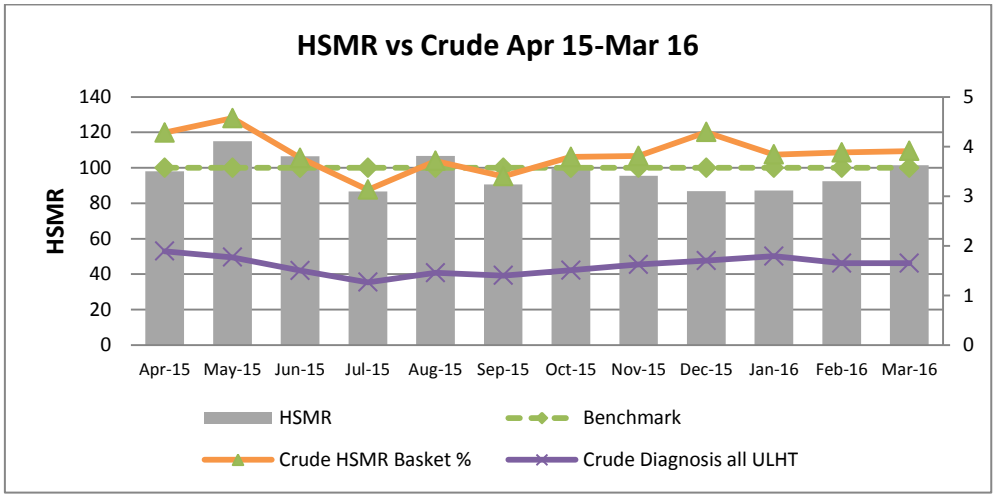
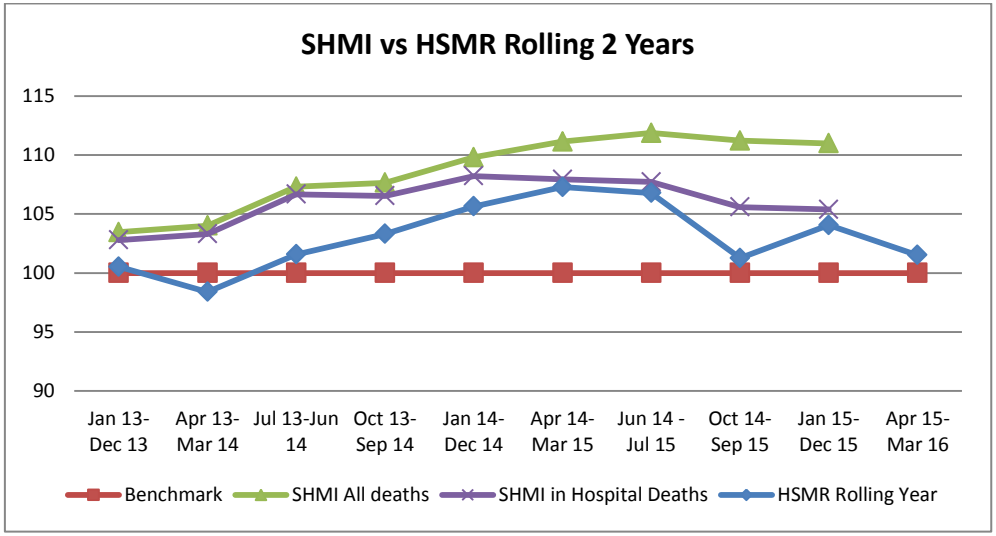
United Lincolnshire Hospitals NHS
NHS Trust

# QUALITY REPORT AUGUST 2016

# SAFE AMBITION 1: Reduction of Harm Associated with Mortality

| Trust/Site | ULHT HSMR Apr 15-Mar 16 12 month | ULHT HSMR Mar-16 | ULHT SHMI Jan 15 – Dec 15 | Trust Crude Mortality YTD Internal source Apr 16-Jul 16 |
|---|---|---|---|---|
| Trust | 101.51 | 97.62 | 110.99 | 1.62% |
| LCH | 112.80 | 111.62 | 112.11 | 1.72% |
| PHB | 93.88 | 92.51 | 110.8 | 1.59% |
| GDH | 77.54 | 62.25 | 106.07 | 1.24% |



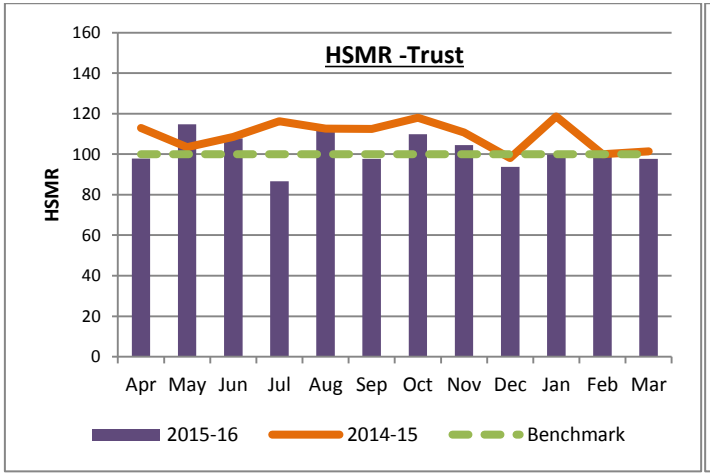



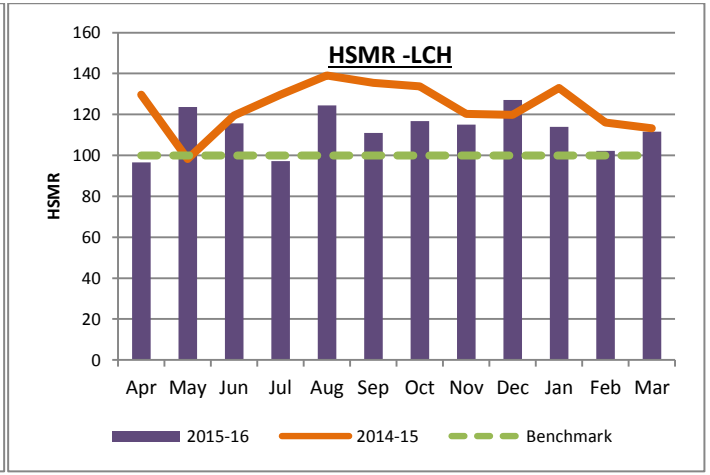

***Performance Overview***

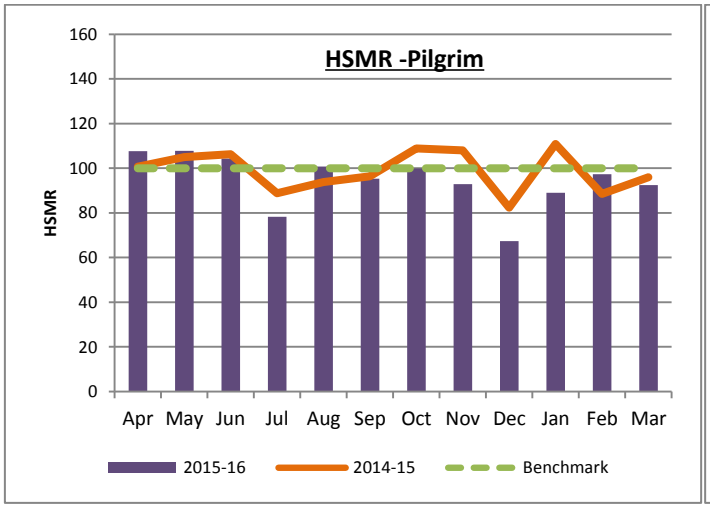
- Dr Foster data has been refreshed again for the period of April 2015 to March 2016, there are marginal changes in the report. This period's data is now locked and data cannot be changed. April and May data will be within next month's data refresh.
- ULHT's HSMR has decreased by 3.71 and is within expected limits.
- All sites have decreased from the previous reporting HSMR figure
- HSMR YTD Alerting diagnosis groups are:
  - **Pulmonary Heart Disease;** alerting for 2 months 182.16.
  - **Septicemia;** 128, driven by Lincoln, no other sites are alerting.
  - **Other Perinatal conditions**; 175.82; driven by pilgrim no other sites are alerting.
  - **Liver disease, alcohol related**; alerting for 2 months 181.58; Lincoln is alerting.
  - For alerting diagnosis please see page 3 for details and actions.
- SHMI has decreased in line with HSMR in the reporting period of Jan 2015 to Dec 2015.
- Crude mortality is showing a downward trajectory in line with HSMR.

