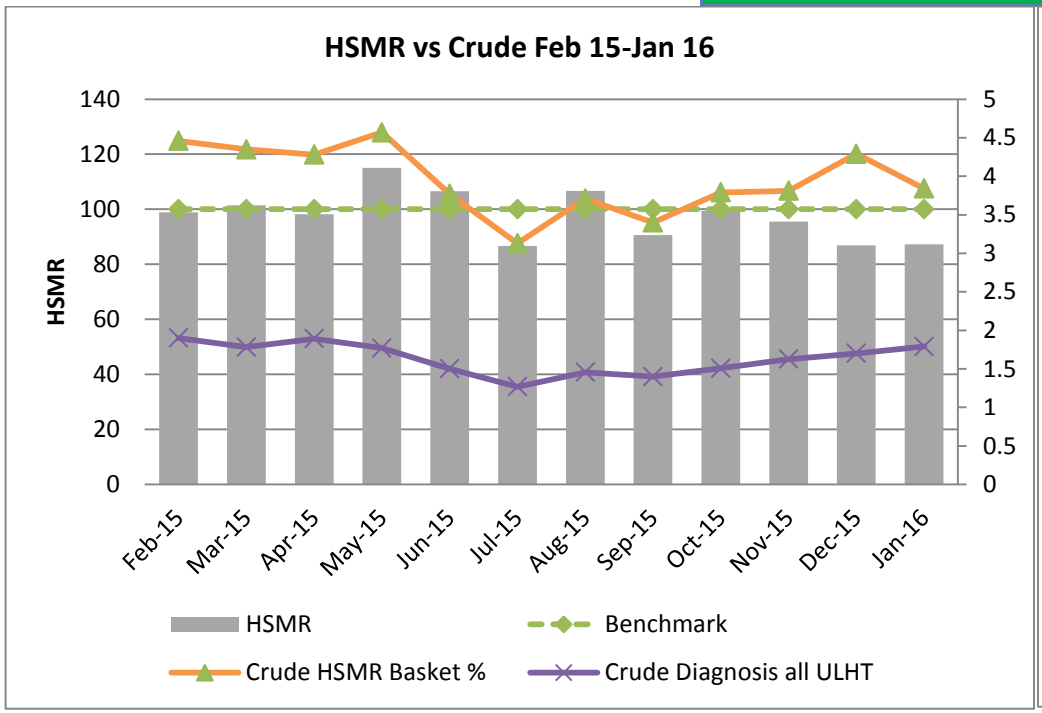
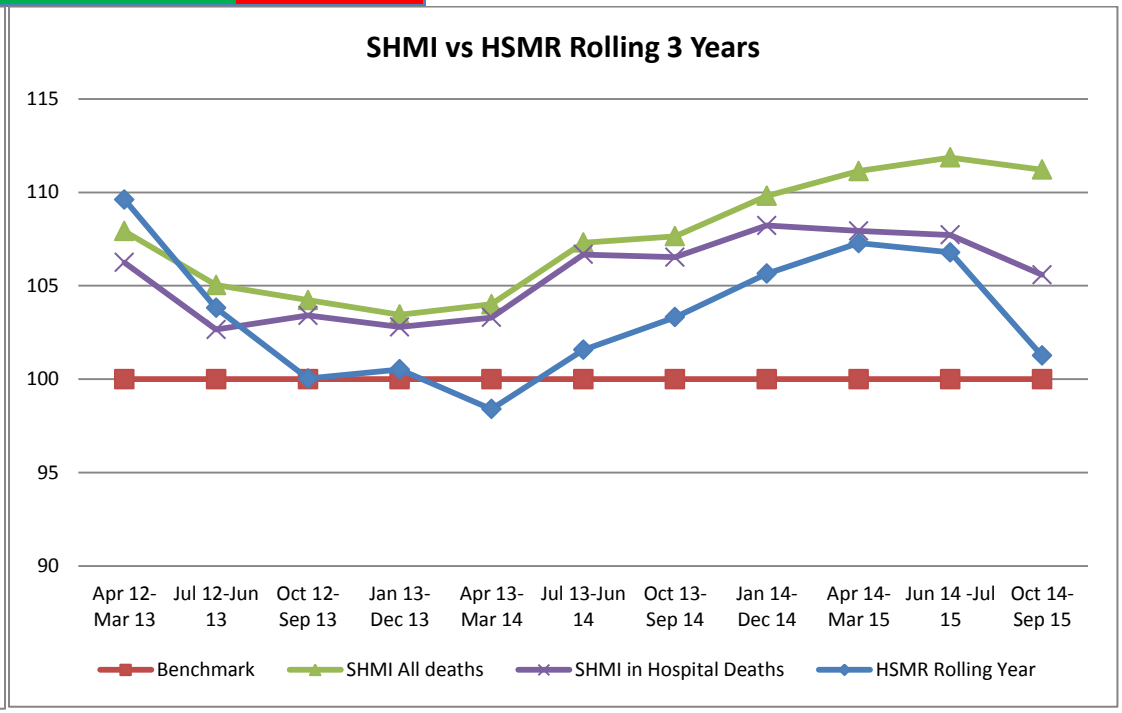
QUALITY REPORT MAY 2016

SAFE AMBITION 1: Reduction of Harm Associated with Mortality

Executive Summary

ULHT HSMR Feb 15-Jan 16	HSMR YTD Apr 15-Jan 16	ULHT HSMR Jan-16	ULHT SHMI Oct 14-Sep 15
99.54	99.31	87.28	111.21





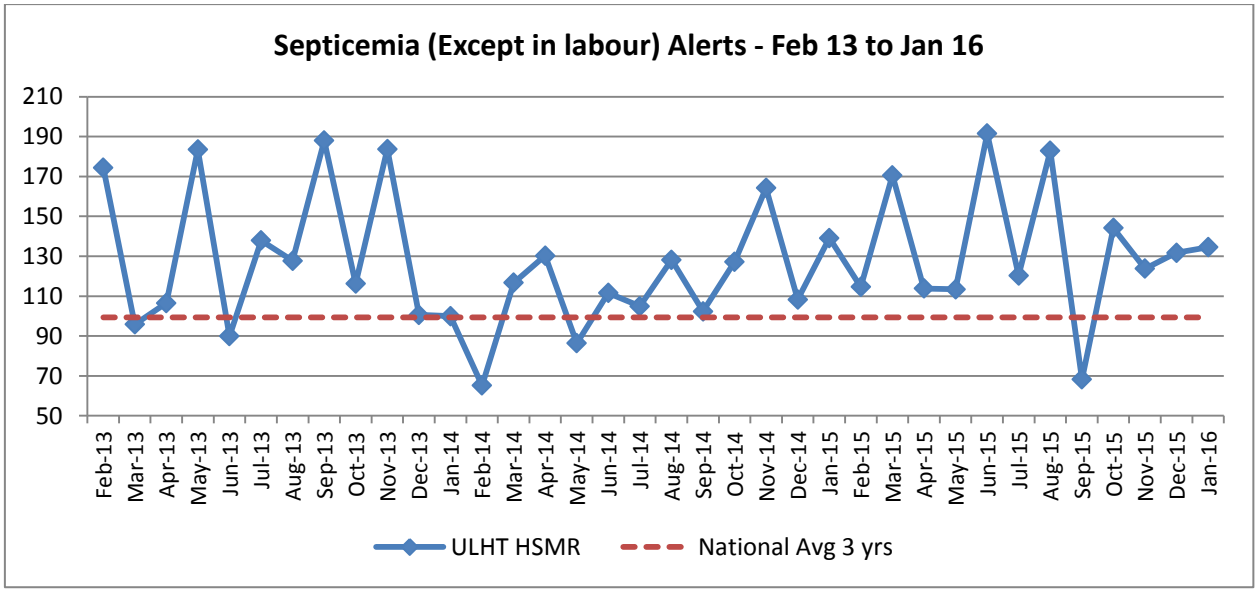
HSMR Diagnosis Groups alerting YTD April 2015 to January 2016:

Diagnosis group	Observed	Expected	Obs. - Exp.	Crude (%)	Exp. (%)	HSMR	Low CI	High CI
Septicemia (except in labour)	166	125.40	40.60	27.95	21.11	132.38	113	154.12
Other perinatal conditions	17	8.31	8.69	2.96	1.44	204.61	119.12	327.62

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

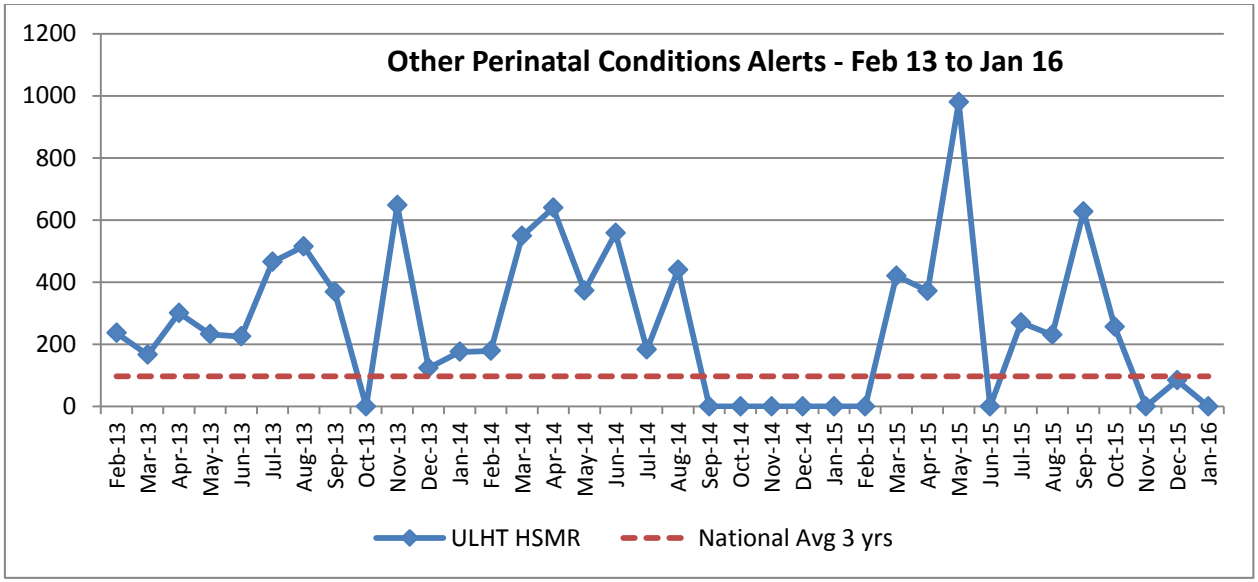
Septicemia (except in labour)



HSMR Septicemia alert overview

- Within the past 3 years sepsis has been sporadically alerting. ULHTs current HSMR YTD is 132.38 against National average of 99.38.
- 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.
- The inclusion of this Diagnosis group in the Dr Foster Alert Prevention scheme that Quality Governance are currently facilitating.

Other Perinatal Conditions

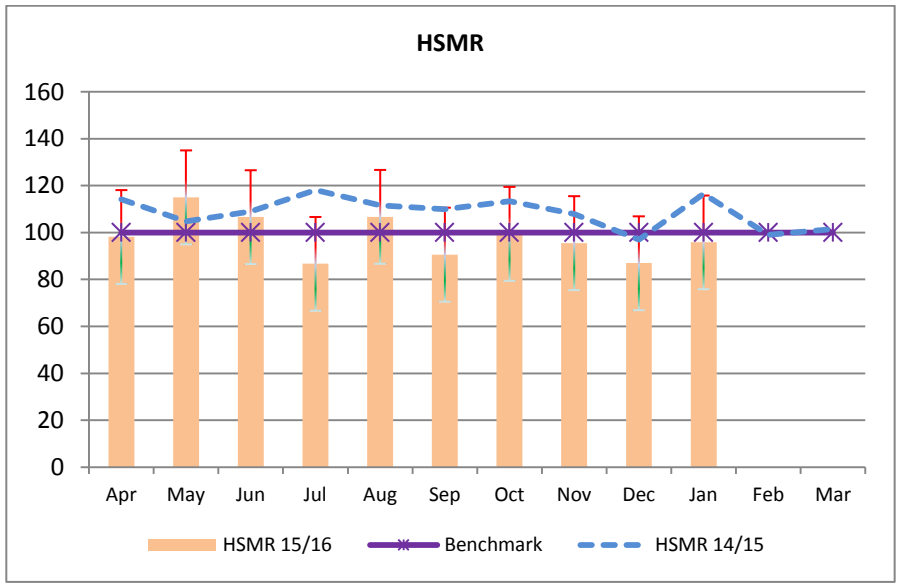


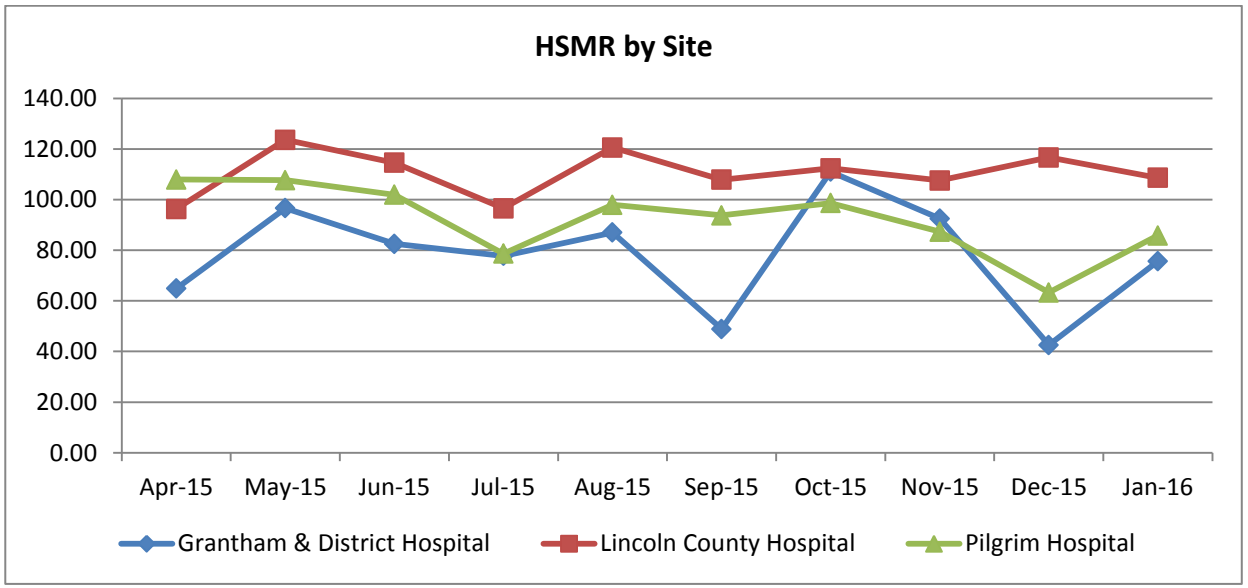
HSMR Other perinatal conditions alert overview

- Other perinatal conditions have been alerting infrequently over the past 3 years. ULHTs current HSMR YTD is 204.61 against a National average of 97.05
- ULHT have conducted casenote reviews on previous alerts.
- It was deemed that in the coding of well babies some comorbidities were not being coded. In December 2015 a First Born Review proforma was introduced to capture correct coding and comorbidities.
- The use of the code P95X (Fetal death of unspecified cause); this has a low risk rate thus reduces HSMRs expected deaths.
- The current 17 deaths are being looked into as 12 of these deaths were coded as P95X.

