NHS
Northern Lincolnshire
and Goole
NHS Foundation Trust

Northern Lincolnshire & Goole NHS Foundation Trust

Annual Quality Account

2016/17

FINAL DRAFT – 19 April 2017

CONTENTS

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

Northern Lincolnshire & Goole NHS Foundation Trust (also referred to as 'the Trust' throughout this report) aim to deliver high quality, high performing, safe and sustainable services to patients – first time and all of the time. The Trust aspires to be great place for staff to work, and be highly recommended by patients to their family and friends as a place of choice for treatment and care. These are our ambitions.

During 2016/17, the Trust has faced a number of challenges and we have not always achieved our ambitions. We are however determined to learn from these challenges and move forward at pace, delivering change and improvement to ensure we consistently focus on providing high quality services to our patients and a dynamic forward thinking work environment for our staff.

How will we do this? The Trust is determined to Improve Together. The Improving Together programme is at the heart and soul of the Trust's improvement agenda bringing together in one place all the key actions and recommendations identified to support the Trust's improvement journey. The Improving Together plan builds on the Trust's achievements, strengths and the progress already made together and uses this as a platform to focus on taking the next steps on our journey. The Improving Together plan combines the Trust's workforce, its Board, its public member representatives and external stakeholders and agencies that the Trust has welcomed, and continues to welcome the support of.

The annual quality account is designed to ensure that NHS bodies throughout the country are accountable to the public for their efforts to deliver the very best quality of care. The Trust is therefore pleased to present its achievements during 2016/17 and outline our performance against a range of quality indicators. The first part of this report focusses on the Trust's achievement of its own internal stretch quality priorities. This also presents the rationale and linkages between performances this past year and the proposed 2017/18 quality priorities and the Improving Together Programme.

The second part of this report then outlines the Trust performance with a host of indicators and national metrics. We present the findings of our most recent Care Quality Commission (CQC) report and outline the areas arising from this where we still need to do more, the areas that feature as part of the Trust's Improving Together journey.

To the best of my knowledge, the information contained in this document is accurate. Using this information alongside a number of other assurance mechanisms and processes will support the Trust Board to focus on delivering our Improving Together quality aspirations.

Richard Sunley

Interim Chief Executive

About Northern Lincolnshire and Goole NHS Foundation Trust

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

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

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

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

Unplanned services: statistics at a glance – during 2016/17:

- 149,409 people attended one of our Accident & Emergency departments during 2016/17 compared with 150,288 in 15/16 and 144,995 in 14/15.

- Whilst there were slightly less attendances to the Trust's A&E departments, 31,258 of these were admitted. This equates to 601 admissions through A&E a week, 86 people a day! Whilst the numbers are increasing, so too is the level of acuity, or the level of dependence on the Trust's healthcare professionals.

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

Follow the Trust on Twitter: @NHSNLaG

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

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

Executive summary of key points

(For full details of the Trust's performance during 2016/17, see part two of this report.)

'At a glance' performance during 2016/17

Clinical Effectiveness

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

QUALITY INDICATORS AT A GLANCE: Jan-17

2016/17 Indicators

Indicator				Time period / RAG		Comparator	Trending	Trust Stretch Target	National Target
CLINICAL EFFECTIVENESS				Most recent data		Previous	Target Achieved		
CE1	Deliver mortality performance within 'expected range' and improving quarter on quarter, until reported SHMI is 95 or better	Official SHMI (Jul 15-Jun 16)		110.5	R	108.9		95	100
		HED data (Nov 15 - Oct 16)		111.3	R	109.9		95	100
		Position vs peers		Within expected range	A	Within expected range	Within expected range	Within expected range	Within expected range
Indicator			**Change**	**Jan-17**		**Previous month**	**Target achieved**	**Trust Stretch Target**	**National Target**
CE2.1	Patients are screened for Sepsis on presentation (Adults)	Trustwide	✓ 2%	100.0%	G	98.0%		90.0%	90.0%
CE2.2	Patients with Sepsis receive antibiotics within 1 hour of presentation (Adults)	Trustwide	✗ -3%	92.0%	G	95.0%		90.0%	90.0%
CE2.3	Patients are screened for Sepsis whilst already in hospital	Adults	✓ 3%	79.5%	R	77.0%		90.0%	90.0%
		Children	✓ 0%	100.0%	G	100.0%			
CE2.4	Patients already in hospital with severe sepsis have IV Antibiotics	Adults	✓ 0%	100.0%	G	100.0%		90.0%	90.0%
		Children	N/A	N/A	G	N/A			
CE3	Screened for Dementia	DPoW	✗ -1.0%	91.0%	G	92.0%		90.0%	None
		SGH	✓ 3.0%	89.0%	R	86.0%			
CE4.1	Technology Appraisal Guidelines (TAGs) to be fully compliant within 3 months of release		✓ 2.0%	98.0%	R	96.0%		100.0%	None
CE4.2	Clinical Guidelines (CGs) / NICE Guidelines (NGs) to be fully compliant within 3 years		✓ 1.9%	87.3%	R	85.4%		90.0%	None
CE5	Transfer of patients for non-clinical reasons (capacity) to not exceed 10% of the total		✗ 0.0%	12.0%	R	12.0%		10.0%	None

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

Comment:

- Mortality indicators have been partially met throughout 2016/17 with the Trust's 'official' SHMI remaining 'within the expected range'. The Trust has not yet met its internally set quality priority and as such this is red rated. Due to the importance of this area, mortality remains a theme for the 2017/18 quality priorities.

- Compliance with the CQUIN indicator regarding sepsis screening on admission and commencement of appropriate treatment has exceeded the targets set. The inpatient screening for sepsis has remained a challenge, but an action plan is in place to improve on this area too.
- The identification and care of patients with dementia has remained a priority for the Trust over the last few years. For the most part during 2016/17, the Trust has met this quality priority; however during the first two months of 2017 performance has slipped in screening patients for dementia within the timescales set as part of this target. The process in place has been strengthened between information teams and operational teams, and the Trust has recently welcomed two dedicated clinical nurse specialists to the Trust to focus on dementia.
- National Institute for Health and Care Excellence (NICE) guidance is another indicator that has not yet been fully achieved but good progress has been made meaning we are very close to achieving this target.
- Transfer of patients for non-clinical reasons has been an indicator selected to help the Trust focus on the subject of internal transfer and discharge of patients enabling the Trust Board receive regular quality measurement on a number of related data. This is an area of priority for the Trust to continuously work to improve the flow through the Trust's hospitals. This has been particularly challenging, as elsewhere within the NHS, during late 2016 and early 2017. The theme of flow, transfer and discharge will remain as quality priorities during 2017/18.

Patient Safety

QUALITY INDICATORS AT A GLANCE: Jan-17

2016/17 Indicators

Indicator			Change	Time period / RAG	Comparator	Trending	Trust Stretch Target	National Target
PATIENT SAFETY				Jan-17	Previous month	Target achieved		
PS1	MRSA Bacteraemia Incidence	(YTD: 1)	✗ 1	1 R	0		0	0
PS2	C Difficile Incidence (ALL cases)	(YTD: 21)	✓ -1	2 G	3		No Target	No Target
	C Difficile ('Lapses in care')	(YTD: 2)	✓ 0	0 G	0		No more than 10 Lapses in Care	No more than 21 Lapses in Care
PS3	Safety Thermometer (Community)		✓ 1.8%	96.40% G	94.6%		95.0%	None
PS4	6 Ward focussed pressure ulcer reductions	DPoW - Ward B6	✓ -1	2 A	3		Decreasing trend	None
		DPoW - Ward B7	✗ 4	4 A	0			
		DPoW - Ward C6	✓ 0	1 R	1			
		SGH - Ward 18	✓ 0	0 R	0			
		SGH - Ward 22	✓ 0	0 R	0			
		SGH - Ward 24	✓ -1	3 R	4			
PS5	Reduction in Number of Avoidable Pressure Ulcers (Grades 2, 3 & 4)	DPoW	✓ 0	0 G	0		50% reduction (no more than 2 per month)	None
		SGH	✓ 0	0 G	0			
		GDH	✓ 0	0 G	0			
PS6	Elimination of Avoidable Repeat Fallers	DPoW	✓ -4	0 G	4		Eliminate All avoidable repeat falls	None
		SGH	✓ -1	0 G	1			
		GDH	✓ 0	0 G	0			
PS7.1	Nutrition care pathway was followed	DPoW	✗ -1.3%	96.0% R	97.3%		100.0%	None
		SGH	✗ -0.8%	99.2% A	100.0%			
		GDH	✓ 0.0%	100.0% G	100.0%			
PS7.2	The food record chart completed accurately and fully in line with care pathway	DPoW	✗ -0.7%	91.3% R	92.0%		100.0%	None
		SGH	✓ 3.4%	99.2% A	95.8%			
		GDH	✓ 0.0%	100.0% G	100.0%			
PS8	The fluid management chart was completed accurately and fully in line with care pathway	DPoW	✗ -1.4%	84.6% R	86.0%		100.0%	None
		SGH	✓ 4.0%	95.5% R	91.5%			
		GDH	✓ 0.0%	100.0% G	100.0%			

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

Comment:

- The Trust had maintained 22 months with no hospital acquired MRSA infections. During January and February 2017, three patients were identified as having had MRSA. The Trust takes prevention and control of infections seriously and reviews the context behind all such reported infections. For C difficile therefore the Trust set a target around ensuring that those related to a lapse in care, or in other words from a

review of the circumstances, were felt to be avoidable, are minimised. This stretch target has been achieved.

- Pressure ulcers and the Trust's focus on reducing these has been a quality priority for a number of years which has seen significant improvements. During 2016/17 the Trust focussed its quality priority on specific ward areas with the intention of using this as a way of supporting wards with higher prevalence of pressure ulcers, to be supported to reduce the incidence. This was designed as a quality improvement target, not a performance target, recognising that some wards, due to the speciality and clinical needs of their patient group would naturally have a greater incidence of pressure ulcers.
- Nutrition and hydration targets have not yet been embedded in line with the Trust's own internally set stretch targets. It is proposed that these remain as themes within the Trust's quality priorities during 2017/18.

Patient Experience

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

QUALITY INDICATORS AT A GLANCE: Jan-17

2016/17 Indicators

Indicator			Change	Time period / RAG		Comparator	Trending	Trust Stretch Target	National Target
PATIENT EXPERIENCE				Jan-17		Previous Month	Target achieved		
PE1	Feedback from the Friends & Family Test is positive	A&E	✗ -4.4%	61.6%	R	66.0%		98.0%	None
		Community	✗ -1.5%	98.5%	G	100.0%			
		Day case	✗ -0.3%	99.3%	G	99.6%			
		Maternity	✓ 0.4%	96.1%	A	95.7%			
		Inpatient	✓ 1.3%	96.0%	A	94.7%			
PE2	Re-opened complaints to not exceed 10% of total closed complaints		✗ 0.6%	5.6%	G	5.0%		10.0%	None
PE3	Complaints relating to communication		No data	No data to report as yet				To be established	None
PE4	Patients feel that medical and nursing staff did everything they could to help control pain.	DPoW	✓ 0.7%	96.2%	G	95.5%		90.0%	None
		SGH	✓ 1.8%	100.0%	G	98.2%			
		GDH	✓ 0.0%	100.0%	G	100.0%			
	Patients received pain relief when they needed it in a timely manner	DPoW	✓ 4.6%	97.4%	G	92.8%		90.0%	None
		SGH	✓ 1.8%	100.0%	G	98.2%			
		GDH	✓ 0.0%	100.0%	G	100.0%			

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

Comment:

- During 2016/17, the Trust was keen to refocus the priority in connection with the Friends and Family test from the response rates to the feedback from patients. The monthly quality report has contained a thematic analysis of this feedback to inform the Trust's sub-committee of the Board focussed on quality and the Trust board itself. This has been supported by patient stories presented at both. Overall, feedback has been positive; however the Trust's two A&E departments have both had low feedback scores in terms of experience. This has been particularly so during recent months where the Trust, alongside many other NHS Trusts, have faced severe pressures on beds and A&E waiting times have unfortunately increased as a result. Work has been invested to ensure that themes from this feedback have been acted upon where possible.
- The various indicators relating to complaints illustrate that the Trust's complaints handling processes have improved and result in much greater support to complainants early on, as demonstrated by the low levels of complaints being re-opened.
- Pain management has been achieved month on month; this important indicator will be monitored during 2017/18 by being included in the routine nursing led audits.

Trust Quality Priorities for 2017/18

As outlined within the 'at a glance' executive summary of performance during 2016/17 (for full details, see part 2 of this report) there is a close correlation between the performance against quality priorities and the consultation and setting of new priorities for the 2017/18 financial year.

The Trust has historically aspired to set a wide range of quality priorities. During the consultation process for setting the 2017/18 priorities, it was felt that the sheer number of targets was in danger of preventing sufficient time and focus being applied to the Trust's core quality priorities. This was also felt to hamper the ability for the Trust Board's sub-committee focussed on quality to receive full assurance from executive owners. On reflection then, for 2017/18, the Trust Board have approved a different approach to be taken to set quality priority 'themes' with underpinning metrics, designed to reduce the number of targets, and ensure that those selected are the core priorities for the Trust to focus on in relation to quality as well as a restructured monthly quality report to enable greater ability for executive owners to outline performance to date, what conclusions are drawn and what action is being taken. Another strengthening arrangement is the alignment of a Non-Executive Director to each of the priority themes to further support the Trust's focus on quality.

The following section focusses on the approved quality priorities for 2017/18, to be monitored within the monthly quality report from April 2017 onwards. Work continues to define the specific measures to be used in order to track progress towards achieving these quality priorities.

Quality Priority Theme 1:

Priority 1: Reducing Mortality (Director Responsible: Medical Director)
Focussed area 1: Respiratory Mortality
Focussed area 2: Out of hospital mortality

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

Rationale:

- Mortality performance remains a key priority for the Trust and the various improvement work streams underway are monitored by the Trust's Mortality Assurance & Clinical Improvement Committee. From the work to date, respiratory mortality has been identified as the Trust's specialty with the highest levels of mortality, therefore this quality priority will ensure focus on the work underway to understand and improve quality elements of care where identified. The second area relates to out of hospital mortality where following collaborative work with commissioners improvements in pathways across organisational boundaries have been identified.

Quality Priority Theme 2:

Priority 2: Increase harm free care (Director Responsible: Chief Nurse)
Focussed area 1: Safety thermometer
Focussed area 2: Care of the deteriorating patient
Focussed area 3: Nutrition and hydration
Focussed area 4: Safe Nurse staffing

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

Rationale:

- The emphasis on the Trust's quality priorities during 2016/17 was on harm free care. This second quality priority theme therefore enables continued focus during 2017/18 and expands on other priorities identified in connection with challenges around staffing availability and levels.

Quality Priority Theme 3:

Priority 3: Providing care resulting in a positive experience (Director Responsible: Chief Nurse & Director of People and Organisational Effectiveness)
Focussed area 1: Patient experience
Focussed area 2: Staff experience

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

Rationale:

- The voice of the patient has been included in previous quality priorities, for 2017/18 it is built upon further to ensure that the patient experience is listened to and acted upon. Another crucial factor in regard to quality and experience is the staff voice; this is therefore also included within this priority to ensure the Trust understands staff experience and what action is needed as a result.

Quality Priority Theme 4:

Priority 4: Outpatient services (Director Responsible: Chief Operating Officer)
Focussed area 1: Learning from patient experience/feedback
Focussed area 2: Outpatient waiting / cancellations

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

Rationale:

- Outpatient services have been the feature of patient feedback received, therefore listening to this feedback, the Trust has approved a specific outpatient focussed quality priority theme.

Quality Priority Theme 5:

Priority 5: Discharge & Transfer (Director Responsible: Chief Operating Officer)
Focussed area 1: Timely access
Focussed area 2: Patient flow

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

Rationale:

- As experienced by other NHS Trusts, the extreme pressures experienced during winter months have been the subject of specific improvement work being undertaken, with support provided by NHS Improvement. Access and flow are critical areas for the Trust to focus on to ensure pressures from increased demand on services are managed effectively.

Quality Priority Theme 6:

Priority 6: Medical Quality Indicators (Director Responsible: Medical Director)
Focussed area 1: Venous Thromboembolism
Focussed area 2: Safe Medical Staffing
Focussed area 3: Infection prevention and control

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

Rationale:

- The Trust recognises that venous thromboembolism is an important element of delivering harm free care and is therefore added as a quality priority. Medical staffing is also critical to the delivery of quality, in the same was as nurse staffing is, this remains an area of challenge for the Trust and the work to manage this challenge and the impact on quality is to be focussed on within this priority theme.

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 2016/17 quality priorities

Information reported within Part 2

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

Priorities for improvement

This section of the report highlights progress during 2016/17 towards achieving the Trust's quality priorities. The quality priorities, and the following report, are divided into three sections:

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

During 2016/17 performance against these quality priorities was monitored within the monthly quality report which is presented and reviewed on a monthly basis by the Trust's Quality and Patient Experience Committee (QPEC) and the Trust Board. In some cases the quality priorities have changed mid-year. Where this is the case, beneath each indicator, the rationale for the change is explained.

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

The targets for 2017/18 are then outlined again in a fourth section of this report:

- Section 2.1d Quality priorities for the 2017/18 financial year.

A note on interpretation of the following information:

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

Overview of the quality of care against 2016/17 quality priorities:

This Section…

2.1a CLINICAL EFFECTIVENESS (CE)

- → **CE1 Mortality**
- → **CE2 Sepsis Detection and Treatment**
- → **CE3 Dementia**
- → **CE4 Evidence Based Practice (NICE)**
- → **CE5 Transfer and Discharge**

2.1b Patient Safety (PS)

2.1c Patient Experience (PE)

2.1a CLINICAL EFFECTIVENESS

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

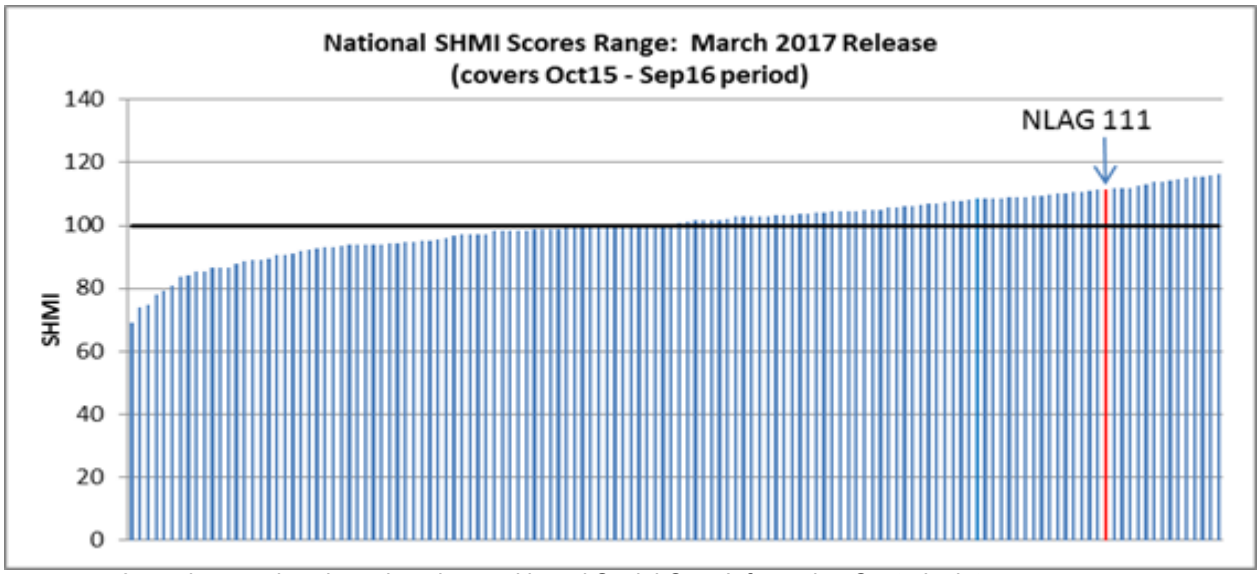
*(**NB:** For a greater understanding as to how mortality is measured, how this information should be interpreted and key definitions, please refer to the glossary section of this report)*

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

- **TARGET:** Deliver mortality performance (Summary Hospital Mortality Indicator (SHMI)) within 'expected range' and improving quarter on quarter, on a Moving Annual Total (MAT) basis at each quarterly publication date until our reported SHMI is 95 or better.
- **Achievement (April 2016 – March 2017):** Using the latest 'official' SHMI indicator published in March 2017, the Trust is currently **within** the 'expected range'. The SHMI is published quarterly and due to its inclusion of deaths outside of hospital, within 30 days of discharge, is always some months behind present day. The data presented below therefore covers the period of October 2015 to September 2016.

The Trust's official SHMI in national context

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



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

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

Comment:

- The Trust's SHMI score was 111 – ranking 122 out of 136 NHS provider organisations included in the data set.
- This continues to be officially within the "as expected range".
- For a more detailed review of the Trust's performance with mortality indicators and greater detail of the work underway see section 2.3a of this report.

Has the quality indicator been changed during the year from that set in last years (2015/16) Quality Account? No, there has been no change to this quality priority during the 2016/17 reporting period.

Rationale for changing this quality priority for 2017/18: The focus for 2017/18 will be looking at important elements that impact on the SHMI and other mortality metrics, the SHMI information will therefore be retained, but for contextual purposes.

CE2 – Sepsis Detection and Treatment

Background:

- Sepsis has been identified as a significant contributor to patient morbidity and mortality. As a result the NHS has focussed a national CQUIN (Commissioning for Quality and Innovation) scheme to help Trusts across the NHS focus on and improve their processes in connection with identifying and treating sepsis.

CE2 – Sepsis Detection and Treatment

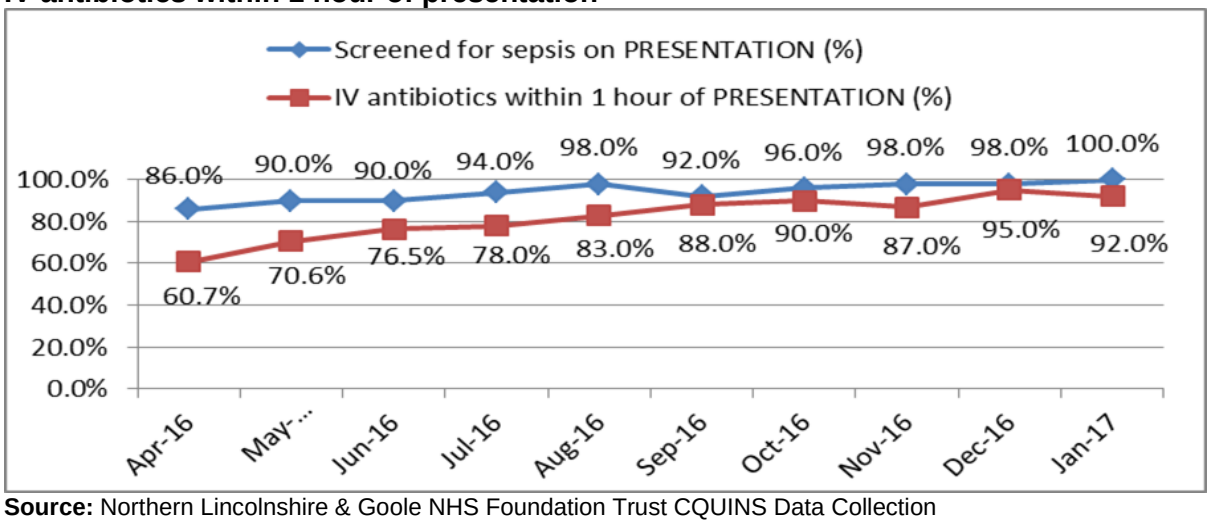
- **TARGET:** During 2016/17 the national CQUIN focussed on 4 key elements relating to sepsis:
- **CE2.1:** 90% of patients who meet the criteria of the local protocol for sepsis screening and were screened for sepsis;
- **CE2.2:** 90% of patients with severe, red flag sepsis or septic shock receive IV antibiotics within 1 hour of presentation;
- **CE2.3:** 90% of patients ALREADY IN hospital who meet the criteria of the local protocol for sepsis screening and were screened for sepsis;
- **CE2.4:** 90% of patients ALREADY IN hospital with severe, red flag sepsis or septic shock receive IV antibiotics within the appropriate timeframe and had an empiric review within 3 days of the prescribing of antibiotics.

- **Achievement (April 2016 – March 2017):** The Trust has seen good performance in relation to this quality target during the 2016/17, to the extent where 3 of the 4 indicators have been fully achieved. The only area not yet achieved is in relation to patients being screened for sepsis whilst already in hospital as inpatients. Work is in progress to improve clinical staff ability to identify patients benefiting from a sepsis screening assessment.

Key points – performance in 16/17 – Patients PRESENTING to hospital:

TARGET: CE2.1: 90% of patients who meet the criteria of the local protocol for sepsis screening and were screened for sepsis

TARGET: CE2.2: 90% of patients with severe, red flag sepsis or septic shock receive IV antibiotics within 1 hour of presentation



Source: Northern Lincolnshire & Goole NHS Foundation Trust CQUINS Data Collection

Comments:

Indicator CE 2.1: The above chart illustrates that the number of patients being screened for sepsis has exceeded 90% now for a number of months. To obtain a sample of 50 patients, 546 records had to be reviewed.

Of this sample of 50 patients, 48 were adult and 2 paediatric patients met the criteria for inclusion within CE 2.1, both children were fully assessed and screened for sepsis.

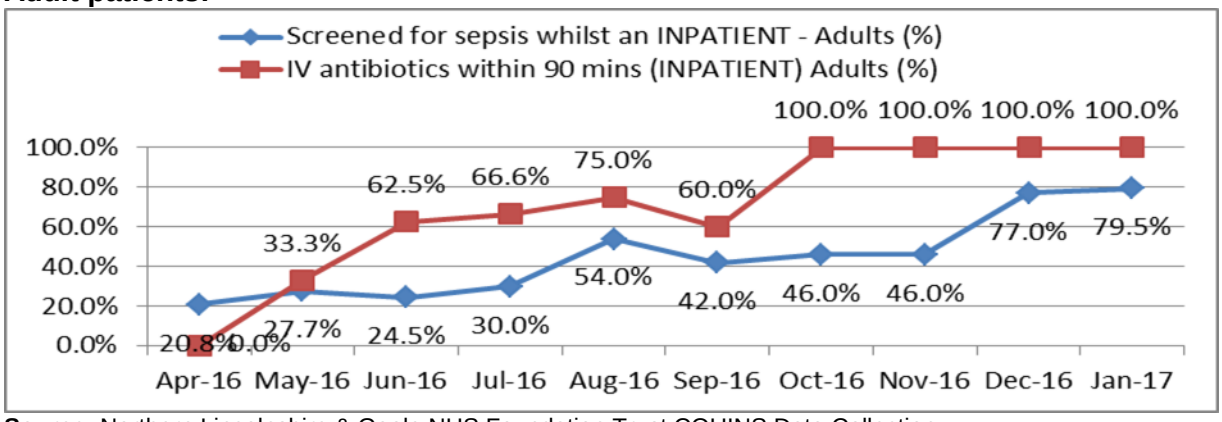
Indicator CE 2.2: Relates to antibiotic commencement and the sample for this was drawn from a random identification of patients who were identified through clinical coding with a sepsis diagnosis (ICD 10 codes, A40 and A41). The results of this review identified that in January, 92% of patients were administered with antibiotics within 1 hour of arrival and there was evidence of review within 72 hours.

Both indicators illustrate the Trust's meeting of the target set for this area demonstrating the Trust's priority for the identification of patients with suspected sepsis and commencement of IV antibiotics in response within 1 hour.

