QUALITY REPORT APRIL 2016

RESPONSIVE DOMAIN

SEE INTEGRATED PERFORMANCE REPORT

SAFE DOMAIN

METRIC	STANDARD	YTD	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	MOVEMENT
Hospital Standardised Mortality Ratio (DFI) (Latest data January 15 - December 15 this is a rolling figure reported in the month specified)	100	N/A	105.83	108.21	107.50	107.63	104.93	105.46	103.33	102.54	101.69	101.69	101.35	101.26	↓
Summary Hospital-level Mortality Indicator (Latest data October 2014 to September 2015)	100	N/A	107.31			101.1			111.1			111.86		111.21	↓
Clostrium Difficile (post 3 days)	59	58	2	3	4	3	5	8	5	2	9	4	6	7	↑
MRSA bactaraemias (post 3 days)	0	1	1	0	0	0	0	0	0	0	0	0	0	0	↔
MSSA		27	1	1	0	3	3	1	2	5	3	3	2	3	↑
ECOLI		67	5	5	6	7	2	8	5	12	3	5	3	6	↑
Never Events (may change when reviewed)	0	2	0	0	0	0	0	0	2	0	0	0	0	0	↔
Serious Incidents reported (may change when reviewed)		82	11	4	8	11	8	5	7	9	8	3	2	6	↑
Harm Free Care % (Safety Thermometer)	95%	92.96%	92%	93.77%	93.88%	94.57%	90.41%	92.83%	93.94%	93.20%	92.57%	93.57%	92.41%	92.41%	↔
New Harm Free Care % (Safety Thermometer)		97.61%	97.51%	97.15%	97.40%	98.30%	95.43%	98.70%	97.60%	97.84%	97.60%	97.53%	98.16%	98.05%	↓
Catheter & New UTIs (Safety Thermometer)		0.29%	0.31%	0.32%	0.33%	0.57%	0.91%	0.11%	0.46%	0.11%	0.0%	0.0%	0.23%	0.11%	↓
Falls (DATIX)		1936	150	150	152	143	141	137	169	164	194	159	187	190	↑
Medication errors (DATIX)		1350	126	122	106	130	103	86	104	108	106	128	120	111	↓
Medication errors (mod, severe or death) (DATIX)		70	4 (M)	5	8	7	4	8	4	4	5	7	9	9	↔
Pressure Ulcers (PUNT) 3/4	0	49	2	2	1	3	4	1	2	3	9	10	5	7	↑
VTE Risk Assessment (Monthly figures only available quarterly)	95%	94.89%	97.07%	98.23%	98.28%	98.08%	88.92%	89.72%	89.94%	94.10%	95.10%	97.50%	96.81%	MB	↓
Overdue CAS alerts (PD = past deadline) (NC = not completed)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	↔
SQD %	90%	86.47%	85.72%	87.91%	83.33%	86.26%	89.30%	86.63%	86.89%	85.08%	87.66%	85.09%	87.30%	Not collected	↑

EFFECTIVENESS DOMAIN

METRIC	STANDARD	YTD	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	MOVEMENT
#NOF 24 hrs	70%	70.27%	76.9%	69.70%	64.29%	65.88%	54.05%	75.61%	83.54%	72.73%	65.28%	64.29%	76.67%	74.24%	↓
#NOF 48 hrs	95%	94.90%	100%	93.94%	98.21%	90.59%	90.54%	93.90%	97.47%	90.91%	95.83%	97.14%	93.33%	96.97%	↑
PPCI - 90 minute door to balloon Q3 Oct - Dec 15			Quarterly	Quarterly	97.30%	Quarterly	Quarterly	97.20%	Quarterly	Quarterly	95.50%	Quarterly	Quarterly	96.80%	↑
PPCI - 150 minute call to balloon Q3 Oct - Dec 15			Quarterly	Quarterly	85.30%	Quarterly	Quarterly	91.30%	Quarterly	Quarterly	85.80%	Quarterly	Quarterly	88.70%	↑
Dementia Screening	90%	85.29%	87.53%	88.50%	88.36%	83.21%	77.20%	80.46%	82.71%	84.28%	87.13%	91.76%	87.02%	MB	↓
Dementia Risk Assessment	90%	90.58%	97.54%	95.63%	96.25%	91.10%	88%	91.05%	92.58%	84.95%	84.64%	82.30%	92.78%	MB	↑
Dementia Referral for Specialist Treatment	90%	69.64%	70.79%	86.42%	84.62%	78.67%	88%	80.82%	68.29%	60.76%	57.63%	23.46%	66.13%	MB	↑
Patients who have had a stroke who spend at least 90% of their time in hospital on a stroke unit	85.10%	72.19%	65%	71%	71%	71%	Not avail	Not avail	75.95%	Quarterly	Quarterly	79.20%	Quarterly	Quarterly	↑
Scanned within 1 hour	47.40%	52.12%	50%	50%	44%	65%	Not avail	Not avail	53.20%	Quarterly	Quarterly	50.50%	Quarterly	Quarterly	↓
Scanned within 24 hours	95.90%	96.52%	97%	97%	95%	96%	Not avail	Not avail	96.90%	Quarterly	Quarterly	97.20%	Quarterly	Quarterly	↑
Death following stroke inpatients stay	13.50%	16.65%	23%	14%	14%	14%	Not avail	Not avail	15.70%	Quarterly	Quarterly	19.20%	Quarterly	Quarterly	↑
Admitted to a stroke unit within 4 hours	61.80%	53.90%	46%	49%	52%	59%	Not avail	Not avail	56.60%	Quarterly	Quarterly	60.80%	Quarterly	Quarterly	↑
eDD (Figures taken 7th March 2016)	98%	76.96%	75.48%	77.20%	76.60%	79.01%	78.66%	78.45%	78.66%	78.21%	76.89%	75.83%	74.65%	73.92%	↓

*MB = Month Behind

WELL - LED DOMAIN

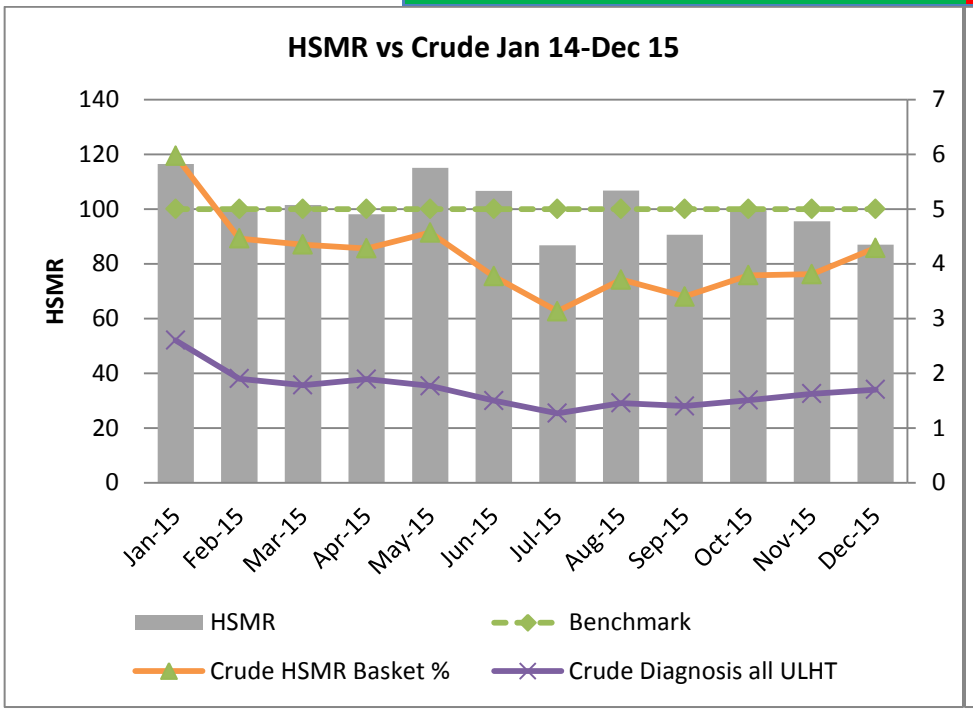
METRIC	STANDARD	YTD	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	MOVEMENT
IP response rate from FFT (November Onwards Includes Day Case)	>30%	30.42%	34%	30%	30%	24%	31%	33%	32%	31%	30%	30%	32%	28%	↓
A&E response rate from FFT	>20%	22.83%	26%	26%	25%	17%	23%	23%	24%	22%	23%	22%	22%	21%	↓

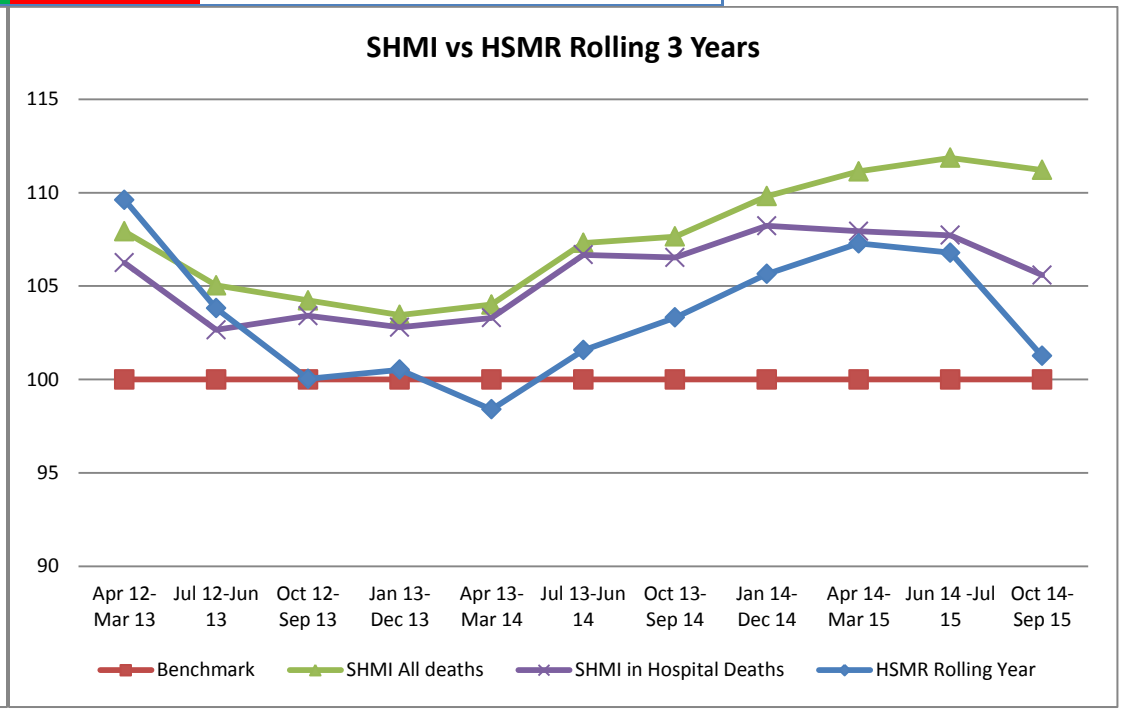
METRIC	STANDARD	YTD	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	MOVEMENT
Inpatient' recommend' scores from FFT (November onwards includes Day Case)		88.58%	90%	91%	89%	90%	88%	88%	89%	90%	88%	87%	88%	85%	↓
A&E 'recommend' scores from FFT		82.92%	83%	84%	84%	81%	83%	83%	83%	84%	83%	83%	83%	81%	↓

SAFE AMBITION 1: Reduction of Harm Associated with Mortality

Executive Summary

ULHT HSMR Jan 15-Dec 15	HSMR YTD Apr 15-Dec 15	ULHT HSMR Dec-15	ULHT SHMI Oct 14-Sep 15	ULHT Crude Mortality % Dec 15	Crude Mortality % National Avg Diagnosis ALL Dec 15
101.26	98.97	87.28	111.21	1.70	1.72





HSMR Diagnosis Groups alerting YTD April 2015 to December 2015:

Diagnosis group	Observed	Expected	Obs. - Exp.	Crude (%)	Exp. (%)	HSMR	Low	High
Septicemia (except in labour)	150	113	36.12	27.78	21.09	131.73	111.49	154.58
Other perinatal conditions	17	7.35	9.64	3.28	1.42	231.14	134.57	370.10

Definitions and data source:

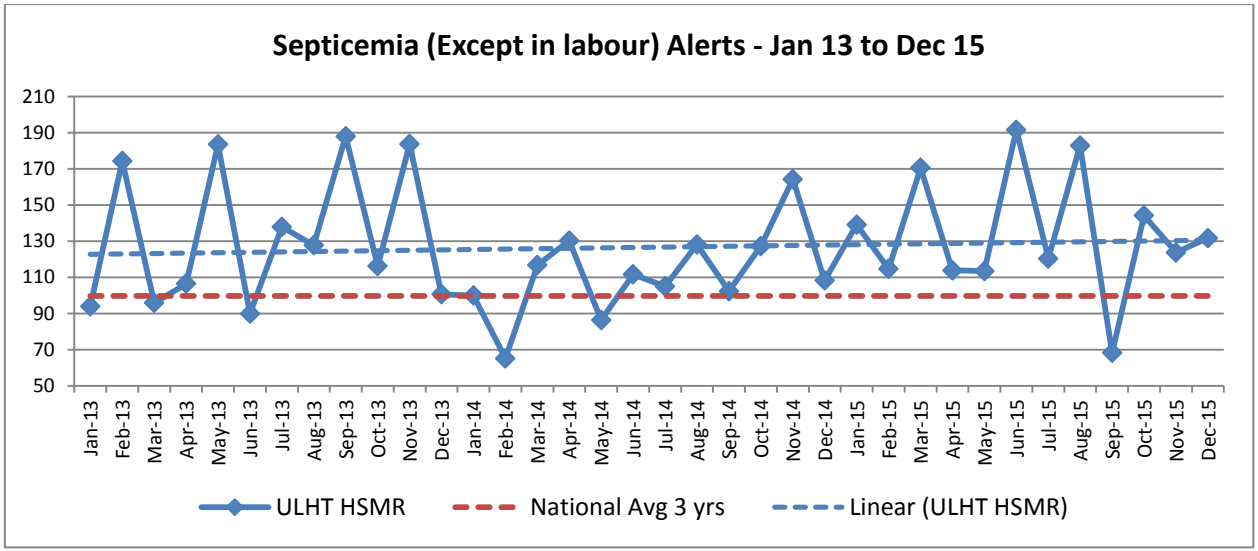
HSMR (Hospital Standard Mortality Ratio); data source Dr foster. Calculated using the 56 key diagnosis areas. 3 month time lapse. National average is from all the 137 non-specialised acute trusts reported within Dr Foster.