Hospital Standardised Mortality Ratio (HSMR)

HSMR Apr 14- Jan 15	HSMR Apr 15- Jan 16	% HSMR reduction(-) Increase (+)
110.89	99.31	-11.58%





Performance Data Overview:

United Lincolnshire Hospitals NHS Trust:

- The current year to date HSMR (April 15 to January 16) is 99.31 which is in line with the Trust and National Benchmark.
- Rolling year HSMR (February 15 to January 16) is 99.54; which is within expected range.
- In month for January 2016 HSMR has increased in line with winter trends to 95.87. A reduction from last year's January position from 116.43.

Lincoln County Hospital:

- HSMR YTD (April 15 to January 16) for LCH is 110.34, which is outside of expected range.
- Rolling year HSMR (February 15 to January 16) for LCH is 111.08, which is outside of expected range.
- In January 2016 has decreased by 8.01 to 108.65 which is outside of expected range. This is a reduction from last year's position at 130.07

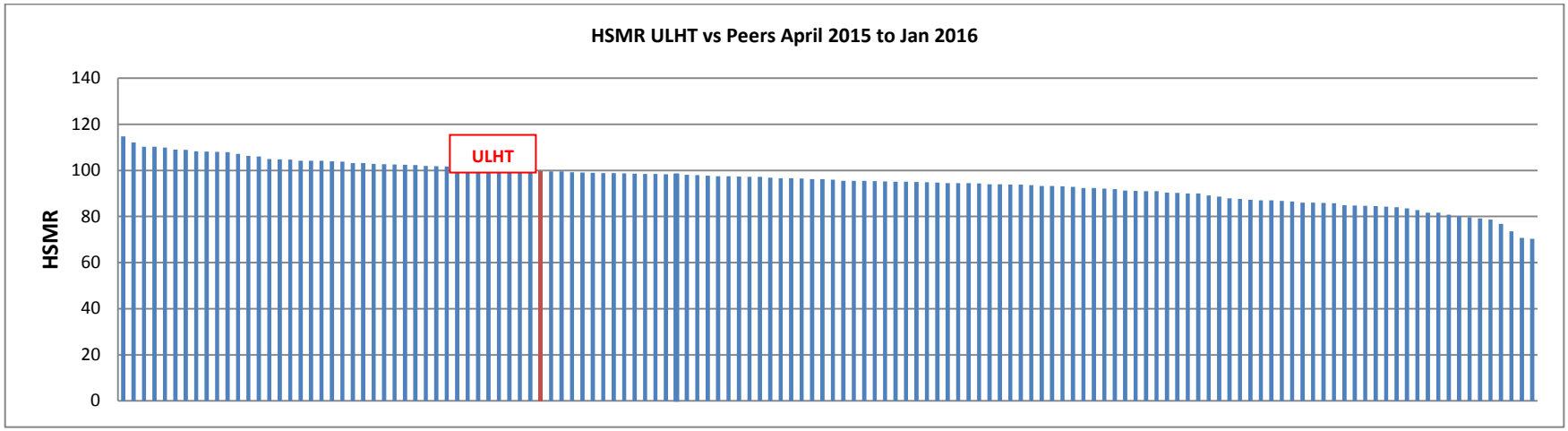
Pilgrim Hospital:

- HSMR YTD (April 15 to January 16) for PHB is 91.91, which is within expected range.
- Rolling year HSMR (February 15 to January 16) for PHB is 92.04, which is within expected range.
- In January 2016 HSMR has increased to 85.77 which is below expected range. A reduction from last year's position at 108.74

Grantham Hospital:

- HSMR YTD (April 15 to January 16) for GDH is 76.69, which is within expected range.
- Rolling year HSMR (February 15 to January 16) for GDH is 75.37, which is within expected range.
- In January HSMR is 75.59; this is within expected range. A reduction from last year's January position at 81.95

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 January 2015) ULHT is 41st out of the 137 acute non-specialist Trust.

HSMR Top 3 Observed Diagnosis Groups- April 2015 to Jan 2016

Diagnosis group	Spells	Spells (%)	Observed Deaths	Expected Deaths	Obs. - Exp.	Crude Rate (%)	Exp. (%)	HSMR	Low Confidence Interval	High Confidence Interval
Pneumonia	1591	3.61	304.00	321.94	-17.94	19.17	20.3	94.43	84.11	105.66
Septicemia (except in labour)	596	1.35	166.00	125.40	40.60	27.95	21.11	132.38	113	154.12
Acute cerebrovascular disease	943	2.12	139.00	156.03	-17.03	14.91	16.74	89.09	74.89	105.19

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 reviewed by the Sepsis task and finish group.
- Stroke is currently not alerting, previous casenote reviews have been undertaken. 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. The results are discussed at the hospital management group.
- For the top diagnosis groups, Quality Governance is incorporating the above diagnosis groups in a peer review Dr Foster Alert Prevention initiative.

Summary Hospital-Level Mortality Indicator (SHMI)

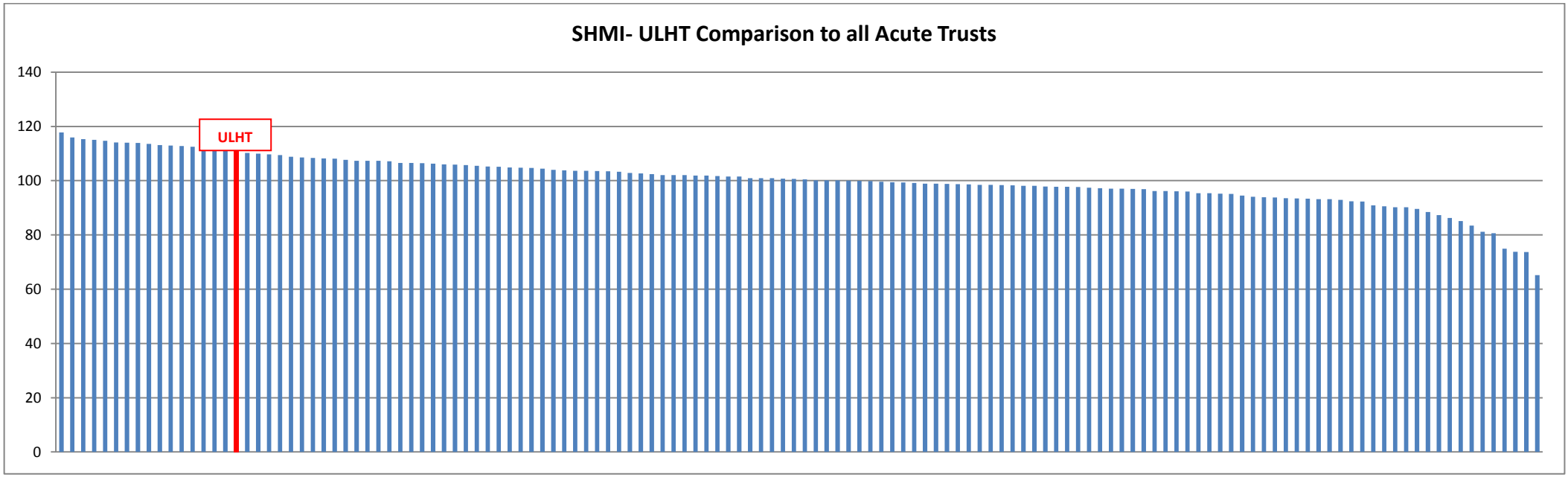
Performance Data Overview:

- Current SHMI reporting period (Oct 14-Sept 15) show that ULHT has decreased to 111.21 for all deaths.
- In hospital deaths are alerting at 105.58.
- In comparison of the 137 non-acute trusts reported within Dr Foster, this is a reduction of 7 places from the previous quarter.
- Alerting Diagnosis for SHMI; due to the time lapse in SHMI reviews were carried out for these alerts when these diagnosis alerted on HSMR.