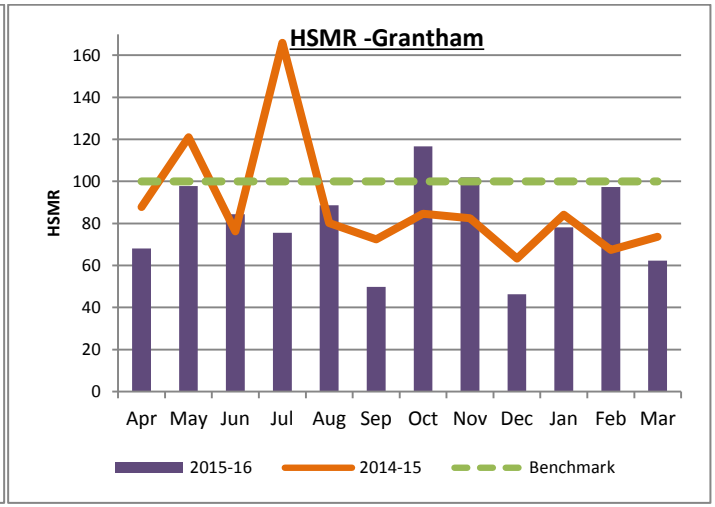
# Hospital Standardised Mortality Ratio (HSMR)

| Trust/Site | HSMR Apr 15-Mar 16 | HSMR in year change reduction(-) Increase (+) | Trust Benchmark |
|---|---|---|---|
| Trust | 101.51 | -3.71 | <100 |
| LCH | 112.80 | -1.62 | <100 |
| PHB | 93.88 | -3.47 | <100 |
| GDH | 77.54 | -11.43 | <100 |




## *HSMR-Performance Data Overview*

**United Lincolnshire Hospitals NHS Trust:**

- HSMR YTD is in line within expected limits. The HSMR is mirroring our decreasing crude mortality.
- In month March 16 HSMR has decreased by 1.94 to 97.62

**Lincoln County Hospital**

- HSMR YTD is outside expected limits and has increased from the previous YTD period.
- In month March 2016 HSMR has increased to 111.62

**Pilgrim Hospital**

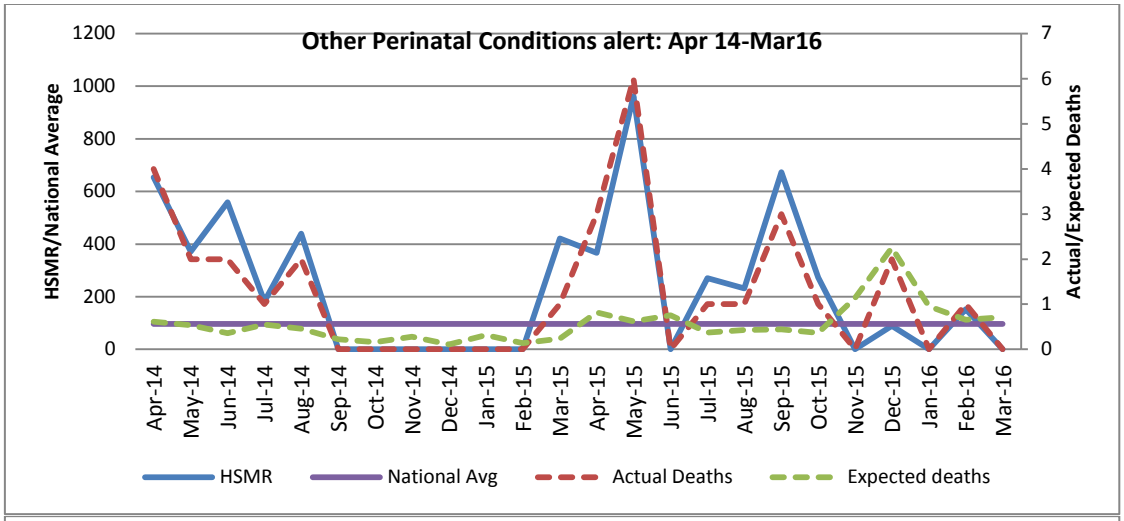
- HSMR YTD is in line within expected limits it has decreased from the previous YTD period.
- In month March 2016 HSMR has decreased by 4.8 to 92.51

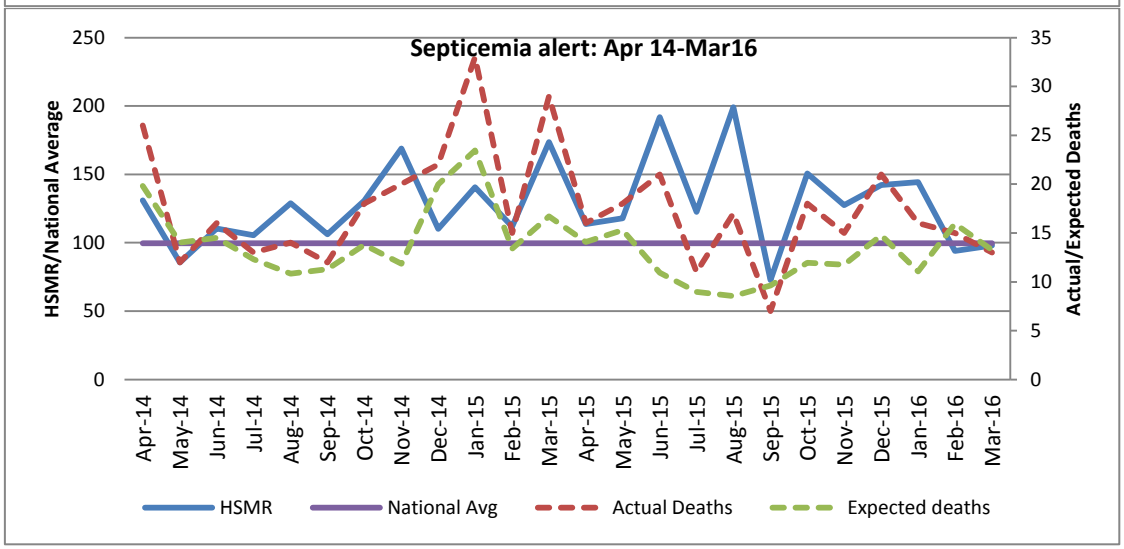
**Grantham Hospital**

- HSMR YTD is in line within expected limits it has decreased from the previous YTD period.
- In month March 2016 HSMR has decreased by 34.98 to 62.25
- Small numbers are the reason for such variability

## HSMR Alerting Diagnosis-YTD April 15-March 16

| Diagnosis group | Observed | Expected | Obs. - Exp. | Crude (%) | HSMR |
|---|---|---|---|---|---|
| Septicemia (except in labour) | 177 | 138.27 | 38.72 | 26.3 | 128 |
| Other perinatal conditions | 18 | 10.23 | 7.76 | 2.62 | 175.82 |
| Pulmonary Heart Disease | 23 | 12.62 | 10.37 | 7.69 | 182.16 |
| Liver disease. Alcohol related | 27 | 14.86 | 12.13 | 23.68 | 181.58 |




### *Alerting Diagnosis Overview*

**Alerting diagnosis are continuously monitored and when alerting for 3 months the diagnosis group will be investigated. The HSMR for septicemia has changed from previous reports due to ongoing analysis and appropriateness of coding.**

**Pulmonary Heart Disease:**

- Has been alerting for 2 months but there is no particular sites alerting.

**Liver disease, alcohol related:**

- Has been alerting for 2 months; with Lincoln site alerting.

**Other perinatal conditions:**

- HSMR has decreased for this diagnosis group.
- Several reviews have been conducted; however there is a coding variance with Medway and Dr Foster. Dr foster has stated these should have been refreshed with the upload. Information services have been contacted to investigate.

**Septicemia (except in labour):**

- HSMR from Feb 16 has been below 100 – within normal limits.
- Lincoln site is the only site alerting.
- ULHT have conducted several casenote reviews.
- Sepsis task and finish group has been working to reduce the HSMR
- The inclusion of this Diagnosis group in the Dr Foster Alert Prevention scheme that Quality Governance are currently facilitating.
- The sepsis task and finish group have facilitated an ongoing audit of sepsis patients with the outreach team.
- Quality governance also facilitate a weekly audit with published results.
- A business case is currently underway for 2 Sepsis nurses.

# Summary Hospital-Level Mortality Indicator (SHMI)

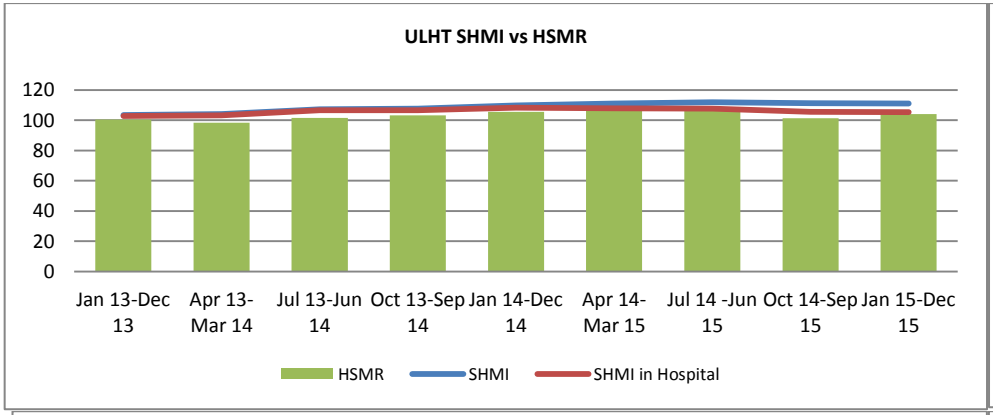
| Death I/O Hospital Jan 15-Dec15 | SHMI Spells | SHMI/ HSMR | Actual Deaths | Expected Deaths |
|---|---|---|---|---|
| **SHMI All deaths** | 82545 | 110.99 | 3591 | 3235.3 |
| **SHMI In hospital deaths** | 82545 | 105.38 | 2436 | 2311.71 |
| **HSMR** | 51873 | 104.05 | 2131 | 2048.06 |

