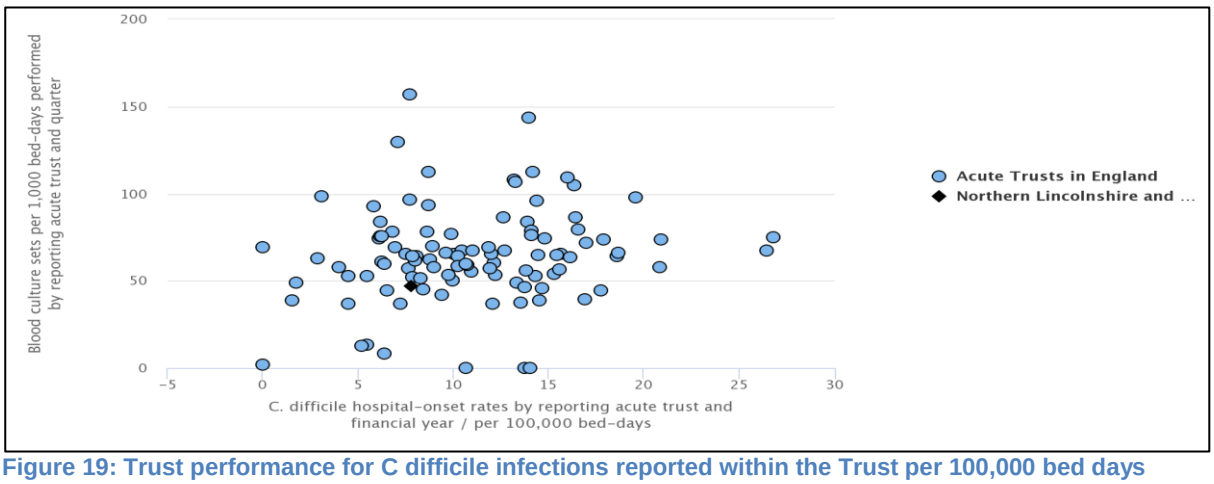


Figure 19: Trust performance for C difficile infections reported within the Trust per 100,000 bed days

- The data above demonstrates that the Trust reported less *C. difficile* infections than the UK average.

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

- The Trust reported 34 healthcare acquired cases to date (as at 27 February 2020) against a trajectory of 36. 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. As such the Trust has, unsurprisingly, seen more cases defined as hospital related, so far there have been

	Hospital onset	Community onset
Diana, Princess of Wales Hospital (DPoW)	15	9
Scunthorpe General Hospital (SGH)	7	3
Goole District Hospital (GDH)	1	0

- The Trust has detected 5 lapses 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 every hospital onset case;
- For each case admitted to hospital, practice is audited by the infection prevention and control team using the Department of Health Saving Lives' audit tools;
- Themes learnt from 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 readmitted into the Trust;
- 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;
- Introduction and review of the cleaning materials used by the Trust's facilities team. This has resulted in a standardisation and introduction of a single biocide cleaner as routine across the Trust.

2.3h Patient safety incidents

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

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

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

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

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

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

- Northern Lincolnshire and Goole NHS Foundation Trust average rate of patient safety incidents reported is above the average of other acute non-specialist NHS organisations. The Trust actively promotes and encourages staff to report all incidents as part of an open and transparent culture designed to support learning and improvement, recognising that high levels of reporting indicates a high level of safety awareness.

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

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

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:

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

- 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 weekly ensuring that appropriate investigation is undertaken in line with agreed timescales and lessons identified are shared for learning lessons. This approach has also increased the quality of Serious Incident investigations to identify and address root causes when harm has occurred.