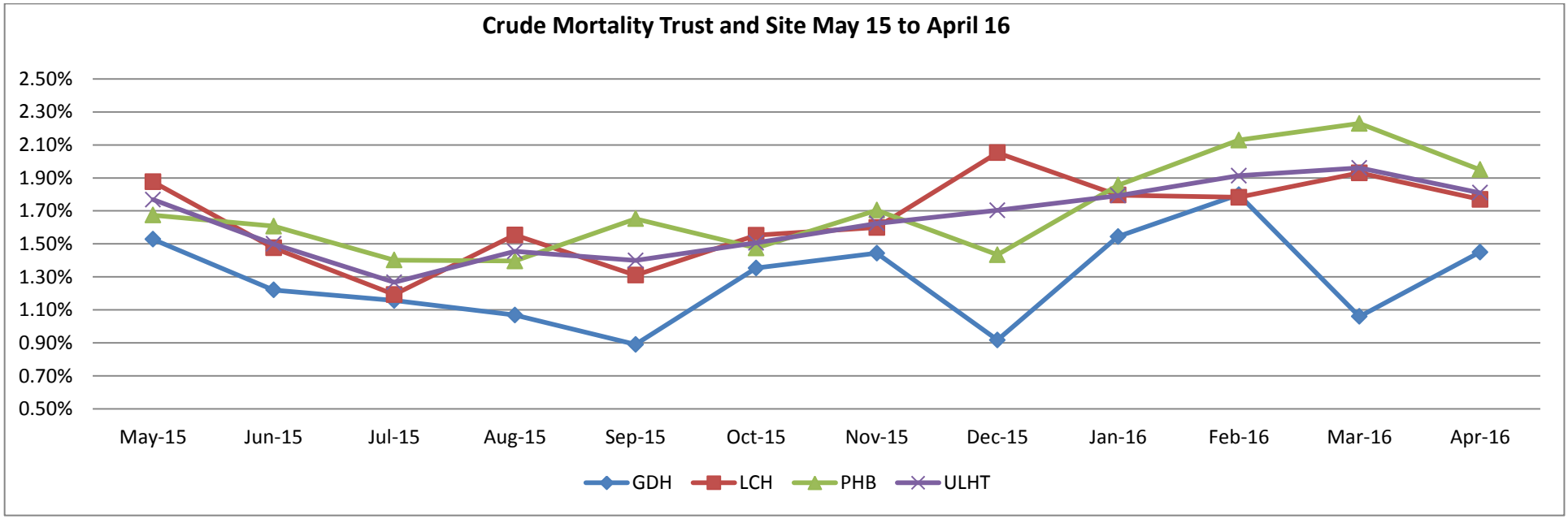
NB: SHMI has a time lapse in the data. The next data refresh is June 2016.

Site	SHMI Oct 14-Sep15	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 Oct 14-Sep 15	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



Crude Mortality



Mortality Reviews

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

Site	No. of Deaths	Reviews Sent	Reviews Complete	Review Completion Compliance %
ULHT	**922**	**614**	**330**	**54%**
LINCOLN	**488**	**372**	**174**	**47%**
PILGRIM	**368**	**203**	**129**	**64%**
GRANTHAM	**66**	**39**	**27**	**69%**

Highlights from Action Plan:

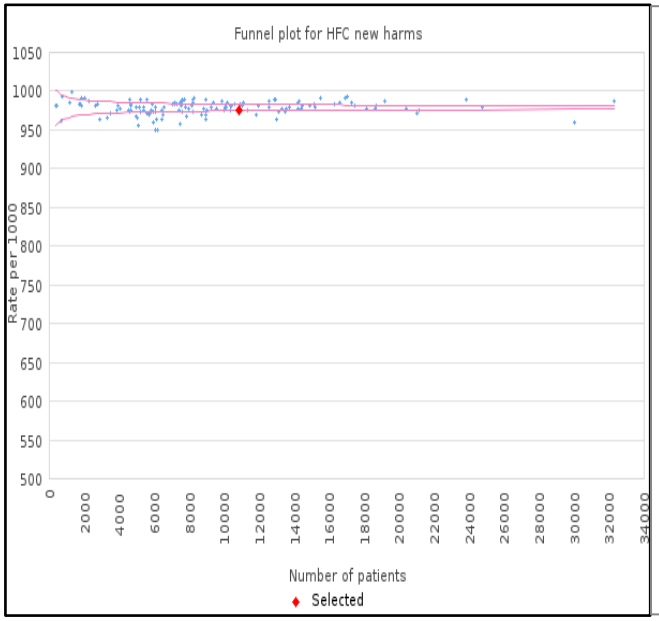
- Working with the CCG all deaths within 48 hours over the age of 75 are being sent to CCG for review regarding avoidable admissions.
- Quality Governance is currently developing a report for the CCG with regard to deaths post 30 days of discharge from the hospital.
- Quality Governance is currently setting up a peer review Dr Foster Alert prevention scheme for primary diagnosis of Acute MI, GI bleeds, stroke, pneumonia and sepsis.
- 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.

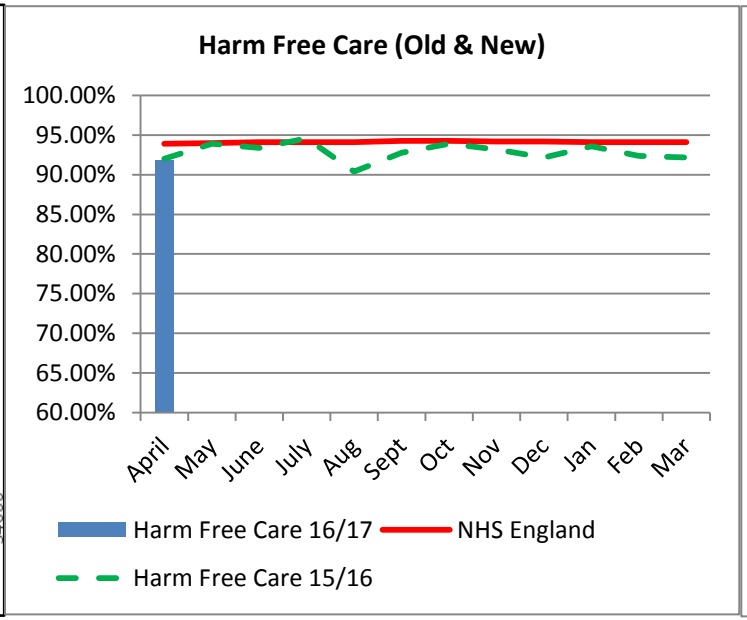
SAFE AMBITION 2 Reduction of Harm Associated with Harm free Care

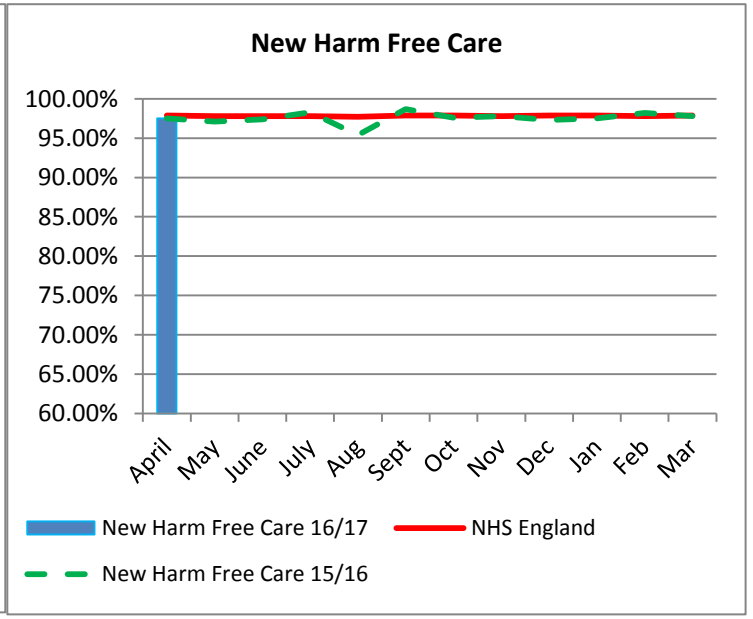
The NHS Safety Thermometer records the presence or absence of four harms:

- 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)

New Harm Free Care 97.51%







Performance Overview

Overview for April 2016

	ULHT %	GDH %	LCH %	PBH %
Harm Free	91.75	93.33	92.34	90.46
New Harm Free	97.51	96.67	98.09	96.92

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. The Harm free care for old and new incorporates harms from the community. The harm free care only includes harms from ULHT. All harms are verified with the specialist nurses.

