NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Northern Lincolnshire & Goole NHS Foundation Trust

Annual Quality Account

2023/2024

Compassion - Honesty - Respect - Teamwork

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

I would like to start this statement by thanking all our staff. I joined the Trust as Group Chief Executive, in a joint role with Hull University Teaching Hospitals (HUTH), in August 2023. Since my first week I have spent much time visiting services across NLaG's three hospitals and community services and speaking with staff. I am privileged to have met so many committed, hard-working staff who want to make a real difference to patients.

As with every part of our NHS, our services are under pressure. The Covid-19 pandemic had an impact on already long waiting lists and I am sorry for the extended waiting times that a number of our patients have had. I am pleased that our Trust was able to continue treating some of its elective patients during the pandemic, working in partnership with neighboring organisations. Our staff worked hard to treat patients who had waited the longest in this reporting year of 2023-24 and I thank all the teams involved in doing that.

We have seen increased pressure on our two Emergency Departments (EDs). Greater numbers of patients have presented to our Departments as well as an increase in ambulance conveyances, similar to other parts of the country. The target to see and admit or discharge patients in Emergency Departments was 76% for March 2024, and was a target we were not able to meet. Whilst we did manage to see and treat most patients in four hours 60% of the time during the year, this is not good enough and I am sorry that this has been our patients' experience.

Our patient wards have had consistently high levels of occupancy. As such, many patients who needed to be admitted had to wait a long time. Far too many waited longer than 12 hours and I sincerely apologise to these patients for this poor experience.

The patients and staff working in the EDs are starting to see the benefits of our investment in the new departments at both Grimsby and Scunthorpe. Building work continued in areas close to both new EDs to create Integrated Acute Assessment Units (IAAUs) and Same Day Emergency Care (SDEC) facilities at both hospitals. The Grimsby unit opened in winter 2023 and the Scunthorpe units opened in April 2024.

However, many staff face the challenge of providing patient care in wards and areas that are of quite poor quality and in need of investment or refurbishment. The Trust Board is acutely aware of this issue, and we are exploring ways to bring in much needed capital to improve these areas as well as those buildings where our support staff face similar working conditions.

Our staff remained focused on patient care during periods of industrial action taken by medical staff around their national terms and conditions. Thank you to everyone who worked over these periods as well as staff who have worked closely with patients whose appointments had to be cancelled and rescheduled. We did, by the end of the year, more or less catch up on our backlogs with a reduction in 65 week waits, which is a fantastic achievement in the circumstances.

Since joining the Trust in August 2023, I have been working with senior staff to put in

place a single shared Executive team as well as a new clinical service structure for the NHS Humber Health Partnership, the new branding name for the Group organisation. With new leadership teams in place in our 14 clinical service care groups as well as a new Group Executive Team too. The next financial year will be one where we can really start to realise the benefits of Group working.

As reported in the 2022/23 Quality Account the Care Quality Commission inspected NLaG's hospitals and community services in early 2022 and published their report in December 2022. The progress the Trust had made was recognised in May 2023 when NHS England, the Trust's regulator, took the decision to allow NLaG to exit the Recovery Support Programme. This was important step and recognised the Trust's progress improving both its clinical services and its financial position. The CQC also identified areas that required further improvements and teams across the Trust have put together a comprehensive action plan to respond to the improvement requirements of the CQC's published report. This will remain a key area of focus in 2024/25.

End of Life (EOL) care was the single area where the CQC rating was 'Inadequate', their lowest available rating. This is why EOL was chosen as one of our five quality priorities for 2023/24, specifically to improve personalised palliative and end of life care to ensure patients are supported to have a good death. There has been the successful recruitment of three additional specialist palliative care clinical nurse specialists and an EOL practice educator. Implementation of seven-day Specialist Palliative Care started at Scunthorpe hospital in August 2023 utilising single point for WebV (electronic) referral. Collaborative working with the Care Plus Group has enabled electronic referrals to the EOL team to be rolled out at Grimsby Hospital in October 2023. A training video for doctors to help recognition of EOL pathway at an earlier stage has been developed. The percentage of in hospital deaths with anticipatory medications prescribed has significantly increased to 93% in February 2024 from 27.7% in 2023.

We have also seen significant progress in other areas of our quality priorities, in particular the Deteriorating Patient workstream, with sustained improvement in the percentage of adult observations recorded on time exceeding the 90% target. The Trust has also sustained achievement of the Commissioning for Quality and Innovation (CQUIN) recording and response to the National Early Warning Score (NEWS2) for unplanned critical care admissions, exceeding the maximum national target 30% in all three quarters to date with the latest quarter 3 compliance of 76.92%.

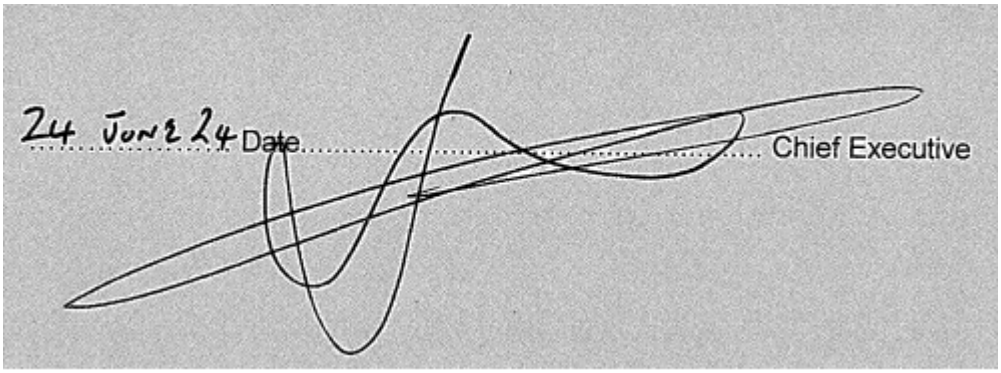
Our commitment to delivering safe maternity care has been recognised by CQC with their latest inspection of our Midwifery led unit at Goole being rated as Good overall. The Trust also achieved all 10 safety actions in the NHS Resolution Maternity Incentive Scheme. Actions included making sure we have an effective workforce in place, ensuring we co-produce maternity services with the Maternity and Neonatal Voices Partnership, showing we have a process in place for getting feedback from people using our services and making sure processes are in place to keeps mums and babies together where possible. This is great news for anyone using our maternity services, as it gives us confidence that the care is of the highest standard.

As has been reported in previous Quality Accounts our challenge for 2024/25 will be to make sure our staff are able to offer the best possible patient care, by looking after our staff and supporting them whilst, at the same time, we do everything we can to reduce

our waiting times and managing the increased demand we are experiencing for urgent and emergency care. I know our staff will continue to rise to the challenge ahead and would like to close this statement by thanking them once again.

I can confirm that the Board of Directors has reviewed this report and can confirm that, to the best of my knowledge, the information contained within it is an accurate and fair account of our performance.

Signature:



Group Chief Executive and Accountable Officer: Jonathan Lofthouse
Northern Lincolnshire and Goole NHS Foundation Trust
Date: 24/06/24

About Northern Lincolnshire and Goole NHS Foundation Trust

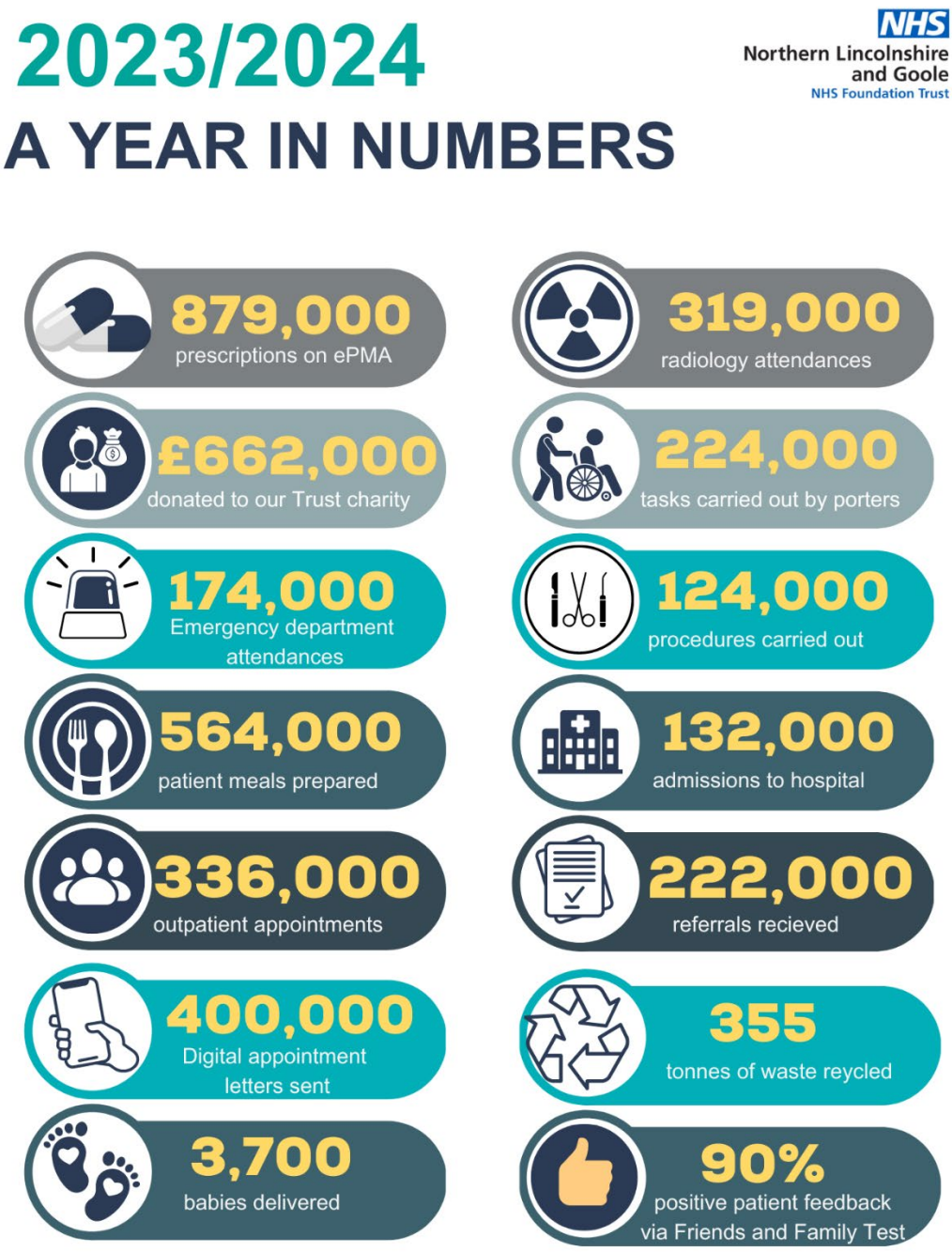
Northern Lincolnshire and Goole NHS Foundation Trust (referred to as 'the Trust' throughout this report) consists of three hospitals and community services in North Lincolnshire. The Trust provides acute hospital services and community services to a population of more than 450,000 people across North and North East Lincolnshire and East Riding of Yorkshire and has approximately 750 beds across three hospitals. The site locations are:

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

The Trust was originally established as a combined hospital Trust on April 1 2001, and achieved Foundation Status on May 1 2007. It was formed by the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust and operates all NHS hospitals in Scunthorpe, Grimsby and Goole. In April 2011 the Trust became a combined hospital and community services Trust (for North Lincolnshire). As a result of this the name of the Trust, while illustrating the geographical spread of the organisation, was changed during 2013 to Northern Lincolnshire and Goole NHS Foundation Trust to reflect that the Trust did not just operate hospitals in the region. The Trust is now part of a Group – NHS Humber Health Partnership – as we work more closely with our colleagues at Hull University Teaching Hospitals NHS Trust.

The Group manages five main hospitals sites: Hull Royal Infirmary, Grimsby Diana Princess of Wales Hospital, Scunthorpe General Hospital, Castle Hill Hospital and Goole Hospital. It provides a wide range of community services across North and North East Lincolnshire, including district nursing, physiotherapy, psychology, podiatry and specialist dental services.

NHS Humber Health Partnership employs over 17,000 staff, sees more than 1,000,000 patients each year and has a budget of £1.4bn.



Figures from 1 April 2023 to 31 March 2024. Rounded figures used

Figure 1: 2023/24 - A year in numbers

Proud Moments of 2023/24

The Trust have received the National Preceptorship for Nursing Quality Mark from the NHS England National Preceptorship Programme. Preceptorship is the way in which newly registered professionals, including nurses, are welcomed into an organisaton and how they are supported to develop their skills, apply knowledge to everyday practice, and gain confidence. The Quality Mark is the national gold standard and was created in October 2022 when NHS England introduced the new national Preceptorship framework for Nursing, which NHS Trusts now use to benchmark themselves against.

Our Macmillan Information Centre at Scunthorpe has been awarded an accreditation in recognition of the high-quality service it provides. The centre has not only achieved the Macmillan Quality Environment Mark (MQEM) award, but received the highest possible overall score, exceeding the level required to maintain the standard. The MQEM award recognises environments that meet the standards required by people living with cancer and celebrates those that go above and beyond to create welcoming and friendly spaces.

The Hospital at Home team at Grimsby hospital was selected from more than 900 entries as finalists in the Community and General Practice Nursing category of the Royal College of Nursing (RCN) Nursing Awards for supporting children to remain at home with their families. Families overwhelmingly rate the service as excellent.

The Safeguarding team and WebV team were shortlisted as finalists at the Health Service Journal (HSJ) Partnership Awards in the Safety Improvement Through Technology category. They have been recognised for transforming their referral system from an outdated, complex system using paper forms, telephone and webpage referrals, to a new streamline electronic system on WebV, our electronic patient record system.

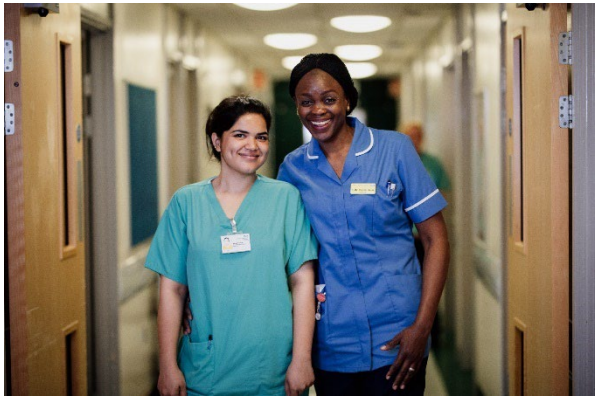
Our new Same Day Emergency Care (SDEC) and Integrated Acute Assessment (IAA) units at the Diana, Princess of Wales Hospital and Scunthorpe General Hospital opened providing us with modern, well-equipped facilities that are purpose-built to meet the needs of our communities for years to come.

Proud Moments of 2023/24

Medicine Division colleagues were honored

to present at the Society for Acute Medicine's Spring 2023 conference in Copenhagen. They highlighted the quality improvement approach they had taken in redesigning the Trust's emergency care pathways moving from Clinical Decisions Units to the Integrated Assessment Units and Same Day Emergency Care model.

The Care Quality Commission (CQC) has rated the Trust's midwifery led unit within Goole District Hospital as good, following an inspection in November 2023.Our commitment to delivering safe maternity care has also been recognised by a national scheme as the Trust achieved all 10 safety actions in the NHS Resolution maternity incentive scheme.



The Trust's international recruitment efforts and commitment to colleague wellbeing has been recognised by a national NHS award. The NHS Pastoral Care Quality Award is a benchmark for recruitment of international nurses and midwives across England. By achieving the award, the Trust has demonstrated a commitment to supporting internationally educated nurses and midwives at every stage of our recruitment and beyond.

All three hospital sites were recognised for successfully achieving high quality data provision recognition

with the National Joint Registry (NJR). The NJR monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement operations to improve clinical outcomes primarily for the benefit of patients, but also to support orthopaedic clinicians and industry manufacturers.

More than 250 staff attended the Trust's Quality Improvement (QI) conference to celebrate the great improvement work that is happening at the Trust.

Carol’s Story – As Told By Her Daughter Sarah

I'm Sarah, my mum was a patient last year which has led me to work with the Trust on a new campaign to improve patient care and experience.

My mum, Carol, was a hairdresser by background but worked as a Phlebotomist at Scunthorpe hospital for 18 years. She was well known and popular with staff and patients because of her kind and empathetic nature. You could always hear her before you saw her, especially her distinctive laugh. She was a shopaholic, obsessed with Alan Titchmarsh and loved going for walks with my dad. She lived for her family.

Sadly, my mum died last year of genetic Creutzfeldt-Jakob disease (CJD). She spent some of her final few weeks in hospital and although she and our family received excellent care at times, there are certain aspects that could have been better. As a fellow NHS colleague, I have never appreciated family-centred care until I was in the position myself. At times, we struggled to do the right thing for mum due to barriers we felt were unnecessary.

For us, it was the little things that made a big impact. For example, due to the disease, mum's cognitive functions were declining rapidly. She experienced a long wait in the Emergency Department (ED) overnight with no access to food or drink. When we were able to feed her, we were spoken to by a staff member for sitting on the bed while trying to do so. She was moved wards during the night which was distressing for her and the presence of security in her room frightened her. As a family, we'd have liked to have spent more time with her on the ward to alleviate some of her confusion. We also felt it would be beneficial to assist with her feeding, but this didn't feel easy outside of visiting hours.

Sarah has worked in partnership with the Trust to improve some of the factors that negatively impacted on her mum’s care and experience and wanted a common sense, person centred approach. We agreed to focus on 4 aspects:

- Time lost with her family when ultimately all the life Carol had left was 5 weeks.
- Visiting – Sarah questioned if our visiting arrangements were really meeting the needs of hospital or patients and families.
- The best utilization of our Security staff when they are called for older confused people – Sarah asked what do staff want security to do & what are security able to do.
- Could the care for older people in emergency areas be improved and is there enough being done to ensure nutrition, hydration and comfort are being addressed for older people in ED’s.

Carol's Campaign was born out of a commitment to work in partnership with Sarah to make changes and influence culture. We agreed we were, without doubt, in this together.

We launched Carol's Campaign in March 2023 after it is presented to Trust Board by Sarah herself.

The key elements to the campaign were:

- Refining the level of security for frail/vulnerable patients.
- Reviewing the accessibility of visiting arrangements across the Trust.
- Positively influencing the culture through compassionate leadership.
- Enhancing the care of older people in the Emergency Department.

What we have done:

- We commenced a quality and compassionate improvement journey with Sarah endorsing all the aspects associated with this campaign as we wanted Carol's name to be synonymous with these partnership developments and for the positive changes to be a legacy to the positive life Carol led.
- We have reviewed thoroughly the training for our security leads to ensure they receive appropriate compassion training.
- We have commenced extended visiting from January 2024 and introduced Care Partners and we will review the visiting.
- We have shared Sarah's story and Carol's campaign widely throughout the Trust so all staff have access to this.
- We have worked closely with the Associate Chief Nurses to review our ED to assess the area and make any improvement needed.

What the changes aim to ensure is that we are providing compassionate and patient-centred care for people when they most need it. We know that having access to the person you need most when you are ill or in hospital can be massive and it can have a huge impact on a person's mental and physical wellbeing.

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

2.1 Quality priority planning for 2024/25

In February 2024 the Trust migrated the Patient Administration System (PAS). In preparation for this significant undertaking, an information services development freeze was put in place in 2023/24 to divert resource to ensure the PAS transition was successful. The work involved to ensure a smooth transition has reduced resource available to support the electronic reporting on the full suite of process and balancing measures associated with the 2023/24 quality priorities which has in turn impacted on the pace of progress.

Drawing on triangulated information from a wide range of quantitative and qualitative data sources including complaints, incidents, inquests, litigations, Structured Judgment Reviews (SJRs), clinical audit, risk registers, staff, and patient surveys and linkages to the Trust's Quality Strategy a long list of potential 2024/25 quality priority topics was developed and shared with staff, the Trust Governors, stakeholders, the Quality Governance Group and the Trust's Quality and Safety Committees in Common. There was agreement that due to the constraints imposed by the ongoing PAS work and the collective desire to fully embed new methodologies until significant improvement is achieved no new topics should be considered and the existing 2023/24 quality priorities should be carried over to 2024/25. Therefore, the 5 quality priority topics for 2024/25 covering patient safety, clinical effectiveness, and patient experience will remain with stretch targets and a refocus on underlying workstreams:

(1) End of Life: To improve personalised palliative and end of life care to ensure patients are supported to have a good death. *(Clinical effectiveness and patient experience).*

(2) Deteriorating Patient: Improved recognition and responding to the deteriorating patient. *(Clinical effectiveness and patient safety*).

(3) Sepsis: Improved recognition and responding to sepsis in patients. *(Clinical effectiveness and patient safety).*

(4) Medication safety: To improve the safety of prescribing weight dependent medication to adults. *(Clinical effectiveness and patient safety).*

(5) Mental capacity: Increase the compliance and quality of Mental Capacity Act (MCA) assessments and best interest recording. *(Clinical effectiveness and patient experience).*

Recognising that communication is a key element linked to our workstreams, it will be included within the quality priorities as an associated qualitative KPI where appropriate. Communication is known to be a broadly applicable element of many aspects of how care is provided, so focusing on patient communication for critical phases of care, such as End of Life and managing patients' mental capacity to make decisions are areas where undertaking patient and their carers views through surveys to gain insight into their

experiences brings value. We also see that elements of communication between staff can contribute to safe and effective care, so the Trust will explore this through the Deteriorating patient workstream as well.

Progress against the 2024/25 quality priorities will be monitored monthly through a defined approach of data analysis and review in the Quality and Safety section of the Integrated Performance Report (IPR), with overall outcome measures included in the Trust Board IPR. Success will be measured through tracking progress and trends against baseline and targets for each of the quality priorities associated Key Performance indicators (KPIs).

Assurance and performance against the quality priorities will also be monitored via the Trust's Quality & Safety Committee in Common, Quality Governance Group and Care Group's monthly performance meetings.

2.2 Looking back on our priorities for improvement in 2022/23

As part of the Trust's annual setting of priorities in 2023/24, the Trust had set 5 quality priorities:

(1) **End of Life:** To improve personalised palliative and end of life care to ensure patients are supported to have a good death.

(2) **Deteriorating Patient:** Improved recognition and responding to the deteriorating patient in patients age 16+.

(3) **Sepsis:** Improved recognition and responding to sepsis in patients.

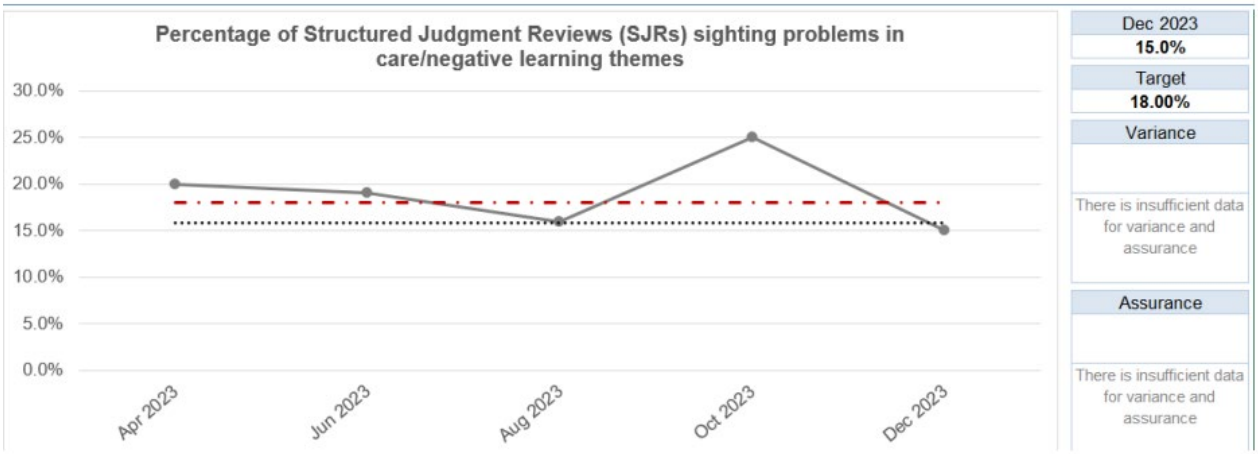
(4) **Medication safety:** To improve the safety of prescribing weight dependent medication to adults.

(5) **Mental capacity:** Increase the compliance and quality of Mental Capacity Act (MCA) assessments and best interest recording.

The Trust has not fully achieved all its priority ambitions however there is evidential progress in several areas with sustained improvements. The graphs and narrative below show a summary of achievement against the key measures of success for each of the quality priorities.