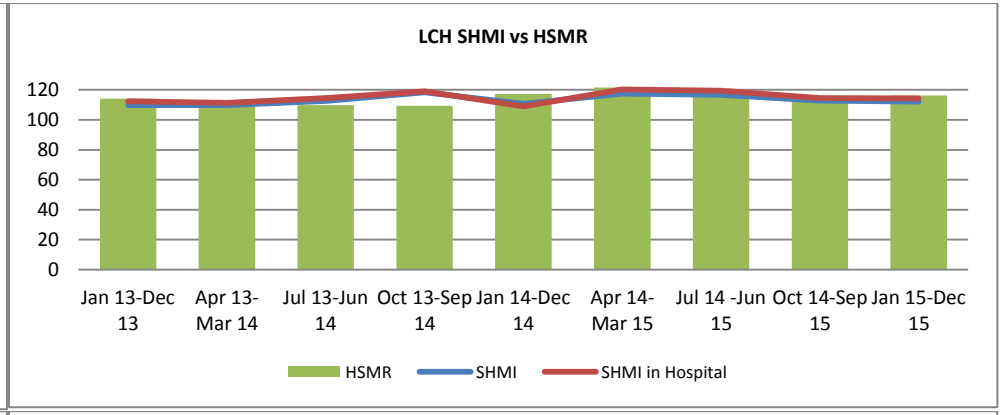
| Trust/Site | ULHT SHMI Jan 15-Dec 15 (Current) |
|---|---|
| **ULHT** | **110.99** |
| **LCH** | **112.11** |
| **PHB** | **110.8** |
| **GDH** | **106.07** |

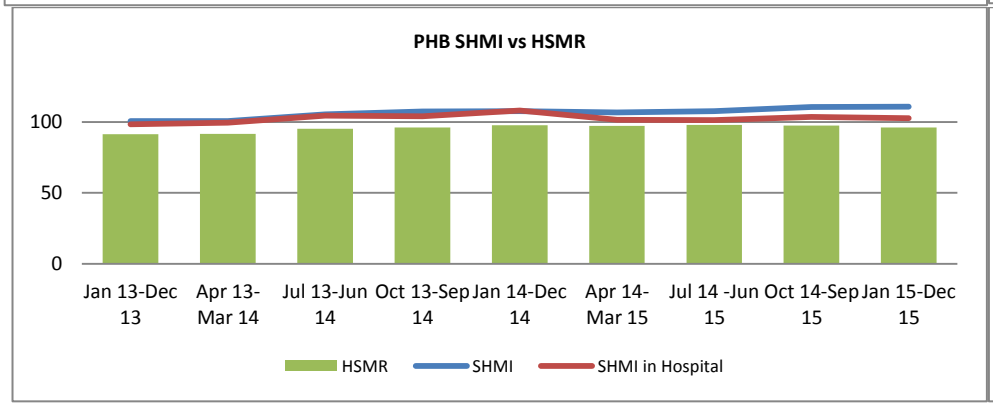
## *SHMI Performance Overview*

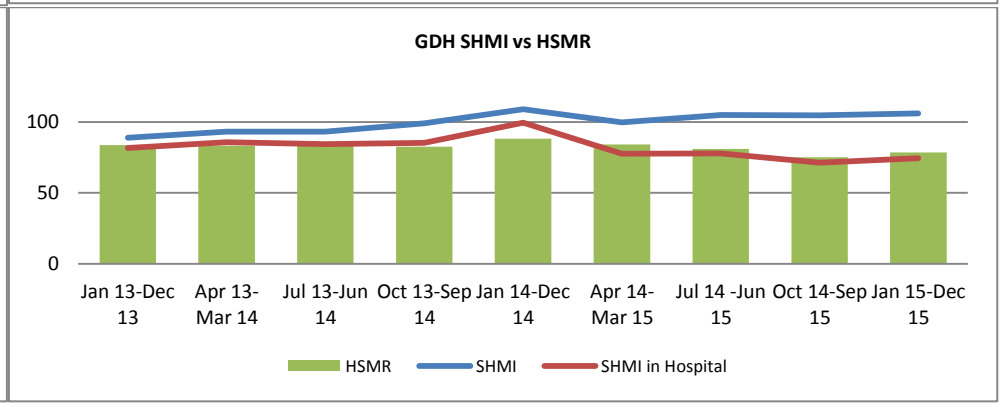
- Current SHMI reporting period (Jan 15-Dec 15) show that ULHT has decreased to 110.99 for all deaths.
- In hospital deaths are in line with HSMR at this time period.
- Alerting Diagnosis for SHMI; due to the time lapse in SHMI reviews were carried out for these alerts when these diagnosis alerted in HSMR. Further analysis is on page 7.
- SHMI in hospital mirrors ULHT's HSMR, therefore with our reducing HSMR ULHT's SHMI should decrease.
- ULHT are working with the CCG's to assess the out of hospital mortality.

**SHMI Graphs by Trust and site-In and out of hospital deaths:**



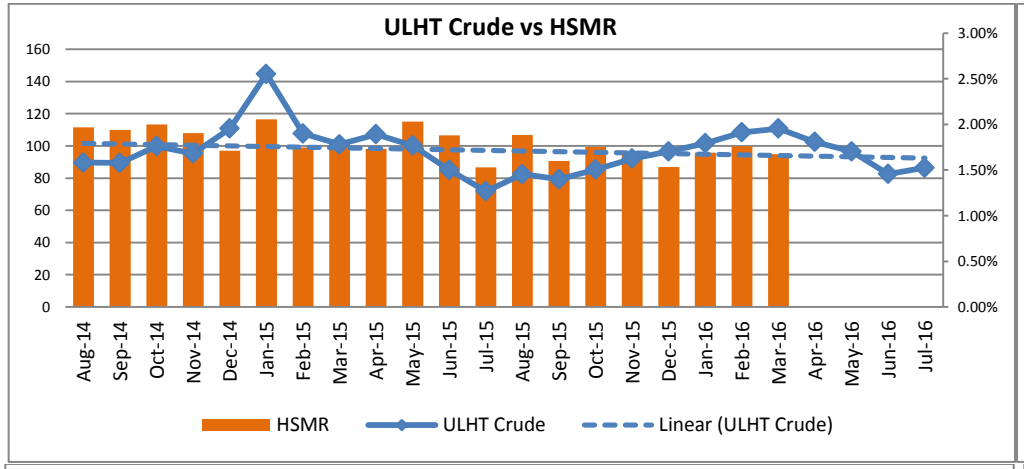



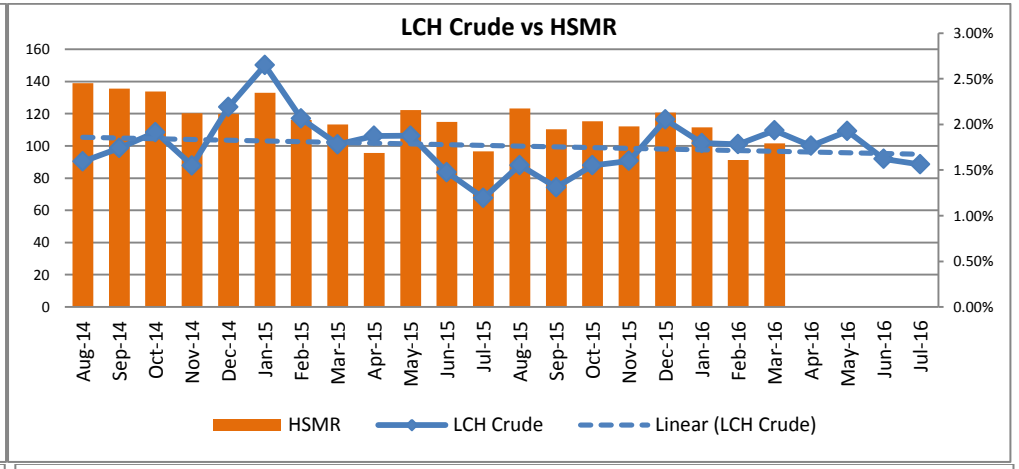
# Crude mortality

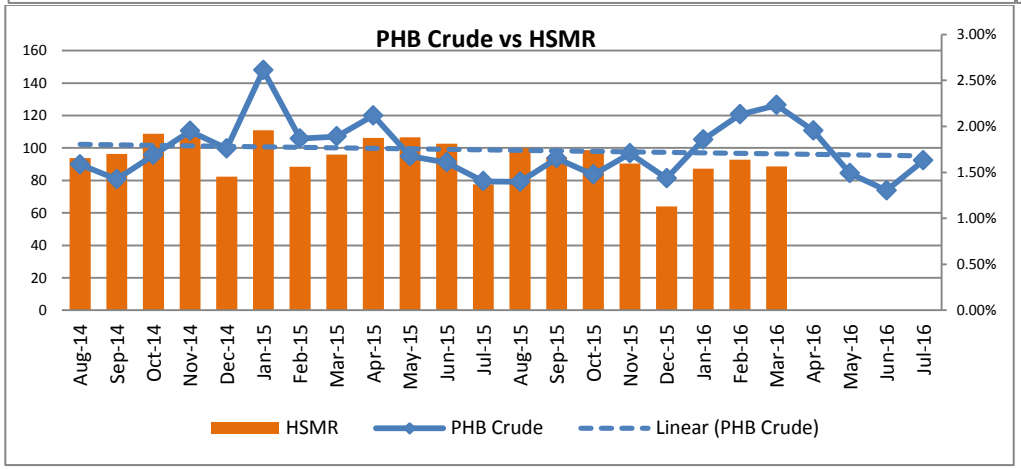
| Trust Site | Dr Foster Crude National Average Apr 15 – March 16 | ULHT data Crude mortality YTD Apr 16-Jul 16 | ULHT data Crude Mortality July 16 |
|---|---|---|---|
| **Trust** | 1.41% | 1.62% | 1.52% |
| **LCH** | - | 1.72% | 1.56% |
| **PHB** | - | 1.59% | 1.63% |
| **GDH** | - | 1.24% | 0.94 |

