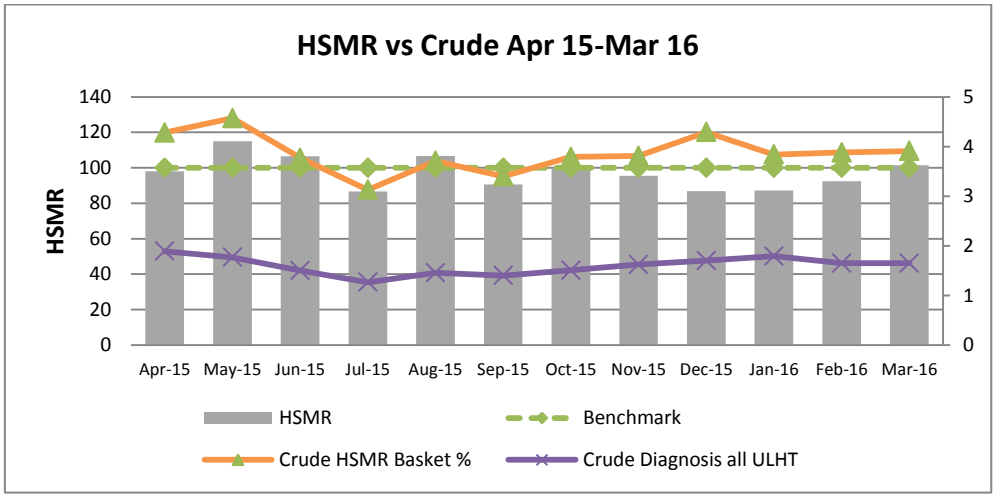
United Lincolnshire Hospitals NHS
NHS Trust

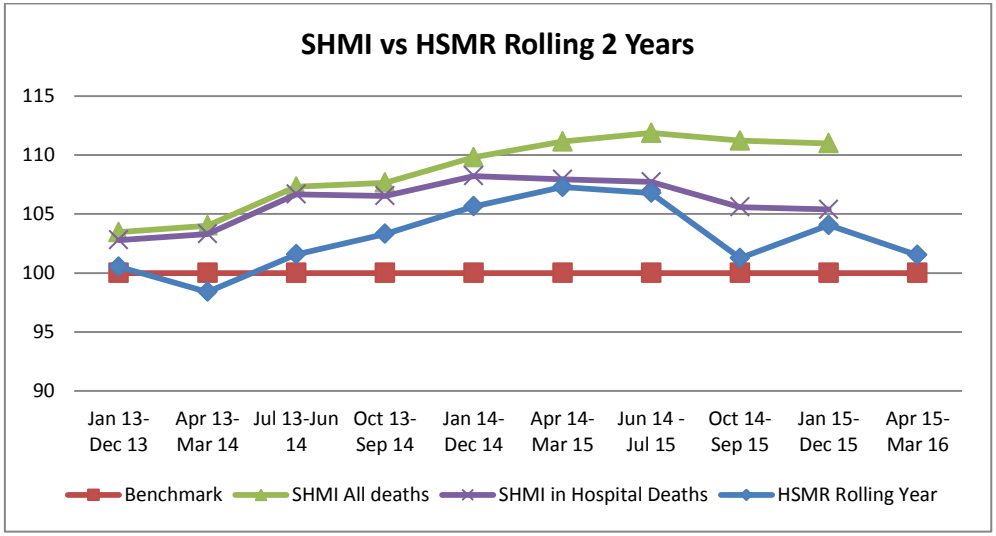
QUALITY REPORT SEPTEMBER 2016

SAFE AMBITION 1: Reduction of Harm Associated with Mortality

Executive Summary

Trust/Site	ULHT HSMR Jun 15-May 16 12 month	ULHT HSMR Apr 16-May 16 YTD	ULHT HSMR May-16	ULHT SHMI Jan 15 – Dec 15	Trust Crude Mortality YTD Internal source Apr 16-Aug 16
Trust	101.76	95.28	88.18	110.99	1.61%
LCH	115.15	108.67	106.90	112.11	1.73%
PHB	92.12	86.48	64.77	110.8	1.54%
GDH	76.06	65.11	75.37	106.07	1.24%



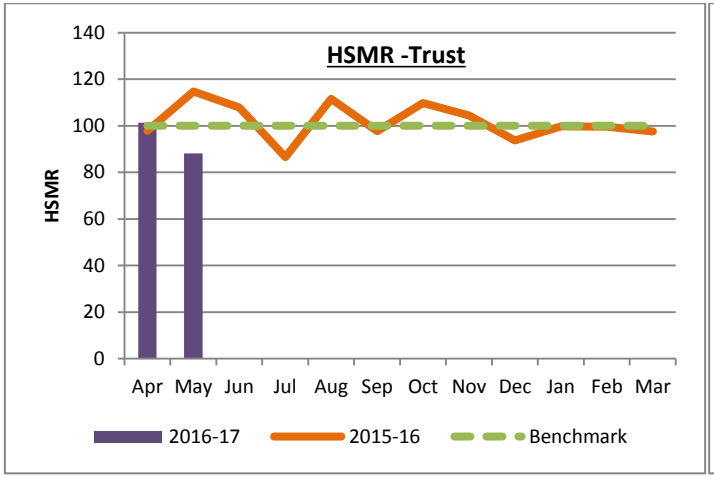


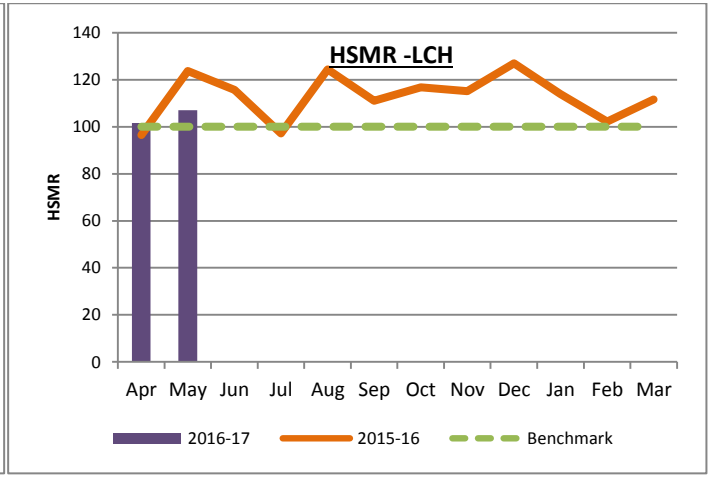
Performance Overview

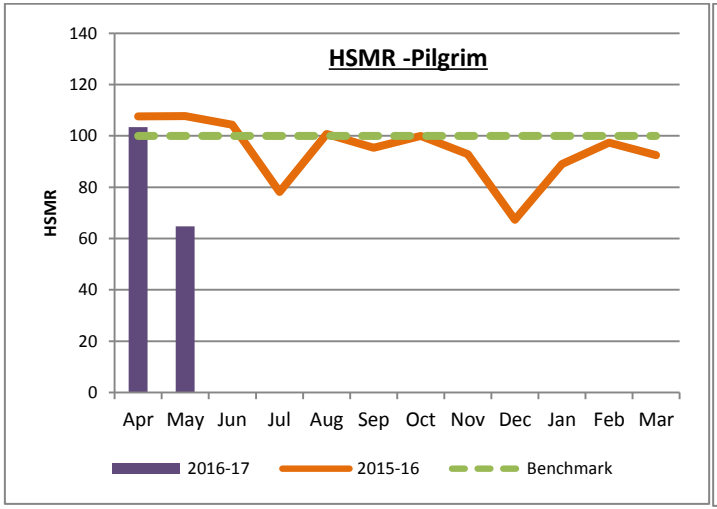
- ULHT's HSMR has increased by 0.25 and is within expected limits. (Jun 15 to May 16)
- In the time period Jun 15 to May 16 LCH has increased and both GDH and PHB have decreased from the previous reporting figure.
- LCH's increase is due to historic alerts. The year to date position shows ULHT and all sites are not alerting and are within expected limits.
- HSMR YTD Alerting diagnosis groups are:
  - **Syncope and collapse:** The coding of this diagnosis group is being investigated as this is a sign and symptom code. The patients have been sent to the respective Consultant for confirmation of the Main Condition Treated. The Patients appear to be cancer patients.
- 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.