SHMI: (Summary Hospital-level Mortality Indicator), data source Dr foster & HSCIC. Includes all deaths 30 days post discharge, is updated quarterly with a rolling year total. National average from all non-specialised acute trusts reported within Dr Foster & HSCIC. SHMI is reported quarterly and there is a 6 month time lapse within the data.

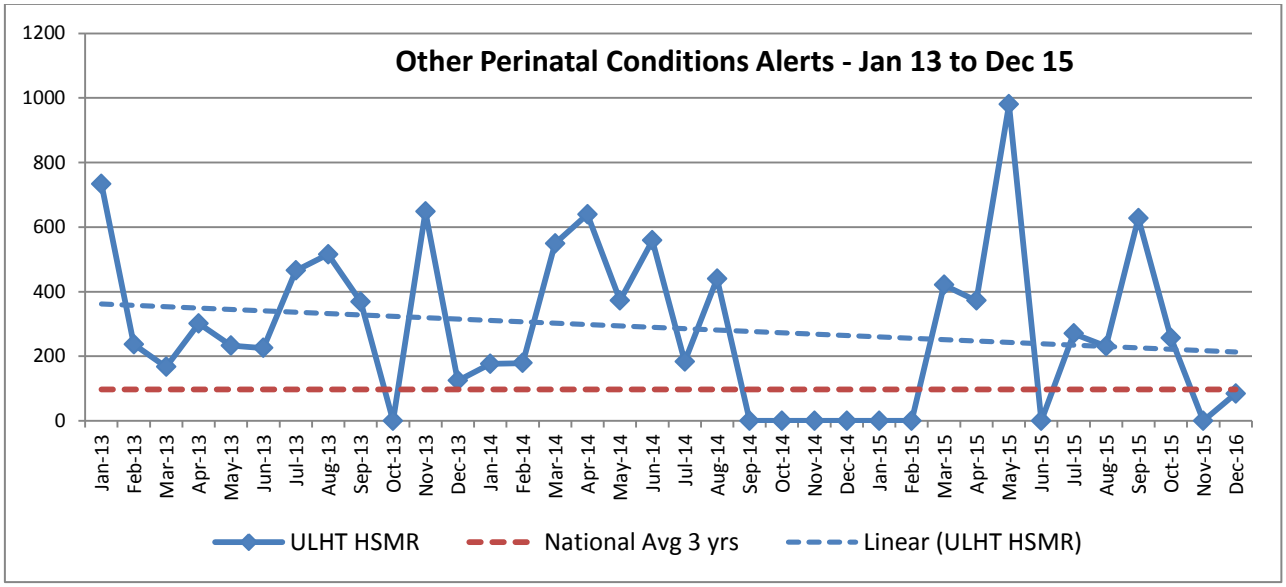
Crude Mortality: ULHT crude; from information support. National average from all non-specialised acute trusts reported within Dr Foster.

HSMR Alerting Diagnosis

Septicemia (except in labour)



Other Perinatal Conditions



HSMR Septicemia alert overview

- Within the past 3 years sepsis has been sporadically alerting inconsistently. ULHTs current HSMR YTD is 131.73 against National average of 99.62.
- The linear trend line over this time period is stagnant.
- ULHT have conducted several casenote reviews.
- From the recommendations of the casenotes reviews a sepsis action plan has been put into place led by the sepsis task and finish group.
- In March 2016 Quality Governance held an Sepsis awareness month; teaching, launch of new bundle. Which was well received.
- Sepsis action plan:

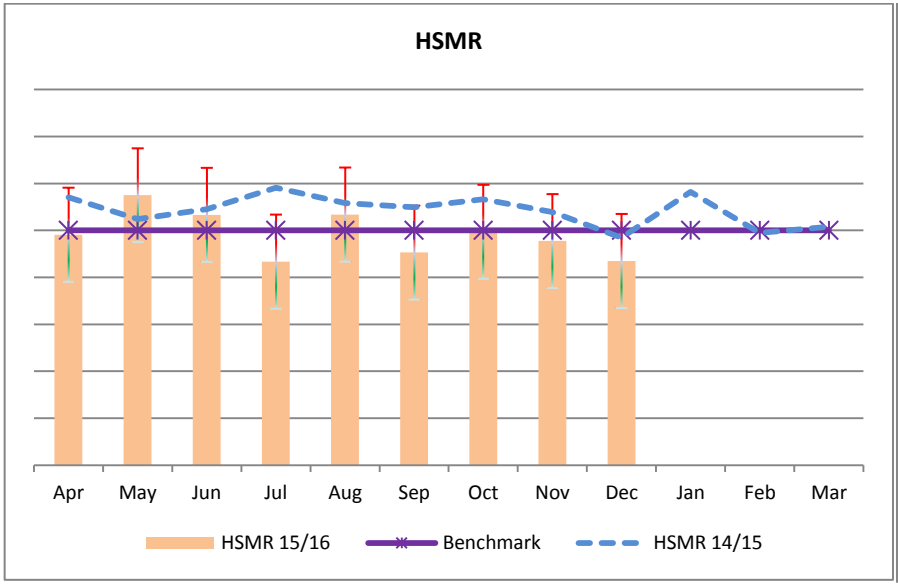
Sepsis Task Finish Group Action Tracker

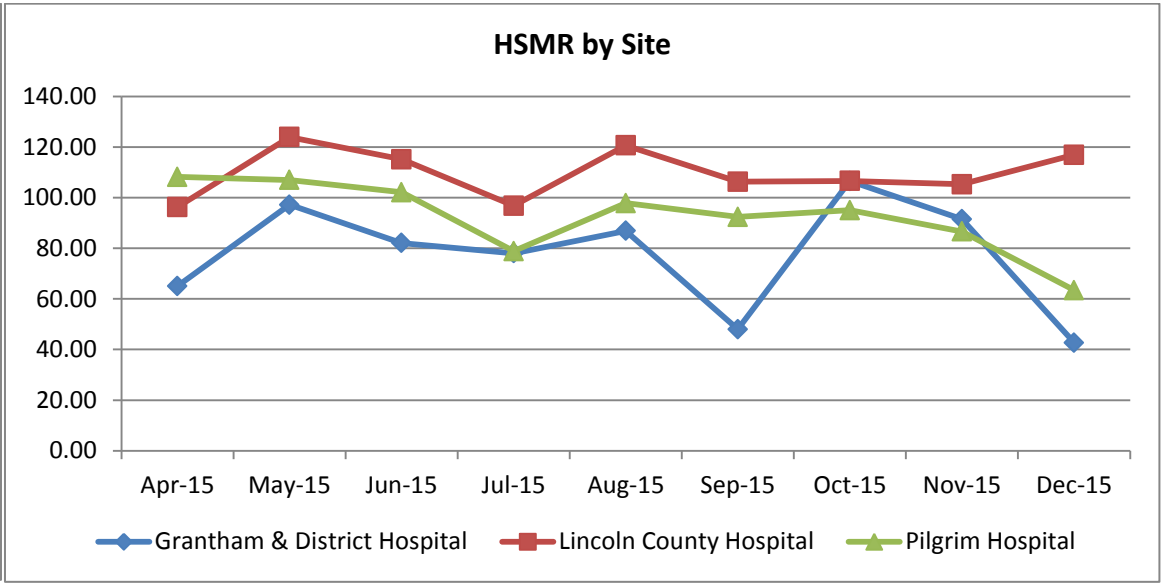
HSMR Other perinatal conditions alert overview

- Other perinatal conditions have been alerting infrequently over the past 3 years. ULHTs current HSMR YTD is 231.14 against a National average of 96.87.
- The linear trend over the past 3 years shows a downward trajectory
- ULHT have conducted casenote reviews on previous alerts.
- It was deemed that in the coding of well babies some comorbidities were being missed off. In December 2015 a First Born Review form was introduced to capture this coding.
- Also the use of the coding P95X (Fetal death of unspecified cause); this has a low risk rate thus reducing HSMRs expected deaths.
- The current 17 deaths are being looked into 12 of these deaths were coded as P95X.

Hospital Standardised Mortality Ratio (HSMR)

HSMR 2014-15	HSMR 2015-16	% HSMR reduction(-) Increase (+)	Trust Benchmark	YTD HSMR vs Trust Benchmark
101.26	98.97	-2.36%	< 100	





Performance Data Overview:

United Lincolnshire Hospitals NHS Trust:

- The current year to date HSMR (April 15 to December 15) is 98.97 which is in line with the Trust and National Benchmark.
- Rolling year HSMR (January 15 to December 15) stands at 101.26; which is within expected range.
- In month for December 2015 HSMR has decreased further to 87.28.

Lincoln County Hospital:

- In December 2015 has increased significantly by 12.86 to 116.92 which is not in expected range.
- HSMR YTD mean trend is currently showing a slight upward trajectory overall.

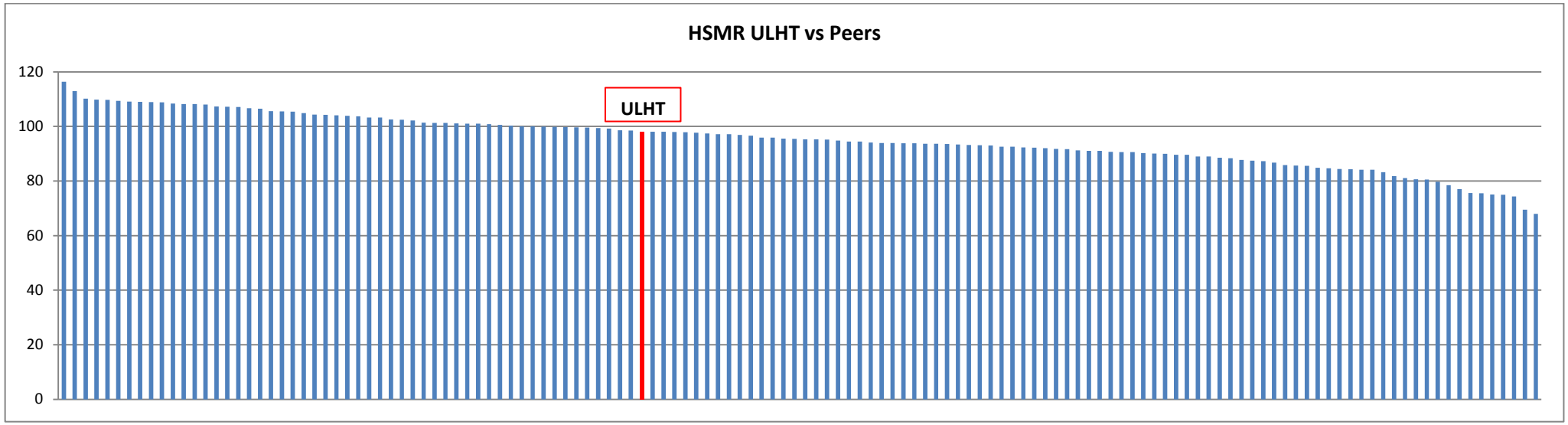
Pilgrim Hospital:

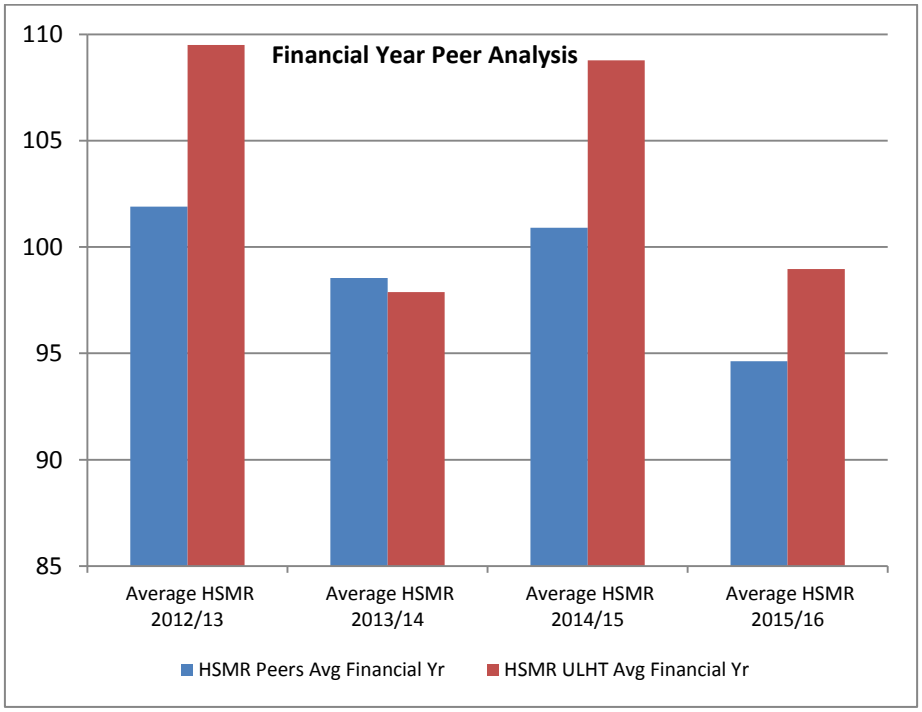
- In December 2015 HSMR has decreased significantly to 63.40 which is well below expected range. Reducing by 23.20 from November.
- HSMR YTD mean trend is currently showing a downward trajectory for Pilgrim.