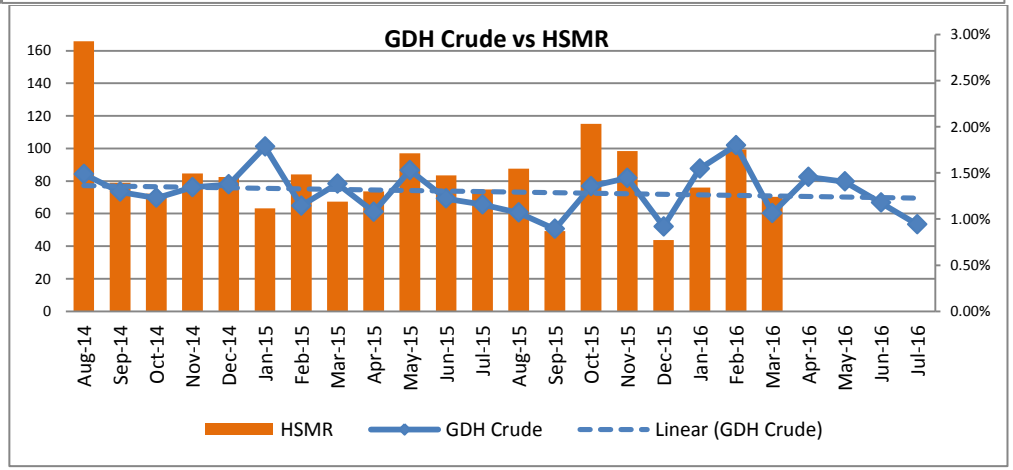
## *Crude mortality overview*

- Against National average (time period: Apr 15 – Mar 16) ULHT is higher by 0.24%. ULHT's average is 1.65%.
- ULHT's crude mortality for year to date has decreased to 1.62%
- ULHT's Crude Mortality shows a slight downward trajectory this is an indication that HSMR will shadow.



**Explanatory Notes:**

The table below outlines each mortality reporting stream and any inclusions and exclusions within the extrapolation to the mortality outcome:

| Inclusions/exclusions | HSMR | SHMI | Crude Mortality (ULHT internal source) | Crude Mortality (Dr Foster ) |
|---|---|---|---|---|
| All diagnoses | No (56 top diagnosis groups only) | Yes | Yes | No (56 top diagnosis groups only) |
| Deaths in Hospital | Yes | Yes | Yes | Yes |
| Deaths out of Hospital | No | Yes | No | No |
| Palliative care patients inclusion | No | Yes | Yes | No |
| Risk profiling in calculation | Yes | Yes | No | No |

**HSMR (Hospital Standardised Mortality Ratio):** is a calculation used to monitor death rates in a trust. The HSMR is based on a subset of 56 diagnoses which give rise to around 80% of in-hospital deaths. For all of the 56 diagnosis groups, the observed deaths are the numbers that have occurred following admission in each NHS Trust during the specified time period. The expected number of deaths in each analysis is the sum of the estimated risks of death for every patient. The ratio is of observed to expected deaths (multiplied by 100). If mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100. The risk profile for each individual patient is calculated based on the following factors – Sex, age on admission, admission method (non-elective or elective), deprivation, diagnosis/procedure subgroup, co-morbidities, number of previous emergency admissions in the preceding 12 months, year of discharge (financial year), palliative care, month of admission and source of admission.

**Dr Foster:** is a complex statistical tool which acts as a spotlight for mortality. Its use and validity has been the subject of much debate nationally, but what is clear is that it is not a measure of excessive or avoidable deaths. Dr Foster is used to identify HSMR to point us to possible areas of concern and, when they are identified, we actively review them through case note reviews. The Dr Foster data has a 3 month time lapse. Dr Foster data is refreshed monthly over the financial year, previous months data may change due to ongoing analysis of coding.

**SHMI (Summary Hospital-level Mortality Indicator)**: is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by the Health and Social Care Information Centre (HSCIC) with the first publication in October 2011. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. SHMI is reported every 6 months and has a 6 month time lapse and in hospital death rate should mirror HSMR therefore HSMR can be a predictor for this.

**Crude mortality:** The crude death rate is the total number of deaths to admissions within the hospital and does not take into account the risk of every patient as in SHMI and HSMR calculations. ULHT internal source is aggregated from our deaths and admissions sourced from our internal information support and is used as a predictor for the HSMR and SHMI trend. There is a variance between Internal source and Dr foster's crude mortality due to the fact that the internal source uses all diagnosis groups not just the 56 top diagnosis groups as in Dr fosters reporting tool.

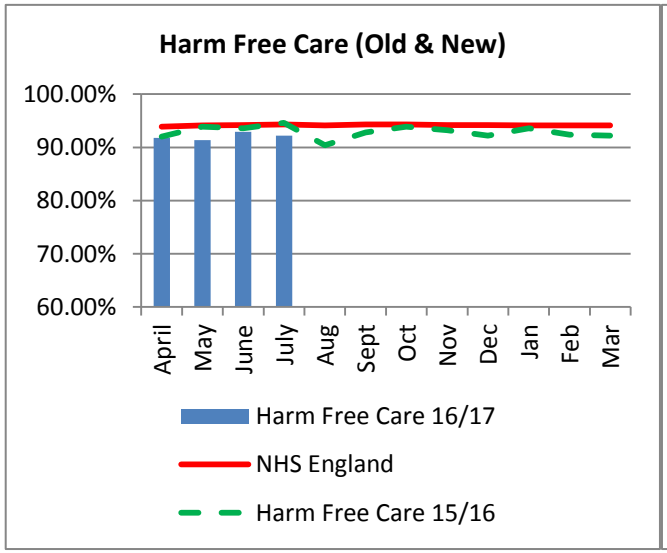
**Residual codes:** These are codes for all signs and symptoms written in the casenotes. The mortality reporting tools take the first primary diagnosis coded if this code is a residual code the reporting tool moves to the second episode; if this is identified as residual code the reporting tool codes the death as a residual code.

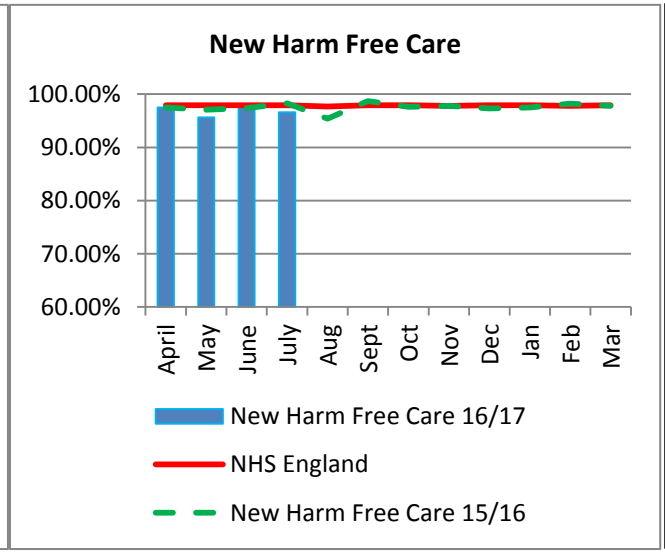
# SAFE AMBITION 2 Reduction of Harm Associated with Harm free Care

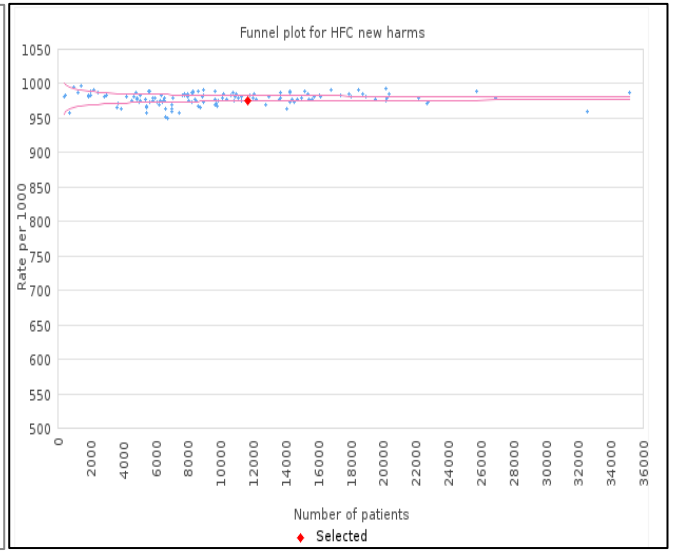
The NHS Safety Thermometer records the presence or absence of four harms:

- 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)

**July New Harm Free Care**
**96.6%**




**Performance Overview**

| Site | No Patients | Harm Free | New Harm Free | PU- All | PU - New | Falls with harm | Cath & all UTI | Cath & New UTI | New VTEs |
|---|---|---|---|---|---|---|---|---|---|
| **National Average** | | 94.30% | 97.90% | 4.20% | 0.90% | 0.50% | 0.70% | 0.30% | 0.40% |
| Grantham | 78 | 96.20% | 98.70% | 2.60% | 1.30% | 0.00% | 1.30% | 0.00% | 0.00% |
| Lincoln | 459 | 89.80% | 96.30% | 5.70% | 0.40% | 2.60% | 2.60% | 0.70% | 0.20% |
| Louth | 5 | 100.00% | 100.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| Pilgrim | 335 | 94.60% | 96.40% | 3.30% | 2.40% | 1.20% | 1.20% | 0.30% | 0.00% |
| **UHT Total** | 877 | 92.20% | 96.60% | 4.40% | 1.30% | 1.80% | 1.90% | 0.50% | 0.10% |

Grantham is better than the national average for all indicators besides PU's New & CAUTI
Lincoln is lower than the national average for all indicators besides PU's All and New VTE's.
Pilgrim is better than the national average for Harm Free, PU's All, Catheters & New UTI's & New VTE's.
ULHT is lower than the national average for all indicators except New VTE's

**Action Plan**

As part of the quarterly meetings with the Lincolnshire Quality forum we will now be focussing on key areas within the metrics of the safety thermometer to share lessons knowledge on improvements other providers have made within these key harms.