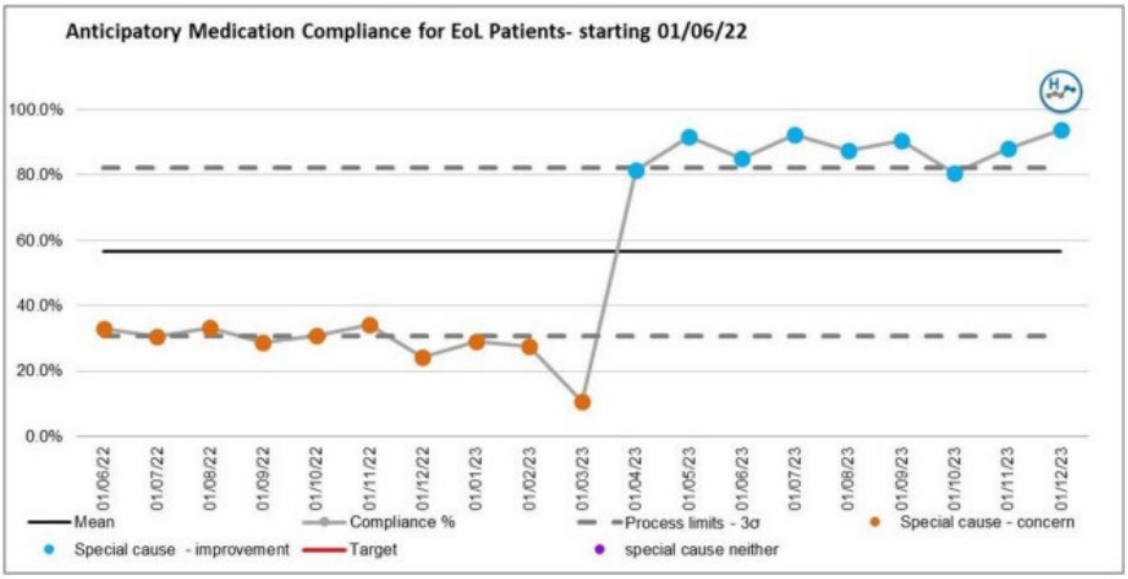
End of Life - Summary of milestones achieved, challenges and next steps

Outcome measure: Reduction in the percentage of Structured Judgment Reviews (SJRs) sighting problems in care/negative learning themes associated with recognition of end of life pathway at earlier stage and the quality of ReSPECT/advanced care planning documentation.



Progress has been made towards reducing the percentage of SJRs sighting problems in care/negative learning themes associated with recognition of end of life pathway at earlier stage and the quality of ReSPECT/advanced care planning documentation with the latest data available in December 2023 achieving 15% which is below the 18% target (lower value is positive).

Process measure: Percentage of in hospital deaths with anticipatory medication prescribed.

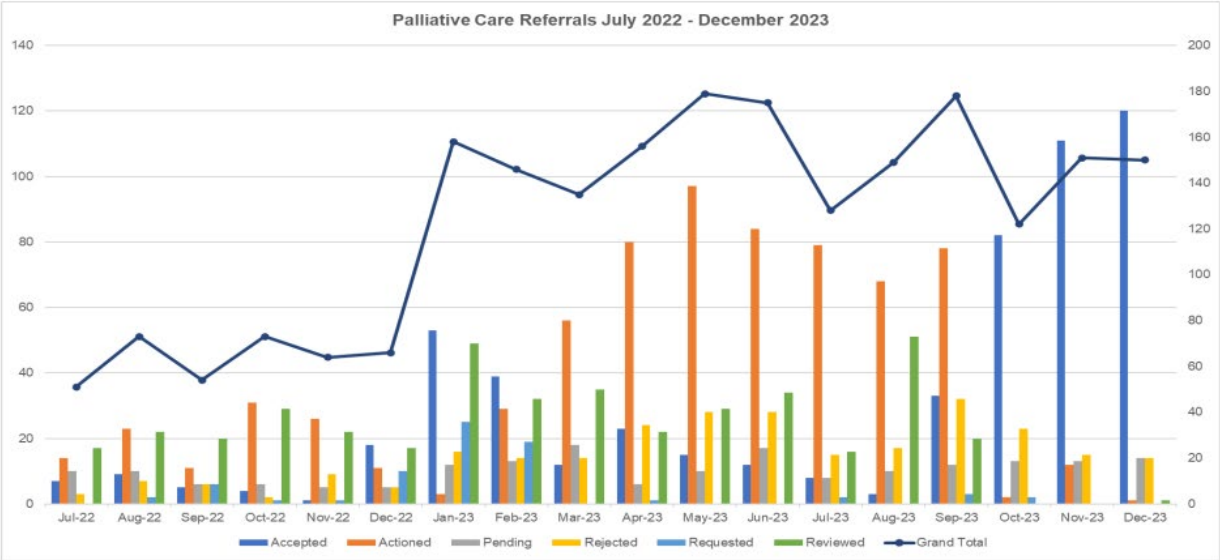


Note: Data from 01/06/22 to 01/03/23 pulled from previous power BI data. From 01/04/23 data pulled direct from WebV.

The deceased patient audit tool that captured data relating to anticipatory medication and linked to the End of Life PowerBI dashboard was moved from Sharepoint to WebV

in March 2023 as part of the End of Life QI project to improve completion compliance. Unfortunately, due to the PAS development freeze the information services team were not able to re-establish automated reporting of this metric. An interim report from WebV was produced which allowed manual identification of this data by the QI team. 94% of anticipatory medication was prescribed in December 2023 and the SPC chart shows special cause improvement since April 2023 coinciding with moving the tool from Sharepoint to WebV.

Process measure: Establish baseline of number of referrals to the End of Life team.



Due to the PAS development freeze automated reporting on the number of referrals to the End of Life and the time from referral to assessment was not possible. An interim report from WebV was produced which allowed manual identification of the number of referrals by the QI team to provide a baseline. It is hoped that reporting on the time from referral to treatment will be developed in 2024/25.

Implementation of 7-day Specialist Palliative Care commenced at SGH on 5 August 2023 utilising single point for WebV referral. Collaborative working with Care Plus Group enabled electronic referrals to the End of Life team to be rolled out at DPoW in October 2023.

There has been successful recruitment of three additional specialist Palliative care clinical nurse specialists and an End of Life practice educator. A gap in access to a Palliative Care Consultant at DPoW remains despite recruitment drives. Planned increase in Consultant capacity is on hold in both North Lincolnshire and North East Lincolnshire currently due to changes in allocated funds. Next steps regarding medical staffing are being considered through the Northern Lincolnshire Strategy Group as a new business case will be required.

An End of Life staff survey was launched to help understand the challenges and areas of focus. There were 109 responses and wards 22 and 17 at SGH and wards IAAU and C3 at DPoW became pilot wards to allow targeted support. Following success in the pilot wards, the care in the last days of life document was electronically rolled out Trust wide significantly increasing completion compliance.

The use of ReSPECT forms is now fully rolled out in all areas. Work has been completed to help improve the level of communication in our discharge summaries around DNACPR decisions and ceiling of care recorded on ReSPECT forms.

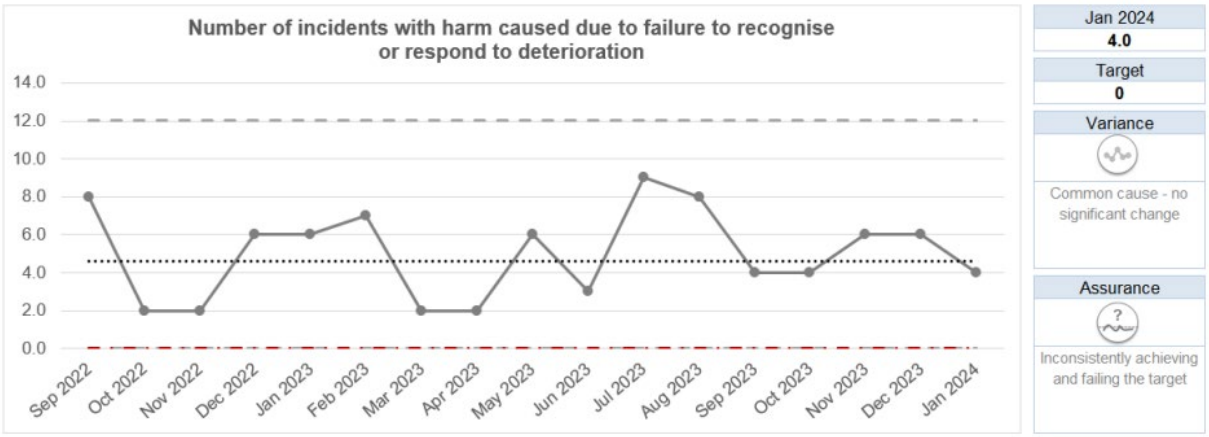
The divisional Doctors Induction has been updated to include an early introduction to ReSPECT and End of Life. Recognition and care planning are included in training delivered by the specialist End of Life team with different options of training delivery offered to improve compliance, including face to face, virtual training and targeted sessions. A training video for doctors to help recognition of End of Life pathway at an earlier stage has been recorded and a tiered approach to training is in development. A questionnaire for Medical staff has been launched to further understand the barriers to early recognition of End of Life and decision making to stop active treatment.

A patient and carer survey has been developed with support from Healthwatch to further understand patient and family experience related to end of life/palliative care communication.

A conference to understand the barriers to early End of Life recognition is planned for June 2024. The focus of the 2024/25 End of Life quality priority will be on improving recognition of End of Life pathway at an earlier stage.

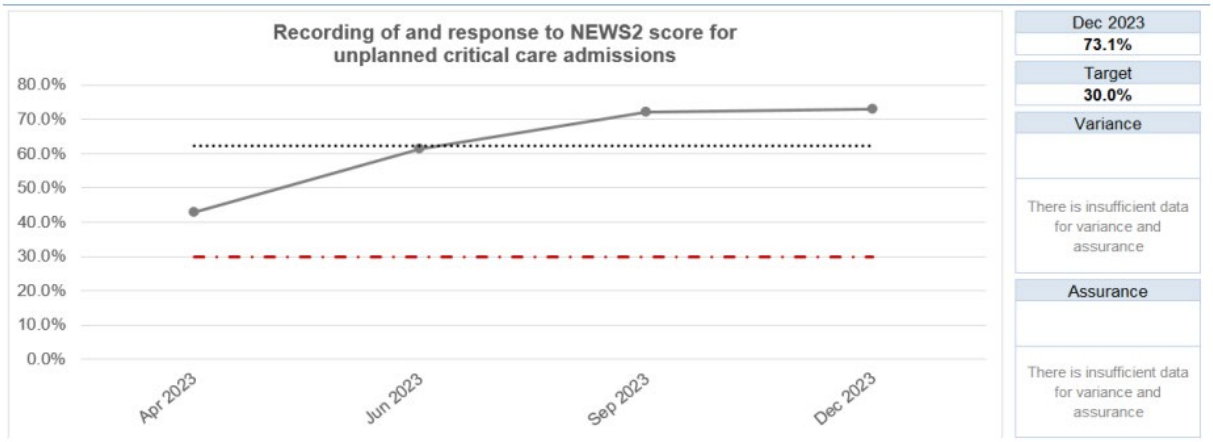
Deteriorating Patient - Summary of milestones achieved, challenges and next steps

Outcome measure: Reduction in the number of incidents with harm caused due to failure to recognise or respond to deterioration.



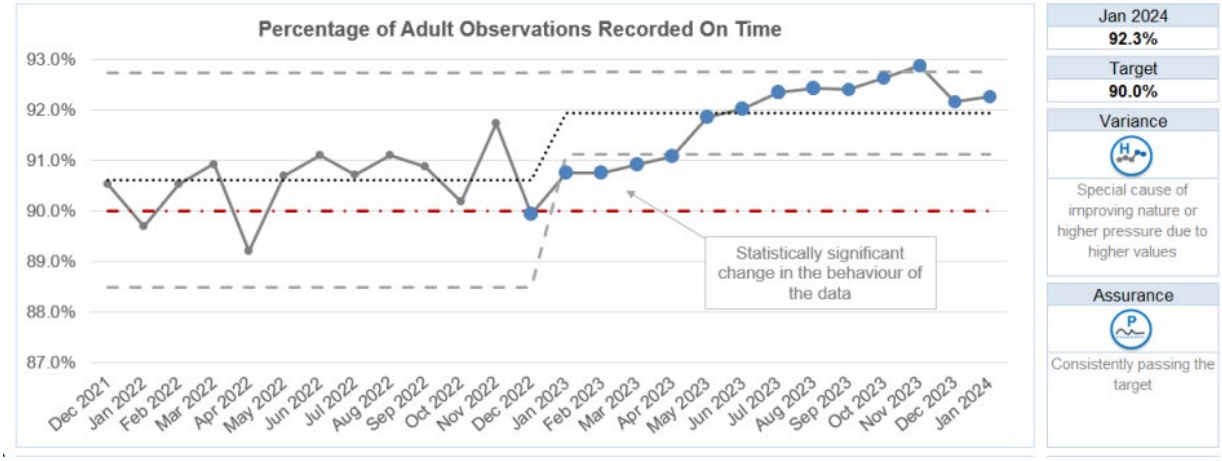
The SPC chart shows normal variation with no significant change in the number of harm incidents reports with a mean of 5.2. All incidents reported between 1 April 2023 to 31 January 2024 were either, near miss, no harm or low/minor harm. It was identified that there were inconsistencies in the category coding used by staff reporting incidents as not all the incidents reported under the deteriorating patient categories were explicitly related to a deteriorating patient. New incident category options have been added to Ulysses to improve accuracy of deteriorating patient incident coding which include failure to follow up on observations/recognise deteriorating patient, failure to escalate deteriorating patient, failure to treat deteriorating patient. Deteriorating patient incidents continue to be monitored through the Deteriorating patient/sepsis group to identify themes and learning.

Process measure: Recording of and response to NEWS2 score for unplanned critical care admissions (Aligned to CQUIN07 2023/24)



Sustained achievement of the CQUIN recording of and response to NEWS2 score for unplanned critical care admissions, exceeding the maximum National target 30% in all quarters to date with the latest quarter 3 compliance of 73.1%. Agreed allocation of time for Clinical Sisters to focus on NEWS2 QI work with nursing teams.

Outcome measure: Percentage of adult observations recorded on time (within 30minute grace period)



There has been a successive improvement in the percentage of adult observations recorded on time exceeding the 90% target. All divisions are expected to present a highlight report to the Deteriorating patient/sepsis group. This has helped to improve engagement and encourage clinical ownership of the improvement work. All clinical sisters and ward managers are continuing to undertake applying QI training to focus on deteriorating patient and escalation. Stop and check continues to be embedded across all areas, encouraging use through night shifts. In the Medicine Division, the escalation pathway has been distributed to all ward nurse base areas and staff rooms to raise awareness.

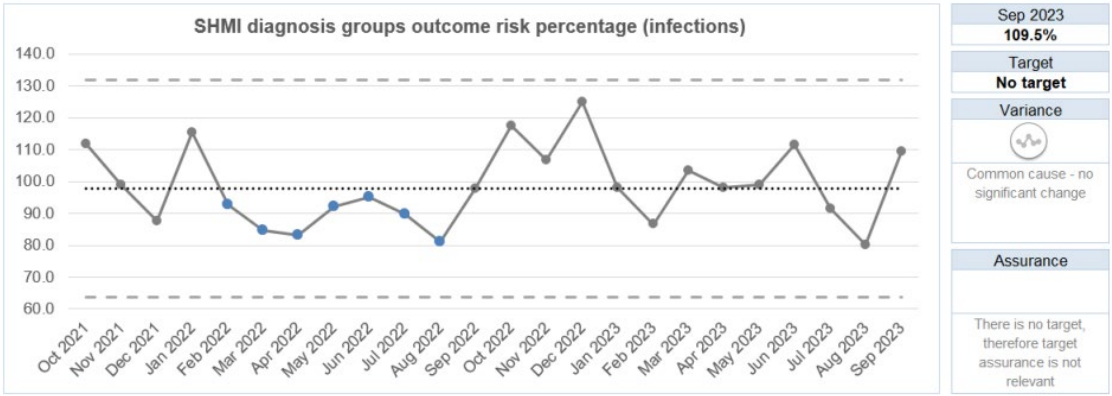
Clinical sisters and key members of staff within the Surgery and Critical Care division are continuing to undertake QI work on escalation of patients. This should support the recognition of deterioration and the appropriate escalation in line with the policy. Monitoring of referrals to Critical Care continues with oversight by the Deteriorating Patient/Sepsis group. Critical Care Outreach at DPoW are planning an electronic escalation pilot on wards

C2 and B3.

Building on the success of the 2023/24 deteriorating patient quality priority, stretch targets will be introduced for 2024/25 to strive towards 95% of adult observations recorded on time with a reduction in the grace period from 30 minutes to 15 minutes. The CQUIN target for recording of and response to NEWS2 score for unplanned critical care admissions will be increased from 30% to 80%. A new process measure of evidence of Situation Background Assessment Recommendation (SBAR) escalation will be introduced with a target of 30%.

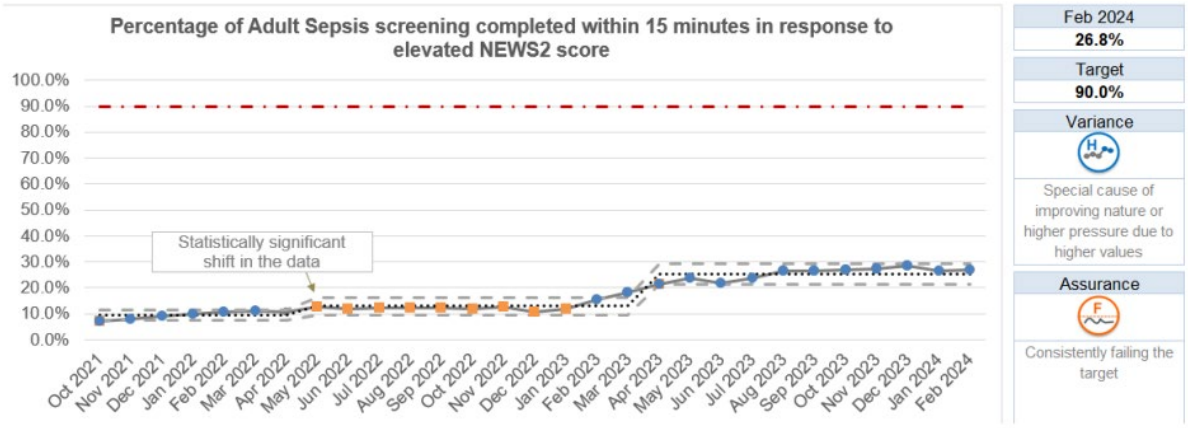
Sepsis - Summary of milestones achieved, challenges and next steps

Outcome measure: Maintain/improve SHMI diagnosis groups outcome risk percentage *(Note: to include diagnosis groups related to infections).*



The SPC chart shows normal variation. The average rate (observed deaths/expected deaths) x 100) of patients that died with an infection related cause, for the period 1 April 2023 to 30 September 2023, was 98.6 which is below the England average 100.

Process measure: Adult primary sepsis screening completed on WebV within 15minutes in response to elevated NEWS2 score.



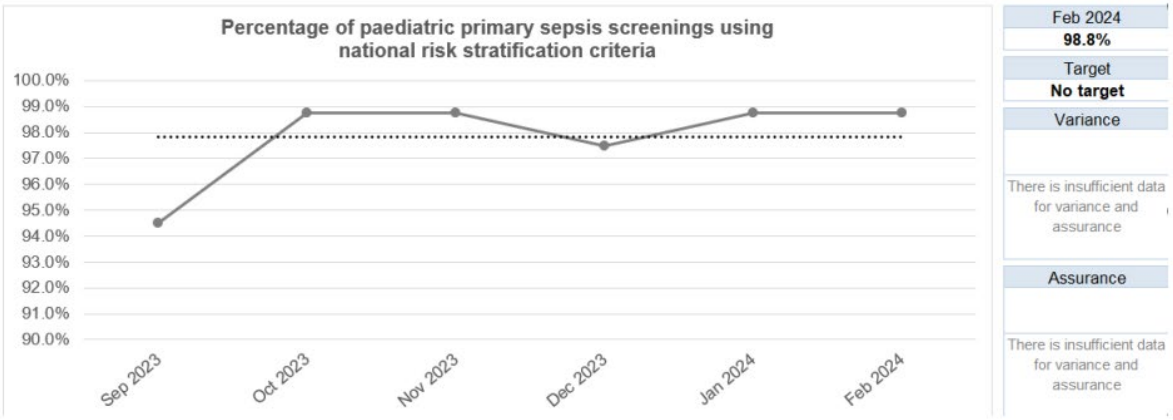
The SPC chart for the percentage of adult sepsis screening completed within 15 minutes in response to elevated NEWS2 score shows sustained special cause of improving nature rising to 26.8% in February 2024 compared to 10.81% in February 2022.

Electronic sepsis screening has been introduced in both Emergency Departments (ED) but challenges exist around IT systems as there is no automatic link to WebV to record sepsis screening from the ED Symphony system resulting in duplication and delays as 2 systems

are in use. A solution is being sought but will require financial investment. Despite these challenges, improvement was seen overall with sepsis screening but further work and system changes are required to improve recording within 15 minutes. With the time constraint removed, compliance of sepsis screening is better and has improved from 32.4% in February 2022 to 50% recorded in February 2024.

A snapshot audit has shown that the time delay of greater than 15 minutes to complete the sepsis screening tool is potentially due to the Health Care Assistant completing observations and escalating to a registered nurse who is then actively caring for the patient but is not completing the sepsis screen on WebV. DP/Sepsis nursing lead and QI lead continue to engage with frontline teams to progress QI work streams. Spot checks continue on the wards to ensure correct pathways and treatments have been followed.

Process measure: Paediatric primary sepsis screening completed in response to triggers to undertake screening using National risk stratification tools for “high risk” and “moderate to high risk” criteria.



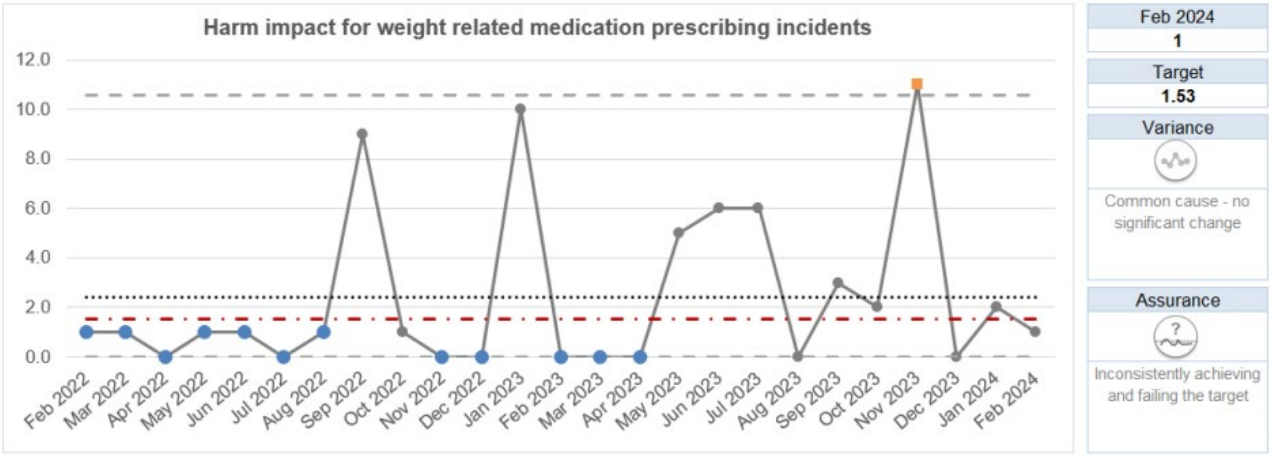
Paediatric sepsis screening audit data was collected from four areas (SGH Disney Ward, SGH Paediatric Assessment Unit, DPoW Rainforest Ward and DPoW Paediatric Assessment Unit). The mean percentage of Paediatric primary Sepsis screening completed in response to triggers to undertake screening using national risk stratification tools for “High Risk” and “Moderate to high risk” criteria was 97.8% although it should be noted that poor documentation and timeliness of treatment has been identified as an issue and will be the focus of improvement work in 2024/25. The audit results are shared with staff at team meetings and ward displays with a focus on a standard of the month.

The Symphony system in ED has been updated to include new prompts to complete a paper screening tool; Has a sepsis screen been considered? and What is the sepsis screen outcome? An audit is underway to quality check compliance with the new prompts.

To improve documentation of assessment, a new process measure of 90% of Paediatric Sepsis screening tools to be completed on presentation to ED/Paediatric Assessment Unit will be introduced as part of the 2024/25 sepsis quality priority.