Grantham Hospital:

- In December 2015 HSMR has decreased significantly by 48.87 to 42.65 which is considerably below expected range.
- HSMR YTD mean trend is currently showing a downward trajectory for Grantham.

HSMR – Peer analysis





The above peer analysis is from Dr Foster information; aggregated from the 137 non-specialised acute Trusts held within Dr Foster.

By analysing the year to date data (April 2015 to December 2015) ULHT is 54th out of the 137 Trusts held within the Dr Foster database.

When analysing the financial years to date for the past three years ULHT have had a predominately higher HSMR than the peers average.

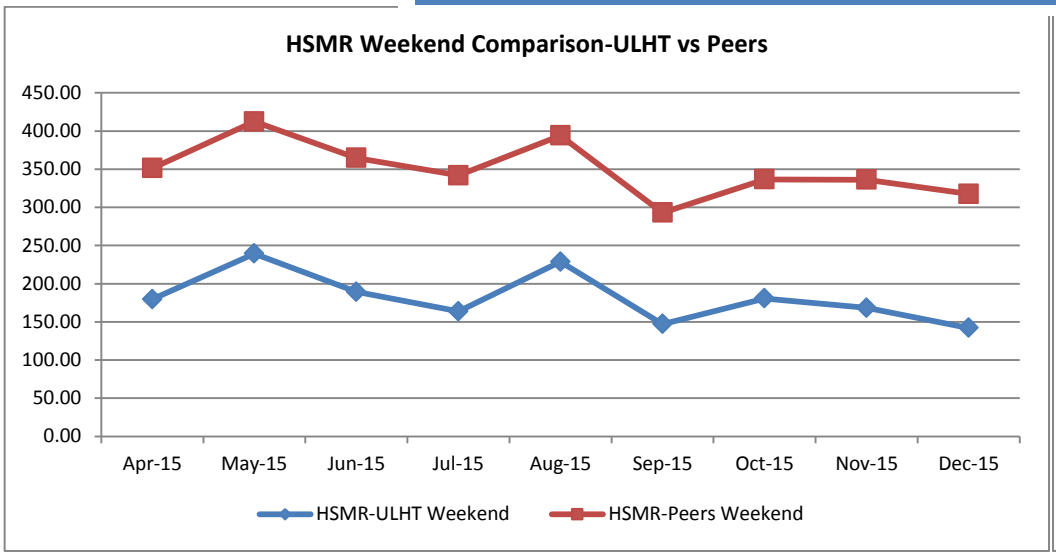
HSMR Top 3 Observed Diagnosis Groups

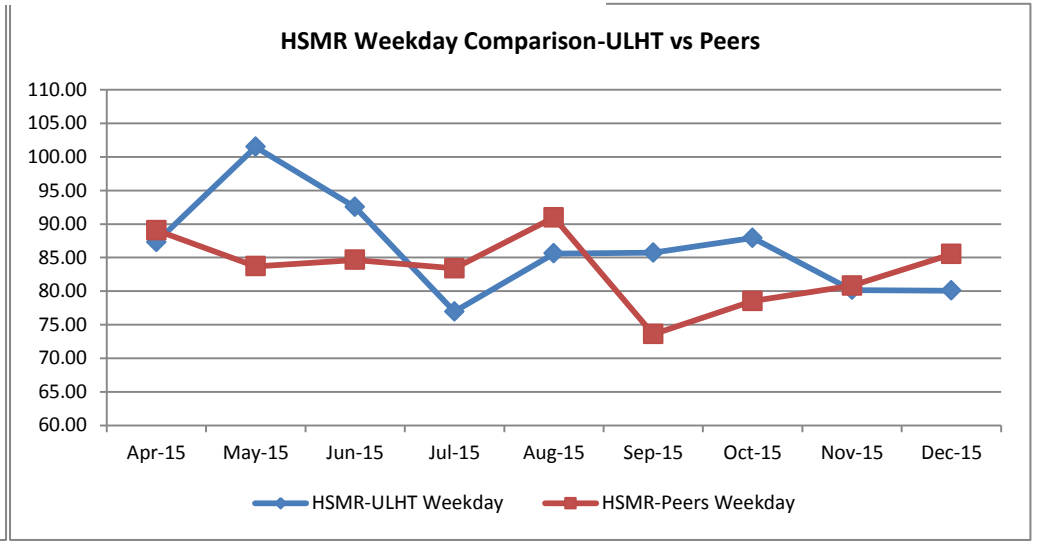
Diagnosis group	Spells	Spells (%)	Observed Deaths	Expected Deaths	Obs. - Exp.	Crude Rate (%)	Exp. (%)	HSMR	Low Confidence Interval	High Confidence Interval
Pneumonia	1390	3.49	256	281.71	-25.71	18.48	20.34	90.87	80.08	102.72
Septicemia (except in labour)	542	1.36	150	113.87	36.13	27.78	21.09	131.73	111.49	154.58
Acute cerebrovascular disease	866	2.16	135	145.14	-10.14	15.79	16.98	93.01	77.98	110.09

HSMR Top 3 observed Diagnosis Group Action Plan

- Sepsis is the only diagnosis group that is alerting within the top 3 observed deaths and is currently being dealt with by the Sepsis task and finish group as per action plan on page 3.
- Stroke currently is not alerting however there have been previous casenote review. Currently Lincoln site pathway is being observed with a Stroke physician monitoring all the coded stroke observed deaths that did not occur on the stroke unit. Dr Leach is reporting this at the hospital management group.
- Pneumonia currently is not alerting a casenote review an Dr Pogsons audit was presented at PSC.

HSMR-Weekend Weekday analysis ULHT vs DR Foster Peers





Summary Hospital-Level Mortality Indicator (SHMI)

ULHT SHMI Oct 14-Sep 15 (Current)	SHMI Oct 13-Sep 15	% SHMI reduction(-) Increase (+)
111.21	107.65	+3.56%

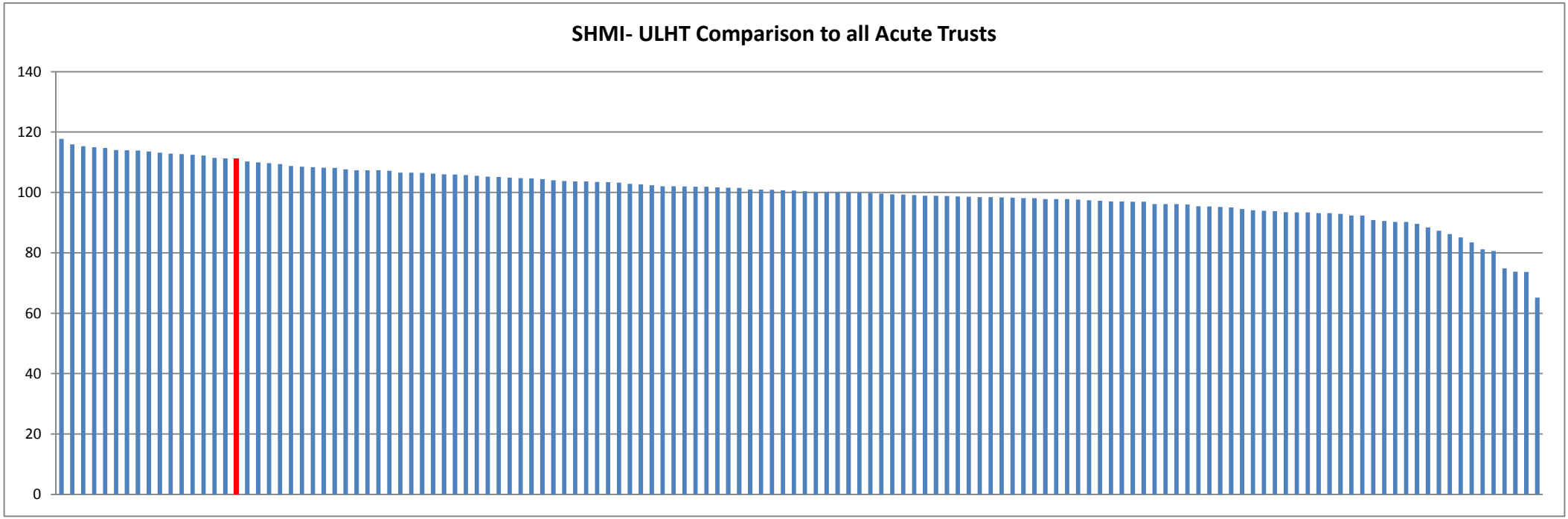
Performance Data Overview:

- Current SHMI reporting period (Oct 14-Sept 15) show that ULHT have decreased to 111.21 for all deaths and higher than the National average.
- Recording 370 more deaths that expected within the current reporting period.
- In hospital deaths are alerting at 105.58.
- ULHT have the 17th highest SHMI out of the 137 non-acute trusts reported within Dr Foster. This is a reduction of 7 places from the previous quarter where ULHT stood in 10th position.
- Alerting Diagnosis at this time are highlighted below - Reviews have subsequently been carried out for the alerts, when these diagnosis alerted for HSMR .
- Both all deaths and In hospital deaths are showing a downward trajectory in a 5 year time span (please see graph below).

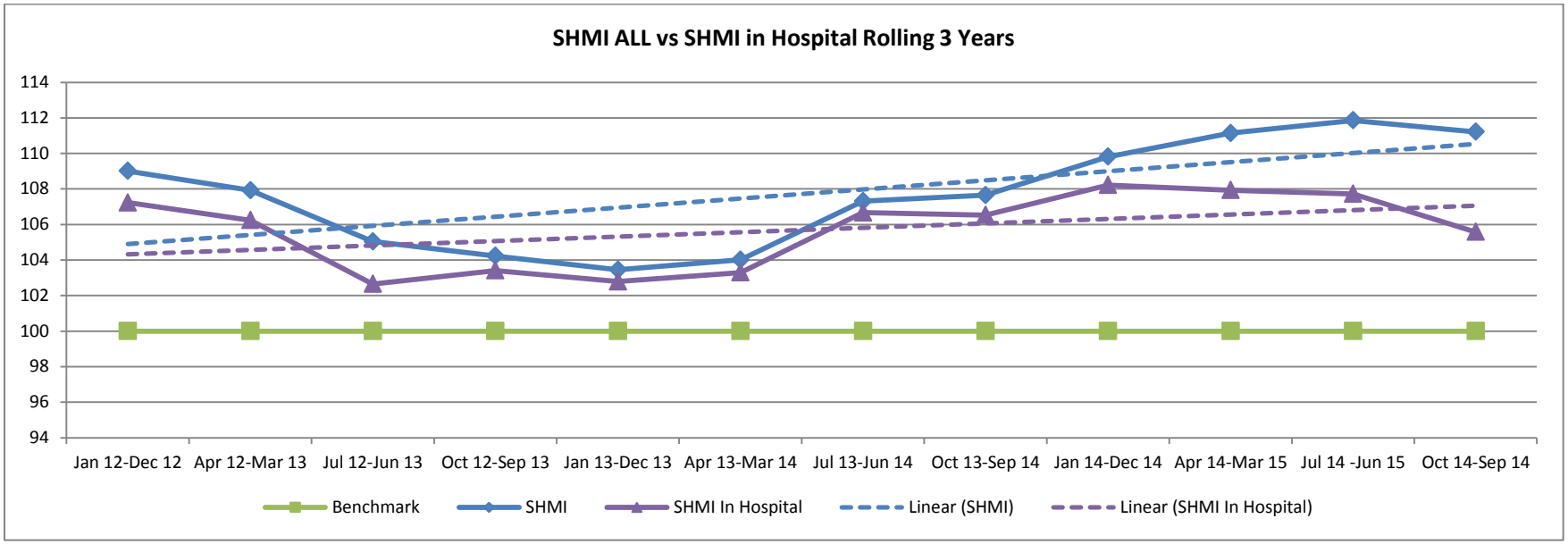
NB: SHMI has a time lapse in the data.