TARGET: CE2.3: 90% of patients ALREADY IN hospital who meet the criteria of the local protocol for sepsis screening and were screened for sepsis

TARGET: CE2.4: 90% of patients ALREADY IN hospital with severe, red flag sepsis or septic shock receive IV antibiotics within the appropriate timeframe and had an empiric review within 3 days of the prescribing of antibiotics

Adult patients:

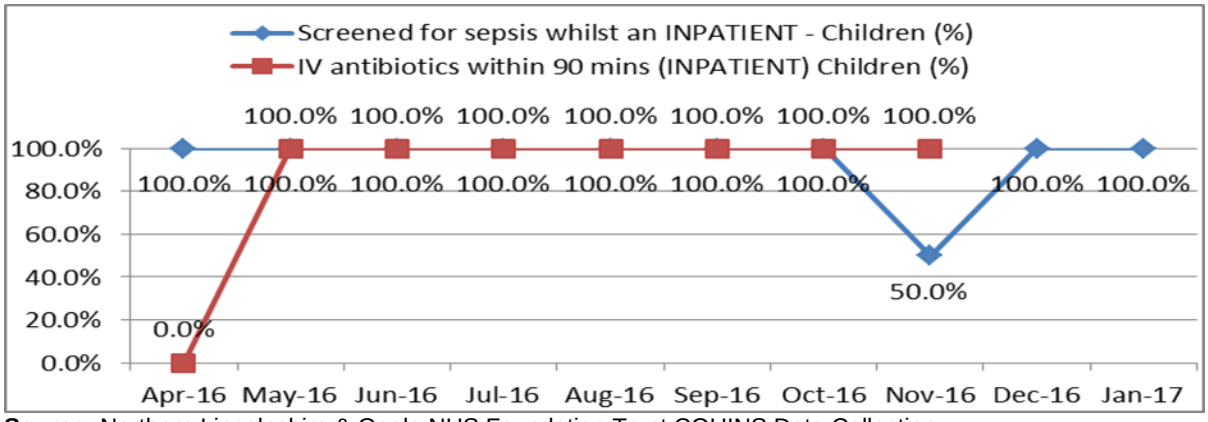


Source: Northern Lincolnshire & Goole NHS Foundation Trust CQUINS Data Collection

Comments:

- The above chart illustrates that the number having antibiotics prescribed for sepsis within 90 minutes has remained at 100%.
- The number of inpatients having sepsis screening has increased to 79.5%. This is the only sepsis indicator not yet achieving the target, the 3 other sepsis indicators have all been achieved and an action plan is in place to achieve this final indicator.

Children:



Source: Northern Lincolnshire & Goole NHS Foundation Trust CQUINS Data Collection

Comments:

Indicator CE 2.3: The methodology used involves a review of 50 patients, split between adults and children, and then presented separately within the preceding charts.

Indicator CE 2.4: The methodology used in connection with the use of IV antibiotics, included identification of patients coded as having sepsis. These cases were then reviewed to ascertain if they had markers of severe, red flag sepsis or septic shock. For January, no paediatric patients had red flag sepsis and therefore there were none applicable to receive antibiotics within 90 minutes.

Action being taken:

- The Trust's Web V system has been expanded to include for patients with an elevated NEWS score an automated prompt to alert staff that this patient is at risk of sepsis and should be screened using the sepsis screening tool. This process has been developed as an electronic system and it is hoped will support the continued work to identify patients at risk whilst in hospital already, not simply on admission. This system is to be piloted on the DPoW site on surgical wards.
- The Trust has worked collaboratively with the East Midlands Ambulance Service (EMAS) to develop a workable protocol for identifying patients at risk of sepsis on attendance by ambulance crews and commencement pre-hospital of appropriate antibiotics. The evaluation of the pilot has demonstrated significant reductions in the delay from call for help to administration of antibiotics. Work is now underway to embed this as practice and expand the trial.

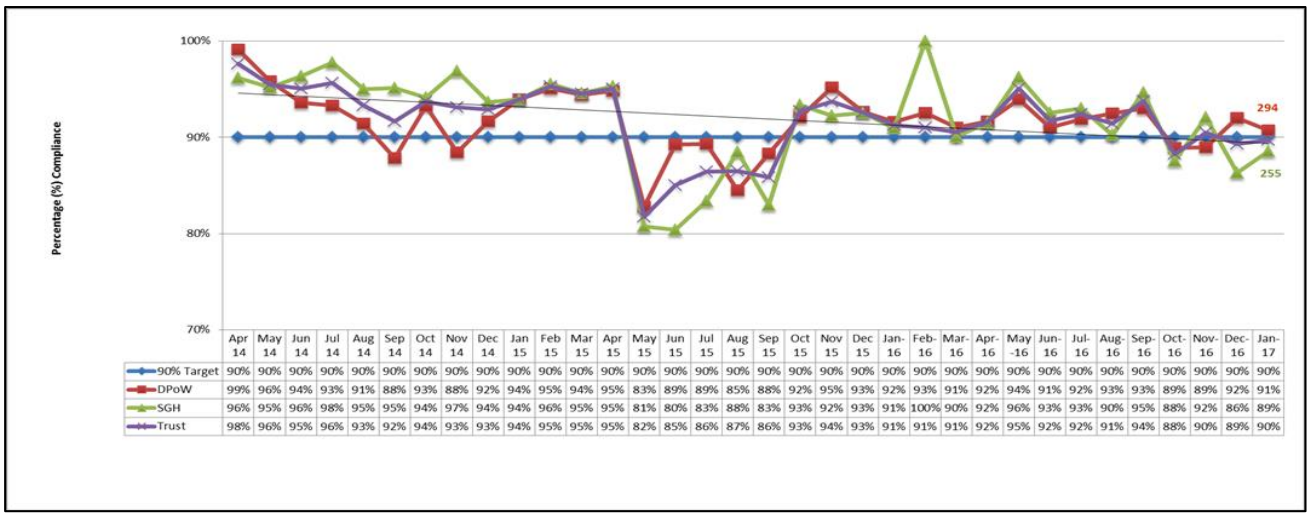
Has the quality indicator been changed during the year from that set in last years (2015/16) Quality Account? No, there has been no change to this quality priority during the 2016/17 reporting period.

Rationale for changing this quality priority for 2017/18: The Trust will continue to monitor on and report performance with this important target during 2017/18 and will feature as part of the mortality improvement programme. The 2017/18 quality priority theme 1 will relate to this area in relation to the mortality improvement work underway.

CE3 – Dementia:

CE3.1: Dementia case screening question

- **TARGET:** 90 per cent of patients aged 75 and over admitted as an emergency to be asked the dementia case finding question.
- **Achievement (April 2016 – March 2017):** The following chart demonstrates that for the most part during 2016/17, this quality priority has been achieved. During January and February the Trust did not achieve this quality priority.



	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan-16	Feb-16	Mar-16	Apr-16	May -16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
90% Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
DPoW	99%	96%	94%	93%	91%	88%	93%	88%	92%	94%	95%	94%	95%	83%	89%	89%	85%	88%	92%	95%	93%	92%	93%	91%	92%	94%	91%	92%	93%	93%	89%	89%	92%	91%
SGH	96%	95%	96%	98%	95%	95%	94%	97%	94%	94%	96%	95%	95%	81%	80%	83%	88%	83%	93%	92%	93%	91%	100%	90%	92%	96%	93%	93%	90%	95%	88%	92%	86%	89%
Trust	98%	96%	95%	96%	93%	92%	94%	93%	93%	94%	95%	95%	95%	82%	85%	86%	87%	86%	93%	94%	93%	91%	91%	91%	92%	95%	92%	92%	91%	94%	88%	90%	89%	90%

Source: NLAG data, intranet, information services team
NB: The above chart data labels refer to the number of patients, not the percentage of patients, as illustrated in the chart axis.

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

Comments:

- Dementia screening has achieved the target of 90% for twelve consecutive months. During January 2017, the Trust's performance is 91% at DPoW and 89% at SGH.
- This is a deterioration in performance and results from the dementia assessment not having been completed within the required timeframe of the first 72 hours. This is being escalated with the Associate Chief Nurses and the Deputies for action within the respective specialty groups.
- To strengthen the focus on dementia, the Trust has recently recruited two new Dementia Clinical Nurse Specialists who will work to oversee this indicator as well as support other dementia focused initiatives. To support their role, the previously used patient level daily monitoring processes will be reinstated.

Has the quality indicator been changed during the year from that set in last years (2015/16) Quality Account? No, there has been no change to this quality priority during the 2016/17 reporting period.

Rationale for changing this quality priority for 2017/18: As the quality priorities have been remodelled for 2017/18, this will not feature as a priority to be reported on within the monthly quality report, but this will continue to be monitored and reported during 2017/18 using other mechanisms.

CE4 – National Institute for Health and Care Excellence (NICE) evidence based practice

*(**NB:** For a greater understanding of NICE guidance and how compliance is assessed, please refer to the glossary section of this report)*

CE4 – Compliance with NICE evidenced based practice:

- **TARGET: CE4.1:** 100% of Technology Appraisal Guidelines (TAGs) to be fully compliant within 3 months of publication.
- **TARGET: CE4.2 :** 90% of Clinical Guidelines (CGs) / NICE Guidelines (NGs) to be fully compliant within 3 years of publication
- **Achievement (February 2017):** The Trust has not yet achieved this quality priority, however, significant progress has been made to the point that the Trust are close to meeting this quality priority for both types of NICE guidance. It should be noted in terms of context for this indicator, each month NICE issue new types of guidance, the Trust's processes therefore need to ensure that previously released NICE guidance is acted upon as well as new monthly releases.

Overall Trust Compliance – NICE Technology Appraisal Guidance (TAGs)

As at the 29 February 2017, Trust compliance with those NICE Technology Appraisal Guidelines (TAGs) that had been assessed using the Trust's Gap Analysis toolkit is as follows:

COLOUR	COMPLIANCE STATUS	COMPLIANCE NUMBERS	COMPLIANCE (%)
GREEN	**FULL COMPLIANCE**	**249**	**98.0%**
AMBER	Partial compliance	3	**1.2%**
PURPLE	Not yet assessed – OVERDUE	2	**0.8%**
RED	Non-Compliant	0	**0.0%**
TOTAL		**254**	**100.0%**

Source: Trust NICE Database

Overall Trust Compliance – All NICE Guidance

As at the 29 February 2016, overall Trust compliance is as follows:

COLOUR	COMPLIANCE STATUS	COMPLIANCE NUMBERS	COMPLIANCE (%)
GREEN	**FULL COMPLIANCE**	**473**	**92.9%**
AMBER	Partial compliance	24	4.7%
PURPLE	Not yet assessed – OVERDUE	12	2.4%
RED	Non-Compliant	0	0.0%
TOTAL		**509**	**100.0%**

Source: Trust NICE Database

Key to abbreviations: Full compliance – fully compliant as declared by teams assessing guideline
Partial compliance – some elements of the guideline not yet compliant with
Not yet assessed – overdue – compliance not yet assessed and deadline missed
Non-compliant – fully non-compliant at present with NICE recommendations

Has the quality indicator been changed during the year from that set in last years (2015/16) Quality Account? No, there has been no change to this quality priority during the 2016/17 reporting period.

Rationale for changing this quality priority for 2017/18: The refreshed quality priorities for 2017/18 do not include this as a quality priority as they are mapped to the Trust's core quality priorities. Trust compliance with NICE guidance will continue to be monitored and reported on to the Trust Governance & Assurance Committee.

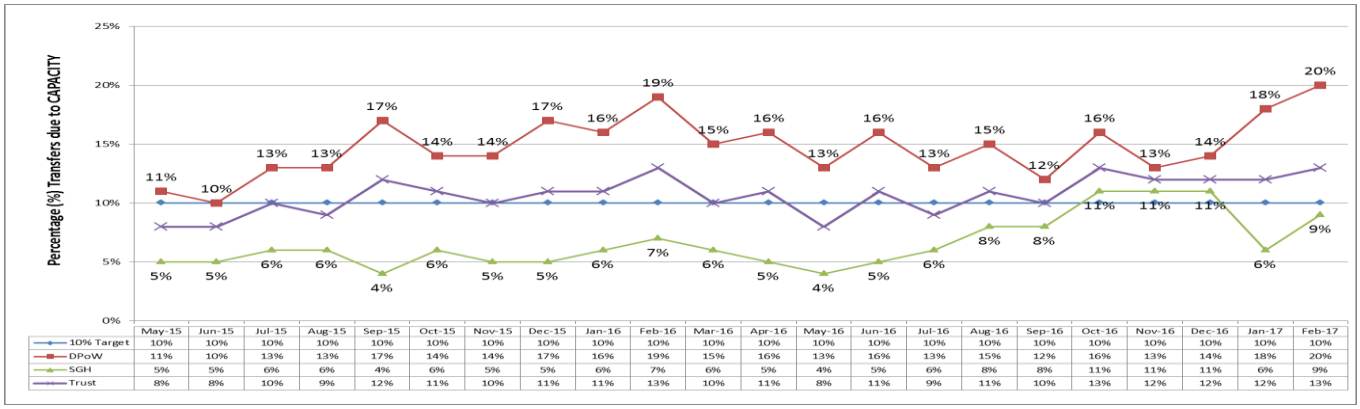
CE5 Transfer and Discharge

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

Transfer and Discharge continues to remain a crucial area of focus for both patient experience and also bed stock efficiencies and flow.

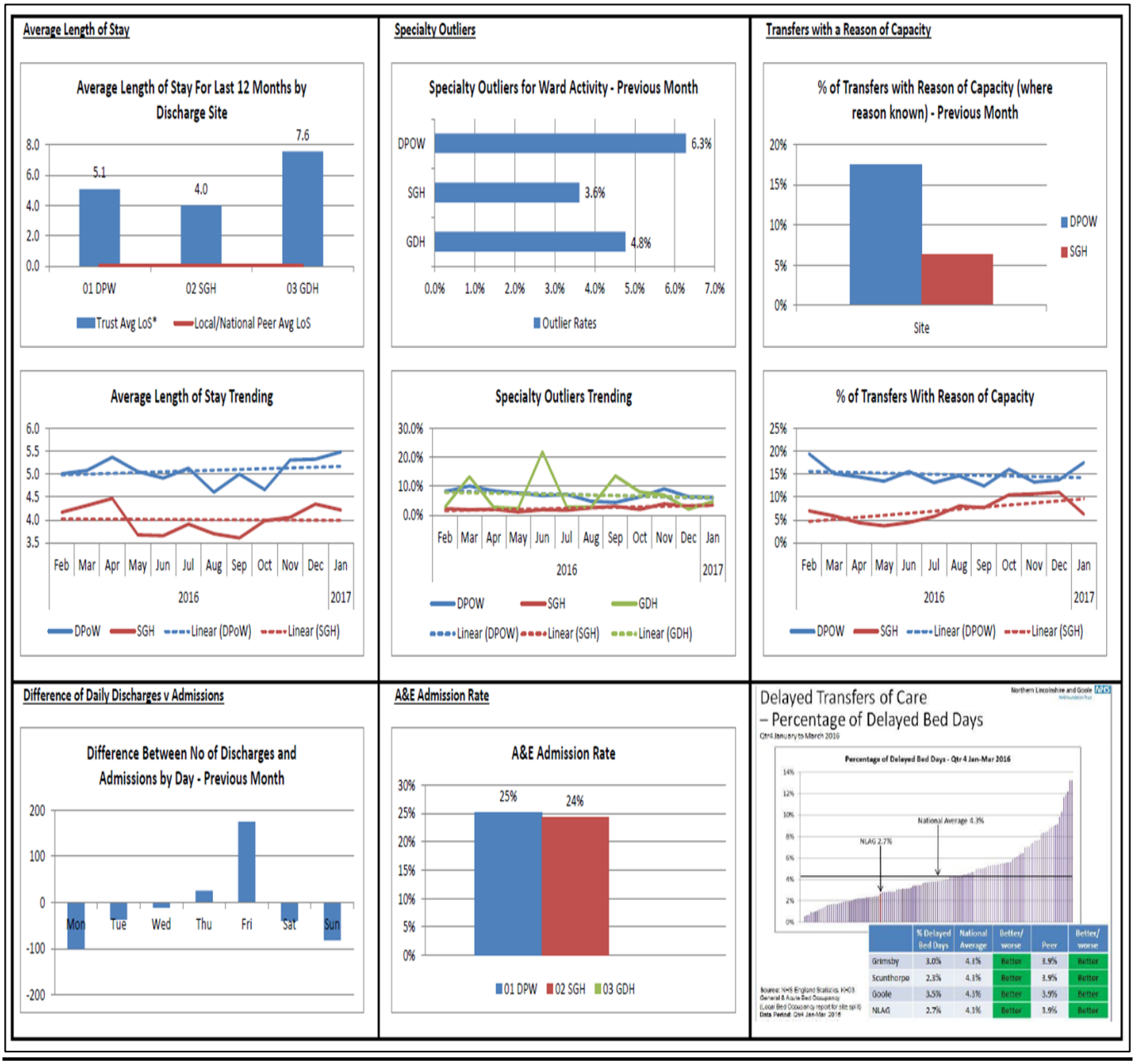
The Trust experienced significant activity surge pressures starting in December which has been reflected in the monitoring graphs.

The chart below demonstrates the percentage trend of transfers at both sites and Trust level that relate to capacity.



Source: Transfer and Discharge Working Group Report, Trust Information Services

The dashboard illustrates the contextual data relating to transfer and discharge in graphical format.



Source: Transfer and Discharge Working Group Report, Trust Information Services

Has the quality indicator been changed during the year from that set in last years (2015/16) Quality Account? No, there has been no change to this quality priority during the 2016/17 reporting period.

Rationale for changing this quality priority for 2017/18: The refreshed quality priorities for 2017/18 include the theme of discharge and transfer and will build further on this area.

Overview of the quality of care against 2016/17 quality priorities:

2.1a Clinical Effectiveness (CE)

This Section…

2.1b PATIENT SAFETY (PS)

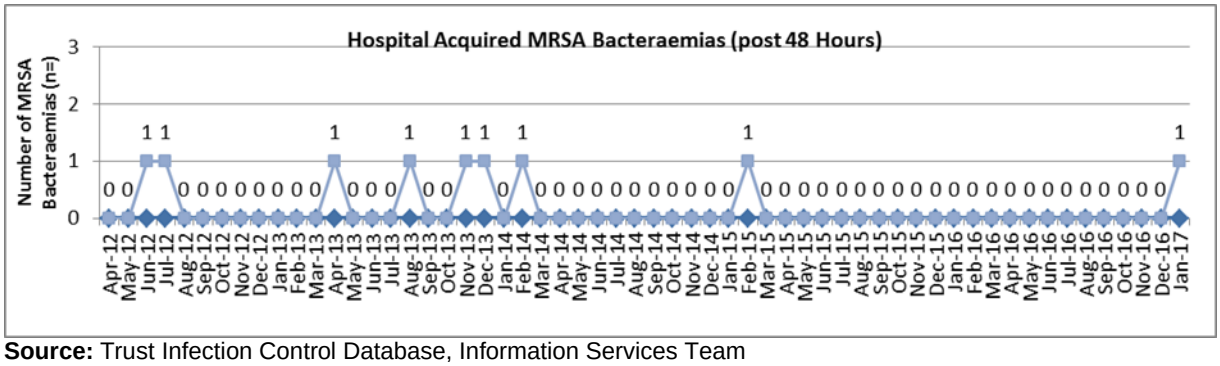
- → PS1 MRSA Bacteremia Incidence
- → PS2 C Difficile
- → PS3 Community Safety Thermometer
- → PS4 Ward Focused Pressure Ulcer Reductions
- → PS5 Trust Focused Pressure Ulcer Reductions
- → PS6 Avoidable Repeat Falls
- → PS7 Nutrition
- → PS8 Hydration

2.1c Patient Experience (PE)

2.1b PATIENT SAFETY

PS1 – MRSA bacteraemia incidence

- **TARGET:** 0 MRSA Bacteraemia developing after 48 hours into the inpatient stay (hospital acquired).
- **Achievement (April 2016 – March 2017):** This target has been met consistently during 2016/17, however during January and February 2017, 3 cases of hospital acquired MRSA have been reported.



Source: Trust Infection Control Database, Information Services Team

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

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
MRSA Incidence	8	4	2	5	1	0

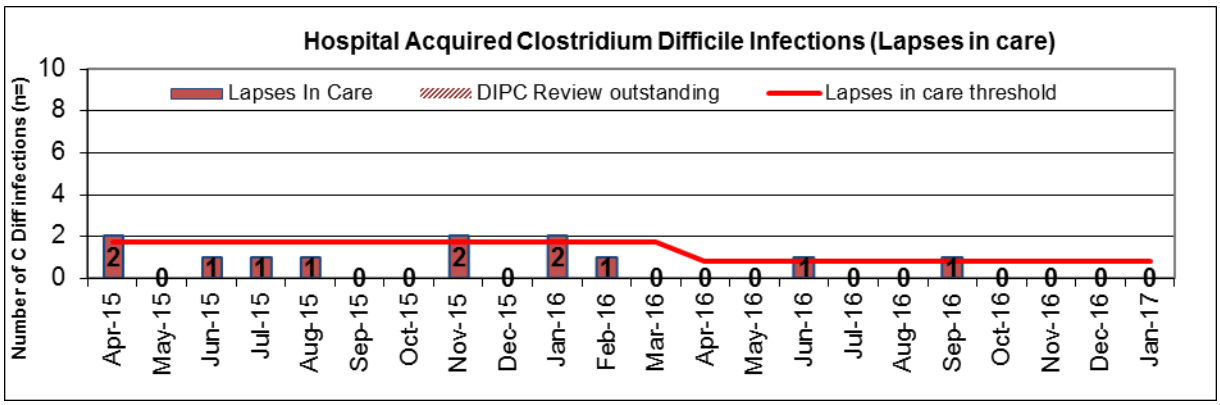
Source: Trust Infection Control Database, Information Services Team

Has the quality indicator been changed during the year from that set in last year's (2015/16) Quality Account? No, there has been no change to this quality priority during the 2016/17 reporting period.

Rationale for changing this quality priority for 2017/18: This will remain an important area under the quality priority theme of medical quality indicators.

PS2 – C. Difficile incidence

- **TARGET:** Achieve a level of no more than 10 hospital acquired C. Difficile cases linked with a lapse in the quality of care, over the financial year 2016/17.
- **Achievement (April 2016 – March 2017):** This target has been met with at present only 4 cases of C Difficile reported as a result of a lapse in care. Performance is illustrated in the following chart. Trust performance against this target is particularly good reflecting on the fact that the national guidance specifies no more than 20, so the Trust's stretch target applied during 2016/17 of no more than 10 has been comprehensively achieved.



Source: Trust Infection Control Database, Information Services Team

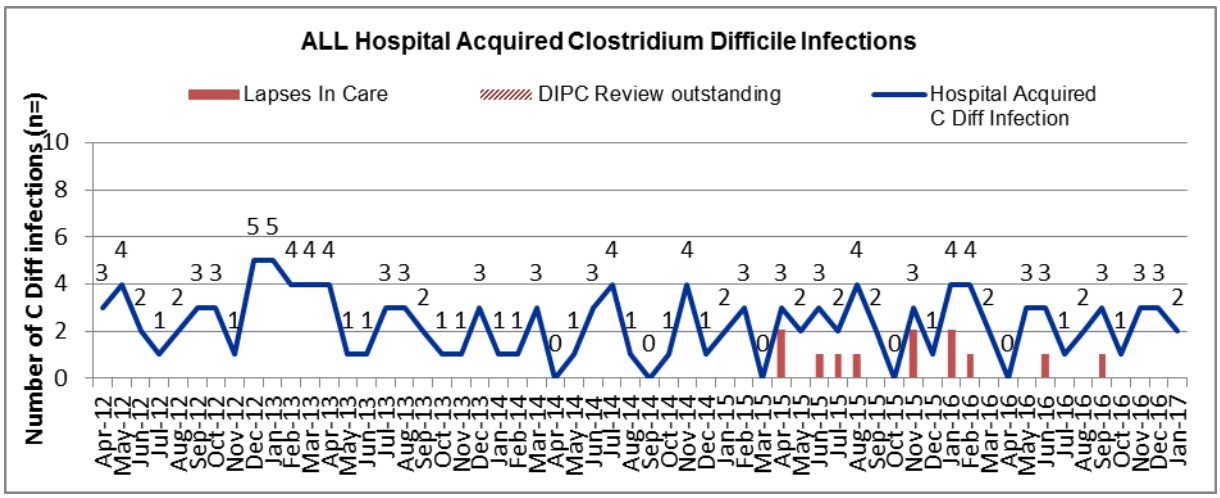
Key to abbreviations: DIPC review – Director of Infection and Prevention Control (DIPC)

Comments:

- A decision as to if this was as a result of a lapse in care (in other words avoidable) is made during the Director of Infection and Prevention Control (DIPC) review of the case. There can be a short delay in undertaking the review.

For completeness: <u>ALL</u> cases of hospital acquired C. Difficile over the financial year 2015/16.

Trust Performance (April 2016 to date): 21 cases (ALL cases)



Source: Trust Infection Control Database, Information Services Team

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

Comments:

- The above chart illustrates the trend since April 2012 for reported hospital acquired Clostridium Difficile cases. The blue line in the chart illustrates **all** reported infections. Added, for clarity, since April 2015 are those within each month deemed to be as a result of a lapse in the quality of care (or where the DIPC review has not yet been held).

Key points – previous performance: Hospital acquired C Diff (post 48hrs, ALL cases)

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
C Diff Incidence	43	41	37	24	20	30

Source: Trust Infection Control Database, Information Services Team

Has the quality indicator been changed during the year from that set in last year's (2015/16) Quality Account? No change has been made to this quality priority.

Rationale for changing this quality priority for 2017/18: This will remain an important area under the quality priority theme of medical quality indicators.

PS3 – Safety Thermometer – Increase in harm free care (Community)

*(**NB:** For a greater understanding of the NHS Safety Thermometer and how this is scored and compliance assessed, please refer to the glossary section of this report)*

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

- **Achievement (April 2016 – March 2017):** The Trust has generally achieved this target. Since October 2015, the Trust had exceeded this target for 14 consecutive months in a row. December 2016 is the only month this target has not been achieved, where it was narrowly missed.

The following table illustrates the total community cumulative percentage of harm free care by month since April 2015.

	Cumulative & of Harm Free Care																					
Reporting Period	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Community Care Total	94.0%	96.0%	92.0%	94.0%	95.0%	94.0%	97.0%	96.0%	98.0%	98.0%	96.0%	97.0%	97.0%	95.7%	98.5%	97.8%	96.9%	97.3%	95.0%	96.4%	94.6%	96.4%

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

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

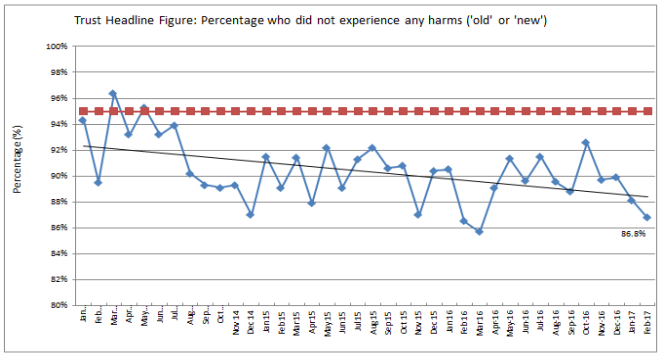
Has the quality indicator been changed during the year from that set in last year's (2015/16) Quality Account? No, there has been no change to this quality priority during the 2016/17 reporting period.

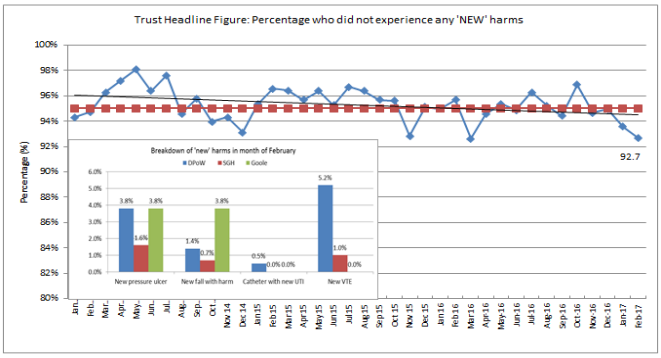
Rationale for changing this quality priority for 2017/18: Increasing the provision of harm free care remains a key quality priority theme.