- 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

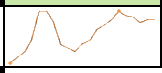
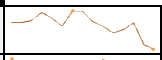
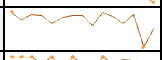
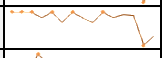
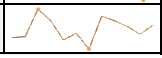
3.1 Overview of the quality of care offered 2019/20

The Trust set out 5 key quality priorities for focus on within 2019/20, which were:

- Priority 1 – Clinical Effectiveness: Mortality reduction
- Priority 2 – Patient Safety: Improved management of the deteriorating patient
- Priority 3 – Patient Safety: Medication safety
- Priority 4 – Patient Experience: Improved patient flow
- Priority 5 – Patient Experience: Cancer pathways

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

Priority 1 – Clinical Effectiveness: Mortality reduction

Priority 1 - Clinical Effectiveness: Mortality Reduction		Most recent data		Previous data	Trending	Target	Source of Target
		Dec 18 - Nov 19		Nov 18 - Oct 19			
1a	Summary Hospital-Level Mortality Indicator (SHMI)	117.6	R	117.7		100	National
		Mar-20		Feb-20			
1b	Learning from deaths: Medicine Division reviews	1.00%	R	6.00%		20%	Local
	Learning from deaths: Surgery Division reviews	50.00%	R	7.00%		100%	Local
	Learning from deaths: National Quality Board reviews	29.00%	R	0.00%		100%	Local
	Patients at end of life dying in preferred place of death	43.00%		35.00%		No target	N/A

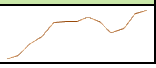
Comments:

- Medicine Division's learning from deaths' performance has consistently achieved the local 20% review target, with recent months' cases still out for review by clinicians and therefore comparison of the latest months' performance against the 20% target should be interpreted with caution.

- Reviews in the Division of Surgery have improved during 2019/20 (again noting caution for most recent month's performance as these are likely to still be with clinicians for review). General surgery at Scunthorpe General Hospital has reviewed all cases, with the same process now in place at DPoW.

- Patients at end of life dying in their preferred place of death is based on those cases where an audit tool was completed and for those patients who were on the last days of life care planning tool who died in hospital (therefore preferred place of death was recorded as in hospital). In a high proportion of patients, the preferred place of death was not documented making assessment of this standard difficult and the results need to be interpreted with caution. The end of life group is reviewing the key performance indicator data available to support a focus on improvement in end of life care.

Priority 2 – Patient Safety: Improved management of the deteriorating patient

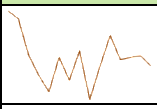
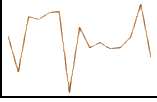
Priority 2 - Patient Safety: Improved management of the deteriorating patient		Most recent data	Previous data	Trending	Target	Source of Target
		Mar-20	Feb-20			
2a	Early Warning Score (NEWS) - Recorded on time (30mins grace period))	89.51% A	89.01%		90%	Local
		December 19 / January 20 Audit				
2b	NEWS appropriate action taken in line with the policy	80.00% A	N/A	N/A	N/A	N/A
2c	Sepsis six compliance:	December 19 Audit				
	Medicine division: Appropriate escalation of care	72.00% A	N/A	N/A	N/A	N/A
	Medicine division: Formal sepsis screening completed	52.00% R	N/A	N/A	N/A	N/A
	Surgery division: Appropriate escalation of care	78.00% A	N/A	N/A	N/A	N/A
	Surgery division: Formal sepsis screening completed	31.00% R	N/A	N/A	N/A	N/A

Comments:

- Performance with NEWS being recorded on time has increased during 2019/20; with evidence from audit work undertaken that escalation of care was also undertaken in 80% of these cases in line with the Trust's policy. This manual audit work will continue to be undertaken on a regular/monthly basis.

- For sepsis, the majority of patients assessed in the audit had appropriate escalation of care when clinically indicated. Whilst escalation action was taken, the formal completion of the sepsis screening tool was not always found recorded. Regular/monthly audits of sepsis will continue to monitor compliance with this standard.

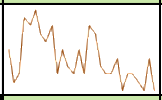
Priority 3 – Patient Safety: Medication safety

Priority 3 - Patient Safety: Medication Safety		Most recent data	Previous data	Trending	Target	Source of Target
		Mar-20	Feb-20			
3a	Reduction in omitted doses	28.00%	28.00%		No target	N/A
3b	Reduction in errors involving insulins	8.00%	12.00%		No target	N/A

Comment:

- As outlined in section 2.1, this data is based on incident reporting and is therefore subjective and not felt to be an accurate measure of medication safety. The Trust has commenced a roll-out of Electronic Prescribing and Medicines Administration (EPMA) where medication safety and incidents related to medications will be better recorded and reported.

