NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Northern Lincolnshire & Goole NHS Foundation Trust

Annual Quality Account

2021/2022

CONTENTS

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

In many ways the challenge the Trust faced in 2021/22 was greater than that faced in the first year of the pandemic. One of the main reasons I say that is our staff started the year tired and stressed after having to deal with multiple issues and changes as a result of the spread of COVID-19 in 2020/21. In April 2021 we were planning to do everything we could to cope with whatever the pandemic threw at us next as well as trying to bring back to 'normal' as many services as we could, particularly undertaking as many elective cases as we could.

I have to report our staff responded superbly to all of the challenges put in front of them throughout the year. Throughout our hospital, community services and support functions our teams went above and beyond, again and again, to do everything they could to care for patients and provide services. We saw incessant and growing demands – for example from patients attending our Emergency Departments (EDs), in responding to changing guidance and to discharging patients from our wards and trying to tackle the backlog of patients needing outpatient, diagnostic and elective care which built up during the pandemic. Our staff coped admirably with all this – I want to thank them publicly and wholeheartedly for their dedication and enormous hard work.

We did everything we can to help them, including giving them all an extra day of annual leave for a token of appreciation for all their efforts fighting the pandemic. We identified staff health and wellbeing as a key priority for 21/22 – without staff available to do their jobs, we wouldn't be able to provide what we need to. Despite this our staff have struggled to maintain their morale and motivation, a point picked up in our disappointing results from the national staff survey which were published in March 2022. These results showed it is clear we need to continue our focus to create a better working environment for our staff. So in 2022/23 our priorities will include, alongside a continued focus on health and wellbeing, developing further how we attract and recruit new staff as well as addressing how we develop and care for the staff we do have.

Responding to the pandemic continued to affect all aspects of how we provided healthcare. We have continuously had to make risk-based decisions to keep our patients safe, which resulted in services being segregated and reducing the scale of some of the services we could offer due to the consequent reduced capacity. This has been complicated further by some of the Trust's ageing estate, although we did make good progress in the year to build our new EDs at Grimsby and Scunthorpe which will open in 2022/23. These restrictions impacted on our improvement ambitions for the year with regards to patient flow through our hospitals. As a consequence I'm sad to report the number of patients waiting more than 12 hours was more than we would want, as was the number of ambulances waiting to hand over patients to the department. I would like to apologise to all patients who waited longer than they expected. In terms of patients attending the departments with minor ailments we did improve how quickly we saw and treated these through the year. This was due to the introduction of an Urgent Care Service, first at Scunthorpe in October 2021 and then at Grimsby in January 2022.

Our planned care (which means operations or other procedures) numbers continued to grow, mainly as a result of the national decision to cancel all planned activity for much of 2021/22. However, we did continue to undertake operations throughout the winter, prioritising those patients with the most urgent needs and those who had been waiting the longest times.

Despite the challenges we faced, this annual Quality Account is also an opportunity to reflect on what the Trust has achieved and its progress against quality goals and to the best of my knowledge the information contained within this report is accurate. We recognise further improvement is required to meet the targets initially set at the beginning of the year, therefore several quality priority indicators have been carried over to 2022/23. Work has also continued throughout the year to achieve the actions identified by the Care Quality Commission (CQC) in their report published in February 2020, following their inspection in September 2019. At the time of writing, we had 83 open actions with significant progress being made.

The Trust has seen a sustained decrease in hospital mortality over the course of the year and has remained within the 'as expected' rating. This is an excellent achievement especially given the Trust's previous position. Work continues with system wide partners to further improve on the progress that has been made. The following report will provide greater details on this and other achievements.

In many ways our challenge for 2022/23 remains the same as it was in 2021/22: to make sure our staff are able to offer the best possible patient care, by looking after them (our staff) and supporting them as they recover from such an intense year, whilst at the same time doing everything we can to bring down our waiting lists and managing the increased demand we are experiencing for urgent care. As I reported in last year's Quality Account, this is no easy task and will require dedication, relentless effort and high levels of resilience. At the same time we will be asking our teams to take on other challenges too – as we move into new buildings, create and embed new digital systems, and deliver more new ways of working. If anyone can manage to do this, our staff can; they are remarkable. Once again, very many thanks to them all.

Signature:

Chief Executive and Accountable Officer: Dr Peter Reading
Date: 20 April 2022

About Northern Lincolnshire and Goole NHS Foundation Trust

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

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

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

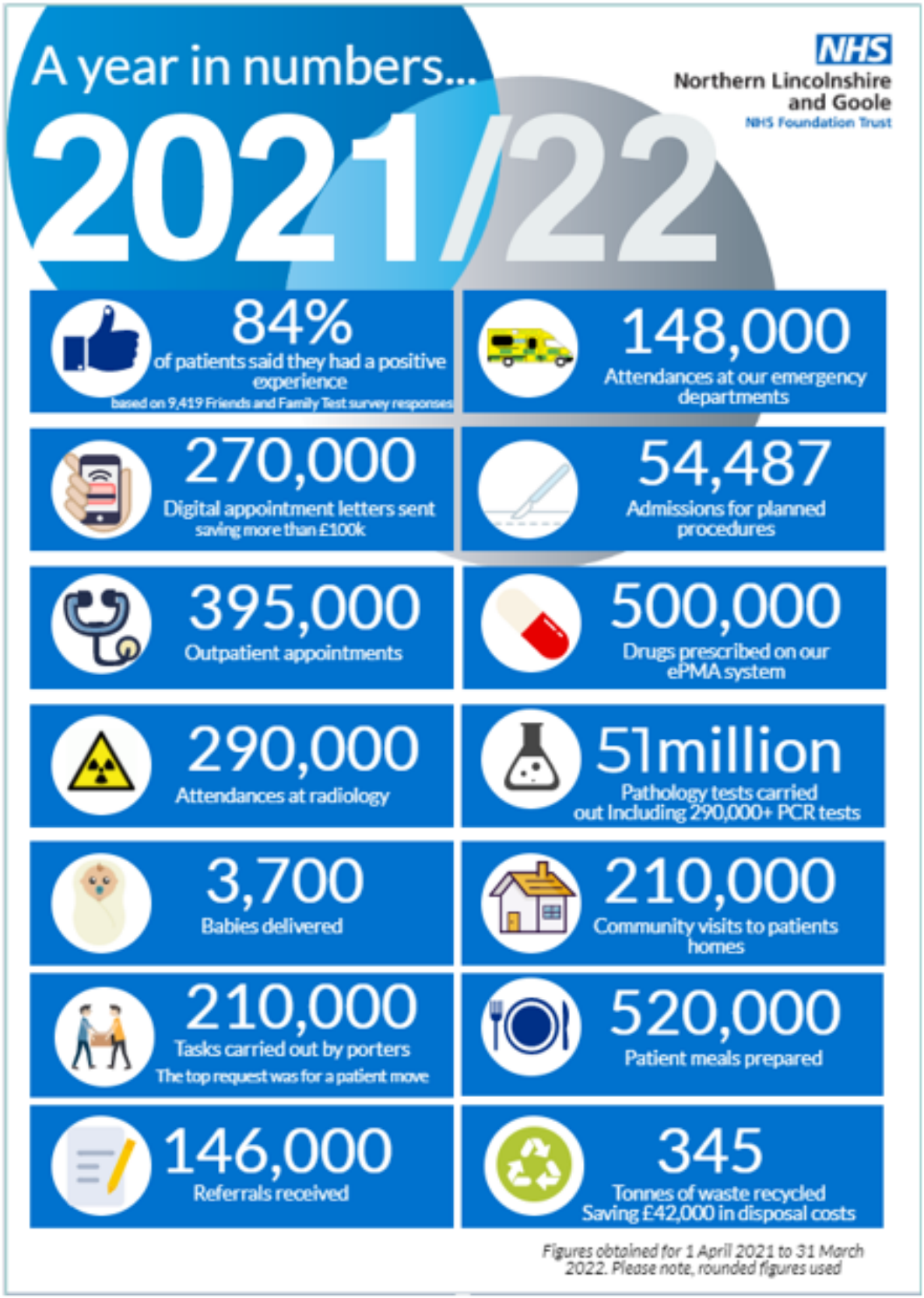


Figure 1: 2021/22 - A year in numbers

Executive summary of key points

5 Quality Priorities for 2021/22:

As part of the Trust's annual setting of priorities, the Trust had set 5 quality priorities:

(1) Reduce mortality rates and strengthen end of life care
(Patient Experience and Clinical Effectiveness)

(2) Improve the management of deteriorating Patients & Sepsis
(Clinical Effectiveness and Patient Safety)

(3) Increasing medication safety
(Patient Experience & Patient Safety)

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

(5) Improve the management of Diabetes
(Clinical Effectiveness and Patient Safety)

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

Covid-19 Pandemic Response:

The Trust's priorities for 2021/22 were set during the Covid-19 pandemic which had a significant impact on the Trust and the wider NHS. As such it should be noted:

(1) Responding to the pandemic pressures and the associated impacts on staff, waiting lists, facilities, etc. were handled as additional pressure.

(2) The pandemic significantly affected Trust performance against some objectives where key personnel/organisational focus needed to be diverted to support the pandemic response and system-wide operational pressures.

Priority 1 - Patient Experience & Clinical Effectiveness	**Outcome**
Reduce mortality rates and strengthen end of life care	**Progress made**

1a) The Trust has sustained a statistically significant improvement with regards to the overall Summary-Hospital Level Mortality Indicator (SHMI) with a score of 106.4 in March 2022, which remains within the 'as expected' range. The intended target of reducing the out of hospital (OOH) element of the SHMI to 110 was not achieved as the current figure for November 2021 (the most recent release of data) is 131.9, and therefore remains above the intended target.

1b) Despite the pandemic and pressures across the healthcare system, data demonstrates an improvement with an average of 17 patients dying within 24 hours compared to an average of 21 in 2020/21.

1c) The same also applies where no statistically significant change has been achieved with regards to reducing the number of emergency admissions for people in the last 3 months of life. Although, data shows positive progress with an average monthly reduction of 7 admissions per month compared to 2020/21.

Priority 2 - Clinical Effectiveness and Patient Safety	Outcome
Improve the management of deteriorating Patients & Sepsis	**Progress made**

2a) Recording of patient observations using NEWS and OEWS in line with timescales was achieved against a target of 90%. This is a significant achievement given the operational and pandemic pressures. However, for paediatrics, whilst the performance is within the expected range of variation, it has regularly passed and failed the target during 2021/22.

2b) The audit data has identified that the Trust is not able to demonstrate compliance in response to escalation in line with the NEWS policy due to the current systems and documentation in place to provide retrospective evidence. This coupled with persistent operational pressures and staffing shortages has made it challenging to make sustained improvement. Work is underway to look at system changes to better support this area of improvement.

2c) The audit data has also demonstrated that further improvement work is required in relation to screening patients for sepsis and meeting the desired 90% target. Whilst the target has not been reached, significant improvement has been observed with an increase to 80% in January 2022 from 34% in May 2021.

Priority 3 - Patient Experience and Patient Safety	Outcome
Increasing medication safety	**Partially achieved**

3a) Operational pressures and staffing shortages within Acute Care services has impacted on the Trust's priority to sustain any improvement in recording patient weights in relation to paracetamol prescribing on the Integrated Admissions ward (IAAU). Audit data has demonstrated further improvement work is required and therefore, this priority is being carried over into 2022/23.

3b) Performance for administering insulin on time in wards using EPMA was consistently above the intended target of 85%, therefore the Trust achieved this indicator.

3c) The Trust also achieved its target in reducing the number of medication omissions without a valid reason for ward areas using EPMA from 13.7% in April 2021 to 2% in February 2022.

Priority 4 - Patient Safety, Experience and Clinical Effectiveness	Outcome
Safety of Discharge	**Not achieved**

Performance against the discharge indicators has been significantly affected by the Covid-19 pandemic and continued system wide pressures. The closure of several residential and nursing homes within the region resulted in the Trust having delayed discharges and being unable to discharge patients safely due to social care constraints. In March 2022 the Trust achieved a 16.4% performance rate against the 30% target in discharging patients home before 12 noon, 66% of patients by 5pm and had 55 patients in hospital for more than 21 days.

The Trust has implemented a discharge improvement plan to drive progress and move towards the intended targets, therefore, this quality priority is being carried over into 2022/23.

Priority 5 - Clinical Effectiveness and Patient Safety	Outcome
Diabetes Management	**Partially achieved**

5a) The Trust continues to face challenges in releasing staff to undertake diabetes mandatory training due to persistent operational pressure and staff sickness levels. Compliance has remained above 85%, thus demonstrating continued long-term improvement despite the challenges.

5b) Performance for the Diabetes Audit on inpatient ward areas has been consistently on par with the intended target of 80%, therefore the Trust achieved this indicator.

5c) Clinical Audit results for the recording of children's blood glucose in the Emergency Department demonstrate an improvement in compliance; however, this fluctuates and has not yet provided sustained assurance. Therefore, the audit will continue to be undertaken as part of the 2022/23 Trust's Quality & Audit Forward Programme to embed improvements.

Quality Priorities for 2022/23:

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

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

This analysis of service user feedback was then used for wider consultation within the Trust and with commissioners which resulted in a short-list of priorities for 2022/23. This was refined further by the Trust's Quality & Safety Committee and Trust Board.

Quality priorities for 2022/23:
Six priorities have been agreed for 2022/23 and relate to several areas/priorities where progress has been made during the period covered by this quality account:

(1) Mortality improvement (n=3)
Indicators within this area remain the same and aim to build on the progress made with mortality performance so far. They seek to support further improvement with advanced care planning for patients who are at end of life and require individualised and holistic plans to ensure care is provided at the right time and in the right place.

(2) Deteriorating Patient (n=3)
These indicators build on the improvements already made in connection with patient observations, but aims to continue focusing on improving the processes and systems around escalation. A new indicator has been added to measure the timeliness of clinical assessment in Emergency Care Centres for both adults and children.

(3) Sepsis (n=2)
These indicators build on the improvements already made in connection with sepsis screening in adults but also continue to focus on the delivery of the sepsis six standards within agreed timeframes. During 2022/23 sepsis management for children will also be measured and reported.

(4) Increasing medication safety (n=3)
These indicators build on the improvements already made in connection to medication omissions and safety around prescribing for drugs that require a 'weight for dosing'. New indicators have also been added to support the further improvement in the reduction / appropriateness of antibiotic prescribing across the Trust.

(5) Friends and Family Test and PALS (n=2)
These are new indicators that focus on patient experience measures which aim to support improvement in responding to PALS complaints within set timescales and improving patient and family feedback rates to enable direct patient driven improvements.

(6) Safety of Discharge (n=5)
These measures continue to focus on the Discharge to Assess project and will enable the Trust to monitor progress with continued improvements in patient flow through the Trust's hospitals. They also focus on performance with issuing discharge communications to the patient's GP Practice within defined timescales.

How progress against 2022/23 quality priorities will be monitored and measured:
Progress will be monitored through the Trust's Quality and Safety section of the Integrated Performance Report. This is a monthly report considered by the Non-Executive Director (NED) Chaired Quality & Safety Committee for assurance purposes.

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

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

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

Interpreting the data presented within this report:
The Trust's monthly quality performance report makes use of Statistical Process Control (SPC) charts to support an understanding of what data trends show and what assurance can be gained.

The annual quality account aims to provide an easy to digest summary of this performance during the 2021/22 period. To achieve this aim the measures used to focus on the Trust's quality priorities are presented in a table that summarises what the data trends show. This presentation will use the following icons to support interpretation of key points.

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

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

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

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

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 2021/22 quality priorities & quality priorities planning for 2022/23

2.1a: Priority 1: Patient Experience & Clinical Effectiveness: End of Life and Related Mortality Indicators

Summary table: Performance during 2021/22:

PATIENT EXPERIENCE & CLINICAL EFFECTIVENESS:							
QP1: Reduce mortality rates and strengthen end of life care	Mar-22	Feb-22	Jan-22	Apr-21	SPC Variation	SPC Assurance	RAG
1a) Reduction in the number of patients dying within 24 hours of admission to hospital.	**15**	14	17	**16**		No target	G
1b) Reduction in the number of emergency admissions for people in the last 3 months of life.	**193**	172	212	**199**		No target	G
1c) Reduction in the out of hospital SHMI to 110, by March 2022.	**131.9**	132.6	135	**137**			R

Progress made (April 2021 – March 2022):
During the 2021/22 period, Trust performance has not met the target set in reducing the out of hospital SHMI. No numerical targets were agreed for reducing the number of patients dying within 24 hours of admission to hospital and reducing the number of emergency admissions in the last 3 months of life, however a reduction in both indicators has been observed on average throughout the year.

1a) Reduction in the number of patients dying within 24 hours
Admission to hospital during the end-of-life phase may adversely affect the patient's experience and may represent a failure in advanced care plans resulting in an unplanned admission. Despite the significant operational pressures associated with the COVID-19 pandemic, the number of patients who died within 24 hours of admission has remained stable and continues within the expected range of variation. Trust data demonstrates an improvement, with a reduction from an average of 21 patients dying within 24 hours of admission during 2020/21 to an average of 17 patients during 2021/22.