CONTEXTUAL INFORMATION: Open and Honest Initiative: Increase in harm free care (Acute) – Harm free acute care to 95% or more patients – as measured by the 'Open and Honest Care: Driving Improvements' Publication

Key Points: Performance to date – Safety Thermometer:

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





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

Key to abbreviations: New harm – Harms developing at least 72 hours after admission
Old harm – Pre-existing harm present prior to hospital admission

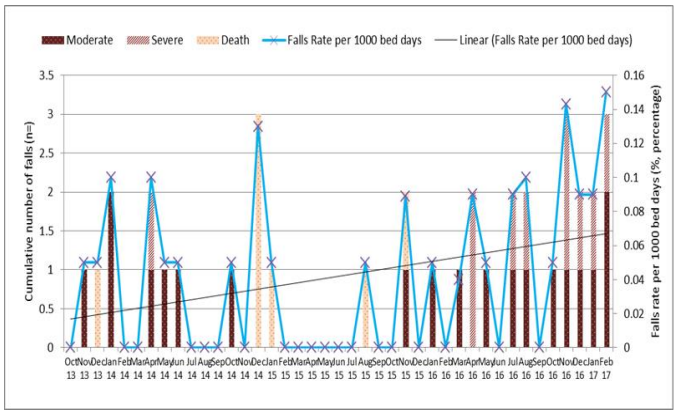
Comments:

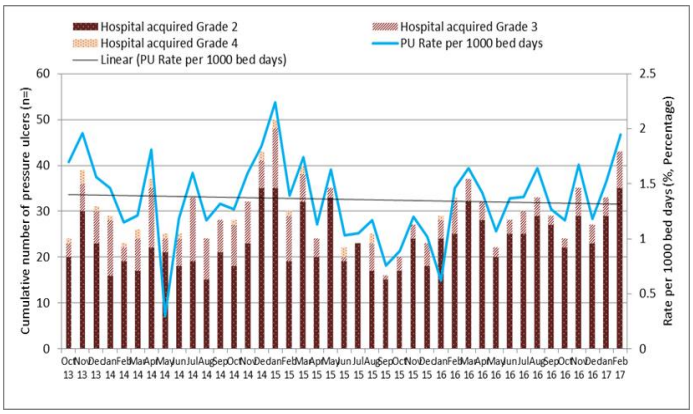
- The charts above illustrate that whilst 86.8% of patients included in this snapshot data did not experience any harm (new or old), a proportion of those patients presented to the acute hospital setting with a pre-existing harm i.e. an 'old' pressure ulcer, or in other words, a pre-existing pressure ulcer already afflicting them prior to hospital admission.
- The chart on the right hand side illustrates those patients with 'new' harms only – those developing at least 72 hours after admission. For February, 92.7% of patients had harm free care. The trend line demonstrates a slight deterioration over time.
- The proportion of patients receiving harm free care should be interpreted with caution, recognising that some harm is not preventable by the Trust.
- During February, the percentage of new harms was partly driven by the number of new pressure ulcer, 3.8% at DPoW and GDH, and 1.6% at SGH. New VTE on the DPoW site also contributed.

CONTEXTUAL INFORMATION: Open and Honest Initiative: Falls & Pressure Ulcers

Key Points: Headline figures – Performance as a Trust (NEW harm only):

The following charts illustrate the number of falls and pressure ulcers, identified from all reported incidents, since October 2013, including the level of harm and the falls rate per 1000 bed days. The chart also illustrates the trend over time.





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

Key to abbreviations: Harm grading – for definitions see glossary
Pressure ulcer grading – for definitions see glossary
Rate per 1,000 bed days – see glossary

Falls: Comments

- The above left hand chart reports the harm classifications following falls, specified by the Open and Honest Initiative, specifically resulting in moderate, severe harm, or harm leading to death.
- The trend line demonstrates an increasing number of falls resulting in harm.

Pressure ulcers: Comments

- The pressure ulcer rate per 1000 bed days demonstrates continuously reducing trend for harm from pressure ulcers.
- In February the overall number of pressure ulcers was 43 in total, comprising 35 grade two and 8 grade three ulcers.
- There have been no grade 4 pressure ulcers for 12 months (since March 2016).

Action now being taken:

- For ease of reference regarding the work underway to improve the quality of care for these patients, please see sections PS4, PS5 and PS6 of this report.

PS4 – Ward focused pressure ulcer reductions

- **TARGET:** Pressure Ulcer prevalence on 6 selected wards to demonstrate a reducing trend over time.
- **Achievement (April 2016 – March 2017):** The Trust has not yet achieved this quality priority. The methodology employed to date has been around identifying ward areas with higher prevalence of pressure ulcers and include these within the prioritised ward areas reported on in this section. Where improvement is noted on the wards included, these are removed and replaced with another ward area with the next highest prevalence.

Key Points – Context:

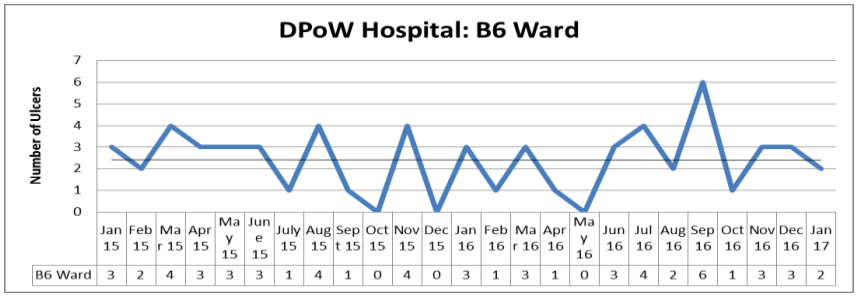
- Pressure ulcers have been a priority for the Trust and the focused work has led to an overall reduction in the incidence of hospital acquired pressure ulcers.
- The bulk of the Trust's focus to date has been Trust and site specific monitoring of the incidence of pressure ulcers. To aid further improvements, this section features for the first time, ward based data to aid specific wards with higher incidences of pressure ulcers to focus on further quality improvements.
- It must be stressed that the following ward based information is presented to aid and support these wards existing quality improvement efforts and to ensure that any further support needed from these areas is available.

Rationale for specific ward area selection

- A retrospective analysis was undertaken assessing the incidence of pressure ulcers during the 2015/16 financial year. This established a baseline understanding.
- From this baseline, a 'blended' approach was used to identify 6 ward areas; this approach looked at both the number of 'avoidable' pressure ulcers and the total incidence of pressure ulcers.
- In total, the number of avoidable pressure ulcers was low, so the 6 ward areas selected had a combination of factors, a relatively high number of pressure ulcers (in total, when compared to other ward areas) and at least 1 avoidable pressure ulcer.

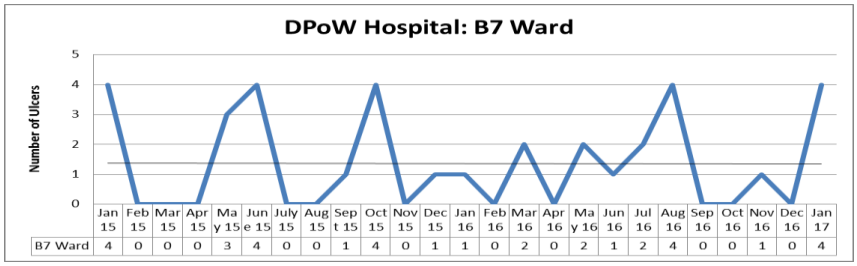
Performance for the 6 ward areas against the quality improvement target for 16/17:

The following charts illustrate the incidence of pressure ulcers since January 2015 and are designed to enable trends in the incidence to be seen on an ongoing basis throughout 2016/17.



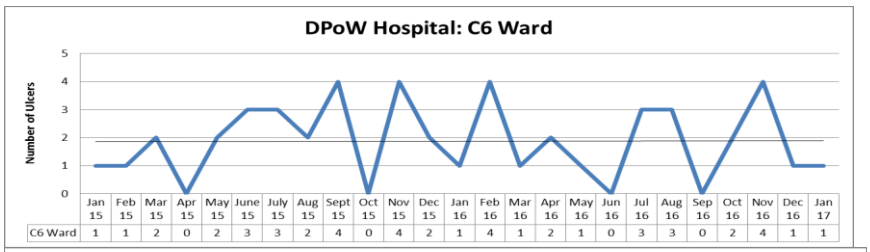
Comment:

- The trend for Ward B6 at DPoW is static over time.
- In January, 2 pressure ulcers reported.



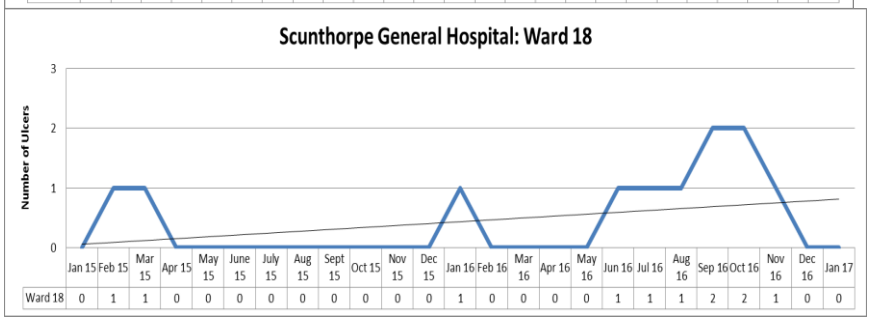
Comment:

- The trend for ward B7 at DPoW is static over time.
- In January, 4 pressure ulcers reported.



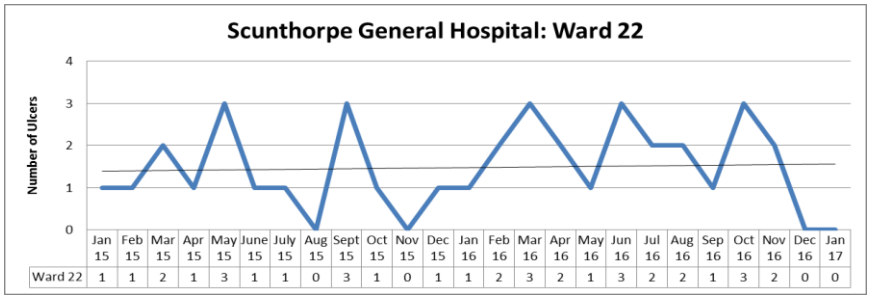
Comment:

- The trend for ward C6 at DPoW is static over time.
- In January, 1 pressure ulcer reported.



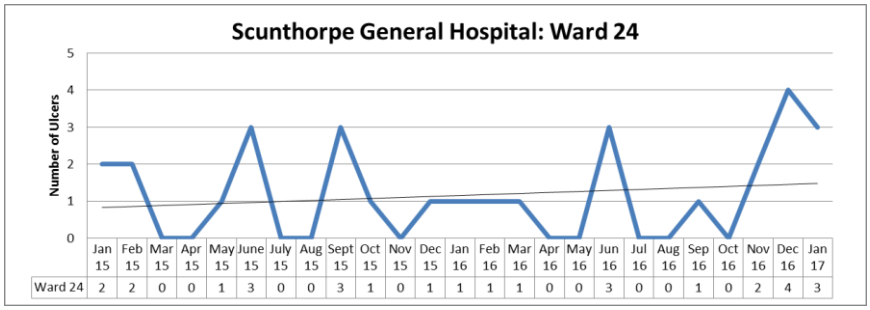
Comment:

- The trend for ward 18 at Scunthorpe General Hospital is **increasing** over time.
- In January, 0 pressure ulcers were reported.
- This ward replaces ward 11 for monitoring within this report.



Comment:

- The trend for ward 22 at Scunthorpe General Hospital is **increasing** over time.
- In January, 0 pressure ulcers were reported.



Comment:

- The trend for ward 24 at Scunthorpe General Hospital is **increasing** over time.
- In January, 3 pressure ulcers reported.

Comment:

- Three of the six wards focussed upon are currently demonstrating an **increasing** trend over time. This is currently based over a 25 month time frame.
- Those wards identified as having an increasing trend are Ward 18 at SGH, Ward 22 at SGH and Ward 24 at SGH.
    - While Ward 18 at SGH does not have huge numbers its incidence has increased over time. In the first instance the bulk of the ward mattress stock has been changed to hybrid types to support what is unquestionably a vulnerable group.
    - Ward 22 at SGH has had increasing operational support designed to address staffing levels that the ward has experienced and providing additional support from the tissue viability nurses to oversee assessment processes. The Quality Matron for the area has been closely involved in this work.
    - Ward 24: The spike in pressure ulcers on Ward 24 during December were all deemed to be unavoidable. From a review of processes some improvements in documentation have been identified and the lead Quality Matron has been providing some support with this. The ward has had a number of staff vacancies which is being mitigated by staff from other areas being moved to help cover shifts which helps ensure staffing to appropriate levels, but complicates consistency in ward specific processes. The Ward manager has been crucial to completion of risk assessments.

Has the quality indicator been changed during the year from that set in last year's (2015/16) Quality Account? No, there has been no change to this quality priority during the 2016/17 reporting period. The indicator underwent a minor amendment when one of the originally identified ward areas improved to the extent it no longer had a high prevalence of pressure ulcers. This ward area was replaced with another ward.

Rationale for changing this quality priority for 2017/18: The 2017/18 quality priority themes include the focus on increasing harm free care, this area of pressure ulcers will remain a feature within this quality theme.

PS5 – Trust focused pressure ulcer reduction

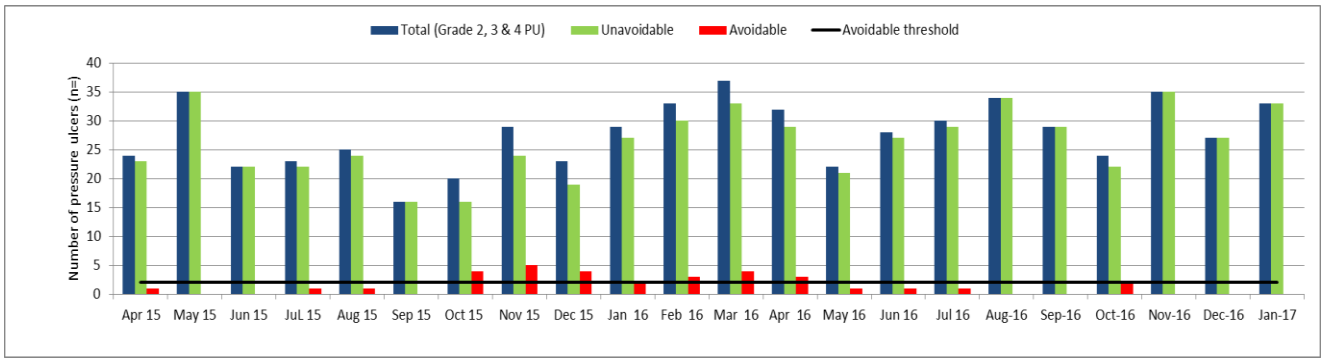
- **TARGET:** a 50% reduction in avoidable grade 2, 3 & 4 pressure ulcers (as measured via the Root Cause Analysis undertaken for every grade 2, 3 & 4 pressure ulcer).
- **Achievement (April 2016 – March 2017):** The Trust has achieved this target consistently during 2016/17.

Key points – Context:

- Following the reporting of a grade two, three or four pressure ulcer, a root cause analysis process is undertaken to understand if this was avoidable or unavoidable. These records are kept by the lead Quality Matron.
- In total for Quarter 1 14/15, of the 87 grade 2, 3 and 4 pressure ulcers, 12 were deemed to be avoidable following the root cause analysis work undertaken. Based on this, setting a 50% reduction target, equates to no more than 6 pressure ulcers per quarter. 6 per quarter, divided by 3 months, equates to no more than 2 avoidable pressure ulcers per reported month.

Key points – Performance:

- The following chart demonstrates the split between avoidable and unavoidable grade two, three and four pressure ulcers.



Source: RCA Records kept by lead Quality Matron

Key to abbreviations: Unavoidable – Root cause analysis found no avoidable factors
Avoidable – Root cause analysis found that the pressure ulcer was avoidable

January – Total Pressure Ulcers (by grade)		
Grade 2	Grade 3	Grade 4
29	**4**	**0**

Comments:

- There were zero avoidable pressure ulcers in January 2017.

Action now being taken:

- The Tissue Viability Nursing (TVN) team continue to ensure a standardised and consistent approach is taken to the classification of avoidable and unavoidable ulcers as part of staff education and the validation process. This provides consistency and assurance, as well as supporting understanding of the context around pressure ulcers. In future any learning will also be discussed at the Skin Integrity Board to support collaborative working between community and acute areas.
- Continued focus on themes arising from pressure ulcer RCA as a driver for change and improvement. As a consequence the TVN team is to trial a discharge pack for patients to support their ongoing community based care. Feedback from community colleagues via the Skin Integrity Board supports this approach.
- Hybrid stocks of beds have been installed across the sites and are being used with no issues raised. All support surfaces will be audited during March 2017 to ensure they are in good condition. Any faulty surfaces will be replaced. The need for further hybrid mattress acquisition will be reviewed then in the new financial year.

- A theme identified from some of the recent RCAs undertaken for pressure ulcers has identified communication to be a theme following admission to the Trust's admission units and then the onward transfer of patients to other wards. In response to this, during September 2016 a trial of a specific SBAR (Situation, Background, Assessment and Recommendation) handover tool was initiated. The trial was not successful and the format was found to be used less, however, following this trial, as part of a review of the documentation used in practice, a condensed format and concise handover section has been built in which deals with skin condition. This will be used firstly on CDU and AMU admission units.
- A revised approach to staffing within the Tissue Viability Team has been developed with interviews for a new role to be held. The roles will work across both acute and community and augment the excellent work already carried out by our nurse specialists.

Has the quality indicator been changed during the year from that set in last year's (2015/16) Quality Account? No, there has been no change to this quality priority during the 2016/17 reporting period.

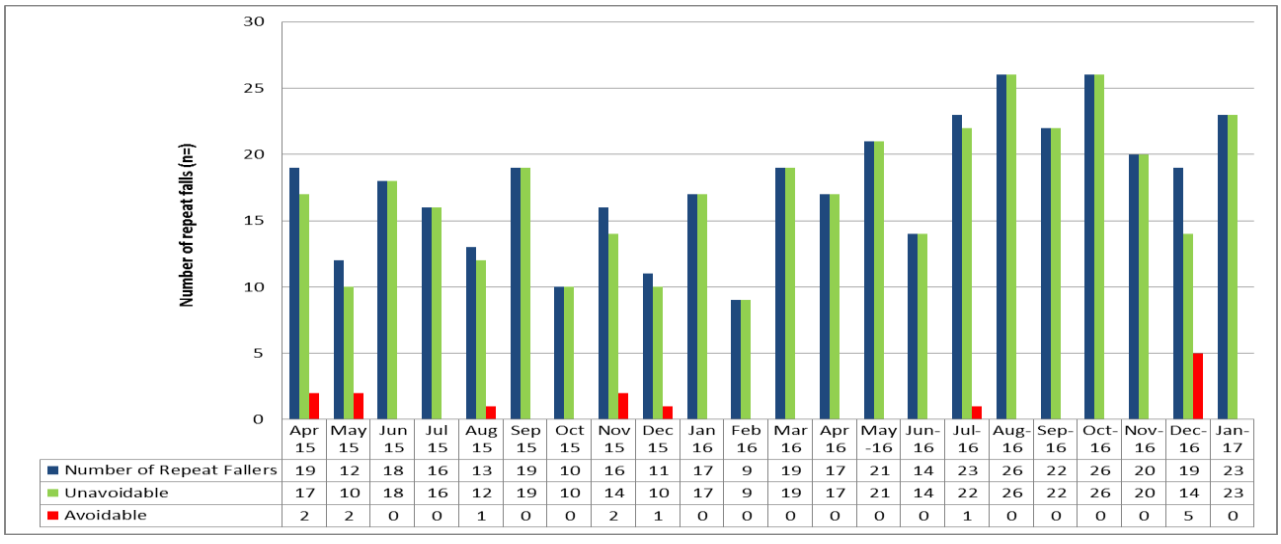
Rationale for changing this quality priority for 2017/18: The 2017/18 quality priority themes include the focus on increasing harm free care, this area of pressure ulcers will remain a feature within this quality theme.

PS6 – Avoidable Repeat Falls

- **TARGET:** Eliminate all avoidable repeat falls (as measured via the Root Cause Analysis undertaken for every repeat faller).
- **Achievement (April 2016 – March 2017):** The Trust has not yet achieved this quality priority. During 2016/17 there have been 5 avoidable repeat fallers that have been identified.

Key points: Repeat Fallers – RCA Outcomes – Eliminate all avoidable repeat fallers

- For every repeat fall a Root Cause Analysis (RCA) is performed to identify lessons that can be learnt to prevent future patients falling.
- Each fall is determined to have been either avoidable or unavoidable.
- The following chart provides a summary of performance per month against this target.



	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May -16	Jun- 16	Jul- 16	Aug- 16	Sep- 16	Oct- 16	Nov- 16	Dec- 16	Jan- 17
Number of Repeat Fallers	19	12	18	16	13	19	10	16	11	17	9	19	17	21	14	23	26	22	26	20	19	23
Unavoidable	17	10	18	16	12	19	10	14	10	17	9	19	17	21	14	22	26	22	26	20	14	23
Avoidable	2	2	0	0	1	0	0	2	1	0	0	0	0	0	0	1	0	0	0	0	5	0

Data Source: RCA Records kept by lead Quality Matron

Key to abbreviations: Repeat fallers – a patient who has had at least one previous fall
Unavoidable – Root cause analysis found no avoidable factors
Avoidable – Root cause analysis found that the pressure ulcer was avoidable

Comments:

- There were zero avoidable repeat falls during January.

Action now being taken:

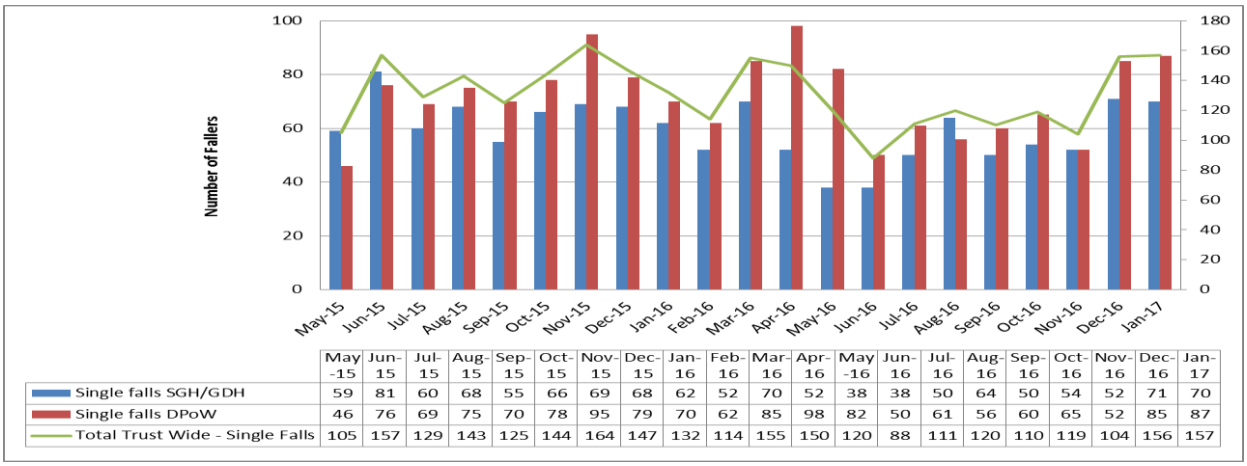
- Targeted input to wards that are experiencing higher numbers of falls. This mirrors the approach being taken around pressure ulcer incidence and is designed to support the wards to reduce incidence and support change.
- This targeted work has already identified some issues around how patients at risk of falls are communicated on transfer and this will be the focus of further Quality Matron work.
- Trial of the use of a 'falls pause' in one clinical area to assess impact. This would see the ward team stop for a brief pause to check all correct process are in place for patients identified at risk of falls, check if any new at risk patients require review and discuss how best to deploy resources to facilitate the current clinical picture. The Stroke Units at both sites have expressed an interest in taking part in this project.
- There is good evidence from RCA that once a fall has occurred staff are putting the full package of interventions in place to prevent reoccurrence. A good example is the Stroke Unit at SGH who still have a number of single falls but are managing to prevent recurrence in a group where a high proportion are inevitably fall risks.

Has the quality indicator been changed during the year from that set in last year's (2015/16) Quality Account? No, there has been no change to this quality priority during the 2016/17 reporting period.

Rationale for changing this quality priority for 2017/18: The 2017/18 quality priority themes include the focus on increasing harm free care; this area of falls will remain a feature within this quality theme.

CONTEXTUAL INFORMATION: Total number of SINGLE falls

- The Quality report has focussed on the Quality Priority target assessing the aspiration to have zero avoidable repeat fallers.
- As additional context to this important area, the following chart presents, for background purposes, the total number of single falls, or more specifically, the total number of patients identified as having had one fall during their hospital stay, since May 2015.



	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Single falls SGH/GDH	59	81	60	68	55	66	69	68	62	52	70	52	38	38	50	64	50	54	52	71	70
Single falls DPoW	46	76	69	75	70	78	95	79	70	62	85	98	82	50	61	56	60	65	52	85	87
Total Trust Wide - Single Falls	105	157	129	143	125	144	164	147	132	114	155	150	120	88	111	120	110	119	104	156	157

Data Source: DATIX, Performance Assurance Team

Key to abbreviations: Single falls – Patient has had a single fall during hospital admission

Comment:

- The chart above illustrates that the number of single falls occurring within the Trust during January was 157. During December and January an increase in the total numbers reported in recent months is noticed.

Action now being taken:

- Critical Care areas have been asked to undertake a root cause analysis on all first falls in order to build a picture of why patients are falling, particularly those areas with increased observation and lower patient to staff ratios.

PS7 – Nutrition

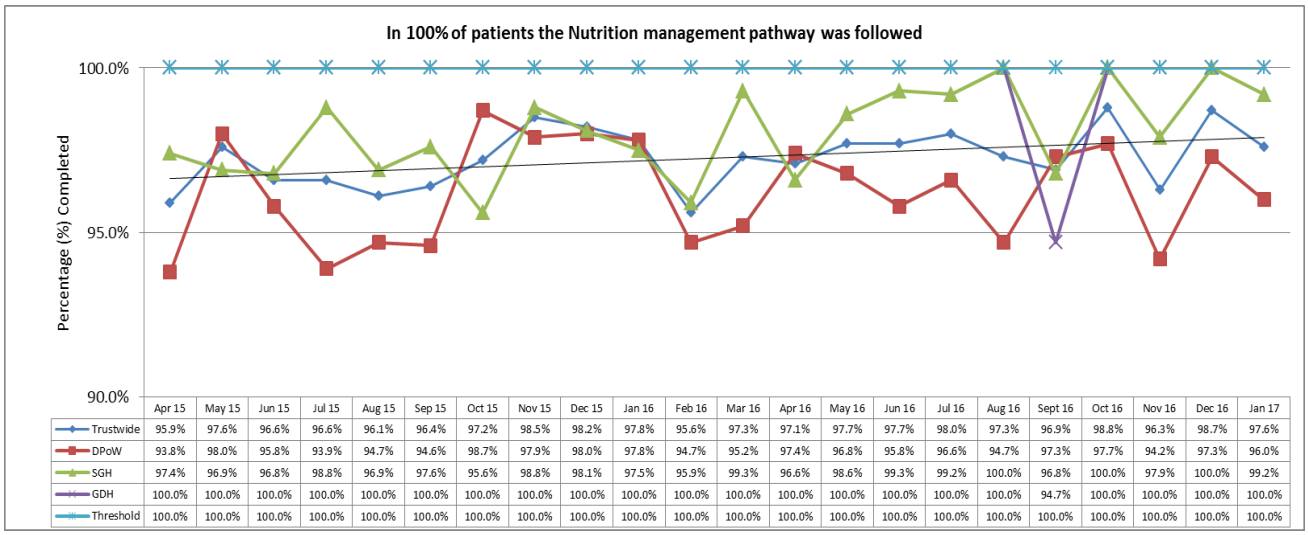
- **TARGET:** Nutrition: 100% of patients had the Nutrition management pathway followed.
- **Achievement (April 2016 – March 2017):** The Trust has not yet achieved this quality priority. However, the trend over time has been one of improvement. Compliance with this quality priority is routinely above 95%.

Key points – Context:

- In September 2013 the Trust adopted a nationally validated tool – the Malnutrition Universal Screening Tool (MUST).
- The MUST screening Tool is used to identify those patients who are at risk of malnutrition – depending on the MUST score – a management plan is then followed for the duration of the patients stay.