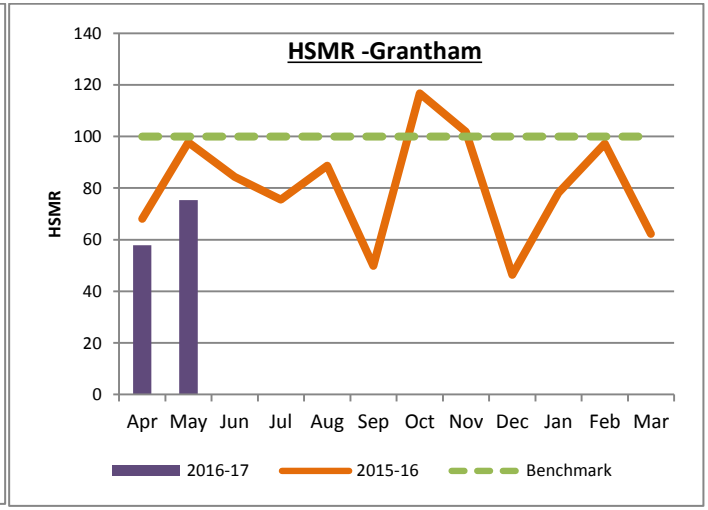
Hospital Standardised Mortality Ratio (HSMR)

Trust/Site	HSMR Jun 15-May 16	HSMR in year change reduction(-) Increase (+)	Trust Benchmark
Trust	101.76	-8.43	<100
LCH	115.15	-6.52	<100
PHB	92.12	-9.44	<100
GDH	76.06	-14.3	<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 May 16 HSMR has decreased by 13.1 to 88.2

Lincoln County Hospital

- HSMR YTD is within outside expected limits and has increased from the previous YTD period.
- In month May 2016 HSMR has increased to 106.99

Pilgrim Hospital

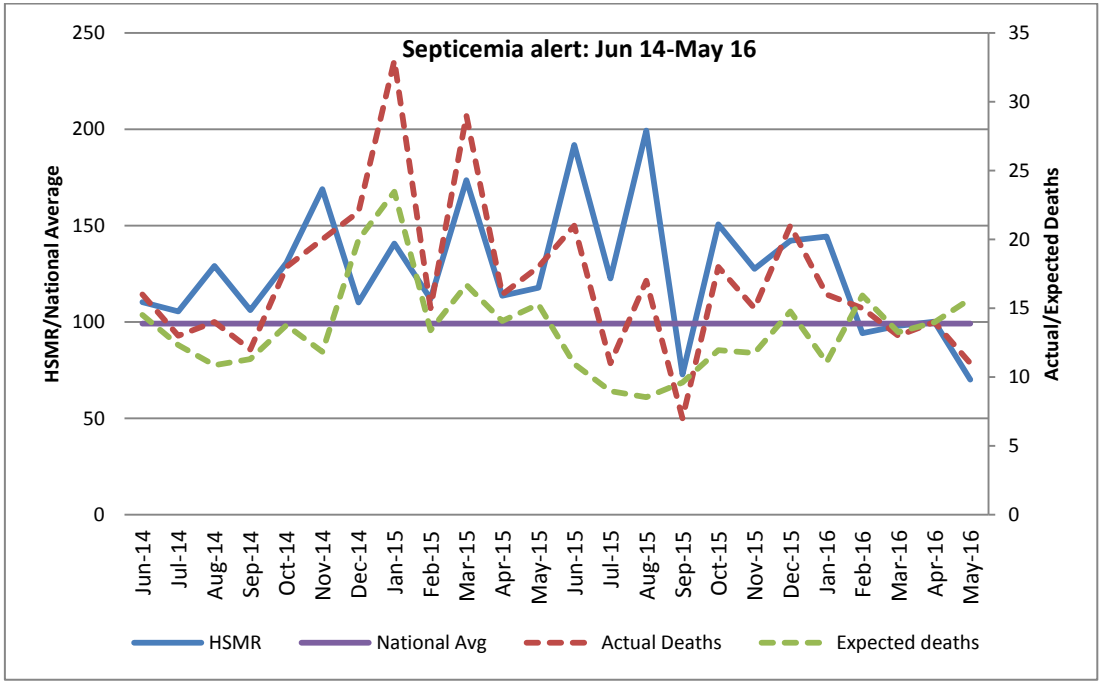
- HSMR YTD is in line within expected limits it has decreased from the previous YTD period.
- In month May 2016 HSMR has decreased by 38.64 to 64.77

Grantham Hospital

- HSMR YTD is in line within expected limits it has decreased from the previous YTD period.
- In month May 2016 HSMR has increased by 17.5 to 75.34
- Small numbers are the reason for such variability

HSMR Alerting Diagnosis-YTD April 16-May 17

Diagnosis group	Observed	Expected	Obs. - Exp.	Crude (%)	HSMR
Syncope	4	0.55	3.45	3.2	726.26



Alerting Diagnosis Overview

Alerting diagnosis are continuously monitored and when alerting for 3 months the diagnosis group will be investigated. Year to date diagnosis groups are used for alerting diagnosis as previous years data cannot be changed in Dr Foster.

Syncope:

- This is a sign and symptom code there are 4 deaths that have had a primary diagnosis coded as R55X Syncope and Collapse.
- Quality Governance have checked the codes against Medway and Mortality Reviews. The Patients details have been sent to the Consultants whom the patients was under to confirm the Primary Diagnosis for recoding.
- This diagnosis group equates to 1% of the Actual Deaths within ULHT

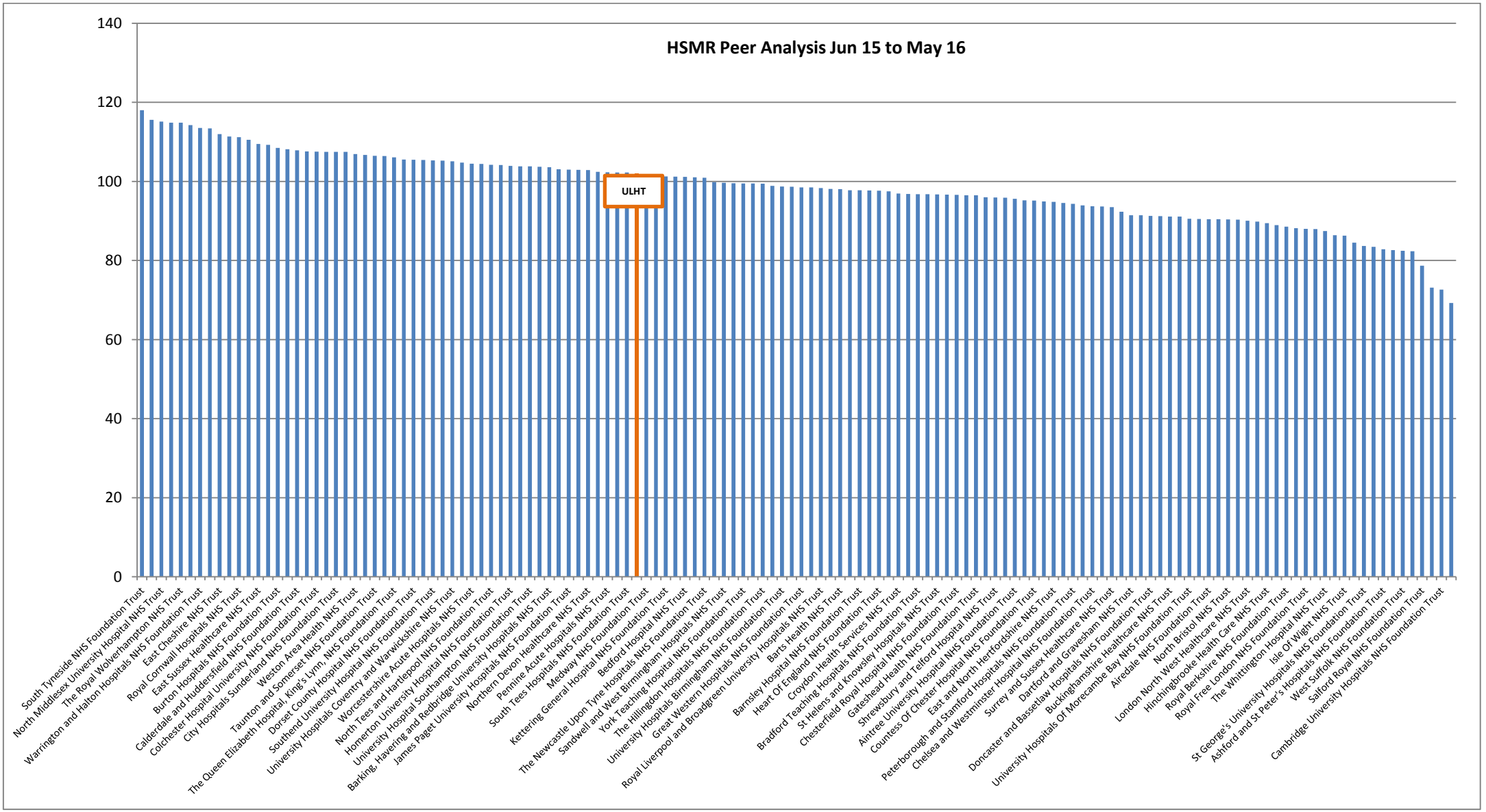
Other Perinatal Conditions:

- This diagnosis is no longer alerting however ongoing work is still progressing and a meeting is being held on 16/09/2016.