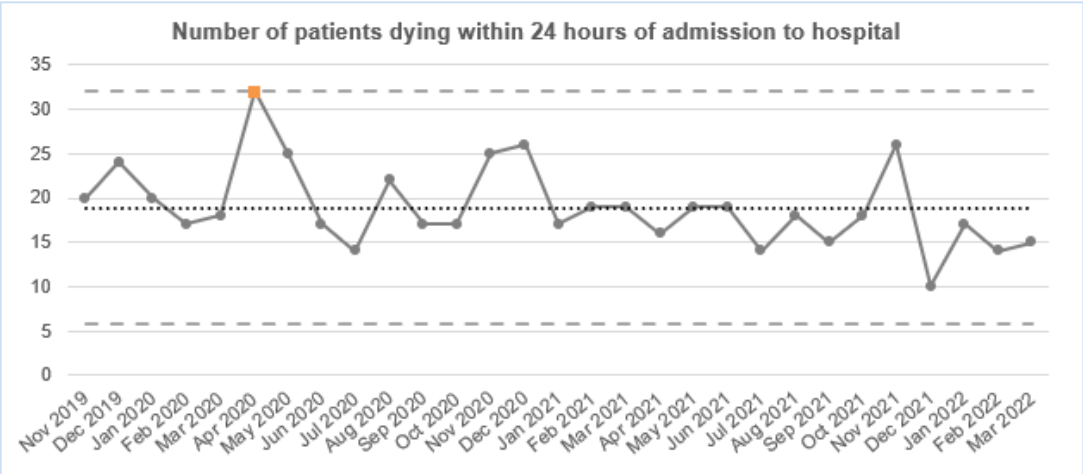


Figure 2: Number of patients dying within 24 hours of admission to hospital

1b) Reduction of emergency admissions for people in the last 3 months of life

Emergency admission to hospital during the end-of-life phase may also represent a failure in advanced care plans and negatively impact the patient's experience. Despite the impact of the COVID-19 pandemic the number of admissions remained stable. Positive progress is demonstrated as data shows an average reduction of 7 admissions per month during 2021/22 compared to 2020/21.

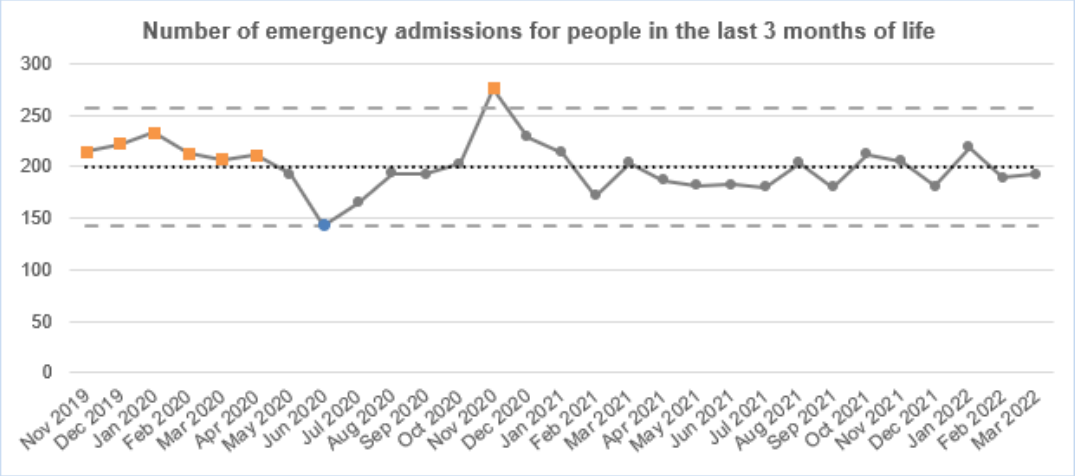


Figure 3: Number of emergency admissions for people in the last 3 months of life

1c) Reduction in out of hospital SHMI to 110 by March 2022

The Trust has sustained a statistically significant improvement with regards to the overall Summary-Hospital Level Mortality Indicator (SHMI) with a score of 106.4 in March 2022, which remains within the 'as expected' range. The Trust aimed to work with partners to reduce the out of hospital (OOH) element of the SHMI to 110 during 2021/22. Based on the most recent published data (November 2021) the Trust has not achieved the target as the current figure is 131.9, and therefore remains above the intended target. However, the figure has reduced from 140 in March 2021, the Trust continues to work with partners to try to bring this down further to fall in line with the agreed target.

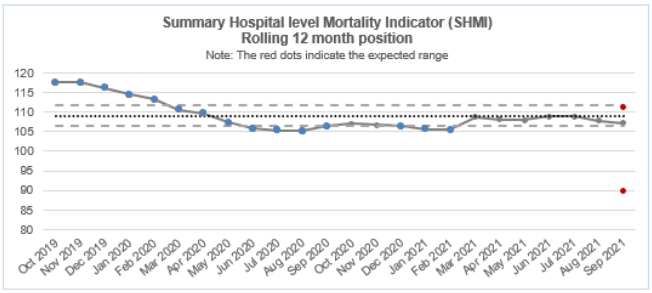


Figure 4: Overall SHMI – 12 month position

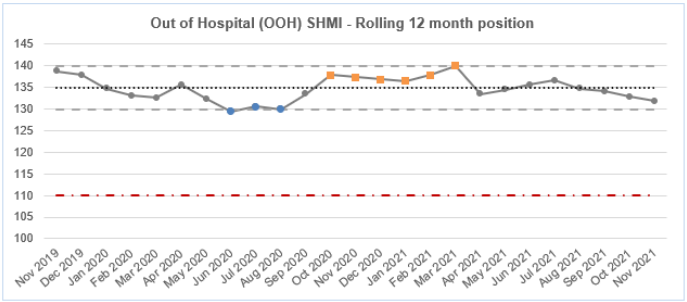


Figure 5: Out of Hospital SHMI – 12 month position

Figure 4: demonstrates the improvement in the Trust's overall SHMI position.

Figure 5: shows the improvements made in the last quarter and from the position in October 2019 despite the operational pressures the Trust has encountered linked to the COVID-19 pandemic.

Milestones achieved during 2021/22:

- Introduction of new national mortality reporting mechanisms to provide the Trust with improved oversight of high-level mortality information and learning from structured judgement reviews.

- Introduction of consultant led screening process to allow investigation into collaborative system processes and identify learning to prevent potential avoidable admissions to hospital.

- Introduction of Medical Examiner to oversee and scrutinise the quality of care for patients who die during admission or within 30 days of discharge.

- A selection of patients who die within 24 hours of admission are reviewed to ascertain further understanding of patient pathways. Findings are discussed at collaborative morbidity and mortality meetings alongside commissioners and other system partners. Cases for learning are shared at specialty specific Quality & Safety Meetings.

- A selection of patients who were admitted to hospital in the last 3 months of life are reviewed by a General Practitioner to identify learning and ascertain further understanding of patient pathways. Review outcomes are discussed at collaborative morbidity and mortality meetings alongside commissioners and other System partners. Cases for learning are shared at specialty specific Quality & Safety Meetings.

- Review of patients identified within certain SHMI diagnosis groups where 'higher than expected' mortality rates have been identified, alongside system partners at collaborative morbidity and mortality meetings.

- Review of system wide medical and nursing palliative care provision in collaboration with local commissioners.

The Trust has listed this as a priority to take forward into 2022/23 recognising that a greater depth of understanding of the factors influencing the out of hospital SHMI rates at both North Lincolnshire and North East Lincolnshire is required. Therefore, the Trust is committed to working alongside local CCGs to improve this position and move towards the intended target.

Progress monitored, measured and reported: Progress with these indicators is monitored within the quality section of the Integrated Performance Report and as such is reported to the Quality & Safety Committee and the Trust Board. Progress is also monitored at the Trust's Mortality Improvement Group (MIG).

Relationship to 2022/23 Quality Improvement Priorities: This quality priority will continue into 2022/23. Focus will be placed on the recognition of the dying patient to allow earlier initiation of end of life and advanced care planning and in gaining a greater understanding of the out of hospital deaths within 30 days of discharge.

2.1b: Priority 2: Clinical Effectiveness and Patient Safety: Deteriorating Patient and Sepsis

Summary table: Performance during 2021/22:

CLINICAL EFFECTIVENESS & PATIENT SAFETY:								
QP2: Deteriorating Patient & Sepsis	**Mar-22**	**Jan-22**	**Nov-21**	**Sep-21**	**May-21**	**SPC Variation**	**SPC Assurance**	**RAG**
2a) ADULTS: 90% of patient observations recorded on time.	**91%**	90%	91%	91%	**91%**			G
2a) CHILDREN: 90% of patient observations recorded on time.	**90%**	100%	80%	95%	**90%**			A
2b) Escalation of NEWS in line with policy *(Audit data available bi-monthly)*	No data	0%	9%	3%	**5%**			R
2c) Sepsis screen in 90% of patients with a sepsis six indicator.	No data	80%	47%	39%	**34%**			R

Progress made (April 2021 – March 2022):
During the 2021/22 period, Trust performance has partially met the target set in recording patient observations in accordance with agreed timescales. Significant improvement has been made in

increasing the number of patients having a sepsis screen (where required), but the Trust was unable to make any positive progress in meeting the target around escalation for deteriorating patients in line with Trust policy.

2a) Timeliness of observations

During the 2021/22 period, the Trust has continued to achieve the target in recording patient observations utilising National Early Warning Score (NEWS) and Obstetric Early Warning Scores (OEWS) in line with agreed timescales. This is a significant achievement given the operational pressures. Audit data also shows that performance for undertaking observations in children is regularly above the target but there were occasions where compliance dropped below the target, suggesting further embedding is required.

The charts below summarise compliance over the year for adults and children compared to the 90% target.

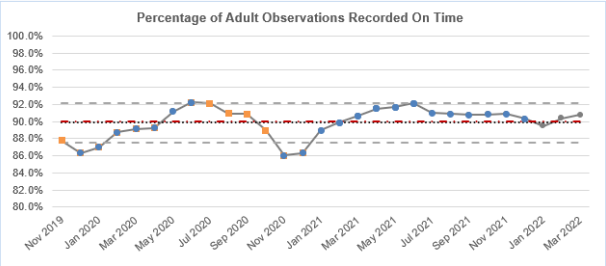


Figure 6: Percentage of adult observations recorded on time

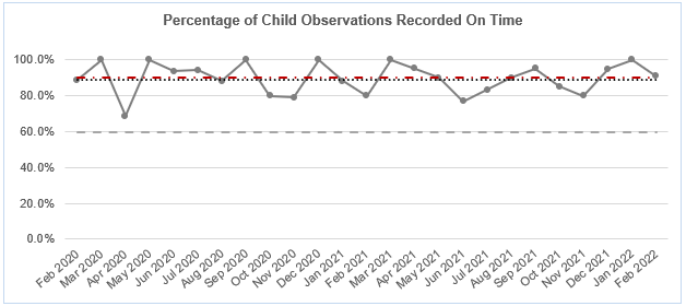


Figure 7: Percentage of adult observations recorded on time

2b) Escalation of NEWS in line with policy

The Trust is not able to demonstrate improvement with regards to escalating patients in line with the NEWS policy to meet the agreed target. The pressures associated with the COVID-19 pandemic has impacted progress being made, however, the audit identified that figures may reflect poorer compliance in recording, than that in actual practice. This is due to the lack of systems to retrospectively capture clinical review times in accordance with the timeframes (which are often not documented until the patient has been treated).

2c) Sepsis screening

Improvement plans linked to sepsis screening and appropriate treatment were not achieved, although positive progress has been observed with the most recent audit data showing an increase from 34% in May 2021 to 80% in January 2022.

Milestones achieved during 2021/22:

- Introduction of electronic systems to record sepsis screening that reports ward-based compliance rates.

- Introduction of a Clinical Nurse Educator and Sepsis Nurse Specialist to provide targeted support to adult ward areas (where data indicates this is required).

- Individual case review (where learning associated with sepsis has been identified) are shared at the Deteriorating Patient and Sepsis Group.

- Introduction of Clinical Nurse Educator within Paediatrics who undertakes regular Paediatric Early Warning Scores (PEWS)/Sepsis audits.

Progress monitored, measured and reported: Progress with these indicators is monitored within the quality section of the Integrated Performance Report and as such is reported to the Quality & Safety Committee and the Trust Board.

Relationship to 2022/23 Quality Improvement Priorities: This quality priority has remained the same throughout 2021/22. Sepsis and the deteriorating patient will remain a priority for 2022/23 with a focus on improving processes around evidencing escalation and treatment for deteriorating patients and patients with identified flags for sepsis. The Trust will also assess sepsis management for children in 2022/23.

2.1c: Priority 3: Patient Safety and Experience: Increasing Medication Safety

Summary table: Performance during 2021/22:

PATIENT SAFETY & PATIENT EXPERIENCE:							
QP3: Increasing medication safety	Feb-22	Jan-22	Dec-21	Jul-21	SPC Variation	SPC Assurance	RAG
3a) Improvements in recording patient weights in relation to paracetamol prescribing on the Integrated Admissions ward (IAAU).	64%	68%	63%	64%		Insufficient data	R
3b) Insulin administered on time in 85% within wards using EPMA.	100%	80%	95%	90%		Insufficient data	G
3c) Reduction in medication omissions without a valid reason for ward areas using EPMA.	2%	2%	2%	14%		Insufficient data	G

N.B. There is insufficient data points to allow assurance to be calculated from SPC calculations. RAG rating has been provided based on data collected during 2021/22 to date.

Progress made (April 2021 – March 2022):

During the 2021/22 period, the Trust has made significant improvement and met the targets regarding insulin administration and in reducing medication omissions without a valid reason, on ward areas. Further improvement is required in recording patient weights to reach the target. This priority is being carried over into 2022/23.

3a) Recording of patient weights

A monthly audit commenced in July 2021, this has helped to get an understanding of the issues associated with weighing patients during acute admission and prescribing 'weight for dosing drugs' on ward areas. From this the results indicate there is additional work still to be done to attain and embed the standards.

3b) Administration of Insulin on Ward Areas

Performance for administering insulin on time in wards using EPMA was consistently above the intended target of 85%, therefore the Trust achieved this indicator. The chart below demonstrates the sustained high compliance throughout 2021/22.

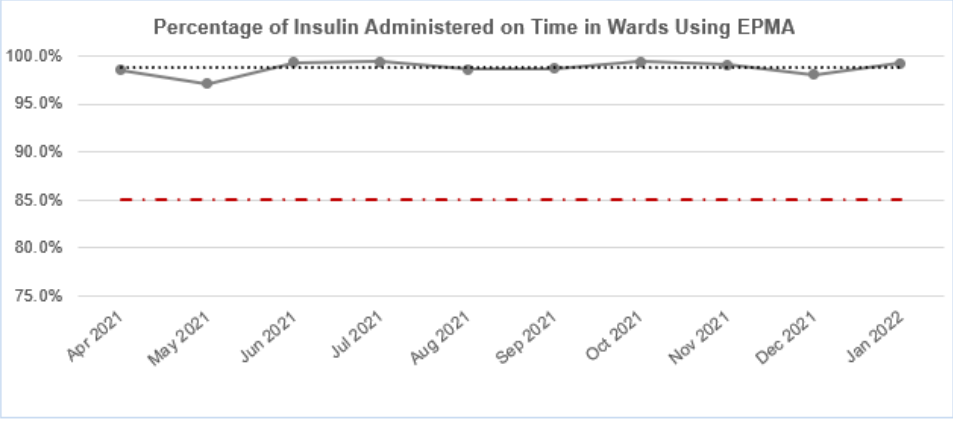


Figure 8: Percentage of Insulin Administered on Time in Wards using EPMA

3c) Reducing the number of medication omissions

The Trust also achieved its target in reducing the number of medication omissions without a valid reason for ward areas using EPMA from 13.7% in April 2021 to 2% in February 2022.

The chart below demonstrates the progress made throughout the year.

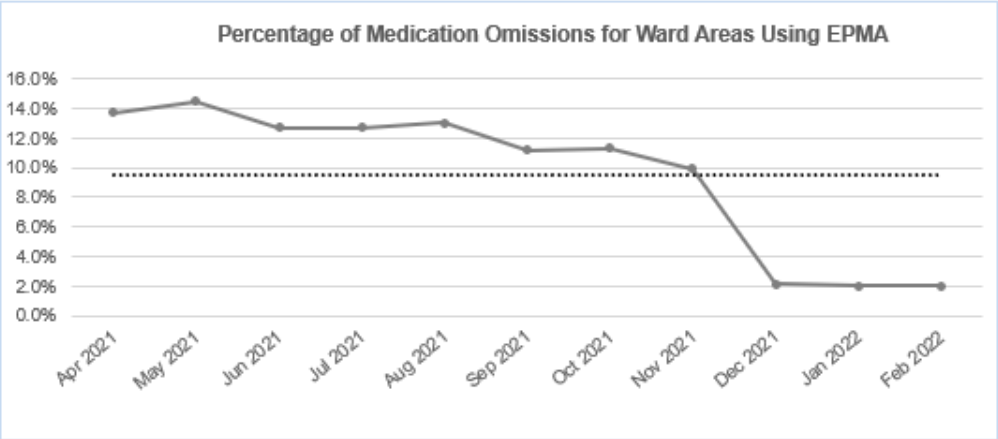


Figure 9: Percentage of Medication Omissions for Wards using EPMA

Milestones achieved during 2021/22:

- Weighing patients - aide memoire added to EPMA in quarter three to remind ward areas to weigh patients to obtain an actual weight. Also, to remind prescribing limits for paracetamol in patients under 50kg.

Progress monitored, measured and reported: Progress with these indicators is monitored within the quality section of the Integrated Performance Report and as such is reported to the Quality Governance Group, Quality & Safety Committee and the Trust Board. Progress against the Weighing and Prescribing Audit standards is also monitored at the Safer Medication Group and has been raised with divisional Governance Groups.

Relationship to 2022/23 Quality Improvement Priorities: An indicator within this quality priority has remained the same throughout 2021/22. Focus on medication safety will be included as a quality priority during 2022/23 and will also focus on antibiotic prescribing practices within the Trust.