Priority 4 – Patient Experience: Improved patient flow

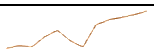
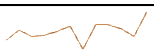
Priority 4 - Patient Experience: Patient Flow		Most recent data	Previous data	Trending	Target	Source of Target
		Feb-20	Jan-20			
4a	Embedding the use of SAFER bundle to improve flow:					
	Medicine Non-Elective LOS	5.7	6.1		No target	N/A
4b	Improved performance against the 4 priority 7DS standards	Sep-19	Apr-19			
	Clinical Standard 2: Emergency admissions assessed by consultant within 14 hours of admission	Not met R	Not met	N/A	Met	National
	Clinical Standard 3: Inpatients have access to 24/7 consultant directed interventions	Not met R	Not met	N/A	Met	National
	Clinical Standard 5: Inpatients have scheduled 7-day access to diagnostic services and be available within 1 hour for critical and 12 hours for urgent patients	Met G	Met	N/A	Met	National
	Clinical Standard 8: Patients with high dependency needs should be seen and reviewed twice daily; then once a clear pathway in place, consultant review every 24 hours	Not met R	Not met	N/A	Met	National

Comment:

- Progress with the implementation of the SAFER care bundle has been measured during 2019/20 using an assessment of medicine non-elective length of stay. This has continued to reduce during 2019/20. Further evaluation of SAFER is now possible through greater detailed information available that will support ward-based performance reviews; specifically length of stay at ward level and the number of discharges before noon.

- Compliance against the four priority seven day service standards has not yet achieved the national standards. In some cases it has not been possible to evidence compliance which has resulted in amending documentation to make it easier to record and therefore measure compliance against these standards. Divisions are currently working to determine what the gaps are in their areas, include these priority standards within business plans for 2020/21 and also include any risks on divisional risk registers.

Priority 5 – Patient Experience: Cancer pathways

Priority 5 - Patient Experience: Cancer Pathways		Most recent data	Previous data	Trending	Target	Source of Target
		Mar-20	Feb-20			
5a	Straight to test for cancer diagnostics:					
	Colorectal cancer	33.30% R	23.10%		>70%	Local
	Lung cancer	74.40% G	70.20%		>70%	Local
	Urology (Prostate Cancer)	73.20% G	75.40%		>70%	Local
5b	Progress with timed cancer pathways:	Achieved?				
	Colorectal cancer	No - Planned Q1 2020		N/A	Yes	Local
	Lung cancer	Yes		N/A	Yes	Local
	Urology (Prostate Cancer)	Yes		N/A	Yes	Local

Comment:

- Lung cancer and prostate cancer have implemented a faster diagnosis process which has resulted in improvements in the proportion of patients diagnosed within 28 days.
- Colorectal cancer will be implementing the faster diagnosis process during quarter one, 2020 as well as working towards a joint single Multi-disciplinary Team (MDT) meeting to improve the performance of the pathway for patients.

3.2 Performance against relevant indicators and performance thresholds

Performance against those indicators that form part of appendices 1 and 3 of the Single Oversight Framework (SOF) is to follow once March 2020 data is available.