Site	SHMI Jul 14-Jun15	Actual Deaths	Expected Deaths
Lincoln County Hospital	112.90	1844	1633.37
Pilgrim Hospital	110.60	1461	1320.92
Grantham & District Hospital	104.78	362	345.48

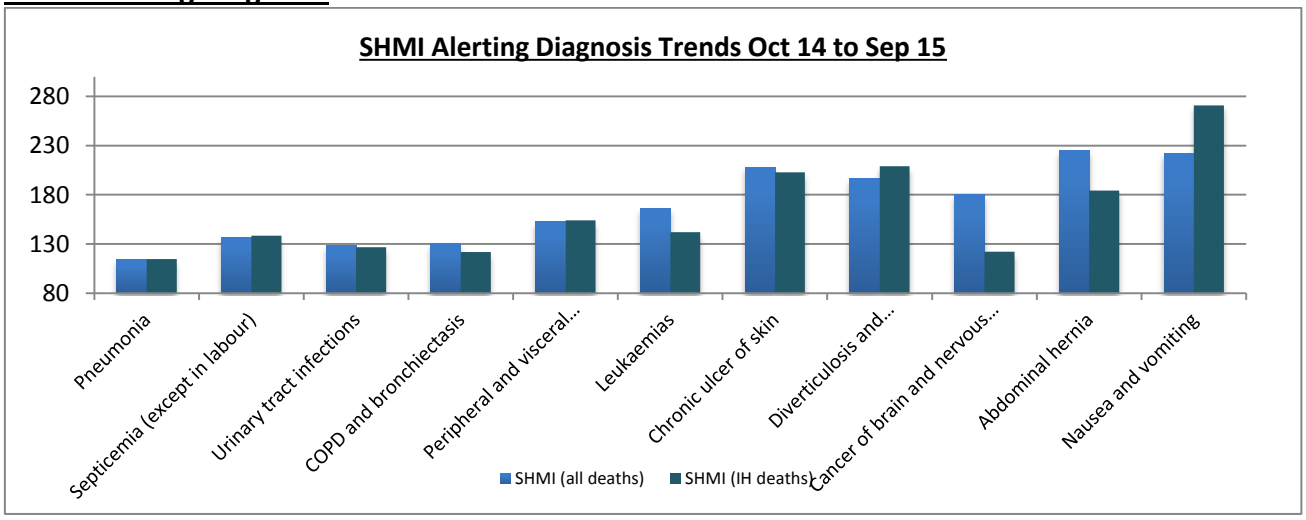
Death I/O Hospital	SHMI Spells	SHMI/ HSMR	Actual Deaths	Expected Deaths
SHMI All deaths	81650	111.21	3672	3301.91
SHMI In hospital deaths	81650	105.58	2492	2360.37
HSMR	53868	103.97	2258	2171.68



SHMI Trends and Alerting Diagnosis



SHMI Alerting Diagnosis

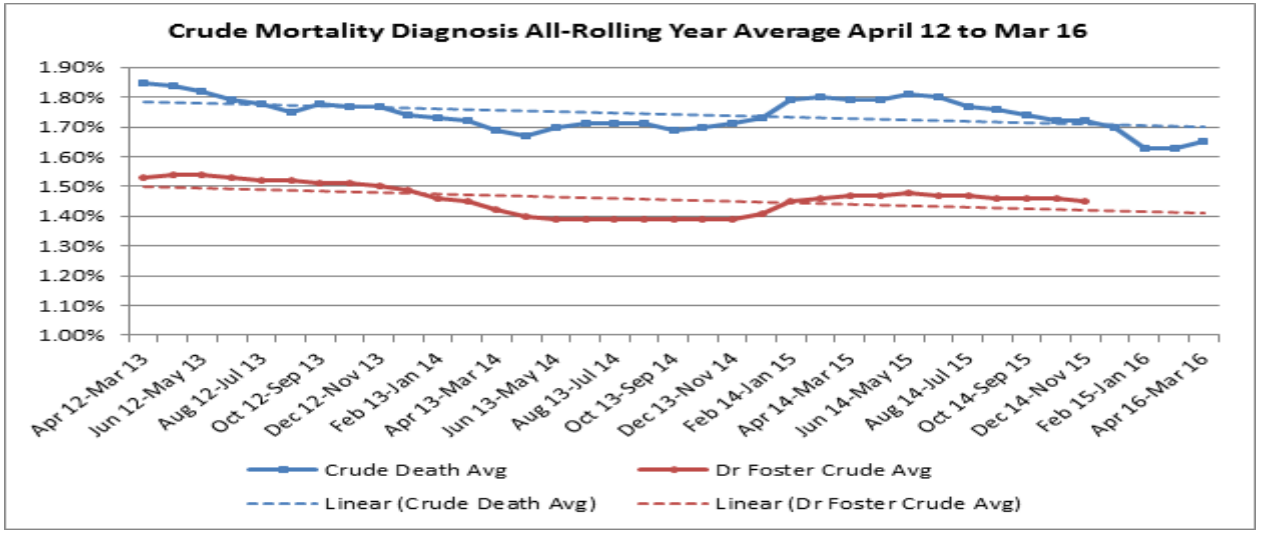


Diagnosis Group	SHMI (all deaths)	SHMI (IH deaths)	Alerting in Hospital
Pneumonia	114.1	114.69	✓
Septicemia (except in labour)	136.3	138.33	✓
Urinary tract infections	128.82	126.81	✓
COPD and bronchiectasis	130.65	121.87	
Peripheral and visceral atherosclerosis	152.98	154.16	✓
Leukaemias	166.37	142.01	
Chronic ulcer of skin	208.18	202.77	✓
Diverticulosis and diverticulitis	196.74	209.06	✓
Cancer of brain and nervous system	180.17	122.05	
Abdominal hernia	224.59	184.3	
Nausea and vomiting	221.88	271.02	

- The alerting diagnosis in hospital are currently not alerting in HSMR apart from Sepsis which is currently being dealt with via the sepsis task and finish group.
- Where ULHT are alerting but not in hospital suggests that post discharge deaths are driving the ULHT SHMI upwards.

Crude Mortality

Crude Mortality Apr 14 – Mar 15 %	Dr Foster Crude National Avg Apr 14-Mar 15	Dr Foster Crude National Average Jan 15 – Dec 15	ULHT Crude Average Jan 15-Dec 15	Crude Mortality Rolling Yr Apr 15-Mar 16	Crude mortality YTD Apr 15-Mar 16	Crude Mortality Mar 16	Movement in Month Feb 16	Movement in Year Mar 15
1.79 %	1.47%	1.73%	1.70%	1.65%	1.65%	1.96%	+0.05	+0.17%

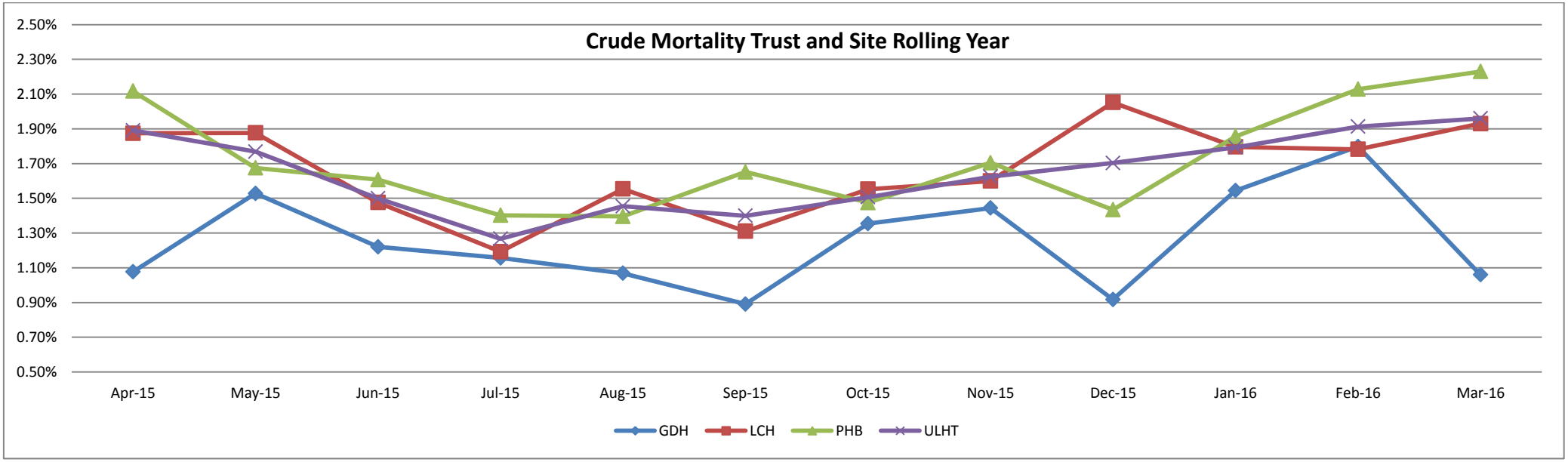


Performance Data Overview:

- Crude mortality rolling average year shows a downward trajectory.
- Against National average (Jan 15-Dec 15) ULHT is lower by 0.03%. ULHT's average is 1.70%.
- ULHT's crude mortality for the rolling year is 1.65%.
- In rolling year ULHT has a slight downward trajectory which is in line with Dr Fosters crude average for all diagnosis.

March 2016 crude mortality by hospital:

- Grantham: 1.06% ⬇
- Lincoln: 1.93% ⬆
- Pilgrim: 2.23% ⬆



Mortality Reviews

Reviews (Jan 2016-Mar 2016):
Review compliance is as follows:

Site	No. of Deaths	Reviews in progress	Reviews Complete	Review Completion Compliance %
ULHT	**743**	**418**	**199**	**48%**
LINCOLN	**388**	**261**	**123**	**47%**
PILGRIM	**295**	**118**	**57**	**48%**
GRANTHAM	**51**	**39**	**19**	**49%**

ULHT Review Grading:
From the completed reviews the following grading's were applied by the reviewing consultants, please note for 64/199 (32%) of reviews complete the grading was not completed by the reviewing consultant:

Grading	Review Count
Grade 0-Unavoidable death, no suboptimal care	116
Grade 1-Unavoidable death, suboptimal care but different management would NOT have affected outcome	16
Grade 2- Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)	3
Grade 3- Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death).	0

ULHT Review Trends:

Positive Trends:

- 81% of patients had a consultant review within 14 hours and received a senior daily review
- 84% of patients where appropriate had an evidenced daily management plan for Fluid balance.
- 98% of patients where appropriate had news completed every 12 hours.
- 81% of patients where appropriate had the sepsis bundle commenced for a News score of 5 or over.
- 95% of patients where escalation was required this was appropriately managed.
- 87% of patients had a management plan appropriate for their stay.
- 81% of reviewers felt the documentation was suitable.
- 98% of the patients where applicable there was no delay in transfer within the hospital.
- 37% of cases were deemed as excellent practice.

Negative Trends:

- 6% of patients were deemed as inappropriate admissions
- 20% of reviews were returned late by reviewers
- 75% of patients the cause of death was not discussed with a senior staff member.
- 50% of patients were deemed appropriate were not on a palliative care pathway.
- 11% of the reviews felt there were issues identified in the patients care those trends include; falls, incorrect IV, inappropriate admission, delay of attendance A&E dept, delay in treating UTI, delay in diabetes referral, delay in ICU referral.
- 13% of patients did not have a management plan that was appropriate for their stay.
- 8% of patients had adverse events during their stay. Trends include; falls, HAP, palliative care decision should have been sooner, developed sepsis and ARDS
- 6% of patients had a delay in procedure.
- 8% of patients there was a delay in clinical review and actions.
- 5% of cases there was failure to act on information available.
- 2% of cases there was failure to rescue a deteriorating patients.
- 18% of patients where appropriate did not receive Duty of Candour
- 13% of cases have been referred to MoRAG for further review by the reviewer.

Actions and Lessons

Lessons Learned:

Issues identified/Lessons to be learned:

- No end of life care planning in the community.
- Lack of Senior Review
- Allergy management
- Coding/Cause of death inaccuracy
- Sepsis bundle not completed
- Documentation missing and illegible; Drug Charts, Emergency Admission Proforma-time of arrival and referral missing, Duty of Candour not documented
- Inappropriate management of fractured sternum
- Filing issue: 1 Patients husbands notes were filed in their notes.
- A registrar drained 500mls of blood from the chest drain and then prescribed and gave clexane immediately.
- Inappropriate early discharge – daily anticoagulation should have been doing as an inpatient was sent home and readmitted with Spontaneous haemothorax due to anticoagulation.
- Failure to escalate deteriorating patient and not put on a palliative care pathway within a timely manner.

Actions taken from MoRAG and Reviews:

- Ensure all lessons learned are disseminated to the relevant teams and discussed at governance meetings.
- Highlight in eDD's for the GPs to put the patients onto Gold Standard
- Contact the original reviewer to explain there was a different outcome after the review and discussion at MoRAG.
- Write to lead Pharmacist regarding Medicine reconciliation for this patient if this is not included in original SI.
- compile short presentation on the appropriate management of sternal fractures and disseminate to all Clinical Directors (medical/surgical/A&E) to present in their Governance meetings.
- IR1 to be completed and notes sent to be filed in correct notes
- Raising a SI for one of the cases
- Duty of Candour –to write to the son of the patient explaining the case has been reviewed as part of MoRAG and the outcome
- Write to the registrar regarding the prescription of clexane after draining blood from the chest drain and cause of death inaccuracy.