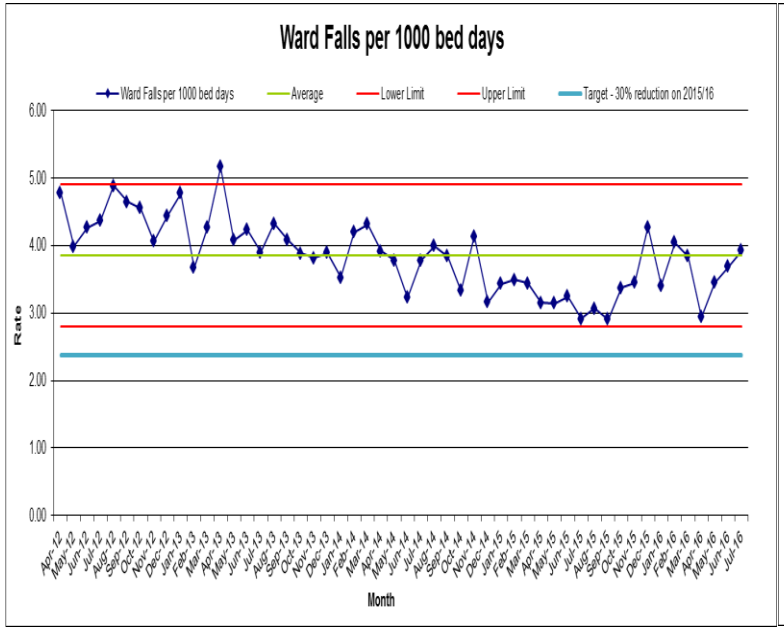
The data is being validated by the leads within these key harms.

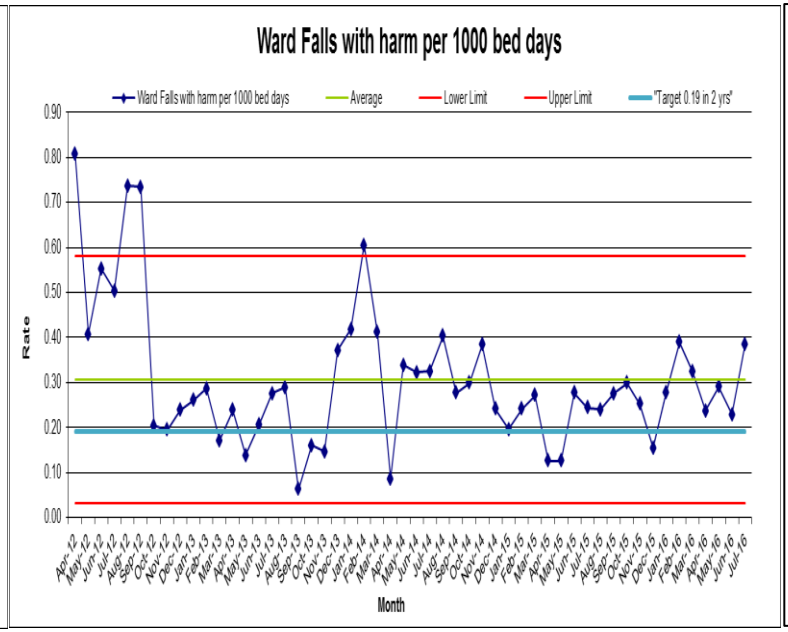
Education is ongoing.

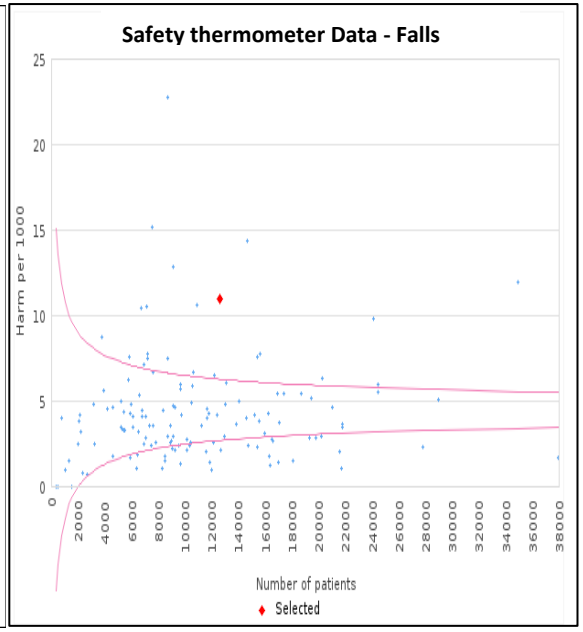
ULHT is an outlier for falls and CAUTI – there are separate work streams focussing on these harms.

Reports are disseminated monthly.

# SAFE AMBITION 3 Reduction of Harm Associated with Falls




**Safety Quality Dashboard July 2015 – July 2016 Trust data**

| Metric Title | Jul-2015 | Aug-2015 | Sep-2015 | Oct-2015 | Nov-2015 | Dec-2015 | Jan-2016 | Feb-2016 | May-2016 | Jun-2016 | Jul-2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient at risk of falls | 325 | 327 | 330 | 320 | 334 | 276 | 332 | 315 | 349 | 360 | 344 |
| Medication review occurred | 67.10% | 69.40% | 69.70% | 68.70% | 71.00% | 66.80% | 71.00% | 64.70% | 65.10% | 67.10% | 70.90% |
| Lying & standing BP completed | 54.00% | 56.70% | 57.10% | 58.60% | 65.60% | 61.80% | 57.30% | 60.10% | 56.20% | 55.60% | 58.00% |
| Care plan 7 activated | 94.50% | 97.50% | 93.90% | 94.60% | 93.60% | 94.40% | 93.90% | 93.50% | 94.00% | 95.50% | 97.10% |
| Reviewed by physio | 56.10% | 63.10% | 68.00% | 64.70% | 74.20% | 71.20% | 71.90% | 77.80% | 79.90% | 81.40% | 82.40% |
| Referred to OT | 78.70% | 83.50% | 82.00% | 86.50% | 89.00% | 85.20% | 86.70% | 83.20% | 90.90% | 89.80% | 91.40% |
| Referred to physio | 88.40% | 88.60% | 90.40% | 90.50% | 92.40% | 89.90% | 86.30% | 86.70% | 86.10% | 87.10% | 88.90% |
| 4 hour actions completed on admission | 82.70% | 86.90% | 86.70% | 87.90% | 88.90% | 88.50% | 87.20% | 83.80% | 91.40% | 90.60% | 93.00% |
| 24 hours actions completed on admission | 39.70% | 41.10% | 44.50% | 38.90% | 46.30% | 42.00% | 39.70% | 43.80% | 41.30% | 42.40% | 46.50% |
| All actions completed within 24 hours of transfer (if necessary) | 37.30% | 39.90% | 44.30% | 38.70% | 37.90% | 37.00% | 33.70% | 35.90% | 33.80% | 32.10% | 33.10% |

**Performance Overview**

Over the past 8 months the incidence of all falls has been at or below the Trust's average for 5 episodes thus reporting a reducing trend on the above SPC chart.

Falls with harm have decreased (0.39) this equates to 11 falls with harm of which 2 were severe and 9 moderate.

Hotspot wards this month were MEAU at LCH and Stroke at Pilgrim. Falls with harm at Pilgrim has increased to 0.61 from 0.25.

The safety thermometer data includes falls in the community if they are from a care setting.