Key points – Performance:

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



	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17
Trustwide	95.9%	97.6%	96.6%	96.6%	96.1%	96.4%	97.2%	98.5%	98.2%	97.8%	95.6%	97.3%	97.1%	97.7%	97.7%	98.0%	97.3%	96.9%	98.8%	96.3%	98.7%	97.6%
DPoW	93.8%	98.0%	95.8%	93.9%	94.7%	94.6%	98.7%	97.9%	98.0%	97.8%	94.7%	95.2%	97.4%	96.8%	95.8%	96.6%	94.7%	97.3%	97.7%	94.2%	97.3%	96.0%
SGH	97.4%	96.9%	96.8%	98.8%	96.9%	97.6%	95.6%	98.8%	98.1%	97.5%	95.9%	99.3%	96.6%	98.6%	99.3%	99.2%	100.0%	96.8%	100.0%	97.9%	100.0%	99.2%
GDH	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.7%	100.0%	100.0%	100.0%	100.0%
Threshold	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Information Services, Nursing Dashboard

NB: The above charts axis starts at <u>90%</u>.

Key to abbreviations:
Trust wide – Performance of all 3 sites
DPoW – Diana, Princess of Wales Hospital, Grimsby
SGH – Scunthorpe General Hospital
GDH – Goole District Hospital
Threshold – Quality target being aimed for – 100%

Comments:

- During January the Trust achieved 97.6% compliance. The chart illustrates performance since April 2015 and note the trend over time demonstrates an improvement.
- Non-compliance may be as a result of non-commencement of a food chart, or a non-referral to dieticians – any areas of concern are always highlighted at the time of the audit to the respective Nurse.

Action now being taken:

- Any areas of concern are highlighted by the Quality Matrons at the time of audit both with the Nurse responsible for the patient's care (to ensure the concern is rectified) and the Senior Nurse on duty (to ensure the concern is cascaded amongst the Nursing team).

- Where there are continued concerns, these are discussed in a meeting with the Assistant Director of Nursing, Head of Quality the Ward Sister / Charge Nurse, Operational and Quality Matrons. Agreed actions are then formulated and may be prioritised according to each area. Whilst this report focuses on Nutrition and Hydration indicators taken from the Nursing Dashboard, it is worth noting that areas of concern cover multiple indicators.

Has the quality indicator been changed during the year from that set in last year's (2015/16) Quality Account? No, there has been no change to this quality priority during the 2016/17 reporting period.

Rationale for changing this quality priority for 2017/18: The 2017/18 quality priority themes include the focus on increasing harm free care, this area of nutrition and hydration will remain a feature within this quality theme.

TARGET: PS7.2: Nutrition

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

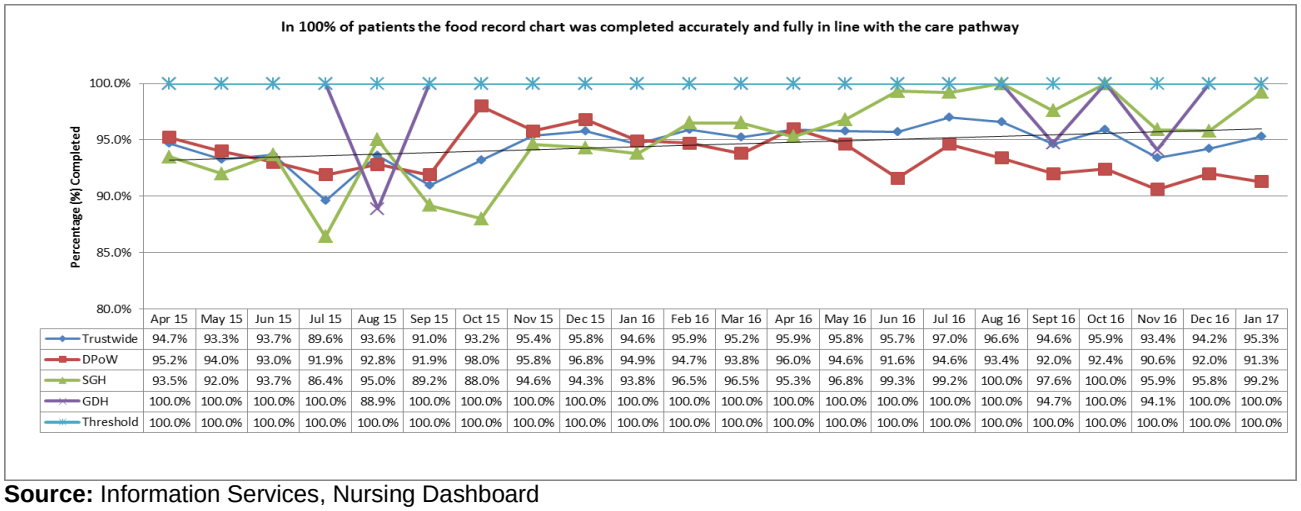
- **Achievement (April 2016 – March 2017):** The Trust has not yet achieved this quality priority. However, the trend over time has been improving with performance at all sites routinely exceeding 90%.

Key points – context:

- Those patients who are identified as moderate to high risk (MUST score >1) need to have a food record chart commenced and completed fully in line with the management plan.

Key points – performance to date:

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



	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17
Trustwide	94.7%	93.3%	93.7%	89.6%	93.6%	91.0%	93.2%	95.4%	95.8%	94.6%	95.9%	95.2%	95.9%	95.8%	95.7%	97.0%	96.6%	94.6%	95.9%	93.4%	94.2%	95.3%
DPoW	95.2%	94.0%	93.0%	91.9%	92.8%	91.9%	98.0%	95.8%	96.8%	94.9%	94.7%	93.8%	96.0%	94.6%	91.6%	94.6%	93.4%	92.0%	92.4%	90.6%	92.0%	91.3%
SGH	93.5%	92.0%	93.7%	86.4%	95.0%	89.2%	88.0%	94.6%	94.3%	93.8%	96.5%	96.5%	95.3%	96.8%	99.3%	99.2%	100.0%	97.6%	100.0%	95.9%	95.8%	99.2%
GDH	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.7%	100.0%	94.1%	100.0%	100.0%
Threshold	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Information Services, Nursing Dashboard

NB: The above charts axis starts at <u>80%</u>.

Key to abbreviations:
Trust wide – Performance of all 3 sites
DPoW – Diana, Princess of Wales Hospital, Grimsby
SGH – Scunthorpe General Hospital
GDH – Goole District Hospital
Threshold – Quality target being aimed for – 100%

Comments:

- During January the Trust achieved 95.3% compliance. The trend line demonstrates improvement over time.

Action now being taken:

- As part of the monthly Quality Matron visits and audit work, ward staff are encouraged, to review and discontinue food record charts that have been commenced when not clinically indicated.
- Any areas of concern are raised at the time of the audit both with the Nurse responsible for the patient's care (to ensure the concern is rectified) and the Senior Nurse on duty (to ensure the concern is cascaded amongst the Nursing team).
- Work is to be undertaken to ensure that wards are using the salmon coloured trays appropriately for patients who require assistance with eating, or who are on a food chart.
- Where there are continued concerns, these are discussed in a meeting with the Assistant Director of Nursing, Head of Quality the Ward Sister / Charge Nurse, Operational and Quality Matrons. Agreed actions are then formulated and may be prioritised according to each area. Whilst this report focuses on Nutrition and Hydration indicators taken from the Nursing Dashboard, it is worth noting that areas of concern cover multiple indicators.

Has the quality indicator been changed during the year from that set in last year's (2015/16) Quality Account? No, there has been no change to this quality priority during the 2016/17 reporting period.

Rationale for changing this quality priority for 2017/18: The 2017/18 quality priority themes include the focus on increasing harm free care, this area of nutrition and hydration will remain a feature within this quality theme.

PS8 – Hydration

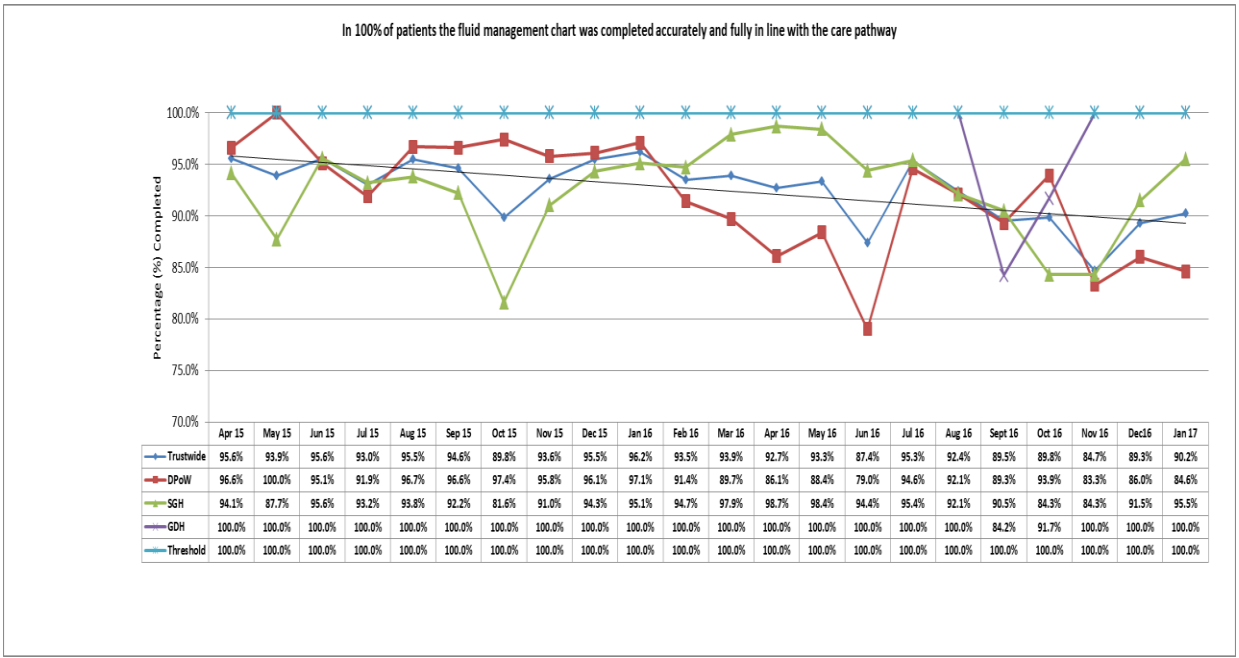
- **TARGET:** 100% of patients the fluid management chart was completed accurately and fully in line with the care pathway.
- **Achievement (April 2016 – March 2017):** The Trust has not yet achieved this quality priority.

Key points – Context:

- Effective and consistent fluid management is recognised nationally as being an area of weak practice as demonstrated in the National Patient Safety Agency (NPSA) (2008) and the National Reporting and Learning System (NRLS) (2008) evidence.
- Accurate fluid balance monitoring is an essential tool in the early identification of a patient whose condition is deteriorating.
- Monitoring the hydration status of patients by using fluid management charts is imperative to reducing the risks of dehydration and the associated complications it can bring.

Key points – performance to date:

- The following chart illustrates the current compliance with ensuring the fluid management chart was used fully and appropriately.



	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec16	Jan 17
Trustwide	95.6%	93.9%	95.6%	93.0%	95.5%	94.6%	89.8%	93.6%	95.5%	96.2%	93.5%	93.9%	92.7%	93.3%	87.4%	95.3%	92.4%	89.5%	89.8%	84.7%	89.3%	90.2%
DPoW	96.6%	100.0%	95.1%	91.9%	96.7%	96.6%	97.4%	95.8%	96.1%	97.1%	91.4%	89.7%	86.1%	88.4%	79.0%	94.6%	92.1%	89.3%	93.9%	83.3%	86.0%	84.6%
SGH	94.1%	87.7%	95.6%	93.2%	93.8%	92.2%	81.6%	91.0%	94.3%	95.1%	94.7%	97.9%	98.7%	98.4%	94.4%	95.4%	92.1%	90.5%	84.3%	84.3%	91.5%	95.5%
GDH	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	84.2%	91.7%	100.0%	100.0%	100.0%
Threshold	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Information Services, Nursing Dashboard

NB: The above charts axis starts at <u>70%</u>.

Key to abbreviations: Trust wide – Performance of all 3 sites
DPoW – Diana, Princess of Wales Hospital, Grimsby
SGH – Scunthorpe General Hospital
GDH – Goole District Hospital
Threshold – Quality target being aimed for – 100%

Comments:

- The chart illustrates performance since April 2015. Note the trend over time is now a deteriorating one. From a detailed review of this area by the Trust's quality matrons in response to the performance data reported here it was identified that this is appears to be a recording issue not a practice issue. There is evidence of fluid management action being taken, but not documented/recorded.
- In addition to this, from a triangulation of Patient Advisory and Liaison contacts (PALs), incidents reported, complaints and Friends and Family test results, no concerns were identified regard patients not being cared for in connection with their nutrition and hydration needs, however, the themes from this did suggest that documentation and recording could be improved.

Action now being taken:

- Work is underway to determine if fluid balance recording could be included within the Web V system to act as an aide memoir but also to enable improved recording. This is being supported by the Non-Executive Director who provides challenge on hydration and nutrition improvement plans.

Has the quality indicator been changed during the year from that set in last year's (2015/16) Quality Account? No, there has been no change to this quality priority during the 2016/17 reporting period.

Rationale for changing this quality priority for 2017/18: The 2017/18 quality priority themes include the focus on increasing harm free care, this area of nutrition and hydration will remain a feature within this quality theme.

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

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

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

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

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

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

Overview of the quality of care against 2016/17 quality priorities:

2.1a Clinical Effectiveness (CE)

2.1b Patient Safety (PS)

This Section…

2.1c PATIENT EXPERIENCE (PE)

→ PE1 Friends & Family Test
→ PE2 Reduction in Re-Opened Complaints
→ PE3 Complaints Relating to Communication
→ PE4 Pain Management

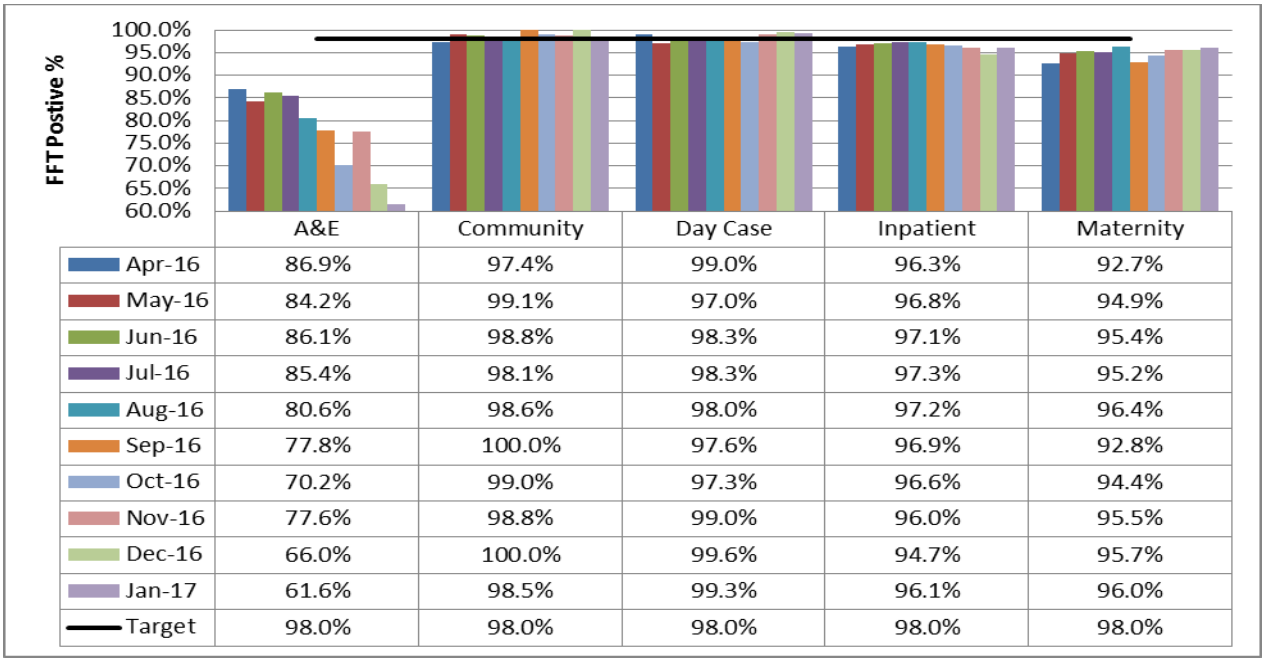
2.1c PATIENT EXPERIENCE

PE1 Friends and Family Test

- **TARGET:** 98% of feedback from the Friends and Family Test is positive.
- **Achievement (April 2016 – March 2017):** The Trust has not yet achieved this quality priority in all the areas assessed, but has demonstrated high levels of positive feedback in a number of areas.

Background:

- The Trust has been focusing within its quality priorities on the Friends and Family Test (FFT) since 2013/14. The focus to date has been on the response rate, the participation in the Family and Friends test by patients recently accessing Trust services.
- Whilst response to surveys is critical, the Trust, in combination with other mechanisms of service user feedback, are keen to look at the actual responses from the FFT and ensure we understand key issues of patient experience from this. With this in mind, then, for 2016/17, the Trust has refocused its quality priority in relation to the FFT to focus on the actual feedback from the survey, not merely the response rates.
- To ensure this feedback is captured for the Trust to proactively use, internal dashboards have been developed to see an overview of the responses received from the various Friends and Family Tests. The tests currently open for service user participation in are as follows:
    - A&E / Emergency Care Centre
    - Day case
    - Inpatient
    - Community
    - Maternity
- The following chart illustrates the feedback from the Friends and Family tests currently being undertaken within the Trust, for the months April through to January 2017.



	A&E	Community	Day Case	Inpatient	Maternity
Apr-16	86.9%	97.4%	99.0%	96.3%	92.7%
May-16	84.2%	99.1%	97.0%	96.8%	94.9%
Jun-16	86.1%	98.8%	98.3%	97.1%	95.4%
Jul-16	85.4%	98.1%	98.3%	97.3%	95.2%
Aug-16	80.6%	98.6%	98.0%	97.2%	96.4%
Sep-16	77.8%	100.0%	97.6%	96.9%	92.8%
Oct-16	70.2%	99.0%	97.3%	96.6%	94.4%
Nov-16	77.6%	98.8%	99.0%	96.0%	95.5%
Dec-16	66.0%	100.0%	99.6%	94.7%	95.7%
Jan-17	61.6%	98.5%	99.3%	96.1%	96.0%
Target	98.0%	98.0%	98.0%	98.0%	98.0%

Source: Information Services, Friends and Family Test Dashboard

By exception: Focus on areas reporting less than 98% positive feedback:

- The following table shows in greater detail those areas, broken down by site, where possible, reporting less than 98% positive feedback to aid further understanding and to guide future work programmes.

January 2017			
FFT Site	**FFT Positive %**	**Negative**	**98% Target**
A&E	**61.6%**	31.0%	98.0%
DPoW	**59.6%**	26.9%	
SGH	**55.6%**	38.1%	
GDH	**96.0%**	4.0%	
Community	**98.5%**	0.0%	98.0%
Day case	**99.3%**	0.0%	98.0%
DPoW	**98.8%**	0.0%	
SGH	**100.0%**	0.0%	
GDH	**100.0%**	0.0%	
Inpatient	**96.1%**	1.4%	98.0%
DPoW	**93.6%**	2.1%	
SGH	**97.7%**	1.0%	
GDH	**100.0%**	0.0%	
Maternity	**96.0%**	0.0%	98.0%
DPoW	**98.7%**	0.0%	
SGH	**92.5%**	1.5%	
Community	**100.0%**	0.0%	

Source: Information Services, Friends and Family Test Dashboard

Comments

- In some instances, patients are misinterpreting the answers to the friends and family test as printed on the FFT slips. This has been identified as a result of a number of cases where the 'free text' comments received by patients have been glowing in praise, however, the ticked answers on the same sheet implied they were 'extremely unlikely' to recommend the Trust. At present, no changes are being made to these cards, however going forward a consensus will need to be agreed as to if action is taken to adjust the scores recorded on these cards in the case of such clear examples of inconsistencies.

Comments:

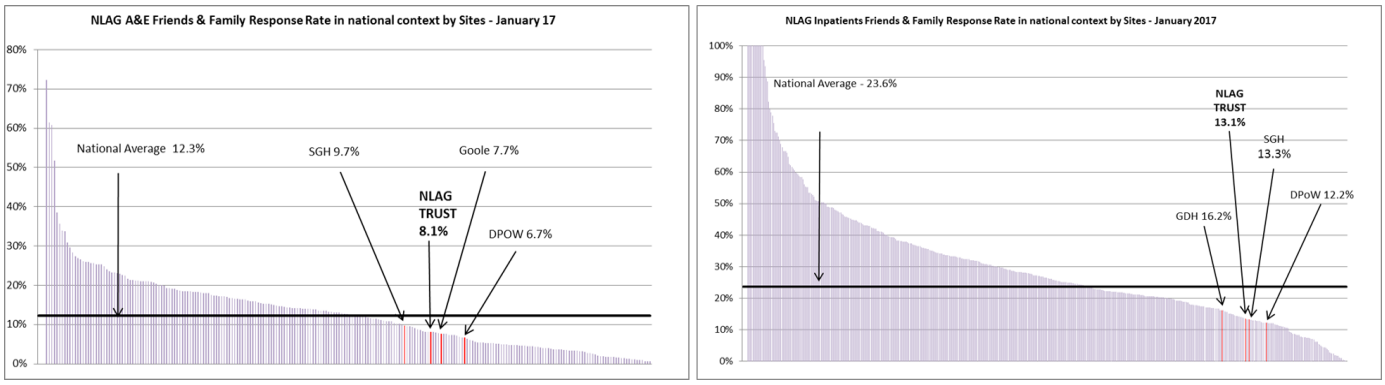
- A&E/ECC response rates continue to be well below our expectations but we must acknowledge the incredible pressures that these Departments are facing currently. This is not only on the actual pace that staff are working at to ensure safe and effective flow through this critical area but also the impact busy, full Emergency Departments have on patients then wanting to stay and complete feedback cards at the end of their visit. Low response rates therefore should result in the patient experience information presented here being interpreted with caution.
- These factors are part of the consideration and drive to convert our NETCALL automated call service to a SMS service with a survey link. This will hopefully provide a more effective methodology for this type of department. We are waiting for this change to go live and are hoping that March/April will see the new system up and running, once the telephone changeover has completed.

- Last month we looked at waiting as a theme from patient feedback. Over the course of last month we have seen unprecedented numbers of patients through our Emergency Departments. We have also seen action having been taken including new vending machines being used in waiting rooms and the implementation of care rounds in Emergency Departments to ensure majors patients (that is those who are most unwell), are provided drinks, positional change, a bed rather than trolley to lie on and other care focussed interventions. Providing this level of care in busy critical areas is difficult but staff are committed to making the experience better.

Thematic Analysis: From the comments left – what do we learn?

- In January we collected **1797** pieces of Friends and Family feedback. Those who would recommend us equated to **93.1%,** those who would not **4.5%.**
- Those 80 people who felt that aspects of their experience were lacking are important to us and those responses are read and forwarded to teams for their awareness and action, as appropriate.
- Our administration staff do an amazing job and are often the very first "face" of our Trust that patients will meet.
- Over a number of months we have seen a theme developing regarding instances where reception staff have been perceived to have been rude. This has been fed back to teams which has led to a positive response and has led to action being taken to ensure Customer Service Training is offered to all applicable staff members. On further reflection and discussion with Our Staff Health and Well Being Group it feels right to look at the pressure staff are put under in these very "front facing" roles. Whilst the basics of customer service are absolutely fundamental, and our expectation, we cannot ignore the daily challenge that staff may experience. The action from this is to look at what our training consists of and an examination as to what our staff feel may be of benefit, with a view of building in some resilience training.
- We aim to equip staff with tools to deal with difficult conversations, understanding patient perspective, and knowing appropriate escalation, how to deescalate conflict and how to keep themselves well.

CONTEXTUAL INFORMATION: Response rates:



Source: NHS England, Friends and Family Test Data

Comments:

- A&E FFT: The Trust ranks 93 out of 141, placed in the bottom 50% of responding organisations,
- Inpatient FFT: The Trust ranks 149 out of 173 Trusts which places the Trust in the bottom 50% of responding organisations.

Has the quality indicator been changed during the year from that set in last year's (2015/16) Quality Account? No, there has been no change to this quality priority during the 2016/17 reporting period.

Rationale for changing this quality priority for 2017/18: The refashioned quality priority themes for 2017/18 will not specifically focus on the Friends and Family test findings, but will focus much more widely on patient and staff experience, so the focus on the patient's voice/experience agenda will continue.

PE2 Reduction in Re-opened complaints

- **TARGET:** Re-opened complaints to not exceed 10% of total closed complaints.

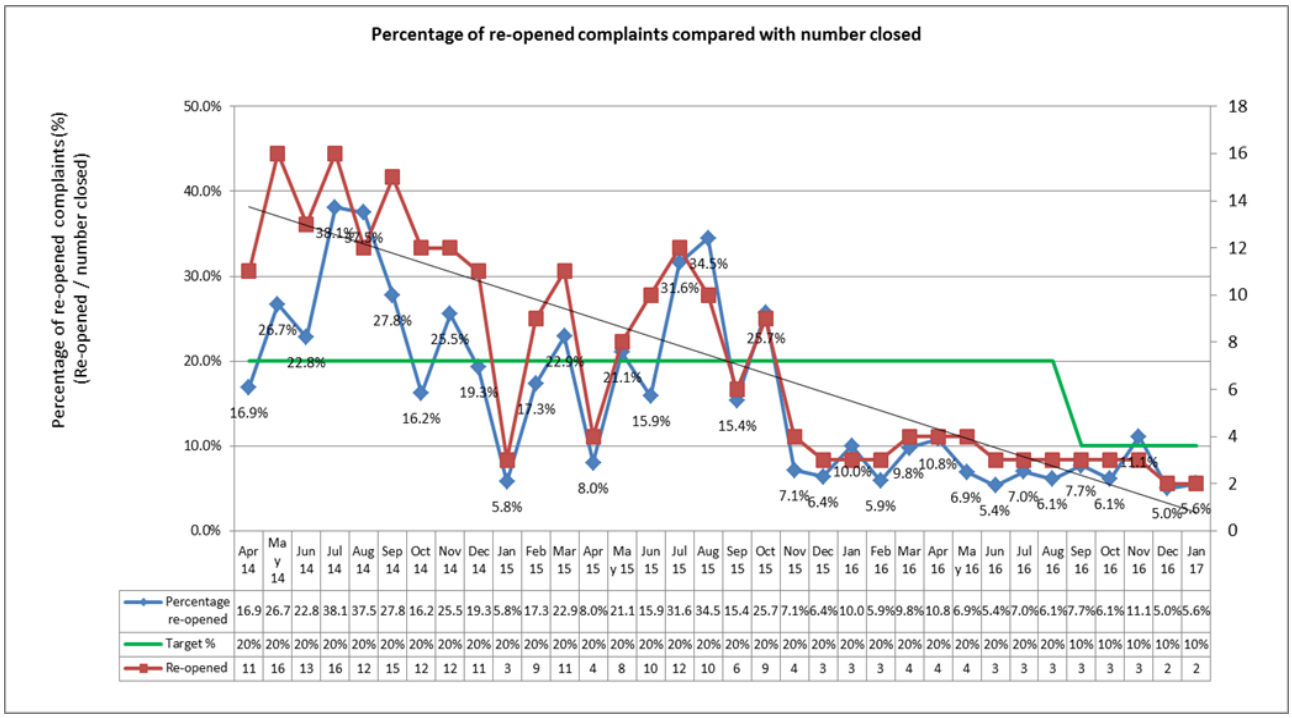
- **Achievement (April 2016 – March 2017):** The Trust has achieved this quality priority during the 16/17 financial year, with all months except one being reported under the quality target being aimed for, demonstrating that the complaints handling process is effective.

Key points – Context:

- To set a numerically based reduction was therefore deemed unrealistic. Instead of a numerical target, a proportional or a percentage target would seem more realistic.
- As a result of improvements in the reduction of re-opened complaints, the Quality Patient Experience Committee (QPEC) agreed a reduction in the target to 10%, including a focussed root cause analysis process for any months where the target is exceeded. This revised target takes effect from September 2016.

Key points – Performance:

- The following chart illustrates the percentage of re-opened complaints compared with the number closed.