Action plan:

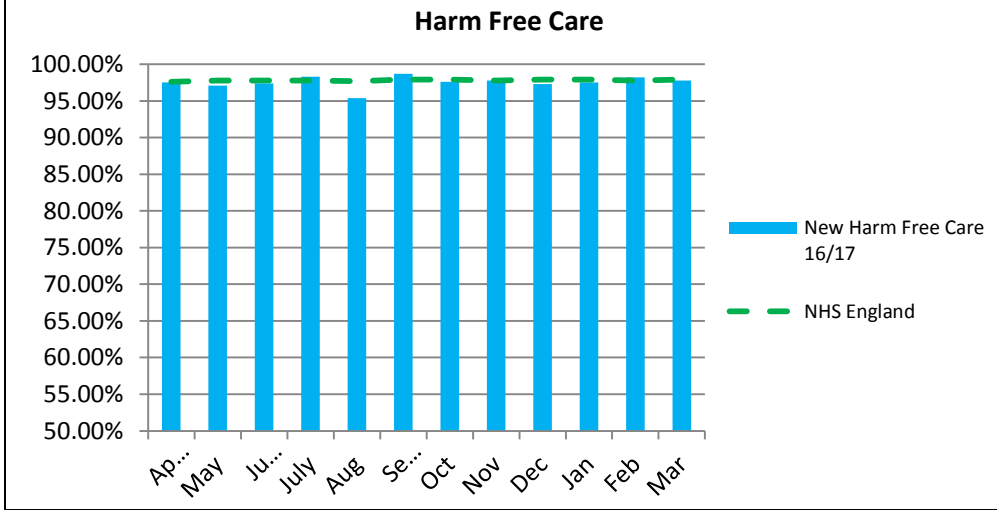
Highlights from Action Plan:

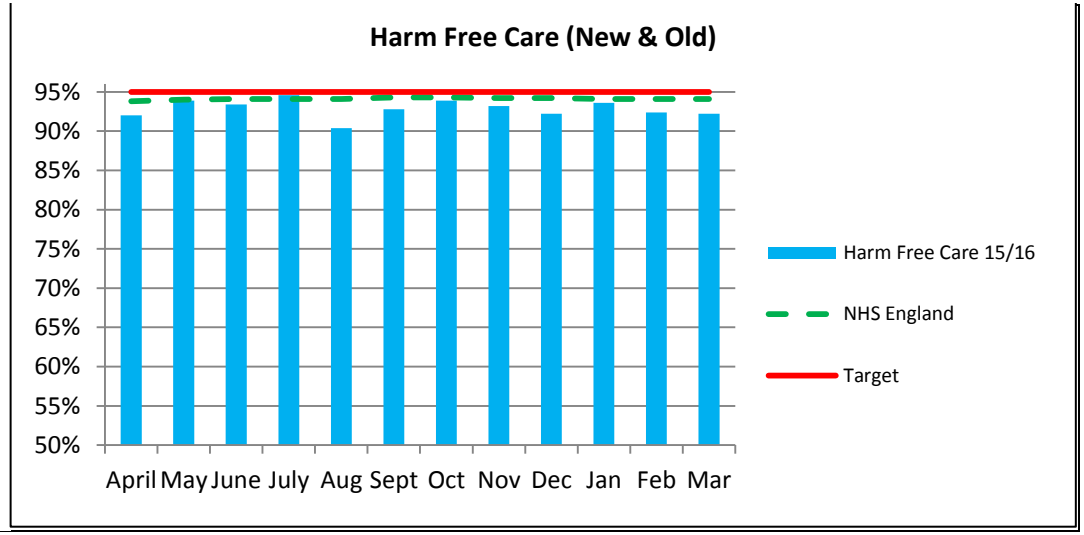
- Quality governance are holding sepsis awareness month; with sepsis champions going round the hospitals. In line with the Sepsis task and finish group action plan.
- Working with the CCG all deaths within 48 hours over the age of 75 are being sent to CCG for review regarding avoidable admissions.
- Other perinatal conditions; is now alerting. Mainly due to the use of P95X(Fetal death of unspecified cause) codes. A review meeting of the First born review form is to be arranged and the alerting P95X deaths are being looked into by the W&C team. 12 of the 17 deaths have been coded as P95X this holds a lower risk rate which lowers our expected death rate used in Dr Foster data. These are currently undergoing a coding review.

SAFE AMBITION 2 Reduction of Harm Associated with Harm free Care

The NHS Safety Thermometer records the presence or absence of four harms:

- Pressure ulcers (Old and New)
- Falls (Falls in hospital and falls in the community if from a care setting within 72 hours)
- Urinary tract infections (UTIs) in patients with a catheter (Old & New)
- New venous thromboembolisms (Old & New)





Performance Data Overview

Harm free care aspiration = 95%, ULHT achieved 92.41% in March 2016
New harm free care (no target set) ULHT achieved 98.05 in March 2016

Harm Free and New Harm Free Care across ULHT March 2016

	ULHT %	GDH %	LCH %	PBH %
Harm Free	92.41	94.00	92.68	91.54
New Harm Free	98.05	98.00	97.78	98.43

Currently on the Safety Thermometer we are an outlier for falls and CAUTI. The falls data includes falls in the community however at Trust level we breakdown this data to allocate falls from community or ULHT.

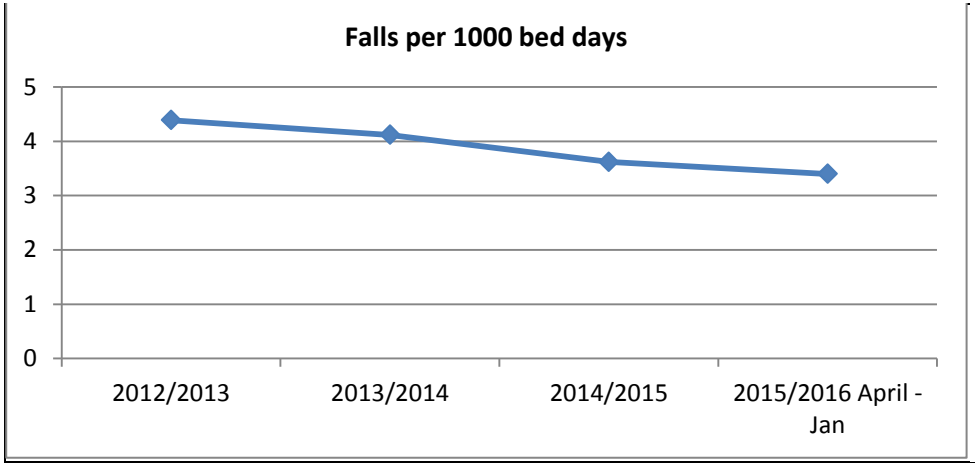
Action Plan

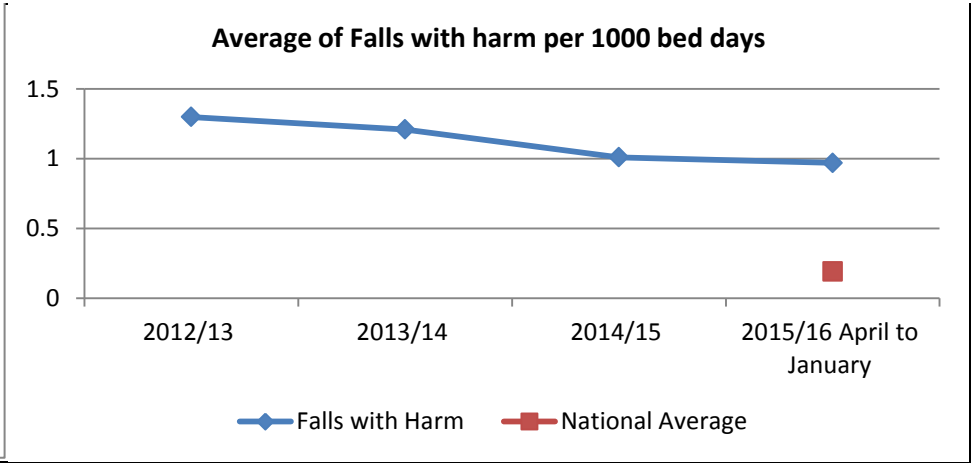
Results for CAUTI / Falls / Pressure Ulcers and VTE are discussed at their respective meetings. There is a work plan for Falls and are currently being developed for pressure ulcers CAUTI and VTE.

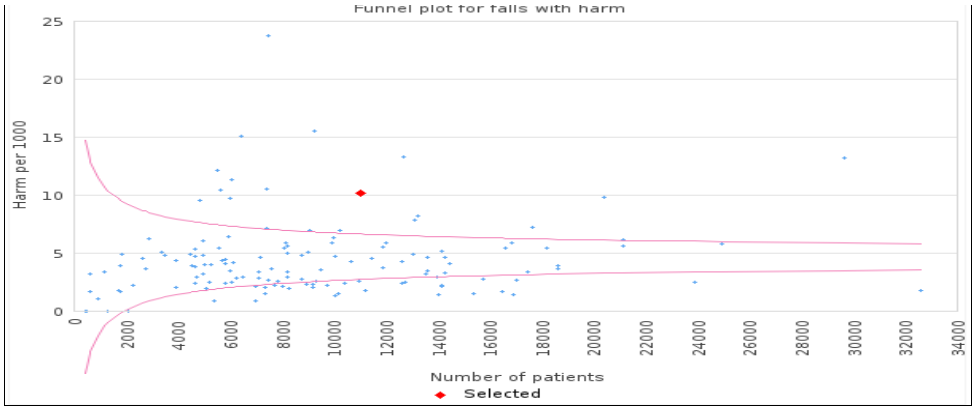
Quarterly reports presented at the Patient Safety Committee on the 4 harms depicting their results and their actions to improve compliance.

All harms are validated by the specialist nurses prior to the data being submitted.

SAFE AMBITION 3 Reduction of Harm Associated with Falls

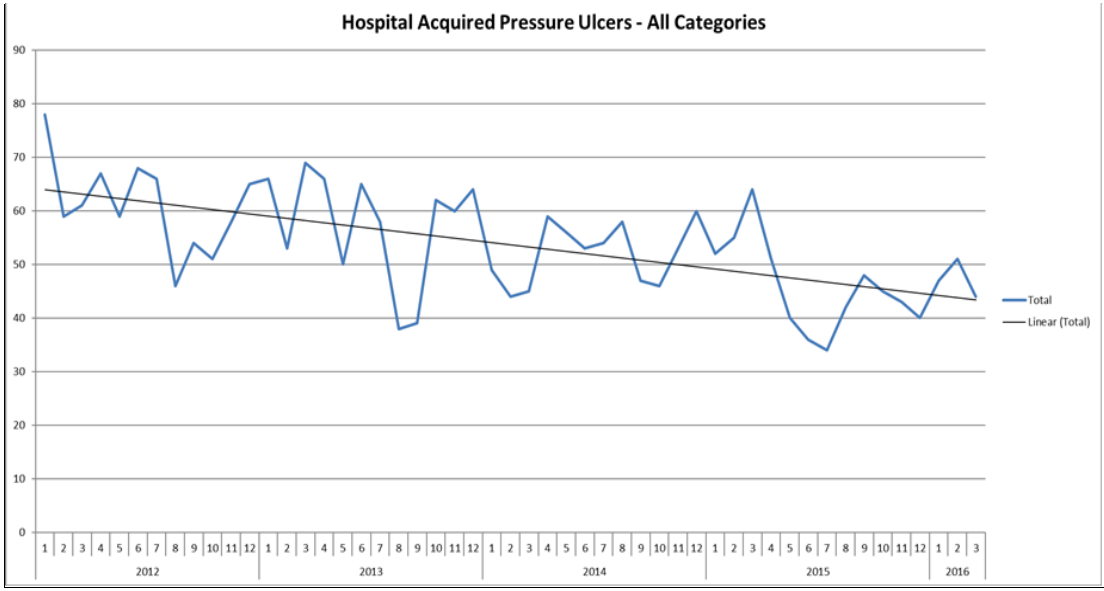


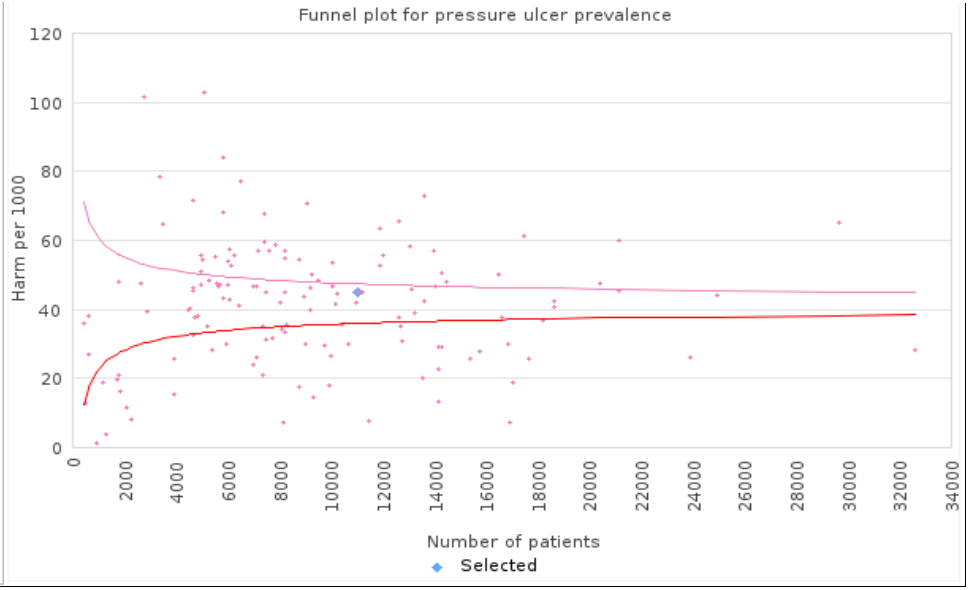




Performance Data Overview	Action Plan
The trajectory for falls will be inserted for the May report The trust remains an adverse outlier against the national average for fall with harm. Despite the overall reduction achieved, the number of falls with harm reported for February 2016 was 1.30 which is an increase from 0.8 which reported in January 2016. In February, the Trust succeeded in utilising less off framework agency; however, this did impact on fill rates so staffing levels under agreed templates needs to be considered when reviewing falls incidence rates. The Safety Thermometer funnel plot also highlights ULHT as an outlier, however, improvement has been made over the previous 6 months. In February, the Trust succeeded in utilising less off framework agency; however, this did impact on fill rates so staffing levels at Pilgrim so the process has been changed.	The ULHT falls group has been relaunched with revised terms of reference and is working towards an agreed annual work plan. The group review performance, themes from scrutiny panels with improvement actions as well as reviewing national policy. The group reports to Patient Safety Committee. In February 2016, the socks provided to patients without secure footwear were improved to double side grip Patient's placemats now include information of prevention of falls Five pilot wards have been identified to pilot the following; Teaching, Patient Safety Huddles, Use of Alarm Kits, Use of Low rise beds and working in partnership with the 1-1 project amongst other actions. The competency booklet which is currently being formulated.