Medication Safety - Summary of milestones achieved, challenges and next steps

Outcome measure: Reduction in harm impact for weight related medication prescribing incidents.



A low number of incidents and infrequent incidents with harm have been identified, so applying a weighted scoring for harm being the 5-point scale of no harm to death caused by the incident has been used. The harm value from 1-5 has been squared to illustrate the significant impact of incidents that cause more harm than others, while monitoring the no harm/near-miss incidents cumulatively. This means that a patient's death would score 25; severe harm 16; moderate harm 9; low harm 4; no harm 1. Whilst not reflected in the chart above, the SPC chart limits have been set in line with historical data points following the SI case in March 2018 with a score of 25. All weight related medication incidents reported between 1 April 2023 and 17 March 2024 were all near miss, no harm, low/minor harm incidents. All incidents are discussed at the Safer Medication Group to raise awareness and share learning.

The National Reporting and Learning System (NRLS) ceased to exist and was superseded with the Learning From Patient Safety Events (LFPSE). The National benchmark reports on under-reporting of patient safety incidents are no longer available. Therefore, the Trust was unable to monitor and report on the previously agreed balancing measure:

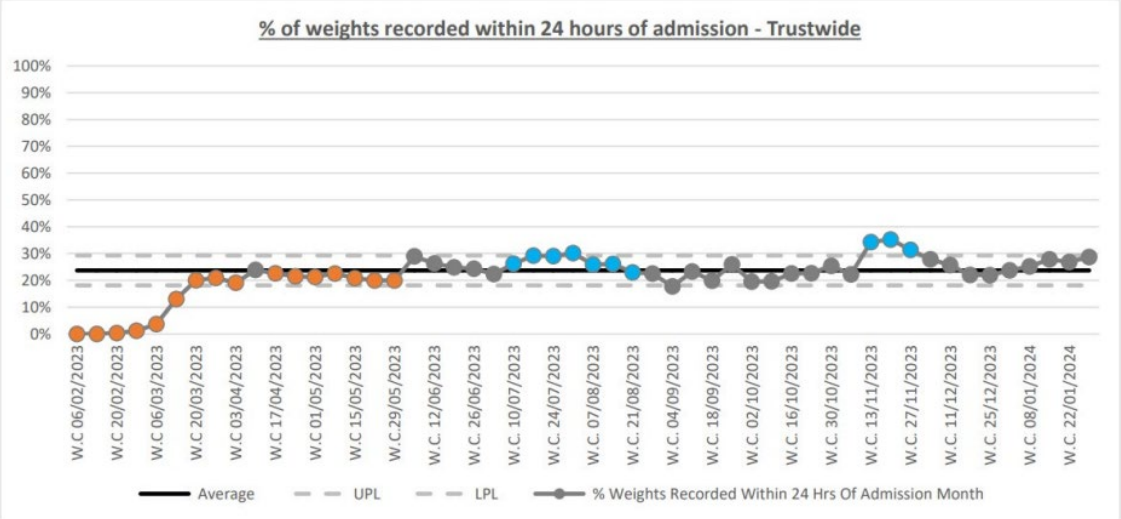
- **Balancing measure:** Potential under-reporting of patient safety incidents.

Weight entry on ePMA and WebV is challenged by dual systems as the two systems don't currently enable data to be shared between the systems meaning it must be entered into both systems manually. Weight data values also cannot be reported by ePMA which combined with the PAS development freeze has meant the Trust was unable to monitor or report on the previously agreed process and balancing measures:

- **Process measure:** Actual weight recorded on WebV within 24 hours.
- **Process measure:** Weight recorded on EPMA matches actual weight recorded in WebV.
- **Balancing measure:** MUST screening within 24 hours of admission.

The Trust is exploring investing in a bot to electronically transfer weight data between systems. In mitigation a self-serve excel dashboard showing data per site, division and ward has been created to allow wards to monitor their own compliance levels with weight

recorded on ePMA within 24 hours and 48 hours. A monthly summary report is taken to the Safer Medication Group and is shared with the Divisions to be discussed at Divisional Governance meetings. A monthly summary report was also provided to ward leaders highlighting the top 3 and lowest 3 wards per division per site to encourage improvement.



The SPC chart shows that the percentage of weights recorded on ePMA within 24 hours of admission has remained static with only slight improvement from 21.42% in April 2023 to 26.69% in January 2024. Due to the PAS migration in February 2024 there has been a pause in available data. In the interim data is being collected manually on pilot wards.

Presentations to raise awareness of the importance of weight recording on ePMA have been delivered to all levels of medical staff as well as sharing at Divisional Governance meetings.

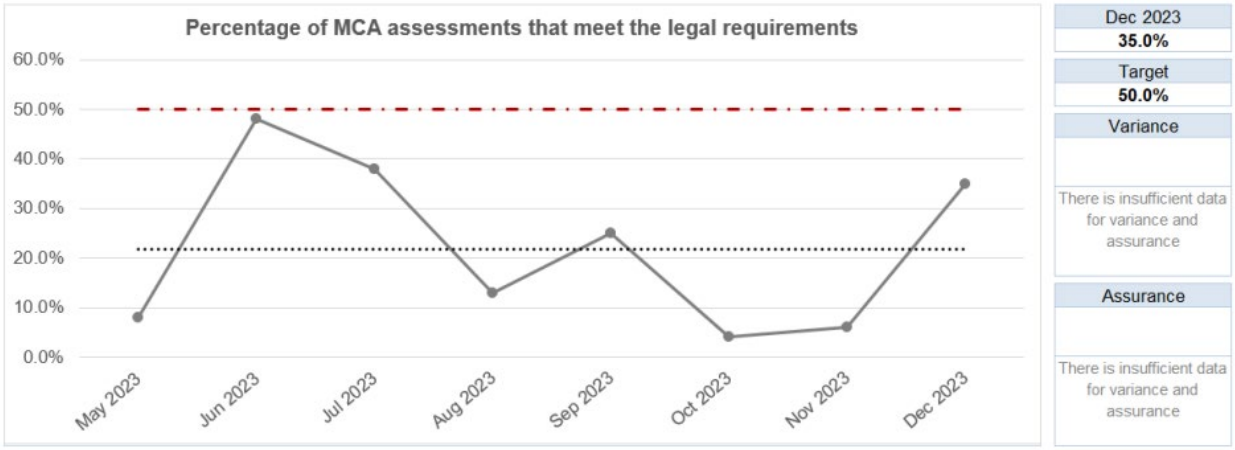
A working group has been formed and a QI project has commenced. Surveys on all inpatient wards were completed to identify problems with recording weights on ePMA. Pilot wards A1, IAAU, B7 and Short Stay at DPoW and wards 5, 24, 28 and Stroke Unit at SGH were identified to trial Plan Do Study Act (PDSA) cycles before rolling out change ideas Trust wide.

The two new EDs have weighing bridges to allow patients arriving to be weighed by Ambulance crews. An observational audit of Ambulance staff weighing patients on arrival at both EDs has been completed which highlighted a site difference in practice with 100% of patients being weighed by the ambulance staff on arrival at DPoW but only 33% of patients were weighed by the ambulance staff on arrival at SGH. Ambulance staff at both sites are weighing patients with additional personal belongings on the trolley. Trust wide 49% were weighed with additional items. SGH had poorer compliance with 77% of patients being weighed with additional items on the trolley compared to 36% of patients at DPoW. An action plan has been developed and a re-audit is planned.

The 2024/25 Medication Safety quality priority will build on the 2023/24 QI work to further improve compliance with weight recorded in EPMA within 24 hours of admission.

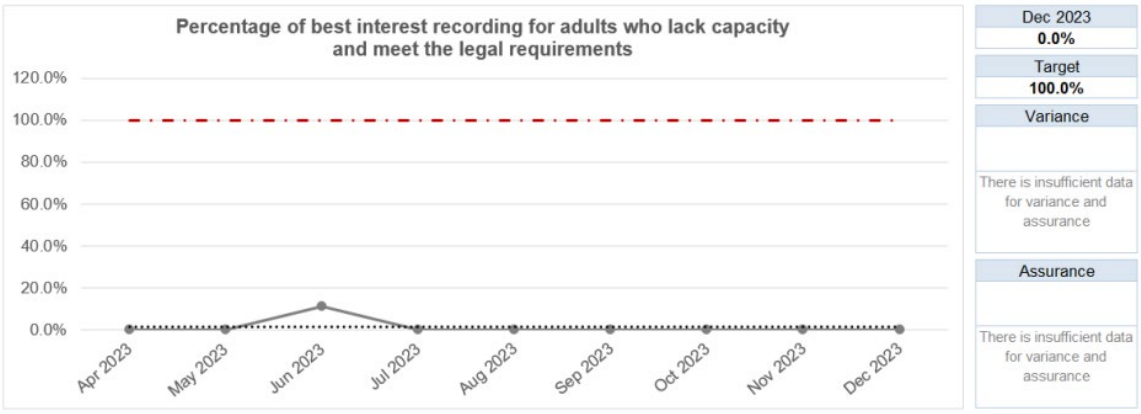
Mental Capacity - Summary of milestones achieved, challenges and next steps

Outcome measure: Percentage of MCA assessments that meet the legal requirements.



The percentage of MCA assessments that meet the legal requirements remains below target but has significantly improved from 6% in November 2023 to 35% in December 2023. We are starting to see improvements in the completion of some elements of the assessments. For example, 66% of assessments completed on Ward B6 in December 2023 had evidence that the patients had been supported to make a decision compared to 0% in May 2023.

Outcome measure: Percentage of best interest recording for adults who lack capacity and meet the legal requirements.



Compliance with best interest recording remains challenged. Progress has been limited due to single resource in the MCA/DoLS team and limited support from the QI team to support the Mental Capacity Quality Priority. Recruitment of a Specialist Nurse MCA/DoLS commenced their substantive post on 17 November 2023.

The **Process measure:** Attendance at bespoke training sessions on MCA assessments and best interest decision recording, was not formally monitored. Instead, bitesize training sessions have been delivered to Ward B6 and bespoke feedback forms for staff who have completed MCA assessment and best interest forms have been introduced and are shared for learning. MCA resource folders have been created and shared with all wards. A staff

survey to measure confidence and understanding of the MCA 2005 was undertaken. The MCA working group continue to meet to share learning and change ideas. The MCA/DoLS lead and Specialist Nurse MCA/DoLS continue to provide targeted support to wards.

The Community & Therapy Services Division have undertaken an audit in MCA assessments in community nursing to determine how many patients admitted to adult nursing caseload have had an MCA assessment undertaken when risk identified. The initial assessment template on SystmOne has been amended. A pathway to support the MCA assessment process has been developed. Best practice examples of MCA assessments tailored to community settings have been shared for learning.

The MCA assessment documentation audit has been transferred over to the Trust's new electronic Audit Management and Tracking System (AMaT). This will enable ward managers access to real time data giving greater oversight. A new process measure monitoring compliance with documenting key elements of the MCA/best interest record audit will be introduced to enable recognition where improvements are made as well as identifying areas for targeted improvement work.

2.3 Statements of assurance from the Board

2.3a Information on the review of services

During 2023/24 the Northern Lincolnshire and Goole NHS Foundation Trust provided and/or subcontracted 7 relevant health services. The 7 services are taken from the Trust's standard contract with the ICB as the "categories of service which the Provider is commissioned to provide under this contract". These are:

- A&E Services
- Acute Services
- Cancer Services
- Community Services
- Diagnostic, Screening and/or Pathology Services
- End of Life Care Services
- Urgent Treatment Centre Services

The 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 2023/24 represents 100% of the total income generated from the provision of relevant health and care services for 2023/24.

2.3b Information on participation in clinical audits and national confidential enquires

During 2023/24, 72 national clinical audits and 7 National Confidential Enquiries into Patient Outcomes and Deaths (NCEPODs) were listed in the Quality Accounts for completion. During 2023/24, 51 national clinical audits and 7 NCEPODs covered relevant health services that Northern Lincolnshire and Goole NHS Foundation Trust provides.

During that period the Trust participated in 50 (98%) of the national clinical audits and 7

(100%) of the NCEPODs. Whilst 2 projects were listed for completion at the beginning of the year, these were delayed by the national audit supplier and will commence in 2024/25. Both audits have been excluded from the Trust's overall participation rate.

Participation did not occur for 1 (2%) national clinical audit; the National Ophthalmology Database Audit as the audit data collection is expected to be via an automated Electronic Patient Record System such as Medisoft that the Trust does not have. Therefore, it was agreed through the Trust's Quality Governance Group not to participate in the audit as diverting clinical resources to collect the vast amount of data required manually would be an adverse risk to the quality of the service. Instead, it was agreed that a local audit project of cataract surgery covering the key standards would be undertaken in its place to allow some level of benchmarking in comparison to the published national audit data.

The tables below list all National Clinical Audits, Clinical Outcome Review Programmes and other national quality improvement programmes which NHS England advise Trusts to Participate in. It also provides a breakdown of those applicable to the Trust and participation details during 2023/24.

Table 1: National Clinical Audits

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
1.	Adult Respiratory Support Audit (BTS)	✓	✓	29	100%	Awaiting National Report
2.	BAUS Nephrostomy Audit	✓	✓	4	100%	Awaiting National Report
3.	Breast and Cosmetic Implant Registry	✓	✓	34	97%	Awaiting National Report
4.	British Hernia Society Registry	N/A	N/A	N/A	N/A	Delayed until 2024/25
5.	Case Mix Programme (CMP)	✓	✓	1338	On-going	Project still underway
6.	Child Health Clinical Outcome Review Programme (NCEPOD)	✓	✓	Please refer to Table 2	Please refer to Table 2	Please refer to Table 2
7.	Cleft Registry and Audit NEtwork (CRANE) Database	X	X	N/A	N/A	N/A
8.	Elective Surgery (National PROMs Programme)	✓	✓	514	78%	Awaiting National Report
9.	**Emergency Medicine QIPs:**					
	Care of Older People	✓	✓	231	115%	Awaiting National Report
	Mental Health (Self-Harm)	✓	✓	388	100%	Awaiting National Report

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
10.	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	✓	✓	186 (Cohort 5)	100%	Awaiting National Report
11.	**Falls and Fragility Fracture Audit Programme (FFFAP):**					
	Fracture Liaison Service Database (FLS-DB)	✓	✓	291	On-going	Project still underway
	National Audit of Inpatient Falls (NAIF)	✓	✓	5	On-going	Project still underway
	National Hip Fracture Database (NHFD)	✓	✓	533	100%	Awaiting National Report
12.	Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit]	✓	✓	468 (Cumulative)	100%	Action Planning
13.	Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	✓	✓	24	100%	Action Planning
14.	Maternal, Newborn and Infant Clinical Outcome Review Programme	✓	✓	25	On-going	Project still underway
15.	Medical and Surgical Clinical Outcome Review Programme	✓	✓	Please refer to Table 2	Please refer to Table 2	Please refer to Table 2
16.	Mental Health Clinical Outcome Review Programme	X	X	N/A	N/A	N/A
17.	**National Adult Diabetes Audit (NDA)**					
	National Diabetes Footcare Audit (NDFA)	✓	✓	89***	On-going	Project still underway
	National Diabetes Inpatient Safety Audit (NDISA)	✓	✓	8	On-going	Project still underway
	National Pregnancy in Diabetes Audit (NPID)	✓	✓	38	100%	Awaiting National Report
	National Diabetes Core Audit	✓	✓	1138	100%	Action Planning
18.	**National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme:**					
	a) COPD Secondary Care	✓	✓	535	On-going	Project still underway
	b) Pulmonary Rehabilitation	X	X	N/A	N/A	N/A
	c) Adult Asthma Secondary Care	✓	✓	174	On-going	Project still underway

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
	d) Children and Young People's Asthma Secondary Care	✓	✓	80	On-going	Project still underway
19.	National Audit of Cardiac Rehabilitation	✓	✓	1093	On-going	Project still underway
20.	National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	X	X	N/A	N/A	N/A
21.	National Audit of Care at the End of Life (NACEL)	✓	✓	40	On-going	Project still underway
22.	National Audit of Dementia (NAD)	✓	✓	243	100%	Awaiting National Report
23.	National Audit of Pulmonary Hypertension	X	X	N/A	N/A	N/A
24.	National Bariatric Surgery Registry	X	X	N/A	N/A	N/A
25.	National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	✓	✓	278 NABCOP	100%	Awaiting National Report
26.	National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	✓	✓	As Above	100%	Awaiting National Report
27.	National Cardiac Arrest Audit (NCAA)	✓	✓	74	On-going	Project still underway
28.	**National Cardiac Audit Programme (NCAP)**					
	National Adult Cardiac Surgery Audit (NACSA)	X	X	N/A	N/A	N/A
	National Congenital Heart Disease Audit (NCHDA)	X	X	N/A	N/A	N/A
	National Heart Failure Audit (NHFA)	✓	✓	397	On-going	Project still underway
	National Audit of Cardiac Rhythm Management (CRM)	✓	✓	312	On-going	Project still underway
	Myocardial Ischaemia National Audit Project (MINAP)	✓	✓	408	On-going	Project still underway
	National Audit of Percutaneous Coronary Intervention (NAPCI)	✓	✓	334	On-going	Project still underway
	National Audit of Mitral Valve Leaflet Repairs (MVLR) [estimated start date April '23]	X	X	N/A	N/A	N/A

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
	The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	X	X	N/A	N/A	N/A
29.	National Child Mortality Database (NCMD)	X	X	N/A	N/A	N/A
30.	National Clinical Audit of Psychosis (NCAP)	X	X	N/A	N/A	N/A
31.	**National Comparative Audit of Blood Transfusion**					
	2023 Audit of Blood Transfusion against NICE Quality Standard 138	✓	✓	67	84%	Awaiting National Report
	2023 Bedside Transfusion Audit	N/A	N/A	N/A	N/A	Postponed until March 2024
32.	National Early Inflammatory Arthritis Audit (NEIAA)	✓	✓	59	On-going	Project still underway
33.	National Emergency Laparotomy Audit (NELA)	✓	✓	221	On-going	Project still underway
34.	**National Gastrointestinal Cancer Audit Programme (GICAP)**					
	a) National Bowel Cancer Audit (NBOCA)	✓	✓	333	100%	Awaiting Publication of Results
	b) National Oesophago-Gastric Cancer Audit (NOGCA)	✓	✓	103	100%	Awaiting Publication of Results
35.	National Joint Registry	✓	✓	845	99%	Awaiting National report
36.	National Lung Cancer Audit (NLCA)	✓	✓	382	100%	Project still underway
37.	National Maternity and Perinatal Audit (NMPA)	✓	✓	3939	On-going	Project still underway
38.	National Neonatal Audit Programme (NNAP)	✓	✓	454	100%	Awaiting National report
39.	National Obesity Audit (NOA)	X	X	N/A	N/A	N/A
40.	National Ophthalmology Database (NOD) Audit*	✓	X	N/A	N/A	N/A
41.	National Paediatric Diabetes Audit (NPDA)	✓	✓	269	Ongoing	Project still underway

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
42.	National Prostate Cancer Audit (NPCA)	✓	✓	346	100%	Awaiting Publication of Results
43.	National Vascular Registry (NVR)	X	X	N/A	N/A	N/A
44.	Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	X	X	N/A	N/A	N/A
45.	Paediatric Intensive Care Audit Network (PICANet)	X	X	N/A	N/A	N/A
46.	Perinatal Mortality Review Tool (PMRT)	✓	✓	24	On-going	Project still underway
47.	Perioperative Quality Improvement Programme	✓	✓	67	100%	Ongoing
48.	**Prescribing Observatory for Mental Health (POMH)**					
	Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	X	X	N/A	N/A	N/A
	Monitoring of patients prescribed lithium	X	X	N/A	N/A	N/A
49.	Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	884	On-going	Project still underway
50.	Serious Hazards of Transfusion UK National Haemovigilance Scheme	✓	✓	17	100%	Awaiting National report
51.	Society for Acute Medicine Benchmarking Audit	✓	✓	70	On-going	Project still underway
52.	The Trauma Audit & Research Network (TARN)	✓	✓	478**	100%	See below**
53.	UK Cystic Fibrosis Registry	X	X	N/A	N/A	N/A
54.	UK Renal Registry Chronic Kidney Disease Audit	X	X	N/A	N/A	N/A
55.	UK Renal Registry National Acute Kidney Injury Audit	X	X	N/A	N/A	N/A

**Note: The Trust did not participate in the National Ophthalmology Database Audit as this is not a mandated audit under NCAPOP and data collection is expected to be via an automated Electronic Patient Record System such as Medisoft that the Trust does not have. Therefore, it was agreed through the Trust's Quality Governance Group not to participate in the audit as diverting clinical resources to collect the vast amount of data*

required manually would be an adverse risk to the quality of the service. Instead, it was agreed that a local audit project of cataract surgery covering the key standards would be undertaken in its place to allow some level of benchmarking in comparison to the published national audit data.

***The University of Manchester (UoM) switched off the TARN platform and allied resources, such as the TARN website, in June 2023 because of the cyber breach. The Trust continued to collect data locally using the nationally established dataset.*

****Scunthorpe General Hospital were unable to submit to the National Diabetes Footcare audit (NDFA) for 11 months of the 2023-2024 period due to accessibility issues. Scunthorpe General Hospital regained access to submit to the NDFA audit as of March 2024.*

Table 2: National Confidential Enquires

Programme / Workstream	Eligible for NLAG	NLAG participated	No. of cases submitted	Participation Rate	Outcome
Testicular torsion	✓	✓	7	100%	Action Planning
Juvenile Idiopathic Arthritis	✓	✓	2	100%	Awaiting national report
Community Acquired Pneumonia	✓	✓	4	57%	Action Planning
Chron's Disease	✓	✓	6	75%	Action Planning
Epilepsy: Hospital Attendance	✓	✓	7	100%	Action Planning
End of Life Care	✓	✓	12	100%	Awaiting national report
Endometriosis	✓	✓	16	100%	Awaiting national report

The reports of 20 National clinical audits were reviewed by the provider in 2023/24 and the Trust intends to take the following actions to improve the quality of healthcare provided:

National Audit Programme	Summary of some actions taken
National Maternity & Perinatal Audit	- Current leaflets relating to instrumental intervention & caesarean births reviewed to ensure information is in a language and format which is accessible and tailored to each birthing person's circumstances.
National Paediatric Diabetes Audit	- Dietician in post to ensure children receive a dietician review to educate children and young people with Type 1 diabetes from diagnosis around carbohydrate counting. - Increase clinic slots to ensure children & young people have at least 4 HbA1c measurements in a year, by managing cancelations and DNA rates.

National Audit Programme	Summary of some actions taken
Epilepsy 12	- Local epilepsy pathway to be implemented based on NICE guidelines to ensure eligible patients have an MRI performed within 6 weeks. - A QIP has been undertaken by the Medical Physics service to improve EEG referral requests to be carried out within 4 weeks of request. - Nurse in post to support mental health issues.
MBRRACE-UK Perinatal Mortality Surveillance	- All stillbirths are reviewed and a PMRT carried out for all deaths to assess care, identify and implement service improvements to prevent future similar deaths.
National Audit of Breast Cancer in Older People	- To introduce the Fitness assessment form for older patients.
National Audit of Care at the End-of-Life (NACEL)	- Relaunch the End of Life document and have an electronic version on WebV - Palliative Care Nursing service to provide a seven day service (8hours during the day) - QI project in progress and new bespoke training package launched.
National Joint Registry (NJR 2022)	- To improve compliance rate for consent taken by alerting trauma coordinators and pre assessment nurses of the possibility of gaining consent retrospectively. - Escalate to the S&CC business manager the number of cases at Goole where consent will be submitted as 'not recorded' and the potential result in the 2023 report if the patients aren't contacted retrospectively.
National Hip Fracture Database (NHFD 2022)	- Discussions with the trauma coordinators and the administrator (DPOW) about the collection and submission of data relating to several lower scoring standards. - The project lead at Scunthorpe to escalate to senior management the importance of having a designated ward for T&O patients as he believes that this is key to improving some of the results. - A business case to be written regarding the development of a dedicated geriatric team for the S&CC Division, either within the division or working with the Medicine Division.
BAUS Management of the Lower End in Nephroureterectomy Audit 21-22	- Review the 2 open cases to establish the reason for the longer length of stay and also the higher than average blood loss and present back to the group for learning.
Sentinel Stroke National Audit programme (SSNAP)	- Stroke Assessment Area to move from ED to within Stroke Unit to improve performance for patients being admitted to Stroke Unit within 4 hours of arrival to hospital. - Recruitment of 0.6 WTE SALT therapist to improve access to SALT therapies
Cardiac Rhythm Management (CRM) Audit	- All Pacing in AV blocks were reviewed by lead clinician to ensure accuracy / learn lessons where applicable. Findings discussed at a regional meeting to prove each case was acting in the patients best interests.
National Oesophageal Cancer Audit (NOGCA 2023)	- Set up a process whereby the UGI CNS staff create a spreadsheet / complete forms on all of the Oesophago-gastric cancer cases they encounter via an emergency admission to try and establish why the patient has presented as an emergency. - To review the patients records of those who were diagnosed following an emergency admission and present findings back to the group.
National Bowel Cancer Audit (NBCA 2022)	- A request should be made to NBOCA to identify the cases that have an unreversed stoma after 18 months so that these specific cases can be reviewed.