	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17
Percentage re-opened	16.9	26.7	22.8	38.1	37.5	27.8	16.2	25.5	19.3	5.8%	17.3	22.9	8.0%	21.1	15.9	31.6	34.5	15.4	25.7	7.1%	6.4%	10.0	5.9%	9.8%	10.8	6.9%	5.4%	7.0%	6.1%	7.7%	6.1%	11.1	5.0%	5.6%
Target %	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	10%	10%	10%	10%	10%
Re-opened	11	16	13	16	12	15	12	12	11	3	9	11	4	8	10	12	10	6	9	4	3	3	3	4	4	4	3	3	3	3	3	3	2	2

Data Source: DATIX, Performance Assurance Team

Comments:

- The percentage of re-opened complaints is **below** the 10% target at 5.6%.
- It is worth noting that in an attempt to improve complainants' satisfaction and improve their feeling of assurance, at the end of each response letter, the complainant is offered the opportunity of a meeting to discuss the findings. More and more complainants are taking up this opportunity and this has an impact on the numbers of reopened complaints reported in this section of the monthly quality report. To test out complainants' satisfaction of this process, the Trust also uses service user satisfaction surveys to help gauge performance from a different

perspective. The chart above illustrates that both the percentage and number of re-opened complaints are demonstrating a downward trend further implying that the complainants' satisfaction in the way their complaint has been handled.

- Following benchmarking work and a recent internal audit into the complaints handling processes in place, the Trust has revised its complaint handling timescale, specifically:

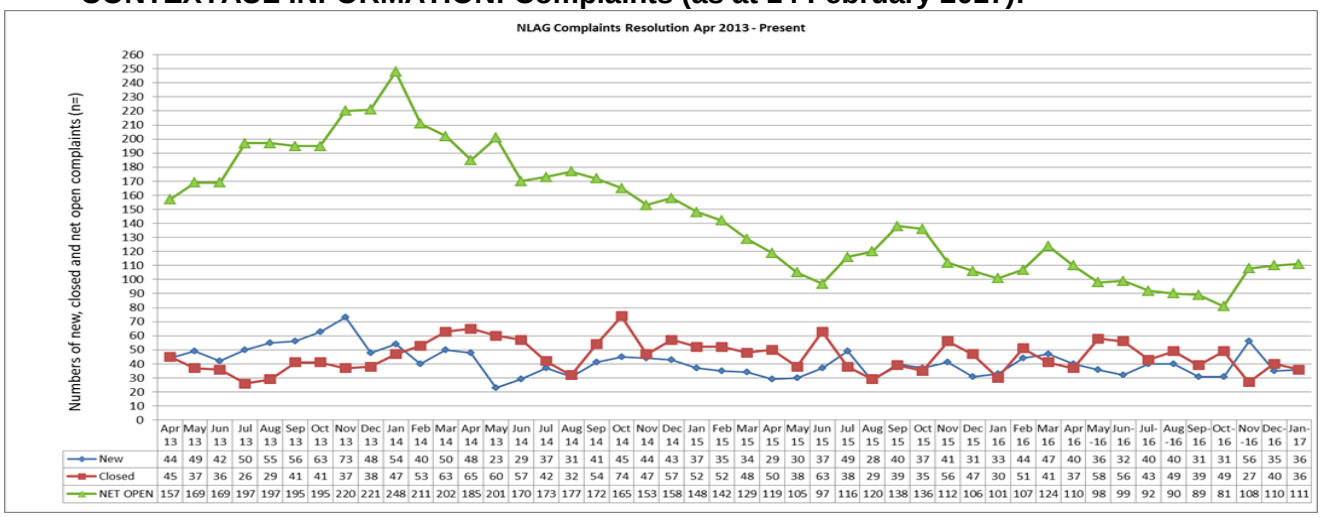
    - Complaint relating to a single area of concern / or single group: Maximum timescale for response: **30 days**

    - Complaint relating to multiple issues relating to one group: Maximum timescale for response: **45 days**

    - Complex complaint relating to multiple issues in multiple groups: Maximum timescale for response: **60 days**

- The Trust's central complaints team is actively working to streamline the process with operational groups to minimise delays in handling of complaints. The central team are also working with operational teams to ensure resulting action plans following complaints have greater ownership at group level.

CONTEXTAUL INFORMATION: Complaints (as at 14 February 2017):



	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 13	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May -16	Jun- 16	Jul- 16	Aug -16	Sep 16	Oct- 16	Nov -16	Dec- 16	Jan- 17
New	44	49	42	50	55	56	63	73	48	54	40	50	48	23	29	37	31	41	45	44	43	37	35	34	29	30	37	49	28	40	37	41	31	33	44	47	40	36	32	40	40	31	31	56	35	36
Closed	45	37	36	26	29	41	41	37	38	47	53	63	65	60	57	42	32	54	74	47	57	52	52	48	50	38	63	38	29	39	35	56	47	30	51	41	37	58	56	43	49	39	49	27	40	36
NET OPEN	157	169	169	197	197	195	195	220	221	248	211	202	185	201	170	173	177	172	165	153	158	148	142	129	119	105	97	116	120	138	136	112	106	101	107	124	110	98	99	92	90	89	81	108	110	111

Data Source: DATIX, Performance Assurance Team

Comments:

- As referred to already, during November, a large increase was seen in the number of 'new' complaints, coupled with a reduced number of closed complaints (as a direct result of the central complaints team responding to the newly received complaints) drives the increase this month in the number of net-open complaints.
- Within previous iterations of this report, the seasonal effect of complaints has been noted and reported on. Surges in the number of new complaints have been seen over the following months in previous years:
    - November 2014,
    - July 2015,
    - March 2016,
    - November 2016.
- During January, one more new complaint than December was received and as a result more complaints were fully dealt with and closed. The net open remains static at 111.

Has the quality indicator been changed during the year from that set in last year's (2015/16) Quality Account? Yes, the quality priority target was reduced to ensure this was stretching. This was reduced from 20% to 10%. Since then, this target too has been met each month except one.

Rationale for changing this quality priority for 2017/18: The refashioned quality priority themes for 2017/18 will not specifically focus on complaints, but will focus much more strongly on the patient and staff experience, so the focus on the patient's voice/experience agenda will continue. Complaints will be reflected within this.

PE3 Complaints relating to communication

- **TARGET:** Reduction of complaints relating to the theme of communication (Specific target to be agreed).

- **Achievement (April 2016 – March 2017):** No specific quality priority was established for this aspect of complaints, as such no target has been measured.

Accurate capture of complaints themes relating to communication:

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

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

- Over the page, the communication related complaints have been broken down and reported on within this monthly report. This will be used to set a more appropriate reduction target for the 2017/18 quality priorities and monitoring of these.

- On the following page this data is presented.

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

- **NB:** The table listed under the 'closed as at…' includes only those complaints closed, with a communication or values code within that month. Therefore no parallels can be drawn from earlier presented numbers of closed complaints as the analysis of the two data sets is different.

OPEN AS AT																
Communication Codes	30-Nov-15	02-Feb-16	23-Feb-16	06-Mar-16	06-Apr-16	18-May-16	14-Jun-16	14-Jul-16	18-Aug-16	22-Sep-16	07-Oct-16	01-Dec-16	19-Dec-16	18-Jan-17	14-Feb-17	Cumulative
Attitude of Staff - Medical/Consultant/Dr/Nursing	0	0	0	0	0	0	13	15	16	16	12	8	17	20	22	139
Communication with patient	1	3	4	4	10	13	10	20	12	11	10	5	6	6	9	124
Communication with relatives/carers	3	3	4	4	8	11	8	8	5	4	5	4	7	5	4	83
Failure to keep relatives informed	8	2	5	4	0	0	0	0	1	3	3	3	4	4	3	40
Failure to listen to patient	1	0	0	0	1	2	5	5	2	1	3	0	6	6	5	37
Communication failure between departments	0	0	0	0	2	1	2	2	3	3	4	1	2	4	4	28
Inconsistent clinical advice given	1	0	1	0	3	3	1	0	1	2	3	0	0	6	7	28
Incorrect/no information given	0	0	0	0	0	2	2	4	3	1	4	2	3	3	1	25
Failure to listen to relatives	1	0	0	0	3	4	3	5	4	1	0	0	1	0	1	23
Delay in reporting test results	0	0	0	0	1	3	3	2	0	1	1	1	2	3	5	22
Communication with GP	0	0	0	0	2	2	2	0	3	2	2	0	1	1	1	16
Inadequate information provided	0	1	1	2	1	1	1	0	2	4	0	0	0	0	0	13
Communication failure within department	0	0	0	1	1	1	1	0	0	4	0	1	2	1	0	12
Inadequate record keeping	1	0	0	0	1	1	1	2	2	1	1	0	0	1	1	12
Breakdown in communication re. appointments	0	0	0	0	1	1	2	2	2	1	0	0	1	1	1	12
Communication between medical teams	0	1	0	0	0	1	2	0	1	0	3	0	1	0	1	10
Quality/Content of letters	0	1	1	1	0	0	0	1	1	1	1	0	1	1	1	10
Failure to act in a professional manner	0	0	0	0	0	0	2	1	1	3	1	0	1	0	0	9
Breaking bad news	0	0	0	0	1	1	1	3	2	0	0	0	0	0	0	8
Breakdown in communication between staff	0	1	1	1	0	1	1	1	1	1	0	0	0	0	0	8
Failure to give adequate discharge advice	1	1	1	0	2	1	1	0	0	0	0	0	0	0	0	7
Test results	0	0	1	2	2	1	1	0	0	0	0	0	0	0	0	7
Failure of staff to introduce themselves	0	0	0	0	0	0	1	1	0	0	2	1	1	0	0	6
Failure to adhere to open & honest policy	1	0	1	0	0	0	0	0	0	0	1	0	1	1	1	6
Failure to communicate test results	1	0	0	0	0	0	0	1	0	0	0	0	2	1	1	6
Unable to contact NLAG staff	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	3
Copying letters	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	2
Breach of Confidentiality by staff	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	2
Physical Abuse/Assault by Staff (Alleged)	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Failure to liaise with patient following incident	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Information on Condition & Treatment	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Incorrect entry on healthcare record	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
TOTALS	20	13	21	20	40	52	66	73	62	61	56	27	59	64	68	634

CLOSED AS AT																
Communication Codes	30-Nov-15	02-Feb-16	23-Feb-16	06-Mar-16	06-Apr-16	18-May-16	14-Jun-16	14-Jul-16	18-Aug-16	22-Sep-16	07-Oct-16	01-Dec-16	19-Dec-16	01-Jan-17	14-Feb-17	Cumulative
Communication with patient	2	0	0	4	8	5	6	4	6	7	3	2	3	6	3	59
Attitude of staff - Consultant/Nursing/Registar/Porters	0	0	2	0	0	0	6	11	10	4	6	6	3	4	5	57
Communication with relatives/carers	0	1	0	2	5	0	5	5	2	3	3	1	1	3	5	36
Failure to keep relatives informed	6	4	3	2	3	1	1	0	1	1	0	1	0	1	2	26
Patient not listened to	0	0	0	4	0	0	0	1	3	2	1	0	0	2	3	16
Failure to listen to relatives	0	1	0	1	0	0	1	4	0	3	2	1	0	1	1	15
Failure to act in a professional manner	0	0	0	0	0	0	2	1	1	2	2	0	1	0	0	9
Failure to communicate test results	2	1	2	0	0	0	0	0	1	1	0	0	0	1	1	9
Communication failure between departments	1	0	1	0	0	0	1	0	1	1	0	1	1	1	1	9
Inadequate information provided	0	0	0	0	1	2	0	1	0	1	2	0	0	0	1	8
Conflicting information	0	0	0	0	0	0	2	1	0	1	1	0	1	2	0	8
Failure to keep patient informed	3	1	0	0	0	0	0	0	0	1	1	0	0	1	0	7
Communication with GP	0	1	0	0	0	0	1	2	0	1	1	1	0	0	0	7
Breaking bad news	0	0	0	1	1	0	1	0	1	1	1	0	1	0	0	7
Incorrect/no information given	0	0	1	0	0	0	1	1	0	1	0	0	0	1	2	7
Delay in giving information/results	0	0	0	0	1	1	0	1	1	1	0	0	0	0	1	6
Communication between medical teams	0	2	0	1	0	0	0	0	1	1	0	0	0	0	0	5
Contradicting clinical advice	1	1	0	0	2	0	0	0	0	0	0	0	1	0	0	5
Incorrect entry on healthcare records	0	0	0	1	2	0	0	0	0	1	0	0	0	0	0	4
Failure to communicate adequate discharge advice	0	0	0	1	0	1	0	1	0	0	0	0	0	0	0	3
Breach of Confidentiality by Staff	0	0	0	0	0	0	2	0	1	0	0	0	0	0	0	3
Breakdown in communication between staff	0	0	0	0	1	0	1	0	0	0	1	0	0	0	0	3
Inadequate record keeping	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	2
Failure to adhere to open & honest policy	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	2
Failure to liaise with patient following an incident	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Information on non-clinical issues	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Unable to contact NLAG staff	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Uniform issues	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Copying letters	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Physical Abuse/Assault by Staff (inc. alleged)	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Quality/content of letter	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
TOTALS	16	12	9	20	25	10	31	35	30	33	25	14	12	23	25	320

Comments:

- Attitude of staff, communication with relatives and carers, failure keeping relatives informed and communication with the patient themselves are the top themes arising from an analysis of communication 'themed' complaints.
- This will be fed into the Patient Experience Group, for assessment and consideration as to an appropriate target to help focus on improved communication.

Has the quality indicator been changed during the year from that set in last year's (2015/16) Quality Account? No, the quality priority target was not established for this area.

Rationale for changing this quality priority for 2017/18: The refashioned quality priority themes for 2017/18 will not specifically focus on complaints, but will focus much more strongly on the patient and staff experience, so the focus on the patient's voice/experience agenda will continue. Complaints themes will be reflected within this.

PE4 – Pain Management

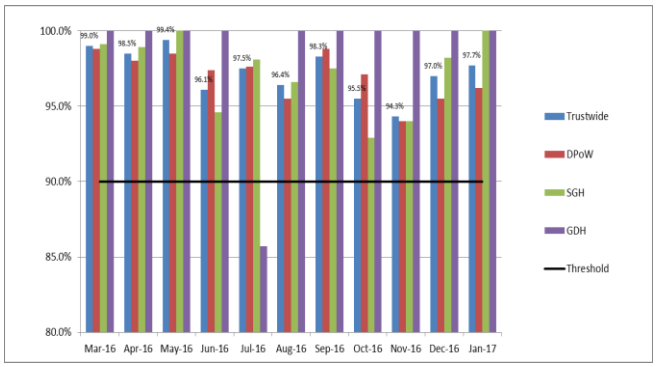
- **TARGET: PE4a:** 90% of patients feel that medical and nursing staff did everything they could to help control pain.
- **TARGET: PE4b:** 90% of patients received pain relief when they needed it in a timely manner.
- **Achievement (April 2016 – March 2017):** This quality priority has been achieved month on month.

Key points – Context:

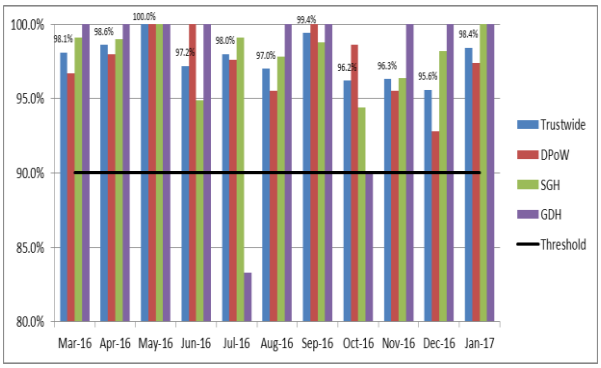
- Following reflections within the 'patient stories' presented to QPEC and the Trust Board, management of pain and administration of pain relief were areas felt to require additional scrutiny.
- To ensure the Chief Nurse directorate are focussed on pain management, this refresh includes specific new questions that relate to pain management, from the patient's unique perspective.

Key points – Performance:

PE4a: Patients felt that staff did everything they could to help control pain



PE4b: Patients received pain relief when they needed it in a timely manner



Comments:

- For the nine months' worth of data available, responses to these new patient experience questions exceed 96%.
- At the mid-year review of the quality priorities, this target was reviewed. It was felt that the methodology (how these questions were asked of patients and by whom) needed to be changed to ensure that patients felt able to honestly provide feedback on this important issue.
- Since this review it has further been agreed to monitor this using a different mechanism, using monthly ward manager completed audits and a focussed pain management audit involving the pain management team. As a result of this change, it is proposed that this indicator, as it demonstrates full compliance, be removed as a quality priority for 2017/18.

Has the quality indicator been changed during the year from that set in last year's (2015/16) Quality Account? No, the quality priority has not changed during 2016/17.

Rationale for changing this quality priority for 2017/18: This quality priority has been met. As a result this indicator will be monitored using a different mechanism for measuring and evaluating performance.

2.1d: Quality priorities for 2017/18

During the consultation process for setting the 2017/18 priorities, it was felt that the sheer number of targets was in danger of preventing sufficient time and focus being applied to the Trust's core quality priorities. This was also felt to hamper the ability for the Trust Board's sub-committee focussed on quality to receive full assurance from executive owners. On reflection then, for 2017/18, the Trust Board have approved a different approach to be taken to set quality priority 'themes' with underpinning metrics, designed to reduce the number of targets, and ensure that those selected are the core priorities for the Trust to focus on in relation to quality as well as a restructured monthly quality report to enable greater ability for executive owners to outline performance to date, what conclusions are drawn and what action is being taken. Another strengthening arrangement is the alignment of a Non-Executive Director to each of the priority themes to further support the Trust's focus on quality.

How agreed:

The priorities for 2017/18 have been discussed and approved by the Trust Board and by the Quality and Patient Experience Committee (QPEC). They have been identified via a number of mechanisms including the following:-

- Discussions with the governors and Non-Executive Directors,
- Feedback from commissioners as part of quality contract meetings,
- The findings from the national patient surveys (out-patient and in-patient),
- The findings from the staff survey and experience measures,
- Findings from patient satisfactions surveys that are undertaken by the Trust including Friends and Family Tests results,
- Feedback from patients using the 'patient story' video approach (played at QPEC and Trust Board meetings) alongside face to face patient stories,
- The results that are published within our nursing dashboard,
- The data provided by our clinical systems where we are identified as being an outlier,
- Information from incidents and complaints,
- Comments received from local Healthwatch organisations as a result of discussions around previous year's Quality Accounts and other dialogue,
- Feedback received and work undertaken to improve as a result of the various external visits or inspections,
- As a result of links to other priority Trust areas e.g. Mortality,
- From themes identified from external inspections, i.e. CQC visits,
- Feedback regarding priorities was also obtained via the Trust's patient panel.

Taking into account the wider public views:

The quality indicators are agreed following discussions with governors who represent the interests of their constituents following their election to this role from public members of the Trust. The findings from the in-patient and out-patient surveys are also considered when developing these proposed indicators to take into account the views of the wider public. The Trust's patient panel was also liaised with to get an understanding of key priorities from their perspective.

How progress will be monitored and measured:

Progress against these indicators will be reported monthly using the monthly quality report. The indicators will include improvement targets to allow for on-going measurement and establishment of qualitative themes from non-quantitative feedback, work continues to develop these specific measures to be used to track progress from April 2017 onwards. A selection of methods will be employed to measure this area including statistical process control (SPC) charts, tables and graphs. The Quality and Patient Experience Committee (QPEC) and the Board will receive this report.

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

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

Quality Priority Themes:

Quality Priority 1: Reducing Mortality (Director Responsible: Medical Director)
Focussed area 1: Respiratory Mortality
Focussed area 2: Out of hospital mortality
Quality Priority 2: Increase harm free care (Director Responsible: Chief Nurse)
Focussed area 1: Safety thermometer
Focussed area 2: Care of the deteriorating patient
Focussed area 3: Nutrition and hydration
Focussed area 4: Safe Nurse staffing
Quality Priority 3: Providing care resulting in a positive experience (Director Responsible: Chief Nurse & Director of People and Organisational Effectiveness)
Focussed area 1: Patient experience
Focussed area 2: Staff experience
Quality Priority 4: Outpatient services (Director Responsible: Chief Operating Officer)
Focussed area 1: Learning from patient experience/feedback
Focussed area 2: Outpatient waiting and / or cancellations
Quality Priority 5: Discharge & Transfer (Director Responsible: Chief Operating Officer)
Focussed area 1: Timely access
Focussed area 2: Patient flow (e.g. consultant transfers / handovers of care)
Quality Priority 6: Medical Quality Indicators (Director Responsible: Medical Director)
Focussed area 1: Venous Thromboembolism
Focussed area 2: Safe Medical Staffing
Focussed area 3: Infection prevention and control

Rationale for quality priorities:

The quality priorities for 2017/18 have been identified as being key quality indicators for the Trust to focus on, linked to the areas for improvement identified during 2016/17, including responding to the CQC inspection report and the resulting action plan overseen by the Improving Together Programme.

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 2016/17 Northern Lincolnshire and Goole NHS Foundation Trust provided and/or sub-contracted 25 relevant health and care services.

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

The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health and care services by the Trust for 2016/17.

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

During 2016/17, 38 national clinical audits and 8 national confidential enquires covered relevant health services that Northern Lincolnshire and Goole NHS Foundation Trust provides.

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

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2016/17 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 2016/17

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
Acute care					
Case Mix Programme (CMP)	Yes	Yes	827	100%	Yes
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	Yes	331/376	88%	Yes
National Emergency Laparotomy Audit (NELA)	Yes	Yes	172	100%	Actions to be agreed
National Joint Registry (NJR)	Yes	Yes	626	100%	Yes
Royal College of Emergency Medicine: Severe Sepsis and Septic Shock in Adults	Yes	Yes	110	100%	Awaiting Publication of Results
Royal College of Emergency Medicine: Moderate & Acute Severe Asthma	Yes	Yes	104	100%	Awaiting Publication of Results
Blood and Transplant					
National Comparative Audit of Blood Transfusion programme					
1. 2015 Audit of Patient Blood Management in Scheduled Surgery;	Yes	Yes	67	100%	Awaiting Publication of Results
2. National Audit of Patients at Risk of Transfusion Associated Circulatory Overload (TACO)	Yes	Yes	Data collection currently ongoing.	100%	Not yet complete
Cancer					
Bowel cancer (NBOCAP)	Yes	Yes	228	Awaiting publication for comparison with HES	Actions to be agreed
Head and neck oncology (DAHNO)	Yes	Yes	173		Awaiting Publication of Results
Lung cancer (NLCA)	Yes	Yes	370 (2016)		Yes
National Prostate Cancer Audit	Yes	Yes	249		Yes
Oesophago-gastric cancer (NAOGC)	Yes	Yes	41		Actions to be agreed
Heart					
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	237/451	53%	Under development
Cardiac Rhythm Management (CRM)	Yes	Yes	386 (deadline June 2017)	100%	Not yet complete
Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	No	N/A	N/A	N/A	N/A

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
National Audit of PCI	Yes (SGH)	Yes	359 (SGH only – deadline June 2017)	100%	Under development
National Adult Cardiac Surgery Audit	No	N/A	N/A	N/A	N/A
National Cardiac Arrest Audit (NCAA)	Yes	Yes	170	100%	Actions to be agreed
National Heart Failure Audit	Yes	Yes	382 (deadline June 2017)	Awaiting final data	Not yet complete
National Vascular Registry	No	N/A	N/A	N/A	N/A
Pulmonary Hypertension (Pulmonary Hypertension Audit)	No	N/A	N/A	N/A	N/A
Long term conditions					
Chronic Kidney Disease in primary care	No	N/A	N/A	N/A	N/A
National Diabetes Audit - Adults (National Core Diabetes Audit)	Yes	Yes	2066	100%	Under development
National Diabetes Audit – Adults (National Diabetes Foot care Audit)	Yes	Yes	139/139	100%	Under development
National Diabetes Inpatient Audit – Adults (NADIA)	Yes	Yes	97	100%	Yes
Inflammatory Bowel Disease (IBD) programme – Biologicals Audit	Yes	Yes	Commenced February 2017	Awaiting data	Not yet complete
Renal replacement therapy (Renal Registry)	No	N/A	N/A	N/A	N/A
National Pregnancy in Diabetes Audit	Yes	Yes	30/35 (data collection ongoing)	86%	Not yet complete
National COPD Audit	Yes	Yes	Commenced 1 February 2017 – 15 cases	Awaiting final data	Not yet complete
BTS: Adult Asthma Audit	Yes	Yes	35	100%	Awaiting Publication of Results
UK Cystic Fibrosis Registry	No	N/A	N/A	N/A	N/A
Mental health					
National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	No	N/A	N/A	N/A	N/A

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
Prescribing Observatory for Mental Health (POMH)	No	N/A	N/A	N/A	N/A
Older people					
Falls and Fragility Fractures Audit Programme (FFFAP) • National Hip Fracture Database (submitted for all)	Yes	Yes	486	100%	Yes
Falls and Fragility Fractures Audit Programme (FFFAP) • Fracture Liaison Service Database (FLS-DB)	Yes	Yes	320/800	40%*	Not yet complete
Sentinel Stroke National Audit Programme (SSNAP) SSNAP Clinical Audit	Yes	Yes	523	100%	Yes
National Audit of Dementia (NAD)	Yes	Yes	106 SGH	100%	Awaiting Publication of Results
Other or TBC					
Nephrectomy Audit (British Association of Urological Surgeons)	Yes	Yes	23	100%	Awaiting Publication of Results
Percutaneous Nephrolithotomy (PCNL) (British Association of Urological Surgeons)	Yes	Yes	8	100%	Awaiting Publication of Results
Radical Prostatectomy Audit (British Association of Urological Surgeons)	No	N/A	N/A	N/A	N/A
Stress Urinary Incontinence Audit (British Association of Urological Surgeons)	Yes	Yes	1	100%	Awaiting Publication of Results
Elective surgery (National PROMs Programme)	Yes	Yes	541	67%	Yes
National Audit of Intermediate Care	No	N/A	N/A	N/A	N/A
National Neurosurgery Audit Programme	No	N/A	N/A	N/A	N/A
National Ophthalmology Database Audit	Yes	Yes	212	100%	Not yet complete
Endocrine and Thyroid National Audit	No	N/A	N/A	N/A	N/A
Women and Children's					
BTS Paediatric Pneumonia	Yes	Yes	Data collection currently underway	100%	N/A
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK) Perinatal Mortality Report (May 2016)	Yes	Yes	29/29	100%	Yes

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK) Cardiac Related Maternal Deaths (Dec 2016)	Yes	Yes	N/A – (managed at tertiary centre)	100%	Yes
Neonatal Intensive and Special Care (NNAP)	Yes	Yes	1820	100%	Awaiting Publication of Results
Total:	**51**				
Eligible for NLAG participation:	**38**				
NLAG Participated in:	**38**				

* The Trust reviewed the considerable resource requirements for submission of accurate data to the Fracture Liaison Service Database and wider service needs and it was determined that a dedicated nursing post was required. A business case was put forward and accepted and a Fracture Liaison Service nurse was recruited, unfortunately this was after the Jan-Jun 2016 period, however the nurse commenced in post on 3rd October 2016 and full data collection and submission is now ongoing in time for the next deadline of May 2017.

National confidential enquires 2016/17

Confidential enquiry	Eligible for NLAG	NLAG participated	Organisational Questionnaires	Number of cases submitted	% of number required	Action planning
Acute Pancreatitis	Yes	Yes	2	9/9	100%	Gap Analysis stage
Mental Health in General Hospitals	Yes	Yes	2	10/10	100%	Gap Analysis stage
Non Invasive Ventilation Study	Yes	Yes	2	5/6	83%	Awaiting Report
Young People Mental Health	Yes	Yes	2	3/4	75%*	Not yet complete
Cancer in Children, Teens and Young Adults	Yes	Yes	2	Awaiting Sample		
Chronic Neurodisability	Yes	Yes	10	Awaiting Sample		
Total:	**6**	**6**				
Eligible for NLAG participation:	**6**					

* The Young People Mental Health study is still underway and therefore the numbers included/eligible will fluctuate until the data collection phase is completed.

The reports of 19 national clinical audits were reviewed by the provider in 2016/17 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Increased information to patients/carers

- RCEM: Audit of VTE in Patients with Lower Limb Immobilization - Patient information leaflets developed and in place for both patients who receive prophylaxis and patients who do not receive prophylaxis for lower limb immobilization - ensuring all patients receive the appropriate patient information leaflet following treatment.
- RCEM Audit of Procedural Sedation - Patient information leaflets developed and in place for patients who undergo procedural sedation in the Emergency Department - ensuring all patients receive the appropriate patient information leaflet following treatment.
- National Head Injury – patient information leaflets now available on the Children's inpatient ward and Outpatient department.
- National Paediatric Diabetes Audit – paediatric/young adult patients are provided with a contract alongside education sessions on how to manage their diabetes.