Indicator	Quarter 1 19/20			Quarter 2 19/20			Quarter 3 19/20			Quarter 4 19/20			19/20 Performance
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	76.7%	77.8%	77.4%	78.3%	78.0%	79.0%	80.0%	80.4%	78.8%	77.3%	77.9%	74.9%	Average: 78.0%
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	82.2%	80.0%	81.4%	80.9%	78.5%	83.0%	85.5%	78.7%	73.4%	66.7%	73.2%	74.2%	Average: 78.1%
All cancers: 62-day wait for first treatment from referral/screening	74.6%	67.1%	67.1%	70.4%	70.3%	61.7%	66.1%	69.1%	71.7%	62.6%	59.1%	*Not yet available*	Average: 67.3%
C.difficile: variance from plan [lapses in care] (target 21)	6	3	1	5	5	4	1	2	5	1	3	2	
Maximum 6-week wait for diagnostic procedures	14.0%	13.3%	13.0%	13.9%	14.2%	13.9%	15.0%	12.0%	17.8%	16.6%	10.5%	21.5%	Average: 14.6%
Venous Thromboembolism (VTE) risk assessment	92.7%	92.8%	92.4%	94.0%	93.3%	94.5%	92.8%	92.0%	90.8%	91.8%	92.0%	91.3%	Average: 92.5%
Summary Hospital-level Mortality Indicator	119	119	120	119	119	117	117	117	*Not yet published*	*Not yet published*	*Not yet published*	*Not yet published*	Average SHMI for Apr 18 - Dec 19 period: 119

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.

In 2019, 39% per cent of Trust staff completed the survey (an increase from 35% per cent the previous year).

The survey was open from September to December 2019, with all staff being encouraged to participate. The survey was offered via a mixed mode method; staff received either a paper or on-line form depending on their role. The survey was publicised in various internal communications across the organisation, including the staff bi-monthly magazine, weekly team brief, the HUB (intranet), all staff emails and at the Chief Executive's monthly senior leadership team cascade.

Detailed performance – NHS staff survey

The Trust undertook a census sample survey during 2019, offering 6,573 eligible staff the opportunity to participate. From this 2,571 surveys were completed and returned.

	2019		2018		Trust improvement/ deterioration
Response rate	**Trust**	**National average**	**Trust**	**National average**	
	39%	**47%**	35%	44%	4% improvement

Source: NHS Staff Survey

Staff Survey 2019 findings

In 2019 reports on eleven themes, as below:

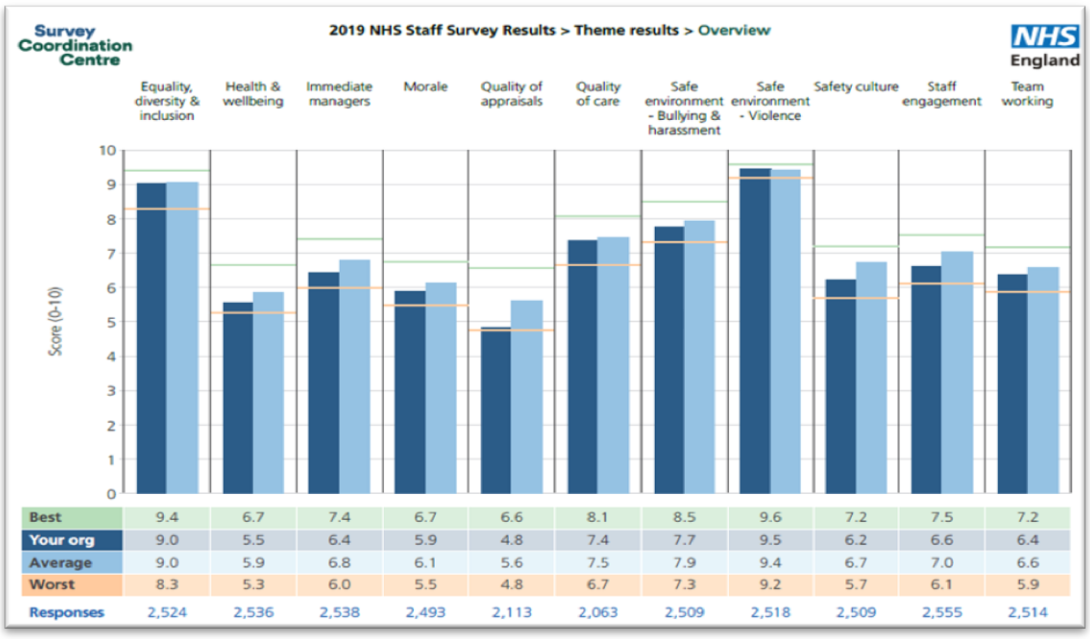


Figure 20: The ten themes now reported in the national staff survey

Comment:

Of the eleven priorities no area deteriorated from 2018 results, indeed:

- Seven areas (Morale, Quality of Appraisals, Quality of Care, Safe Environment: Bullying and Harassment, Safe Environment: Violence, Staff Engagement and Team Working) all experienced an in-year improvement;

- Quality of Care experienced a statistically significant improvement.