Septicemia (except in labour):

- Sepsis has not been alerting for the previous 4 months. and is no longer alerting YTD but is alerting within the last 12 months. Sepsis is still under the HSMR top Observed deaths and importance is not be taken off this diagnosis group.
- No individual sites are alerting
- ULHT have conducted several casenote reviews.
- Sepsis task and finish group has been working to reduce the HSMR
- 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.
- The business case for the Sepsis Nurses have been approved.

HSMR – Peer analysis



Summary Hospital-Level Mortality Indicator (SHMI)

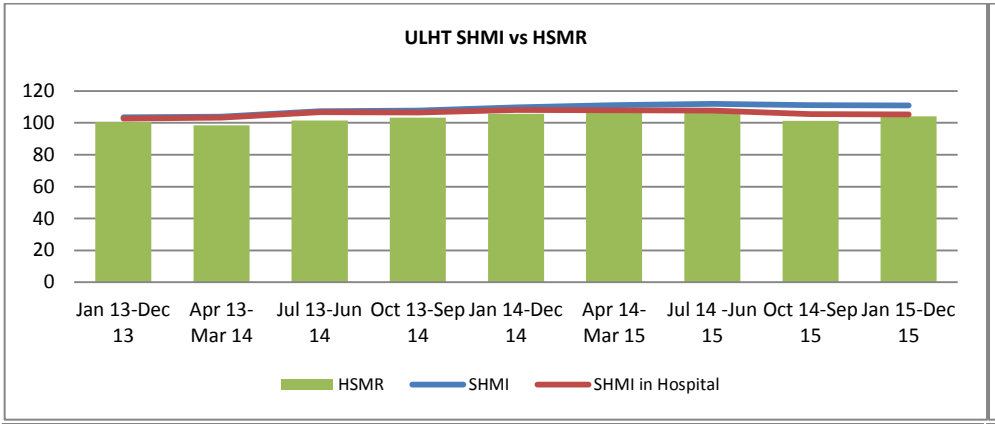
Death I/O Hospital Jan 15-Dec15	SHMI Spells	SHMI/ HSMR	Actual Deaths	Expected Deaths
SHMI All deaths	82545	110.99	3591	3235.3
SHMI In hospital deaths	82545	105.38	2436	2311.71
HSMR	51873	104.05	2131	2048.06

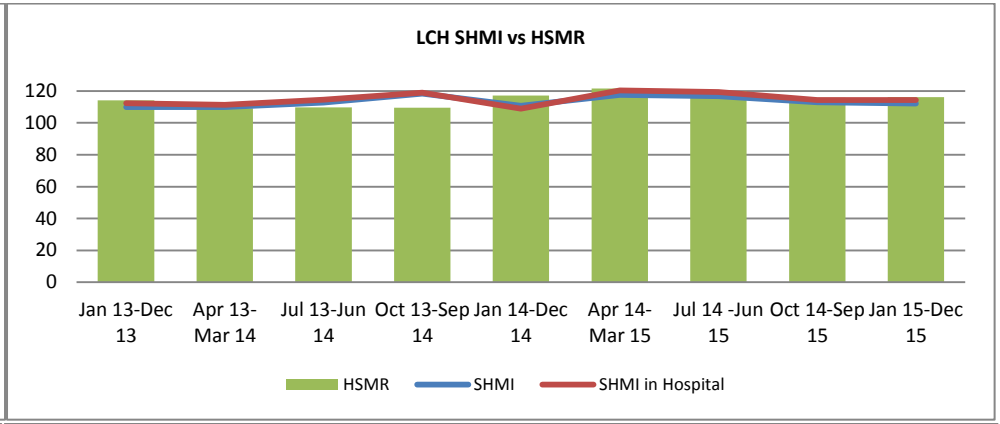
Trust/Site	ULHT SHMI Jan 15-Dec 15 (Current)
ULHT	**110.99**
LCH	**112.11**
PHB	**110.8**
GDH	**106.07**

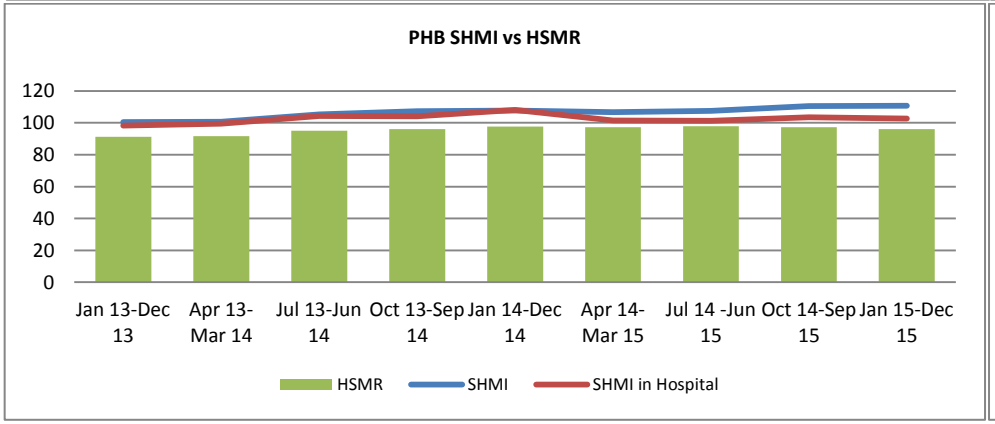
SHMI Performance Overview

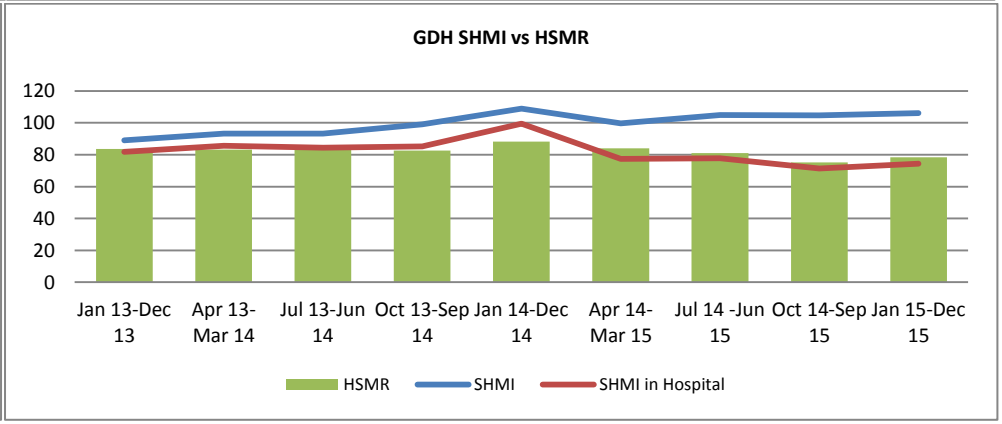
- Current SHMI reporting period (Jan 15-Dec 15) show that ULHT has decreased to 110.99 for all deaths.
- In hospital deaths are in line with HSMR at this time period.
- Alerting Diagnosis for SHMI; due to the time lapse in SHMI reviews were carried out for these alerts when these diagnosis alerted in 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:

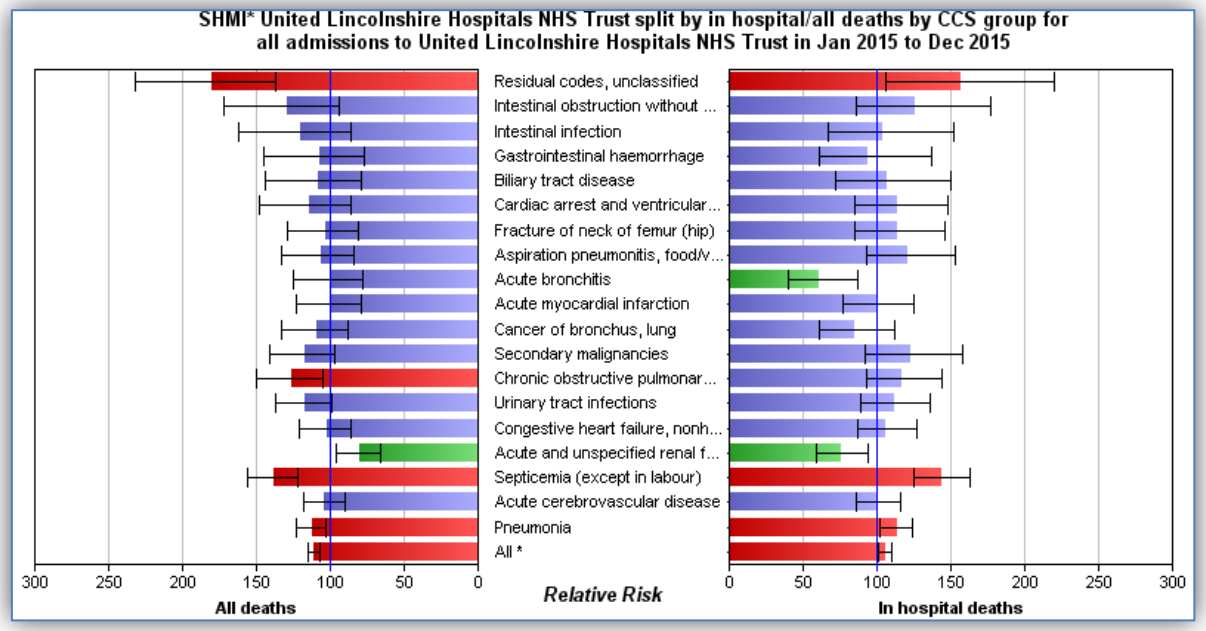








SHMI alerting diagnosis



SHMI alerting diagnosis overview

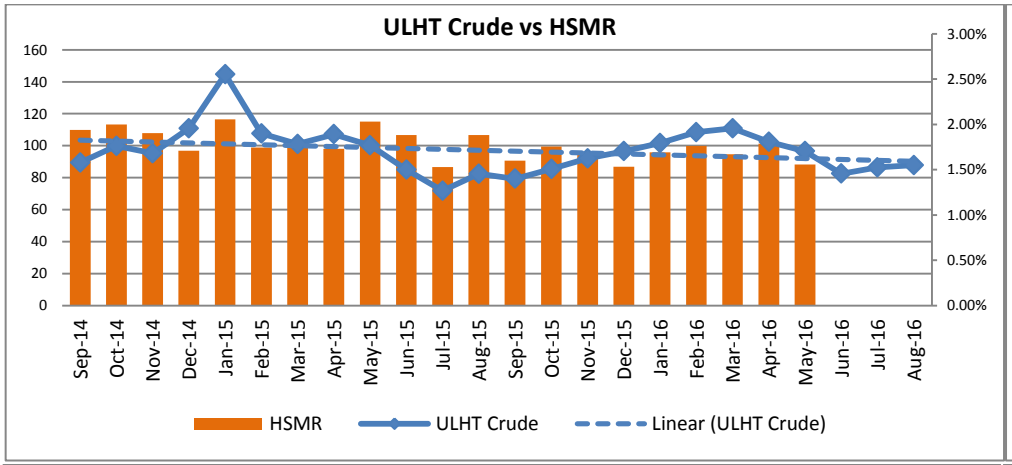
- Within the time period of January 2015 to December 2015.
- In hospital alerting diagnosis for ULHT are:
  Residual codes, Septicemia and Pneumonia.
- Septicemia alert was driven by the Lincoln and Pilgrim sites.
- Residual codes (signs and symptoms) were not alerting on any particular site. (Please see page 10 for an explanation of Residual Codes)
- At this time period within the HSMR basket; Septicemia replicates the SHMI alert. Pneumonia is not alerting at this time.
- All alerting diagnosis mirror in hospital apart from COPD; suggesting that post 30 day discharge mortality have initiated the alert.
- Diagnosis within this time period alerting in HSMR have had reviews and action plans. Pneumonia although not alerting in this time period have had subsequent reviews.

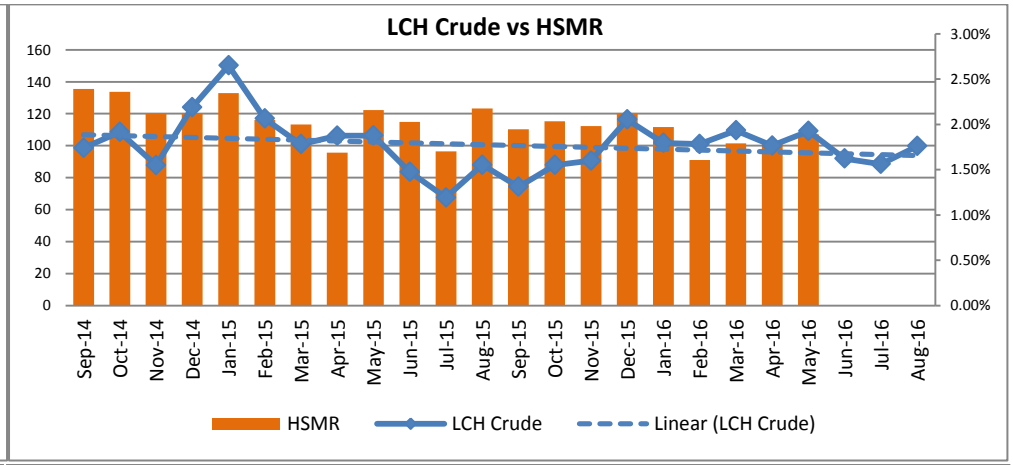
Crude mortality

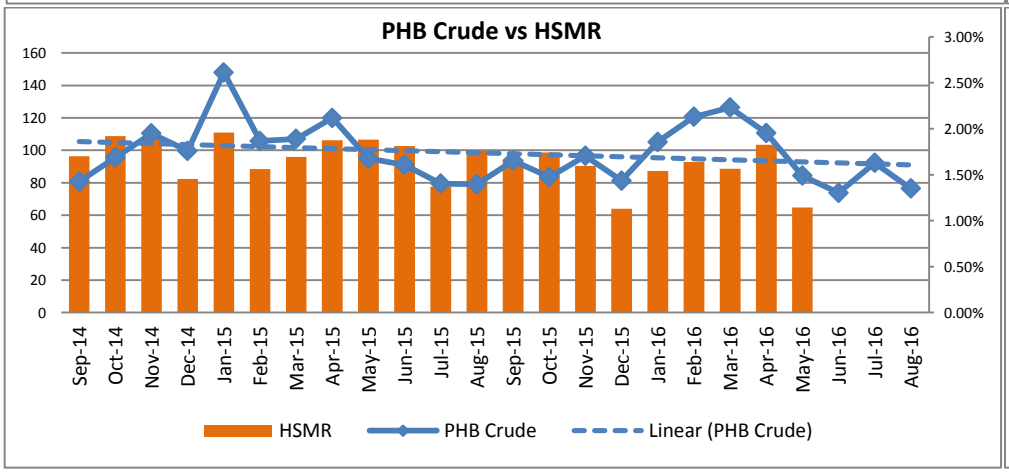
Trust Site	Dr Foster Crude National Average Jun 15 – May 16	ULHT data Crude mortality YTD Apr 16-Aug 16	ULHT data Crude Mortality July 16
Trust	1.41%	1.61%	1.55%
LCH	-	1.73%	1.76%
PHB	-	1.54%	1.35%
GDH	-	1.24%	1.21%