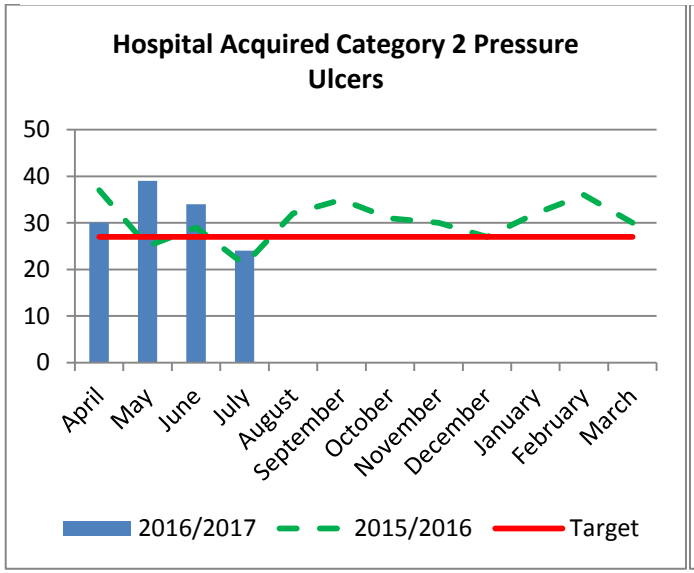
**Action Plan**

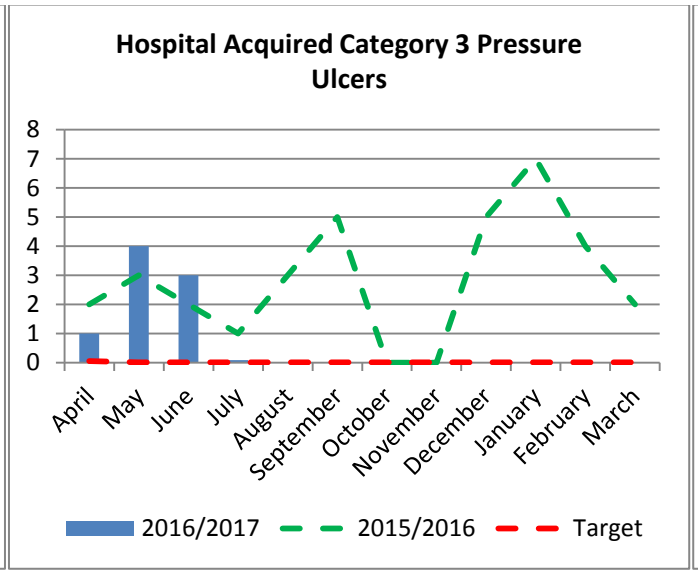
MEAU staff at LCH are piloting the falls competency booklet.

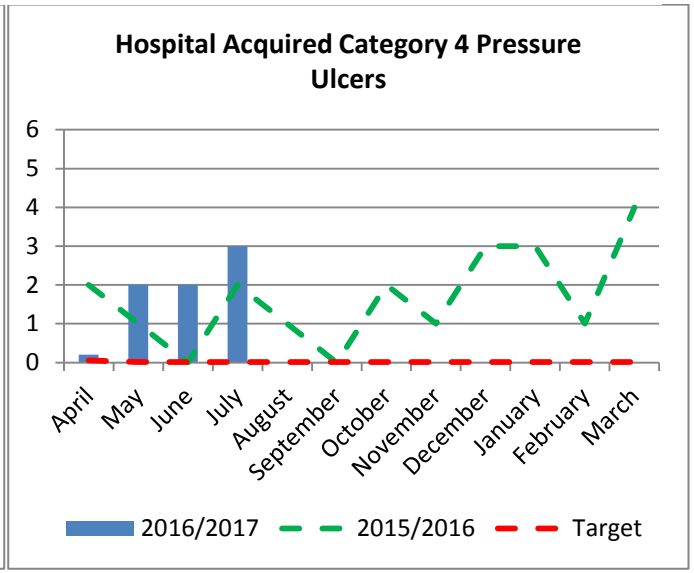
HoN and Consultant Nurse for Frailty will be undertaking some targeted work.

Falls conference in November 2016

# SAFE AMBITION 4 Reduction of Harm Associated with Pressure Ulcers




**Safety Quality Dashboard July 2015 – July 2016 Trust data**

| Metric Title | Jul-2015 | Aug-2015 | Sep-2015 | Oct-2015 | Nov-2015 | Dec-2015 | Jan-2016 | Feb-2016 | May-2016 | Jun-2016 | Jul-2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Pressure area care risk assessment completed within 24hrs | 99.30% | 99.00% | 98.80% | 98.50% | 98.30% | 99.40% | 97.80% | 98.00% | 97.90% | 98.10% | 99.00% |
| Pressure area care risk assessment updated weekly | 86.20% | 89.40% | 81.90% | 85.20% | 85.60% | 82.50% | 79.40% | 86.10% | 85.50% | 78.00% | 75.30% |
| Pressure-relieving equipment in situ if required | 97.40% | 92.80% | 94.30% | 97.70% | 96.30% | 93.50% | 93.40% | 96.20% | 93.00% | 92.30% | 96.00% |
| Repositioning chart commenced if required | 94.00% | 94.00% | 95.10% | 96.00% | 98.00% | 98.80% | 97.60% | 99.00% | 95.90% | 95.40% | 96.10% |
| Pressure area care plan activated if required | 94.90% | 94.20% | 92.00% | 94.40% | 97.30% | 95.70% | 90.50% | 94.80% | 91.40% | 93.80% | 95.10% |

**Data Overview**

In the current YTD 2016/17 the Trust has recorded 213 compared to 222 episodes of Pressure Damage (Categories 2 to 4) in the same period, - a decrease of 5%. This decrease includes the improved assessment and reporting of Category 2 Pressure Damage within all ULHT clinical areas.

During the last month (July) 3 Category 4 Pressure lesions were reported in the Trust, however it should be noted that these were all deteriorating not new ulcers (lesions had previously been identified as Hospital acquired Category 3 pressure damage).There were no category 3 pressure ulcers.

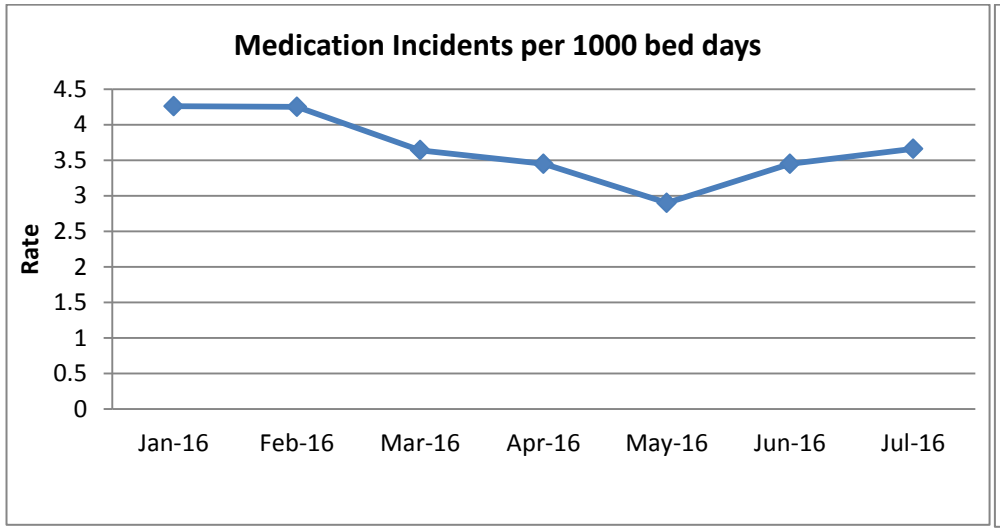
The current trust incidence for the last reported month (July) is = 1.15% (Cat 1), 7% (Cat 2), 0.35% (Cat 3) and 0.9% (Cat 4) as calculated per 1000 in-patient bed days.

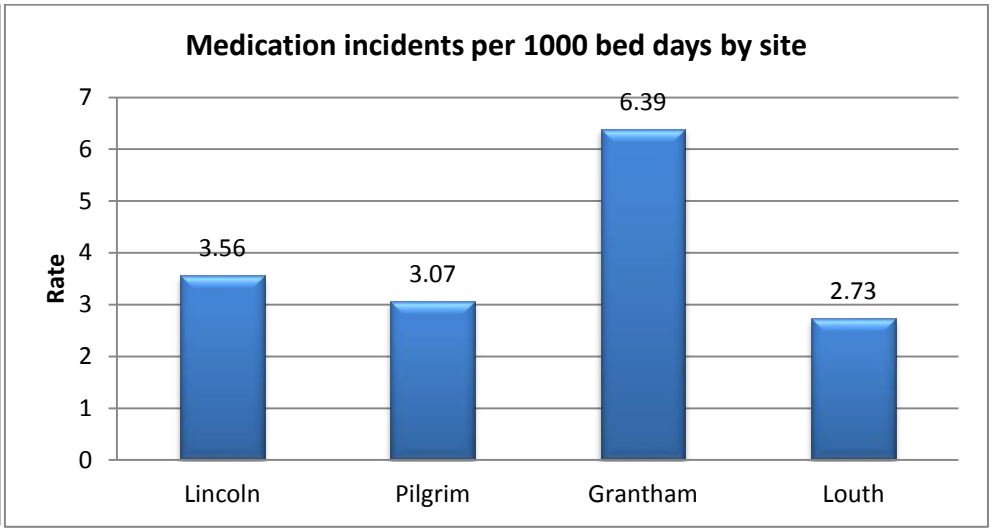
**Action Plan**

Two of the three reported deteriorating pressure ulcers were assessed on a patients heel and therefore all clinical areas have been reminded of the current ULHT heel prevention policy and intervention flowchart (published in 2015) by the TV Team and the team have worked with a number of staff to update them re: appropriate management and ongoing intervention techniques.

For all serious PU harms the internal SI process has been commenced.