2.1d: Priority 4: Patient Experience, Patient Safety & Clinical Effectiveness: Improve the safety of discharge

Summary table: Performance during 2021/22:

PATIENT SAFETY, CLINICAL EFFECTIVENESS & PATIENT EXPERIENCE:							
QP4: Safety of Discharge	Mar-22	Feb-22	Jan-22	Apr-21	SPC Variation	SPC Assurance	RAG
4a) Improve the proportion of patients discharged before 12 noon.	16.4%	15.2%	16.3%	**16.9%**			R
4b) Improve the proportion of patients discharged before 5pm.	66.3%	66.0%	67.1%	**69.9%**		No target	R
4c) Improving trend showing a reduction in length of hospital stay above 21 days.	55	71	62	**0**			R

Progress made (April 2021 – March 2022):
During the 2021/22 period, Trust performance has not been able to achieve the target, and as such has been unable to make any positive progress in improving the proportion of patients discharged before 12 noon and before 5pm. The Trust has also been unable to meet the target in reducing the number of patients having a hospital stay greater than 21 days. Progress against this priority has been negatively affected by the persistent system-wide operational and pandemic related pressures during this period, and although the Discharge to Assess process is fully embedded within the Trust, further improvement work is required to review system-wide discharge pathways.

4a) Proportion of patients discharged before 12 noon
Performance for discharging patients before 5pm has been consistently below the 30% target, therefore the Trust has not achieved this indicator. Performance in March 2022 was 16.4%, this reflects the difficulties experienced with flow throughout the hospital and in the community over the last several months. Shortages in available workforce to meet service needs has also contributed to delays in patient pathways. The chart below shows performance in this area.

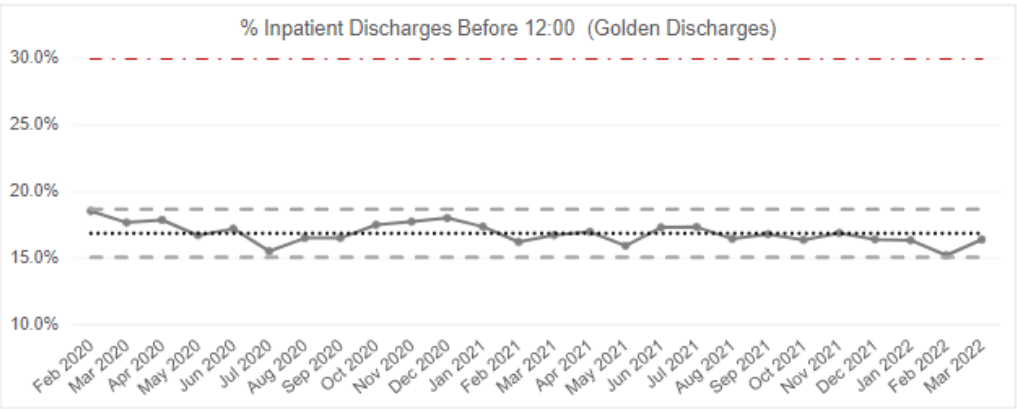


Figure 10: Percentage of Discharges before 12:00

4b) Patients discharged before 5pm
Performance for discharging patients before 5pm reflects the difficulties experienced with flow throughout the hospital and in the community over the last several months. Shortages in available workforce to meet service needs has also contributed to delays in patient pathways and timely discharge. Performance in March 2022 shows that 66% of patients were discharged before 5pm.

4c) Reduction in the length of stay above 21 days
The Trust has made significant improvements in this area over the last year and is now the third best performing Trust in the whole of the north region (Out of 52 Trusts). However, since the new year, the Trust has seen a slight increase, this is because although lots of improvement work has been undertaken, for example, discharge rounds, board rounds and implementation of the hospital discharge policy (D2A), our system partners (particularly in north Lincolnshire and Lincolnshire) experienced significant pressures within their services, with closed care homes and limited packages of care available due to staff shortages. At the time of writing the Trust had 70 patients ready for discharge by the acute team, however there is a delay in their discharge as our social care partners are unable to meet their needs, therefore creating a longer stay in hospital for these patients. The Trust is working with system partners to manage this on a daily basis.

The following chart highlights the impact of the improvement work which commenced in March 2021, it also shows the impact of the system wide pressures from October 2021 to date.

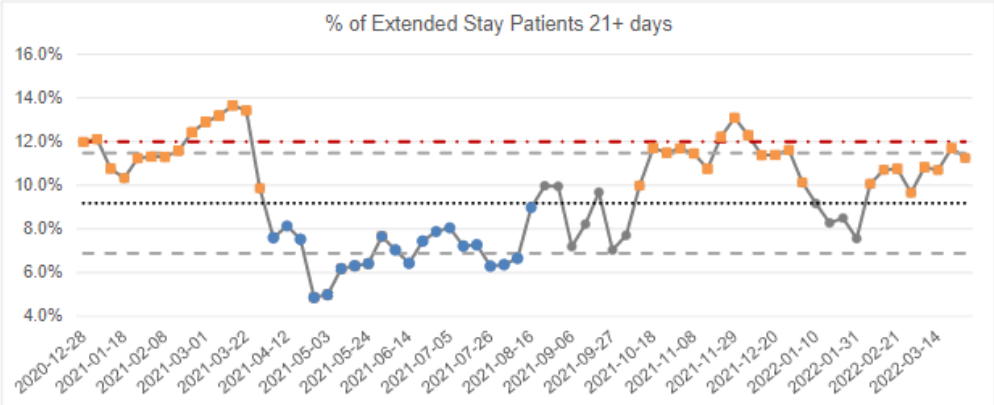


Figure 11: Percentage of patients with a hospital stay of 21+ days

Milestones achieved during 2021/22:

- Daily board rounds are undertaken on inpatient wards.
- Discharge rounds are undertaken at weekends to support patient flow and discharge.
- Long length of stay reviews take place twice weekly in medicine division – led by the senior triumvirate.
- Introduction of a Matron within the site team to support flow and progress on discharge.
- Daily 12 noon meetings take place seven days per week led by the site senior team allowing oversight of delayed discharges.
- The Trust are in the process of developing a discharge improvement plan which triangulates all aspects impacting discharge pathways including board rounds, transport, checklist and the discharge lounge.
- The Trust plans to implement a six-day provision for acute Speech and Language Therapy.
- Work is underway to expand the Trust's virtual wards, particularly around palliative care, frailty and acute respiratory infection.
- Discharge improvement meetings introduced on a fortnightly basis to discuss themes.
- Introduction of a seven-day service for the provision of equipment at North and North East Lincolnshire.
- Introduction of a respiratory on call seven-day service.
- In December the Same Day Emergency Care (SDEC) hours increased and is now open between 8am to 10pm at both hospital sites. This allows extra time to turn the patients round and home rather than admitting into a hospital bed.

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

Relationship to 2022/23 Quality Improvement Priorities: The quality priority theme has remained the same throughout 2021/22. Access and flow will feature as a priority for the Trust during 2022/23 as part of the pandemic recovery work. There are also links to the discharge to assess project and the timeliness of discharge letters as part of the Trust's 22/23 quality priorities.

2.1e: Priority 5: Clinical Effectiveness & Patient Safety: Improve diabetes management

Summary table: Performance during 2021/22:

CLINICAL EFFECTIVENESS & PATIENT SAFETY:							
QP5: Diabetes Management	Feb-22	Jan-22	Dec-21	Apr-21	SPC Variation	SPC Assurance	RAG
5a) Diabetes Audit findings.	85%	77%	80%	**80%**			G
5b) 100% of BM taken in ECC in adults when NEWS of >1	100%	95%	90%	**93%**			A
5b) 100% of BM taken in ECC in children when PEWS of >1	88%	83%	83%	**75%**			A
5c) 90% relevant staff have completed mandatory diabetes training.	88%	87%	85%	**85%**			A

Progress made (April 2021 – March 2022):
During the 2021/22 period, the Trust has achieved the target in accordance with diabetes audit standards, but due to operational and staffing pressures has just fallen short of achieving the 90% target of staff completing mandatory diabetes training. Improvement has been observed in carrying out BM testing in the Emergency Departments, however, further embedding is required to reach the 100% target. For both adults and children BM measurements were undertaken on average in 88% of patients throughout the year.

5a) Diabetes Audit Findings
A monthly audit has been designed and implemented. This has helped to get an understanding of the management of diabetes across ward areas, and for most part of the year the audit data shows the Trust are achieving the 80% target. The Chart below demonstrates this sustained improvement.

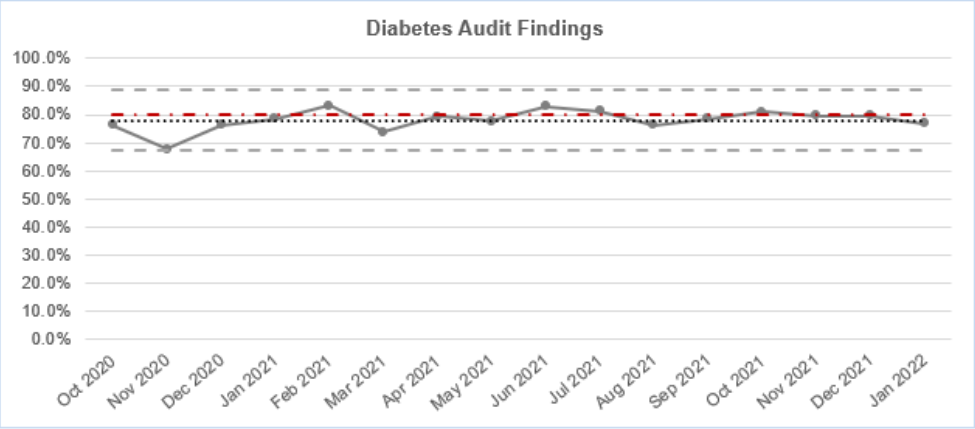


Figure 12: Diabetes Audit Findings

5b) BM Testing in Emergency Care Centres with NEWS/PEWS >1
The Trust's Emergency Departments continue to face significant operational and pandemic related pressures, which has impacted on positive progress being made in embedding BM testing during 2021/22. As a result, performance against this indicator has fluctuated, particularly for children. Throughout the year performance for adults has been 94% against the 100% target and for children an average of 82% has been achieved against the target. Performance may be lower for paediatric patients as the Paediatric Emergency Nursing remain within the Emergency Department which allows expert oversight and often negates the need for blood glucose recording in some instances.

The charts below provide an overview of performance over the last two years.

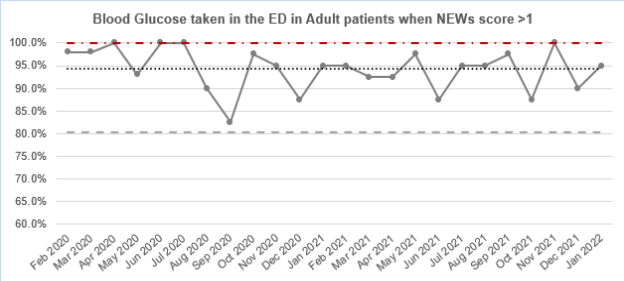


Figure 13: Percentage of patients with a blood glucose taken in ED in adult patients when NEWS score is >1

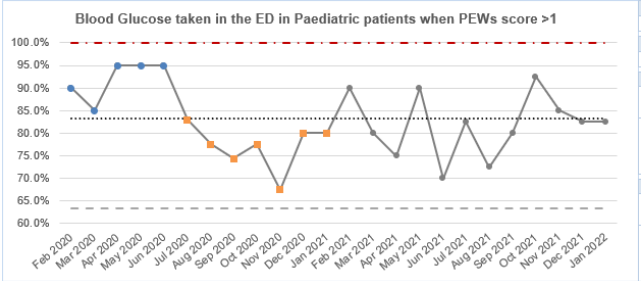


Figure 14: Percentage of patients with a blood glucose taken in ED in paediatric patients when NEWS score is >1

5c) Diabetes mandatory training

The Trust continues to face challenges in releasing staff to undertake mandatory training due to persistent operational pressure and staff sickness levels. Whilst these pressures are reflected in the performance during this period, the Trust continues to demonstrate long term improvement and remains within the control limits and above the Trust's mean average. The chart below demonstrates this performance.

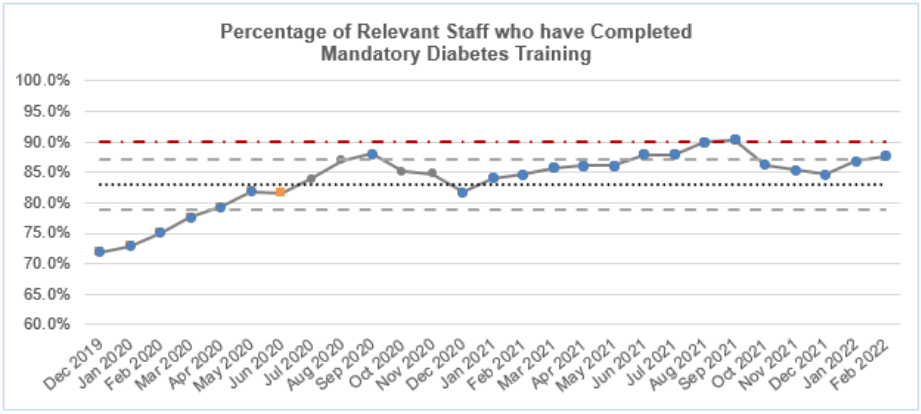


Figure 15: Percentage of relevant staff who have completed mandatory diabetes training

Milestones achieved during 2021/22:

- The trust placed particular focus on providing educational support to the wards to highlight the need for Glucose monitoring.

- Diabetes Specialist Nurses provided supportive feedback to wards on an on-going basis on BM management (particularly BM testing throughout the night).

- Diabetes Specialist Nurses have supported specific case discussions on wards where incidents were reported.

- Clinical Nurse Educators reviewed non-compliant cases where children, with abnormal vital signs, have not had BM testing whilst in the Emergency Department. Findings from the reviews have been fed back to the Emergency Department team for learning lessons.

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

Relationship to 2022/23 Quality Improvement Priorities: This quality priority has remained the same throughout 2021/22. Paediatric performance of BM testing in the Emergency Department will be audited in 2022/23 as part of the Trust's Quality & Audit Programme to gain assurance and ensure practice becomes embedded.

2.1f: Quality Priority planning for 2022/23

The Trust has agreed 6 quality priority areas for 2022/23:

1. Mortality Improvement
   (Clinical Effectiveness & Patient Experience)

2. Deteriorating Patient
   (Clinical Effectiveness & Patient Safety)

3. Sepsis
   (Patient Safety)

4. Increasing Medication Safety
   (Clinical Effectiveness, Patient Safety & Patient Experience)

5. Friends & Family Test and PALS
   (Patient Experience)

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

How these priorities were set:

The quality priorities for 2022/23 were set in accordance with the Trust's quality strategy longer term objectives. The priorities were also based on a comprehensive programme of consultation which involved the identification and formulation of a 'long-list' of prospective areas for priority focus. This was then consulted on with local residents and service users through the use of a survey made available by the Trust's communications and patient experience teams as well as CCG partners.

This analysis of service user feedback was then used for wider consultation within the Trust and with commissioners which resulted in a short-list of priorities for 2022/23. This was refined further by the Trust's Quality & Safety Committee and Trust Board.

How progress against 2022/23 quality priorities will be monitored and measured:

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

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

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

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

2.2 Statements of assurance from the Board

2.2a Information on the review of services

During 2021/22 the Northern Lincolnshire and Goole NHS Foundation Trust provided and/or subcontracted 7 relevant health services.

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

The income generated by the relevant health services reviewed in 2021/22 represents 100% of the total income generated from the provision of relevant health and care services for 2021/22.

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

During 2021/22, 48 national clinical audits and 2 national confidential enquires covered relevant health services that Northern Lincolnshire and Goole NHS Foundation Trust provides.