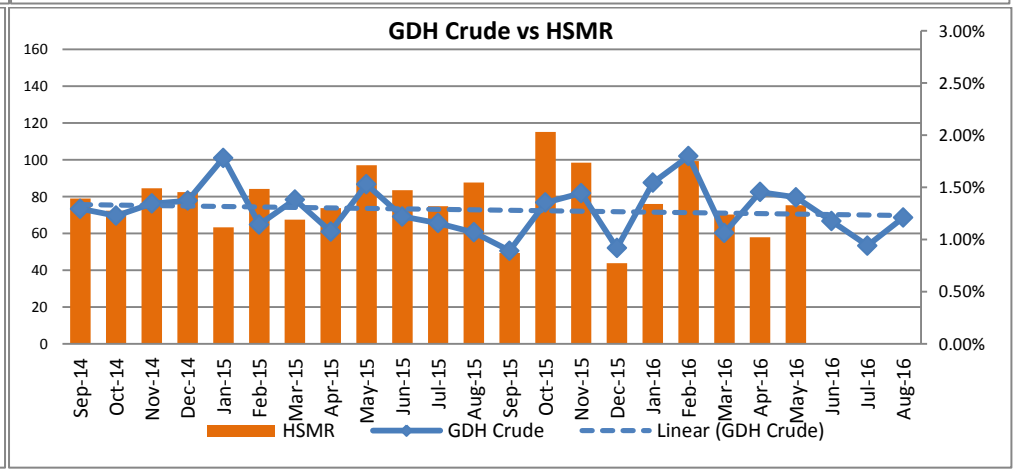
Crude mortality overview

- Against National average (time period: Jun 15 – May 16) ULHT are higher by 0.23%. ULHT's average is 1.64% for this time period.
- ULHT's crude mortality for year to date has decreased to 1.61%
- 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.

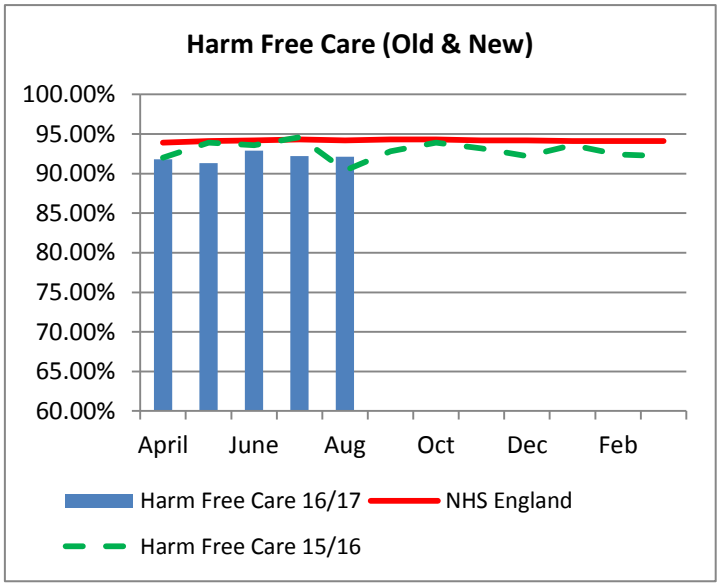
Residual codes: These are codes for all signs and symptoms written in the casenotes. The mortality reporting tools take the first primary diagnosis coded if this code is a residual code the reporting tool moves to the second episode; if this is identified as residual code the reporting tool codes the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

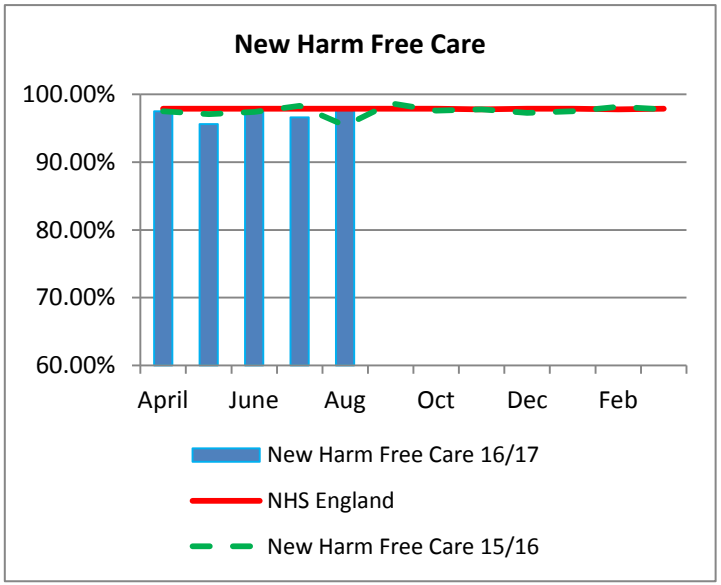
SAFE AMBITION 2 Reduction of Harm Associated with Harm free Care

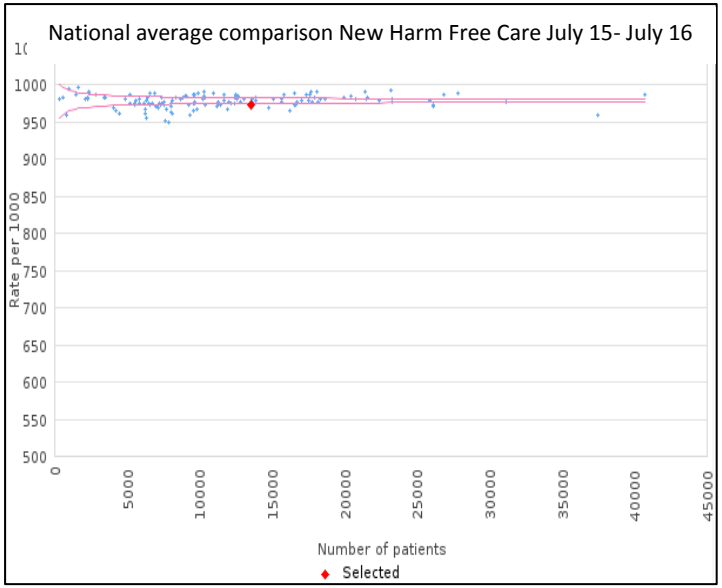
The NHS Safety Thermometer records the presence or absence of four harms:

- 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)

August New Harm Free Care
98%







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		94.2%	97.9%	4.3%	0.9%	0.6%	0.7%	0.3%	0.4%
Grantham	86	91.9%	100%	5.8%	0%	0%	2.3%	0%	0%
Lincoln	460	93.9%	97.4%	4.1%	1.3%	0.9%	0.9%	0%	0.4%
Louth	3	100%	100%	0%	0%	0%	0%	0%	0%
Pilgrim	303	89.4%	98.3%	9.2%	1.0%	0.3%	1.0%	0.3%	0%
UHT Total	852	92.1%	98%	6.1%	1.1%	0.6%	1.1%	0.1%	0.2%

Grantham is better than the national average for all indicators besides PU's all and Cath & all UTI
Lincoln is lower than the national average for all indicators besides PU's all, Cath & new UTI and New VTE's.
Pilgrim is better than the national average for falls with harm, Cath & new UTI and New VTE's.
All sites except Lincoln are higher than the national average for New Harm Free Care
ULHT is higher than the national average for falls with harm, Cath & new UTI and new VTE

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.

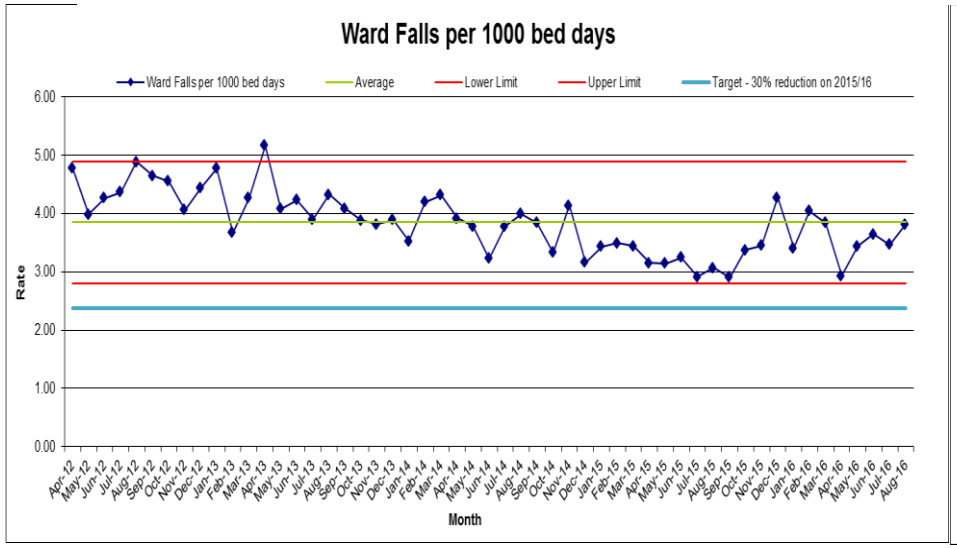
The data is validated by the leads within these key harms prior to submission.