# SAFE AMBITION 5 Reduction of Harm Associated with Medication



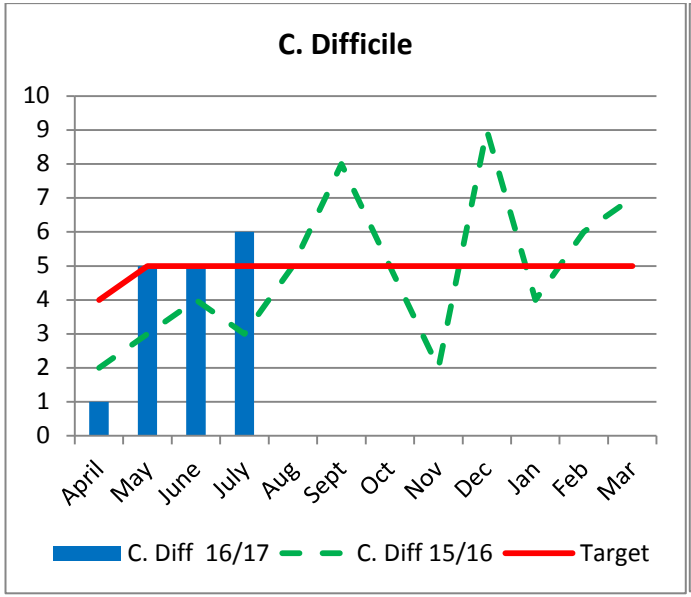



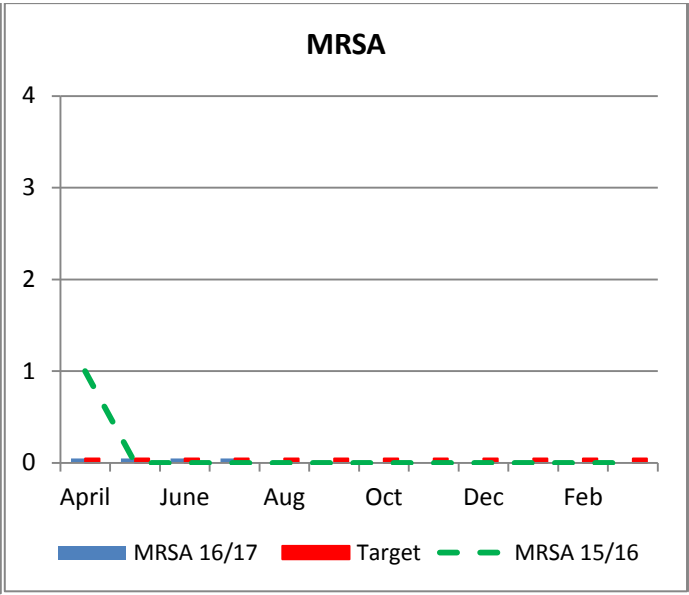

**Safety Quality Dashboard July 2015 – July 2016 Trust data**

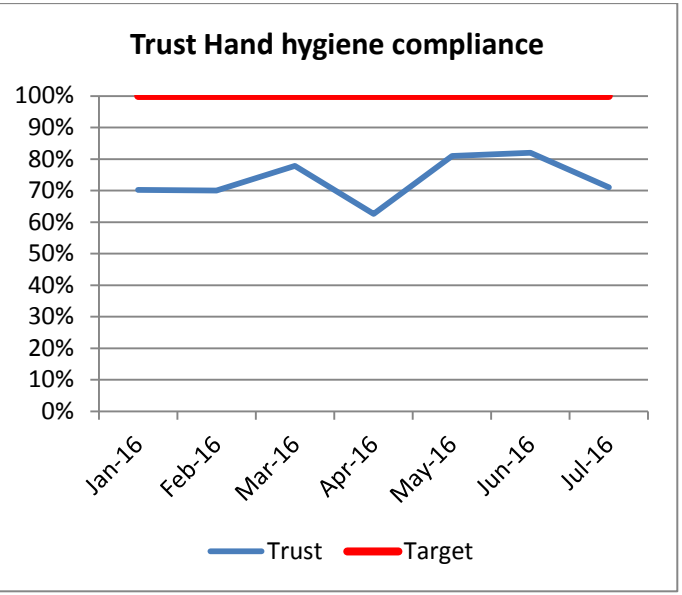
| Metric Title | Jul-2015 | Aug-2015 | Sep-2015 | Oct-2015 | Nov-2015 | Dec-2015 | Jan-2016 | Feb-2016 | May-2016 | Jun-2016 | Jul-2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicine chart demographics correct | 77.70% | 69.10% | 61.80% | 62.00% | 67.90% | 61.60% | 68.30% | 79.80% | 73.80% | 71.90% | 75.00% |
| Allergies documented | 99.40% | 97.00% | 96.50% | 96.60% | 100.00% | 98.40% | 100.00% | 98.70% | 99.40% | 95.50% | 96.80% |
| All medicines administered on time | 92.40% | 93.60% | 90.90% | 88.50% | 90.10% | 85.80% | 86.00% | 91.10% | 88.80% | 89.40% | 87.90% |
| Allergy nameband in place if required | 92.60% | 86.50% | 83.40% | 94.10% | 92.00% | 86.60% | 90.40% | 89.50% | 91.20% | 80.60% | 91.00% |
| Identification namebands in situ | 98.60% | 97.70% | 99.50% | 98.80% | 99.30% | 99.40% | 98.50% | 99.20% | 97.90% | 97.90% | 98.80% |

| **Performance Data Overview** | **Action Plan** |
|---|---|
| There were 134 incidents reported in July. The total number of medication incidents per 1000 bed days was 3.66. A slight increase from June.<br>The top 4 drug groups for omitted doses were, antimicrobials, insulins, opiates and anticoagulants.<br>There were 6 incidents reported against Pharmacy. Number of incidents per 100,000 items dispensed is 9.47.<br>Q3 CD audits for Grantham have been completed and the have achieved a 93% pass rate. | Clexane trial to commence on 2 wards at Lincoln, targeting the administration time of Clexane and looking to reduce the number of omitted doses/missed signatures.<br><br>CD audits for Lincoln and Pilgrim are to be completed.<br><br>Letter to be sent from Chief Nurse to those areas consistently failing their CD audit. |

# SAFE AMBITION 6 Reduction of Harm Associated with Infection

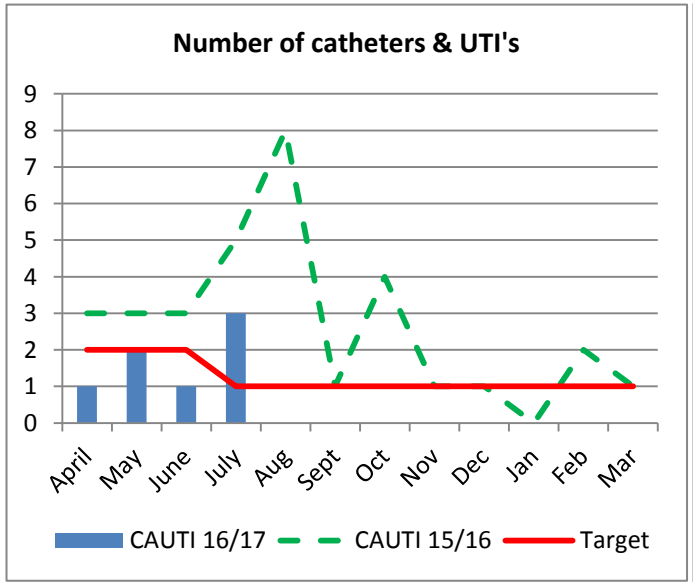


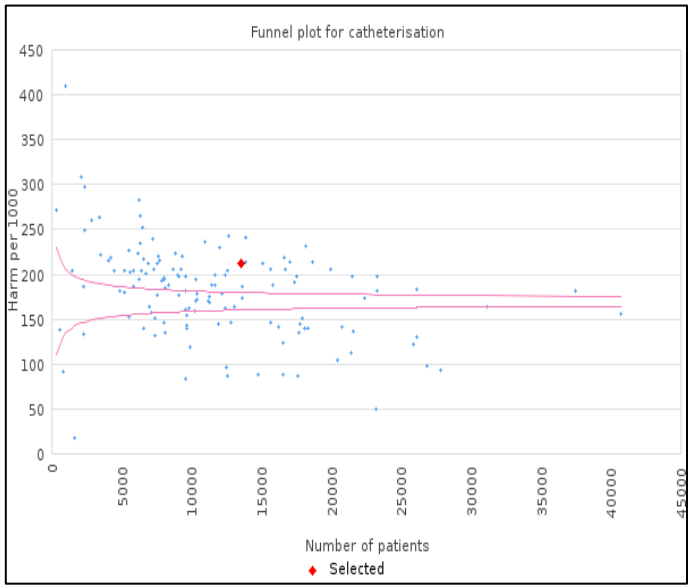




| Performance Data Overview | Action Plan |
|---|---|
| The annual trust trajectory for 2016-17 has been set as 59 cases by NHS England. This trajectory remains the same as 2015-16.<br><br>There has been six cases of hospital attributable (trajectory five), over trajectory by one case for the month. This brings the total of hospital attributable cases to seventeen. There was also two community acquired cases reported for July 2016.<br><br>A period of increased incidence is declared when there are 2 cases of hospital acquired cases of clostridium difficile on the same ward within a 28 day period. There were no Periods of increased incidence this month.<br><br>There has been zero cases of hospital attributable MRSA (trajectory zero). The case in May was found not to be hospital acquired.<br><br>All wards and departments undertake 10 observations per month of opportunities when hand hygiene should be carried out. The reason for the low score is due to staff not submitting their completed audit. | Increasing awareness of the importance of complying with the hand hygiene audit.<br>Cleaning review now completed.<br>Action plan to be completed for each area.<br>Refresher training given to staff.<br>New Micad system commenced on 16th May 16. |