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

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

This guidance was changed in May 2021 when all Trusts received the following communication:

> *"In order to support the National Clinical Audit Patient Outcome Programme (NCAPOP) with monitoring and improving patient care, please accept this letter as notice that NHS England and Improvement is mandating a restart to data collection in England for the NCAPOP.".*

The Trust participated in 48 or 100% of the national clinical audits and 100% 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 2021/22 and those in which it participated in are as follows:

NB: *The table which follows lists:*

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

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
BAUS Urology Audit – Cytoreductive Radical Nephrectomy	No	N/A	N/a	N/a	BAUS stated this should have been removed from Quality Accounts
BAUS Urology Audit – Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	Yes	Yes	22	100%	Awaiting publication of national report
British Spine Registry	No	N/A	N/A	N/A	N/A
Case Mix Programme (CMP)	Yes	Yes	1287	100%	Awaiting publication of results
Cleft Registry and Audit Network (CRANE)	No	N/A	N/A	N/A	N/A
Elective Surgery - National PROMs Programme	Yes	Yes	378	86.1%	Report writing/Action planning
Falls and Fragility Fractures Audit programme (FFFAP) National Hip Fracture Database (submitted for all)	Yes	Yes	531	100%	Awaiting National Report
Falls and Fragility Fractures Audit programme (FFFAP) Fracture Liaison Service Database	Yes	Yes	669	On-going	Yes
Falls and Fragility Fractures Audit programme (FFFAP) National Falls Audit	Yes	Yes	12	Ongoing	Project still underway
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Yes	Yes	442 (Cumulative)	100%	Yes
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	Yes	10	100%	Yes
Mandatory Surveillance of HCAI	Yes	Yes	461	100%	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal morbidity & mortality confidential enquiries	Yes	Yes	21	100%	Report writing/Action planning
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiry	Yes	Yes	1 Maternal death	100%	Report writing/Action planning
National Asthma and chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **Adult COPD**	Yes	Yes	727	On-going	Yes

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
National Asthma and chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **Adult Asthma**	Yes	Yes	149	On-going	Yes
National Asthma and chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) **Children and Young People Asthma**	Yes	Yes	48	ongoing	Project still underway
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	310	100%	Awaiting Publication of Results for 2021
National Audit of Cardiac Rehabilitation (NACR)	Yes	Yes	812	100%	Report writing/action planning
National Audit of Care at the End of Life (NACEL)	Yes	*Yes*	80 cases 254 Quality Survey letters	100%	Awaiting Publication of Results
National Audit of Dementia	Yes	Yes	50	100%	Report writing/action planning
National Audit of Pulmonary Hypertension (NAPH)	No	N/A	N/A	N/A	N/A
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Yes	166 (Cohort 3)	100%	Awaiting Publication of Results
National Bariatric Surgery Registry (NBSR)	No	N/A	N/A	N/A	N/A
National Cardiac Arrest Audit (NCAA)	Yes	Yes	103	100%	Project still underway
National Cardiac Audit Programme (NCAP) – Heart Failure	Yes	Yes	625	Ongoing	Project still underway
National Cardiac Audit Programme (NCAP) – MINAP	Yes	Yes	292	Ongoing	Project still underway
National Cardiac Audit Programme (NCAP) – Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	377	Ongoing	Project still underway
National Cardiac Audit Programme (NCAP) – Cardiac Rhythm Management	Yes	Yes	290	Ongoing	Project still underway

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
National Cardiac Audit Programme (NCAP) – Adult Cardiac Surgery	No	N/A	N/A	N/A	N/A
National Cardiac Audit Programme (NCAP) – Congenital Heart Disease	No	N/A	N/A	N/A	N/A
National Child Mortality Database	No	N/A	N/A	N/A	N/A
National Clinical Audit of Anxiety and Depression	No	N/A	N/A	N/A	N/A
National Clinical Audit of Psychosis	No	N/A	N/A	N/A	N/A
National Comparative Audit of Blood Transfusion Programme *2021 Audit of Patient Blood Management & NICE Guidelines*	Yes	Yes	73	100%	Report writing/action planning
National Comparative Audit of Blood Transfusion Programme *2021 Audit of the perioperative Management of Anaemia in children undergoing elective surgery*	N/A	N/A	N/A	N/A	Project was postponed due to Covid
National Diabetes Audit – Core Audit	Yes	Yes	1220	100%	Yes
National Diabetes Audit – Inpatient HARMS	Yes	Yes	20	Ongoing	Yes
National Diabetes Audit – Foot Care	Yes	Yes	105	84%	Project still underway
National Pregnancy in Diabetes (NPID) Audit	Yes	Yes	42	100%	Action planning
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	26	Ongoing	Project still underway
National Emergency Laparotomy Audit (NELA)	Yes	Yes	196	82%	Awaiting Publication of Results
National Gastro-intestinal Cancer Programme Bowel Cancer (NBOCAP)	Yes	Yes	252	100%	Report writing/action planning
National Gastro-intestinal Cancer Programme Oesophago-gastric cancer (NOGCA)	Yes	Yes	83	100%	Report writing/action planning
National Joint Registry (NJR)	Yes	Yes	929	97%	Yes
National Lung Cancer Audit (NLCA)	Yes	Yes	391	100%	Yes
National Maternity and Perinatal Audit (NMPA)	Yes	*Yes*	3273	*97.1%*	Report writing/action planning

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	652 All babies admitted. NNAP extract numbers based on eligibility	100%	Awaiting Publication of Results
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	160	ongoing	Project still underway
National Prostate Cancer Audit	Yes	Yes	242	100%	Report Writing / Action Planning
National Vascular Registry	No	N/A	N/A	N/A	N/A
Neurosurgical National Audit Programme	No	N/A	N/A	N/A	N/A
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	No	N/A	N/A	N/A	N/A
Paediatric Intensive Care Audit Network (PICANet)	No	N/A	N/A	N/A	N/A
Perinatal Mortality Review Tool	Yes	Yes	21	100%	Action Planning
Prescribing Observatory for Mental Health (POMH-UK)	No	N/A	N/A	N/A	N/A
RCEM QIP: Consultant Sign Off	Project postponed to April 2022		N/A	N/A	N/A
RCEM QIP: Infection Control	Yes	Yes	240	Ongoing	Yes
RCEM QIP: Pain in Children	Yes	Yes	25	Ongoing	Project still underway
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	666	100%	Project still underway
Sentinel Stroke National Audit Programme (SSNAP) Early Supported Discharge Data	Yes	Yes	203	100%	Report writing/Action planning
Serious Hazards of Transfusion	Yes	Yes	17	Ongoing	Project still underway
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Yes	67	100%	Yes
Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	Yes	Yes	0	Ongoing	Project still underway
The Trauma Audit & Research Network (TARN)	Yes	Yes	494	Ongoing	Yes
UK Cystic Fibrosis Registry	No	N/A	N/A	N/A	N/A
UK Renal Registry National Acute Kidney Injury programme	No	N/A	N/A	N/A	N/A

National confidential enquires 2021/22

Confidential enquiry	Eligible for NLAG	NLAG participated	Organisational Questionnaires	Number of cases submitted	% of number required	Action planning
Physical Health Care of inpatients in Mental Health Hospitals	No	N/A	N/A	N/A	N/A	N/A
Dysphagia in People with Parkinson's	Yes	Yes	Yes	4	100%	Yes
Transition from child to adult health services	Yes	Yes	Ongoing			

A number of published **national** clinical audits were reviewed by the provider in 2021/22 and the Trust intends to take the following actions to improve the quality of healthcare provided (a sample of the actions agreed are summarised):

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

- National Neonatal Audit Programme:
  - Posters are displayed on all nursery doors to ensure parents are aware that they are to be involved and updated in the care of their baby.
- MBRRACE Perinatal Mortality Review Tool:
  - The parent engagement material from MBRRACE has been reviewed. The templates and leaflets are in use to improve the engagement of parents
- National Paediatric Diabetes Audit, PREMS:
  - A Ketone card is distributed to all new and existing patients who are on an Insulin Pen & Pump with the relevant contact details for the service.
  - Ketone monitoring & illness management is discussed as part of the annual education checklist during the patient's annual review.

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

- National Neonatal Audit programme:
  - Raise the importance of using the Jitsi Meet App and alternative communication methods to involve parents and update them on their baby within 24 hours of admission by discussion in ward huddles and medical training meetings.
  - Badger is to be included within the Doctor induction training day to ensure awareness of the NNAP measures.
  - The Quarterly dashboards published by NNAP are presented at the Trust wide Children's service clinical audit meeting to ensure staff are aware of the NNAP standards and any shortfalls in compliance are identified.
- National Hip Fracture Database:
  - NHFD charts showing the improvement in mortality and time to theatre to be displayed in SGH Theatres to boost staff morale.
  - SGH Project Lead to raise issues around the lack of a dedicated Orthopaedic ward at SGH with senior management.
  - National Hip Fracture Database: To clarify with NHFD what is the definition of a pressure ulcer occurring during the acute admission, and to then ensure staff at both sites follow this definition when collecting data.
- National Bowel Cancer Audit: To email all colorectal consultants and stoma nurses with information of the 3 major concerns (90-day mortality rate, 18 month unclosed diverting ileostomy rate, and permanent stoma procedure rate) to raise awareness of the issues.

- National Emergency Laparotomy Audit: NELA have introduced Early Warning Reports for various criteria – to send copies of the Early Warning Mortality Report and Early Warning Admitted to Critical Care Report to the Critical Care delivery Group for information/discussion.
- National Joint Registry: To discuss how to better embed the NJR Consent process into the existing consent process for emergency cases with Trauma coordinators, Day Surgery Unit Manager and relevant Matrons.
- Trust wide Intensive Care National Audit and Research Centre Case Mix Programme: The team made aware to escalate any significant issues to matrons with regard to achieving 4-hour discharge from time of decision.
- National Baus Renal Colic Audit:
  - Mr Khan to contact A&E about NSAIDS needing to be given out to renal colic patients as per the pathway.
  - Mr Khan to email urology clinicians to reiterate the importance of accurate documentation of stone prevention advice.
- NACAP Asthma & COPD Audits: Clinical standards and performance shared with Emergency department teams to highlight need for early intervention to improve patient care.
- National Heart Failure Audit: Clinical lead raised awareness of the clinical need and pathway for referring patients with Heart Failure.
- NACAP Children's & Young People Asthma audit:
  Targeted sessions for medical staff are to be implemented to ensure the PEF is completed before discharge.
- Fracture Liaison Service Database:
  - Completed a review into Vertebral Fractures to influence referrals to the service going forward and ensure various teams and departments within the Trust understand the importance of referring to the Fracture Liaison Service

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

- Trust wide Intensive Care National Audit and Research Centre Case Mix Programme: Review patients who have been discharged out of hours and create a summary of the data relating to the patients and their diagnosis, with regard to the discharge home, to produce a narrative why it was delayed and send to the group.
- Fracture Liaison Service Database: Engage with patients in clinics asking how service can be improved gathering some qualitative data as evidence.
- NABCOP: Design and introduce a 3 monthly feedback pro-forma to ascertain if patients have sufficient information about their care & treatment.

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

- EIA: One stop clinic set up to aid diagnosis in single visit and commencement of treatment regime.
- Children's & Young People Asthma (NACAP)
  - The BTS discharge care bundle has been added to WEBV. This is to ensure the patients have all the relevant information of their care when discharged.
- SSNAP:
  - The handover to the community team is to take place at time of the patient's discharge to allow longer term needs to be identified and reduce the length of stay.
- NABCOP:
  - To introduce the Fitness assessment form for older patients and ensure this is uploaded to the Somerset system
  - Ensure patients have sufficient information about their care and treatment and are engaged in a shared decision-making process by introducing a patient feedback pro-forma.

- National Neonatal Audit Programme:
  - Explore the feasibility of recruiting a data clerk to ensure the data is cleansed regularly on BadgerNet
  - Purchase of a ward trolley to enable the ward laptop to be present when seeing patients and parents to allow medical team to be input information into Badger at point of care
  - Ward round templates updated to ensure that it is documented that parents are present or have been contacted by telephone to update them on their baby
- National Paediatric Diabetes Audit Prems:
  - Dietician availability is to be reviewed and explore the feasibility of being available in all clinics.
- National Hip Fracture Database: New hip fracture pathway to be amended at the first opportunity, in order to allow any nerve block given in A&E or on the ward to be easily documented.
- National Joint Registry:
  - Data validation for the audit to be undertaken via webtool data review system on an ongoing basis, rather than prior to the end of the deadline period.
  - To assess whether a process can be put in place to identify patients who did not document consent for their details to go on the NJR and contact them via telephone for permission, so their details can be submitted.
- National Prostate Cancer Audit: Performance status to be put on two week wait referral form for GP to fill in.
- MBRRACE – Perinatal Mortality Review Tool:
  - An external member is now included as part of the PMRT review team to improve the process of PMRT.
- Fracture Liaison Service Database:
  - Undertake a review to evidence case ascertainment estimations are hugely overestimated using the Hip Fracture methodology and feedback to audit supplier.

A number of **local** clinical audits were reviewed by the provider in 2021/22 and the Trust intends to take the following actions to improve the quality of healthcare provided (a sample of the actions agreed are summarised):

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

- Paediatric Pews & Sepsis audit
  - An addition to the Monthly dashboard has been implemented to monitor the use of the Sepsis pathway in children who are admitted, and the results are presented at the Clinical Audit meeting to raise the importance of adhering to policy.
- Audit of Paediatric Discharge Summaries
  - A Poster has been designed to raise awareness of areas of low compliance. This is displayed on the wards to highlight the importance of accuracy when completing the discharge summary.
  - The monthly rapid cycle documentation audit is discussed at the Clinical Audit meeting to highlight the importance of documenting patient height, weight, head circumference and centiles.
- Trust wide Outpatient Medical Documentation Audit 20/21: Share Outpatient Documentation Audit results at OPD staff meetings at all sites, at Clinical Sciences Governance Meeting and at Patient Access Business Meeting to raise awareness.

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

- Trust wide Outpatient Medical Documentation Audit: To raise the benefits of moving to digital documentation for outpatient clinics with the management team, as this would mean date/time and name, grade etc would be recorded 100% of the time automatically.
- Documentation Audit: To recommend the Trust implements the documentation of Ward Rounds on WebV as soon as possible to improve documentation by raising it at the Surgery and Critical Care Governance meeting.

- Paediatric Documentation: Electronic documentation has been piloted and is to be re-introduced during 2022 to ensure mandatory fields are completed.
- Maternity Documentation: A new data collection form has been designed and implemented to streamline the collection of data.
- Emergency Department Documentation: ED clerking document underwent revision to ensure a consistent approach across both hospitals. Prior to 2021 the emergency departments used different clerking forms.
- Audit of Weighing Prescribing:
  - Undertake continuous monthly audit on patients admitted to acute care to improve obtaining actual weight of patients, specifically those who appear to have estimated weights of around 50KG to ensure best practice in prescribing is followed
  - Add aide/memoir to the trusts Electronic Prescribing System to encourage obtaining the actual weight of patients and warn regarding prescribing of drugs that require a weight for dosing
- Audit of Blood Glucose Management on Ward Areas:
  - Undertake continuous monthly audit on patients who are prescribed insulin and/or sulphonylureas who are out of target range (below 4 (Hypo) or above 11 (Hyper)
  - Undertake “Diabetes Days” on wards to raise awareness with Diabetes Specialist Nurses feeding back best practice and standards of care for Diabetic patients

2.2c Information on participation in clinical research

The research team priorities for 2021/22 have been urgent Public Health studies and the restarting of other research trials.

The Trust’s research recruitment target has been exceeded with a balanced mixture of both COVID-19 and non COVID-19 clinical research studies. Clinical Characterisation Protocol for Severe Emerging Infection (CCP) and SIREN (staff research) studies were both high recruiters. In addition, a collaborative research study called FASTer was run within our ECC’s at both Grimsby and Scunthorpe Hospitals saw high recruitment over July and August 2021.

Again, this year clinical research has allowed the world’s population to gain knowledge and develop treatments during the pandemic and the Trust has played its part in supporting this.

The number of patients receiving relevant health services provided or sub-contracted by Northern Lincolnshire and Goole NHS Foundation Trust in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee was 2082, an increase of 1,095 from last year.

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

Due to the on-going pandemic NHS England continued to suspend CQUINs for 2021/2022. Payments continued to be made on a block arrangement, and included the element identified for CQUINs.

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

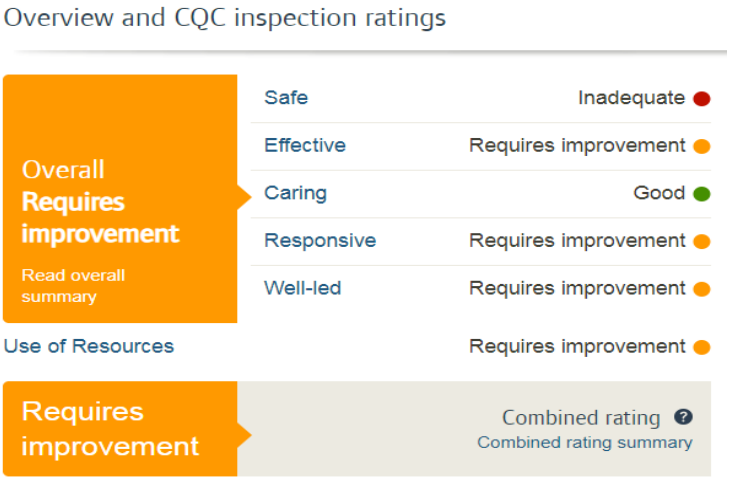
Northern Lincolnshire and Goole NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

The Care Quality Commission has not taken enforcement action against the Trust during 2021/22.

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

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

From their last visit of the Trust in September and October 2019 (of which the report was published on the 7 February 2020) the outcome was as follows:



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

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

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

Despite the pandemic, the Trust has continued to progress with the CQC improvement programme of work following the last inspection. A monthly report provides detail and assurance on progress. At the time of writing, the Trust had 83 open CQC actions, of those, 56 are green and on target, 21 are amber (with significant mitigation in place) and 3 actions are red.

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

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

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

2.2f Information on quality of data

Northern Lincolnshire and Goole NHS Foundation Trust submitted records during 2021/22 to the Secondary Uses Service for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data:

Which included the patient's valid NHS Number was:

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

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

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

2.2g Information governance assessment report

Throughout 2020/21 and 2021/22 there have been several changes to the reporting of the data and Security Protection Toolkit (DSPT). NHSX recognised that organisations would find it difficult to fully complete the toolkit without impacting on their Covid-19 response. The date for the finial submission for 2020/2021 was moved to the 30 June 2020 from the usual 31st March and continues to remain the 30th June for the 2021/2022 submission. It is proposed that this final submission date will remain for future toolkit returns.

The status of the final submission for 2020/21 was ‘Approaching Standards’.

The 2020/2021 improvement plan has been updated and reviewed a number of times by NHS Digital throughout 2021, however it was announced by NHS Digital that the final submission of the 2020/2021 improvement plan which was due to take plane in December 2021 would no longer be required due to the increasing impact COVID 19 and the Log4J cyber incident was having on organisations and would allow organisations to focus their efforts on responding to both these areas.

The 2021/22 Version of the DSPT was released on the 20th July 2021, with an initial baseline assessment date of the 28 February 2022 followed by the final submission of the 30 June 2022. At the time of compiling this report the Trust has still yet to submit its final response and is therefore not in a position to provide a submission statement for 2021/22.

2.2h Information on payment by results clinical coding audit

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

Northern Lincolnshire & Goole NHS Foundation Trust will re-commence an internal audit programme in April 2022. This will include a trust-wide random sample audit of 200 FCEs and speciality specific audits. Additionally, a rolling programme of individual coder audits will commence in 22/23 to ensure data quality and identify any training requirements.