Increased awareness and education of staff

- SSNAP - The definition of an Enhanced Supported Discharge (ESD) Team has been obtained from SSNAP and disseminated to staff involved in SSNAP to try to improve the clarity on which patients should be considered discharged under ESD.
- SSNAP – The importance of documentation providing rationale in any cases were thrombolysis has not been given and the importance of immediate referral and transfer to SGH whenever a patient is diagnosed with stroke, unless special circumstances apply.
- National Patient Blood Management – identify patient blood management champions to help educate staff regarding patient blood management (including clinicians about evidence based transfusion practice).
- National End of Life Care Audit – raise awareness of the importance of high standards of record keeping in relation to end of life care, raise the profile of the 'My Future Care plan' document through both informal and formal training sessions.
- National Diabetes Foot care Audit – Training to be offered to primary care practice nurses to maintain/improve skill base and related to this in the National Diabetes Inpatient Audit (NADIA) - Programme of Foot Care training to be rolled out to all nursing staff trust-wide.
- National Diabetes Inpatient Audit (NADIA) - Insulin prescribing sessions for junior medical staff to be carried out at Induction and designated Pharmacist teaching sessions. Diabetes Management, Hypoglycaemia management and Management errors to be included as part of the in-house weekly teaching programme for junior doctors.
- National PCI Audit - Cardiology clinicians to promote the use of Radial Artery for patients undergoing PCI procedure.
- RCEM Mental Health Audit - Training in mental health has been provided for all doctors, nursing and Health Carers in the Emergency Department.
- RCEM Vital Signs in Children Audit - Vital Signs to be added to the Induction Checklist.
- UK TARN – A rolling programme of audits has been introduced including time to CT scan, trauma activations and pre-alerts for trauma and the results are part of the standing items for discussion by the group.

Identified need for further evaluation/patient surveys

- SSNAP – Prospective audit of thrombolysis to assist in developing an action plan for this area.
- National PCI Audit – Instigate a process for validation on a quarterly basis to ensure greater than 90% completion for all key fields.
- National Diabetes Foot care Audit – Snapshot audit of foot risk assessments to be carried out by end of March 2017.
- National Diabetes Foot care Audit – Tool to be developed for root cause analysis of

amputations by the clinical network, for use across Yorkshire and the Humber. Tool to be commenced by clinicians at HRI, completing the initial part in the event of an amputation, and passed on to the Trust to complete.

- National Neonatal Audit Programme (NNAP) - identified a high number of babies admitted to the Neonatal Unit with a low temperature. Further local review underway to identify any possible issues.
- Epilepsy 12 – Highlighted that new epilepsy patients were not being educated regarding safety in water. Local review being undertaken to assess whether more recent diagnosed patients have received the information or whether further work is required.

Changes to service/process

- RCEM: Audit of VTE in Patients with Lower Limb Immobilization - Develop and introduce a Venous Thromboembolism (VTE) Risk Assessment For Ambulatory Trauma Patients Requiring Temporary Lower Limb Immobilisation In Emergency Department / Minor Injuries Unit.
- RCEM Audit of Procedural Sedation - Develop and introduce a Pathway for Procedural Sedation in the Emergency Department.
- MBRRACE Perinatal mortality – Introduction of bereavement midwife.
- National Diabetes Inpatient Audit (NADIA) - Changes made to the 'Guidance for Diabetes Foot Care form' that forms part of the Capillary Blood Glucose Monitoring to make form user-friendly and encourage use and 'Guidance for Diabetes Foot Care Form' updated.
- National Diabetes Foot care Audit – Multi-disciplinary foot service are to try and direct all patients presenting with a diabetic foot ulcer as the primary or secondary problem to the correct ward under Diabetes care.
- National Lung Cancer Audit – Introduction of LIVE Multi-Disciplinary Team Meetings.
- UK TARN – A plan to amend the major trauma forms at the next update to include a prompt for whether Tranexamic Acid has been considered and used. Until these are introduced a sticker has been added to the old forms to highlight to staff to record the same.
- National Diabetes Audit – To assist with increasing engagement in people of working age or younger a transition clinic has been put in place at SGH with 2 x Young Adult Clinics held per month.
- RCEM Mental Health Audit – introduction of a Mental Health Assessment in Self-Harm patients along with the TAG (Threshold Assessment Grid) assessment form for the purpose of assessing a person's mental health.
- BTS National Chronic Obstructive Pulmonary Disease (COPD) Audit - Dedicated Multi-Disciplinary Team Meeting to be introduced.
- BTS National Chronic Obstructive Pulmonary Disease (COPD) – Introduction of Smoking Cessation HCA at DPOW and Smoking Cessation Service at SGH.

The reports of 16 local clinical audits were reviewed by the provider in 2016/17 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Increased awareness and education of staff

- Maternity Documentation – Multidisciplinary documentation workshops being carried out on a monthly basis to raise awareness regarding requirements for documentation.
- WHO Checklist (Obs & Gynae) raise awareness of the requirement to complete all elements of the WHO checklist.
- DNACPR – Awareness to be raised with clinicians regarding the completion of the documentation including discussions and decisions through awareness sessions.
- Second Trimester Miscarriage – Study day arranged for all clinical staff to attend relating to the management of stillbirths.
- End of Life Care Document – Continuous education regarding the use of the

document for both hospital and community services. To attend GP sessions to raise awareness and promote the use of the document.

- Safeguarding Supervision – awareness to be raised amongst staff regarding the requirements of preparing and undertaking a supervision session.
- Local Audit of Vital Signs in Children (Goole MIU) - In order to raise awareness a poster is to be displayed in the staff room.
- Local Audit of Documentation (Goole MIU) - Display minimum generic standards for Record Keeping in the department to ensure all clinicians are aware of the required standards.
- Local Audit of Trauma Team Initiation (Emergency Department) - Ensure criterion for trauma team activation is clearly visible in the Emergency Department and particularly near the pre-alert ED phone.
- Local Audit of Trauma Team Initiation (Emergency Department) - Ensure trauma team activation forms part of Junior Doctor Induction for A&E / ECC doctors.
- Audit of ECC X-Ray Requests for Foot and Ankle Combined (DPOW) - Production of a poster to be displayed in the ECC and an Ottawa Guidelines sticker as an aide memoir for staff.
- Audit of Parenteral Nutrition - TPN to be added to the Junior Doctor Induction Training Programme.

Changes to service/process

- Maternity Documentation – introduction of ward safety briefings to discuss lessons learnt at each handover and patient safety walk rounds on the relevant maternity wards. CTG champions also identified to raise awareness of the requirements surrounding CTG.
- Re-audit of Customised Growth – local guideline updated to mirror NICE Guidance regarding offering growth scans to women where intrauterine growth restriction is recognised.
- Community Services Record Keeping – SystmOne updated with mandatory fields so that staff are required to ask all relevant questions relating to the patients care and management plans.
- Management of Women in Recovery – Amendments to be made to the current template on WEB V to ensure all observations are undertaken and recorded in the recommended time frame.
- Second Trimester Miscarriage – Patient pathway to be re-designed to include the introduction of a checklist to ensure all documentation requirements are completed and information is given to the patient. Also, specific patient information leaflet to be introduced for use.
- DNACPR – Introduction of continuation sheet (with prompts) specifically to evidence decisions relating to DNACPR.
- Omitted Doses – Pharmacy Dashboard developed for view by nursing teams to review performance against CQC medicines management standards including omitted medicines.
- Local Audit of Vital Signs in Children (Goole MIU) – Implement the use of PEWS charts within MIU.
- ECC Minors Triage Patient Flow Re-Audit - Streaming nurse who guides patients to the appropriate area now in place, along with the addition of a flow co-ordinator to work approximately 9am – 9.30pm, 7 days per week.
- Audit of Parenteral Nutrition – Implementation of a Multi-Disciplinary Nutrition Team and the TPN Guideline to be updated to reflect the process along with re-designing the TPN Prescription Chart.

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 2016/17 that were recruited during that period to participate in research approved by a research ethics committee is not known as this data is not collected. However, those patients recruited to NIHR adopted research studies was 544 as of end February 2017.

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

The Trust takes part in clinical research, this is because it believes that research is important because it helps to improve healthcare by finding out which treatments work best for patients. It also gives patients the opportunity to access novel and innovative treatments and therapies. Within the department we have adopted the NIHR strapline of 'Today's research is Tomorrow's Treatment' which captures the essence of what our service is about.

The research and development department offers a central corporate function within the Trust and takes an organisational-level lead in ensuring that research is conducted and managed to high scientific, ethical and financial standards. The R&D function is delivered from two offices based at the Scunthorpe and Grimsby sites and is led and managed by the head of research and professional development supported by a team of 13 Research Nurses, three Data-Coordinators and a Research Governance Manager.

Within the research and development department, our aims are:

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

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

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

There are currently 92 Organisational Projects open to recruitment within the Trust, these include

- 11 of these studies are commercial
- 61 are adopted onto the NIHR (National Institute for Health Research) Portfolio.
- 8 studies are commercially adopted portfolio studies.
- 20 account for other studies which are currently open.

How the research and development team help to deliver research

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

- By identifying patients suitable for research studies– involvement is entirely voluntary

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

We currently have research Projects open in the following areas:

Oncology	Diabetes	Dermatology	Paediatrics
Dementia	Ear	Ophthalmology	ED
Paediatric	Musculoskeletal	Mental Health	Vascular Medicine
Haematology	Gastrointestinal	Rheumatology	Nursing
Stroke	Obstetrics	ITU	Management
Cardiology	Gynaecology	Surgery	Neurology

The R&D department is dedicated to supporting and furthering research, development and innovation within the Trust. The department provides assistance and guidance on how to:

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

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

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

A proportion of Northern Lincolnshire & Goole NHS Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between Northern Lincolnshire & Goole NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2016/17 and for the following 12-month period are available electronically at:

https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/

The areas of care which were included within the CQUIN scheme for 2016/17 included the following:-

- Staff Health & Wellbeing Initiatives

- Healthy Food for Staff and visitors
- Flu Vaccines
- Sepsis – Emergency Department Screening
- Sepsis – Inpatients
- Antimicrobial Stewardship – reduction in antibiotic consumption
- Antimicrobial Stewardship – empiric review on Antibiotic Prescription
- Adults at Risk
- COPD Care Bundle

The amount of income in 2016/17 which was conditional upon achieving quality improvement and innovation goals was £6.5 million.

The monetary total value for 2016/17 CQUIN indicators was £6.5 million. The Trust is currently in discussions with commissioners regarding the CQUIN financial value that the Trust will receive.

2.2e Information on Never Events

The Trust reported 2 never events during 2016/17. These can be broken down into the following categories, including historical context and related incidents:

	2016/17	2015/16	2014/15	2013/14
Retained Foreign Object	1	2	0	1
Ophthalmology – wrong lens inserted	0	1	0	11
Wrong site nerve block	1	1	0	0

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

Learning derived from incidents:

- The root causes for the 2016/17 never events related to:
  - Failure to carry out checking processes
  - Poor record keeping
  - Process lacking adequate fail-safes
  - Staff working in unfamiliar environment/with unfamiliar team
  - Prosthesis sizes with same colour coding

- As a result of these high-level summary of root causes, the following actions to prevent recurrence have been taken:
  - Pathway developed to outline clear management of patients with invasive devices, covering communication and documentation.
  - ITU documentation amended to include prompts regarding drains to act as effective fail-safe.
  - Audit programme in place to assess progress and effectiveness of new pathway over time and test embedding.

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

- These incidents have been brought to the attention of the clinical teams involved.
- These never events, along with other learning from incidents and complaints form a core part of the different clinical areas Quality & Safety meetings/sessions enabling senior and junior staff alike to share learning as a result to prevent recurrence.
- The learning from these incidents is also discussed in Specialty Business Meetings for clinicians and Ward Manager Meetings for cascade to nursing staff.

- The investigation and root cause analysis is shared with the various areas management team to alert them to the issues identified for wider dissemination.
- Lessons are summarised in one page 'Learning the Lessons' documents which are shared on the intranet, in Learning Lessons folders located in ward areas and within Learning Lessons newsletters which are disseminated Trust wide.

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

Northern Lincolnshire and Goole NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is conditional. The Trust has conditions on its registration.

The Care Quality Commission has taken enforcement action against the Trust during 2016/17.

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 November 2016, of which the report was published on the 6 April 2017):

Overall rating for this trust	Inadequate
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Inadequate

The Trust's view of the report's findings:

- The Trust is disappointed, but fully accepts the shortfalls identified by the Care Quality Commission (CQC).
- The CQC's findings have led to their recommendation that the Trust be placed in 'quality special measures'. This does not mean that the Trust's services are unsafe, rather that in some areas high quality care is not consistent.
- The CQC found that the staff employed by the Trust are caring, citing evidence of dignity and respect being observed.

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

- Since the CQC's visit during November 2016, the Trust has already taken action and made improvements, for example, we have:
    - Recruited ten additional midwives in maternity services and four additional nurses in A&E at Scunthorpe, which helps provide better continuity of care for patients and has improved staff morale,
    - Almost eliminated the use of agency staff to cover for health care assistants. This provides a better experience for patients and reduces costs,
    - Strengthened the way we care for people in A&E, particularly those who are at risk of deteriorating; identifying and responding to them more quickly and ensuring the basic needs of all patients are met,
    - Strengthened processes in maternity services to make sure we can respond more quickly when units are short-staffed,

- Improved communications between maternity services and our anaesthetics team, reducing delays for women who need treatment for caesareans, epidurals, tears etc.,
- Identified ways to improve engagement with and between our clinicians, appointed a 'freedom to speak out guardian' (an individual to whom concerns can be easily reported and without formality), and refreshed our policy to encourage staff to raise concerns when they have them,
- Reviewed and strengthened how we share lessons amongst and between teams; with regular staff 'huddle' meetings focused on patient safety issues,
- Nominated an individual to make sure the 'safer surgery checklist' is always completed as it should be in our maternity services,
- Reduced the numbers waiting for an ophthalmology outpatient appointment by more than 900 people between November and February, although we still have some way to go to make sure everyone gets a timely appointment,
- Appointed a dedicated porter to reduce delays for those patients in Scunthorpe A&E who need taking to wards, radiology and x-rays etc.,
- Strengthened our plans to improve referral to treatment times, so more patients can be seen and treated within 18 weeks,
- Improved our waiting list processes and the quality of our data systems, helping to make sure we can offer timely appointments to people.

- The Trust has also reviewed the full contents of the CQC reports in detail and as a result has strengthened our approach to quality improvement across the organisation. A key part of this is the Trust's ***Improving Together*** programme which will support this focus on quality improvement to further embed this as part of the Trust's daily business for all our staff.
- The *Improving Together* programme will require the Trust to focus in some areas on embedding right systems and processes and to learn from each other. Other improvement areas will be longer term, for example relating to cultural changes and other improvements that the Trust cannot make in isolation, recognising the part we play in the wider health system.
- The *Improving Together* programme will support the Trust's determination to work hard to make the necessary improvements and to deliver quality care to the highest standard consistently, every day, in every service for our patients and local communities.

How is Northern Lincolnshire & Goole NHS FT implementing the duty of candour?

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

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

process of being open a framework supporting staff and the individual and their relatives involved.

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

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

  Reference: NHS Litigation Authority, 2009. Circular: Apologies and Explanations. London. NHS Litigation Authority.

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

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

2.2g Information on quality of data

Northern Lincolnshire and Goole NHS Foundation Trust submitted records during 2016/17 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:

- 100.00 per cent for admitted patient care
- 99.9 per cent for outpatient care
- 98.7 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
- 99.9 per cent for accident and emergency care.

2.2h Information governance assessment report

The Trust's Information Governance Assessment Report overall score for 2016/17 was 69% and was graded satisfactory.

2.2i Information on payment by results clinical coding audit

The Trust was not subject to the payment by results clinical coding audit during 2016/17 by the Audit Commission.

2.3 Trust performance against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital (formally the Health and Social Care Information Centre (HSCIC)).

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:

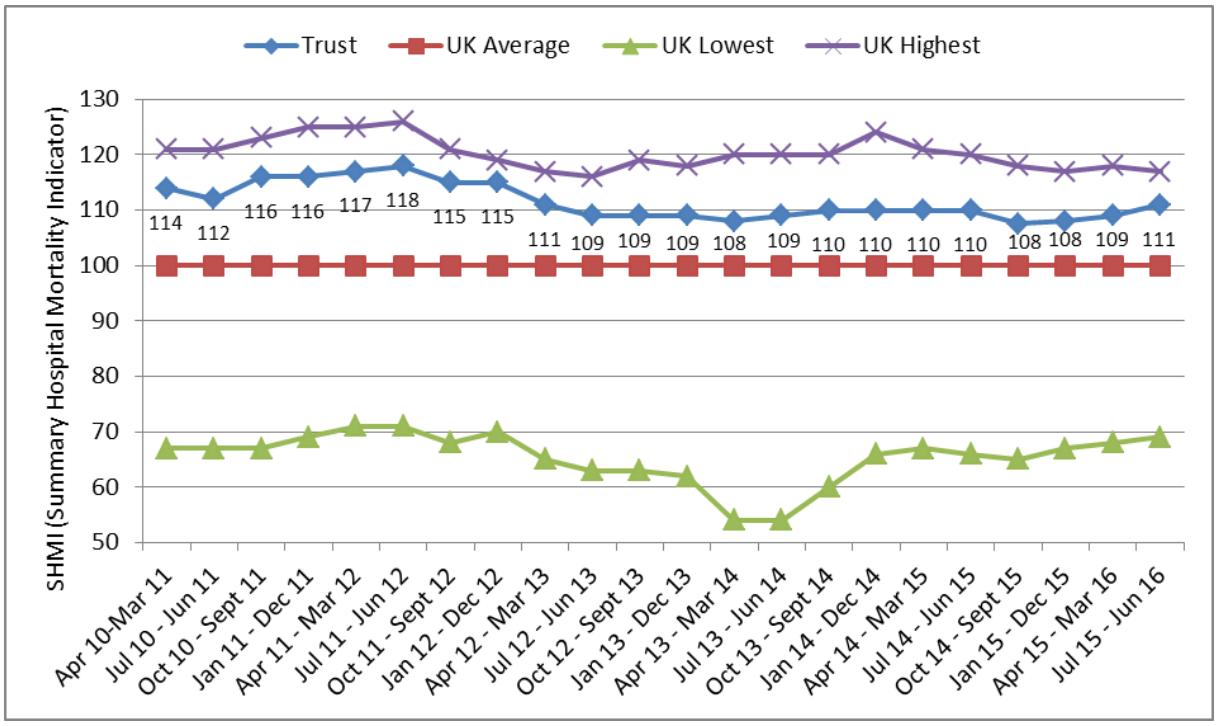
> The Trust considers that this data is as described for the following reasons *[insert reasons]*.
>
> The Trust *[intends to take or has taken]* the following actions to improve the *[percentage / proportion / score / rate / number]*, and so the quality of its services, by *[insert descriptions of actions]*.

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;



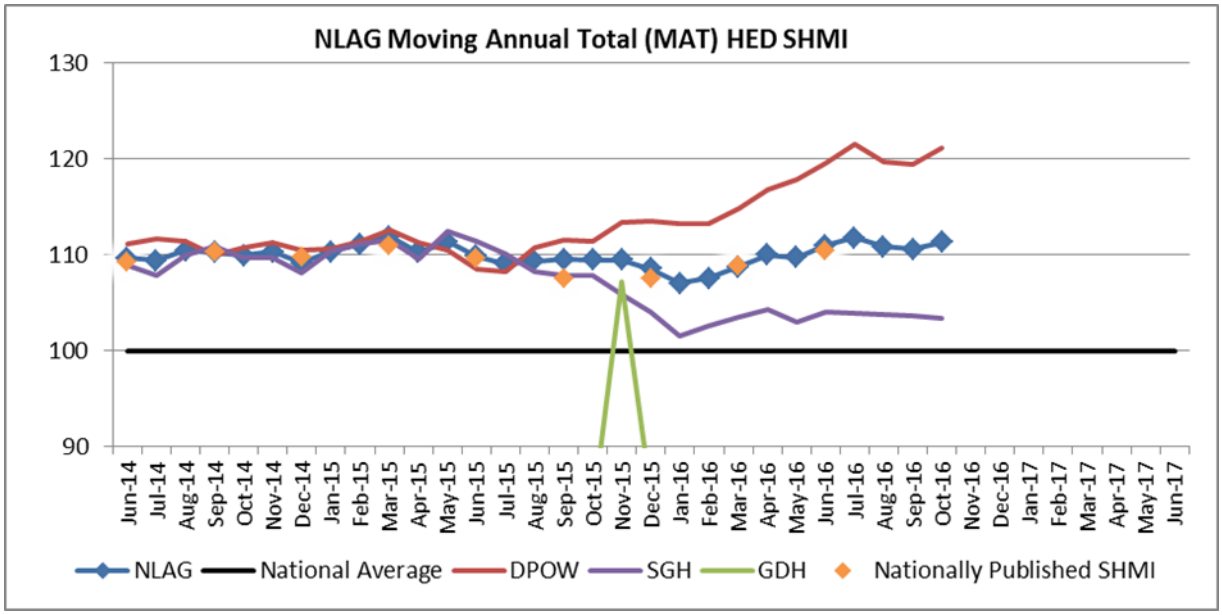
Source: NHS Digital Quality Account Indicators Portal

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

Comments:

- The above chart illustrates the Trust's performance against the Summary Hospital Mortality Indicator (SHMI). The SHMI is a Standardised Mortality Ratio (SMR). SHMI is the only SMR to include deaths outside of hospital in the community (within 30 days of hospital discharge). This inclusion of community mortality means the information needed comes from the Office for National Statistics, this results in delay in the reporting of the SHMI. To illustrate the most recently available SHMI reports performance July 2015 to June 2016.

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



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

Key to abbreviations: NLAG – Northern Lincolnshire and Goole NHS Foundation Trust,
Moving Annual Total (MAT) – A moving annualised average, each months data includes that month plus the 11 months preceding, providing a more reliable presentation of trends over time,
National average – The United Kingdom average,
DPoW – Diana, Princess of Wales Hospital,
SGH – Scunthorpe General Hospital,
GDH – Goole District Hospital,
HED SHMI – The Healthcare Evaluation Data (HED) product provides a provisional SHMI on a monthly basis by which the Trust can report mortality in various internal reporting,
Official SHMI – the 'official' SHMI publication, published quarterly, illustrates that the 'provisional' HED data is a reliable indicator to monitor Trust performance on a monthly basis.

Comments:

- The above chart illustrates that the Trust's mortality performance has improved, but more recently has reverted back to static performance at approximately 110.

- There are still differences between the Trust's individual hospital sites, and there is a significant difference between the in-hospital element of the SHMI i.e. deaths taking place in hospital, and the out of hospital part of the indicator, i.e. those deaths that take place within 30 days of discharge in the community. Both of these important elements are monitored monthly by the Trust's mortality report and the Trust's Mortality Assurance and Clinical Improvement Committee (MACIC). This committee has membership from community providers and more recently public health to ensure a wider understanding.

- While 100 is the national average and is commonly defined as 'expected' mortality, it is recognised that this statistical measure is not an absolute indicator of performance. As a result of this, the Health and Social Care Information Centre (HSCIC) publish an organisation's position nationally, determining the national lowest and highest, as well as a Trust banding, which illustrates if an organisation is statistically an outlier, using 95 per cent confidence intervals. This banding is illustrated as follows.

Publication date	Sample time frame	Trust value	Trust banding
October 2011	April 2010 – March 2011	1.14	1
January 2012	July 2010 – June 2011	1.12	2
April 2012	October 2010 – September 2011	1.16	1
July 2012	January 2011 – December 2011	1.16	1
October 2012	April 2011 – March 2012	1.17	1
January 2013	July 2011 – June 2012	1.18	1
April 2013	October 2011 – September 2012	1.15	1
July 2013	January 2012 – December 2012	1.15	1
October 2013	April 2012 – March 2013	1.11	2
January 2014	July 2012 – June 2013	1.09	2
April 2014	October 2012 – September 2013	1.09	2
July 2014	January 2013 – December 2013	1.09	2
October 2014	April 2013 – March 2014	1.08	2
January 2015	July 2013 – June 2014	1.09	2
April 2015	October 2013 – September 2014	1.10	2
July 2015	January 2014 – December 2014	1.10	2
October 2015	April 2014 – March 2015	1.11	1
January 2016	July 2014 – June 2015	1.10	2
March 2016	October 2014 – September 2015	1.08	2
June 2016	January 15 - December 15	1.08	2
September 2016	April 15 - March 16	1.09	2
December 2016	July 15 - June 16	1.11	2

Source: NHS Digital Quality Account Indicators Portal

Key to abbreviations: Trust value – The Trust's SHMI score,

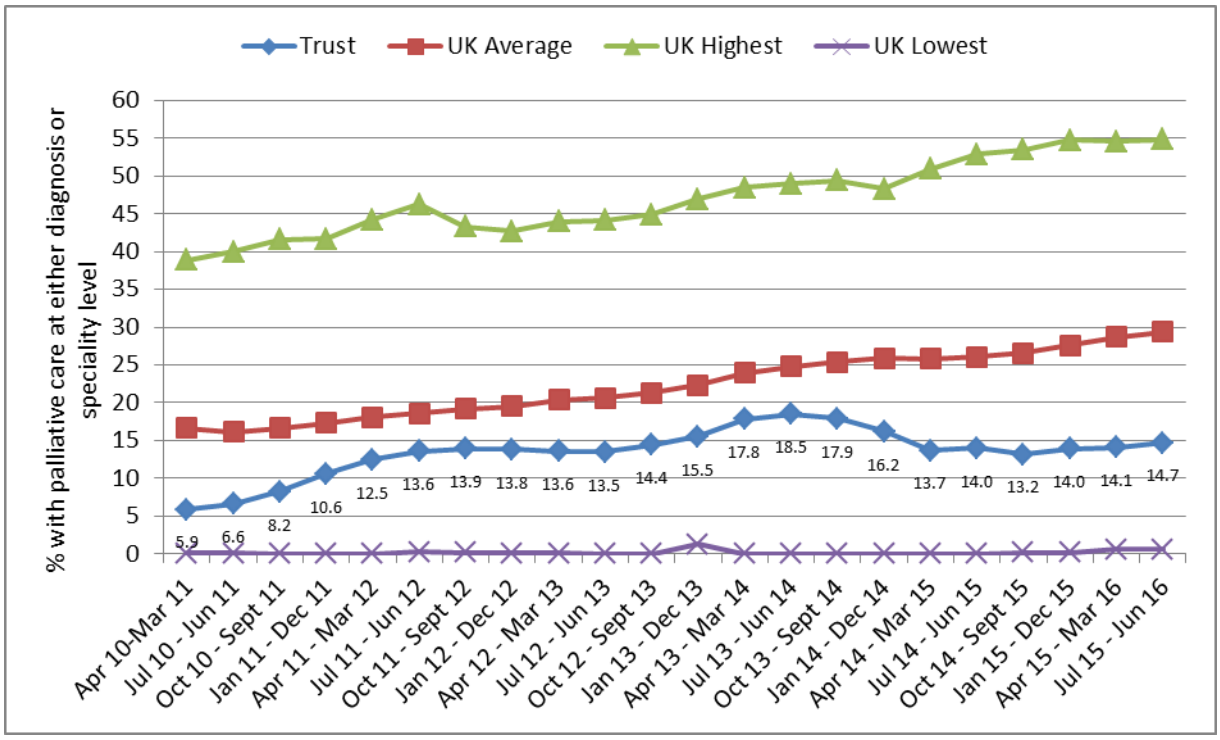
Trust banding – The Trust's banding – determining if it is an outlier using statistically calculated levels of confidence (95 per cent confidence intervals).

Comments:

- Banding numbers are based on a 95 per cent control limit, the bandings there mean:
    - 1 – higher than expected,
    - 2 – as expected,
    - 3 – lower than expected.

- The above table illustrates that the Trust is statistically within the 'as expected' range for its mortality performance.