Future priorities and targets

The Trust recognises that its staff are the organisation's greatest asset. As such there are numerous existing staff engagement, staff reward, quality improvement, leadership development and apprenticeship opportunities underway. The Trust is continuing to invest in its 'Pride and Respect' organisational values/anti-bullying programme.

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

- **Staff Survey Work stream 1:** The continued corporate focus on staff engagement linked to staff voice/continuous service improvement, a much greater focus on staff wellbeing (in particular focusing on mental health) and investment in staff sense of value felt as a result of having their annual appraisals.

- **Staff Survey Work stream 2:** Invest in Divisional Staff Survey Action Teams. Each Divisional leadership team, supported by their HR Business Partner to work with their own staff, to jointly agree between themselves a maximum of three areas from within the survey that they want to improve within their area of work.

The above two work streams will be endorsed by the Trust Management Board and be monitored through the Workforce Committee.

3.4 Information on patient survey report

Introduction

The National Inpatient Survey for 2019 was sent out to 1,250 patients who stayed within one of the Trust's hospitals as inpatients, 45% of those chose to respond. These responses help the Trust understand where to align patient experience priorities in conjunction with the other patient experience intelligence received by the Trust.

Response rate compared with previous year:

	2019		**2018**	
Response rate	**Trust**	**National average**	**Trust**	**National Average**
	45%	**44%**	45%	43%

Source: NHS Patient Survey

These are the highlighted areas where we performed higher than the 74 Trusts we were benchmarked against and also the areas where we can focus our attention for improvement during the coming year.

	Top 5 scores (compared to average)
63%	Q19+. Hospital: food was very good or good
63%	Q50. Discharge: was not delayed
96%	Q20. Hospital: offered a choice of food
13%	Q52. Discharge: delayed by no longer than 1 hour
86%	Q48+. Discharge: felt involved in decisions about discharge from hospital

	Bottom 5 scores (compared to average)
43%	Q58+. Discharge: told side-effects of medications
52%	Q9. Admission: did not have to wait long time to get to bed on ward
69%	Q25. Doctors: not talked in front of patients as if they were not there
56%	Q60+. Discharge: told of danger signals to look for
60%	Q33. Care: staff did not contradict each other

	Most improved from last survey
73%	Q6. Planned admission: was admitted as soon as necessary
86%	Q48+. Discharge: felt involved in decisions about discharge from hospital
59%	Q56. Discharge: patients given written/printed information about what they should or should not do after leaving hospital
93%	Q39. Care: enough privacy when discussing condition or treatment
82%	Q68+. Overall: rated experience as 7/10 or more

	Least improved from last survey
81%	Q21+. Hospital: got enough help from staff to eat meals
43%	Q58+. Discharge: told side-effects of medications
52%	Q9. Admission: did not have to wait long time to get to bed on ward
77%	Q61+. Discharge: family or home situation considered
77%	Q59+. Discharge: given clear written/printed information about medicines

Actions to be taken as a result:

Divisional action plans will be created and the Patient Experience Group will monitor this over the coming year. The Patient Experience team have launched a trial for a rolling adult inpatient survey using themes and questioning from the National Inpatient Survey. This near “real time” survey approach will support ongoing oversight and improvements regarding these key areas.

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

Annex 1.1: Statements from Commissioners

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

North East Lincolnshire CCG,

North Lincolnshire CCG,

East Riding of Yorkshire CCG.

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

Commissioners acknowledge that the Trust's overall CQC rating remains as 'Requires Improvement and the Clinical Commissioning Groups are pleased to see an improvement in the Well-led domain, which has moved from 'Inadequate' to 'Requires Improvement'. However there are significant concerns regarding the reduction to Inadequate within the safe domain and the lack of progress, pace or sustained improvement within the other domains across the Trust.