2.2i Learning from Deaths

During 2021/22, 1,475 of Northern Lincolnshire & Goole NHS Foundation Trust's patients died. This comprised of the following number of deaths which occurred in each quarter of that reporting period:

- 319 in the first quarter
- 369 in the second quarter
- 402 in the third quarter
- 385 in the fourth quarter

As at the 31st March 2022, 1,392 case record reviews and 49 investigations have been carried out in relation to 1,475 deaths. In 36 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 302 in the first quarter
- 339 in the second quarter
- 388 in the third quarter
- 363 in the fourth quarter

1 representing 0.06% of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. [Definition: using Royal College of Physicians (RCP) question: "Avoidability of Death Judgement Score" for patients with a score of 3 or less – see narrative below for more information].

In relation to each quarter, this consisted of:

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

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

Any case reviews completed that identify that further understanding is needed, are reviewed a second time by the appropriate specialty clinical lead. This process links into the Trust's Serious Incident process. This data is not a measure of deaths that were avoidable, but as an indicator to support local review and learning processes with the aim of helping to improve the standard of patient safety and quality of care. The denominator used in the calculation is the total number of deaths during 2021/22.

Summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified during 2021/22

And,

Description of the actions which the Trust has taken and those proposed to be taken as a consequence of what has been learnt during 2021/22

And,

An assessment of the impact of the actions taken by the Trust during 2021/22:

The Trust has not found from the mortality reviews completed, evidence of systematic failings in care delivery leading to 'Avoidable' deaths. The Trust views mortality reviews as an opportunity

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

Patient flow has been affected across the wider healthcare system, both by normal winter pressures and additional pressures associated with the COVID-19 pandemic. This has placed a strain on services and the Trust's ability to see and treat patients in the Emergency Department within normal timeframes. Several structured judgement reviews identified long ambulance waits in the community and delayed admission to hospital due to the lack of bed availability for patients requiring admission and infection control measures. During 2021/22 the Trust have:

- Introduced the Urgent Care Service along with new patient pathways with streamlined access to clinician review.

- Second senior reviews introduced in the Emergency Department where long stay patients are identified.

- Support has also been secured from the Community Response Team GP which allows certain ambulance calls to be transferred to North Lincolnshire Single Point of Access.

- The Trust continues to embed the Discharge to Assess programme to support effective management of flow to reduce bed occupancy and mitigate delays in discharge.

Due to the unprecedented pressures across the healthcare system the actions remain ongoing with activity and flow monitored on a daily by the Trust's multidisciplinary senior management teams.

Clinical monitoring has been identified as requiring improvement. Reviewers identified occasions where clinical observations indicated patients were deteriorating but at time of retrospectively reviewing the patient's records, there was a lack of evidence to support that the appropriate escalation and reviews had taken place. During 2021/22 the Trust have:

- Refreshed the Deteriorating Patient Policy and amended pathways for escalation.

- Completed a selection of case note reviews for patients admitted to Critical Care Units to assess the quality of care prior to admission. Findings are reported to the Deteriorating Patients and Sepsis Group.

- Introduction of WEB V ward based monitoring which has allowed targeted support to be provided by the Clinical Nurse Educator.

- Provision of ongoing education to clinical teams.

The Trust is working towards introducing escalation via WEB V systems, this action remains ongoing at the time of writing.

The quality of **documentation and record keeping** remains an area requiring further improvement. During 2021/22 the Trust have:

- Introduced the Trust Learning Group – record keeping was identified as a theme to raise awareness of the expectations of basic record keeping standards.

- The Trust has undertaken specialty specific documentation audits throughout the year and fed back the findings to the clinical teams.

This is an area that will remain a focus for improvement for 2022/23.

Advanced care planning also remains an area requiring further improvement. This was a common theme identified from screening reviews and structured judgement reviews (SJR) where reviewers identified opportunities in the patient's pathway where greater consideration and planning could have potentially prevented hospital admission, and supported patients to die at home with the appropriate community support in place. During 2021/22 the Trust have:

- Undertaken in depth reviews alongside community and primary care partners to discuss the quality of care provided, identify gaps in provision of services or pathways that could have enabled patients to die in their preferred place. Identified findings are shared with the CCGs and has supported the development of the refreshed Out of Hospital Mortality Strategy. The key actions being taken or planned relate the following areas:

  - The RESPECT (Recommendations Summary Plan for Emergency Care and Treatment) document has now been rolled out within the acute Trust and in the community, an audit is currently underway to assess the quality of the forms completed and identify areas where further improvement is identified. Findings will then be fed into education provided by a dedicated trainer/lead facilitator supporting.

  - Electronic Palliative Care Coordination System or (EPaCCs) has been rolled out across the wider Humber Coast and Vale Integrated Care System and therefore covers Northern Lincolnshire. Work is ongoing to ensure this is accessible to hospital based clinicians.

  - Review of palliative care provision (nursing and medical) to focus on advanced planning in the community.

  - The Trust have undertaken a pain assessment audit and triangulated the findings with other available intelligence. As a result, the Trust are currently reviewing the pain assessment tool, policy and staff training to ensure patients have the necessary pain assessment undertaken to enable the appropriate anticipatory medication prescribing in hospital and in the community.

Recognition of the end of life (EOL) is essential in ensuring patients have the appropriate end of life care, however, in addition to other feedback mechanisms, screening reviews and structured judgement reviews continue to highlight that further improvement is required. This relates to; earlier recognition of dying patients to enable discussions with patients and families, involvement of the palliative care team and earlier initiation of the EOL pathway/RESPECT documentation. The Trust have an EOL improvement plan in place, the following key actions being taken or planned relate the following areas:

- The Trust collaborates with local community CCG, primary care and ambulance service partners to undertake end to end mortality reviews based on SJR/screening reviews to discussed potential 'missed opportunities' around earlier recognition. Cases where learning is identified are fed back to GP practices and shared with the acute care teams where applicable. The quality of reviews undertaken have been impacted by the lack of access to the patient's complete healthcare record due to the governance surrounding accessing patient records. This remains a priority for the Trust and across the ICS.

- Training of the completion of RESPECT forms continues within the Trust to encourage earlier discussions around EOL care and initiation.

- Work has commenced with Primary care to pilot the EARLY tool within 2 practices across Northern Lincolnshire.

- The Trust participated in the National Audit of Care at the End of Life for 2021/22. Data collection allowed immediate lessons to be learnt that were weaved into EOL training and education sessions. Early feedback from the national audit provider, focusing on high level

themes, and patient/family feedback, suggests further work is required to improve communication. Results also highlight the impact of the COVID-19 pandemic on EOL experiences.

- The use of Family Voices Diaries was implemented to improve listening and communication with both patients and their carers/relatives.

- The Trust have introduced the BLUEBELL model on several acute ward areas. The Model encourages the discussions and earlier identification of EOL and provides staff with the skills and confidents to identify and discuss patients end of life care needs. The positive impact of implementing this model is demonstrated in staff feedback and via early feedback from families using the Family Voices Diary.

- The EOL pathway documentation is currently under review and will be carried forward as an action into 2022/23.

The Trust completed 116 case record reviews and 19 investigations after 1st April 2021 which related to deaths which took place before the start of the reporting period.

Four of the patient deaths, representing 0.22% before the reporting period (2020/21), are judged to be more likely than not to have been due to problems in the care provided to the patient. Each case was reviewed using the Structured Judgement Review (SJR) which includes a 6 factor Likert scale ranging from Score 6: “Definitely Not Avoidable” to Score 1: “Definitely Avoidable”. The above number of cases includes all those deaths that were classified as scoring less than or equal to 3 on this 6 factor scale. This assessment is the initial reviewer’s evaluation from the retrospective analysis of the medical record. Any case reviews completed that identify that further understanding is needed, are reviewed a second time by the appropriate specialty clinical lead. This process links into the Trust’s Serious Incident Framework. It should be stressed that this data is not a measure of deaths that were avoidable, rather it is designed as an indicator to support local review and learning processes with the aim of helping to improve the standard of patient safety and quality of care.

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

2.2j Details of ways in which staff can speak up

Annual Update on Speaking Up:

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

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

- Raise concerns with their line manager. If this is not possible for any number of reasons, staff have further established routes in place and available to them to speak up, including:

    - Through the Trust’s nominated Freedom to Speak Up Guardian
    - Via the Human Resources Department, a part of the Trust’s People Directorate
    - Using ‘Shout Out Wednesday’ in Family Services to raise any concerns.
    - Logging an incident on the Trust’s incident reporting tool hosted on Ulysses

- Contacting ‘Ask Peter’ which provides an anonymous channel to communicate concerns directly to the Chief Executive.

Freedom to Speak Up Guardian:

The Trust’s Freedom to Speak Up Guardian, their role, contact details and the principles of Freedom to Speak Up process is communicated to all new starters within the Trust as part of the corporate induction programme. The Trust’s appointment of a substantive guardian in 2020 has led to a significant increase in the number of concerns raised and the role of the Guardian is now being widely publicised to all.

The Guardian role and the Speaking Up process is further promoted through printed and digital materials in the Trust and in the past 12 months there have been several promotional events (including a highly publicised campaign for the NGO Speak Up month in October), and additional magazine features. The Guardian is active on social media and regularly uses it as a way of communicating to staff. The Freedom to Speak Up Guardian is accessed via a generic email address and a dedicated mobile telephone number. Staff can also raise concerns using the Staff App, which gives another portal to access Guardian support.

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

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

During 2020/21 there was a significant increase in concerns raised with 143 cases brought to the Guardian, and 2021/22 has seen a further increase with 157 cases being raised through the Guardian route. The latest staff survey indicates increased confidence in staff being able to raise concerns about unsafe clinical practice but a decline in confidence that the organisation will address concerns. There is also a decrease in staff perception feeling safe to raise concerns about other issues so further work is required to improve this. These findings reflect a national trend.

2.2k Annual report on rota gaps and plan for improvement

The Trust has made significant progress with management of Medical and Dental rotas. The latest data for February 2022 showed a vacancy rate of 13.05%, compared with 15.40% in April 2021. This vacancy rate includes an increase in establishment of 54.75 whole time equivalent staff for 2021/22. For trainees, the latest data available is for August 2021, this demonstrated a fill rate of 80.10% which was a decrease of 11.02% in comparison to the previous year. The overall fill for all medical staff grades has been affected by COVID-19 absence and risk assessments that have limited the duties that some doctors are able to conduct.

Workforce and Recruitment meetings now take place regularly, monthly for Surgery & Critical Care and Medicine and fortnightly for Family Services division. Temporary Staffing attend as part of the development of the Resource Centre (RC) and the groups to identify and plan for vacancies. Vacancies are advertised and active steps taken to follow up any interest in the area. Staffing levels continue to give cause for concern and more is needed to be done to develop alternatives such as Physician's Associates (PA) and Advanced Clinical Practitioners (ACP). Workforce objectives, as part of the Trust objectives, are monitored by the Workforce Committee which is a sub committee of the Trust board. The Trust has an established ACP program with planned annual cohorts supported by Health Education England.

Rota Co-ordination has improved in 2021, the Trust is in the process of transitioning to an electronic rostering system for greater visibility to identify the workforce needs and but there is still work to be done. Both A&E departments are fully implemented onto e-Rostering and the Rota Co-Ordinator team is now fully established. The Trust is continuing its efforts to diversify the clinical workforce and thereby reduce sole reliance on medical staff.

2.3 Reporting against core indicators

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

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

a) The national average for the same and;

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

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

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

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

Some of the mandatory indicators are not relevant to Northern Lincolnshire and Goole NHS Foundation Trust; therefore the following indicators reported on are only those relevant to the Trust.

2.3a Summary Hospital-Level Mortality Indicator (SHMI)

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

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

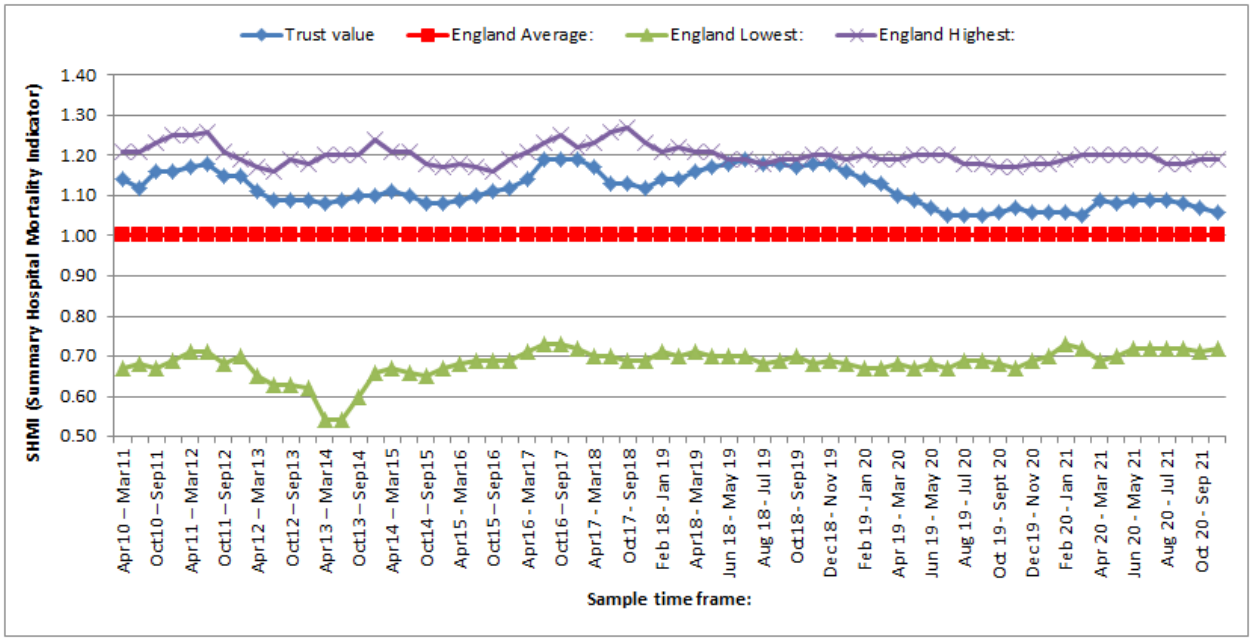


Figure 16: Trust's SHMI score, trended over time

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

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

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

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

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

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

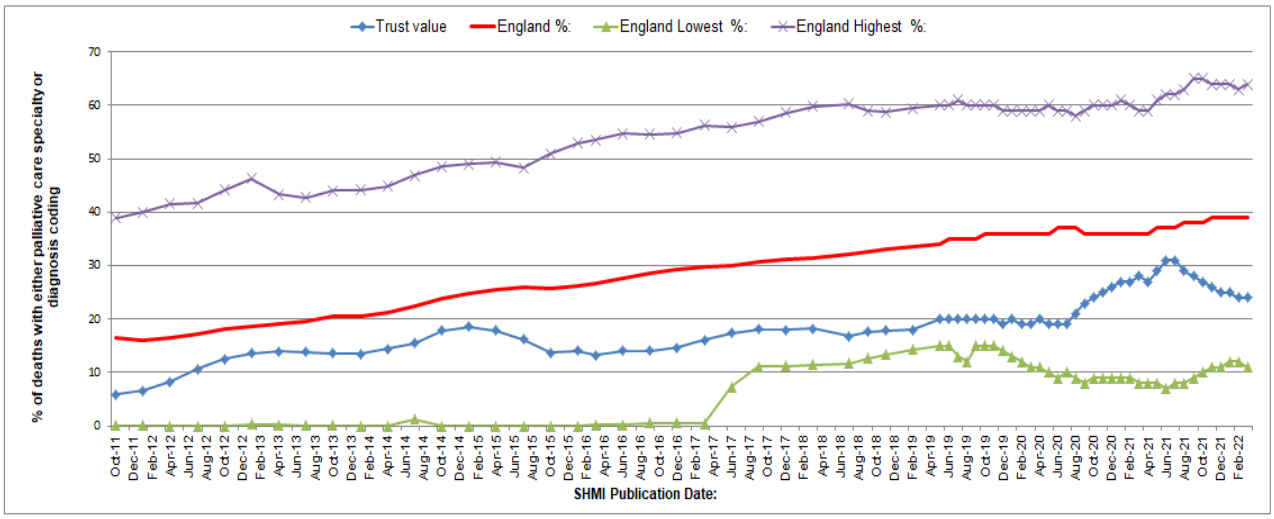


Figure 17: Percentage of patients with a coded palliative care code, compared with other UK Trusts

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

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

- The above chart illustrates the percentage of patients with a palliative care code used at either diagnosis or specialty level. Palliative care coding is a group of codes used by hospital coding teams to reflect palliative care treatment of a patient during their hospital stay. There are strict rules that govern the use of such codes to only those patients seen and managed by a specialist palliative care team.

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

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

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

- The palliative care level information captured has decreased during 2021/22. This may be a result of the normal higher rates of activity resuming within the hospital following reduced activity during the height of the COVID-19 pandemic. Data continues to highlight a difference between hospital sites with SGH having higher levels of palliative care coding than DPOW. This reflects the disparity of consultant-led Palliative care provision between both hospitals and related Clinical Commissioning Groups and is likely to impact palliative care coding. This forms part of the end of life improvement plan and is being addressed collaboratively between primary and secondary care. Funding has now been secured and recruitment of a Palliative Care Consultant at Grimsby is underway to address the disparity.

  Clinical record keeping has been identified within the Trust as an area where further improvement is required. The quality of documentation can vary across the Trust which may have impacted on the accuracy of the coding and contributed to the dip identified.