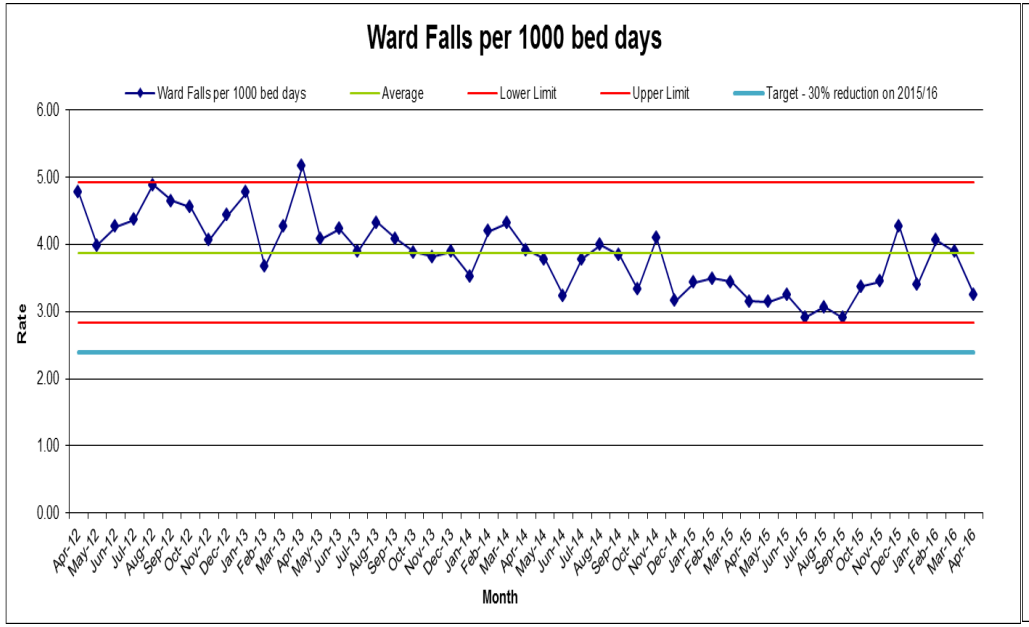
Action Plan

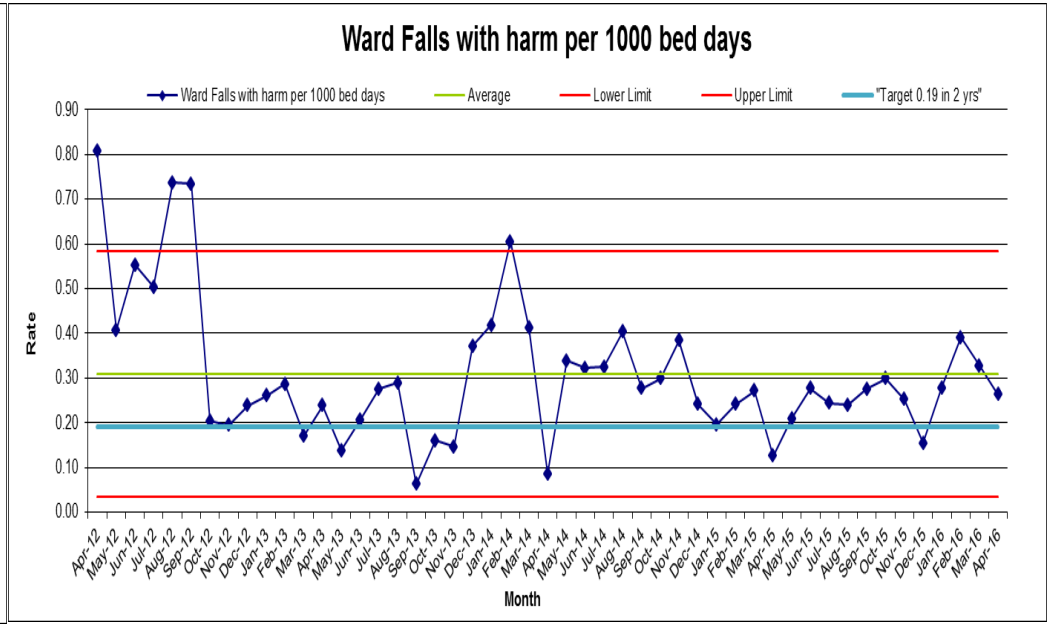
The specialist nurses for VTE and CAUTI visit the ward when a harm has occurred to review the care the patient received. An RCA proforma is currently being developed for hospital acquired thromboembolism (HAT). All patients who have a HAT will have a RCA completed.

The CAUTI task & finish group will be reviewing the patients who have received to review themes and share lessons learnt.

The maternity unit have commenced collecting the maternity safety thermometer in April 2016. The data does not have sufficient numbers to be able to analyse data and compare our care nationally.

SAFE AMBITION 3 Reduction of Harm Associated with Falls





Performance Data Overview

Falls are nationally measured per 1000 occupied bed days broken down by all falls and falls with harm. This method of measurement was introduced to the Trust in October 2015. The falls with harm data demonstrated that the Trust was a significant outlier and as such was identified as a key quality priority for the Trust. Data quality verification was undertaken as part of formulating the annual accounts and an anomaly was identified. Falls are categorised on DATIX as No Harm, Low Harm, Moderate Harm, Severe Harm and Death. Only moderate, severe harm and death are included in the calculation of falls with harm.

The monthly data generated by information services has also included low harm in the calculation which has significantly adversely affected the falls prevention performance data leading to interpretation that the Trust is a significant outlier against national average (0.97 vs. 0.19)