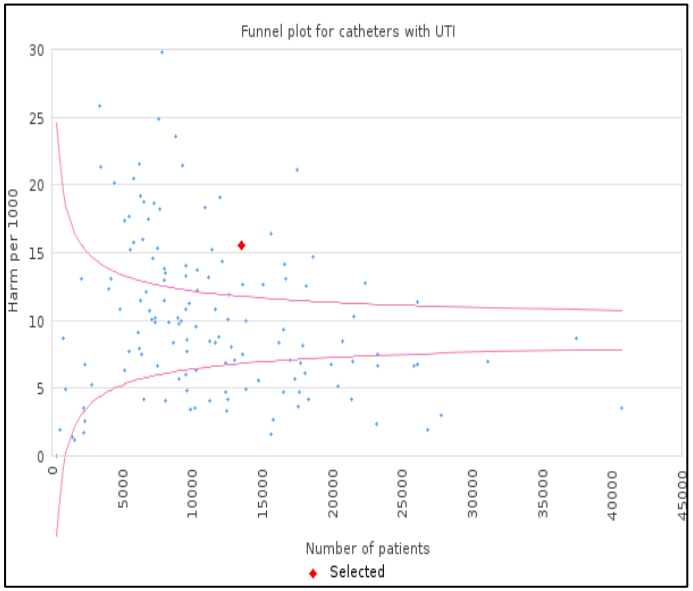
# SAFE AMBITION 6 Reduction of Harm Associated with Infection




**Safety thermometer national comparison of catheters**




**Safety thermometer national comparison of catheters & UTI**




**Safety Quality Dashboard July 2015 – July 2016 Trust data**

| Metric Title | Jul-2015 | Aug-2015 | Sep-2015 | Oct-2015 | Nov-2015 | Dec-2015 | Jan-2016 | Feb-2016 | May-2016 | Jun-2016 | Jul-2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of urinary catheters in-situ | 85 | 52 | 65 | 93 | 87 | 57 | 65 | 73 | 72 | 74 | 75 |
| Urinary catheter record demographics correct | 95.30% | 96.20% | 89.20% | 90.30% | 85.20% | 89.50% | 90.90% | 87.70% | 90.10% | 84.90% | 90.40% |
| Urinary catheter record completed &signed daily | 70.20% | 83.00% | 71.90% | 59.60% | 72.40% | 63.20% | 54.50% | 64.40% | 72.20% | 57.50% | 57.50% |
| TWOC occurred within 3 days for acute retention | 76.50% | 83.30% | 70.00% | 34.80% | 47.10% | 50.00% | 14.30% | 25.00% | 100.00% | 50.00% | 36.40% |
| Documented evidence why catheter needed | 92.60% | 96.20% | 87.50% | 90.30% | 84.10% | 89.50% | 83.30% | 83.60% | 87.30% | 87.30% | 89.00% |
| Urinary catheter bags secure | 100.00% | 100.00% | 100.00% | 100.00% | 98.90% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% |
| Urinary catheter care plan activated | 90.60% | 96.20% | 84.60% | 77.40% | 83.00% | 91.10% | 74.20% | 78.10% | 83.30% | 82.20% | 87.50% |

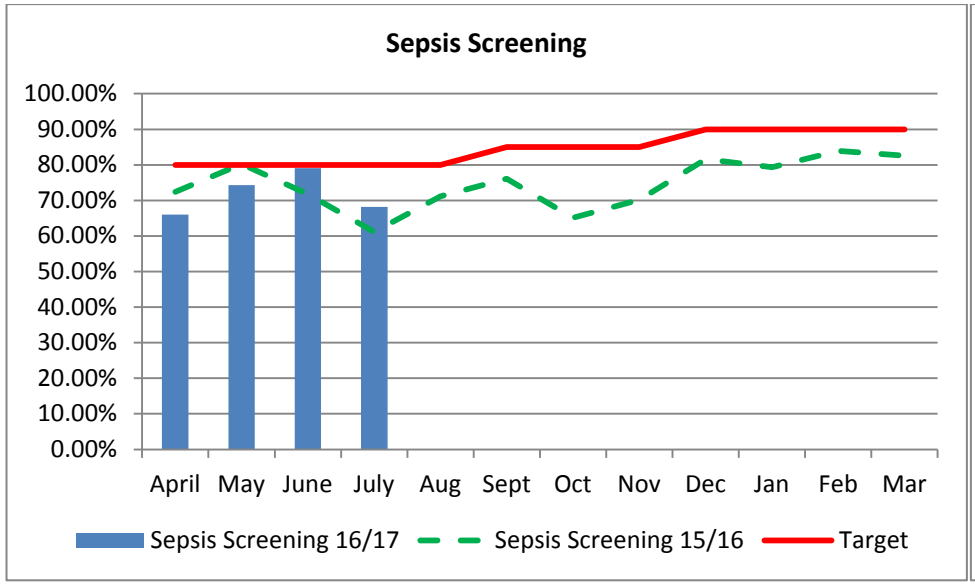
**Performance Data Overview**

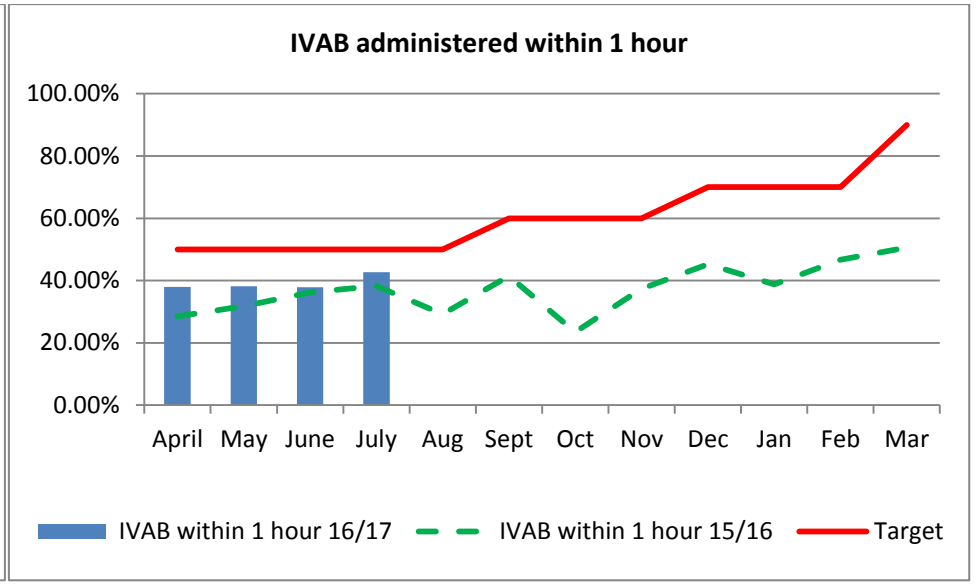
There were 2 CAUTIs at Lincoln and 1 at Pilgrim for July 2016.
The safety thermometer data is still demonstrating ULHT as outlier due to the spike in August 2015.
The number of catheters we insert is also showing us as an outlier compared to national statistics.
Compliance with catheter processes is still showing us as an outlier for reviewing catheters daily and removing catheters on day 3 for acute retention.

**Action Plan**

Pilot is nearing its completing on catheter packs. Plan to be developed on the outputs of the pilot.
Lessons being learnt on the patients identified with CAUTIs and communications will be developed on these.
Junior doctors have completed an audit on patients with catheters and will be presenting their data to their colleagues in the next few weeks.

# SAFE AMBITION 7 Reduction of Harm Associated with Deterioration




**Safety Quality Dashboard July 2015 – July 2016 Trust data**

| Metric Title | Jul-2015 | Aug-2015 | Sep-2015 | Oct-2015 | Nov-2015 | Dec-2015 | Jan-2016 | Feb-2016 | May-2016 | Jun-2016 | Jul-2016 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient demographics correct | 92.10% | 95.00% | 95.90% | 96.50% | 98.30% | 98.50% | 99.00% | 98.00% | 98.10% | 98.80% | 99.50% |
| Patient observations on time and complete | 75.00% | 77.40% | 66.40% | 71.80% | 75.00% | 76.70% | 72.90% | 77.60% | 79.20% | 79.10% | 80.00% |
| NEWS score added correctly | 95.20% | 94.50% | 96.10% | 95.00% | 98.30% | 98.80% | 95.80% | 96.20% | 97.10% | 98.30% | 98.10% |
| Evidence of escalation if required | 84.20% | 77.30% | 90.00% | 74.10% | 66.70% | 94.40% | 92.00% | 81.50% | 91.20% | 78.00% | 78.30% |
| Evidence of reset baseline | 96.90% | 95.50% | 90.90% | 89.70% | 78.10% | 87.00% | 85.00% | 96.60% | 100.00% | 75.00% | - |

**Performance Data Overview**

The compliance for screening has decreased however at Lincoln they achieved 92.31% for screening and 75% for administration of IVAB within 1 hour. Grantham achieved 78.26% for screening and 39.13% for administration of IVAB. Pilgrim site is still struggling to improve their compliance achieving 42.42% for screening and 27.59% for IVAB within 1 hour.

Observations on time and correct are still within the 80%. The rollout of eCOBS is ahead of their schedule at Pilgrim. Requested data from eCOBS for the results of compliance with NEWS.

HSMR is within normal limits for the last 2 months.

**Action Plan**

A workshop is being held on the 27th September with the Pilgrim senior staff to review key patient safety priorities one of which will be sepsis.

The Business case has been submitted – awaiting feedback.

Sepsis boxes have arrived and plan to roll out with the PGD.

First meeting with EMAs to explore paramedics delivering sepsis 6 on arrival.

Sepsis bundle being incorporated within eCOBS.

eLearning has gone live

Numerous publicity campaigns are also occurring.