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:

- Despite the impact of the pressures associated with COVID-19, clinician led coding validation sessions and mortality screening reviews have continued throughout 2021/22. As at the end of February 2022 the target of reviewing more than 85% of all hospital deaths has been achieved, thus supporting the accuracy of Trust data recording, and helps the Trust better understand specific areas requiring Trust and wider system focus. As a result, a reduction in the number of related alerts with 'higher than expected' deaths has been observed.

- As the SHMI includes out-of-hospital deaths (within 30 days of discharge), it can be broken down into in-hospital and out-of-hospital mortality indices. The in-hospital SHMI performance is 'as expected', however, the out-of-hospital SHMI remains higher with Trust average difference of 36 points. The Trust's mortality reviews continue to identify a theme of patients being admitted to hospital at end of life to provide symptom control, often where the acute hospital is not the chosen place of death. This highlights the need of having advanced care plans and RESPECT forms in place which may then prevent hospital admission. The system-wide pressures associated with the COVID-19 pandemic has hampered progress being made in this area. However, the Trust are working closely with CCG colleagues to gain further understanding of the issues. During 2022/23 the Out of Hospital Group and the Trust's Mortality Improvement Group plan to meet to agree a way forward.

- The Trust have worked collaboratively with NHS England/Improvement 'Better Tomorrow: Learning from Deaths, Learning for Lives' team to pilot the national Mortality Reporting Dashboard (after being identified as a 'flagship Trust'). This includes the roll out electronic mortality reviews to allow greater oversight of available SHMI, Medical Examiner and learning from deaths data. Continued focus will be placed on this area throughout 2022/23 to embed the new reporting measures.

- During 2021/22 the Trust continued to be outliers for SHMI indicators relating to secondary malignancies and lung cancer. During this period the Trust has worked with community partners to review these outlying areas in greater detail and understand contributing factors. At the time of writing the Trust is no longer identified as an outlier for lung cancer related SHMI rates and are in the process of undertaking specific case reviews for secondary malignancies to identify gaps in service provision.

- The Trust identified improvement opportunities for patients dying with alcohol related liver disease and for patients with a heart valve disorder. Processes and services for these areas of care were reviewed which resulted in improved pathways for heart valve clinic referrals being implemented, and funding being provided by Public Health to support the services around alcohol prevention and the introduction of an alcohol support team.

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

2.3b Patient Reported Outcome Measures (PROMS)

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

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

Type of surgery	Sample time frame	Trust adjusted average health gain	National average health gain	National highest	National lowest
Hip replacement (Primary)	April 2011 – March 2012	0.405	0.416	0.532	0.306
	April 2012 – March 2013	0.461	0.438	0.538	0.369
	April 2013 – March 2014	0.426	0.436	0.545	0.342
	April 2014 – March 2015	0.436	0.437	0.524	0.331
	April 2015 – March 2016	0.485	0.438	No data available	No data available
	April 2016 – March 2017	0.501	0.445	No data available	No data available
	April 2017 – March 2018	0.453	0.468	0.56	0.376
	April 2018 – March 2019	0.483	0.469	0.55	0.33
	April 2019 – March 2020	0.447	0.459	0.54	0.35
	April 2020 – March 2021	0.410	0.472	0.574	0.393
Knee replacement (Primary)	April 2011 – March 2012	0.317	0.302	0.385	0.180
	April 2012 – March 2013	0.357	0.319	0.409	0.195
	April 2013 – March 2014	0.332	0.323	0.416	0.215
	April 2014 – March 2015	0.339	0.315	0.204	0.418
	April 2015 – March 2016	0.349	0.320	No data available	No data available
	April 2016 – March 2017	0.361	0.324	No data available	No data available
	April 2017 – March 2018	0.323	0.338	0.416	0.233
	April 2018 – March 2019	0.305	0.341	0.410	0.253
	April 2019 – March 2020	0.335	0.335	0.19	0.215
	April 2020 – March 2021	0.334	0.315	0.399	0.181

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

Comment:

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

- The above tables show the adjusted health gain reported by the patient reported using the EQ-5D index, following their surgery.
- EQ-5D index collates responses given in 5 broad areas (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression) and combines them into a single value.
- The single value scores for the EQ-5D index range is from -0.594 (worse possible health) to 1.0 (full health).

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

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

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

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

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

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

- Previously when data concerns have been identified, this has been discussed with Trauma and Orthopaedic Surgeons who have identified areas of improvement and implemented change to address this. Discussion of the most recent results (published in February 2022) will take place at the next Orthopaedics Clinical Audit Meeting in May 2022 alongside an investigation into the data to identify any contributing factors.

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 during the reporting period.

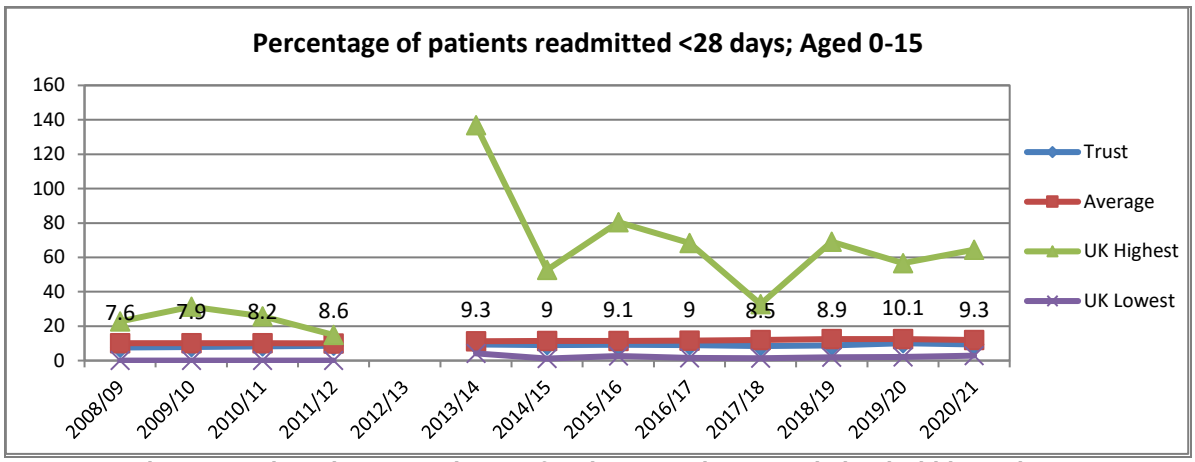


Figure 18: Chart demonstrating % of patients aged 0-15 readmitted within 30 days

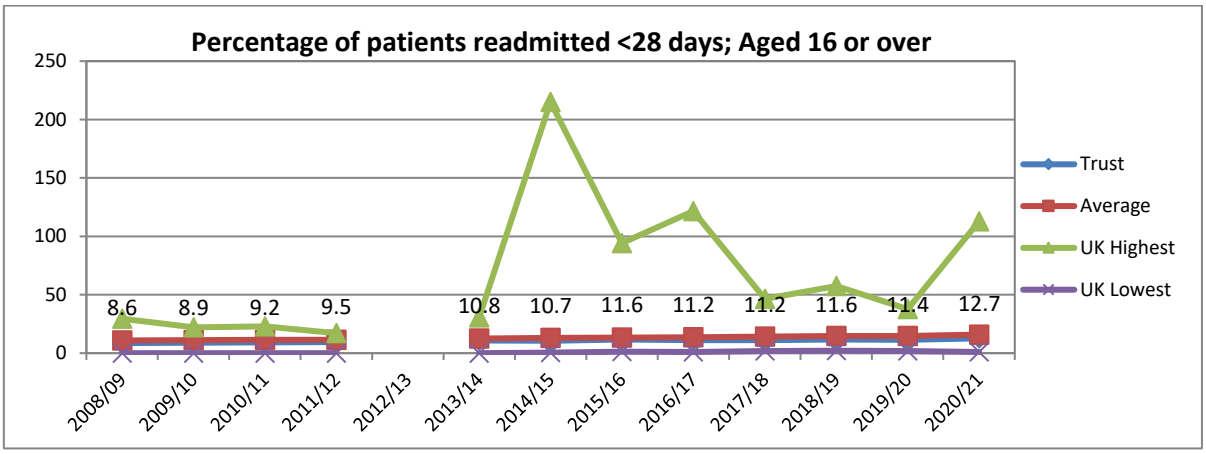


Figure 19: Chart demonstrating % of patients aged 16 or over readmitted within 30 days

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

Comment:

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

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

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

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

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

2.3d Responsiveness to the Personal needs of patients

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

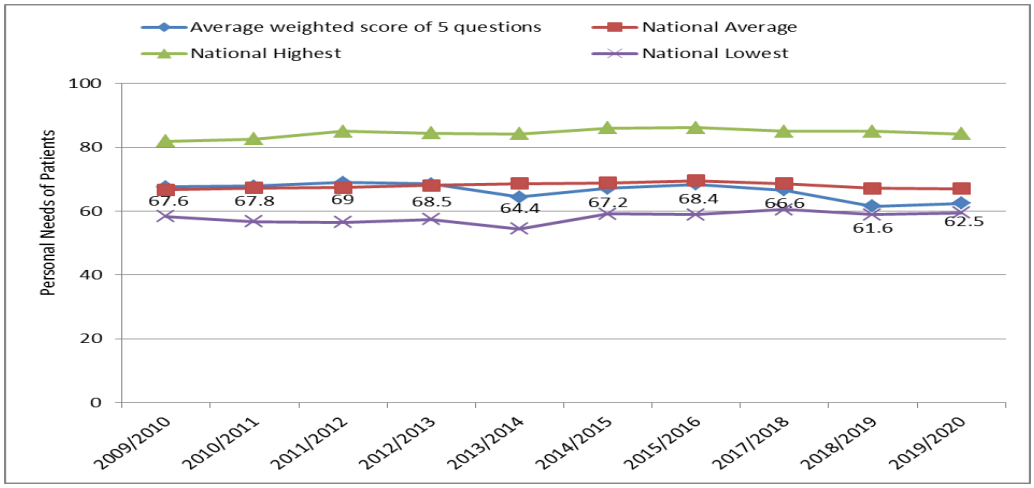


Figure 20: Trust performance with five weighted scores from the national inpatient survey used to determine the Trust's responsiveness to patient's receiving care in its acute services

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

Comment:

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

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

"*Responsiveness to patients' personal needs".*

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

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

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

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

Due to Covid-19, the surveys that provide this data were halted, and therefore no more recent data is available. The data presented here is the same as reported in the 2020/21 quality account.

Northern Lincolnshire and Goole NHS Foundation Trust is committed to involving patients, carers and families in their care, treatment and relevant decision making. The COVID 19 pandemic has resulted in unprecedented challenges which resulted in prioritising clinical activity. This means that whilst progress is being made consideration has to be given to the local and national picture which has definitely affected the pace to achieve respective outcomes.

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

The local rolling inpatient survey, INSIGHTs, has been utilised to map key elements from the national surveys. Ensuring patient views are captured throughout every month enabling oversight, discussions and actions.

Introduction of the Family Liaison Assistant role across key areas, which focused on communication and patient wellbeing. The role has provided patients with the opportunity to discuss issues and have general support for their wellbeing. This has been further supported by the Patient Experience Officers who have provided support on all wards and departments, ensuring patients and families are connected. They have worked to resolve issues and provided a pivotal conduit between patients and staff to create a better involvement.
The Trust is delivering two discharge projects that are working in collaboration. The processes and quality of discharge are central to ensuring safety of medication post discharge alongside safety netting advice which is appropriate for patients and families.

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

The data made available to the Trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

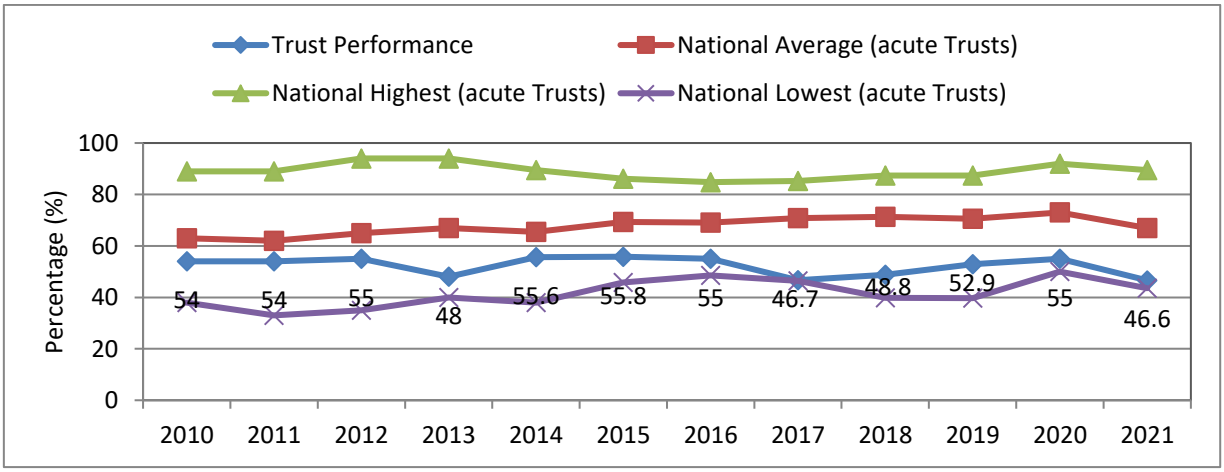


Figure 21: Trust reported performance for staff recommending the Trust as a provider to family and friends

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

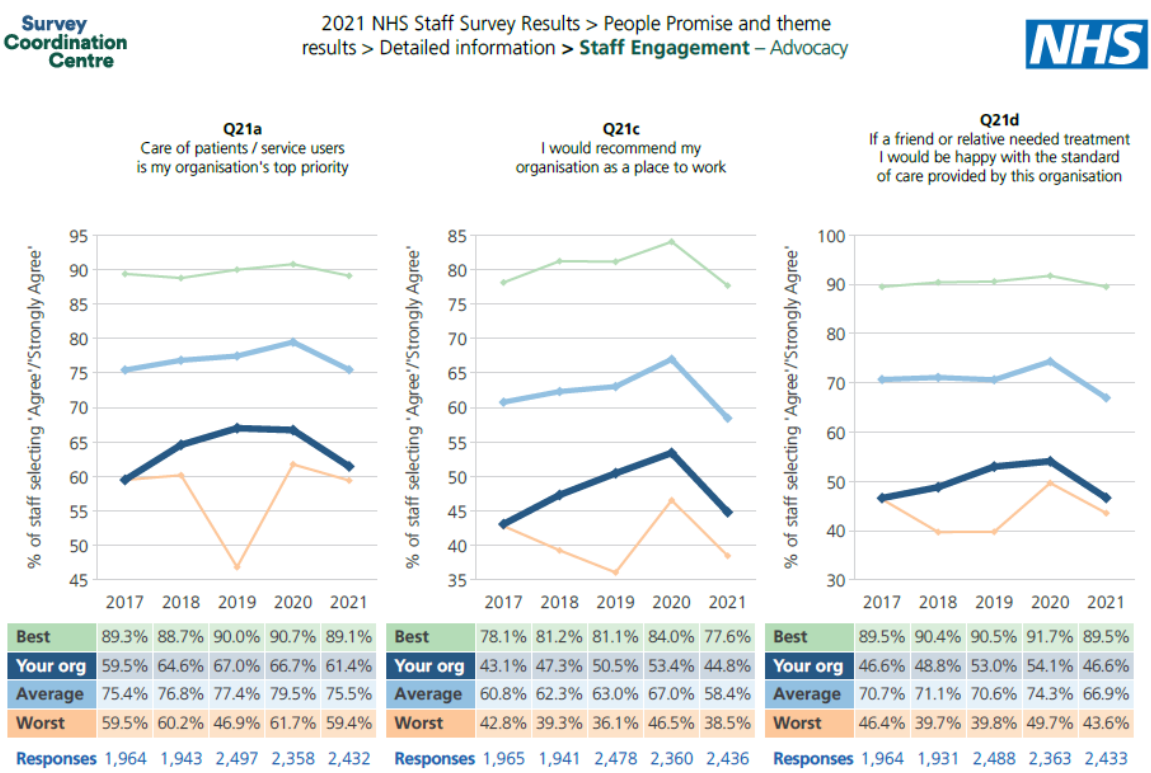


Figure 22: Trust reported performance for staff recommending the Trust as a provider to family and friends

Source: NHS Staff Survey Results

Comments:

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".

46.6% of staff surveyed would recommend the Trust; as you can see this trend is system wide across the whole NHS and is likely as a response to the pressures presented by the pandemic.

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

The unprecedented pressures the COVID-19 pandemic continued to impact on overall staff wellbeing and levels of engagement, resulting in a reduction in most scores in 2021 compared to 2020. The Trust notes that there is much work to do across all staff survey themes.

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

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

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

- The launch of a two year culture transformation programme collaborating with our staff on what actions we need to take to improve employee experience.

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

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

- A two year Equality, Diversity and Inclusion action plan to strengthen our inclusion, diversity and equity.

- A two year health and wellbeing plan designed to build on progress made to date and embed effective leadership of our staff's health and wellbeing.

2.3f Risk assessed for venous thromboembolism

The data made available to the Trust by NHS Digital regarding the percentage of patients admitted to hospital and were risk assessed for venous thromboembolism during the reporting period are shown in the table below.