National Audit Programme	Summary of some actions taken
National Prostate Cancer Audit (NPCA 2022)	- Ask the cancer tracker to input performance status into Somerset from 2WW referral. - Recruit additional hours to the cancer tracking team to assist with submitting quality data.
ICNARC Case Mix Programme (2021-2022)	- To review the mortality cases for DPOW ITU and present results back to group for learning. - To undertake a review of late discharges from DPOW HDU and present results back to group for learning. - ICNARC Clinical Audit Officer to provide the doctors with a minimum set of criteria as per ICNARC standards that need to be documented in the notes. - DPOW ITU Manager to send the admission forms to SGH ITU Managers so they can order and roll the forms out on their units and both sites can start trialing.
National Emergency Laparotomy Audit (NELA) 2022	- Invite Sepsis CNS to attend an audit meeting to discuss on-going work in the trust around sepsis and prescribing antibiotics within an hour
COPD Audit	- Piloted daily in-reach to AAU & Respiratory wards to identify patients with COPD for review within 24hrs of admission
Fracture Liaison Service Database	- Fracture Liaison Nurse working directly with acute care, setting up a process where radiology also informs FL Nurse when Spinal fractures are identified.
Early Inflammatory Arthritis	- Implemented a small reduction on new and follow up clinic lists to facilitate improved performance for EIA patients against National Key Performance indicators
National Audit of Dementia	- Acute and Emergency Clerking forms amended to incorporate Delirium screen using 4AT. Agreement to mandate 4AT within the Emergency Department electronic system for patients over 75 with a NEWs score of 4 or below.

The reports of 18 local clinical audits were reviewed by the provider in 2023/24 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Local Audit Topic	Summary of some actions taken
Medical Documentation	- Attendance of Medical Defence Union at Medicine Quality and Safety/Audit Committee to discuss clinical documentation with examples if issues identified Nationally
Frailty in the ED Audit (CQUIN Pilot)	- Introduction of mandated Frailty Scoring within ED Electronic Systems for patients over 65yrs and implementation of Improved Frailty Pathway documentation to capture comprehensive geriatric assessment.
Local Version of National Ophthalmology Database Audit (NOD 2022-2023)	- Individual reports to be sent to the clinicians, reporting on VA Loss and PCR rate based on the operating surgeon.
Paediatric SEPSIS Audit	- Monthly data displayed on the ward to raise awareness. - SEPSIS E learning for all staff - SEPSIS discussed in the Nursing huddle and Dr's safety huddle daily to ensure patients on the ward have been screened. - SEPSIS communication tool to be introduced to aid SBAR. Credit card style awaiting to be approved and printed.

Local Audit Topic	Summary of some actions taken
Paediatric Early Warning Scoring	- The Monthly Dashboard is used to monitor the use of the PEWS Tool and presented at the Clinical Audit Meeting. - Areas of low compliance are displayed as standard of the month in the wards.
Paediatric Documentation	- Implementation of electronic documentation at DPOW, awaiting role out at SGH.
S&CC Documentation Audit 2021/2022	- To add where applicable to the "DNACPR status should be documented on admission" question to avoid cases being marked as non compliant when they weren't applicable. - Project lead to ask junior doctors to update the Web-V clinical handover every day with patient details to improve documentation for General Surgery.
Seven Day Hospital Services S&CC 2021/2022	- The group to discuss at the General Surgery Business Meeting the practicalities of trying to ensure that patients who have been admitted longest without a review are seen first on the ward round.
Intentional Rounding	- New weekly pressure ulcer review group commenced. To review documentation and embed changes for the pressure ulcer management pathways part of the audit. - Daily Stop & Check introduced to review documents and care by nurse in charge
Adult Nursing Documentation	- Electronic Nursing admission document currently being trialled at Goole and rolled out across the Trust once WebV3 introduced
MUST – Nutrition Risk Assessment	- Nutritional CNS to instigate weekly ward round. - Training package reviewed and delivered to all new staff both RN, NQN and HCA on induction.
Audit on efficacy of MatNeo tool in the prevention of reducing major PPH >1500ml	- Medical staff huddle to include the PPH protocol to ensure the Mat Neo is used for every patient and updated.
Seven day services (Gynae)	- Consultants to document post-take ward round to ensure patients are reviewed with 14 hours of admission.
Safe and Secure: Controlled Drug Monitoring and Storage	- Each area of non-compliance is incident reported and investigated, reviewed and actions taken by the ward/area manager. - Any trends are discussed at the Safer Medication group, and Pharmacy governance group and any lessons learnt will be shared via the safer medicines newsletter.
Safe and Secure: Controlled Stationary Monitoring and Storage	- Each area of non-compliance is incident reported and investigated, reviewed and actions taken by the ward/area manager. - Any trends are discussed at the Safer Medication group, and Pharmacy governance group and any lessons learnt will be shared via the safer medicines newsletter.
JAG Colonoscopy Audit	- Implement a trial of different bowel preparation, which will be reviewed on a monthly basis.
JAG Endoscopy Service 30-Day Mortality and 8-Day Readmission 2022	- Information services to adjust the coded section that the SQL Server collects data for the report from. This will provide some assurance that all of the patients who have an endoscopic procedure will be identified in the report.
JAG Trust wide flexible Sigmoidoscopy Audit	- After the EndoVault update in November all audit templates to be reviewed to ensure all data required is captured.

Local Audit Topic	Summary of some actions taken
Chest X-ray Quality Audit	- In order to improve chest radiograph positioning and centering feedback to radiographers regarding issues with chest positioning. Include image examples from the audit demonstrating incorrect technique. - Increase the radiographer comments for sub-optimal examinations by feeding back to radiographers the results of the audit and why examinations are needed.

The Trust takes part in the annual Learning Disability improvement standards audit that measures performance against the NHS improvement standards (2018). The aim of the standards is to ensure the provision of high quality, personalised and safe care for adults and children with learning disabilities and/or autism across England. The standards against which trust performance is measured are respecting and protecting rights, inclusion and engagement, workforce and specialist learning disability services, the first three are universal standards that apply to all NHS trusts, and the fourth is a specialist standard that applies specifically to trusts that provide services commissioned exclusively for people with a learning disability or autism. The audit consists of data collection around factors such as the percentage of patients admitted to the Trust with a learning disability in a 12 month period, reasonable adjustments that are provided to patients and audits carried out specifically into patient with a learning disability, In addition 50 staff and 100 patient surveys are sent out that were directly returned to NHSBN that look at factors such as waiting times in A+E, patient choice and carer engagement. Compliance with these standards demonstrates that a trust has the right pathways and resources in place to deliver high quality patient outcomes that people with a learning disability or autism, their families and carers deserve and expect. The timing of the audit changed in 2023 and therefore we are currently awaiting the results from 2022/23. For those areas where there is an identified gap the Trust has an improvement plan to address these, this will be updated following receipt of the report.

2.3c Information on participation in clinical research

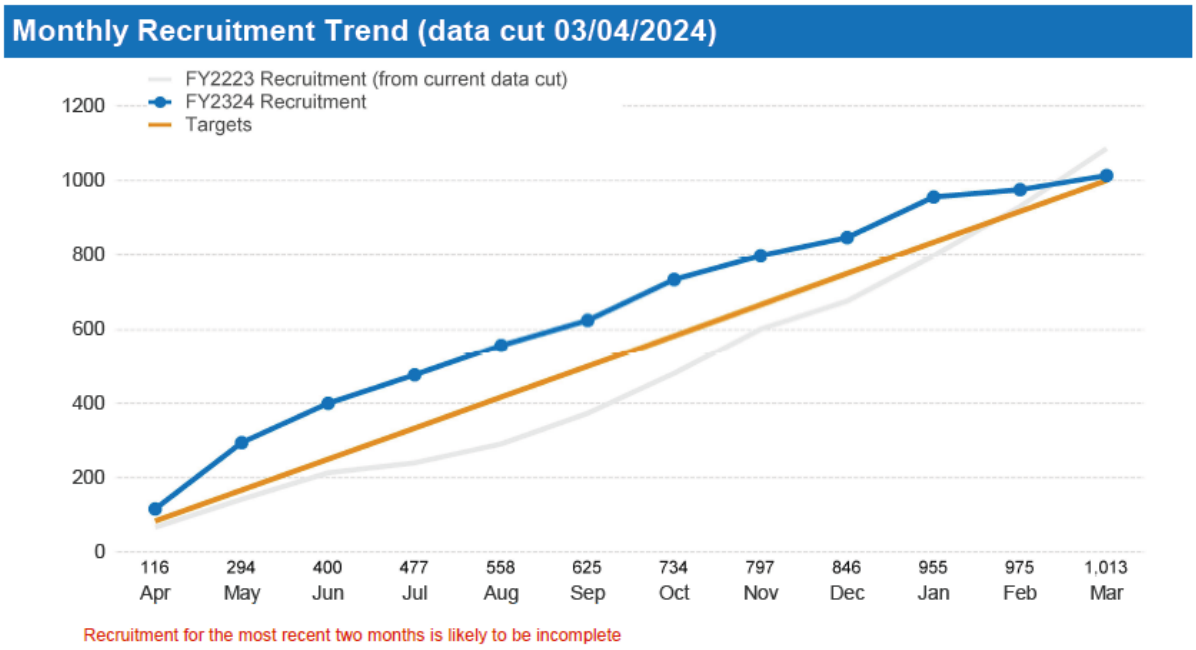
What is Clinical Research?

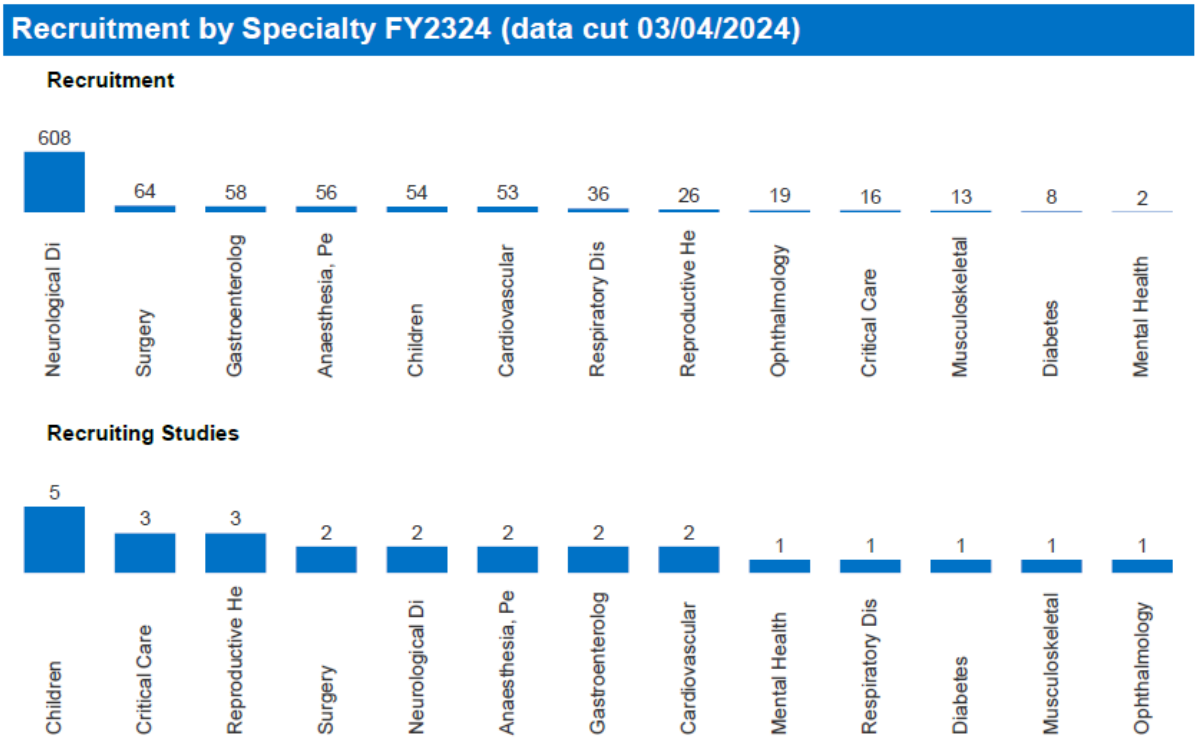
Clinical Research is an arm of medical science that establishes the safety and effectiveness of Medication, Diagnostics products, Medical devices, and Treatment regimens which may be used for the prevention, treatment, diagnosis of relieving symptoms of a disease.

'Todays Research is Tomorrows Treatment'

Participation in Clinical Trials

The number of patients receiving NHS services provided or sub – contracted by Northern Lincolnshire & Goole NHS Foundation Trust in 2023/2024 that were recruited during that period to participate in research approved by a research ethics committee or Health authority was 1034 and the target for the Trust was set at 1000.



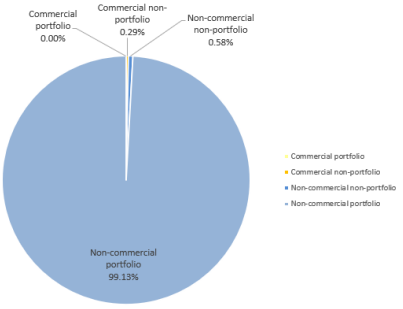


Commercial Trials

Over the last year we have had an imbalance of commercial trials that we had hoped for within the Trust. We have recruited very well into non-commercial trials and the National Institute for Health and Care Research (NIHR) Portfolio trials.

We would like to concentrate as a Trust into building up our commercial portfolio, this will be noted in the next financial report.

Project Type	Recruitment
Commercial portfolio	0
Commercial non-portfolio	3
Non-commercial non-portfolio	6
Non-commercial portfolio	1025
Total:	1034



Participation in Research Patient Survey

PRES Target	PRES Total	PRES % Tar...	Q1	Q2	Q3	Q4
43	54	125.58%	7	16	19	12

The NIHR Clinical Research Network asks thousands of patients that take part in research to share their experiences of taking part in a clinical trial. The Participant in Research Experience Survey (PRES) aims are to place participation and experience in research at the heart of research delivery. Responses from our research patients have highlighted through the years we have taken part that we have improved year on year. This year's responses to date are no exception we have 97% of our patients feel they are fully prepared for their research experience with NLAG research staff and feel valued when taking part in NLAG research. The patients gave 100% as they felt they were treated with courtesy and respect by the NLAG research staff. The patients that took part in research have said that they would consider taking part in research again 97%.

Celebrating Research Success
Paediatric Research Nurse has managed to achieve great success with her trials and has managed to recruit her first patient into a commercial trial called M21-572. We now have a Research Midwife who is proceeding to make good progress within the Obstetrics and Gynaecology team. We are as a Trust currently supporting the set-up of the Born and Bred in (BABi) this study originated from the Bradford Teaching Hospitals Trust. This study is a data linkage birth cohort study supporting the review of to the health and well being of families across our region. The study offers fantastic potential to assess the contributing factors of childhood disease, assess the impact of migration, explore the influences of pregnancy and childbirth on subsequent health and generate future research work that has potential to improve the health for some of our most disadvantaged within our region and society. The Trust are looking to work with maternity services and external partners in North Lincolnshire, North East Lincolnshire and East Yorkshire. This will enable us to maximise the benefits of cohort work.

Research and communications and engagement strategy
The Research Department are now collaborating with HUTH and providing information with regards to a Newsletter. We do promote research through social media page within the Trust and this is accessible to the patients who live in the community. We promote research within the Trust on the internal and external internet.

Black Asian and Minority Ethnic (BAME) and Research Trials
The Trust are looking at how best we can provide opportunities to engage BAME and socially deprived communities in research participation.

Partnerships: Hull University Teaching Hospitals NHS Trust
The Research departments of both Northern Lincolnshire & Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust at both Hospitals have commenced dialogue as to how we can pool resources, expand research programmes across sites and streamline the governance processes

2.3d Information on the Trust's use of the CQUIN framework

The Commissioning for Quality and Innovation (CQUIN) framework is about improving the quality of healthcare. Commissioners reward excellence by linking a proportion of income to the achievement of locally set and agreed improvement goals. These goals are embedded into contracts and are essential for the implementation of National Institute for Health and Care Excellence (NICE) Quality Standards, resulting in improved patient care, experience, and improvements against outcomes.

Use of the CQUIN payment framework
A proportion of the Trust's income in 2023/24 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement, or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

For 2023/24 the requirement for national ICB CQUINs was to report on all applicable CQUINs but also choose 5 schemes, for each contract, that would have a financial value attached.

The breakdown of the National CQUIN indicators is based on 1.25% of contract value. Funding was given to the Trust based on the assumption that the Provider would achieve full compliance with the applicable CQUIN Indicators and would therefore earn the full 1.25% value.

National CQUIN schemes 2023/24 for ICBs include:

- Flu vaccinations for frontline healthcare workers (Non-financial)
- Supporting patients to drink, eat and mobilise (DrEaMing) after surgery (Financial)
- Compliance with timed diagnostic pathways for cancer services (Non-financial)
- Prompt switching of intravenous to oral antibiotic (Non-financial)
- Identification and response to frailty in emergency departments (Financial)
- Timely communication of changes to medicines to community pharmacists (Financial)
- Recording of NEWS2 score, escalation time and response time for unplanned critical care services (Financial)
- Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway (Non-financial)
- Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery (Financial)
- Assessment and documentation of pressure ulcer risk (Financial)
- Assessment, diagnosis and treatment of lower leg wounds (Financial)

NHS England Specialised Services (NHSE):
The Trust receives a CQUIN value of 1.25%. The CQUIN payment was based on the block contract value: however, CQUIN is not payable on high-cost drugs, devices, listed procedures identified in the National Payment System and all other expenditure contracted on "pass through" basis.

The NHSE specialised schemes of 2022/23 include:

- Shared Decision Making (SDM) conversations (Financial)

The Trust has achieved the highest performance to date with the full CQUIN programme. Of the 6 financially incentivised CQUINs, 5 have exceeded the maximum targets. The assessment and documentation pressure ulcer risk assessment CQUIN did not achieve the full target but did exceed the minimum target and was within the payment range. Operational pressures impacting on completing the risk assessments within 6 hours of admission remains a challenge and will be taken forward in 2024/25 with the introduction of electronic risk assessments.

For the non-financial CQUINs, the Trust exceeded the maximum target for 3, showed improvement over each quarter for 1 and has not achieved the target for 1. There has been a national apathy towards vaccinations which has contributed to the under performance. The biggest improvement was seen in the non-financial CQUIN13 (Assessment, diagnosis and treatment of lower leg wounds) which achieved 39.43% in Q4 compared to 18.33% in Q1.

Key	
	Maximum target achieved or exceeded
	Minimum target achieved
	Target not achieved

Indicator	Financial / Non-financial	Min	Max	Q1	Q2	Q3	Q4	Full year performance
CQUIN01 Flu vaccinations for frontline healthcare workers	Non-financial	**75%**	**80%**	**N/A**	**N/A**	**27.27%**	**26.55%**	
CQUIN02 Supporting patients to drink, eat and mobilise (DrEaMing) after surgery	Financial	**70%**	**80%**	**83%**	**93%**	**98%**	**92.5%**	
CQUIN03 Compliance with timed diagnostic pathways for cancer services	Non-financial	**35%**	**55%**	**76.3%**	**74.2%**	**68.3%**	**64.1%**	
CQUIN04 Prompt switching of intravenous to oral antibiotic (Target: Lower is better)	Non-financial	**60%**	**40%**	**32%**	**37%**	**38%**	**33%**	

Indicator	Financial / Non-financial	Min	Max	Q1	Q2	Q3	Q4	Full year performance
CQUIN05 Identification and response to frailty in emergency departments	Financial	**10%**	**30%**	**67.51%**	**68.51%**	**69.10%**	**70.44%**	
CQUIN06 Timely communication of changes to medicines to community pharmacists	Financial	**0.5%**	**1.5%**	**1.07%**	**1.53%**	**1.46%**	**1.57%**	
CQUIN07 Recording of and response to NEWS2 score for unplanned critical care admissions	Financial	**10%**	**30%**	**61.53%**	**72.41%**	**76.92%**	**73.27%**	
CQUIN10 Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	Non-financial	**80%**	**85%**	**92.30%**	**90%**	**92.85%**	**83.33%**	
CQUIN11 Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	Financial	**65%**	**75%**	**N/A**	**83%**	**N/A**	**83%**	
CQUIN12 Assessment and documentation of pressure ulcer risk	Financial	**70%**	**85%**	**80%**	**81.37%**	**71.05%**	**72.54%**	
CQUIN13 Assessment, diagnosis and treatment of lower leg wounds	Non-financial	**25%**	**50%**	**18.33%**	**26.43%**	**38.98%**	**39.43%**	

2.3e Information relating to the Trust's registration with the Care Quality Commission

Northern Lincolnshire and Goole NHS Foundation Trust is registered with the Care Quality Commission for the provision of a number of regulated activities at three locations managed by the Trust. The Trust had a Trust wide inspection in 2019 and 2022 and a service level inspection in 2023 for Maternity at the Goole Midwifery Led Unit.

The Care Quality Commission has not taken enforcement action against the Trust during 2023/24. The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reported period.

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

	Safe	Effective	Caring	Responsive	Well-led	Overall
Trustwide	**Requires Improvement** ↑ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Good** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022
Diana Princess of Wales Hospital	**Requires Improvement** ↑ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Good** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022
Goole District Hospital	**Good** ↑ Feb 2024	**Good** ↔ Nov 2022	**Good** ↔ Nov 2022	**Good** ↑ Nov 2022	**Requires Improvement** ↔ Feb 2024	**Good** ↑ Nov 2022
Scunthorpe General Hospital	**Requires Improvement** ↑ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Good** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022
Overall Trust	**Requires Improvement** ↑ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Good** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022	**Requires Improvement** ↔ Nov 2022

The Trust underwent a Care Quality Commission inspection in June and July 2022, with the visit report published in December 2022. Arising from that inspection the Trust retained its overall rating of 'Requires Improvement' although significant improvements were noted. The Trust received a rating of 'Good' for the 'caring' domain and for Goole District Hospital overall. A 'Requires Improvement' rating was given for the: 'safe', 'effective', 'responsive', 'use of resources' and 'well-led' domains. The Trust underwent a focused maternity inspection for the Goole Midwifery Led Unit in November 2023, the findings of which helped to retain the overall 'Good' rating for Goole Hospital.

Following the last Trust wide inspection report in 2022, the Trust amended the action plan rating system to an assurance based system, meaning that actions would no longer be rated blue/green/amber/red to language in line with Recovery Support Programme and uses these ratings for all CQC action plans:

Full assurance	Evidence of embedded and sustained improvement
Significant assurance	Evidence of improvement and the improvements becoming embedded, but yet to be sustained
Moderate assurance	Some evidence of improvement but this has yet to be embedded and sustained
Limited assurance	Limited evidence of improvement and limited evidence of the improvements being embedded or sustained
No assurance	No evidence of improvement

A monthly report provides detail and assurance on progress for the Trust's action plan and is presented at the following Committees-in-Common with Hull University Hospitals NHS Trust: Quality and Safety, Workforce, Education & Culture and Performance, Estates and Finance.

At the time of writing in March 2024, the Trust had 122 CQC actions on the combined plan.

- 30 rated **full assurance**
- 32 rated **significant assurance**
- 45 rated **moderate assurance**
- 15 rated **limited assurance**
- Zero rated **no assurance**

Of these actions rated full assurance, 23 have been submitted to the CQC with details of how assurance has been attained and the action has been met.
In April 2024, following the move to a group structure with Hull University Teaching Hospitals NHS Trust, a full review of the action plan commenced to align actions with new care groups. The action plan was refreshed and some actions that had been closed have been removed. Four additional actions were included that had arisen form the latest Goole Midwifery Led Unit inspection. This has resulted in a much more focused action plan with fewer number of actions for monitoring.

The the Trust has in place a quarterly review of all closed CQC actions. If assurance is obtained that the actions remains embedded the action remains closed, if sufficient evidence isn't available or the action lead has identified a deterioration in performance then the action will be re-opened. This process provides assurance that actions previously considered to be completed are still embedded.