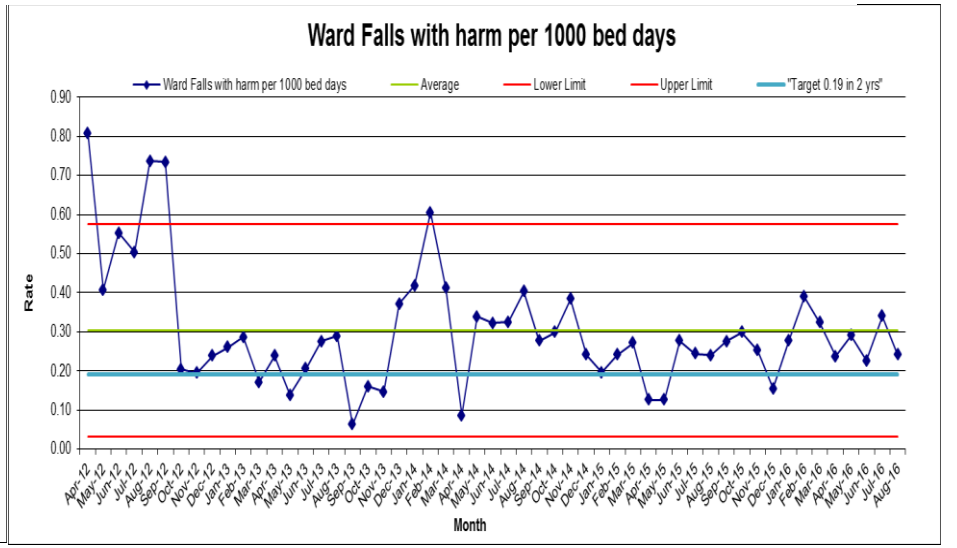
Education is ongoing.

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





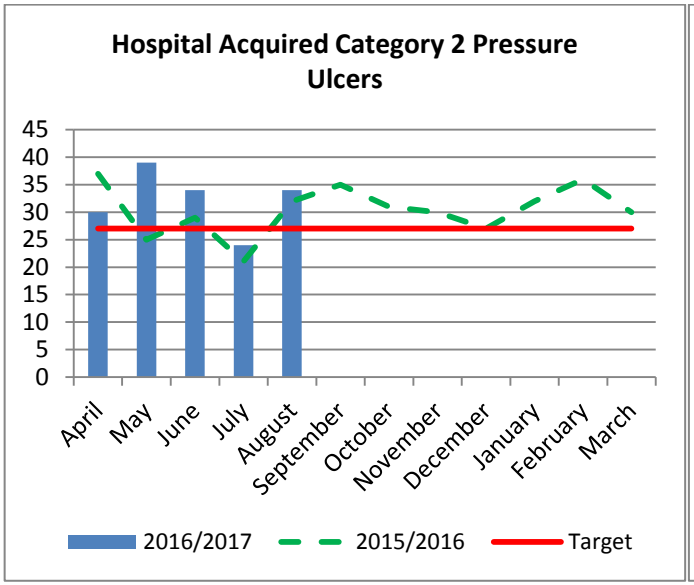
Safety Quality Dashboard Aug 2015 – Aug 2016 Trust data

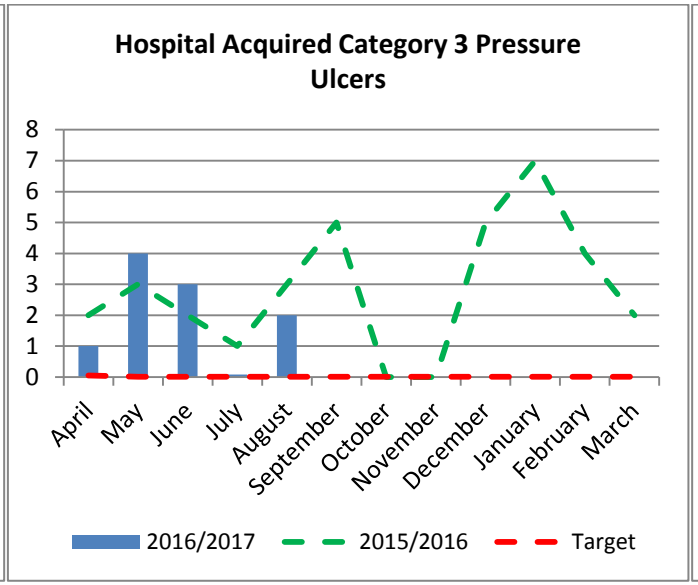
Metric Title	Aug-2015	Sep-2015	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	May-2016	Jun-2016	Jul-2016	Aug-2016
Patient at risk of falls	327	330	320	334	276	332	315	349	360	344	336
Medication review occurred	69.40%	69.70%	68.70%	71.00%	66.80%	71.00%	64.70%	65.10%	67.10%	70.90%	66.50%
Lying & standing BP completed	56.70%	57.10%	58.60%	65.60%	61.80%	57.30%	60.10%	56.20%	55.60%	58.00%	62.60%
Care plan 7 activated	97.50%	93.90%	94.60%	93.60%	94.40%	93.90%	93.50%	94.00%	95.50%	97.10%	96.40%
Reviewed by physio	63.10%	68.00%	64.70%	74.20%	71.20%	71.90%	77.80%	79.90%	81.40%	82.40%	78.50%
Referred to OT	83.50%	82.00%	86.50%	89.00%	85.20%	86.70%	83.20%	90.90%	89.80%	91.40%	80.40%
Referred to physio	88.60%	90.40%	90.50%	92.40%	89.90%	86.30%	86.70%	86.10%	87.10%	88.90%	90.10%
Actions completed within 4 hours on admission	86.90%	86.70%	87.90%	88.90%	88.50%	87.20%	83.80%	91.40%	90.60%	93.00%	88.10%
Actions completed within 24 hours on admission	41.10%	44.50%	38.90%	46.30%	42.00%	39.70%	43.80%	41.30%	42.40%	46.50%	42.20%
Actions completed within 24 hours of transfer (if necessary)	39.90%	44.30%	38.70%	37.90%	37.00%	33.70%	35.90%	33.80%	32.10%	33.10%	39.30%

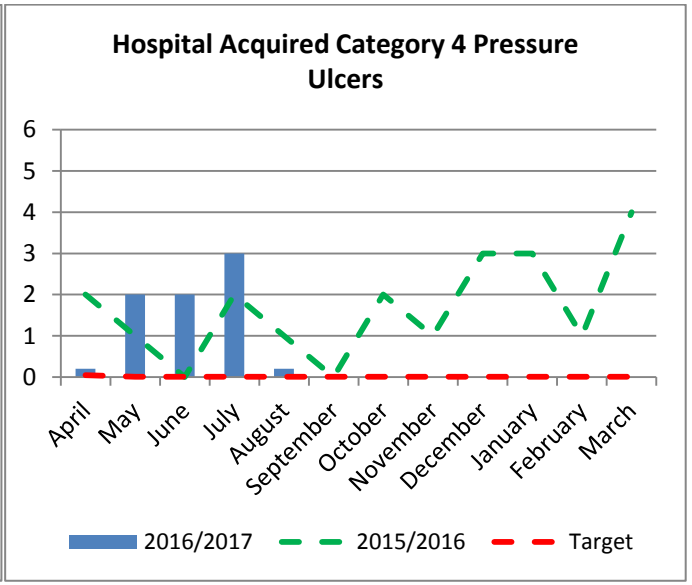
Performance Data Overview

- Falls with harm across the Trust is 0.24 which is a reduction from last month.
- Last year, the Trust achieved an overall reduction in all falls and falls with harm; year to date (fiscal year) that reduction is being sustained as a Trust wide figure
- From a site perspective:
  - Grantham are reporting further reduction with a year to date average of 0.23 for falls with harm compared to 0.27 last fiscal year. For all falls, Grantham are also reporting a reduction with an year to date average of 4.74 compared to 5.45.
  - LCH are reporting a further reduction in falls with harm at 0.19 compared to 0.22 for 2015/2016 but are experiencing more falls with no or low harm suggesting that the severity of harm is reducing
  - Pilgrim are reporting the same number of all falls but the level of harm has increased to 0.39 from 0.29. New Heads of Nursing are in place and plans have been made for DCN to discuss falls performance, SQD and prevention on a quality session with Matrons on 27th September 2016