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



Source: NHS Digital Quality Account Indicators Portal

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

Comment:

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

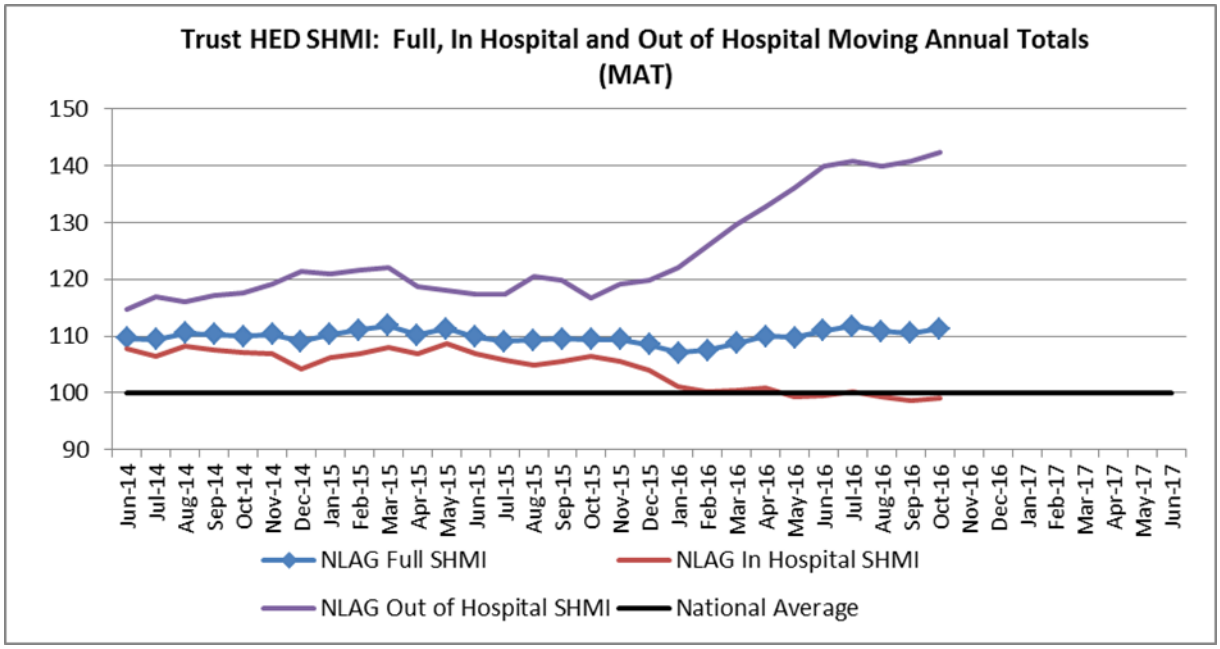
- Palliative care coding is a group of codes used by hospital level coding teams to reflect palliative care treatment of a patient during their hospital stay. Different statistically calculated Standardised Mortality Ratios (SMR) has treated this group of patients differently depending on the indicator.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

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

- The above charts illustrate the percentage of patients each quarter where palliative care codes have been used in either the patient's specific diagnosis or at the specialty team level of those caring for the patient is gradually increasing for the Trust. The UK average demonstrates an increasing trend.

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

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



Source: HED Information, CHKS

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

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

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

- A detailed board paper is produced on a monthly basis outlining Trust performance across a number of mortality indicators. This report has evolved over time and now includes a dedicated section relating to community/out of hospital mortality to ensure relevance to all involved in overseeing performance in this important area.
- The Trust uses the mortality performance data to focus on more detailed individual case note scrutiny assessing the quality of care provided. This review process is designed to enable healthcare professionals to review the care quality with a view to identifying both areas for improvement work and also lessons to be learnt from excellent quality of care. Using this tool provides the Trust with qualitative information regarding key 'improvement themes'.
- Using the two aforementioned resources (1) mortality performance data and (2) the quality of care outcomes tool, the Trust has focussed on 6 clinically led improvement projects, including:
    - Gastroenterology,

- Respiratory,
- Cardiology,
- Deteriorating patient/sepsis,
- End of life/care of the dying,
- Stroke.

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

2.3b: Patient Reported Outcome Measures (PROMS)

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

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

during the reporting period.

Type of surgery	Sample time frame	Trust adjusted average health gain	National average health gain	National highest	National lowest
Groin hernia	April 2010 – March 2011	0.121	0.085	0.156	-0.020
	April 2011 – March 2012	0.084	0.087	0.143	-0.002
	April 2012 – March 2013	0.083	0.085	0.157	0.015
	April 2013 – March 2014	0.051	0.085	0.139	0.008
	April 2014 – March 2015	0.085	0.084	0.154	-0.006
	April 2015 – March 2016	No data available	No data available	No data available	No data available
Varicose vein	April 2010 – March 2011	No data available	0.091	0.155	-0.007
	April 2011 – March 2012		0.094	0.167	0.047
	April 2012 – March 2013		0.093	0.175	0.023
	April 2013 – March 2014		0.093	0.150	0.023
	April 2014 – March 2015		0.095	0.154	-0.002
	April 2015 – March 2016		No data available	No data available	No data available

Type of surgery	Sample time frame	Trust adjusted average health gain	National average health gain	National highest	National lowest
Hip replacement (Primary)	April 2010 – March 2011	0.438	0.405	0.503	0.264
	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	No data available	No data available	No data available	No data available
Knee replacement (Primary)	April 2010 – March 2011	0.316	0.299	0.407	0.176
	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	No data available	No data available	No data available	No data available

Source: NHS Digital Quality Account Indicators Portal, Primary data used, EQ-5D Index used

Comment:

- For 2015/16, no national data has been available for the Trust to report its compliance against. The most recent information available instead is for the 2014/15 reporting period.
- The above table shows the Trust's reported adjusted health gain, which is a measure of the patient's own reported outcome following surgery within the Trust.
- The Patient Reported Outcome Measure (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 of which the Trust has no power to influence. This is illustrated in varicose vein surgery, which the Trust does not provide hence why no data is available.

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

- The results for the 14/15 year demonstrate that the Trust was not an outlier for any of the health gain outcomes for any of the procedures.
- Quarterly reports are received from the Health and Social Care Information Centre (HSCIC) that provide progress updates on both the participation rates, and the overall health gain reported by patients.

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

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

2.3c: Readmissions to hospital

The data made available to the Trust by NHS Digital with regard to the percentage of patients aged:

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

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

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

Source: NHS Digital Quality Account Indicators Portal

Comment:

- The above table does not contain any more recent data after the 2011/12 reporting period. There has been no updated information added to the NHS Digital Quality Account indicators site, therefore the Trust cannot provide any further update on this section.

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

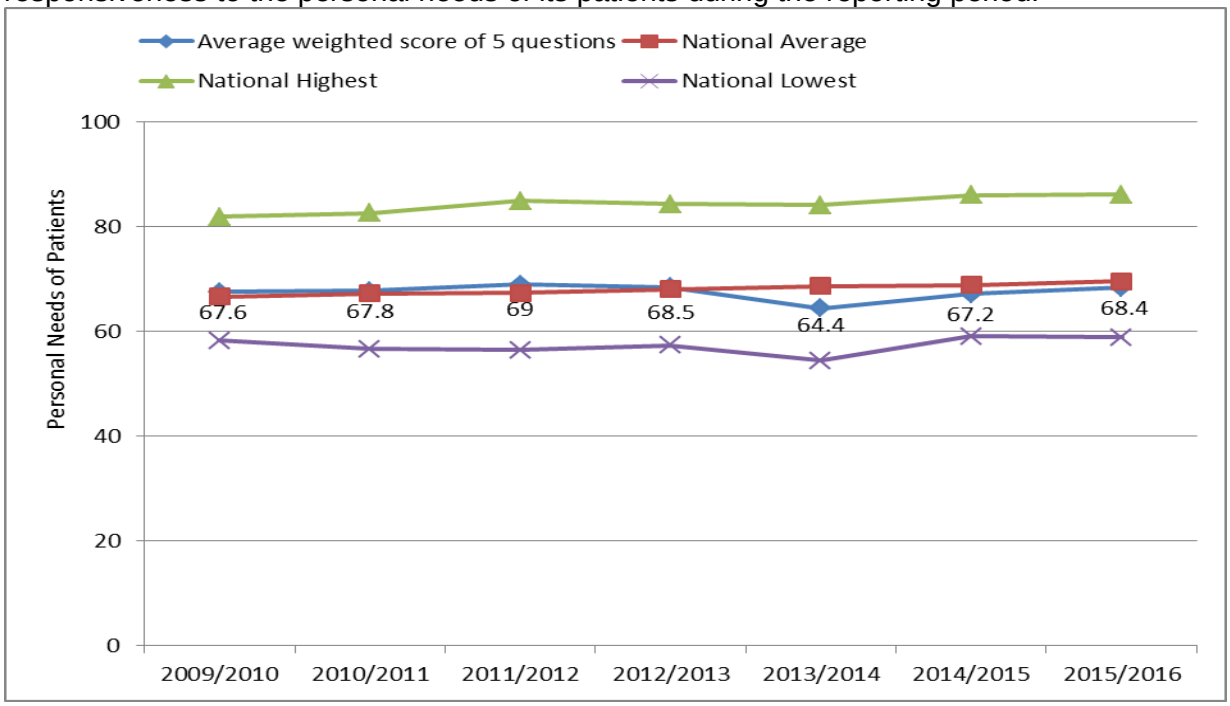
- The Trust has been consistently below the national rates for re-admissions.

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

- The Trust continues to monitor its readmission rates on a monthly basis (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.



Source: NHS Digital Quality Account Indicators Portal

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

Comment:

- The table above highlights the average weighted score for five specific questions. This information is presented in a way that allows comparison to the national average and the 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 this data is as described for the following reasons:

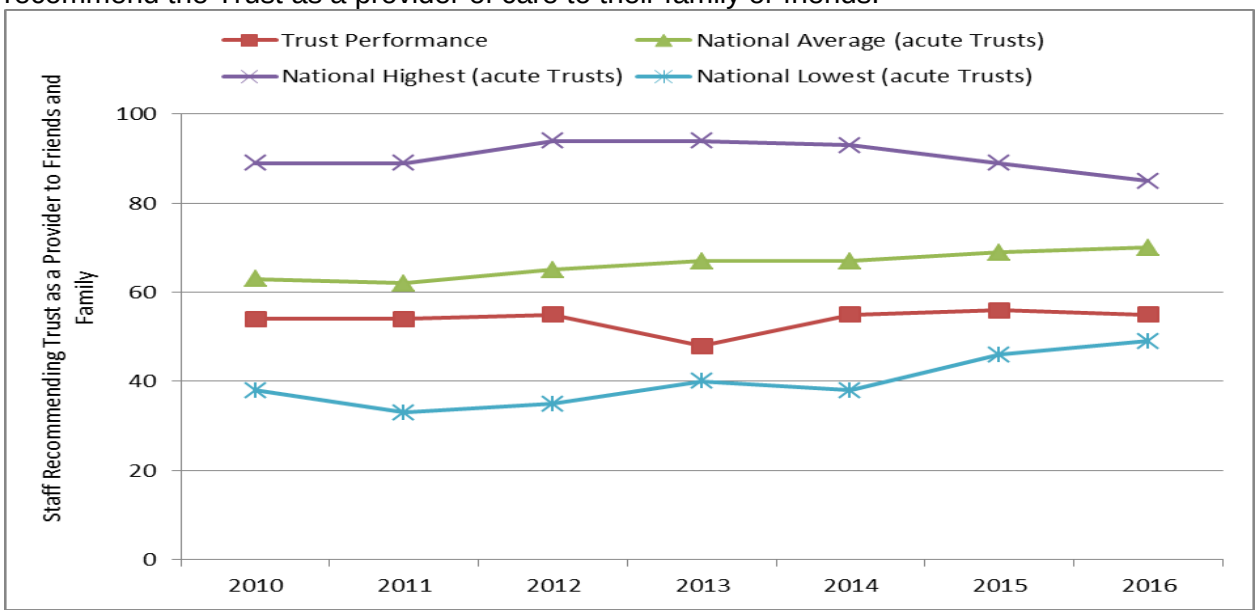
- The Trust response rates are on par with the national average. Monitoring of the first four questions remains a key area of focus. Our Quality Matron team ask these questions of 10 patients on every inpatient ward, every month. This data is uploaded to our nursing dashboard and is scrutinised by our senior nursing team and actioned accordingly.

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

- Ensuring that patients feel part of the decision making process is essential to person centred care and we will continue to monitor and review this on a monthly basis. We are using patient experience stories to highlight the importance of this.
- We always want our patients to feel they can find someone to talk to during their stay and are supporting this by embedding the #Hellomynameis culture throughout the Trust alongside the use of named nurse boards. Through a robust recruitment programme we are establishing a consistent workforce which will work within our Trust Vision and Values framework.
- By providing welcoming patient and visitor rooms within clinical areas we are supporting private areas for conversations, and are committed to supporting this across the Trust.
- Our operational matrons continue to support their ward leaders in establishing the good practice of providing patient information leaflets on discharge, this assurance is sought via the monthly Matrons Forum Assurance document.

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.



Source: NHS Digital Quality Account Indicators Portal

Trust performance – Northern Lincolnshire and Goole NHS Foundation Trust,

National average – The United Kingdom average,
National highest (acute Trusts) – The Trust/hospital/unit reporting highest scores,
National lowest (acute Trusts) – The Trust/hospital/unit reporting lowest scores.

Comment:

- The above table illustrates the percentage of staff answering that they "Agreed" or "strongly agreed" with the question: "If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust".
- 55% of staff surveyed would recommend the Trust.

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

- Feedback from staff is that they would recommend the Trust for treatment as they perceive the Trust as providing quality services delivered by dedicated, caring and compassionate staff.
- Concerns regarding the Friends and Family Test relate to perceptions over staff numbers, in particular the number of doctor and registered nurse vacancies. The Trust notes this as both a local and indeed national issue for the NHS as a whole.

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

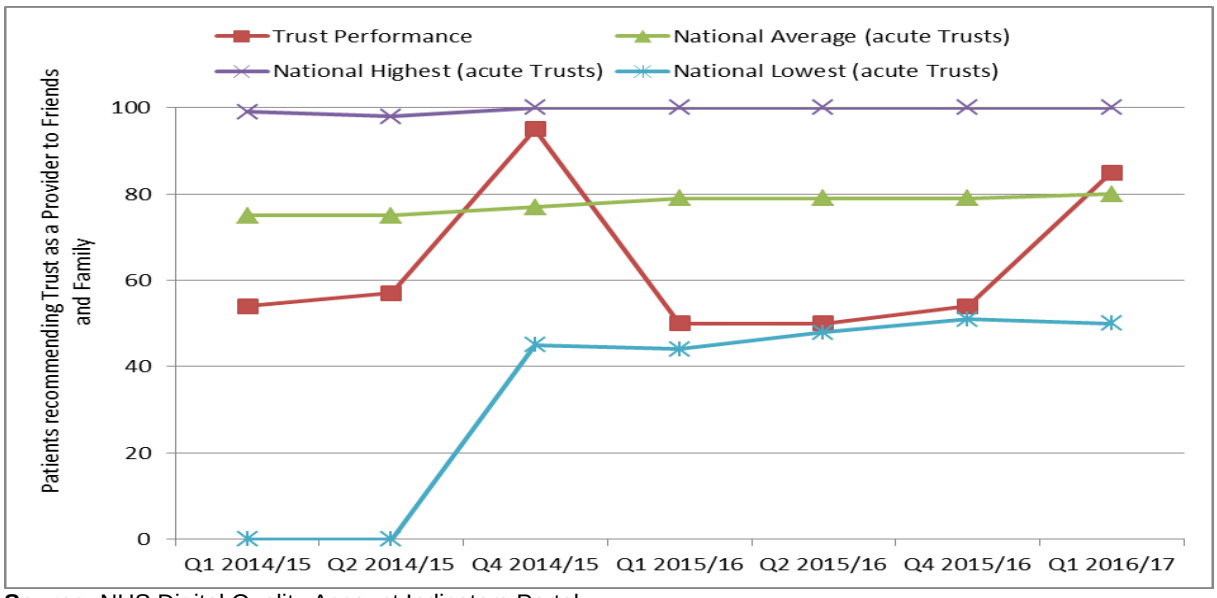
- The People and Organisational Effectiveness Directorate was established and is enacting a significant Friends and Family Test/Staff Survey action plan based on the key findings within the staff survey. This forms part of the Trust's Improving Together Programme focussed on Organisational Development and Culture.
- This improvement plan aims to increase staff engagement and ability to influence service developments and importantly seeks to increase the use and impact of patient and service user feedback on Trust developments. Specific actions in response to the staff survey include, but are not limited to:
    - A Trust Board development programme,
    - A medical engagement programme,

- An organisational culture programme,
- Staff listening events,
- Insights discovery with key staff across the organisation,
- Opportunities to ascertain from staff improvement ideas and opportunities,

- The Trust has an increased focus on staff engagement with a new Staff Engagement Strategy, trained Organisational Development practitioners and a significant number of tailored staff engagement (Listening into Action) initiatives due to be launched throughout 2017/18.
- There are dedicated registered doctor and nurse recruitment and retention work streams aligned to the Trusts sustainability plan to focus on the issues relating to attracting new registered doctors and nurses and retaining the existing registered workforce.

2.3f: Patients recommending Trust as a provider to friends and family

The data made available to the Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency, with regard to patients recommending the Trust as a provider to Friends & Family.



Source: NHS Digital Quality Account Indicators Portal

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

Comment:

- The above table illustrates the percentage of staff answering that they “Agreed” or “strongly agreed” with the question: “Would you recommend this Trust to a Family Member or Friend?”.

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

- There is good engagement from wards areas regarding Friends and Family, this is however combined with a lower than we would like response rate from our A&E departments. Whilst staff appreciate the value of patient feedback we acknowledge there are reasons why the process often causes difficulties, such as patients wishing to leave immediately after treatment and not complete paper based feedback and staff being heavily engaged with clinical activity and prioritising this.

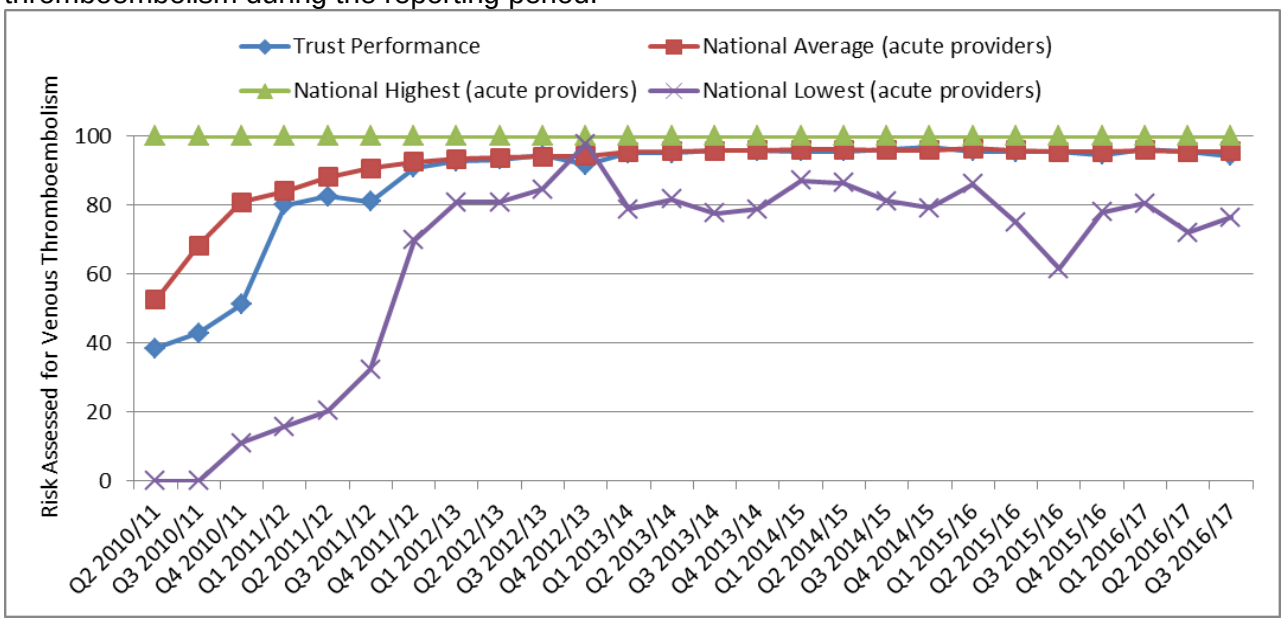
- Some areas, due to their patient group have a lower response rate which we acknowledge, such as stroke units and oncology.
- Our focus is around areas owing the data, which is supported by NHS England FFT lead, rather than a focussing on response rates.
- However the value of having adequate feedback to ensure it is representative remains part of the Friends and Family Test vision.

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

- Exploring other methodologies for A&E, the automated call back service NETCALL, which supports the paper based feedback is currently being reviewed to change to an SMS text service. This is based on other Trusts feedback about improving their response rates.
- Increased visibility of percentages and feedback at ward level.
- A web based system which continues to develop, allowing all staff accessing to their FFT results, helping promote ownership and quality improvement thinking.
- 1:1 meetings with ward leaders to understand any issues and promote understanding of the value of FFT.
- We continue to build on the good foundation of establishing processes of collecting Friends and Family responses with our focus set on improving understanding, ownership and actions to drive patient led quality initiatives.

2.3g: 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.



Source: NHS Digital Quality Account Indicators Portal

Key to abbreviations: Trust – Northern Lincolnshire and Goole NHS Foundation Trust,
National average – The United Kingdom average for acute Trusts,
National highest – The Trust/hospital/unit reporting highest compliance rates,
National lowest – The Trust/hospital/unit reporting lowest compliance rates.

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 two, 2010/11. As illustrated in the above table the Trust has consistently achieved above 90 per cent since quarter four, 2011/12 and is now performing on par with the national average for this indicator.

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

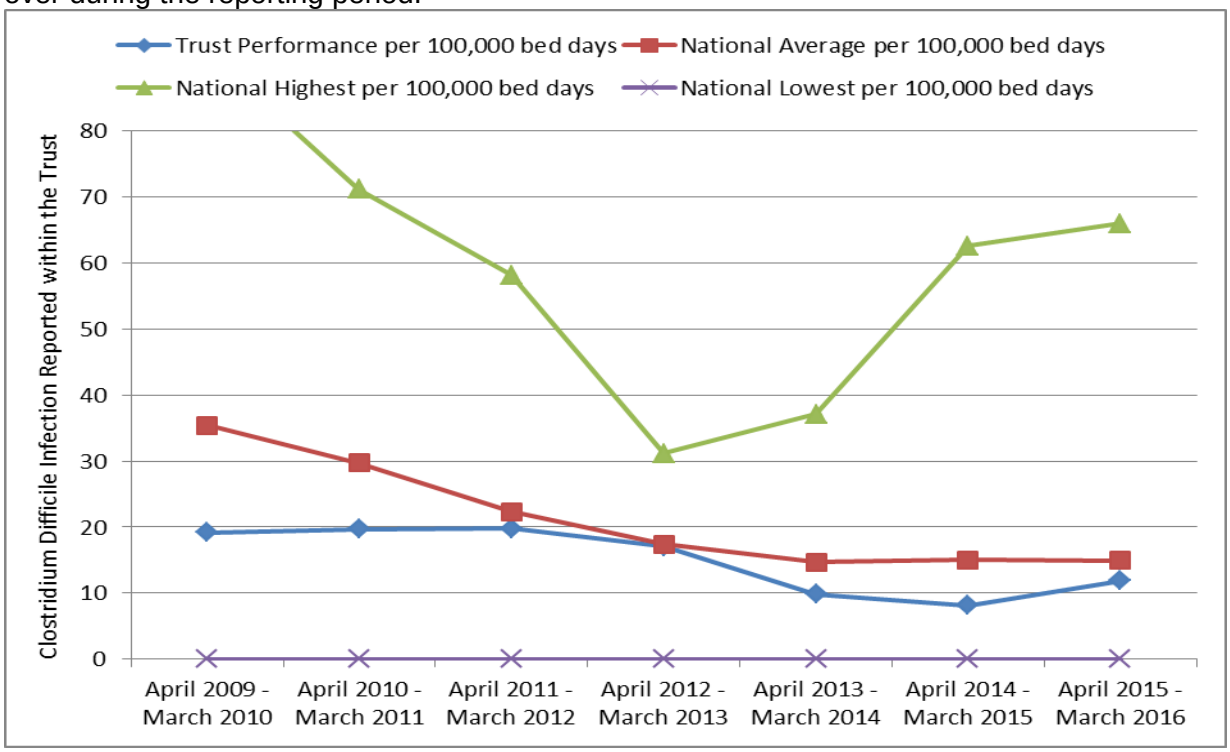
- The Trust is striving to oversee compliance with VTE risk assessments and prophylaxis prescribed. This is accomplished through monthly reporting through the Trust's performance framework. Where possible this overall compliance is broken down to ward and department level to aid continued understanding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

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

- The Trust has revamped the risk assessment screening documentation used to assess a patients risk factors and is working to embed this as part of the Trust's Electronic Patient Record, housed within the Trust's Web V system. Particular emphasis has been placed on improving VTE risk assessments for patients with lower limb immobility.

2.3h: 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 C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.



Source: NHS Digital Quality Account Indicators Portal, Trust apportioned cases

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

Comment:

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

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

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

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

- The Trust has an evidence based C. difficile policy and patient care pathway.
- Multi-disciplinary team meetings are held for inpatient cases to identify any lessons to be learnt and root cause analysis is conducted for every hospital acquired case and a director of infection prevention and control (DIPC) review is held where there has been a breach in practice or the patient has died.
- For each case admitted to hospital, practice is audited by the infection prevention and control team using the Department of Health Saving Lives' audit tools.
- The RCA process is currently being modified to adopt a Post Infection Review process to allow benchmarking with best practice and share lessons learnt in a timely manner.
- Themes learnt from PIR process will be monitored by the Infection Prevention & Control Committee and shared with relevant bodies.
- Current C.difficile occurrences will be made more visible on the intranet site to facilitate clinical staff to benchmark performance against peers.
- The formation of a HCAI working group to explore all matters pertaining to IPC where relevant lessons and infection cases will be discussed with multidisciplinary teams.
- The use of a GDH sticker and actions to be taken has been rolled out to help prevent future CDI cases by streamlining use of broad spectrum antimicrobials.
- GPs will be sent a letter to inform them of a patients C.difficile/GDH status again to help reduce the amount of antimicrobial use and prevent future CDI cases.
- Existing antimicrobials steering group to produce learning resources for prescribers and non-prescribers on best practice associated with reducing antimicrobial consumption which will assist in reducing CDI incidence.
- Implementation of a modified electronic hand hygiene assessment tool to capture compliance with WHO 5 moments. Information to be made available on the intranet so staff can compare performance with peers.
- Development and implementation of a rolling programme of antibiotic prescribing audits reviewed by the steering group and the HCAI working group.
- Currently exploring the possible use of an app based system to facilitate junior medical staff with antimicrobial policies.
- Undertaking a cultural survey across the trust to establish potential barriers with antimicrobial prescribing and measures to alleviate these.

2.3i: 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 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
October 2015 – March 2016	5,395	42.8	39.6	75.9	14.8
April 2015 – September 2015	5,570	44.7	39.3	74.7	18.1
October 2014 – March 2015	5,483	43.2	37.1	82.2	3.6
April 2014 – September 2014	5,124	41.5	35.9	75.0	0.2

Source: NHS Digital Quality Account Indicators Portal

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

Comment:

- The above table demonstrates the total number of patient safety incidents and the rate per 1,000 bed days reported.
- 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 encourage staff to report all incidents, this is in line with NHS England, who state *"Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are."*
- The Trust is continuing to actively encourage and promote incident reporting, and therefore expects the number of incidents reported to remain high and potentially increase in number in order to continue the work streams focussing on learning from incidents. The emphasis continues on reducing harm from patient safety incidents, the number and percentage in figure b) below demonstrates this.
- The Trust is continuing to actively encourage and promote incident reporting, and therefore expects the number of incidents reported to remain high and potentially increase in number in order to continue the work streams focussing on learning from incidents. The emphasis continues on reducing harm from patient safety incidents, the number and percentage in figure b) below demonstrates this.