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

2.3f Information on Quality of Data

Northern Lincolnshire and Goole NHS Foundation Trust submitted records during 2023/24 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 (as of April 2024) which included the patient's valid NHS Number was:

- 99.76 % for admitted patient care
- 99.97 % for outpatient care
- 99.39 % for accident and emergency care.

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

- 100 % for admitted patient care
- 100 % for outpatient care
- 100 % for accident and emergency care.

2.3g Information governance assessment report

The Information Governance Data Security and Protection Toolkit (DSPT) is part of the Department of Health's commitment to ensuring the highest standards of information governance. It allows organisations to measure their compliance against legislation and central guidance and helps identify any areas of partial or non-compliance.

It remains Department of Health and Social Care policy that all organisations that process NHS patient information provides assurance via the IG Toolkit and is

fundamental to the secure usage, sharing, transfer, storage, and destruction of data both within the organisation and between external organisations. The Trust are currently working on the current version of the DSPT which was launched July 2023. The submission deadline for the 2023/2024 DSPT Assessment is the 30th June 2024.

The 2022/23 Version of the DSPT was released in July 2022, with an initial baseline assessment date of the 28 February 2023 followed by the final submission of the 30 June 2023. The current status for Northern Lincolnshire and Goole Hospitals NHS Foundation Trust following submission of the 22/23 DSPT was Approaching Standards.

As of March 2023, there was 1 action remaining on the improvement plan. Responses to this action will be captured in the 2023/24 return. The remaining action is detailed below, at the time of submission the Trust reported 90% of staff had completed their mandatory Data Security Training with the Toolkit year.

22/23 DSP ref	2020/21 DSPT Evidence Item Text
3.2.1	Have at least 95% of all staff, completed their annual Data Security Awareness Training?

2.3h 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.

To provide coding quality assurance Northern Lincolnshire & Goole NHS Foundation Trust audited a sample of just over 200 Finished Consultant Episodes (FCEs - the time a patient spends under the continuous care of one care professional) for the period April 2023 – March 2024. A regular programme of individual coder audits conducted by NHS England approved Clinical Coding Auditors is in place. Established coders are audited every 12 months, novice and trainees coders are audited every 3 to 6 months.

Using the Data Security and Protection Toolkit Attainment Levels for Clinical Coding in an Acute Trust (table below) the Trust's coding sample achieved the level of Standards Exceeded. The Trust will continue a rolling programme of yearly audits for all Clinical Coding staff throughout 2024/25.

Data Security and Protection Toolkit Attainment Levels for Clinical Coding in an Acute Trust

	Level of Attainment	
	Standards Met	Standards Exceeded
Primary Diagnosis	>=90%	>=95%

Secondary Diagnosis	>=80%	>=90%
Primary Procedures	>=90%	>=95%
Secondary Procedures	>=80%	>=90%

Trust coding sample results

Date	Primary diagnosis %	Secondary diagnosis %	Primary procedure %	Secondary procedure %	FCEs	Number of case notes examined
April 2023-March 2024	96.06%	98.32%	97.35%	94.54%	203	164

2.3i Learning from Deaths

During 2023/2024, 1,796 of Northern Lincolnshire & Goole NHS Foundation Trust's patients died in hospital as an inpatient. In addition to this, 256 deaths occurred in ED or were dead on arrival and there were 16 still births. The inpatient deaths comprised of the following number of deaths which occurred in each quarter of that reporting period:

- 471 in the first quarter
- 365 in the second quarter
- 450 in the third quarter
- 510 in the fourth quarter

As at the 1st April 2024, 1,793 have been reviewed by the Medical Examiners, 141 have had a Structured Judgement Review (SJR) and 3 have been subject to a serious incident investigation. There were no cases which were subjected to both a SJR and a serious incident investigation. The number of deaths in each quarter for which an SJR or a serious incident investigation was carried out (as of 1st April 2024) was:

- 48 in the first quarter
- 26 in the second quarter
- 29 in the third quarter
- 38 in the fourth quarter

6 representing 0.3% 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:

- 2 representing 0.20% for the first quarter.
- 1 representing 0.06% for the second quarter.
- representing 0.15% for the third quarter.
- 0 representing 0% for the fourth quarter.

These numbers have been estimated using the 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 SJR completed that identifies that further understanding is needed is subject to a second independent review. 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.

Summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified during 2023/24

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 2023/24

And,

An assessment of the impact of the actions taken by the Trust during 2023/24:

Following on from the success of the introduction of the Medical Examiner Service at the Diana Princess of Wales Hospital site in April 2021 the Trust expanded the service in July 2022 to include Scunthorpe General Hospital and all Emergency Department non-coronal deaths. The service now has full establishment with 1.2 whole time equivalent Medical Examiners comprising of 9 Medical Examiners and 4 full time equivalent Medical Examiner Officers. This is an invaluable service that oversees and scrutinises the quality of care for patients who die during admission. The benefits of the service for the families or carers are likely to be the most impactful as the service provides clarity, dissipates doubts, and helps to alleviate negative thoughts and experiences the families or carers may be experiencing. Providing a voice to the bereaved at this most difficult of times is critically important and rewarding. It allows them to make significant improvements in what happens after death, including identifying areas for improvement as well as highlighting good practice. The service ensures a correct and accurate cause of death is registered and appropriate deaths are referred to the coroner.

Representatives from the Medical Examiners attend the Trust’s Mortality Improvement Group and share a case review for learning bi-monthly. The Trust has invested in a bespoke module for SystmOne to allow primary care to refer deaths to the Medical Examiner Service for review. This will facilitate more robust scrutiny of community deaths.

In November 2023, the Trust transitioned onto a new electronic Audit Management and Tracking (AMaT) system which has a Mortality and Morbidity Review (MaMR) module for completing SJRs. This system was to replace the previous, SJR Plus System, provided by NHS England that had proved problematic resulting in a backlog of SJRs. The new system has gained positive feedback from users and engagement with timely completion of SJRs, clearing the backlog of SJRs.

The Trust is committed to continuously learning from deaths to improve the quality of care provided to patients, their families, and carers. The following learning themes have been identified in 2023/24:

- Incomplete or poor-quality documentation in Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) documents.
- Missed opportunity for recognition of End of Life (EOL) pathway at earlier stage.
- Lack of anticipatory care planning.
- Quality of inpatient Medical/Nursing Documentation.

Actions implemented to address areas for improvement include:

- The divisional Doctors Induction has been updated to include an early introduction to ReSPECT and End of Life.
- Recognition and care planning are included in training delivered by the specialist End of Life team with different options of training delivery offered to improve compliance, including face to face, virtual training and targeted sessions.
- A training video for doctors to help recognition of End of Life pathway at an earlier stage has been recorded and a tiered approach to training is in development.
- A questionnaire for Medical staff has been launched to further understand the barriers to early recognition of End of Life and decision making to stop active treatment.
- The palliative care consultant at SGH has been attending the Medicine Quality and Safety/Audit Committee to provide ReSPECT training.
- The General Medicine Council (GMC) attended the medicine Division's Quality Safety meeting and provided a very detailed presentation in relation to Clinical Documentation.
- The implementation of the 7-day Specialist Palliative Care Clinical Nurse Specialists commenced on 1 August 2023.
- The Bluebell model fully rolled out across the trust in all 3 acute sites with good evidence of how individual elements impact on patient care being documented in the Care in the Last Days of Life document.
- Introduction of electronic referrals to the End of Life team via WebV introduced.
- Collaboration with chaplaincy and voluntary services continues.
- Re-design of the Family Voices Diary to improve compliance.
- The care in the last days of life document was electronically rolled out Trust wide significantly increasing completion compliance.
- End of Life champions are in place within ward areas.
- The Mental Capacity Act/Deprivation of Liberty Safeguards team have been providing additional training and support to staff to improve compliance and quality of mental capacity assessments and best interest forms.
- An End of Life staff survey was launched to help understand the challenges and areas of focus.
- There has been successful recruitment of three additional specialist Palliative care clinical nurse specialists and an End of Life practice educator.

- Work has been completed to help improve the level of communication in our discharge summaries around DNACPR decisions and ceiling of care recorded on ReSPECT forms.
- A patient and carer survey has been developed with support from Healthwatch to further understand patient and family experience related to end of life/palliative care communication.

2.3j Details of ways in which staff can speak 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 several 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 (FTSU).
  - Via the Human Resources Department, a part of the Trust's People Directorate.
  - Logging an incident on the Trust's incident reporting tool hosted on Ulysses.

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 widely publicised to all. Feedback shows staff would feel safe to speak up again.

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.

In October 2023, the Guardian began a recruitment campaign for colleagues to volunteer to become 'Speak Up Champions', this role will support the work of the Guardian as they will be available for colleagues to speak to, raise awareness of the Guardian and will be able to signpost to appropriate support services. Champions had to complete an application and have line manager support, so that they will be given the time to be actively involved in making speaking up, business as usual. Champions will not take on any cases. The development of Champions is something that the National Guardian's Office recommend to support the work of the FTSU Guardian. All Champions must complete recognised NGO/HEE Speak Up, Listen Up and Follow Up modules to increase their awareness and also undertake National Guardian Office Champions Training. To date (March 2024), there are 15 Champions trained. The Guardian will continue to advertise the role as part of their Communications strategy.

In February 2023, the Trust formally adopted the Freedom to Speak Up Policy and Process for the NHS, which was developed by the NGO and NHSE with a recommendation that all Trusts adopt it. The Policy has been amended to include relevant Trust contacts. 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 the Director of People (who is the Executive Sponsor) 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 HR business partners. This information now forms part of the Divisions performance review meetings and information and can be used in conjunction with other HR intelligence data to highlight potential areas for further analysis.

During 2022/23 there was a significant increase in concerns raised with 220 cases brought to the Guardian. This figure has already been exceeded for 2023/24 and is expected to be over 300. The latest staff survey results indicate an increased confidence in staff being able to raise concerns either clinical or about anything else to the organization and an

increase in confidence that the organization will address issues.

The FTSU Guardian has produced an annual progress report against the Trust's Freedom To Speak Up Strategy 2020-2024 which looked at the objectives set out in the strategy, progress made against them, and if additional actions are required to fulfil them. It is hoped that most objectives set out in the strategy will be met by 2024 and no additional actions were identified at this stage.

Future workstreams for the FTSU Guardian in 2024/25 include working with HUTH FTSU Guardian to produce a Group 'Freedom To Speak Up' strategy, and alignment of reporting themes for consistency of reporting. As we are two sovereign organisations, submission of data to the National Guardians Office will be separate and the Guardians will support employees of their respective organisations, this is in line with National Guardian Office requirements.

2.3k Information about the Guardian of Safe Working Hours

The 2016 national contract for junior doctors encouraged stronger safeguards to prevent doctors from working excessive hours. With this came the introduction of a 'Guardian of Safe Working Hours' in organisations that employ, or host, NHS doctors and dentists in training to oversee the process of ensuring they do not work excessive hours with inadequate breaks. The contract has stipulations on the length and frequency of shifts as well as rest breaks.

Exception reporting is a valuable instrument that provides up to date information regarding pressure points in the system. It ensures safe working hours and improves the morale of doctors in training, the quality of medical training and patient safety. It is also the agreed contractual mechanism for ensuring that trainees are paid for all work done.

The Guardian of Safe Working will support safe care for patients through protection and prevention measures to stop doctors working excessive hours. The Guardian of Safe Working oversees the exception reporting process and has the power to levy financial penalties where safe working hours are breached. The role sits independently from the management structure, and the Guardian is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and / or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe.

The safety of patients is a paramount concern for the NHS and for us as a Trust. Staff fatigue is a hazard to both patients and staff. The safeguards for working hours of doctors in training are outlined in the TCS and are designed to ensure that this risk is mitigated, and that this mitigation is assured.

There are no trainees within the Dentistry service at the Trust and so the Annual Report applies only to doctors in training. Fill rates for doctors in training at the Trust continue to be high, over 80%, which has helped with rotas, working hours, and ensuring access to

educational opportunities.

Rota design and co-ordination currently sits within the Workforce Resource Centre. This provides oversight of rota design and ensures that the terms and conditions of service as per the Junior Doctors Contract are met within that design.

Data Analysis
Number of training posts (total): 317.98
Number of doctors in training posts: 315.44 (includes 243.24 doctors in training programmes and 72.2 doctors in trust grade positions)
Number of training post vacancies: 2.54
Number of LTFT trainees: 52

The table below, provides a breakdown by specialty of the total number of exception reports received during the period April 2023 to March 2024.

Directorate	Total number of exceptions submitted	Number of trainees Per Area	Reports per trainee (2023/24)	Reports per trainee (2022/23)
Surgery and Critical Care	27	65	0.42	0.7
Family Services	40	59	0.68	0.3
Medicine	158	128	1.2	1.7
Grand Total	**225**	**252**	**-**	**-**

The number of immediate safety concerns received this year had decreased - 9 of the 225 reports received highlighted an immediate safety concern this year, in comparison with 25 of 252 reports the previous year. This ratio of immediate safety concerns to overall reports highlights that the system is being used appropriately and isn't just being used as a last resort when things are unsafe. This is a reassuring finding which we hope to see continue.

The majority of the reports received concern excess hours worked. The reason for this is likely to be that it is an easily recognisable incident which can be quantified, and thus is more likely to be reported. There appears to be an increase in the number of reports submitted in July and August, which is to be anticipated owing to the Junior Doctors rotating jobs. This usually settles down as the doctors, in particular the foundation year one doctors, become more familiar with their roles and therefore more efficient and less likely to need to stay after hours. There has been a high rate of reporting for excess hours during January and February, this is in keeping with what has been experienced in previous years and is likely to be due to a combination of winter pressures and staff sickness. It is reassuring to see that the impact of the consultant strikes seems to have been fairly minimal, with lower levels of reporting for lack of support during service commitments in the strike months of September and October.

The Trust was granted £60,000 of national money in 2021 to improve facilities for doctors in training and working in partnership with the doctors this has now been used to upgrade the doctors rest facilities and enhance the doctor's mess. This work has now been completed, and upgraded rest areas are available on both sites.

Fill rates remain high but this does not always translate in the reduction in need for locums and further work at Directorate level is required to understand the demands for locums, with the aim to reduce the reliance on locum doctors.

There have been no fines imposed for breaches of the Doctors in Training Contract. These fines were imposed for doctors missing breaks, and for excessive working hours. All money previously generated through fines has been spent on wellbeing resources to benefit the Doctors in Training.

This past year continued to see an improvement in engagement with our doctors in training. We will continue to build on this during the next academic year.

The Guardian of Safe Working holds monthly Junior Doctor Forums (JDF). Issues addressed at the JDF over the past year have included:

- Rota concerns
- Working conditions
- Locum pay
- Mandatory training requirements

There is a defined slot at the JDF to discuss quality improvement and there is a dedicated point of contact within the quality improvement office to support the Junior doctors.

The Guardian of Safe Working circulated a survey in the last quarter of the year. This showed that the role is well embedded in the trust, and the Junior Doctors felt able to approach the Guardian for help when needed. The role is held in positive regard, which we hope will continue in the coming years.

2.4 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. However, due to the impact of COVID-19 some national data collection was paused leading to delays in publication. Consequently, to retain consistency and to comply with the national guidance the tables within the report have been populated with the latest published data that is available from NHS Digital. Where appropriate the narrative provides a local update.

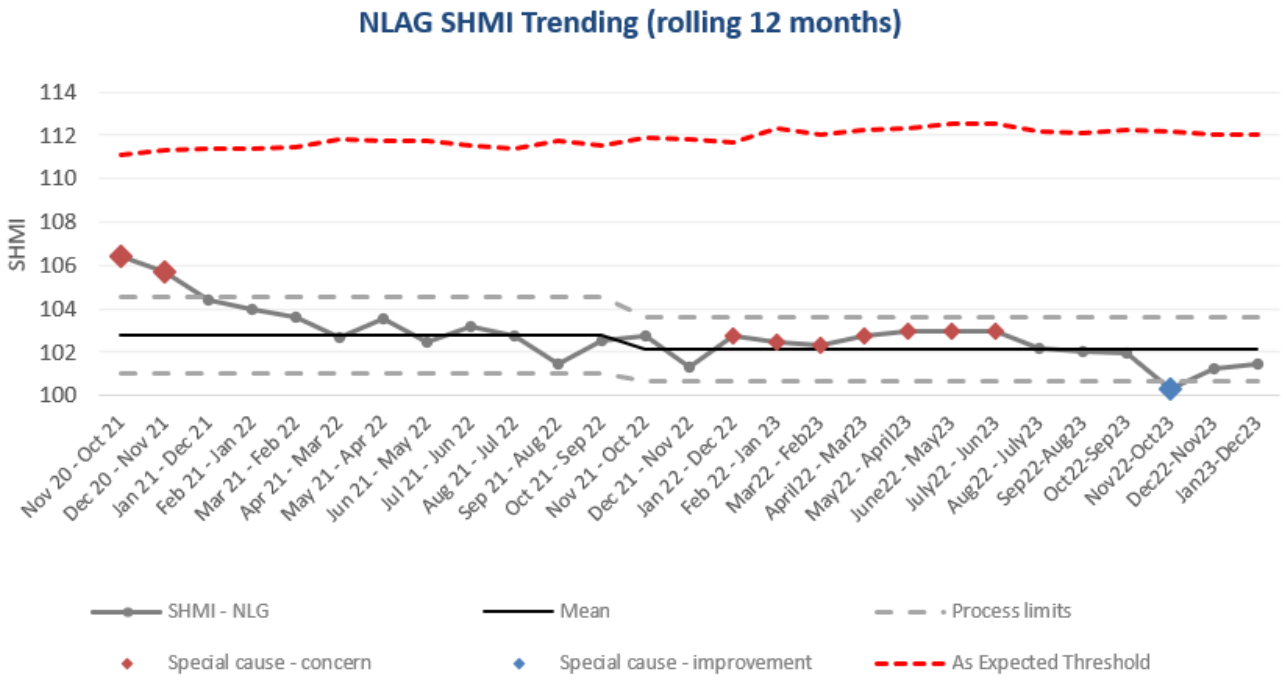
For each indicator, the number, percentage value, score, or rate (as applicable) for the last two reporting periods as well as the lowest and highest values and national average for each indicator for the latest reporting period will be represented in table format below. Some of the mandatory indicators are not relevant to Northern Lincolnshire and Goole NHS Foundation Trust; therefore, the following indicators reported on are only those relevant to

the Trust.

2.4a Domain 1 – Preventing people from dying prematurely

Indicator	Trust value Jan 2022 – Dec 2022	Trust value Jan 2023 – Dec 2023	NHS (England) Jan 2023 – Dec 2023	National highest Jan 2023 – Dec 2023	National lowest Jan 2023 – Dec 2023
The value of the SHMI for the Trust for the reporting period*	1.03	1.01	1.00	1.25	0.72
The banding of the SHMI for the Trust for the reporting period*	2 (as expected)	2 (as expected)	2 (as expected)	1 (higher than expected)	3 (lower than expected)
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period*	23%	23%	42%	67%	16%

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of- interest/hospital-care/quality-accounts). *Reporting period January 2021 to December 2022



- 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'. The rolling 12-month SHMI value for the Trust for the period January 2023 – December 2023 was 101.14.

- 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 continues 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.

- 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. Planned increase in consultant capacity is on hold in both North Lincolnshire and North East Lincolnshire currently due to changes in allocated funds. Next steps regarding medical staffing are being considered through the Northern Lincolnshire Strategy Group.

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:

- Clinician led coding validation sessions and mortality screening reviews have continued throughout 2023/24.
- Education around requirements to complete Co-morbidities sheet to be completed.

- Education to clinicians regarding coding rules supported by appropriate phrasing guide.
- Fracture of neck of femur, reintroduced dedicated ward at SGH.
- Teaching sessions and case study presentations have been shared at Divisions Quality & Safety meetings to share learning and reduce coding errors.
- The Trust is taking a pro-active approach to monitoring outcome risk of death for each SHMI diagnosis group and undertakes deep dive work with case reviews to learn from any early warning indicators to prevent future outlier alerts.
- Quality Summit packs created triangulating information from NICE, GIRFT, National Audits and Model Hospital identifying areas of good practice and areas for improvement.
- Referral for Gastrointestinal Bleed under review.
- Education for Junior Doctors on the appropriateness of referring patients with suspected Gastrointestinal Bleed.
- The 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.
- Implementation of 7-day Specialist Palliative Care commenced at SGH on 5 August 2023 utilising single point for WebV referral. Collaborative working with Care Plus Group enabled electronic referrals to the End of Life team to be rolled out at DPoW in October 2023.
- Successful recruitment of three additional specialist Palliative care clinical nurse specialists and an End of Life practice educator.

2.4b Domain 3 – Helping people to recover from episodes of ill health or following injury

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 *(Not applicable as no longer performed by the Trust)*

The PROMs is a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. The table shows 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). As participation is voluntary, patients can choose not to participate in PROMs.

Type of surgery	Sample time frame	Trust adjusted average health gain	National average	National highest	National lowest
Hip replacement (Primary)	April 2020 – March 2021	0.410	0.472	0.574	0.393
	April 2021 – March 2022	0.465	0.462	0.534	0.375
Knee replacement (Primary)	April 2020 – March 2021	0.334	0.315	0.399	0.181
	April 2021 – March 2022	0.288	0.324	0.417	0.245

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)

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

The data period of April 2020 – March 2021 was during the peak of the COVID-19 pandemic and this resulted in some activity being cancelled altogether and limited restoration for the remainder of the period, the number of modelled records more than halved from the previous year. Also, some lower risk patients were transferred to the independent sector which would likely influence the Trust's average patient reported outcomes scores.

Patient-reported outcomes following primary knee and hip replacement surgery are within the statistically calculated confidence intervals for EQ-5D measures.

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 presented at the Quality Governance Group and also the Quality and Safety Committee.
- Some lower risk patients were transferred to the independent sector to help reduce waiting lists.
- To improve participation rates, the process for handing out the questionnaires should be the same across the Trust so patients who are pre-assessed at one site and then have surgery at another won't be missed. A trial is taking place at DPOW for the ward clerk to hand out the pre-operative questionnaires on the day of the patient's surgery which will mirror the current process at GDH.

Patients readmitted to a hospital within 30 days of being discharged

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

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

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

Indicator	Trust value April 2021 – March 2022	Trust value April 2022 – March 2023	National average	National highest	National lowest
Percentage of patients aged between 0 to 15 readmitted to a hospital within 30 days of being discharged.	12.4	14.9	12.8	302.9*	3.7
Percentage of patients aged 16 or over readmitted to a hospital within 30 days of being discharged.	12.1	12.6	14.4	46.8	2.5

**The score of 302% is considered an anomaly. The next highest data presented by NHS Digital is 37.9%.*

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

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

The Trust is below the England average for readmissions in patients aged over 16 years. This is borne out by local performance reporting against peer benchmarked data.

The Trust is above the England average for readmissions in patients aged between 0 to 15. This is thought to be a data quality issue relating to ward attenders following treatment from the Hospital at Home team being coded incorrectly as readmissions.

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.
- Patient flow and discharge workstreams continue in order to achieve national targets.
- Discharge lounge consultation to standardise and extend opening to 10pm completed.
- Weekly expert panel in place to review adult patients with multiple admissions, supported by Northern Lincolnshire system partners.
- A deep dive into the coding of Hospital at Home and ward attender patients is underway to improve coding accuracy.

2.4c Domain 4 – Ensuring people have a positive experience of care

Responsiveness to the Personal needs of patients

The Trust reviews its responsiveness to the needs of patients through monitoring responses to five specific questions:

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?

There has been no new data made available to the Trust by NHS Digital about the Trust's responsiveness to the personal needs of its patients since 2020. Therefore, the table below shows the data up to the most recent entry covering hospital stays between 01 July 2019 to 31 July 2019 (data collected between 01 August 2019 to 31 January 2020). 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.

Indicator	Trust value 2019 - 2020	National average	National lowest	National highest
Responsiveness to inpatients personal needs	62.5	67.1	59.5	84.2

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

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

The data is provided by the national survey contractor.

The Trust has continued to take the following actions to improve the quality of its services, represented by this data, by:

The Trust continues to gather patient feedback about patient involvement in care and decisions through its monthly INSIGHT survey programme, which supports the national inpatient survey questions, and the 15 Step assurance programme. This feedback provides opportunity for divisions to work closely with areas where feedback indicates further improvement is required.

The recent National Maternity Survey shows a consistent position, in comparison to the 2022 survey with a positive or maintained improvements to our internal and external benchmark scores.

The Trust recommenced Friends and Family Test (FFT) feedback which had been paused during the pandemic, this is collected via text message, paper cards and QR codes. There has seen an increase in staff engagement and positive responses. The introduction of the new FFT provider service has also seen a recent improvement in Emergency Department responses. From mid-November 2023 monthly reports were available for all wards and services. FFT will be utilised as a thematic tool for all areas to allow for triangulation of themes and feedback, to improve quality of service.