The data has been adjusted and rerun using the national definition**.**

Action Plan

A pharmacy lead for falls has been identified

Lying and Standing Blood Pressure Video script has been written

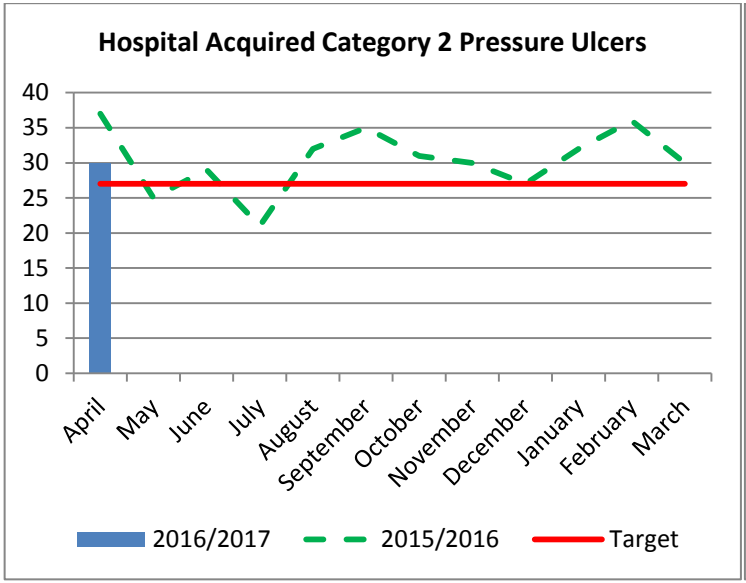
Falls Workbook first draft completed

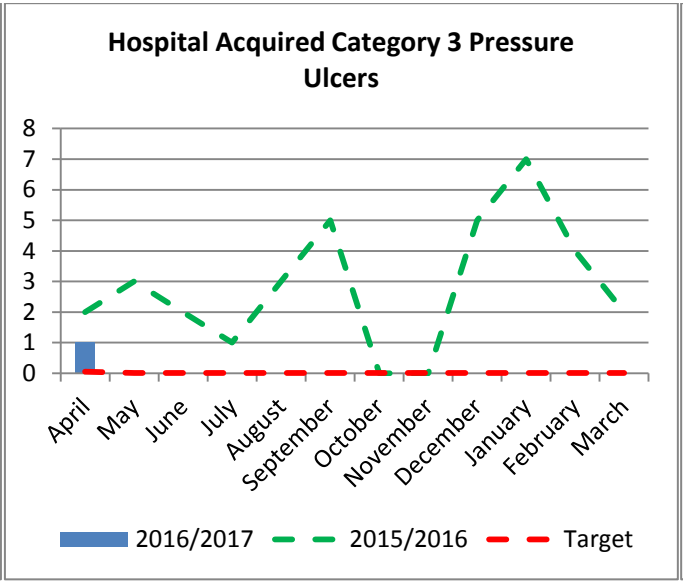
Enhanced Care Project in place that will review how high risk patients are being cared for

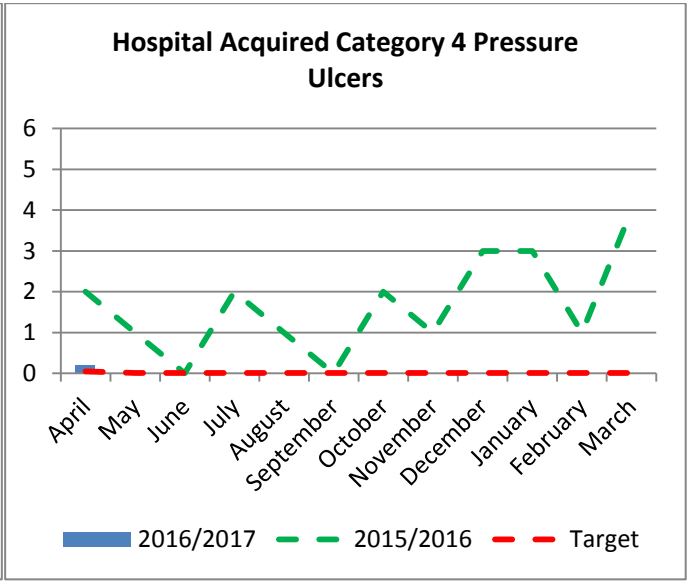
Professional Standards Meeting for Heads of Nursing arranged

Intranet content drafted

SAFE AMBITION 4 Reduction of Harm Associated with Pressure Ulcers







Performance Data Overview

Data continues to be recorded, monitored and reported monthly on the Trusts intranet tool PUNT (Pressure Ulcer Notification Tool). This data is being cross referenced with Datix reports – especially for all Category 3 and 4 reported Pressure Damage. Safety Thermometer data is also reported monthly as required.

Monthly Scrutiny Panels have now been commenced on all ULHT hospital sites to investigate all reported Pressure Damage of Category 3 or 4 – chaired by the Deputy Chief Nurse and attended by members of the ULHT Tissue Viability team as well as relevant clinical staff.

Recurrent themes being identified further to the Scrutiny panels are incomplete documentation; incorrect assessment of pressure damage; delayed use of preventative equipment; lack of understanding by some clinical staff of the importance of pressure ulcer prevention and the consequences of the same for our patients.

Action Plan

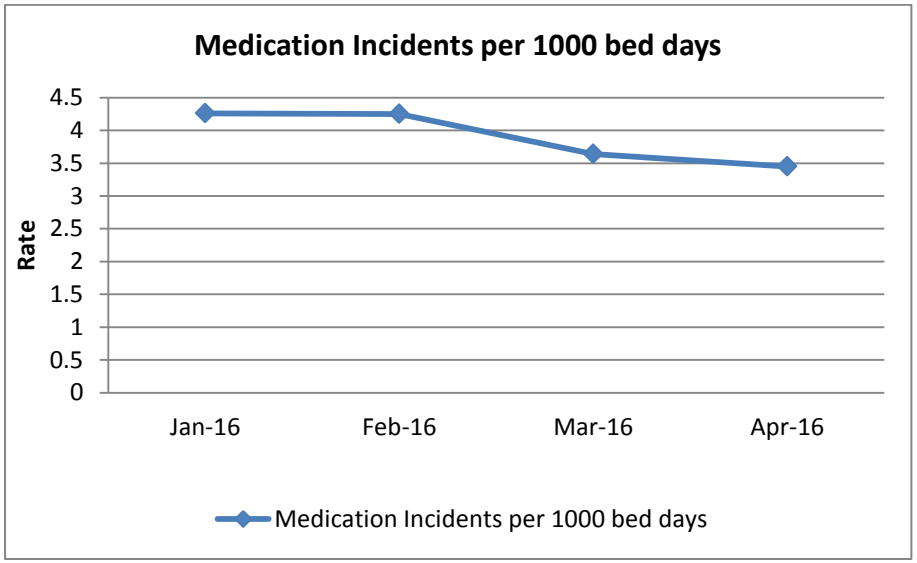
JD written and agreed for the employment of two additional Tissue Viability staff (both 0.5wte), to work at LCH and PHB sites. Remit to work on and with staff in clinical areas identified as PU 'hotspots' to assist with all aspects of pressure ulcer prevention (including completion of all relevant documentation in a timely manner) and the early recognition of any signs of Pressure Damage.

Further clinical/educational input is arranged to identify areas requiring additional support – focusing on the importance of preventative/assessment and documentation issues.

Tissue Viability documentation (within the ULHT Adult Assessment Booklet) is currently being updated as part of broader documentation review.

At the Tissue Viability annual Link Nurse Conference (8th June), the Nurse Consultant will ask Link Nurses to act as PU champions for respective clinical areas and to report how many staff have completed their PUPCA training (Pressure Ulcer Prevention Competency Assessment) and how many staff have recently completed any Pressure Ulcer Training Update and ongoing PUNT training (required by the Trust before any qualified staff member accesses PUNT).