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

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 of patient safety incidents reported involving severe harm or death (%)	Acute – Non-specialist national highest rate involving severe harm or death (%)	Acute – Non-specialist national lowest rate involving severe harm or death (%)
October 2015 – March 2016	9	0.07	0.16	0.97	0.00
April 2015 – September 2015	6	0.05	0.17	1.12	0.03
October 2014 – March 2015	6	0.09	0.2	1.53	0.02
April 2014 – September 2014	12	0.10	0.2	1.09	0.00

Source: NHS Digital Quality Account Indicators Portal

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

Comment:

- The above table demonstrates the total number and rate per 1,000 bed days of patient safety incidents involving severe harm or death.

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

- The Trust undertakes regular analysis of incident data, producing a wide range of monthly, quarterly and annual analysis reports which are shared throughout the organisation via a number of committees/groups/forums. These reports enable aggregate analysis of data, along with analysis of particular themes. The relevant group/committee reviews the reports, and considers recommendations, which look to improving patient safety and addressing known risks identified in these reports.

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

- A key focus group is the Learning Lessons Review Group. There are a number of multi-disciplinary sub-groups of the Learning Lesson Review Group focussing on prevention initiatives to reduce the harm from patient safety incidents, and also to reduce the number of incidents. These groups are considering issues such as patient misidentification, clinical handover, communication and documentation.
- Learning lessons remains a key priority area for the Trust and this will feature as part of the Trust's Improving Together programme.
- The Trust Falls Prevention Group is a multidisciplinary group with an ongoing action plan to reduce the risk and preventing harm to patients. A number of initiatives have been introduced and these are having a positive effect on reducing the number of falls and harm to patients. Further initiatives are under consideration to sustain this reduction.
- The Trust has also developed a programme of quality and safety half day sessions that run at least quarterly in each of the Directorate groups. The idea behind these sessions is to enable clinical staff providing the service to be able to have time to present cases of learning for discussion of lessons learnt and to disseminate good practice.

Part 3: Other information

An overview of the quality of care based on performance in 2016/17 against indicators

3.1 Overview of the quality of care offered 2016/17

Parts 2.1a, 2.1b and 2.1c of this report outlined progress during 2016/17 towards achieving the priorities for this financial year just ended which the Trust set out in its previous Annual Quality Account for 2015/16. The quality priorities in part two were presented in three distinct sections: clinical effectiveness (2.1a), patient safety (2.1b) and patient experience (2.1c).

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

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

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

During 2016/17 the following quality priorities were monitored by the monthly quality report which was presented and reviewed on a monthly basis by the Trust's Quality and Patient Experience (QPEC) Committee and the Trust Board. The 'at a glance' overview of performance that follows is viewed continually throughout the year within the monthly quality report; as a result these are constantly changing based on the real time nature of these indicators. A summary of the Trust's performance against these key indicators (outlined within part 2 in full) are summarised as follows:

QUALITY INDICATORS AT A GLANCE: Jan-17

2016/17 Indicators

Indicator			Time period / RAG	Comparator	Trending	Trust Stretch Target	National Target
CLINICAL EFFECTIVENESS			**Most recent data**	**Previous**	**Target Achieved**		
CE1	Deliver mortality performance within 'expected range' and improving quarter on quarter, until reported SHMI is 95 or better	Official SHMI (Jul 15-Jun 16)	110.5 R	108.9		95	100
		HED data (Nov 15 - Oct 16)	111.3 R	109.9		95	100
		Position vs peers	Within expected range A	Within expected range	Within expected range	Within expected range	Within expected range

Indicator			Change	Jan-17	Previous month	Target achieved	Trust Stretch Target	National Target
CE2.1	Patients are screened for Sepsis on presentation (Adults)	Trustwide	✓ 2%	100.0% G	98.0%		90.0%	90.0%
CE2.2	Patients with Sepsis receive antibiotics within 1 hour of presentation (Adults)	Trustwide	✗ -3%	92.0% G	95.0%		90.0%	90.0%
CE2.3	Patients are screened for Sepsis whilst already in hospital	Adults	✓ 3%	79.5% R	77.0%		90.0%	90.0%
		Children	✓ 0%	100.0% G	100.0%			
CE2.4	Patients already in hospital with severe sepsis have IV Antibiotics	Adults	✓ 0%	100.0% G	100.0%		90.0%	90.0%
		Children	N/A	N/A G	N/A			
CE3	Screened for Dementia	DPoW	✗ -1.0%	91.0% G	92.0%		90.0%	None
		SGH	✓ 3.0%	89.0% R	86.0%			
CE4.1	Technology Appraisal Guidelines (TAGs) to be fully compliant within 3 months of release		✓ 2.0%	98.0% R	96.0%		100.0%	None
CE4.2	Clinical Guidelines (CGs) / NICE Guidelines (NGs) to be fully compliant within 3 years		✓ 1.9%	87.3% R	85.4%		90.0%	None
CE5	Transfer of patients for non-clinical reasons (capacity) to not exceed 10% of the total		✗ 0.0%	12.0% R	12.0%		10.0%	None

Indicator			Change	Time period / RAG	Comparator	Trending	Trust Stretch Target	National Target
PATIENT SAFETY				**Jan-17**	**Previous month**	**Target achieved**		
PS1	MRSA Bacteraemia Incidence	(YTD: 1)	✗ 1	1 R	0		0	0
PS2	C Difficile Incidence (ALL cases)	(YTD: 21)	✓ -1	2 G	3		No Target	No Target
	C Difficile ('Lapses in care')	(YTD: 2)	✓ 0	0 G	0		No more than 10 Lapses in Care	No more than 21 Lapses in Care
PS3	Safety Thermometer (Community)		✓ 1.8%	96.40% G	94.6%		95.0%	None
PS4	6 Ward focussed pressure ulcer reductions	DPoW - Ward B6	✓ -1	2 A	3		Decreasing trend	None
		DPoW - Ward B7	✗ 4	4 A	0			
		DPoW - Ward C6	✓ 0	1 R	1			
		SGH - Ward 18	✓ 0	0 R	0			
		SGH - Ward 22	✓ 0	0 R	0			
		SGH - Ward 24	✓ -1	3 R	4			
PS5	Reduction in Number of Avoidable Pressure Ulcers (Grades 2, 3 & 4)	DPoW	✓ 0	0 G	0		50% reduction (no more than 2 per month)	None
		SGH	✓ 0	0 G	0			
		GDH	✓ 0	0 G	0			
PS6	Elimination of Avoidable Repeat Fallers	DPoW	✓ -4	0 G	4		Eliminate All avoidable repeat falls	None
		SGH	✓ -1	0 G	1			
		GDH	✓ 0	0 G	0			
PS7.1	Nutrition care pathway was followed	DPoW	✗ -1.3%	96.0% R	97.3%		100.0%	None
		SGH	✗ -0.8%	99.2% A	100.0%			
		GDH	✓ 0.0%	100.0% G	100.0%			
PS7.2	The food record chart completed accurately and fully in line with care pathway	DPoW	✗ -0.7%	91.3% R	92.0%		100.0%	None
		SGH	✓ 3.4%	99.2% A	95.8%			
		GDH	✓ 0.0%	100.0% G	100.0%			
PS8	The fluid management chart was completed accurately and fully in line with care pathway	DPoW	✗ -1.4%	84.6% R	86.0%		100.0%	None
		SGH	✓ 4.0%	95.5% R	91.5%			
		GDH	✓ 0.0%	100.0% G	100.0%			

Indicator			Change	Time period / RAG	Comparator	Trending	Trust Stretch Target	National Target
PATIENT EXPERIENCE				**Jan-17**	**Previous Month**	**Target achieved**		
PE1	Feedback from the Friends & Family Test is positive	A&E	✗ -4.4%	61.6% R	66.0%		98.0%	None
		Community	✗ -1.5%	98.5% G	100.0%			
		Day case	✗ -0.3%	99.3% G	99.6%			
		Maternity	✓ 0.4%	96.1% A	95.7%			
		Inpatient	✓ 1.3%	96.0% A	94.7%			
PE2	Re-opened complaints to not exceed 10% of total closed complaints		✗ 0.6%	5.6% G	5.0%		10.0%	None
PE3	Complaints relating to communication		No data	No data to report as yet			To be established	None
PE4	Patients feel that medical and nursing staff did everything they could to help control pain.	DPoW	✓ 0.7%	96.2% G	95.5%		90.0%	None
		SGH	✓ 1.8%	100.0% G	98.2%			
		GDH	✓ 0.0%	100.0% G	100.0%			
	Patients received pain relief when they needed it in a timely manner	DPoW	✓ 4.6%	97.4% G	92.8%		90.0%	None
		SGH	✓ 1.8%	100.0% G	98.2%			
		GDH	✓ 0.0%	100.0% G	100.0%			

3.2 Performance against relevant indicators and performance thresholds

To Update with Quarter 4 Information – available 20 April 17

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

NHS IMPROVEMENT COMPLIANCE FRAMEWORK SUMMARY
Performance Against Key Thresholds For The Period 1st April 2016 to 31st January 2017

PERFORMANCE METRIC	WEIGHTING	2016/17 QTR 1	2016/17 QTR 2	2016/17 QTR 3	Threshold	STP Trajectory	Jan-16	QTR 4 Actual To Date	Qrt 4 WEIGHTING
1. Infection Control*									
Total Hospital Acquired C.Difficile Cases Lapses in Care (YTD)	1.0	G	G	G	21		0	2	G
2. Referral to Treatment Waiting Times									
Incomplete - Maximum waiting time of 18 weeks	1.0	R	R	R	92%	92.71%	79.51%	79.51%	R
3. Cancer * **									
31 day wait diagnosis to treatment	1.0	G	G	G	96%		99.13%	98.72%	G
i) 31 day wait for subsequent treatments - Surgery	1.0	G	G	G	94%		100%	100%	G
ii) 31 day wait for subsequent treatments - Anti cancer drugs		G	G	G	98%		100%	100%	G
i) 62 day wait GP referral to treatment POST alloaction		R	G	R	85%	87.80%	67.08%	68.32%	R
ii) 62 day wait GP referral to treatment PRE allocation	1.0	R	G	R	85%	87.80%	69.68%	71.29%	R
ii) 62 day wait Consultant screening service referrals allocation		G	G	G	90%		100%	100%	G
i) 2 week wait referral to consultation	1.0	G	G	G	93%		95.97%	95.99%	G
ii) 2 week wait breast symptomatic referrals		G	G	G	93%		94.12%	95.65%	G
4. A&E									
A&E 4 Hour Wait Compliance	1.0	R	R	R	95%	89.01%	80.0%	80.0%	R
5. Data Completeness Community Services **									
5i) Referral to treatment information	1.0	G	G	G	50%		99.9%	99.9%	G
5ii) Referral Information		G	G	G	50%		99.9%	99.9%	G
5iii) Treatment Activity Information		G	G	G	50%		93.0%	93.0%	G
6. Access **									
Access to healthcare for people with learning disability	0.5	G	G	G	Y/N		Y	Y	G

* Quarterly Cumulative figures	Total NHS Improvement Compliance	Total Monitor Compliance Score 3.0
** Forecast Position	NHS Improvement	Monitor Compliance Rating Green
*** Provisional Data -	NHS Improvement	Monitor Over ride Rating Red

Comments:

- To be added when data fully available for Quarter 4 16/17.
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3.3 Information on staff survey report

Summary of performance – NHS staff survey

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

In 2016, 41.1 per cent of our staff completed a survey (an increase from 33.7 per cent the previous year).

The survey was open form September to December 2016, and all staff were encouraged to participate. Prizes were offered for the 500th, 1,000th, 1,500th and so on staff who completed their survey and the survey features 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 cascade meeting.

Detailed performance – NHS staff survey

The Trust, as in previous years, undertook a census sample survey offering 6,133 staff the opportunity to participate. Despite a marginal increase nationally in the number of staff overall participating in the survey the Trust experienced a 7.7% increase in its return rate. This was reassuring and provides the Trust with confidence in the survey findings.

	2015		2016		Trust improvement/ deterioration
Response rate	Trust	National average	**Trust**	**National average**	
	33.7%	38.0%	**41.1%**	**39.9%**	7.7% improvement

Source: NHS Staff Survey

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

Staff Survey 2016 findings

Highest five ranking scores:

	2015		2016		Trust improvement/ deterioration
Highest five ranking scores	Trust	National average	**Trust**	**National average**	
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	92%	90%	**92%**	**90%**	No change
Percentage of staff working extra hours	69%	72%	**70%**	**72%**	Increase
Percentage of staff reporting most recent experience of harassment, bullying or abuse	19%	37%	**47%**	**45%**	Increase
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	29%	28%	**27%**	**27%**	Decrease
Percentage of staff appraised in the last 12 months	86%	86%	**88%**	**87%**	Increase

Source: NHS Staff Survey

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

Lowest five ranking scores:

	2015		2016		Trust improvement/ deterioration
Lowest five ranking scores	Trust	National Average	**Trust**	**National Average**	
Percentage of staff agreeing that their role makes a difference to patients / service users	86%	90%	**88%**	**90%**	Increase
Effective use of patient / service user feedback	3.52	3.70	**3.51**	**3.72**	Decrease
Recognition and value of staff by managers and the organisation	3.34	3.42	**3.30**	**3.45**	Decrease
Staff recommendation of the organisation as a place to work or receive treatment	3.51	3.76	**3.51**	**3.76**	No change
Percentage of staff satisfied with the opportunities for flexible working patterns	44%	49%	**44%**	**51%**	No change

Source: NHS Staff Survey

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

Regarding staff feeling of experiencing harassment, bullying or abuse from staff:

	2015		2016		Trust improvement/ deterioration
KF26	Trust	National Average	**Trust**	**National Average**	
The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	27%	26%	**25%**	**25%**	Decrease

Source: NHS Staff Survey

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

Regarding staff perception over equality of career progression staff reported:

	2015		2016		Trust improvement/ deterioration
KF27	Trust	National Average	**Trust**	**National Average**	
The percentage believing that Trust provides equal opportunities for career progression or promotion	88%	87%	**88%**	**87%**	No change

Source: NHS Staff Survey

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

Future priorities and targets

After reviewing the staff survey's findings the Trust is focussing its efforts during 2017/18 on:

- Reviewing and reinforcing reported incident feedback mechanisms to staff. This is to ensure staff receive and recognise the different formats used to convey feedback on incidents that are reported. This ensures staff can see both the outcome and actions taken to help learn lessons and to respond to concerns as appropriate.
- Further investment to be made in acknowledging and recognising the efforts and endeavours of staff. This is to demonstrate that within the challenging context that the Trust and staff are working, they are valued at a local managerial/group and corporate level. Linkages will be made to recognising staff who receive outstanding patient praise and compliments.
- A review and investment in staff communications with a particular focus on senior management communications with front line staff. This will link to a drive to increase the visibility and presence of the Trusts leadership/management teams to those working in front facing patient areas.
- A review and investment in the staff voice with a particular focus on proactively listening to staff service improvement ideas and involving staff in decision making processes.
- To review how the Trust listens to patient/service user feedback to improve and develop patient services; engaging with Trusts who are perceived as being leaders in using patient feedback to inform decision making.
- To review the Trust's approach to staff flexible working and where possible to adopt further family friendly working practices.

Finally the Trust has recently appointed an Equality and Diversity (E&D) Lead who will commence engaging with and understanding the E&D concerns contained within the staff survey to produce a Board level report outlining the key findings and SMART actions to address the concerns.

To complement the above activities the Trust recommenced its local quarterly pulse check survey, the Morale Barometer in March/April 2017. The findings from this local survey will help the Trust to measure the impact of the above actions and provide real-time insight into staff job satisfaction and sense of engagement.

The Staff Experience, Health and Wellbeing group via QPEC will monitor progress against the above areas of activity. This progress will be formally reported to Trust Board. Equally as important, the Trust has committed to working with staff and staff side to address the above areas of concern and to provide workforce wide update communications.

3.4 Information on patient survey report

Introduction

The National Inpatient Survey for 2016 was sent out to 1250 of patients who stayed in our Trust, 530 choose to respond. This extensive questionnaire helps provide a more detailed insight into their care received and provides a mechanism by which we can focus our improvement priorities in a patient led way.

Response rate compared with previous year:

	2015		2016	
Response rate	Trust	National average	**Trust**	**National average**
	45%	45.1%	**44%**	**41%**

Source: NHS Patient Survey

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

Comments:

This 2016 patient survey has highlighted many positive aspects of the patient experience.

- Overall: **84%** rated care 7+ out of 10.
- Overall: treated with respect and dignity **83%**.
- Hospital: room or ward was very/fairly clean **98%.**
- Hospital: toilets and bathrooms were very/fairly clean **95%.**
- Care: always enough privacy when being examined or treated **88%.**

One area where we performed significantly better than the average of the 82 Trusts was with regard to the Trust offering a choice of food. This is greatly rewarded and illustrates that we are seeing positive feedback of the immense work that has gone into improving our patient menu and choice of food.

However, the following areas are reported by patients as being rated lower than the average of the other 82 Trust in the National Inpatient Survey run by Picker Institute.

- [Nurses] Did not always know which nurse was in charge of care,
- [Discharge] Delayed by 1 hour or more,
- [Discharge] Not given any written/printed information about what they should or should not do after leaving hospital,
- [Nurses] Sometimes, rarely or never enough on duty,
- [Care] Not always enough privacy when discussing condition or treatment,
- [Doctors] Did not always get clear answers to questions,
- [Care] Staff contradict each other,
- [Doctors] Did not always have confidence and trust,
- [Hospital] Patients using bath or shower area who shared it with opposite sex,
- [Care] Not enough (or too much) information given on condition or treatment,
- [Doctors] Talked in front of patients as if they were not there,
- [Hospital] Bothered by noise at night from staff,
- [Care] Not always enough privacy when being examined or treated.

Actions to be taken as a result:

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

- To ensure that the questions are incorporated into improvement plans within the Trust, to avoid repetition but also to increase ownership of actions,
- The 2015 Inpatient Survey Action Plan has been updated and any actions which are completed, and reflected in an historical Trust improved position will be archived. Actions which appear on the 2016 survey as being worse nationally, but historically worse also will be moved over onto the designated plan for improvement alongside any new actions,
- Our desire is to strengthen the ownership of the related actions which will be developed to ensure improvement. This journey belongs to all of us.

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees To Update on receipt of comments from stakeholders, after the 28 April 2017

Annex 1.1: Statements from Commissioners

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

Feedback to follow….

Annex 1.2: Statement from Healthwatch organisations

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

Feedback to follow….

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

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

Feedback to follow….

Annex 1.4: Statement from the Trust governors'

Feedback to follow….

Annex 2: Statement of directors' responsibilities in respect of the Quality Report To Update during April/May 2017

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

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 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 2016 to the [date of this statement]
    - Papers relating to quality reported to the board over the period April 2016 to [the date of this statement]
    - Feedback from commissioners dated [insert date]
    - Feedback from governors dated [insert date]
    - Feedback from Local Healthwatch organisations dated [insert date]
    - Feedback from Overview and Scrutiny Committees dated [insert date]
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated [insert date]
    - Latest national patient survey [insert date]
    - Latest national staff survey [insert date]
    - The head of internal audit's annual opinion of the trust's control environment dated [insert date]
    - CQC inspection report dated [insert date].
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

……Date ……Chairman

……Date ……Chief Executive

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

To update on receipt of the independent auditor's report

Annex 4: Glossary

SECTION 1

Clinical Effectiveness (CE)

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".

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

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

As this is the 'official' NHS mortality indicator of choice, it is calculated using a strict methodology then ensures all NHS organisations are measured in the same way using the same indicators. Interestingly, in the calculation of 'expected mortality' the SHMI does not adjust for regional deprivation levels.

Unlike other SMRs, the SHMI includes deaths in the community up to 30 days following a person's discharge from hospital. So whilst SHMI contains the word 'hospital' in the title, this signifies that the patient admission to the hospital is the index date on which the SHMI operates covering that in-hospital episode and the 30 days immediately following discharge. Mortality outside of hospital is not covered by SHMI if no hospital contact is made. SHMI is only calculated for those patients having hospital contact.

SHMI should therefore be viewed as a wider healthcare community mortality indicator, not solely a reflection of the hospital Trust.

Another key note of importance is that SHMI (or any other SMR) should not be misunderstood to be a measure of quality of a healthcare system or be interpreted to mean that a SHMI indicator above 100 means that there is evidence of 'avoidable' deaths. National guidance stresses that a raised (or lowered SHMI) should be used as a smoke alarm, to investigate and understand in greater detail.

As a result of the SHMI including community mortality within the indicator, it is based not only on in-hospital recorded data but on information from the Office for National Statistics (ONS). This introduces a significant delay in publishing information on the healthcare community. As a result, when SHMI information is published each quarter, the time frame included within the report is between six and 18 months out of date. To illustrate this, in January 2016, the SHMI was published focusing on the time frame of July 2014 – June 2015. Therefore while the SHMI is a useful tool to aid the Trust's understanding of this important area, it has struggled to use this effectively in order to monitor ongoing performance due to the significant time lag in reporting.

What is Healthcare Evaluation Data (HED)

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

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

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

How is mortality performance monitored within the Trust?

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

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

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

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

Commissioning for Quality & Innovation Framework (CQUIN): The CQUIN payment framework enables commissioners to

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

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

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

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

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

KEY DEFINITIONS TO INTERPRET COMPLAINTS DATA:

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

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

Dementia – methodology for determining compliance with Quality Target:

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

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

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

CE3.2 – Further risk assessment.

All patients admitted aged 75 and above, who have scored positively on the case finding question, or who have a clinical diagnosis of delirium and who do not fall into exemption categories should then receive a more detailed diagnostic assessment using the 6 item Cognitive Impairment Test (6CIT).

CE3.3 – Referred in line with local pathway.

Following the roll out of the national CQUIN for dementia, it was agreed locally with Rotherham Doncaster & South Humber NHS Foundation Trust in North Lincolnshire and NAVIGO Health & Social Care Community Interest Company in North East Lincolnshire that in patients with a positive diagnostic assessment (6CIT score of 8 or above) or inconclusive should be referred to them for a specialist Mental Health Liaison Team review.

Fall: A sudden, unintended, uncontrolled downward displacement of a patient's body to the ground or other object. This includes situations where a patient falls while being assisted by another person, but excludes falls resulting from a purposeful action or violent blow.

Unavoidable Fall: Impossible to avoid the fall(s) from happening. Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure

Avoidable Fall: The fall(s) could have been avoided. Recognises that some of these events are not always avoidable, given the complexity of healthcare; therefore, the presence of an event on the list is not an a priori judgment either of a systems failure or of a lack of due care

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

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

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

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

MUST – Malnutrition Universal Screening Tool: The total MUST score for a patient is worked out from their BMI, the amount of unplanned weight loss they may have and the 'acute disease effect' (if the patient is acutely ill and there has been or likely to

be no nutritional intake for >5 days). The MUST score triggers appropriate action, as described below:

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

National Institute for Health and Care Excellence (NICE) guidelines: The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. NICE was originally set up in 1999 to reduce variation in the availability and quality of NHS treatments and care.

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

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

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

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

Pressure Ulcer: Definition of Avoidable and Unavoidable Pressure Ulcer

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

The Wound, Ostomy and Continence Nurses Society of the US have produced a position paper which points to a clear definition of "avoidable" pressure ulcer (WOCNS) March 2009. However, the DH are using a modified version of the Avoidable d Unavoidable pressure ulcers definitions from the Centre for Medicare and Medicaide (CMS) 2004, to keep with the UK policy Terminology.

The modified definitions are:

AVOIDABLE PRESSURE ULCER:

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

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

UNAVOIDABLE PRESSURE ULCER:

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

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

Pressure ulcer grading from the European Pressure Ulcer Advisory Panel (EPUAP):
Category/Grade 1: Non-blanchable redness of intact skin

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

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

Category/Grade 2: Partial thickness skin loss or blister

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

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

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

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

Further description: The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast,

areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

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

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

Further description: The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable.

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

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

Safety Thermometer methodology for Community & Therapy Services:

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

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

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

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

Safety Thermometer methodology for Acute Services:

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

- Pressure ulcers grades 2,3 & 4
- Falls – all falls reported, even if no harm occurred
- Catheter associated UTIs – those treated with antibiotics
- VTE – risk assessment, prophylaxis and treatment of DVT or PE

Harm:

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

Harm Free Care:

- Safety Thermometer enables the calculation of the proportion of patients who received harm free care. This is calculated by dividing the number of patients receiving harm free care (as the numerator) by the total number of patients surveyed (the denominator).
- Patients with more than one of the harms listed, will not be classified as harm free care and are thus not counted in the numerator. Patients recorded as having multiple harms are removed from the numerator in the same way as those with only one harm.

Proportion of patients with 'harm free' care:

- Those patients **without** any documented evidence of a pressure ulcer (any origin, category 2-4), harm from a fall in care in the last 72 hours, a urinary infection (in patients with a urinary catheter) or a new VTE (treatment started after admission).

Proportion of patients with 'harm free' care – new harms only:

- Those patients **without** any documented evidence of a **new** pressure ulcer (developed at least 72 hours after admission to this care setting, category 2-4), harm from a fall in care in the last 72 hours, a **new** urinary infection in patients with a urinary catheter which has developed since admission to this care setting, or a new VTE (treatment started after admission).

Community Safety Thermometer: VTE is not relevant as an indicator. In community practice, patients are not routinely risk assessed for VTE and any concerns regarding a patient in this matter would be referred to the patient's GP or to the acute Trust via A&E attendance. In the same way, prophylaxis, unless prescribed by a doctor, would not routinely be commenced by community staff. Due to these differences, the individual elements of this indicator have been classed as not applicable to the community care safety thermometer results. As a result, VTE is not included in the following section pertaining to community care Safety Thermometer results**.**

Sigma: A sigma value is a description of how far a sample or point of data is away from its mean, expressed in standard deviations usually with the Greek letter σ or lower case s. A data point with a higher sigma value will have a higher standard deviation, meaning it is further away from the mean.

Special Cause Variation: the pattern of variation is due to irregular or unnatural causes. Unexpected or unplanned events (such as extreme weather) can result in special cause variation. Systems which display special cause variation are said to be unstable and unpredictable. When systems display special cause variation, the process needs sorting out to stabilise it. This is most commonly reported using two types of special cause variation, trends and outliers. If a trend, the process has changed in some way and we need to understand and adopt if the change is beneficial or act if the change is a deterioration. The outlier is a one-off condition which should not result in a process change. These must be understood and dealt with on their own (i.e. response to a major incident).

Identifying Special Cause Variation – agreed rules:

- Any point outside of the control limits,
- A run of 7 points all above or below the central line, or all increasing / decreasing,
- Any unusual patterns or trends within the control limits,
- The proportion of points within the middle 1/3 of the region between the control limits differs from 2/3.

Standard Deviation: Standard deviation is a widely used measurement of variability or diversity used in statistics and probability theory. It shows how much variation or "dispersion" there is from the "average" (mean, or expected/budgeted value). A low standard deviation indicates that the data points tend to be very close to the mean, whereas high standard deviation indicates that the data are spread out over a large range of values.

Annex 5: Mandatory Performance Indicator Definitions

The following indicators:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period,
- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer and discharge,
- Data completeness community services, referral to treatment information.

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 within the technical definitions that accompany *Everyone counts: planning for patients 2014/15 - 2018/19* and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf.

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

Detailed descriptor

E.B.3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period

Numerator

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

Denominator

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

Accountability

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

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 within the technical definitions that accompany *Everyone counts: planning for patients 2014/15 - 2018/19* and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf.

Detailed rules and guidance for measuring A&E attendances and emergency admissions can be found 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 these cases. In this scenario the NHS foundation trust may present an additional indicator in the quality report which only relates to its own activity and have this reported indicator be subject to the limited assurance opinion.

Numerator

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

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

Denominator

The total number of unplanned A&E attendances

Accountability

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

Indicator format

Reported as a percentage

Data completeness: Community services: Referral to treatment activity. To update as part of the external audit review of the indicators

The data completeness report shows the number of patients that have been registered onto SystmOne Units per month. Of these registered patients how many have had an open referral recorded against them.

Theoretically all patients that are registered onto SystmOne, should have an open referral recorded at the same time as they are registered, therefore for data completeness we would expect this to be 100%.

A report is available which shows how many patients are registered during the month, and how many of these also had an open referral recorded, to ensure data completeness. Failure to record an open referral results in the episode being unable to be used for contracting and finance purposes.

As SystmOne is a live system, historic information is not stored, so in order to audit this process the Trust relies on assessing the previous month's extract of data for completeness analysis purposes.