The Trust Patient Advice and Liaison Service (PALS) team always provide a supportive signposting service for patients and families. Dedicated work within the PALS team has seen a significant increase in reducing the timeliness of responses to patients and relatives. A change to the complaints process has seen the time to resolve complaints reduce which ensures patients or their relatives receive a response in a timely manner.

Following a complaint from a family member Carols campaign was launched which resulted in a review of hospital visiting times. The Trust recognizes the positive benefits that visiting offers so the times were changed to 11-8 to offer visitors increased flexibility to visit. What the changes aim to ensure is that we are providing compassionate and patient-centered care for people when they most need it.

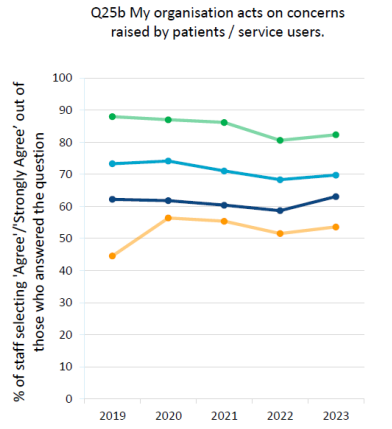
This change included the launch of the care partner scheme. Care Partners are people who support or care, unpaid, for a friend or family member. It is usually the person who the patient wants to support them in times of need or distress. They will have open access to visit when required by the patient.

We know that having access to the person you need most when you are ill or in hospital can be massive and it can have a huge impact on a person's mental and physical wellbeing.

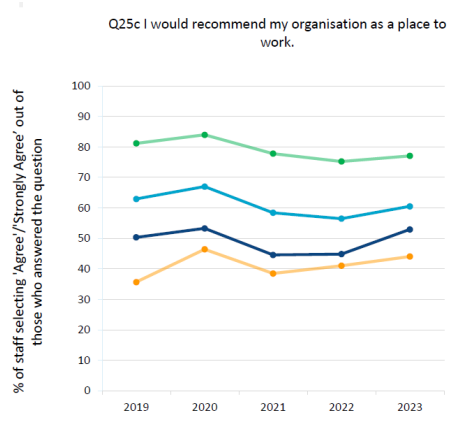
Staff recommending Trust as a provider to friends and family

The data made available by NHS Digital with regards 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 is taken from the Trust's NHS Staff Survey Benchmark report 2023 published on 07 March 2024.

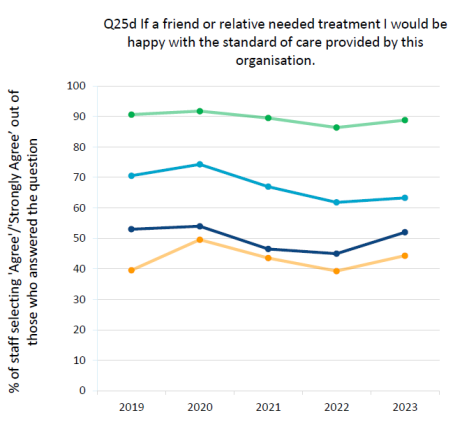
Indicator	Trust value 2022	Trust value 2023	National average	National lowest	National highest
The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	45%	52.03%	63.32%	44.31%	88.82%



	2019	2020	2021	2022	2023
Your org	62.20%	61.80%	60.39%	58.68%	63.09%
Best result	87.98%	87.02%	86.18%	80.61%	82.34%
Average result	73.32%	74.14%	71.07%	68.32%	69.78%
Worst result	44.56%	56.41%	55.39%	51.54%	53.59%
Responses	2491	2358	2428	2348	3469



	2019	2020	2021	2022	2023
Your org	50.35%	53.28%	44.57%	44.84%	52.95%
Best result	81.18%	83.99%	77.82%	75.24%	77.09%
Average result	62.94%	67.00%	58.40%	56.48%	60.52%
Worst result	35.64%	46.44%	38.47%	41.03%	44.05%
Responses	2478	2360	2436	2352	3473



	2019	2020	2021	2022	2023
Your org	52.98%	53.97%	46.54%	45.00%	52.03%
Best result	90.62%	91.76%	89.51%	86.38%	88.82%
Average result	70.57%	74.32%	66.99%	61.82%	63.32%
Worst result	39.54%	49.58%	43.54%	39.27%	44.31%
Responses	2488	2363	2433	2349	3477

Source: Northern Lincolnshire and Goole NHS Foundation Trust Staff Survey Benchmark Report 2023.

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

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” as published on the Staff Survey Coordination Centre website.

52.03% of staff surveyed would recommend the Trust (+7% since 2022); the increase in the Trust’s score is higher compared with other organisations nationally and in the integrated Care System (ICS) and is likely to be a response to the positive changes that the Trust has made in the last year. It should be noted that the England average increased from 61.9% in 2022 to 63.32% (+1.4% since 2022).

Whilst 2022 scores demonstrated that pressures and backlog of responses to health concerns and treatment the COVID-19 pandemic impacted on overall staff wellbeing and levels of engagement, resulting in a reduction in most scores in 2022 compared to 2021, 2023 shows a marked improvement overall. The Trust has worked on and across all staff survey themes through dedicated cultural and services improvement plans. It should be noted that despite continuous service pressures the Trust’s score in relation to “Care of patients/service users is my organisations top priority” continues to improve against 2022 and above national trends.

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

For the last four 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 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. As a result of investment in leadership development the Trust has piloted and rolled out 13 cohorts across all professions priority areas and management groups in 2023.

- The continuation of a cultural transformation programme developed with our staff since August 2022 to improve employee experience resulted in high levels of staff engagement and voice: the Trust has since rolled out a culture transformation working group and Board. 2023 has seen the development of a culture change academy aimed at individuals, teams, leaders and the development of a network of culture change ambassadors.

- 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.

- Implementation of an Equality, Diversity, and Inclusion action plan to strengthen our inclusion, diversity and equity. The Trust has launched 3 staff networks Black and Minority Ethnic (BME), Disability, LGBTQ+ in 2022 and launched the Women's network in 2023. A provision of educational programmes from 2023 onwards, ran with and through the staff networks, will support a more inclusive and equitable workforce and workplace.

- The Trust's 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, introduced Schwartz rounds, growing a network of wellbeing champions and offering training in the field of Mental Health First Aid along with a review of our staff wellbeing spaces, improvement of rest areas, and implementation of financial wellbeing services and education, social wellbeing and career wellbeing in collaboration with organisational development and learning and education.

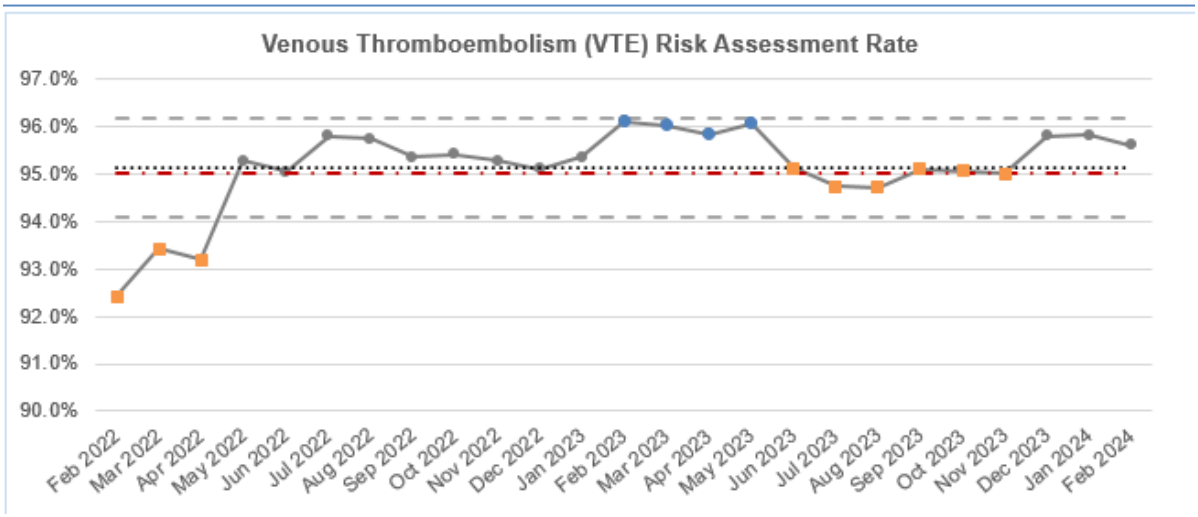
- The Trust aims to further develop this work in 2024 through leadership programme, culture programmes, coaching, mentoring and the development of a culture change academy aimed at individuals, teams, leaders, and a network of culture change transformation and the introduction of a dedicated People Promise Manager in May 2024.

2.4d Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

Risk assessed for Venous Thromboembolism (VTE)

The national VTE data collection and publication was paused to release NHS capacity to support the response to the Covid-19 pandemic. National data collection remains

paused, so the below data only reflects local Trust performance data.



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

- 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. Since the introduction of the EPMA system VTE risk assessment rate has significantly improved and remained above the Trust's 95% target since May 2022,

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

Clostridium Difficile infection reported within the Trust

The data made available to the Trust by NHS Digital regarding 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 is shown in the table below. *(Most recent data published by NHS digital on 6 October 2023).*

Indicator	Trust value 2020/21	Trust value 2021/22	Trust value 2022/23	National average 2022/23	National lowest 2022/23	National highest 2022/23
The rate per 100,000 bed days of cases of C. difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	7.9	5.1	8	18.3	0	73.3

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

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

The data shows that the Trust has maintained a position beneath the England average and is one of the best performing acute hospitals in Enagland which is a major achievement.

The definitions for reporting Clostridium difficile cases changed in April 2019 meaning cases detected after 2 days would be attributed as Hospital Onset Healthcare Associated (HOHA) as opposed to the previous guidance, which specified 3 days previously. Cases would also be classed as Community Onset Healthcare Associated (COHA) if the patient was an in-patient within the previous 4 weeks.

Due to success of considerable reduction of cases in previous years, the trajectory for the year 2023 - 2024 of 20 cases was extremely challenging. The Trust had a Clostridium difficile infection objective of no more than 20 cases and ended the year on 18 reported cases combining Hospital-onset healthcare associated and Community-onset healthcare associated cases. There were no significant lapses in practice/care detected from the post infection reviews undertaken. Despite exceeding the threshold, The Trust performed exceptionally well for Clostridium difficile rates for all England acute trusts based on 100,000 bed days and the best performing trust in the region and in the lowest quartile nationally.

The Trust has continued to take the following actions to improve the quality of its services, represented by this data, by:

- Capital and planning teams factored the need to increase isolation capacity in building schemes e.g. The new Integrated Acute Admission Unit and Same Day Assessment Unit at Diana Princess of Wales Hospital and Scunthorpe General Hospital.
- The Trust has an evidence-based Clostridium 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 are monitored by the

Infection Prevention & Control Committee and shared with relevant bodies.

- The bespoke IPC alert which informs the IPC team to previous cases of Clostridium difficile.

- GPs are sent an email to inform them of a patient's Clostridium difficile status again to help reduce the amount of antimicrobial use and prevent future Clostridium difficile cases; This is now incorporated into the patient discharge letter.

- The continuation of a rolling programme of antibiotic prescribing audits reviewed by the Infection Prevention & Control Group.

- PathLinks antimicrobial formulary reviewed with latest national standards.

- The Trust participated in the National Point Prevalence survey of healthcare associated infections antimicrobial use and antimicrobial stewardship in England. This will provide information and actions to improve antimicrobial prescribing and management. This can also have a positive patient outcome to minimize the acquisition of CDI.

- Updated antimicrobial Trust intranet site, the HUB, to make access to content easier for prescribers.

Patient safety incidents

Time frame	Trust number of patient safety incidents reported	Trust rate of patient safety incidents reported per 1,000 bed days	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	Percentage of safety incidents that resulted in severe harm or death
April 2021 – March 2022	15,533	72.6	25	0.11	0.16%
April 2022 – March 2023*	24,488	99.98	36	0.15	0.15%
April 2023 – March 2024*	19,627	82.29**	33	0.14	0.17%

Source: NRLS Organisation data workbook for the period April 2021 – March 2022. *From April 2022 there has been no data published nationally therefore this has been calculated internally by the Trust. **Bed days data is not available for the month of March 2024 due to the Trust switching to a new Electronic Patient Record (EPR) system in February 2024. Bed days for March 2024 has therefore been calculated using an average of the bed days from April 2023 – February 2024.

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

- A significant increase in incidents reported is noted for the reporting period April 2022 – March 2023 in comparison to the previous year (April 2021 – March 2022) and the subsequent year (April 2023 – March 2024). This was due to a requirement to report all Emergency Department 12-hour trolley waits on an individual basis. This was subsequently

changed to recording a daily summary of these types of incidents resulting in a reduction of incidents reported in April 2023 – March 2024.

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

- The Trust continues to monitor incident rates locally and actively promotes and encourages staff to report all incidents including near misses as part of an open and transparent culture designed to support learning and improvement, recognising that high levels of reporting indicate a high level of safety awareness. This is particularly so when the high level of reporting is for no/low harm or near miss incidents. 98% of patient safety incidents reported in each of the timeframes shown in the table were in this category of harm levels.

- The Trust continues to monitor the data for understanding of key themes and sharing learning opportunities.

- The Trust continually works towards improving learning in the organisation and has a learning strategy in place.

- In December 2023 the Trust commenced transition to the new Patient Safety Incident Response Framework (PSIRF) as part of the new national initiative. The Trust has completed a number of proportionate learning responses focusing on areas where improvement will have the greatest impact as outlined in the Trust's Patient Safety Investigation Response Plan. Findings from these reviews are used to identify themes and trends across the organisation for learning and improvement purposes.

- The Trust oversees the identification and management of incident investigations weekly at the Learning Response Panel ensuring that the appropriate learning response is undertaken in line with the PSIRF and Patient Safety Incident Response Framework Policy and Plan. Incidents are also reviewed at a daily incident navigation meeting to actively determine the appropriate management of those incidents so that valuable learning can be identified and acted upon as early as possible to improve the quality of our services.

PART 3: Review of Quality Performance

3.1 Performance against relevant indicators and performance thresholds

Performance against indicators that form the Oversight Framework (not already reported on within this document) are shown as follows for 2023/24.

Indicator	Quarter 1 23/24 (Percentage)			Quarter 2 23/24 (Percentage)			Quarter 3 23/24 (Percentage)			Quarter 4 23/24 (Percentage)			Target	Full year average
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	64.49	65.07	63.91	63.16	61.87	61.24	61.85	61.46	60.48	61.50	60.58	60.47	92%	60.47% (March 2024 snapshot)
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	61.28%	65.15	65.25	63.28	65.38	64.34	60.77	65.61	61.46	60.35	59.42	66.36	76%	63.22%
All cancers: 62-day wait for first treatment from referral/screening	54.73%	68.23	61.54	55.94	48.54	50.00	51.97	43.67	50.70	49.44	52.11	70.89	85%	54.81%
Maximum 6-week wait for diagnostic procedures	38.52%	35.79	35.31	37.04	36.49	31.49	26.78	25.04	26.37	22.03	16.47	15.47	1.0%	28.9%

3.2 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: 2nd October 2023 to 24th November 2023
Embargoed Findings: Received – 28th February
2024 NHSEI Publication: 7th March 2024

Key Facts

Benchmark Comparators: 122 Acute & Acute Community Trusts
Benchmark Response Rate: 45% (-1 % on 2022 survey)
NLaG Response Rate: 48% (+13% on 2022 survey)
NLaG Survey Mode: Blended (3512 completed / +1097 on 2022)

Staff Survey 2023 findings

The 2023 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
Your org	7.03	5.76	6.52	-	5.39	5.82	6.49	6.65	5.84
Best result	7.71	6.37	7.16	-	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	-	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	-	5.05	5.60	6.35	6.34	5.54
Responses	3486	3489	3454	-	3242	3467	3479	3496	3495

Note. 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Health and Well-Being

Due to national technical issues in gathering data the Trust cannot fully evidence the impact of its actions on:

- Positive action being taken regarding health and wellbeing support.
- The uptake of staff working flexibly.

More guidance is available on the survey coordination centre

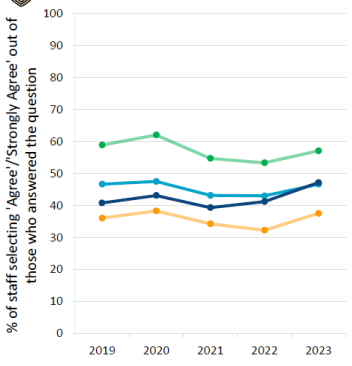
However, there are sufficient markers that indicate a positive outcome with regards to Health and Wellbeing for the Trust as follows:

Health and Safety Climate

Improvements in this particular theme will be felt by our staff and reduce the feeling of burnout with a focus on staffing which improved by +8.59% (q3i) as well as having sufficient resources and equipment (c+5.4% q3h) and calls for continued in investment in

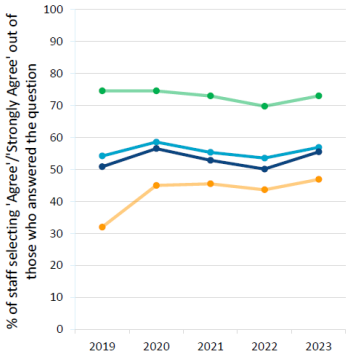
this area.

Q3g I am able to meet all the conflicting demands on my time at work.



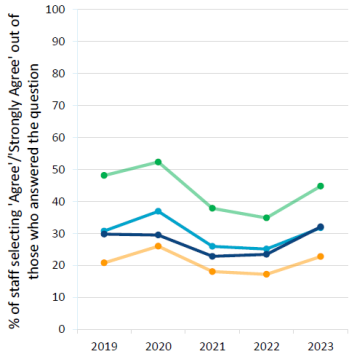
	2019	2020	2021	2022	2023
Your org	40.75%	43.09%	39.30%	41.16%	47.15%
Best result	58.86%	61.99%	54.69%	53.31%	57.08%
Average result	46.63%	47.50%	43.12%	42.96%	46.63%
Worst result	36.05%	38.27%	34.26%	32.24%	37.52%
Responses	2547	2379	2461	2355	3480

Q3h I have adequate materials, supplies and equipment to do my work.



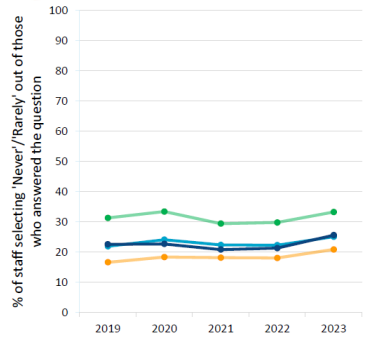
	2019	2020	2021	2022	2023
Your org	50.85%	56.50%	52.84%	50.09%	55.47%
Best result	74.53%	74.54%	72.96%	69.73%	72.97%
Average result	54.19%	58.54%	55.33%	53.52%	56.88%
Worst result	31.96%	44.99%	45.51%	43.63%	46.87%
Responses	2551	2383	2480	2353	3488

Q3i There are enough staff at this organisation for me to do my job properly.



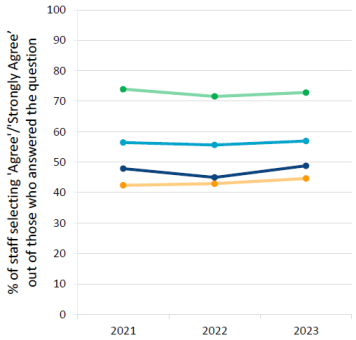
	2019	2020	2021	2022	2023
Your org	29.78%	29.48%	22.82%	23.45%	32.04%
Best result	48.09%	52.30%	37.83%	34.84%	44.76%
Average result	30.74%	36.89%	25.94%	25.11%	31.75%
Worst result	20.78%	25.99%	18.06%	17.19%	22.75%
Responses	2546	2388	2480	2356	3491

Q5a I have unrealistic time pressures.



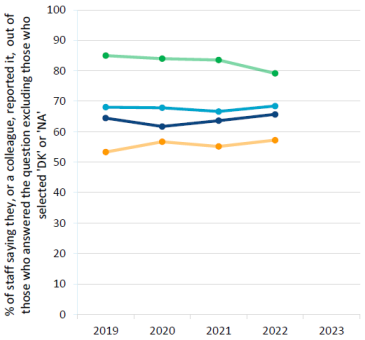
	2019	2020	2021	2022	2023
Your org	22.61%	22.70%	20.85%	21.33%	25.61%
Best result	31.33%	33.42%	29.43%	29.80%	33.29%
Average result	21.94%	24.12%	22.39%	22.31%	25.08%
Worst result	16.62%	18.37%	18.16%	18.05%	20.88%
Responses	2537	2383	2478	2348	3483

Q11a My organisation takes positive action on health and well-being.



	2021	2022	2023
Your org	47.84%	44.98%	48.79%
Best result	73.93%	71.57%	72.85%
Average result	56.44%	55.65%	56.95%
Worst result	42.41%	42.92%	44.63%
Responses	2426	2306	3479

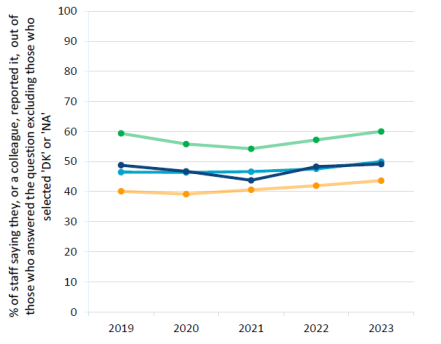
Q13d The last time you experienced physical violence at work, did you or a colleague report it?



	2019	2020	2021	2022	2023
Your org	64.47%	61.69%	63.61%	65.68%	
Best result	84.97%	83.98%	83.53%	79.14%	
Average result	68.03%	67.86%	66.62%	68.43%	
Worst result	53.29%	56.69%	55.14%	57.21%	
Responses	233	216	202	267	

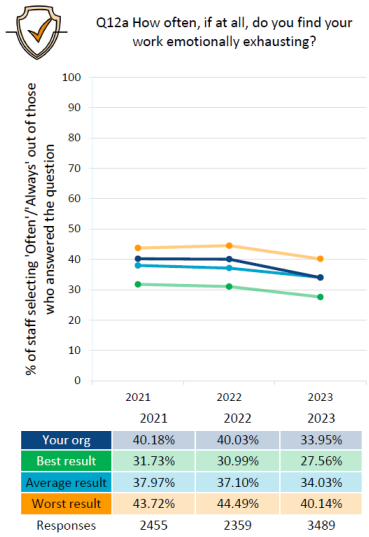
Note. 2023 results for Q13d have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Q14d The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?