We fully support the quality priorities identified by the Trust for the next financial year and would like to reiterate our commitment to leading system quality improvement across the unexpected mortality and end of life agendas. It is also acknowledged that the quality priorities that have been identified allow for the Trusts journey to continue from a number of priorities that were started in the 2019/2020 financial year.

Commissioners have been disappointed that the improvement that was made in the Summary Hospital-level Mortality Indicator (SHMI) for a short period of time has not been maintained, and whilst recognising that SHMI is not necessarily a measure of quality we feel that more needs to be done by the Trust and by the wider system to ensure it does not remain an outlier. We recognise that work continues regarding this including the management of the deteriorating patient and end of life care. It has been positive to see the reduction in the theme of fluid and electrolyte management being identified in structured judgement reviews, indicating that the activity the Trust has undertaken in response to this is having a positive impact.

Work on the improved management of the deteriorating patient has seen an improvement in the number of National Early Warning Scores (NEWS) being conducted on time, but commissioners were concerned to see that only 80% of patients requiring an escalation had this done appropriately. The impact of not meeting all of the standards for the seven day service self-assessment is also concerning.

The work that has been carried out to reduce the number of long waiters on the waiting lists is acknowledged by the commissioners but concerns remain about patients that are on the waiting list and the possible clinical harm.

Good quality Cancer Service delivery and performance remains to be a national priority and a commissioning priority, so it is positive to see that Cancer Pathways is a continued area of focus. We recognise the improvement that has been made in 2019/2020 with two of the Trust pathways, lung and prostate; but commissioners are concerned about the lack of progress that

has been made in 2019/2020 within the colorectal and upper GI pathways both of which were identified as areas requiring improvement in the 2019/2020 quality accounts.

It is encouraging to see the increase in the number of concerns raised by staff and the Trusts self-assessed interpretation of this as an improving culture. The improvements seen in the staff survey, including more staff recommending the Trust as a provider to friends would also indicate an improving culture within the organisation. Commissioners will welcome a continued improvement in all these areas in line with the pride and respect work that is being undertaken across the trust. The Freedom to Speak Up focus that has been undertaken by the Trust in respect to the internal audit, also gives commissioners assurance on this process which also shows an improvement of culture at the Trust.

It has also been noted the progress made with improved medical engagement in a number of areas, which commissioners hope will continue to drive forward the quality and patient safety agenda's through the ownership of improvements initiated by clinical staff.

Commissioners note the continued improvement in patient flow within the Trust, thus improving the patient experience by reducing their overall length of stay and we welcome the continued work on patient experience that will be taken forward into 2020/21.

We 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.

Lincolnshire East CCG.

Whilst the Trust shared a copy of the 2019/20 quality account with Lincolnshire East CCG, it was not possible for the CCG to provide a comment to the Trust for inclusion here.

Annex 1.2: Statement from Healthwatch organisations

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

Healthwatch in North Lincolnshire, East Riding of Yorkshire and North East Lincolnshire welcome the opportunity to provide a statement on the Quality Account for Northern Lincolnshire and Goole NHS Foundation Trust. The following statement is the joint response from North and North East Lincolnshire Healthwatch and Healthwatch East Riding of Yorkshire.

All 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 Chief Executive statement is very useful and provides a good introduction to the Account. Although his tone remains optimistic, it is reassuring to know that he acknowledges there is work still to be done and is taking all necessary steps to take the Trust forward on its improvement journey.

The new infographic section that has been included in the quality account this year is a welcomed as an easy tool for the public to understand some of the improvements made in in 2019/2020.

It is positive to see that the priorities for the period were focused on five key areas, and there have been some clear improvements made towards these priorities. It is particularly encouraging to see the introduction of a new twilight shift for registered nurses to help increase staffing levels in the evenings and at weekends, and the improvements in diagnostics with less delay in imaging and reporting.

However, the issue of patient safety within the trust does still remain concerning, and was highlighted by the recent CQC report. The Trust is still struggling to meet some national targets such as the SHMI indicator, and medication safety continues to be an issue, particularly around diabetes care. It is hoped these issues can be addressed and improved in 2020/2021.