SAFE AMBITION 4 Reduction of Harm Associated with Pressure Ulcers





Performance Data Overview

There continues to have been a reduction in all categories except category four which still totals greater than at the same time last year.

For the Year overall there has been a 19% reduction in Category 3; 22% reduction in Category 2 and 23% reduction in Category 1 pressure ulcers reported on PUNT.

Pressure Ulcers for March 2016

Category 4	Category 3	Category 2
Ward 8a(PBH) Navenby Ward (LCH) Carlton Coleby (LCH) Stroke Unit (LCH)	Ward 1 (GDH) Nettleham Ward (LCH) Johnson Ward (LCH)	29 Category 2 pressure ulcers across the Trust

The Safety Thermometer data demonstrates ULHT to be within acceptable limits.

Action Plan

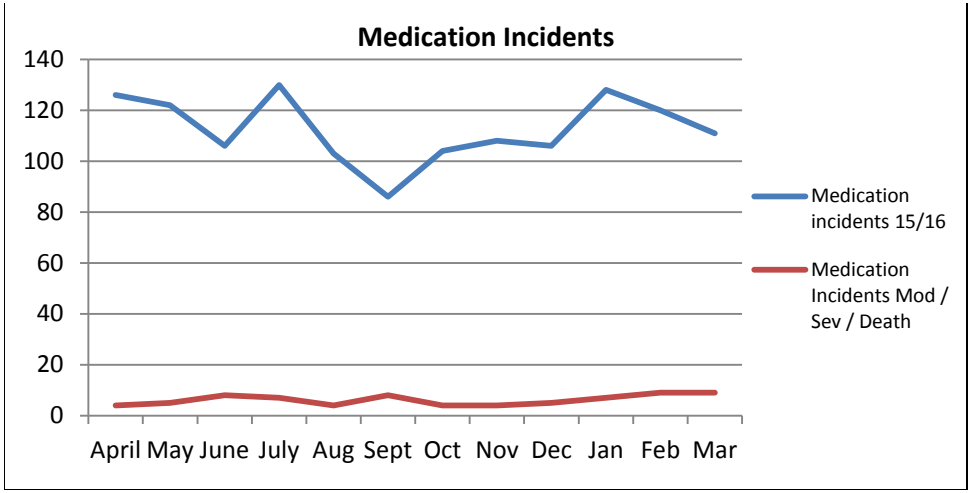
To have data for the Trust on pressure ulcers separated into category 2 / 3 & 4 pressure ulcers per 1000 bed days.

Two Band 5 Staff Nurse seconded posts, one on the PHB site and one on the LCH site (2 days a week on each) will be advertised soon and their focus is on Pressure Ulcer prevention.

Further ongoing work has been undertaken with the Consultant Nurse for Tissue Viability regarding the identification of an annual plan for the TV Team which includes defining metrics to monitor performance improvement.

Pressure Ulcer scrutiny panel has been formed to review category 3 & 4 pressure ulcers to help identify themes and share lessons.

SAFE AMBITION 5 Reduction of Harm Associated with Medication



Medication Incident	Number
Omitted medicine/ingredient	33
Wrong/unclear dose or strength	24
Other	20
Wrong drug/medicine	10
Wrong frequency	8
Contra-indication in relation to drugs or conditions	7
Patient allergic to treatment	6
Wrong formulation	3
Mismatching between patient and medicine	3
Wrong storage	3
Adverse drug reaction (when used as intended)	2
Wrong quantity	1

Performance Data Overview

Antimicrobials were the most omitted drugs accounting for 46% of high risk drugs omitted and 36% of all medications omitted.
7 of the 9 (78%) moderate rated incidents involved a priority/high risk drugs.
24 (20%) incidents reported were due to doses being wrong or unclear.
There were 6 incidents reported this month involving patients receiving medicines that they are allergic to. 5 of the incidents were due to patients receiving doses of a penicillin drug despite having a penicillin allergy and all of those 5 incidents occurred at Pilgrim hospital.

There were 10 incidents reported that involved errors made by the Pharmacy department. Pharmacy issued 71,276 items in February making the error rate 0.01%.

Quarterly Controlled Drug audits in process raising compliance from 17% in 2014 to 80% currently. There are still problematic areas where there is non-compliance.
Areas non-compliant
Lincoln – Bardney & Waddington
Pilgrim – A&E / Bostonian / AMU / ICU

Action Plan

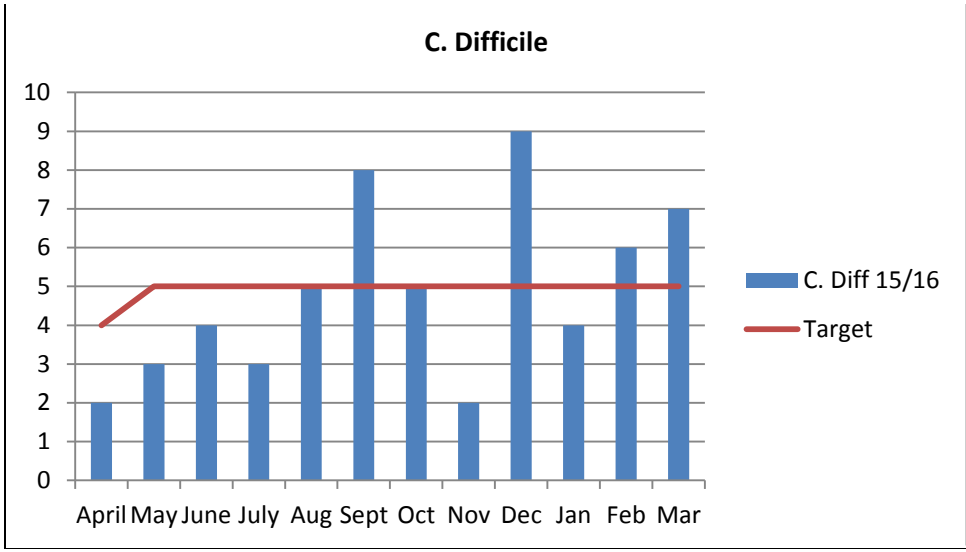
Data per 1000 bed days will be available from May 2016

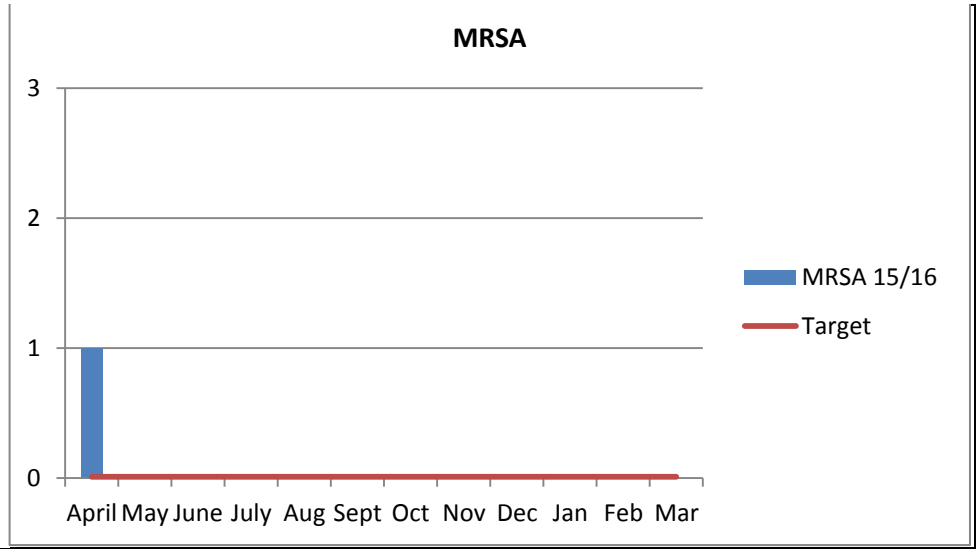
HoN will be requested to feedback at the Medicines Optimisation Meeting on the actions they are taking related to the incidents within their area.

Medicines report is discussed at the Speciality Governance Meeting

Due to the volume of Insulin incidents discussion between the Diabetes team and pharmacy to improve management. A business case has been developed for an eLearning package.
The anticoagulation chart has been redesigned and will be launched in June 2016

SAFE AMBITION 6 Reduction of Harm Associated with Infection





Performance Data Overview

There have been seven (7) cases of hospital attributable (trajectory 5), bringing the total of hospital attributable cases to fifty seven (57). There was also one (1) community acquired case reported for March 2016. The trust came under trajectory by 2 cases for the year.

There has been zero cases of hospital attributable (trajectory 0). The Trust reported two (2) cases of community acquired cases for March 2016. This brings the total of hospital attributable MRSA bacteraemia to one (1) case, which breaches the Trust trajectory of zero (0) cases.

There have been three wards with confirmed norovirus this month- Burton ward on the Lincoln site and wards 6A and 5B on the Boston site.
Wards 7B and AMU on the Boston site were also monitored due to patients with episode of diarrhoea and/or vomiting.

Outbreak of Influenza A (HINI) on Waddington ward in February/March 2016.

Servicetrac scores below an acceptable level on the ward

Action Plan

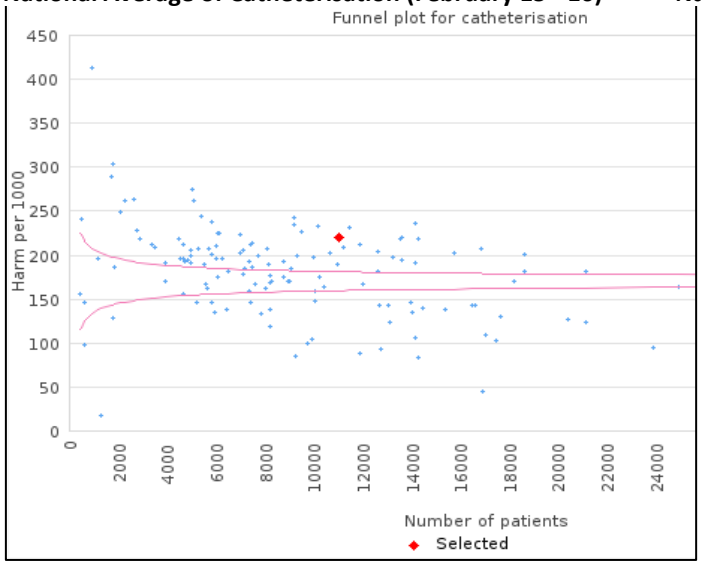
Servicetrac
Cleaning review completed and report going to Trust board
Action plan to be completed for each area
Refresher training given to staff
Score to be >95%

Training
Infection prevention annual update training is a mandatory (core) requirement for all clinical staff and non-clinical staff who work in non-clinical areas. The Trust target of compliance is 80%. E-learning is available for both clinical and non-clinical staff. Non-compliant staff are monitored by the Training and Education Department and is escalated to the chair of the site Infection Prevention Group.

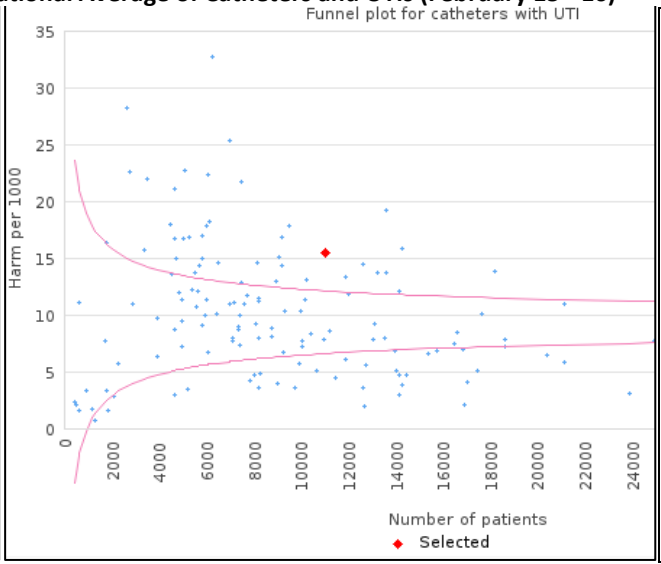
Infection Prevention resources
Shortlisting has commenced for a 1 WTE Band 6 substantive Infection Prevention Nurse

SAFE AMBITION 6 Reduction of Harm Associated with Infection

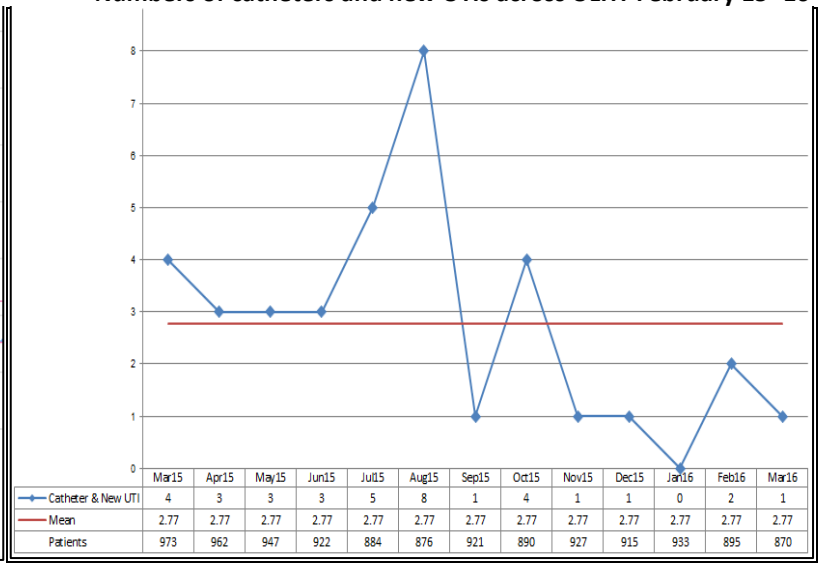
National Average of Catheterisation (February 15 - 16)



National Average of Catheters and UTIs (February 15 - 16)



Numbers of catheters and new UTIs across ULHT February 15 -16



	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15	Nov15	Dec15	Jan16	Feb16	Mar16
Catheter & New UTI	4	3	3	3	5	8	1	4	1	1	0	2	1
Mean	2.77	2.77	2.77	2.77	2.77	2.77	2.77	2.77	2.77	2.77	2.77	2.77	2.77
Patients	973	962	947	922	884	876	921	890	927	915	933	895	870

Metric Title	Feb-2015	Mar 2015	Apr-2015	May-2015	Jun-2015	Jul-2015	Aug-2015	Sep-2015	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016
Number of urinary catheters in-situ	61	58	85	68	85	85	52	65	93	87	57	65	73
Urinary catheter record completed &signed daily	84.7%	80.0%	76.5%	80.6%	68.6%	70.2%	83.0%	71.9%	59.6%	72.4%	63.2%	54.5%	64.4%
TWOC occurred within 3 days for acute retention	58.8%	23.5%	60.0%	71.4%	38.5%	76.5%	83.3%	70.0%	34.8%	47.1%	50.0%	14.3%	25.0%
Documented evidence why catheter needed	88.5%	85.7%	86.0%	88.2%	82.6%	92.6%	96.2%	87.5%	90.3%	84.1%	89.5%	83.3%	83.6%
Urinary catheter care plan activated	88.5%	87.9%	88.2%	89.9%	89.5%	90.6%	96.2%	84.6%	77.4%	83.0%	91.1%	74.2%	78.1%

Performance Data Overview

As a result of the high number of Catheter associated urinary tract infections within ULHT, the CAUTI Task and Finish Group has been established.
The Group is responsible for developing, promoting and monitoring an effective CAUTI review process within ULHT with the aim of reducing CAUTIs across the Trust.