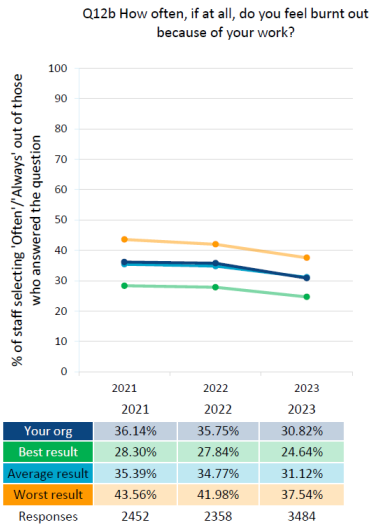


	2019	2020	2021	2022	2023
Your org	48.77%	46.72%	43.75%	48.31%	49.17%
Best result	59.36%	55.82%	54.24%	57.20%	60.00%
Average result	46.49%	46.39%	46.64%	47.58%	49.96%
Worst result	40.11%	39.16%	40.62%	41.97%	43.66%
Responses	921	856	862	856	1157

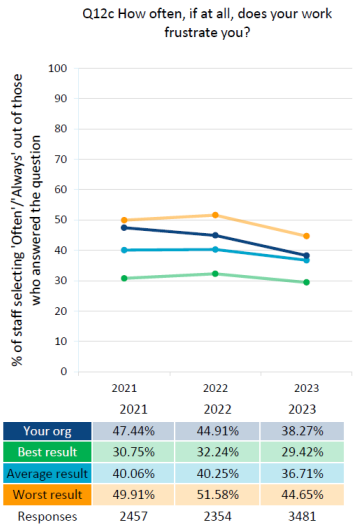
Burnout



	2021	2022	2023
Your org	40.18%	40.03%	33.95%
Best result	31.73%	30.99%	27.56%
Average result	37.97%	37.10%	34.03%
Worst result	43.72%	44.49%	40.14%
Responses	2455	2359	3489

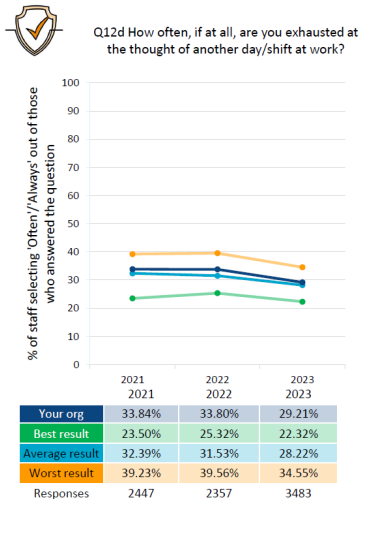


	2021	2022	2023
Your org	36.14%	35.75%	30.82%
Best result	28.30%	27.84%	24.64%
Average result	35.39%	34.77%	31.12%
Worst result	43.56%	41.98%	37.54%
Responses	2452	2358	3484

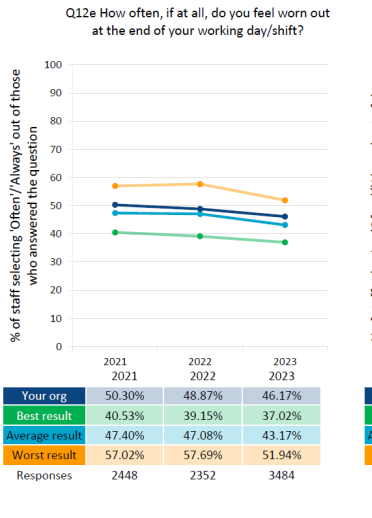


	2021	2022	2023
Your org	47.44%	44.91%	38.27%
Best result	30.75%	32.24%	29.42%
Average result	40.06%	40.25%	36.71%
Worst result	49.91%	51.58%	44.65%
Responses	2457	2354	3481

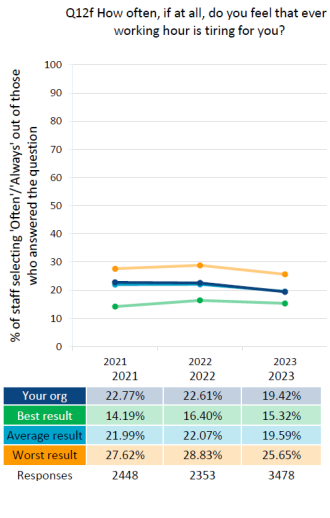
Generally we see an improvement in staff burnout throughout the Trust across all questions relating to burnout (-6.08% q12a; -4.93% q12b ; -6.64% q12c; -4.59% q12d ; -2.7% q12e; -3.19% q12f ; -1.82% q12g) which helps paint a more positive picture about work practices, better staffing, better work life balance as evidenced below and directly correlated to a reduction in work pressures and a better health and safety climate.



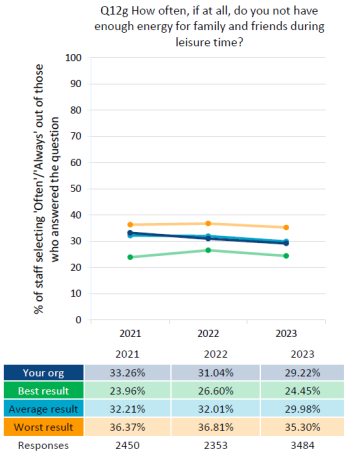
	2021	2022	2023
Your org	33.84%	33.80%	29.21%
Best result	23.50%	25.32%	22.32%
Average result	32.39%	31.53%	28.22%
Worst result	39.23%	39.56%	34.55%
Responses	2447	2357	3483



	2021	2022	2023
Your org	50.30%	48.87%	46.17%
Best result	40.53%	39.15%	37.02%
Average result	47.40%	47.08%	43.17%
Worst result	57.02%	57.69%	51.94%
Responses	2448	2352	3484

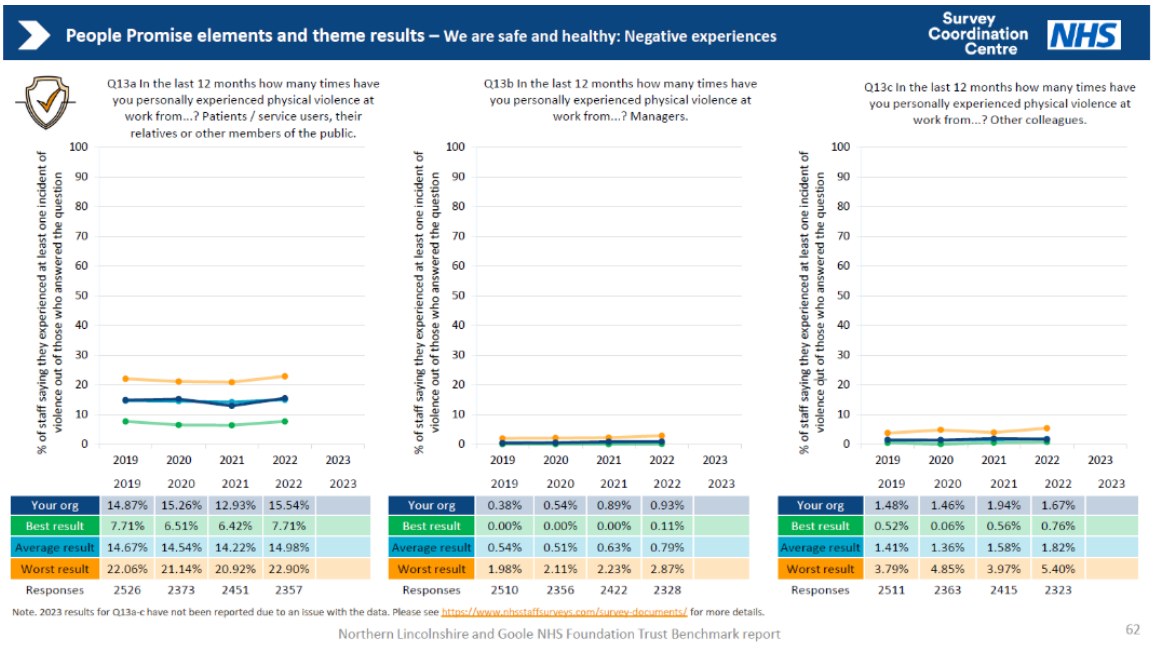


	2021	2022	2023
Your org	22.77%	22.61%	19.42%
Best result	14.19%	16.40%	15.32%
Average result	21.99%	22.07%	19.59%
Worst result	27.62%	28.83%	25.65%
Responses	2448	2353	3478



	2021	2022	2023
Your org	33.26%	31.04%	29.22%
Best result	23.96%	26.60%	24.45%
Average result	32.21%	32.01%	29.98%
Worst result	36.37%	36.81%	35.30%
Responses	2450	2353	3484

Negative experience



	2019	2020	2021	2022	2023
Your org	14.87%	15.26%	12.93%	15.54%	
Best result	7.71%	6.51%	6.42%	7.71%	
Average result	14.67%	14.54%	14.22%	14.98%	
Worst result	22.06%	21.14%	20.92%	22.90%	
Responses	2526	2373	2451	2357	

	2019	2020	2021	2022	2023
Your org	0.38%	0.54%	0.89%	0.93%	
Best result	0.00%	0.00%	0.00%	0.11%	
Average result	0.54%	0.51%	0.63%	0.79%	
Worst result	1.98%	2.11%	2.23%	2.87%	
Responses	2510	2356	2422	2328	

	2019	2020	2021	2022	2023
Your org	1.48%	1.46%	1.94%	1.67%	
Best result	0.52%	0.06%	0.56%	0.76%	
Average result	1.41%	1.36%	1.58%	1.82%	
Worst result	3.79%	4.85%	3.97%	5.40%	
Responses	2511	2363	2415	2323	

Note. 2023 results for Q13a-c have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

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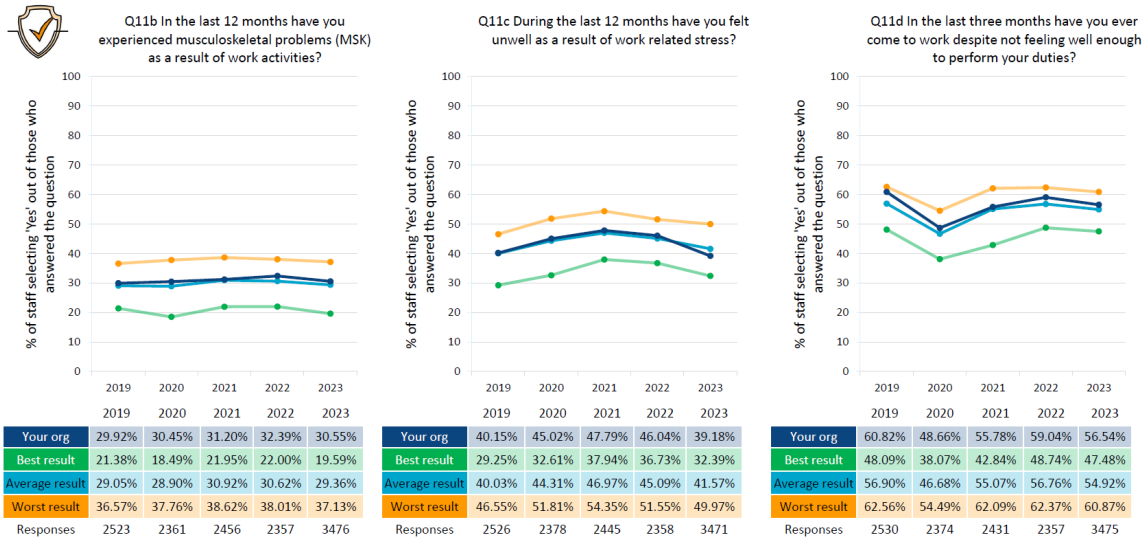
No data was available to evidence whether there was a reversal of the trend regarding physical violence, however we see a marked improvement this year compared to 2022 regarding MSK (-1.84% q11b), stress (-6.86% q11c) and staff not feeling compelled to come to work if they are feeling unwell (-2.5% q11d).



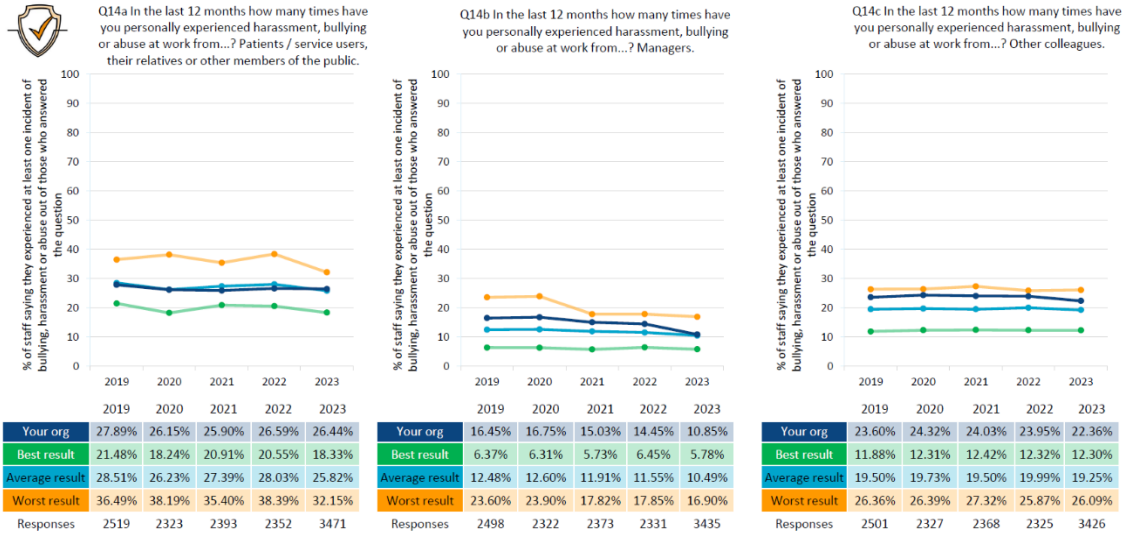
	2019	2020	2021	2022	2023
Your org	29.92%	30.45%	31.20%	32.39%	30.55%
Best result	21.38%	18.49%	21.95%	22.00%	19.59%
Average result	29.05%	28.90%	30.92%	30.62%	29.36%
Worst result	36.57%	37.76%	38.62%	38.01%	37.13%
Responses	2523	2361	2456	2357	3476

	2019	2020	2021	2022	2023
Your org	40.15%	45.02%	47.79%	46.04%	39.18%
Best result	29.25%	32.61%	37.94%	36.73%	32.39%
Average result	40.03%	44.31%	46.97%	45.09%	41.57%
Worst result	46.55%	51.81%	54.35%	51.55%	49.97%
Responses	2526	2378	2445	2358	3471

	2019	2020	2021	2022	2023
Your org	60.82%	48.66%	55.78%	59.04%	56.54%
Best result	48.09%	38.07%	42.84%	48.74%	47.48%
Average result	56.90%	46.68%	55.07%	56.76%	54.92%
Worst result	62.56%	54.49%	62.09%	62.37%	60.87%
Responses	2530	2374	2431	2357	3475

Although no improvement was markedly noticed regarding harassment, bullying and abuse from patient towards staff, there is a marked reduction in q14b (c-4%) and q14c (c-1.5%).

The introduction of training programmes on civility and respect in 2023 through 2024 for colleagues as well as the leadership and management development programme are hoped to have positive impact on fostering a culture of respect and an environment where people are treated with dignity systematically.



	2019	2020	2021	2022	2023
Your org	27.89%	26.15%	25.90%	26.59%	26.44%
Best result	21.48%	18.24%	20.91%	20.55%	18.33%
Average result	28.51%	26.23%	27.39%	28.03%	25.82%
Worst result	36.49%	38.19%	35.40%	38.39%	32.15%
Responses	2519	2323	2393	2352	3471

	2019	2020	2021	2022	2023
Your org	16.45%	16.75%	15.03%	14.45%	10.85%
Best result	6.37%	6.31%	5.73%	6.45%	5.78%
Average result	12.48%	12.60%	11.91%	11.55%	10.49%
Worst result	23.60%	23.90%	17.82%	17.85%	16.90%
Responses	2498	2322	2373	2331	3435

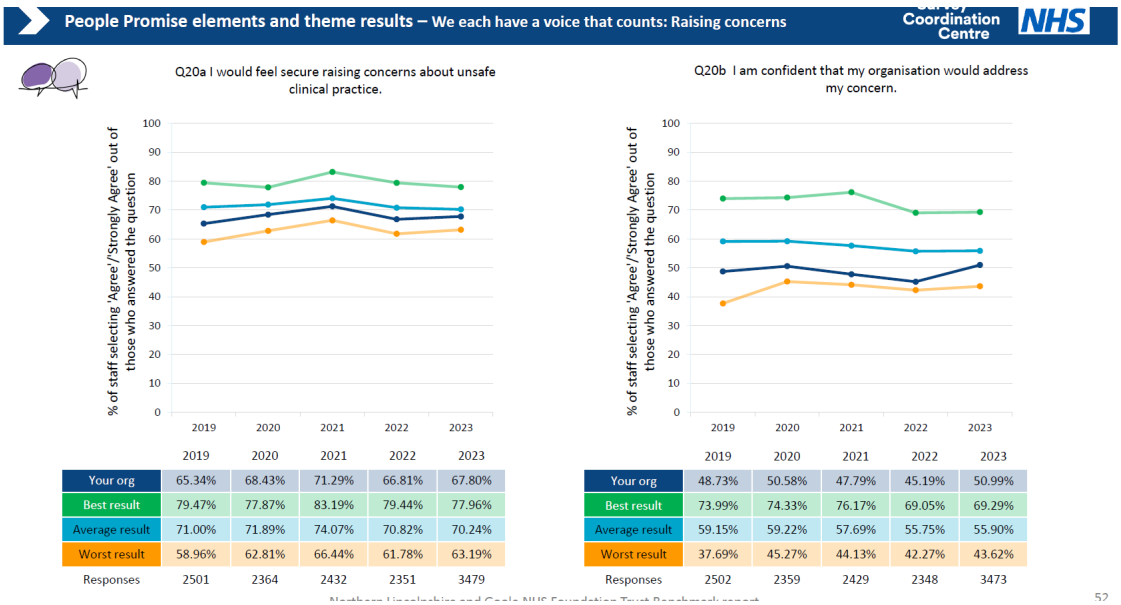
	2019	2020	2021	2022	2023
Your org	23.60%	24.32%	24.03%	23.95%	22.36%
Best result	11.88%	12.31%	12.42%	12.32%	12.30%
Average result	19.50%	19.73%	19.50%	19.99%	19.25%
Worst result	26.36%	26.39%	27.32%	25.87%	26.09%
Responses	2501	2327	2368	2325	3426

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 to support managers and staff through the challenges of the pandemic.

The Trust are committed to further work on health and wellbeing, as set out in our two-year health and wellbeing plan, and our Trust's participation in the NHSE Health and Wellbeing Trailblazer Pilot. The Trust is 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 Schwartz Rounds and a series of pop-up wellbeing Hubs planned for 2023/2024 to continue well into 2024/25
- Introduction of health and wellbeing activities
- Supporting staff burnout required given Q11d and staff continuing to work when unwell is increasing.

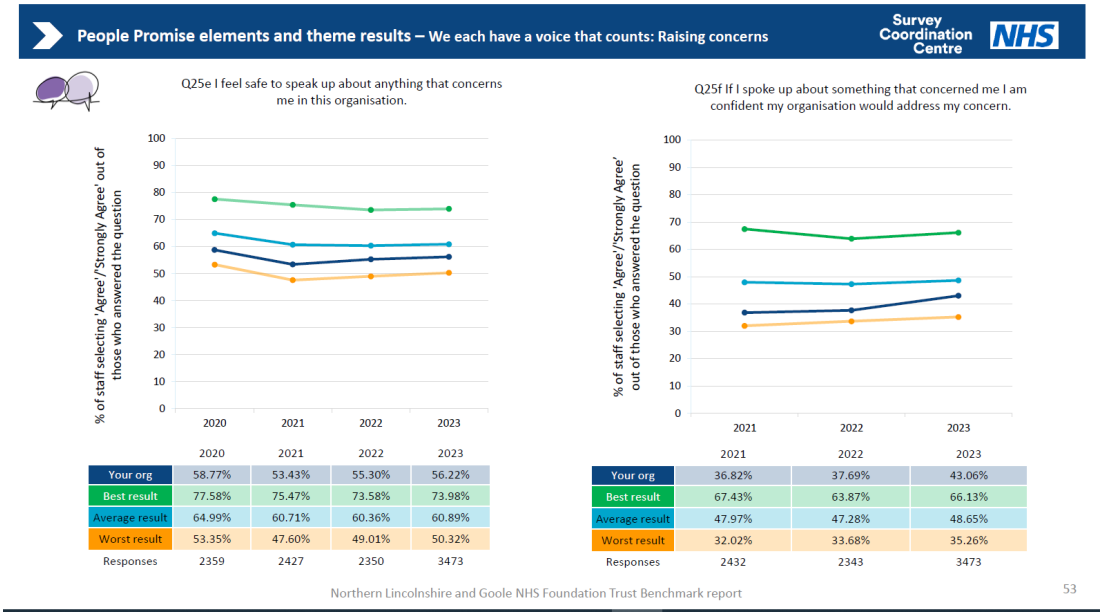
Safety Culture



	2019	2020	2021	2022	2023
Your org	65.34%	68.43%	71.29%	66.81%	67.80%
Best result	79.47%	77.87%	83.19%	79.44%	77.96%
Average result	71.00%	71.89%	74.07%	70.82%	70.24%
Worst result	58.96%	62.81%	66.44%	61.78%	63.19%
Responses	2501	2364	2432	2351	3479

	2019	2020	2021	2022	2023
Your org	48.73%	50.58%	47.79%	45.19%	50.99%
Best result	73.99%	74.33%	76.17%	69.05%	69.29%
Average result	59.15%	59.22%	57.69%	55.75%	55.90%
Worst result	37.69%	45.27%	44.13%	42.27%	43.62%
Responses	2502	2359	2429	2348	3473

Since 2018 significant progress has been made relating to staff feeling secure raising concerns about unsafe clinical practice (+8.9% since 2017 in 2021). Although we saw in 2022 there was a loss of confidence in raising concerns and addressing these the Trust has reversed the trend in 2023 to above pre-pandemic levels (+1% q20a; +5% q20b in 2023 compared to 2022).

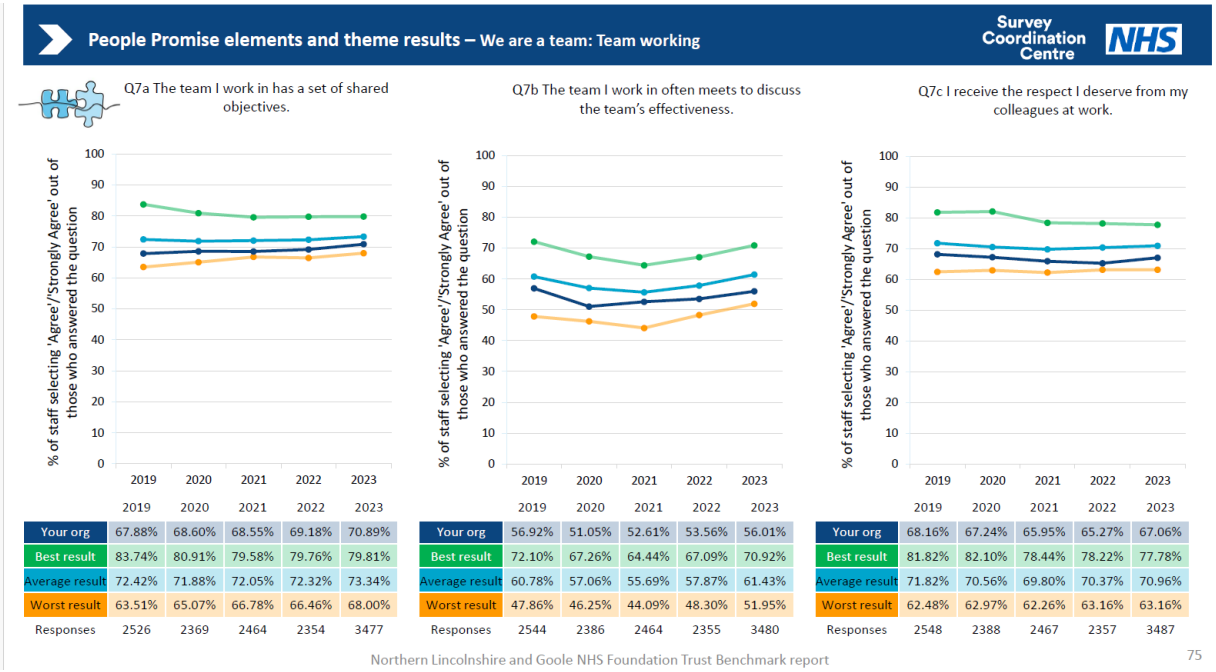


	2020	2021	2022	2023
Your org	58.77%	53.43%	55.30%	56.22%
Best result	77.58%	75.47%	73.58%	73.98%
Average result	64.99%	60.71%	60.36%	60.89%
Worst result	53.35%	47.60%	49.01%	50.32%
Responses	2359	2427	2350	3473

	2021	2022	2023
Your org	36.82%	37.69%	43.06%
Best result	67.43%	63.87%	66.13%
Average result	47.97%	47.28%	48.65%
Worst result	32.02%	33.68%	35.26%
Responses	2432	2343	3473

Whereas 2021/22 saw a decrease in staff feeling they are able to speak up about anything that concerns them in the organisation there has been a marked improvement with the introduction of our FTSU Guardian and the Trust taking a proactive approach to improve on this as part of the Culture Transformation programme and Just and Learning Culture.

Team Working



	2019	2020	2021	2022	2023
Your org	67.88%	68.60%	68.55%	69.18%	70.89%
Best result	83.74%	80.91%	79.58%	79.76%	79.81%
Average result	72.42%	71.88%	72.05%	72.32%	73.34%
Worst result	63.51%	65.07%	66.78%	66.46%	68.00%
Responses	2526	2369	2464	2354	3477

	2019	2020	2021	2022	2023
Your org	56.92%	51.05%	52.61%	53.56%	56.01%
Best result	72.10%	67.26%	64.44%	67.09%	70.92%
Average result	60.78%	57.06%	55.69%	57.87%	61.43%
Worst result	47.86%	46.25%	44.09%	48.30%	51.95%
Responses	2544	2386	2464	2355	3480

	2019	2020	2021	2022	2023
Your org	68.16%	67.24%	65.95%	65.27%	67.06%
Best result	81.82%	82.10%	78.44%	78.22%	77.78%
Average result	71.82%	70.56%	69.80%	70.37%	70.96%
Worst result	62.48%	62.97%	62.26%	63.16%	63.16%
Responses	2548	2388	2467	2357	3487

We see a continuous improvement in scores since last year as an indication that some improvements have been made and felt by our staff. In addition to the Trusts implementing

the Leadership Development Strategy last year more Teamworking and Line management skills have been put into action to achieve higher levels of staff engagement. Our core leadership skills programme of work supports improvement in this theme.