We recognise the concerted effort to continue to improve the quality and safety of services, and understand that the Trust is now working in even more challenging times than could have ever been anticipated. Healthwatch North Lincolnshire, North East Lincolnshire and East Riding would like to offer support to the Trust during this difficult period.

We look forward in continuing to work more closely with Northern Lincolnshire and Goole NHS Foundation Trust in the future and seeing how their new priorities are developed.

Healthwatch Lincolnshire
Healthwatch Lincolnshire welcomes the opportunity to comment on the latest Quality Account for North Lincolnshire and Goole Trust (NLAG). We acknowledge all the highlights and work undertaken which has been demonstrated within the report. We also acknowledge the priorities for the forthcoming year as beneficial. However what would be useful is for the report to provide the reader with a better understanding of how the 'patient experience' is being monitored. It is appreciated that often 'metrics and RAG rating' is considered as benchmarking and

measurement of patient of experience, but doesn't provide the real insight into how the Trust actually captures what patients and their families and carers are really feeling.

During the last 12 months, Healthwatch Lincolnshire have received 13 cases of patient feedback. It is acknowledged that this is a relatively small proportion of Lincolnshire patients flowing into NLAG services, on the whole the feedback has been positive citing good care from staff and a caring attitude from the Trust. However patient and family feedback on 'emergency' care received through NLAG sites reported long waits, poor pain relief and poor communication with family.

We recognise that feedback across the health and care sector as a whole, consistently focusses on patient communication as the main driver for poor experiences, this is both between medical and patient to ensure their understanding is the same, and between providers across county borders, this is something that we don't feel is identified within the work and plans for the forthcoming year and could be strengthened.

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

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

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

Given both the exceptional circumstances at the time of drafting this response and the practical barriers to meeting and agreeing a response within NLG's timescales, the panel's comments will be very limited in nature. The panel would have much preferred to consider the draft Quality Account in depth and responded accordingly. Unfortunately this was not possible on this occasion but, of course, we are happy to liaise or discuss the panel's views with NHS England or colleagues from elsewhere if required.

For a number of years, the panel has used this opportunity to raise serious concerns about the Trust's overall performance in many areas and its future sustainability. Unfortunately, despite some improvements in 2018/19, the panel must again raise serious concerns about local performance, most notably evidenced by the publication of the CQC report on the Trust in January 2020. The most worrying aspect of the CQC report was the deterioration of the 'Safe' domain to a rating of 'inadequate', highlighting a number of incidents of patients coming to harm, poor services for those with mental health conditions, breaches in emergency care, concerns around the management of infection control in Critical Care and in services for children and young people, and insufficient staffing. However, the panel does acknowledge that these are findings from the CQC Inspection taking place between 24-27 September 2019 and that the above concerns may now have been addressed.

Given the significant overlap in the CQC reports and the Quality Account, the panel intends to closely monitor and oversee NLG's actions as soon as is practically possible, most notably by scrutiny of progress on action plans arising from the CQC's work, in order to assure the people of North Lincolnshire that services are improving and to hold the Trust's leadership to account. The panel has now requested a virtual meeting to these ends. We cautiously welcome the CQC's decision to increase the rating for the 'Well-led' domain, and the panel considers the next twelve months to be crucial in justifying this rating and in the Trust's wider development.

In addition to the above, the panel wishes to sincerely thank and acknowledge the critical contribution of all of NLG's clinicians and medics, nurses, and other staff in responding to the ongoing issues.

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

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

Lincolnshire – Health Scrutiny Committee for Lincolnshire

The Trust shared with the health scrutiny panels in Lincolnshire, East Riding of Yorkshire and North East Lincolnshire, however it was not possible for colleagues to provide comments for inclusion here.