SAFE AMBITION 5 Reduction of Harm Associated with Medication



Number of incidents reported by site and level of harm

Site	No harm	Low Harm	Moderate Harm	Severe Harm	Death	Total
GRANTHAM & DISTRICT HOSPITAL	6	1	1			**8**
LINCOLN COUNTY HOSPITAL	61	5	2			**68**
LOUTH HOSPITAL	1					**1**
PILGRIM HOSPITAL	28	2	1			**28**
Total	**96**	**8**	**4**	**0**	**0**	**108**

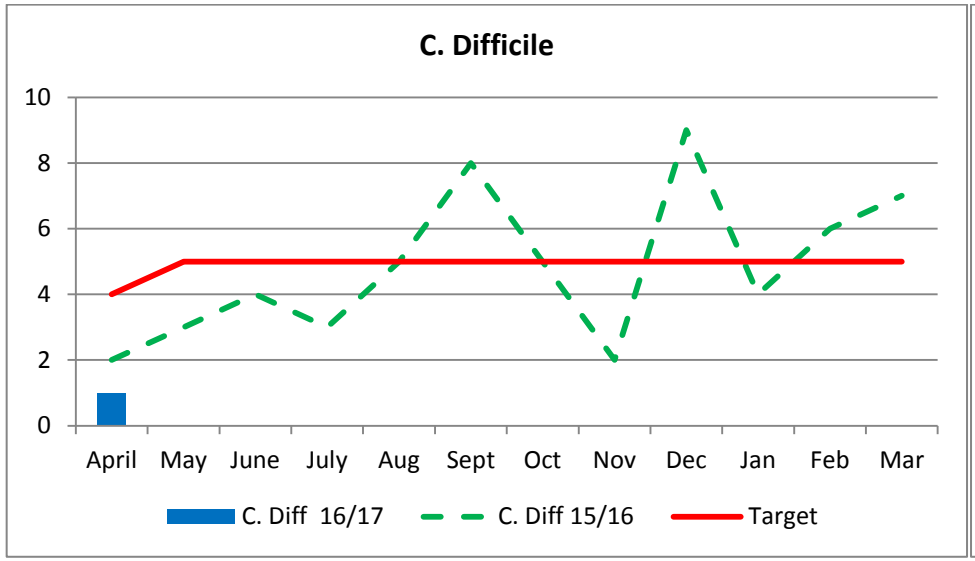
Performance Data Overview

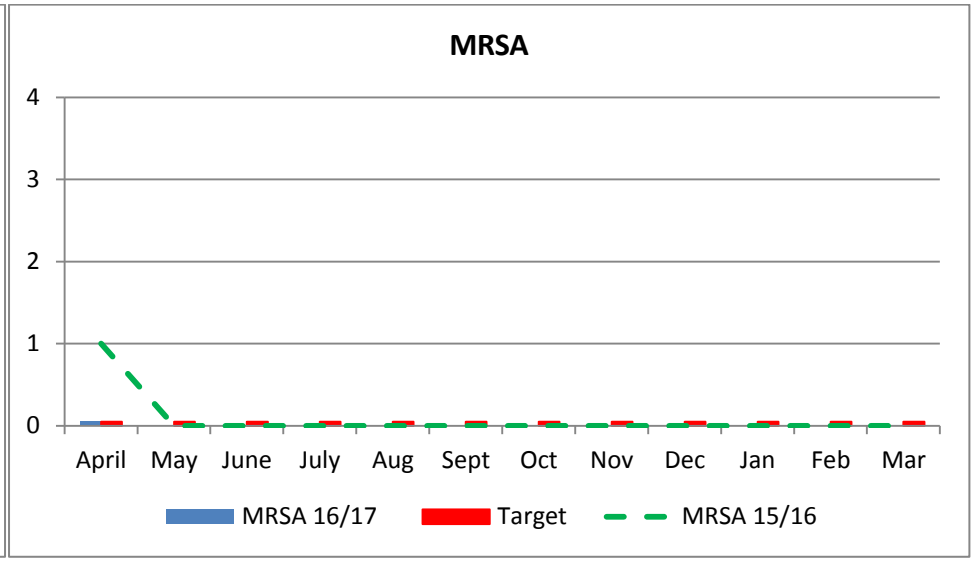
Total number of medication incidents per 1000 bed days has decreased monthly from January this year from 4.26 to 3.45.
Omitted medicines continue to be the most reported incident. Antimicrobials, opiates, insulin and anticoagulants continue to be the top four high risk medication groups that are omitted.
The CD audits have continually improved each quarter. The Trust has gone from a 22% to an 82% pass rate.

Action Plan

Heads of nursing will be asked to provide a short report on the outcomes of incidents for their area to provide assurance that issues are being addressed appropriately.
The Omitted Medicines Policy was reviewed and circulated to all staff. It highlights what action to take when a medicine is not available.
The anticoagulant chart has undergone a redesign to help improve the prescribing and administration of anticoagulants. It is due to launch in June.
CD audits are ongoing and are completed quarterly. CD management is discussed with the ward leaders and action plans are produced to address any issues that arise.
We now have an antimicrobial consultant pharmacist who is working with microbiology to improve antimicrobial stewardship.

SAFE AMBITION 6 Reduction of Harm Associated with Infection





Performance Data Overview

The annual trust trajectory for 2016-17 has been set as 59 cases of C. Difficile by NHS England. This trajectory remains the same as 2015-16
There has been one (1) case of hospital attributable (trajectory 4), bringing the total of hospital attributable cases to one (1).

There has been zero cases of hospital attributable MRSA (trajectory 0). This brings the total of hospital attributable MRSA bacteraemia to zero (0) cases.

There have been four wards with confirmed norovirus this month- MEAU on the Lincoln site had 7 patients affected and 6 staff members. Digby and Navenby wards were also monitored due to patients experiencing diarrhoea and/or vomiting. On the Grantham site, EAU, ward one and CCU were all closed due to confirmation of norovirus.

Hand Hygiene Compliance for the Trust is 63%
Grantham 79%
Lincoln 78%

Louth 38%
Pilgrim 56%

Action Plan

ULHT is part of the NHS Improvement collaborative programme which focuses on patients who are carriers of C Difficile. This programme has the ambition of lowering infection rates.

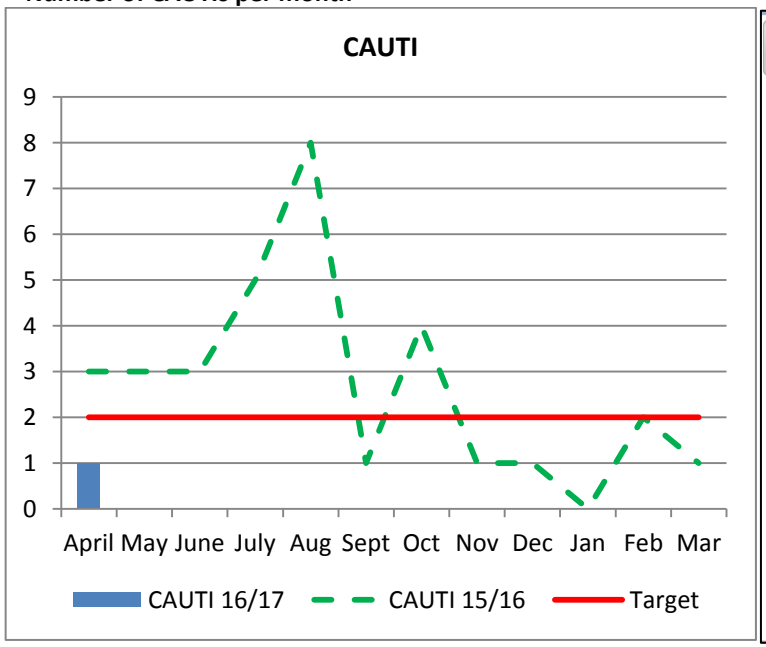
There are drop in sessions for all staff for hand hygiene commencing in May. This will start in Lincoln and will be rolled out across the Trust.

The Infection Control Team complete Compliance Assessment Tool on patients who have been colonised with MRSA, C Difficile or carriers of C Difficile. The purpose of this is to ensure staff are adhering to policy.