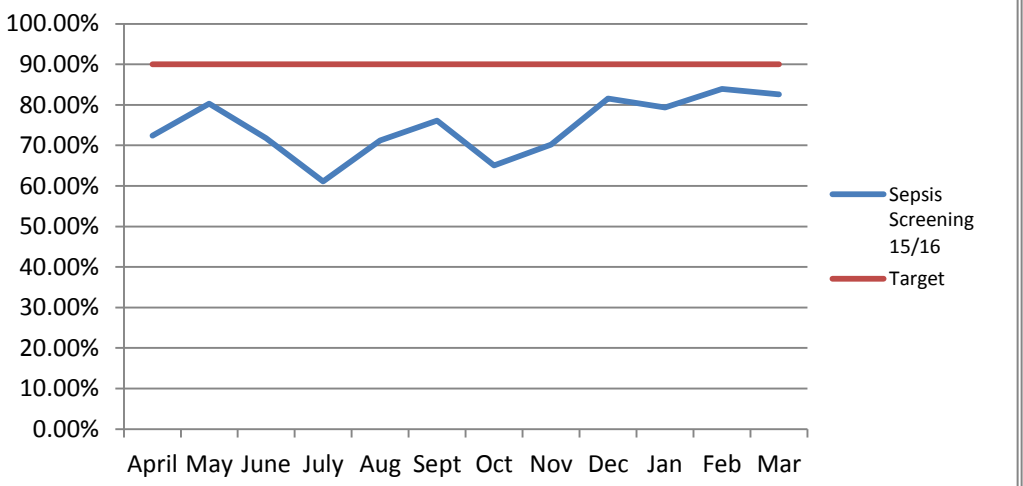
The number of CAUTI's has reduced considerably since March 2015 to present. The SQD data demonstrates poor compliance with the catheter record being signed daily which encompasses the question if the catheter is still required. Also catheters that have been inserted for acute retention are not being removed on day 3 as per Trust policy.

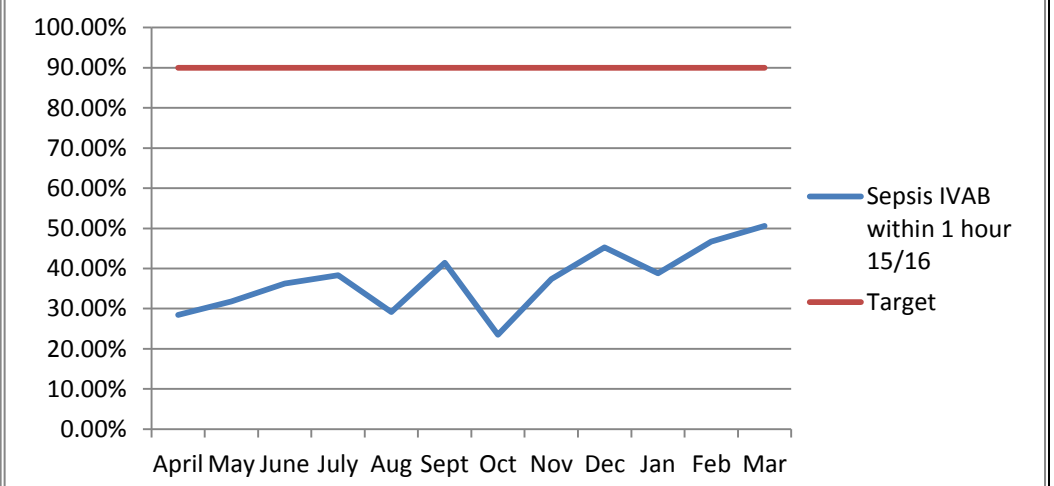
Action Plan

Updated Catheter care bundle has been launched on all wards
Standardising catheter care through staff education by the Urology Nurse Specialists
A nurse led catheter removal protocol is currently being developed

Daily catheter review
The most important CAUTI prevention strategy after placement of the catheter is to maintain awareness of the catheter's existence, as healthcare providers may be unaware the catheter is in place. Thus, a key step in prompting removal of unnecessary catheters is frequently reminding nurses and physicians that the catheter remains in place. Catheter reminder interventions in our trust include a daily checklist to assess continued catheter need and an electronic reminder that a catheter is still in place such as the electronic white boards.

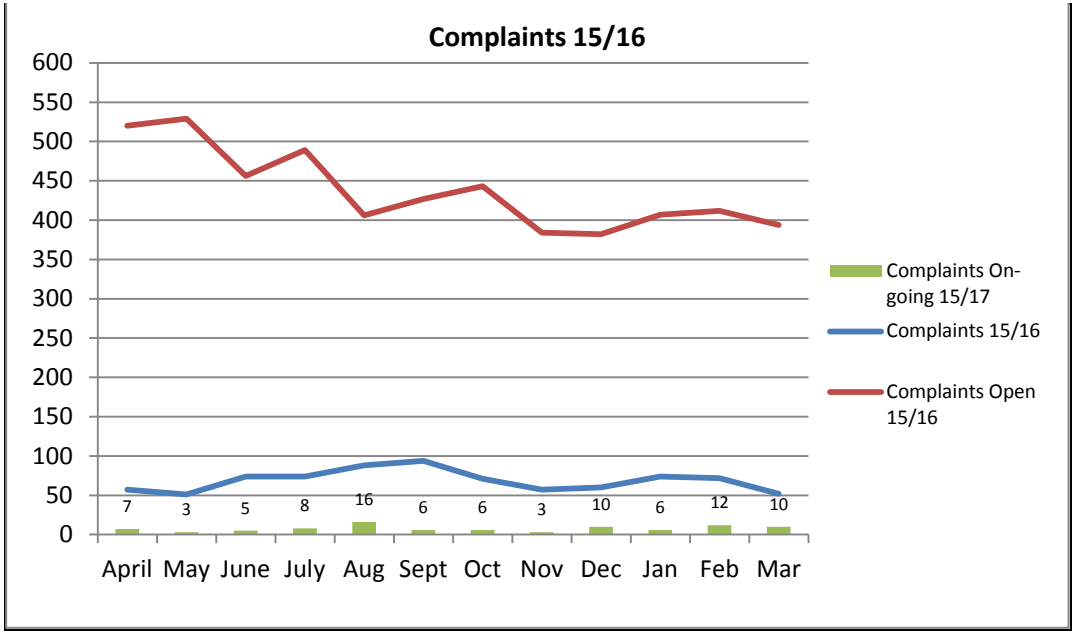
SAFE AMBITION 7 Reduction of Harm Associated with Deterioration





Performance Data Overview	Action Plan
The data for Sepsis screening is collected weekly by the data coordinators on the emergency admission wards. The data has improved considerably since the audit has commenced and currently achieving 82%. The CQUIN for 16/17 is to achieve 90% screening by quarter 4.	A Sepsis campaign was held during the month of March to launch the updated Sepsis bundle by Quality Governance. Approximately 900 clinical staff were trained on the updated Sepsis bundle. A Task & Finish committee has been developed , chaired by Dr Wolverson (Sepsis Trust Lead) A Sepsis Nurse pilot in Lincoln A&E for 5 weeks is commencing on the 18th April 2016 Sepsis boxes which contain all equipment necessary to treat the Sepsis within 1 hour are being investigated. Podcast being developed by Dr Loryman eLearning package being developed 2 sets of notes coded with Sepsis will be reviewed monthly and discussed at the Task& Finish Committee Results from the weekly audits are feedback to the relevant department and discussed at Speciality Governance meetings

SAFE AMBITION 11 Reduction of Harm Associated with Complaints



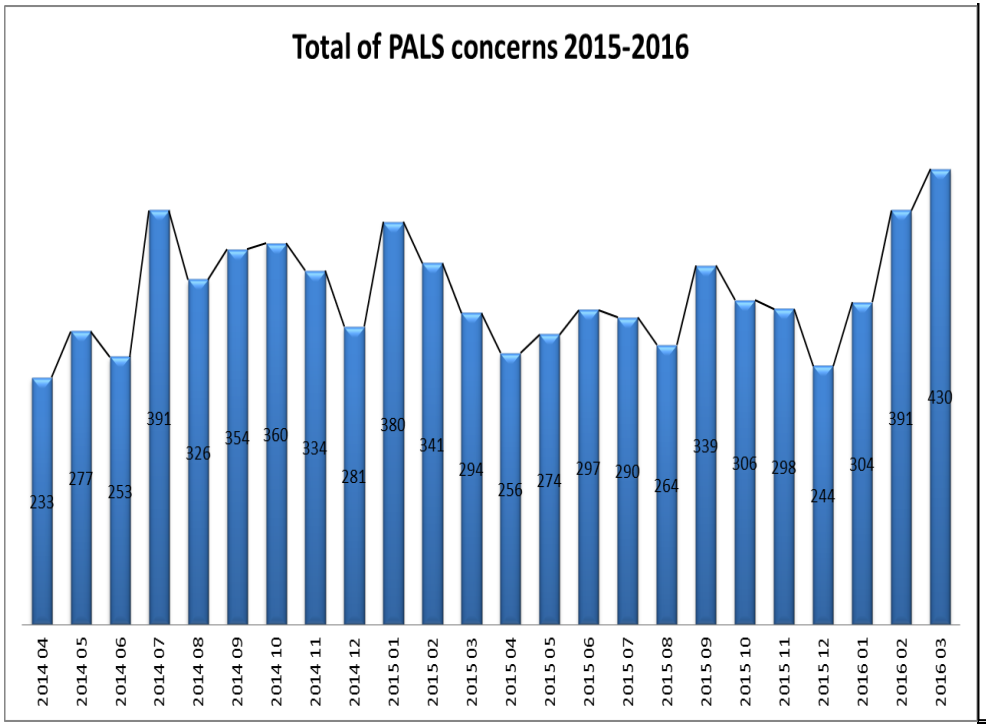
verdue complaints	February 2016			March 2016		
Business Unit	LCH	PHB	GDH	LCH	PHB	GDH
Surgical	33	4	0	34	4	0
Medicine	37	9	0	37	6	0
Grantham	0	0	6	0	0	5
Women and Children's	15	2	1	15	1	1
Corporate Services	4	0	0	2	0	0
Path Links	0	0	0	0	0	0
TACC	2	0	0	2	0	0
Clinical Support Services	3	0	1	2	0	1
Totals	**94**	**15**	**8**	**92**	**11**	**7**