SAFE AMBITION 4 Reduction of Harm Associated with Pressure Ulcers







Safety Quality Dashboard Aug 2015 – Aug 2016 Trust data

Metric Title	Aug-2015	Sep-2015	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	May-2016	Jun-2016	Jul-2016	Aug-2016
Pressure area care risk assessment completed within 24hrs	99.00%	98.80%	98.50%	98.30%	99.40%	97.80%	98.00%	97.90%	98.10%	99.00%	98.80%
Pressure area care risk assessment updated weekly	89.40%	81.90%	85.20%	85.60%	82.50%	79.40%	86.10%	85.50%	78.00%	75.30%	76.00%
Pressure-relieving equipment in situ if required	92.80%	94.30%	97.70%	96.30%	93.50%	93.40%	96.20%	93.00%	92.30%	96.00%	93.50%
Repositioning chart commenced if required	94.00%	95.10%	96.00%	98.00%	98.80%	97.60%	99.00%	95.90%	95.40%	96.10%	96.40%
Pressure area care plan activated if required	94.20%	92.00%	94.40%	97.30%	95.70%	90.50%	94.80%	91.40%	93.80%	95.10%	92.10%

Performance Data Overview

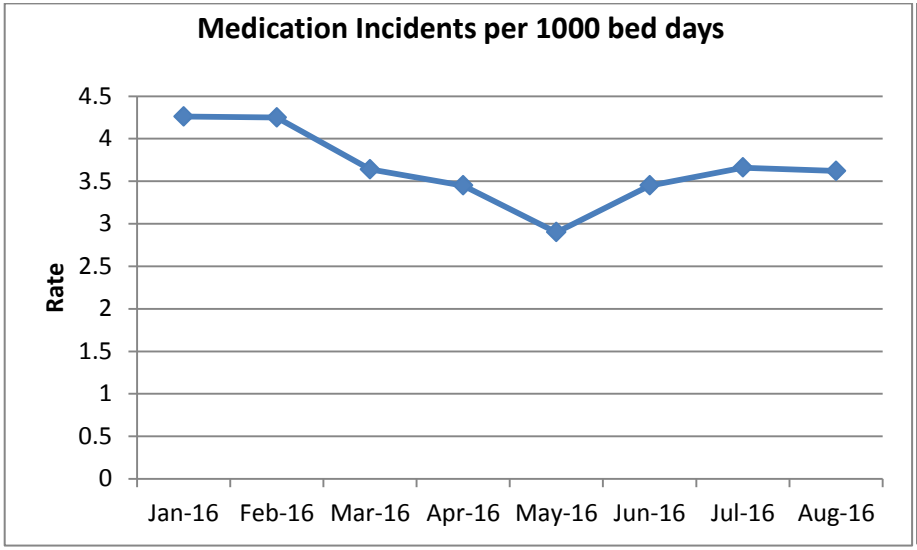
Recorded Category 3&4 PU's:

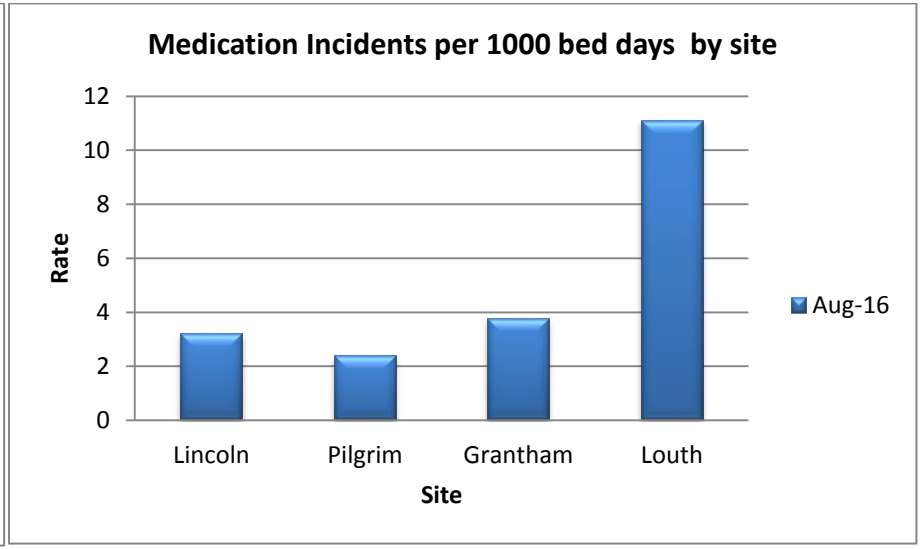
Since April 2016, although there have been a number of Pressure Ulcers reported as deteriorating from Category 2 to 3 and Category 3 to 4 Pressure Ulcers (10 and 6 respectively) within the boundaries of ULHT – these are in the main identified as a result of a patients deteriorating medical condition as evidenced on completion of the internal RCA process – since April 2015, in fact there has only been one brand new Category 4 and two Category 4 pressure Ulcer reported across all sites of All PUNT data validated by Nurse Consultant – Tissue Viability.

Action Plan

As all of the deteriorations -as reported in the previous section - involved Pressure Ulceration on patient's heels, all clinical areas have been reminded of the ULHT heel prevention policy and intervention flowchart (introduced in 2015) and appropriate management and ongoing intervention techniques by the ULHT Tissue Viability team. Relevant elements of the 'Pick and Mix' clinically based education continues across all ULHT as planned/in identified areas of need (as highlighted by PUNT reports). Furthermore the Internal SI investigation/Pressure Ulcer Scrutiny Panel process has been commenced.

SAFE AMBITION 5 Reduction of Harm Associated with Medication





Safety Quality Dashboard Aug 2015 – Aug 2016 Trust data

Metric Title	Aug-2015	Sep-2015	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	May-2016	Jun-2016	Jul-2016	Aug-2016
Medicine chart demographics correct	69.10%	61.80%	62.00%	67.90%	61.60%	68.30%	79.80%	73.80%	71.90%	75.00%	78.50%
Allergies documented	97.00%	96.50%	96.60%	100.00%	98.40%	100.00%	98.70%	99.40%	95.50%	96.80%	98.10%
All medicines administered on time	93.60%	90.90%	88.50%	90.10%	85.80%	86.00%	91.10%	88.80%	89.40%	87.90%	88.00%
Allergy nameband in place if required	86.50%	83.40%	94.10%	92.00%	86.60%	90.40%	89.50%	91.20%	80.60%	91.00%	87.60%
Identification namebands in situ	97.70%	99.50%	98.80%	99.30%	99.40%	98.50%	99.20%	97.90%	97.90%	98.80%	98.00%

Performance Data Overview

There were 109 incidents reported in August. The total number of medication incidents per 1000 bed days was 3.62. A slight decrease from July and over the last 8 months an overall downward trend is shown.

The top 4 drug groups for omitted doses were, antimicrobials, insulins, opiates and anticoagulants.

There were 9 incidents reported against Pharmacy. Number of incidents per 100,000 items dispensed is 13.8.

Q3 CD audits for Grantham have been completed and the have achieved a 93% pass rate. Audits for Lincoln and Pilgrim are still underway but early signs show improvement.