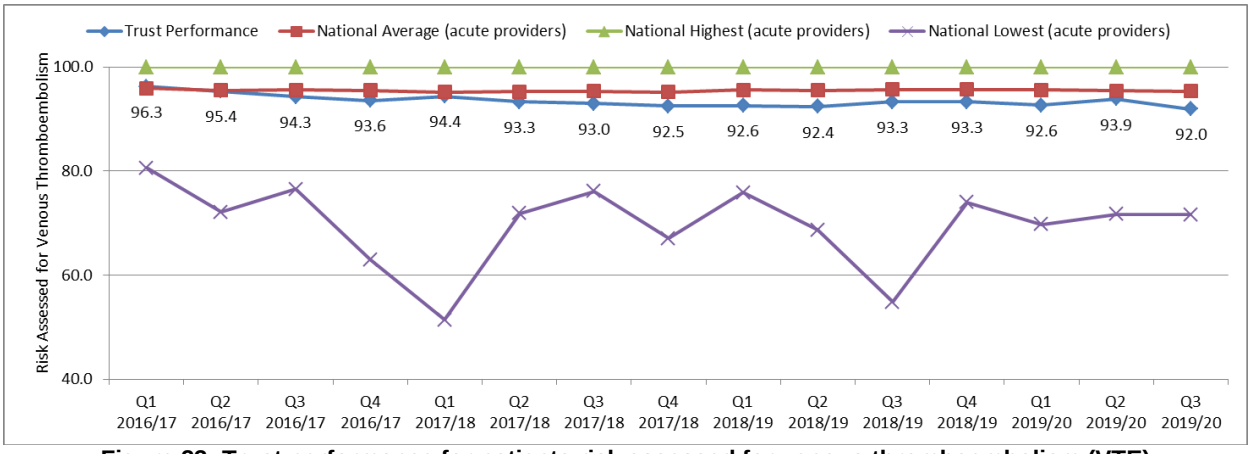


Figure 23: Trust performance for patients risk assessed for venous thromboembolism (VTE)

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

Comment:

- The above table illustrates the percentage of patients admitted to the Trust and other NHS acute healthcare providers who were risk assessed for venous thromboembolism (VTE) since quarter one, 2016/17.

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

- Due to Covid-19, the surveys that provide this data were halted, and therefore no recent data is available. The data presented is the same as reported in the 2020/21 quality account.

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

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

- The Trust completed the implementation of an Electronic Prescribing and Medicines Administration (EPMA) system in November 2021. The system is having the desired effect

in improving patient safety as built in controls prompt doctors to undertake full VTE risk assessments in a timely manner, prior to prescribing or administering medications. Reporting for March 2022 demonstrated an improvement to 90% compliance.

- The Trust appointed two clinical leads to support further improvement and to provide ongoing education and support to clinical staff to understand and overcome identified barriers.

- Trust policy and patient information leaflets are currently being reviewed to fall in line with the latest NICE guidance and to reflect delivery of VTE risk assessment through EPMA. Progress has been slower than anticipated due to the persistent operational pressures impacting on acute care services.

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

2.3g Clostridium Difficile infection reported within the Trust

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

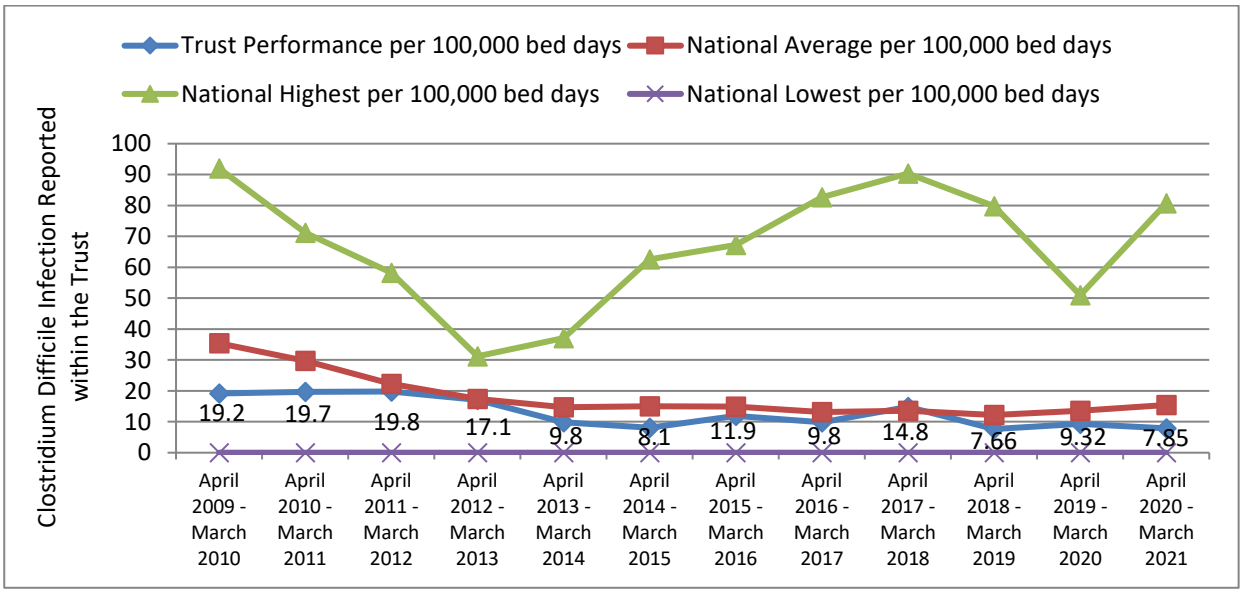


Figure 24: Trust performance for *C difficile* infections reported within the Trust per 100,000 bed days

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

Comment:

The above table illustrates the rate of *C. difficile* per 100,000 bed days ending 20/21, for the Trust (Hospital onset only), for specimens taken from patients aged two years and over.

The data shows that the Trust, for the latest reporting period, is beneath the UK average and one of the best performing acute hospitals in the UK which is a major achievement.

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

The Trust reported 20 healthcare acquired cases for the year ending March 2022 compared to 28 last year. The definitions for reporting *C. difficile* cases changed in April 2019 meaning cases

detected after 2 days would be attributed as Hospital onset (HOHA) as opposed to the previous guidance, which specified 3 days previously. Cases would also be classed as Hospital related (COHA) if the patient was an in-patient within the previous 4 weeks.

	HOHA	COHA
Diana, Princess of Wales Hospital (DPoW)	5	3
Scunthorpe General Hospital (SGH)	7	3
Goole District Hospital (GDH)	2	0

The Trust has detected no significant lapses in practice/care contributing to the development of the infection.

The Trust has taken significant actions to maintain low rates of infection and maintain the quality of its services by:

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

2.3h Patient safety incidents

The data made available to the Trust by NHS Digital regarding:

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

Time frame	Trust number of patient safety incidents reported	Trust rate of patient safety incidents reported per 1,000 bed days	Acute – Non-specialist average rate of patient safety incidents per 1,000 bed days	Acute – Non-specialist highest rate per 1,000 bed days	Acute – Non-specialist lowest rate per 1,000 bed days
April 2015 – September 2015	5,570	44.7	39.3	74.7	18.1
October 2015 – March 2016	5,395	42.8	39.6	75.9	14.8
April 2016 – September 2016	5,953	49.5	40.8	71.8	21.1
October 2016 – March 2017	6,536	52.3	41.1	69.0	23.1
April 2017 – September 2017	6,347	52.4	42.8	111.7	23.5
October 2017 – March 2018	5,897	48.0	42.6	124.0	24.2
April 2018 – September 2018	5,806	48.3	44.5	107.4	13.1
October 2018 – March 2019	6,176	50.0	46.6	95.9	16.9
April 2019 – September 2019	7,275	59.2	49.8	103.8	26.3
October 2019 – March 2020	8,105	65.5	50.7	110.2	15.7
April 2020 – September 2020	7,570	79.9	Data not available	Data not available	Data not available
October 2020 – March 2021	7,547	69.7	Data not available	Data not available	Data not available
April 2021 – September 2021	7,889	69.0	Data not available	Data not available	Data not available

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

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

- The data published for all Trusts is now annual and is not available 6 monthly. Data for 2021 is not yet available by organisation.

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

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

Time frame	Trust number of patient safety incidents reported involving severe harm or death	Trust rate of patient safety incidents reported involving severe harm or death per 1,000 bed days	Acute – Non-specialist national average rate of patient safety incidents reported involving severe harm or death per 1,000 bed days	Acute – Non-specialist national highest rate involving severe harm or death per 1,000 bed days	Acute – Non-specialist national lowest rate involving severe harm or death per 1,000 bed days
April 2015 – September 2015	6	0.05	0.17	1.12	0.03
October 2015 – March 2016	9	0.07	0.16	0.97	0.00
April 2016 – September 2016	7	0.06	0.16	0.60	0.01
October 2016 – March 2017	21	0.17	0.16	0.53	0.01
April 2017 – September 2017	24	0.20	0.15	0.64	0.00
October 2017 – March 2018	21	0.17	0.15	0.55	0.00
April 2018 – September 2018	21	0.17	0.16	0.54	0.00
October 2018 – March 2019	15	0.13	0.15	0.49	0.01
April 2019 – September 2019	31	0.25	0.16	0.67	0.00
October 2019 – March 2020	20	0.2	0.16	0.5	0.00
April 2020 – September 2020	49	0.51	Data not available	Data not available	Data not available
October 2020 – March 2021	94	0.86	Data not available	Data not available	Data not available
April 2021 – September 2021	21	0.18	Data not available	Data not available	Data not available

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

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

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

- Due to Covid-19 and the lack of available data, the national indicators were not updated with new data periods. Therefore, the table has been populated with local data updates only from April 2020 onwards from Ulysses Risk Management software system.

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

- The increase in numbers during October 2020 – March 2021 was due to incidents added retrospectively as severe harm/death for each patient who may have acquired COVID in hospital and then required treatment in ITU or who subsequently died with Covid-19. Letters of apology were sent to each patient's family.

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

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

Part 3: Other information

An overview of the quality of care based on performance in 2021/22 against indicators

3.1 Overview of the quality of care offered 2021/22

The Trust set out 5 key quality priorities for focus on within 2021/22, which were:

As part of the Trust's annual setting of priorities, the Trust had set 5 quality priorities:

1. Reduce mortality rates and strengthen end of life care
   (Patient Experience and Clinical Effectiveness)

2. Improve the management of deteriorating Patients & Sepsis
   (Clinical Effectiveness and Patient Safety)

3. Increasing medication safety
   (Patient Experience & Patient Safety)

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

5. Improve the management of Diabetes
   (Clinical Effectiveness and Patient Safety)

Priority 1 – Reduce mortality rates and strengthen end of life care

PATIENT EXPERIENCE & CLINICAL EFFECTIVENESS:							
QP1: Reduce mortality rates and strengthen end of life care	Mar-22	Feb-22	Jan-22	Apr-21	SPC Variation	SPC Assurance	RAG
1a) Reduction in the number of patients dying within 24 hours of admission to hospital.	**15**	14	17	**16**		No target	G
1b) Reduction in the number of emergency admissions for people in the last 3 months of life.	**193**	172	212	**199**		No target	G
1c) Reduction in the out of hospital SHMI to 110, by March 2022.	**131.9**	132.6	135	**137**			R

Comment:
The Trust has made positive progress in moving towards the target, however, the system-wide effect of Covid-19 has impacted on full delivery of these quality priorities. This will remain as a quality priority for 2022/23 to ensure further improvement is made in collaboration with community partners.

Priority 2 – Deteriorating patients and sepsis

CLINICAL EFFECTIVENESS & PATIENT SAFETY:								
QP2: Deteriorating Patient & Sepsis	Mar-22	Jan-22	Nov-21	Sep-21	May-21	SPC Variation	SPC Assurance	RAG
2a) ADULTS: 90% of patient observations recorded on time.	**91%**	90%	91%	91%	**91%**			G
2a) CHILDREN: 90% of patient observations recorded on time.	**90%**	100%	80%	95%	**90%**			A
2b) Escalation of NEWS in line with policy *(Audit data available bi-monthly)*	No data	0%	9%	3%	**5%**			R
2c) Sepsis screen in 90% of patients with a sepsis six indicator.	No data	80%	47%	39%	**34%**			R

Comment:
The Trust has sustained good practice in ensuring patients have the required observations recorded within set timescales, however, further work is required to improve processes and documentation for recording the escalation of deteriorating patients and sepsis six pathways. These areas will remain as a quality priority for 2022/23 to ensure further improvement is made.

Priority 3 – Increasing medication safety

PATIENT SAFETY & PATIENT EXPERIENCE:							
QP3: Increasing medication safety	Feb-22	Jan-22	Dec-21	Jul-21	SPC Variation	SPC Assurance	RAG
3a) Improvements in recording patient weights in relation to paracetamol prescribing on the Integrated Admissions ward (IAAU).	64%	68%	63%	**64%**		Insufficient data	R
3b) Insulin administered on time in 85% within wards using EPMA.	100%	80%	95%	**90%**		Insufficient data	G
3c) Reduction in medication omissions without a valid reason for ward areas using EPMA.	2%	2%	2%	**14%**		Insufficient data	G

Comment:
The Trust have achieved the targets for administering insulin on time and reducing medication errors on ward areas. However, further work is required to improve the recording of patient's weight during admission. This will remain as a quality priority for 2022/23 to drive improvement.

Priority 4 – Improve the Safety of Discharge

PATIENT SAFETY, CLINICAL EFFECTIVENESS & PATIENT EXPERIENCE:							
QP4: Safety of Discharge	Mar-22	Feb-22	Jan-22	Apr-21	SPC Variation	SPC Assurance	RAG
4a) Improve the proportion of patients discharged before 12 noon.	16.4%	15.2%	16.3%	16.9%			R
4b) Improve the proportion of patients discharged before 5pm.	66.3%	66.0%	67.1%	69.9%		No target	R
4c) Improving trend showing a reduction in length of hospital stay above 21 days.	55	71	62	0			R

Comments:
Progress against these priorities have been significantly impacted upon by the Covid-19 pandemic and system-wide operational pressures. These areas are remaining as key Trust priorities to support recovery actions.

Priority 5 – Improve diabetes management

CLINICAL EFFECTIVENESS & PATIENT SAFETY:							
QP5: Diabetes Management	Feb-22	Jan-22	Dec-21	Apr-21	SPC Variation	SPC Assurance	RAG
5a) Diabetes Audit findings.	No data	77%	80%	80%			G
5b) 100% of BM taken in ECC in adults when NEWS of >1	No data	95%	90%	93%			A
5b) 100% of BM taken in ECC in children when PEWS of >1	No data	83%	83%	75%			A
5c) 90% relevant staff have completed mandatory diabetes training.	88%	87%	85%	85%			A

Comments:
Good progress has been made with a number of these areas. Whilst diabetes care will not be carried over into 2022/23 as a quality priority, achievement of BM testing in the Emergency Departments will be measured as part of the annual Quality & Audit Forward Programme for 2022/23.

3.2 Performance against relevant indicators and performance thresholds

Performance against indicators that form the Single Oversight Framework (SOF) are shown as follows for 2021/22.

Indicator	Quarter 1 21/22			Quarter 2 21/22			Quarter 3 21/22			Quarter 4 21/22		
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	66.3%	68.2%	69.0%	68.4%	68.9%	68.1%	67.9%	69.1%	68.7%	70.0%	70.7%	*Not yet available*
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	72.3%	72.7%	74.6%	63.9%	59.8%	53.2%	52.9%	58.2%	58.9%	62.4%	63.4%	61.9%
All cancers: 62-day wait for first treatment from referral/screening	67.1%	61.5%	65.8%	70.7%	62.4%	66.3%	60.9%	63.5%	65.5%	58.8%	63.1%	*Not yet available*
C.difficile: variance from plan [lapses in care] (target 21)	0	0	0	0	0	0	0	0	0	0	0	0
Maximum 6-week wait for diagnostic procedures	39.8%	39.7%	33.3%	32.4%	36.1%	31.5%	34.4%	30.9%	31.0%	27.1%	18.3%	*16.6%*
Venous Thromboembolism (VTE) risk assessment	79.3%	77.7%	80.4%	76.5%	76.1%	87.6%	92.8%	93.7%	92.3%	93.1%	92.4%	93.4%
Summary Hospital-level Mortality Indicator	108	N/A	109	109	108	107	106	106	*Not yet available*	*Not yet available*	*Not yet available*	*Not yet available*

3.3 Information on staff survey report

Summary of performance – NHS staff survey

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

Timeline

Survey Window: 4th October to 26th November 2021
Embargoed Findings: Received – 24th February 2022
NHSEI Publication: 30th March 2022

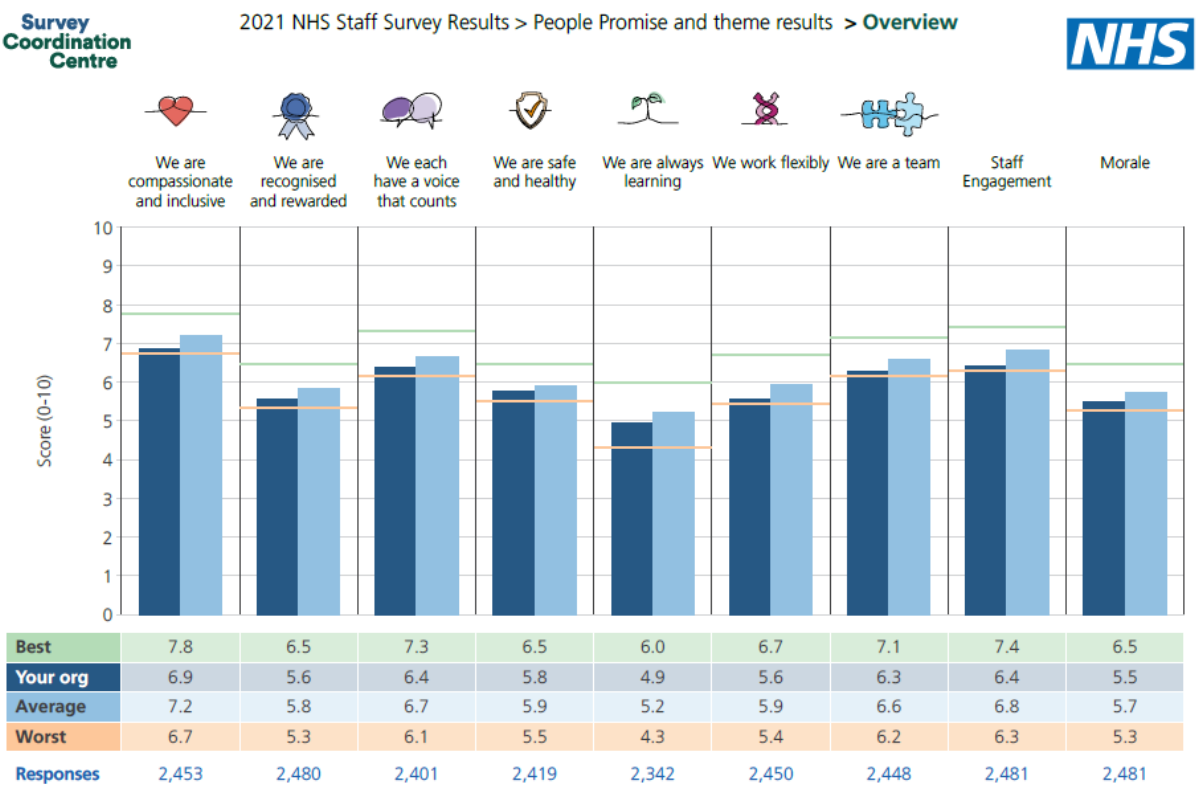
Key Facts

Benchmark Comparators: 126 Acute & Acute Community Trusts
Benchmark Response Rate: 46% (+2% on 2020 survey)
NLaG Response Rate: 38% (+2% on 2020 survey)
NLaG Survey Mode: Paper and Online (2,542 completed)

Staff Survey 2021 findings

The 2021 survey questions are aligned to the seven themes of the People Promise. Staff Engagement and Morale remain included as in previous years.