Annex 1.4: Statement from the Trust governors'

Feedback from:
The Trust's Lead Governor

The Council of Governors is very appreciative of the progress the Trust has made during the year despite continuing to be in double special measures. Trust progress is regularly presented to the Board, as well as relevant committees and the Council of Governors meetings by means of the Integrated Performance Report. This report is constantly being improved in both its content and appearance following feedback received. Governors are encouraged to attend some of the key committee meetings in addition to holding their own sub-committees such as the Governor Assurance Group and the Quality Review Group, which assist in reassuring the Council that it has an accurate and current understanding if Trust progress.

The Quality Account is very well presented and reflects the hard work carried out by the Board and all staff to assist in improving the staff and patient experience. Each of the 5 quality priority themes are explored in turn, listing the actions and initiatives in place towards improving each one. Each theme also lists the patient outcomes in easy to read bullet points displayed in a green box. The Council is pleased to see the detailed lists of actions taken in many areas such as, increasing information to patients/carers/families, increasing awareness and education of staff, and, changes to services and processes.

Initiatives implemented in the previous year to improve opportunities for staff to comment have gained further traction during this year with the 'Ask Peter' Chief Executive system proving to be popular. The effectiveness of the Freedom to Speak Up Guardian work is regularly reported to Board. Improvements have been made in reducing the 52-week waits and prioritising patients on cancer pathways, as well as in mortality reporting. The Council is encouraged to see that the Trust has welcomed 850 new staff over the year.

The Account also contains the agreed 5 quality priority areas for 2020/21, which take in to account the CQC recommendations following the inspection report of Trust services in February 2020. Governors are encouraged to see these priorities are set to further improve the patient experience and their safety.

Annex 1.5: Response from the Trust to stakeholder comments

During the unprecedented circumstances facing the country and the NHS due to the Covid-19 pandemic, the Trust is grateful for the support of local stakeholders and acknowledges these comments.

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 2019/20 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 2019 to the 7 April 2020
    - Papers relating to quality reported to the board over the period April 2019 to 7 April 2020
    - Feedback from commissioners dated 29 April 2020
    - Feedback from governors dated 22 April 2020
    - Feedback from Local Healthwatch organisations dated 24 April 2020
    - Feedback from Overview and Scrutiny Committees dated 29 April 2020
    - The trust's draft complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2019-2020
    - Latest national inpatient survey 2020
    - Latest national staff survey 2020
    - The head of internal audit's annual opinion of the trust's control environment dated May 2020
    - 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 for the most part reliable and accurate, however, following internal auditing, the Trust has identified some errors in the referral to treatment pathway coding, which has resulted in the recording of incorrect pathway timings. This data contributes to the reporting of waiting list performance. An independent audit has been commissioned by the Trust to confirm actions taken to validate the data;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- The majority of data underpinning the measures of performance reported in the Quality Report are robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review. From these internal controls and scrutiny and review of data during 2019/20, the Trust identified errors in the data for some treatment pathways referral to treatment clock stops. In response the Trust has commissioned an external audit and the outcome of this is to be completed by the end of June 2020. The waiting list data may not provide a true picture of the Trust's waiting list position. The directors are confident that the extent of the data quality issues are being understood and a robust and reliable plan of action will be agreed following the audit results to ensure the required data quality standards and prescribed definitions for waiting list data are adhered to and are assured that progress in this area will be reported to directors of the board; and
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

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 2019/20 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.

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

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

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

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

Harm:

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

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.

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

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

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

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

Annex 5: Mandatory Performance Indicator Definitions

The following indicators:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways,
- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

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

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways

Source of indicator definition and detailed guidance

The indicator is defined in the technical definitions that accompany *Everyone counts: planning for patients 2014/15-2018/19* at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf

Detailed rules and guidance for measuring referral to treatment (RTT) standards are at https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

Detailed descriptor:
EB3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period

Numerator:
The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks

Denominator:
The total number of patients on an incomplete pathway at the end of the reporting period

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

Indicator format:
Reported as a percentage.

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

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

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

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

> *We are an acute trust. Can we record attendances at a nearby type 3 unit in our return?*

Such attendances can be recorded by the trust in the following circumstances.

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

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

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

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

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

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

Denominator:
The total number of unplanned A&E attendances

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

Indicator format

Reported as a percentage.

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