Next Steps

Continue to deliver on cultural and leadership objectives aligned to Trust priorities and Leadership Development Strategy. These are overseen by the Culture Transformation Board and the Workforce Committee.

3.3 Information on patient survey report

The national survey programme provides a year-on-year review of person-centred validated questions and responses. This data allows the Trust to monitor internal progress and benchmarking. During 20223/24 the Trust implemented a comprehensive action plan based on the 2022 national inpatient survey (2023 survey results are still being collated nationally), of which the headlines are detailed below.

The 2022 National Adult Inpatient Survey for Northern Lincolnshire and Goole NHS Foundation Trust shows the sustaining of internal improvement, which was largely made during the period relating to the 2020 to 2021 survey dates.

The survey was completed across all adult inpatient areas during November 2022 39% inpatients completed a survey. 98% of those who responded were White British, with 1% respondents Asian or Asian British. There was a fairly even split of those identifying as male or female, with the majority of responses completed by those over 66 year of age.
A total of 61 questions were asked in the 2022 survey, of these 50 can be positively scored, with 41 of these which can be historically compared.

1250	1181	39%	40%	41%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (458)	Average response rate for similar organisations	Your previous response rate

81%	Q46. Rated overall experience as 7/10 or more
99%	Q45. Treated with respect and dignity overall
97%	Q17. Had confidence and trust in the doctors

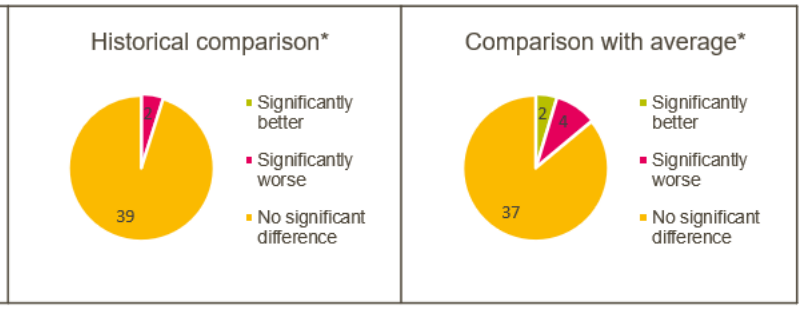


*Chart shows the number of questions that are better, worse, or show no significant difference

There are many positives within the report which should be celebrated.

Positive headlines are:

- ✓ 97% rated room fairly clean
- ✓ 96% patients asked said they got enough to drink
- ✓ 95% doctors answered questions clearly
- ✓ 97% patients had confidence and trust in doctors
- ✓ 98% of nurses answered questions clearly
- ✓ 97% nurses included patients in conversations
- ✓ 100% patients had confidence and trust in nurses
- ✓ 99% patients overall were treated with dignity and respect

The charts below show the top & bottom 5 scored questions compared to the picker average and also the Trust most improved and declined scores.

Top 5 scores vs Picker Average	Trust	Picker Avg
Q12. Food was very good or fairly good	74%	69%
Q14. Able to get food outside of meal times	78%	75%
Q9. Got enough help from staff to wash or keep clean	93%	91%
Q15. Got enough to drink	96%	94%
Q47. Asked to give views on quality of care during stay	15%	13%

Bottom 5 scores vs Picker Average	Trust	Picker Avg
Q34. Family or cares involvement in discussions about leaving the hospital	52%	60%
Q51. Condition(s) taken into account during your care and treatment whilst in hospital	81%	87%
Q39. Given information about medicine at discharge	81%	86%
Q33. Felt involved in decisions about discharge from hospital	71%	76%
Q7. Staff explained reasons for changing wards at night	76%	81%

Most improved scores	Trust 2022	Trust 2021
Q14. Able to get food outside of meal times	78%	71%
Q35. Staff discussed need for additional equipment or home adaptation after discharge	83%	77%
Q32. Explained how well procedure had gone	83%	79%
Q31. Questions before procedure were answered well	95%	92%
Q47. Asked to give views on quality of care during stay	15%	12%

Most declined scores	Trust 2022	Trust 2021
Q2. Did not mind waiting as long as did for admission	59%	73%
Q10. Able to take own medication when needed to	84%	90%
Q37. Given information about what they should or should not do after leaving hospital	76%	80%
Q12. Food was very good or fairly good	74%	78%
Q46. Rated overall experience as 7/10 or more	81%	85%

What we know is that our admission and discharge processes are two of the biggest challenges, not only in our NHS, but nationally.

An overarching action plan is now in place based on the 2022 survey findings.

Divisional ownership of the actions will be monitored quarterly via Divisional Patient Experience Reviews and Patient Experience Group meetings, any escalations will be through Quality Governance Group, actions will only be closed when suitable monitoring evidences improvement.

Due to the time span of national surveys, they are, in effect, always year behind by the time results are analysed and shared, the Trust conducts its own ongoing inpatient survey

programme. The INSIGHTS local survey programme surveys 10 patients on each adult inpatient ward monthly and monitors this feedback. It remains the Trust's commitment to listen and act on patient feedback and prioritise actions that matter to patients most.

3.4 Quality Improvement Journey

The Quality Improvement (QI) program for the trust has continued to develop in year with over 1000 staff trained at different levels in QI methodologies by the QI Academy during 23/24. This includes 458 Foundation Level Doctors from across the Integrated Care System at "Applying QI" level, where they are able to apply their QI skills by delivering a Quality Improvement Project (QIP). 32 Trust staff (and 18 Integrated Care Board staff member) have been trained in Leading & Coaching QI, enabling staff to not only enact their QI skills but lead larger programmes of change. 115 Quality Improvement Projects (QIPs) have been registered during the year with over 40 of these demonstrating measurable improvement so far with a further 42 at the planning and testing phase with the remainder in the earlier stages of development.

In addition, the Trust has run several trust wide QI collaborative events with measurable outcomes involving 50 clinical areas from across the trust. These include the QI collaborative which focused on increasing timely assessment and reassessment of patients pain to ensure the highest levels of care have been provided. This saw excellent engagement with clinical teams resulting in moving the trust position from 20% of pain assessments completed electronically in May 2023 up to a sustained position of over 95% from July 2023 until the project was handed over to business as usual in November 2023. Other benefits were also realised including saving Pain CNS time on a daily basis equal to 237 hours per year. Also, with the move to electronic assessment this saved £3,714 in printing costs.

Other key work within the year was in relation to the successful implementation of a service redesign within Maternity Triage services. The Ockenden report outlines a number of recommendations in relation to how maternity services should conduct triage for pregnant women with medical related concerns who are 16 week plus. These recommendations outline the need to follow a recognised model of triage to priorities timely assessment, i.e. the Birmingham Symptom Specific Obstetric Triage System (BSOTS). This Quality Improvement Project aim is to Implement a fully operational Maternity Triage Service across the whole of the Maternity Service in NLAG, that utilises a Nationally recognised Triage Model (BSOTS). In order to enhance the patient experience and care. The first phase of this work related to a single point of access triage phone line which over the year answered 10436 calls from concerned women. In addition to the patient experience benefits this also released nursing time to care on the wards of 20hrs per week or 1040 per year. The second phase of this work focused on face to face triage post initial phone assessment and in the first 5 months of opening saw 2485 women with positive feedback from patients surveyed.

The trust held its second QI conference with over 250 attendees which included regional speakers along with many examples of QI work from across the organisation. This was a great opportunity for the organsiation to celebrate its improvement journey and its staff. For the first time awards were also presented to staff who had promoted and led improvement within their areas.

The Trust will continue to build on its strong QI foundations to deliver outstanding quality of care to our patients in 2024/25. Reviewing with our HUTH colleagues what learning can we share as we look to build a culture of QI across the group.

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

Annex 1.1: Statements from Commissioners

Feedback from:
North East Lincolnshire Place - Humber and North Yorkshire Integrated Care Board (ICB) and Lincolnshire ICB

The Humber & North Yorkshire Integrated Care Board (ICB) welcome the opportunity to review and comment on Northern Lincolnshire and Goole NHS Foundation Trust's Quality Report for 2023/24 and this response also includes reflections from Lincolnshire ICB.

We recognise the ambitions of the Trust, commitment and hard work of the workforce to deliver good quality care throughout the past year and we would like to say thank you to all staff and volunteers across NLaG. It is extremely positive to see so many achievements highlighted within the report, and we welcome the informative and illustrative content celebrated within the opening pages of the Quality Account. The patient and family narrative conveying Carol's story and the partnership working between the Trust and family is commendable. The approach to learn and implement changes that will positively impact other patient journeys from a family's experience is excellent practice.

The ICB's are supportive of the Trust's Quality Priorities for 2024/25. The continued focus on driving improvement in the delivery, experience and outcomes associated within End of Life, deteriorating patients, sepsis, medication safety and mental capacity is welcomed by the ICB. Further concentration on these areas will assist with embedding changes and continued focus to help support the realisation of the Trust's objectives to make sustained improvements.

The Quality Account candidly outlines challenges in performance and the associated experience of care, recognising those areas where further improvements are required. As a whole system we will continue to work in collaboration with NLaG to support improvements in key areas such as waiting times and flow through the Emergency Departments to improve the overall experiences and quality of care for our population.

The ICB would also like to congratulate the Trust for the work which is being undertaken in research. We note the partnership work planned with the Research Department at the Hull University Teaching Hospital and we will look forward to hearing more about this in 2024/2025.

There have been significant national changes to quality associated programmes that have required local implementation during this Quality Account period, one of which being the implementation of the National Patient Safety Incident Response Framework. The Trust have worked closely with ourselves, involving the ICB in their implementation of the Framework and sharing resources, knowledge and experience with other healthcare providers.

Since the last Annual Quality Account, the Trust have formally exited the Recovery Support Programme (previously known as special measures). This is a significant achievement and alongside the Improved CQC ratings demonstrates continuous improvements.

The ICB remain committed to working with NLaG and wider system partners to improve the quality and safety of services available for the population of the patients served by the Trust in order to improve patient experience and patient outcomes.

Annex 1.2: Statement from Healthwatch organisations

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

Healthwatch response to the Annual Quality Accounts 2023/2024

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

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

Healthwatch are pleased to see that the Northern Lincolnshire & Goole NHS Foundation Trust have now exited the recovery program. The trust has recognised and evidenced that that there are still further improvements to be made and have a robust action plan in place that will remain a key focus for 2024/25.

The summary clearly sets out what you have achieved during 2023/24 against your 5 priority areas and what still needs working on, and where progress has been made. The Trust has also clearly indicated what the priorities will be for 2024/25 and how you hope to achieve them.

Healthwatch carried out research on 2022/23 to ascertain what service users and their families thought about the End of Life pathway, what worked for them and what needed to improve. Recommendations were made by Healthwatch North and North East Lincolnshire. We are pleased that the trust has been responsive to our recommendations around the development of communication and the Bluebell model. The Trusts expansion of the palliative and end of life care team is very much welcomed alongside the implementation of the seven-day specialist palliative care service. We are also pleased to see the significant increase in the prescription of anticipatory medications which is allowing the residents of

North Lincolnshire to experience dignified, pain free deaths.

Healthwatch are disappointed to see the figures relating to the percentage of Mental Capacity Assessments that meet legal requirements. Although there has been some improvement within this area, the figures are still low and quite rightly are again placed on the quality priority planning for 2024/25.

Patients across Northern Lincolnshire have experienced lengthy waits in both emergency departments to be seen, treated, admitted or discharged. You have been unable to meet set targets and have recognised that this is unfortunately not good enough. However the new developments consisting of the Integrated Acute Assessment Units (Grimsby) and Same Day Emergency Care Provision (Scunthorpe) are now open and are supporting to provide extra patient care in comfortable and up to date surroundings.

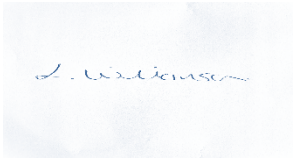
We at Healthwatch are pleased to see the personal account of Carol – As told by her daughter and the development of Carols Campaign. This story evidenced that Carols family have been listened too and action has been taken with regards to their concerns. The trust has committed to work in partnership with her daughter and will continue to provide person centered care when it is needed most.

“A year in numbers” and “proud moments” of 2023/24 are a welcome addition to the account. This supports patient accessibility to information and aides public understanding of the trusts progress and achievements.

We would like to thank all your staff for the hard work they have put in during 2023/24 to achieve a better service for the people of North Lincolnshire.

Tracy Slattery
Delivery Manager
Healthwatch North East Lincolnshire

Lucy Wilkinson
Delivery Manager
Healthwatch North Lincolnshire



James Dennis
Delivery Manager
Healthwatch East Riding of Yorkshire

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

Feedback from:
Lincolnshire – Health Scrutiny Committee for Lincolnshire

Introduction

Many patients in the northern part of the administrative county of Lincolnshire use and rely on the hospital services provided by the Trust, and the Health Scrutiny Committee for Lincolnshire is grateful to the Trust for allowing it to make a statement on this document, which was presented to representatives of the Committee by the Associate Director for Quality Governance and the Head of Quality Assurance.

Priorities for Improvement

Progress in 2023/2024

The Committee notes that improvements were made across most of the measures for the five priorities, although in one or two instances these targets were not met, and further actions are planned in the coming year.

Priorities for 2024/2025

The Committee accepts the reasons for rolling forward the five 2023/24 quality priorities into 2024/2025, which include aligning its priorities with those of Hull University Teaching Hospitals NHS Trust, where a group arrangement is in place. Priorities 1 *(End of Life Care),* 2 (*Deteriorating Patient*) and 5 (*Mental Capacity*) emphasise both compassion and communication as important elements in the treatment and care of patients, which we strongly support.

National Priorities

Aside from the Trust's care improvement priorities in this document, we would like to refer to two national priorities:

Elective Waiting Lists

We understand that during 2023/24 the Trust made further progress on reducing waiting times, with only 30 patients waiting over 65 weeks by March 2024. We look forward to the Trust meeting the national ambition to eliminate waits over 52 weeks by March 2025, but recognise that waiting times of one year inevitably impact on the overall wellbeing of patients.

Urgent and Emergency Care

Meeting the four-hour A&E performance target has remained one of the greatest challenges across all the NHS, and the Committee is aware of the targets set locally towards performance recovering this national standard. This has been against a background of

increased attendances at A&E overall, and increased acuity of those patients attending. We accept that A&E is dependent on other factors such as the timely discharge of patients, who no longer need hospital care, but we look forward to improvements in the coming year.

Humber Acute Services Review

During the autumn of 2023, the Committee responded to the consultation by NHS Humber and North Yorkshire Integrated Care Board on proposals for changes to hospital services at Scunthorpe General Hospital and Diana Princess of Wales Hospital. The Committee did not support the proposals and recorded its concerns which focused on patient access and transport, as well as potential impacts on the services at neighbouring trusts. A decision on these proposals is expected during 2024/25, and the Committee will be monitoring the affected services in the future.

Achievements During 2023/24

The Committee welcomes the achievements during 2023-24 listed in the *Proud Moments* section, in particular the new same day emergency care and integrated acute assessment units in both Grimsby and Scunthorpe.

Engagement with the Committee

As the Trust engages regularly with three other health overview and scrutiny committees representing the local authority areas where its main sites are located, engagement with the Health Scrutiny Committee for Lincolnshire is not typical. As mentioned above, the Committee considered proposals as part of the Humber Acute Services Review, and representatives from the Trust were present for these items.

Presentation and Clarity of the Quality Account

The Committee acknowledges that composing a document that meets the aims of including all the required content and the need for accessibility to the public will always be a challenge. The Committee acknowledges an early draft of the document was considered and looks forward to the final version addressing as far as possible the presentation and readability issues, such as font size and the clarity of explanations.

Conclusion

The Committee is grateful for the opportunity of making a statement on the Trust's quality account for 2023/2024 and looks forward to the Trust continuing with its progress on its standards of care and continuing to provide the acute hospitals of choice for a significant number of patients in the administrative county of Lincolnshire.

Feedback from:
East Riding of Yorkshire Council – Health, Care and Wellbeing Overview and Scrutiny Sub-Committee
No feedback received.

Feedback from:
North Lincolnshire Council – Health, Integration and Performance Scrutiny Panel

North Lincolnshire Council's Health, Integration and Performance Scrutiny Panel welcomes the Trust's Annual Quality Account, and supports the aims and priorities outlined within.

We look forward to meeting regularly with Trust representatives throughout the forthcoming year to discuss both the Account and the performance and delivery of local services.

Cllr D Robinson, Chairman, Health, Integration and Performance Scrutiny Panel

Feedback from:
North East Lincolnshire Council – Health, Housing and Wellbeing Scrutiny Panel
No feedback received.

Annex 1.4: Statement from the Trust's Council of Governors

The Council of Governors is pleased to have been given the opportunity to comment on the Trust's Quality Account for 2023/24 which demonstrates a continuation in the significant quality improvements that have been achieved over recent years through the efforts of NLaG staff at all levels of the organisation.

Throughout the year governors continued to prioritise seeking robust assurance regarding the quality and safety of all hospital and community services provided by the Trust in the context of our duty to hold Non-Executive Directors (NEDs) to account for the performance of the Trust Board. We received regular reports at Council of Governors meetings on progress in implementing the Trust's quality priorities. We were represented at meetings of the Quality & Safety Committee in an observer capacity and NED chairs made themselves available to brief bi-monthly Governor Assurance Group meetings on committee highlights and to answer our searching questions.

Governors are pleased to see the progress that has been made against many of the Trust's 2023/24 quality priorities. Maintenance of a consistent downward in-hospital mortality trajectory has been particularly impressive although more work is required with integrated care system place partners to drive improvements to out of hospital mortality rates. In this context it is particularly pleasing to see the emphasis that has been placed on improving the quality of palliative and end of life care which is the one area of NLaG service provision still rated 'inadequate' by the Care Quality Commission.

The Council of Governors supports the decision to seek to embed and build upon improvements to the five 2023/24 quality priorities rather than identifying a new set of priorities for 2024/25. In our role as representing the interests of our trust members and service users we intend to seek feedback to inform the selection of a fresh set of quality priorities for 2025/26.

Annex 1.5: Response from the Trust to stakeholder comments

The Trust are grateful to stakeholders for their views and comments on the Quality Account for the period 20223/24.

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

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

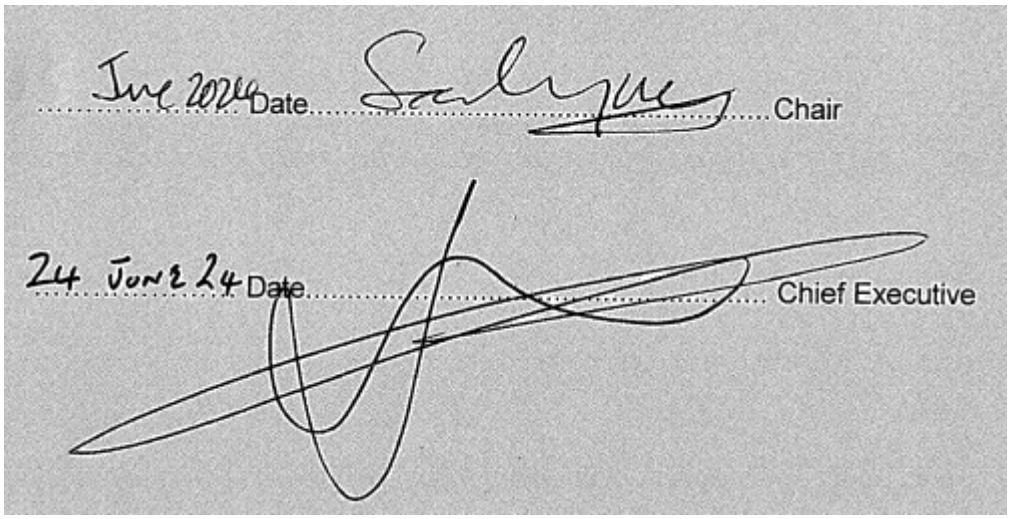
NHS England has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2023/24 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2023 to March 2024
    - Papers relating to quality reported to the board over the period April 2023 to March 2024
    - Feedback from commissioners
    - Feedback from governors
    - Feedback from Local Healthwatch organisations
    - Feedback from Overview and Scrutiny Committees
    - Latest national inpatient survey 2022
    - Latest national staff survey 2024
    - CQC inspection report published 2 December 2022
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the quality report is routinely quality checked to ensure it is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the quality report is routinely quality checked to ensure it is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The Quality Report has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board



Annex 3: Glossary

Ceiling of Care: The course of treatment considered to be the predetermined highest level of intervention deemed appropriate by a medical team, aligning with patient and family wishes, values and beliefs. These crucial early decisions aim to improve the quality of care for patients in whom they are deemed appropriate.

Clostridium Difficile (C. Difficile): A species of bacteria of the genus Clostridium that causes severe diarrhoea and other intestinal disease when competing bacteria in the gut flora are wiped out by antibiotics.

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.

Deteriorating Patient: Sometimes, the health of a patient in hospital may get worse suddenly. There are certain times when this is more likely, for example following an emergency admission to hospital, after surgery and after leaving critical care. However, it can happen at any stage of an illness. It increases the patient's risk of needing to stay longer in hospital, not recovering fully or dying. Monitoring patients regularly while they are in hospital and taking action if they show signs of becoming worse can help avoid serious problems.

Electronic Palliative Care Coordination system EPaCCs: Single shared record for preferred place of care and advanced decisions.

EPMA stands for Electronic Prescribing and Medicines Administration and is the digital prescribing system used by Medics and Pharmacists at the Trust.

Family and Friends Test (FFT): From April 2013, all patients will be asked a simple question to identify if they would recommend a particular A&E department or ward to their friends and family. The results of this friends and family test will be used to improve the experience of patients by providing timely feedback alongside other sources of patient feedback.

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".

Summary Hospital-level Mortality Indicator (SHMI): The SHMI is a measure of deaths following hospital treatment based on all conditions, which occur in or out of hospital within 30 days following discharge from a hospital admission. It is reported at Trust level across the NHS in England using standard methodology.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD): NCEPOD promote improvements in healthcare and support hospitals and doctors to ensure that the highest possible quality of safe patient care is delivered. NCEPOD use critical senior and appropriately chosen specialists to critically examine what has actually happened to the patients.

National Early Warning Score (NEWS2): Nationally defined way of monitoring patients' observations to determine if there are signs of deterioration over time. Sometimes referred to as Early Warning Scores each Trust will have an agreed policy to act on NEWS scores escalating care were appropriate. In some cases, NEWS escalation will not occur, for example when a patient is receiving end of life care, such decisions will be agreed with patients and their families.

Patient Advice & Liaison Service (PALS): The PALS service offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

Patient Reported Outcome Measures (PROMS): Patient Reported Outcome Measures are questionnaires that ask patients about their health before and after an operation. This helps to measure the results or outcome of the operation from the patient's point of view. This outcome is known as the 'health gain'. All NHS patients undergoing planned hip replacement, knee replacement, varicose vein or groin hernia surgery procedures are invited to fill in PROMs questionnaires.

A Recommended Summary Plan for Emergency Care and Treatment (ReSPECT): Provides a summary for a person's clinical care and treatment in a future emergency in which

they do not have capacity to make or express choices.

Same Day Emergency Care (SDEC): Same Day Emergency Care is one of the many ways the Trust is working to provide the right care, in the right place, at the right time for patients. It aims to benefit both patients and the healthcare system by reducing waiting times and unnecessary hospital admissions.

Sepsis: A medical condition that is characterised by a whole body inflammatory state and the presence of a known infection.

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.

Key to Statistical Process Control (SPC) charts

Variation of the data

This indicates the trend of the data at the time of reporting (no change, concerning or improving)

Colours:

Grey = no significant change
Blue = significant improvement or low pressure
Orange = significant concern or high pressure

Improving, declining or staying the same


No change: common cause – no significant change

Concerning: Special cause of concern or higher pressure due to higher values

Concerning: Special cause of concern or higher pressure due to lower values

Improving: Special cause of improving nature or lower pressure due to higher values

Improving: Special cause of improving nature or lower pressure due to lower values

Assurance of the target

This indicates whether the target is being met (randomly passing, consistently passing, or failing), and if the indicator is expected to reliably hit the target.

Annex 4: Mandatory Performance Indicator Definitions

No external audit of indicators included in the report has been required as part of the 2023/24 Quality Account reporting process, this follows national guidance received to all NHS Trusts.

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