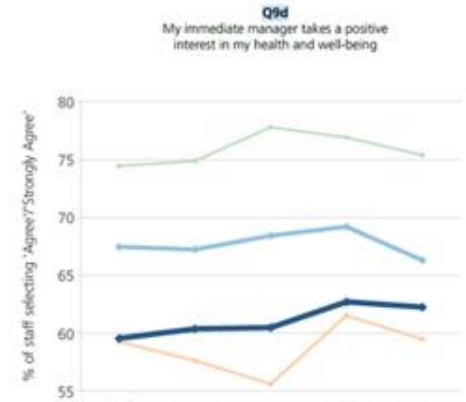
The chart below demonstrates Trust results in comparison to peer organisations.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	6.9	5.6	6.4	5.8	4.9	5.6	6.3	6.4	5.5
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	2,453	2,480	2,401	2,419	2,342	2,450	2,448	2,481	2,481

Figure 25: Key reported in the national staff survey

Health and Well-Being



	2017	2018	2019	2020	2021
Best	74.4%	74.9%	77.8%	76.9%	75.4%
Your org	59.5%	60.4%	60.5%	62.7%	62.2%
Average	67.5%	67.2%	68.4%	69.2%	66.3%
Worst	59.3%	57.6%	55.6%	61.5%	59.5%
Responses	2,008	1,967	2,532	2,383	2,453

From the pandemic the Trust can evidence:

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

Figure 26: Focus on: Health and Well-being

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

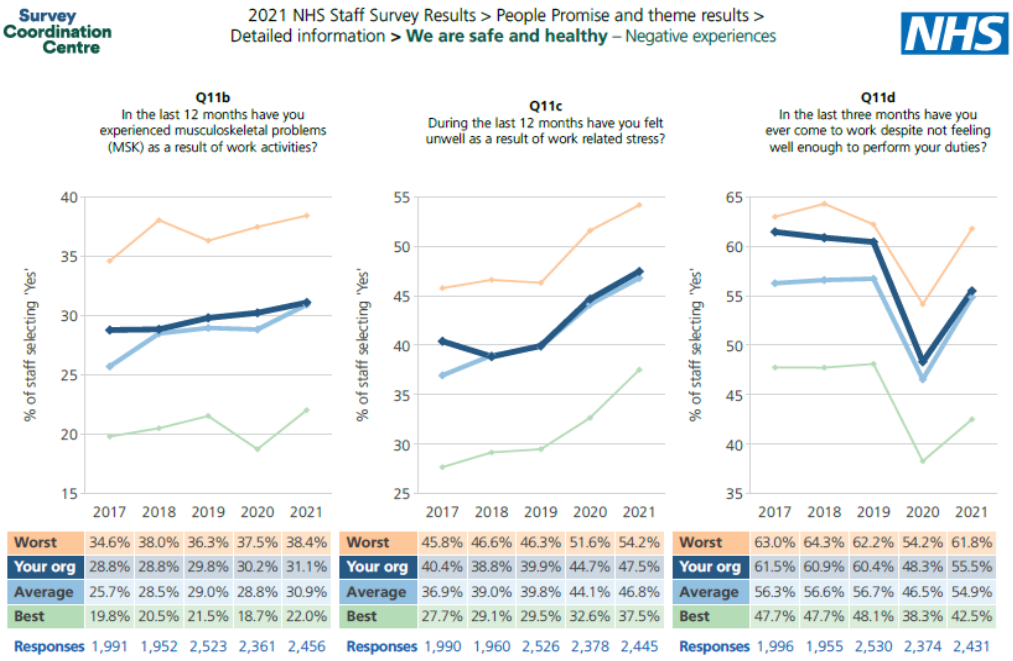


Figure 27: Focus on: Health and Well-being

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

- The support of staff psychological wellbeing with skills training and sessions in CISM training, further funding of clinical psychologists, the introduction of Schwartz Rounds and a series of pop up wellbeing Hubs planned for 2022/3.

- Consideration given to supporting staff burnout is required given Q11d and staff continuing to work when unwell (despite c.12% in-year reduction reporting for work while unwell).

Safety Culture

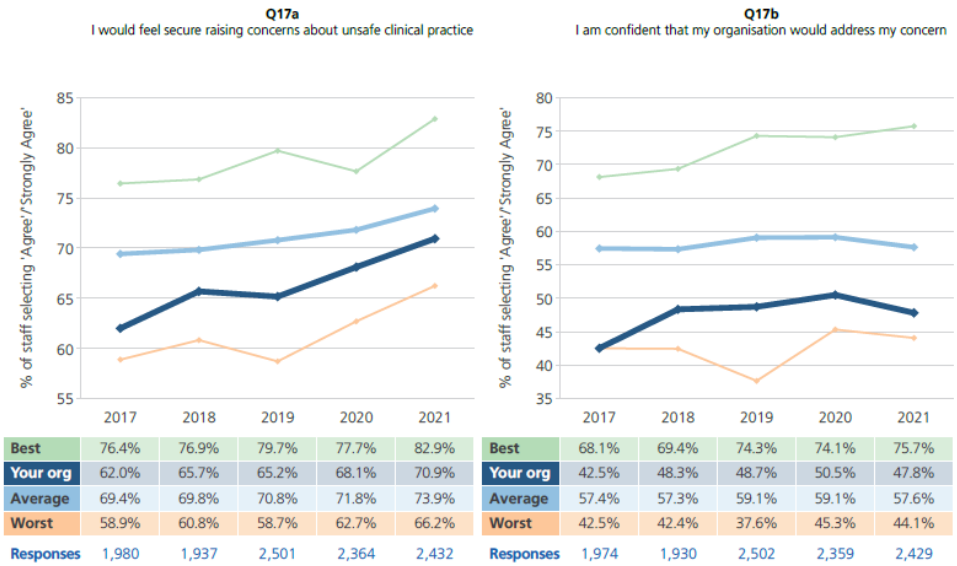
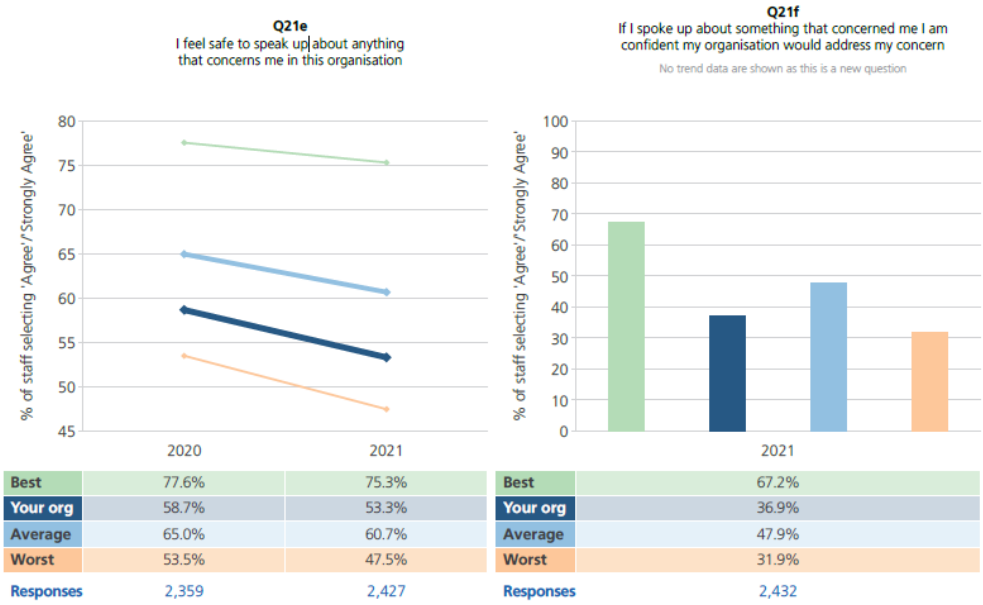


Figure 28: Focus on: Safety culture

Since 2017 significant progress has been made relating to staff feeling secure raising concerns about unsafe clinical practice (+8.9% since 2017).



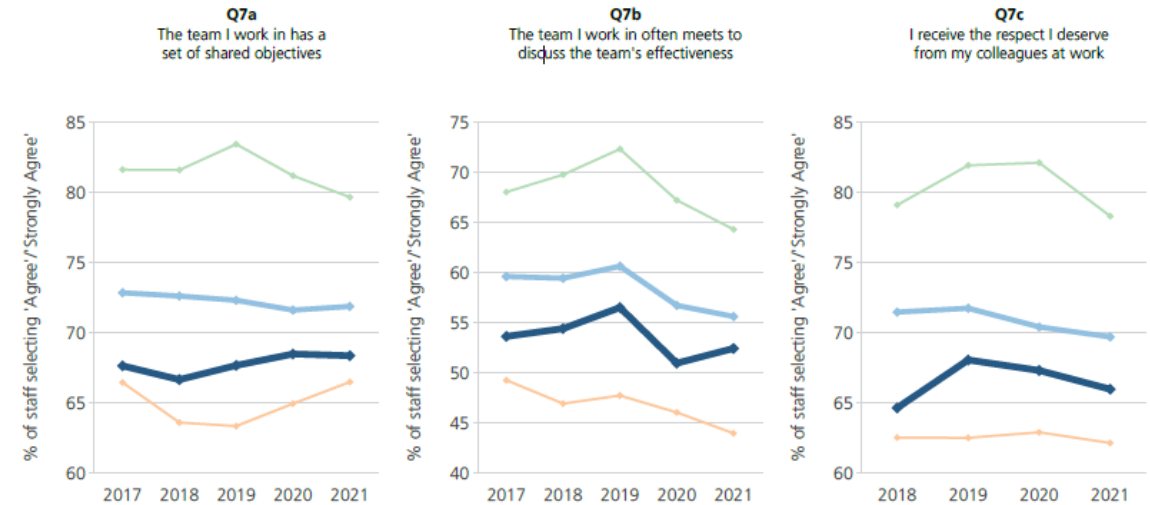
	2020	2021
Best	77.6%	75.3%
Your org	58.7%	53.3%
Average	65.0%	60.7%
Worst	53.5%	47.5%
Responses	2,359	2,427

	2021
Best	67.2%
Your org	36.9%
Average	47.9%
Worst	31.9%
Responses	2,432

Figure 29: Focus on: Safety Culture

There has been a decrease of 5% from 2020 to 2021 in staff feeling they are able to speak up about anything that concerns them in the organisation. The Trust have a proactive programme of work in place to improve on this as part of the Culture Transformation programme and Just and Learning Culture.

Team Working



	2017	2018	2019	2020	2021
Best	81.6%	81.6%	83.4%	81.2%	79.6%
Your org	67.6%	66.6%	67.7%	68.5%	68.3%
Average	72.8%	72.6%	72.3%	71.6%	71.9%
Worst	66.4%	63.6%	63.3%	64.9%	66.5%
Responses	2,033	1,978	2,526	2,369	2,464

	2017	2018	2019	2020	2021
Best	68.0%	69.8%	72.3%	67.2%	64.3%
Your org	53.6%	54.4%	56.5%	50.9%	52.4%
Average	59.6%	59.4%	60.6%	56.7%	55.6%
Worst	49.2%	46.9%	47.7%	46.0%	43.9%
Responses	2,035	1,974	2,544	2,386	2,464

	2018	2019	2020	2021
Best	79.1%	81.9%	82.1%	78.3%
Your org	64.6%	68.0%	67.3%	66.0%
Average	71.5%	71.7%	70.4%	69.7%
Worst	62.5%	62.5%	62.9%	62.1%
Responses	1,989	2,548	2,388	2,467

Figure 30: Focus on: Team Working

As you can see from Q7a-c, there has been no significant change to our scores.

The Trusts recently approved Leadership Development Strategy, consisting of 3 strands of work, includes the strengthening of competence and confidence in our leadership community to build, lead and manage effective teams. Teamworking and Line management are central to high levels of staff engagement. Our forthcoming core leadership skills programme of work will support improvement in this theme.

Next Steps:

Following the recent refresh of the People Directorate's Trust priorities and the ratification of the Leadership Development Strategy and the inception of both a Culture Transformation Board and Working Group, the key deliverables are:

We will further develop how we seek to **attract and recruit new** staff by:

- Developing an overall Recruitment Plan
- Reviewing our recruitment practices
- Developing new roles (including nurse apprenticeships) to attract staff and support existing workforce shortages
- Increasing flexible and hybrid working opportunities clinically and non-clinically for our new starters.

We will **develop and care for our own staff** by:

- Implementing a nursing career pathway
- Exploring opportunities with partners, to introduce new clinical roles
- Reviewing our approach to flexible and hybrid working, and retire and return
- Continuing to raise awareness of and expand access to health and wellbeing services for staff.

We will continue to **improve our culture and staff engagement** within the Trust by:

- Conducting a culture diagnostic exercise to understand better what matters to staff, and build actions to address these needs, overseen and monitored through the introduction of a Culture Transformation Board
- Further embedding Just and Learning Culture practices
- Designing and implementing a 3-strand Leadership Development Strategy
- Strengthening our efforts to increase and celebrate the diversity of our workforce

3.4 Information on patient survey report

Due to Covid-19 the National Inpatient Survey was not undertaken in 2021. The National Inpatient Survey for 2020 contributes to the Trust understanding where to align patient experience priorities in conjunction with the other patient experience intelligence received by the Trust.

The survey response rates were in line with previous years, as seen below:

1250 Invited to complete the survey	1195 Eligible at the end of survey	**44%** Completed the survey (528)	45% Average response rate for similar organisations	45% Your previous response rate

The survey detailed aspects of the respondents stay where they reported a better experience than the other Trusts surveyed or internal improvement since the last survey results, such as how good the food was. The year on year improvement views helps the Trust understand how quality

improvement measures taken from previous survey actions or projects have impacted on patient's experience.

The areas for development, relating to the survey, are taken from the lower scores as seen in the red section of the table below:

Top 5 scores vs Picker Average	Trust	Picker Avg
Q12. Food was very good or fairly good	79%	70%
Q2. Did not mind waiting as long as did for admission	69%	68%

Most improved scores	Trust 2020	Trust 2019
Q12. Food was very good or fairly good	79%	63%
Q10. Able to take own medication when needed to	83%	77%
Q38. Given written/printed information about what they should or should not do after leaving hospital	64%	59%
Q21. Always or sometimes enough nurses on duty	89%	85%
Q36. Staff discussed need for additional equipment or home adaptation after discharge	79%	76%

Bottom 5 scores vs Picker Average	Trust	Picker Avg
Q3. Did not have to wait long time to get to bed on ward	66%	82%
Q5. Not prevented from sleeping at night	38%	49%
Q41. Told who to contact if worried after discharge	69%	78%
Q38. Given written/printed information about what they should or should not do after leaving hospital	64%	73%
Q42. Staff discussed need for further health or social care services after discharge	75%	82%

Most declined scores	Trust 2020	Trust 2019
Q24. Right amount of information given on condition or treatment	75%	80%
Q42. Staff discussed need for further health or social care services after discharge	75%	79%
Q47. Asked to give views on quality of care during stay	7%	11%
Q41. Told who to contact if worried after discharge	69%	73%
Q40. Knew what would happen next with care after leaving hospital	79%	81%

The actions to be addressed were matched against those aspects of care deemed most important to patients, through Picker's relational aspects of care mapping processes.

Divisional teams are taking their own actions and reporting progress through a single combined central monitored improvement plan. This allows for improved triangulation of opportunities, sharing of quality improvement successes and increased oversight through quarterly support and challenge conversations at the Patient Experience Group. The four areas for development are:

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

Glossary

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

Harm:

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

Mortality Data: - How is it measured?

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

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

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

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

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

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

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

Mandatory Performance Indicator Definitions

No external audit of indicators included in the report has been required as part of the 2021/22 Quality Account reporting process, this follows national guidance received to all NHS Trusts.

This page has been left intentionally blank