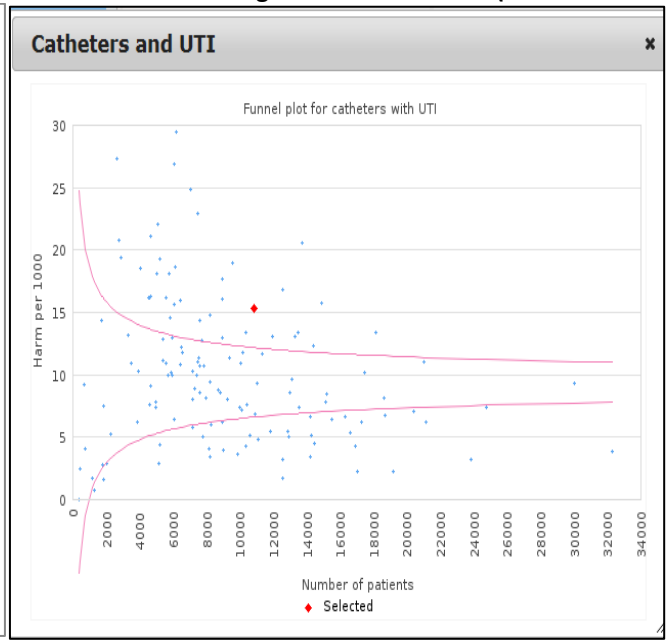
The Infection Team visit wards and perform regular audits to assess compliance with Infection Prevention & Control Code of Practice compliance.

SAFE AMBITION 6 Reduction of Harm Associated with Infection

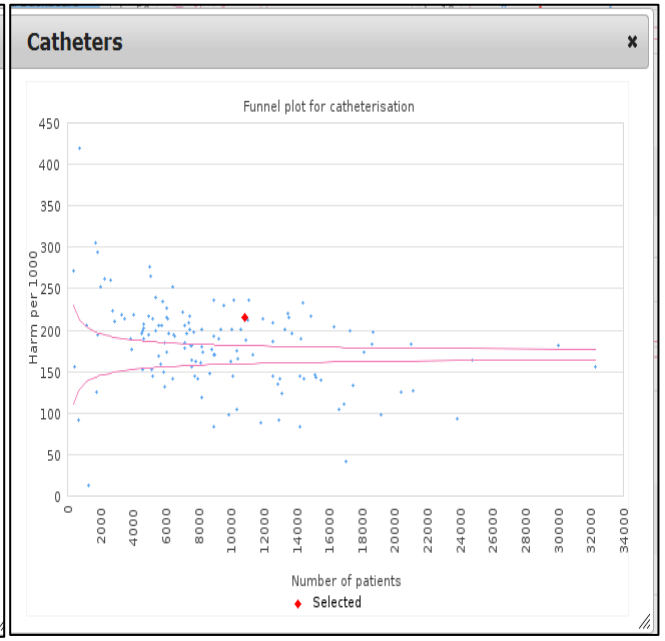
Number of CAUTIs per month



National Average of catheters & UTI (March 15- March 16)

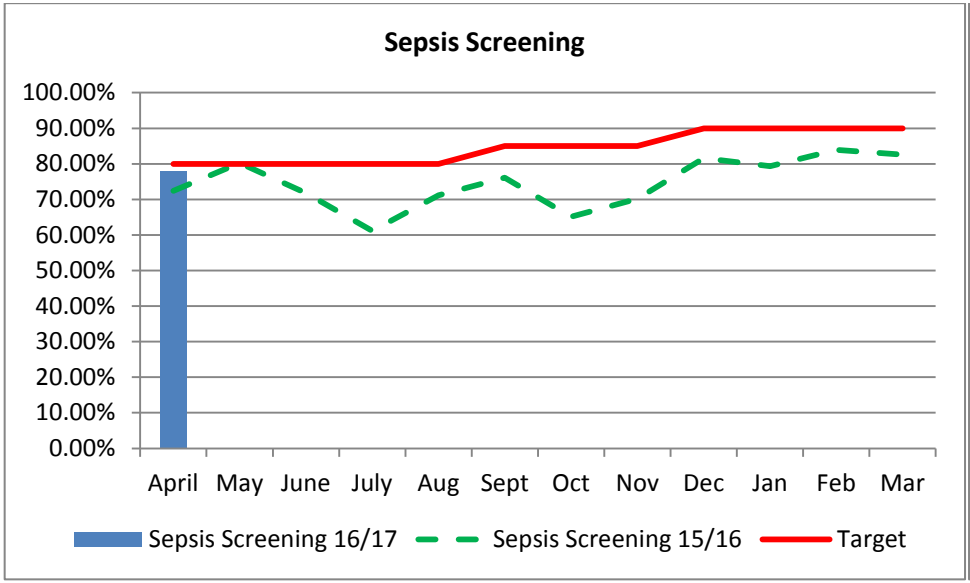


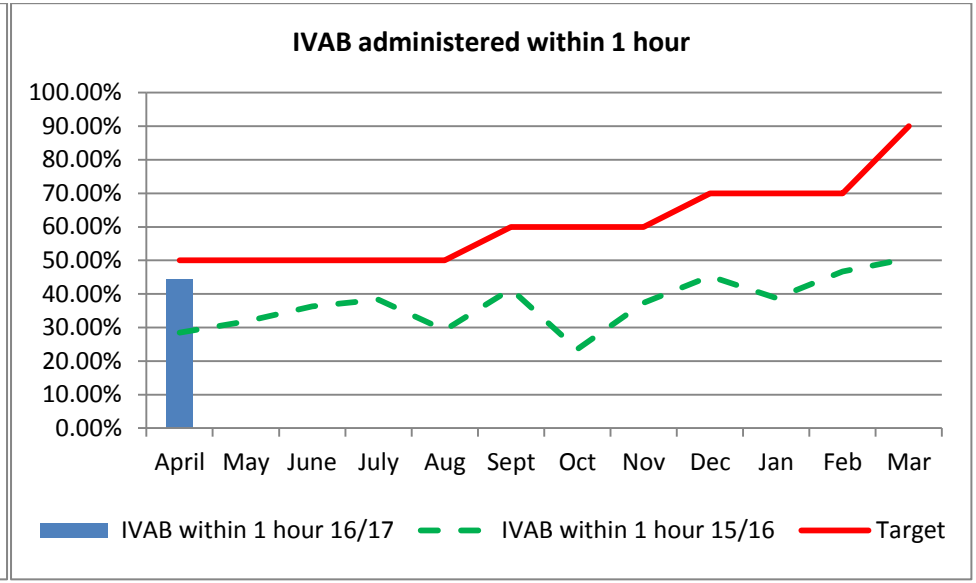
National Average of catheters (March 15- March 16)



Performance Data Overview	Action Plan
During the course of 15 /16 there were 32 CAUTI at ULHT. We have given a target of 30% reduction for 16/17 which equates to 2 a month. Since November 2015 we have been under our 16/17 trajectory. In comparing our data against the National Thermometer data we are an outlier for both catheters and catheters and UTI.	Ongoing education by the Urology Nurse Specialist. Key focus is not inserting the catheters which is the focus of the education. The Urology Specialist Nurses confirm all CAUTIs on the Safety Thermometer. As part of the Task & Finish Group any patient with a CAUTI will have their notes reviewed to enable lesson learnt and share learning. Ongoing monthly audits on catheter are completed as part of the Safety Quality Dashboard.

SAFE AMBITION 7 Reduction of Harm Associated with Deterioration





Performance Data Overview	Action Plan
Compliance for Sepsis screening has improved . We achieved 78.1% against a trajectory of 80%. IVAB administered within 1 hour is below trajectory . With the actions from the Sepsis Task & Finish Committee we will see improvements. The Trust Sepsis Lead will be meeting with the site leads to discuss improvements.	A comprehensive action plan has been developed to enable us achieve our trajectory of 90%. The Sepsis boxes have been agreed and are in the process of being ordered. The PGD for nurses in A&E is currently being developed and planning to go to the next Medication Optimisation Committee for approval. eLearning package has been developed and will be rolled out. It will be distributed to the junior doctors as part of their induction programme. Sepsis Nurse pilot has finished in A&E at Lincoln. A report will be drafted and presented at the next Sepsis Task & Finish Committee. Patients who have been coded as Sepsis will have their notes reviewed to ensure patient was admitted with Sepsis. This will be fed back at the monthly Sepsis Task & Finish Committee.