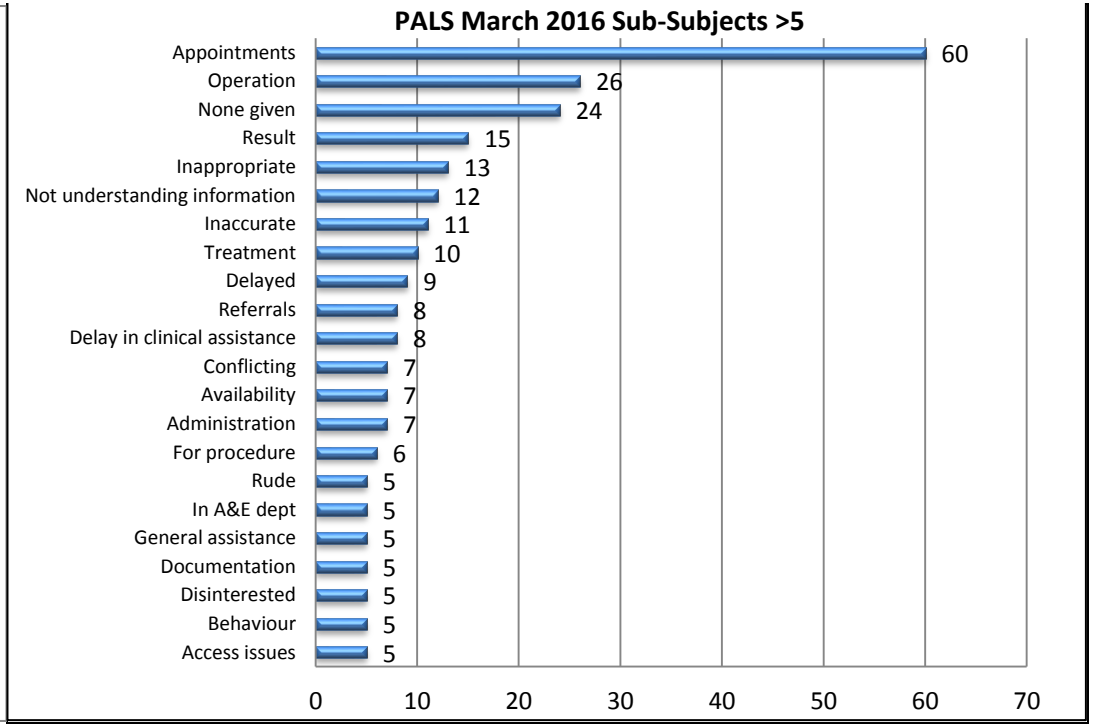
Performance Data Overview

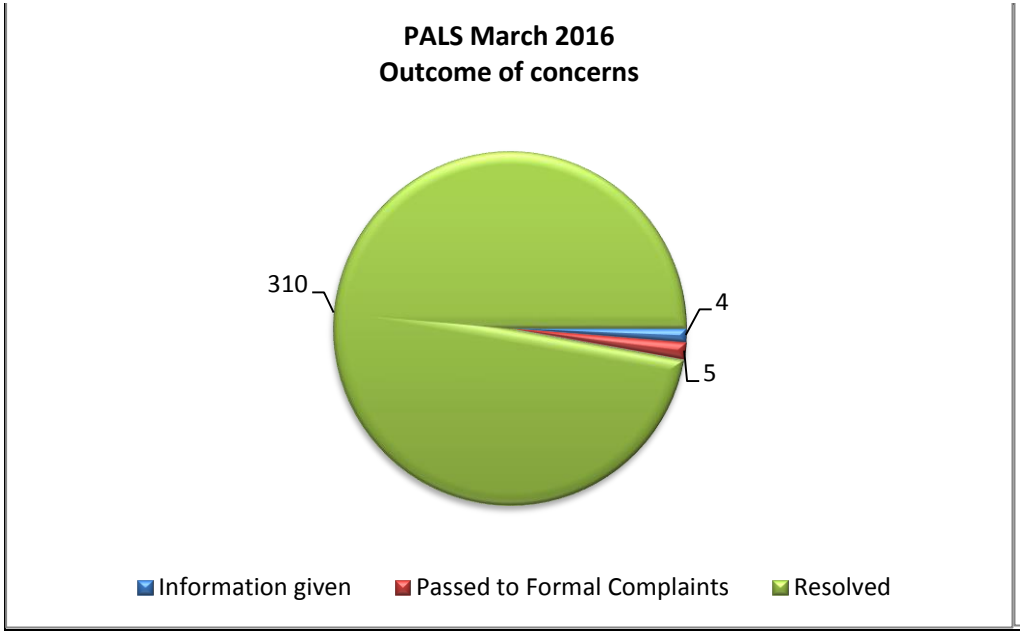
In total there are 110 overdue complaints across the trust. 23 of these are either at Trust HQ for approval and sign off or awaiting the 30 days before closure. Therefore the number still requiring further work is 87.

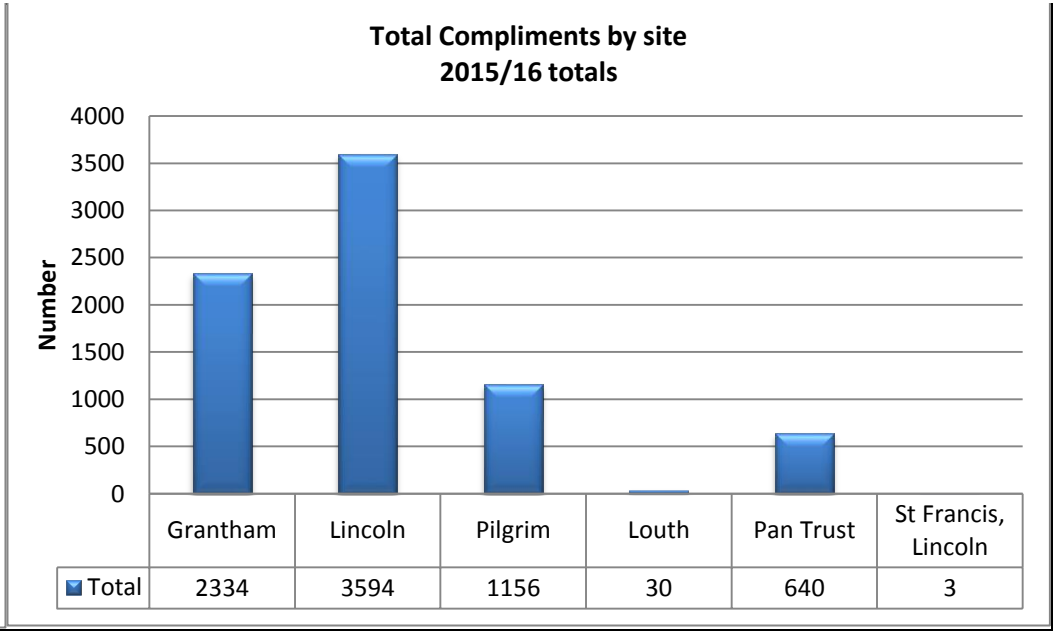
Action Plan

We are continuing to organise more and more meetings to sit with staff and go through the complaints face to face and cutting down on emails and phone calls. The case manager training is now finalised and dates are being scheduled this will include small groups or 1-1 sessions as and when requested or indicated. With the additional training and support we hope to then see a vast improvement in quality, productivity and responses going out on time and this will also improve working relationships within the hospital

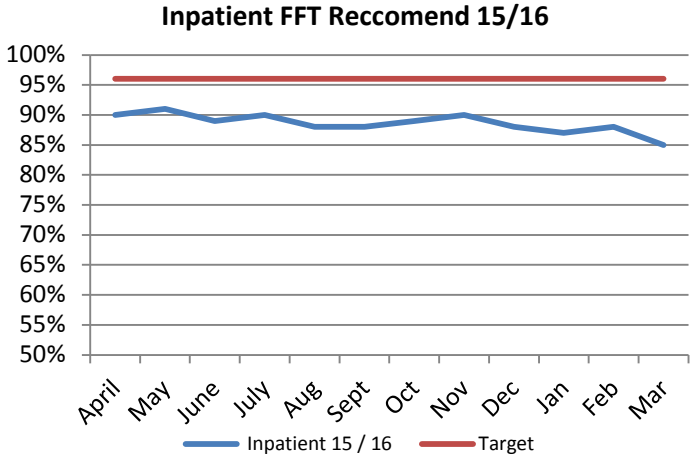

Total of PALS concerns 2015-2016
233
277
253
391
326
354
360
334
281
380
341
294
256
274
297
290
264
339
306
298
244
304
391
430
2014 04
2014 05
2014 06
2014 07
2014 08
2014 09
2014 10
2014 11
2014 12
2015 01
2015 02
2015 03
2015 04
2015 05
2015 06
2015 07
2015 08
2015 09
2015 10
2015 11
2015 12
2016 01
2016 02
2016 03

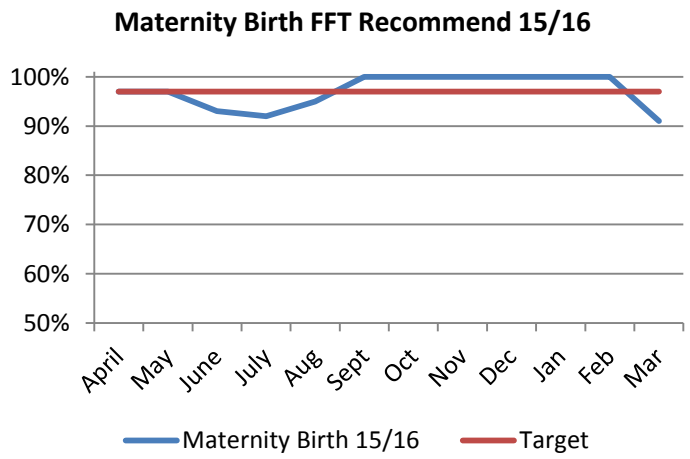

PALS March 2016 Sub-Subjects >5
Appointments 60
Operation 26
None given 24
Result 15
Inappropriate 13
Not understanding information 12
Inaccurate 11
Treatment 10
Delayed 9
Referrals 8
Delay in clinical assistance 8
Conflicting 7
Availability 7
Administration 7
For procedure 6
Rude 5
In A&E dept 5
General assistance 5
Documentation 5
Disinterested 5
Behaviour 5
Access issues 5
0
10
20
30
40
50
60
70

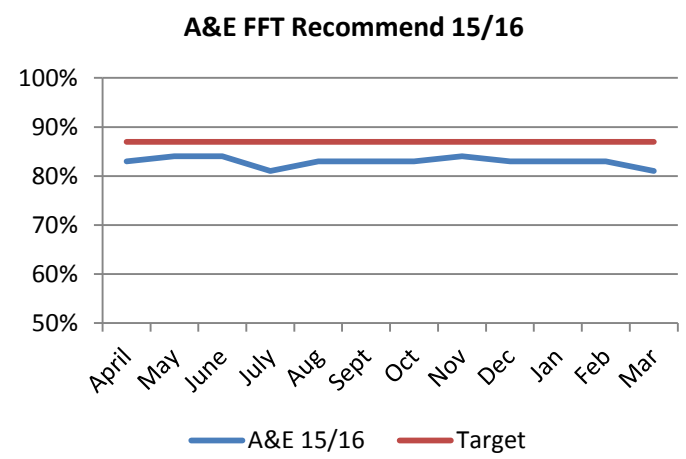

PALS March 2016
Outcome of concerns
310
4
5
Information given
Passed to Formal Complaints
Resolved

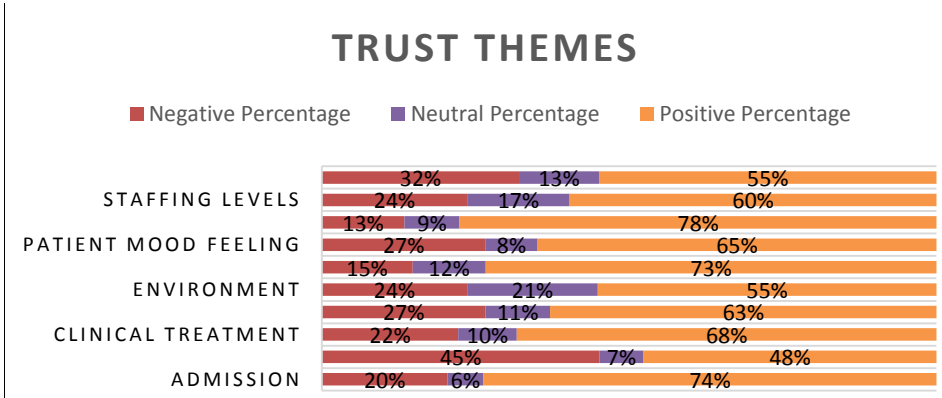

Total Compliments by site
2015/16 totals
Number
4000
3500
3000
2500
2000
1500
1000
500
0
Grantham
Lincoln
Pilgrim
Louth
Pan Trust
St Francis, Lincoln
Total
2334
3594
1156
30
640
3

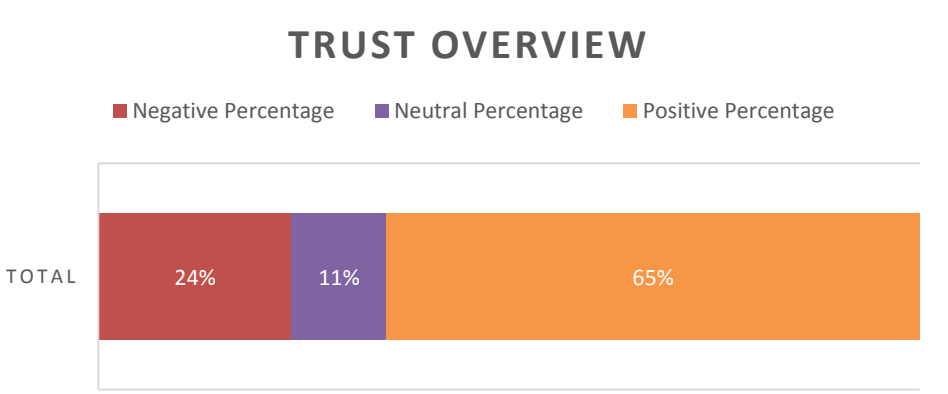
SAFE AMBITION 12 Reduction of Harm by Improving Patient Experience











Overall Performance Data

Following the national publication of FFT data, the Trust remains in the lowest 20% quartile for FFT would recommendation rates for Inpatients and Emergency Care whilst achieving above the national average for response rates.

Sentiment analysis breaks down each comment received by from patient into phrases, using punctuation and scored according to the sentiment within in the phrase – positive or negative. A score is given to every phrase and then an average score is applied.

41 stories were posted to Patient Opinion during February and were viewed **6,806** times. This equates to each story being read **166** times.

Action Plan

The national drive for FFT in 2017/17 is service improvement using the comments received and not the % sample rates. Whilst it is appreciated that % sample rates are important the Trust must concentrate on improving the % recommends across all areas covered by FFT. The trust is currently in the lower quartile across all streams of FFT both nationally and regionally.