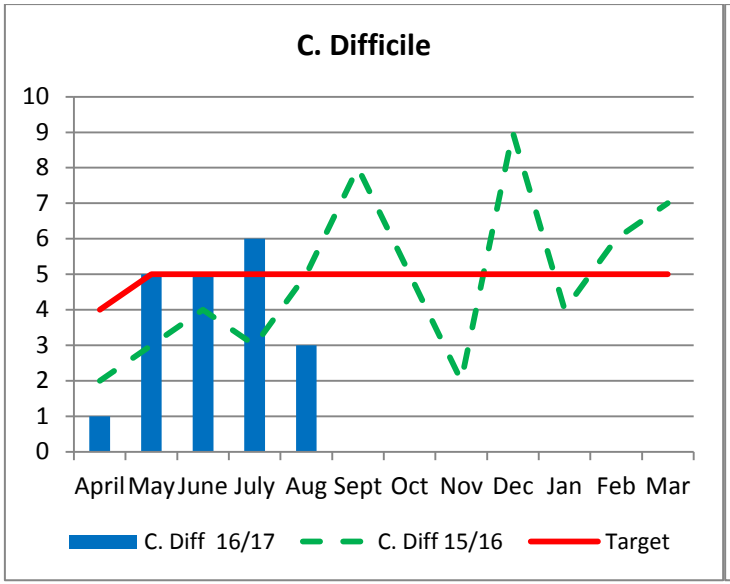
Action Plan

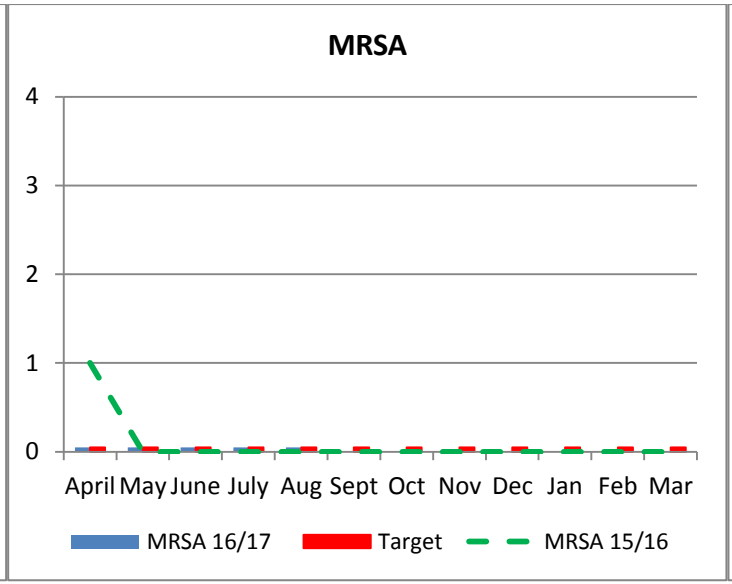
Anticoagulant chart is to be reviewed at the next VTE committee meeting.

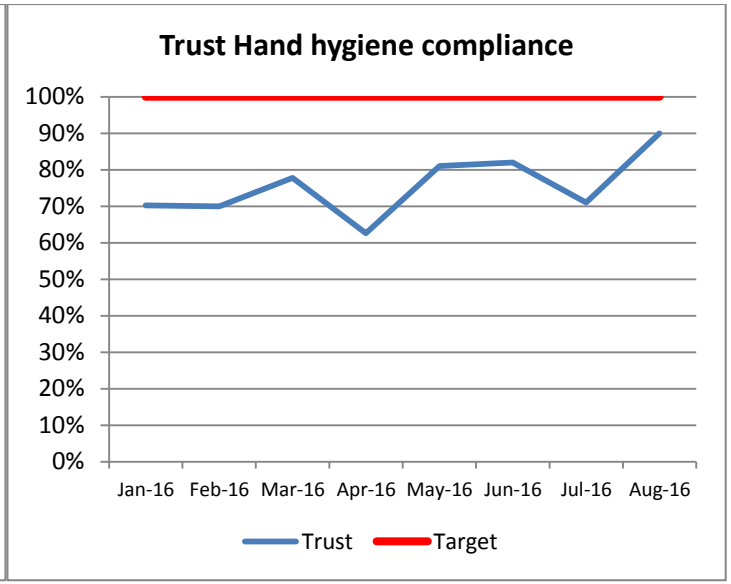
Insulin policy is in the process of being written by the pharmacy department and the diabetes team.

Antimicrobials continue to be managed through the antimicrobial stewardship and the antimicrobial consultant pharmacist. An allergy awareness poster is being produced to increase allergy awareness.

SAFE AMBITION 6 Reduction of Harm Associated with Infection

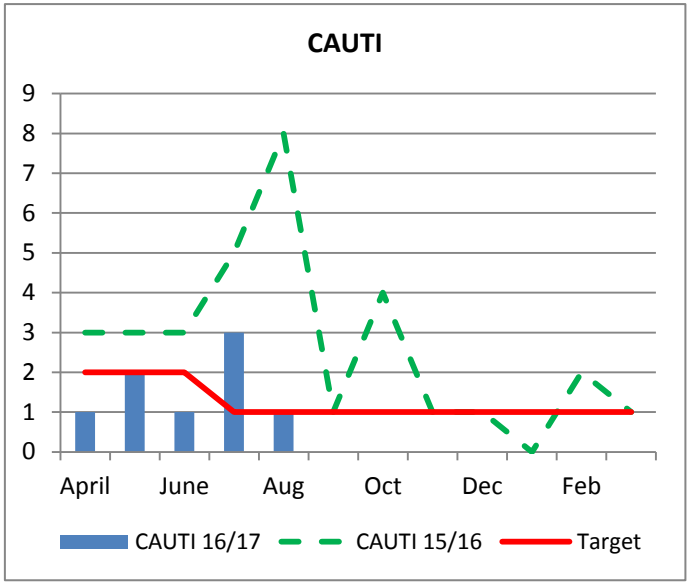


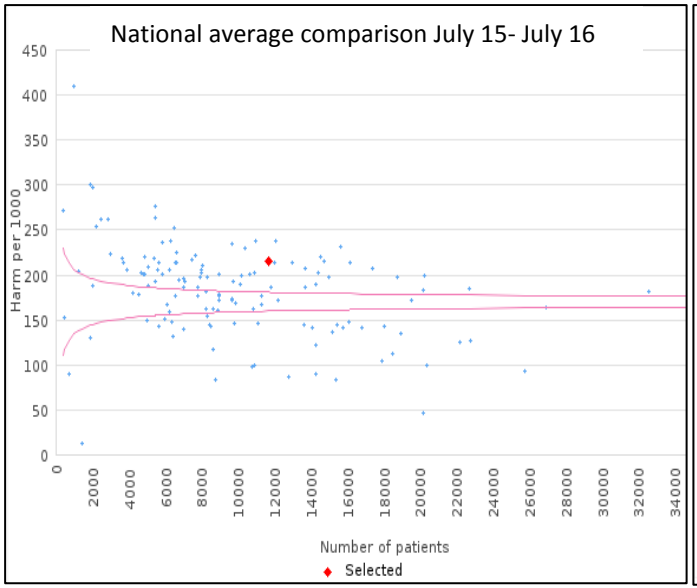


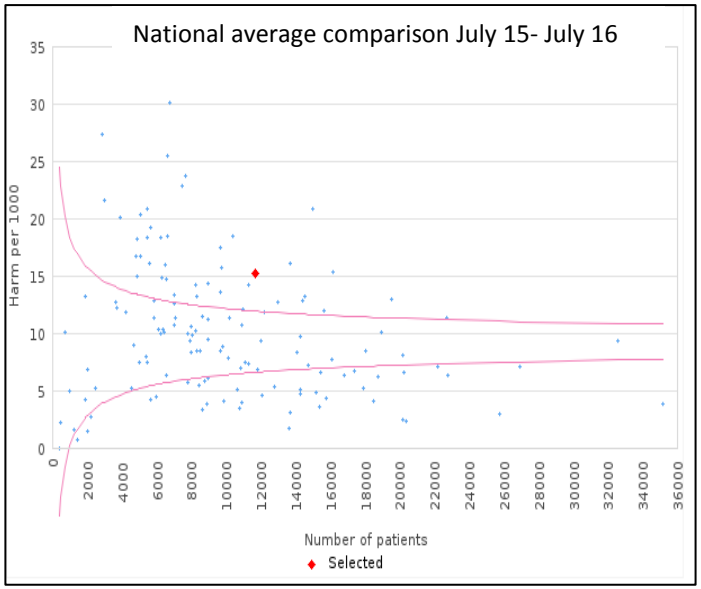


Performance Data Overview	**Action Plan**
The annual trust trajectory for 2016-17 has been set as 59 cases by NHS England. This trajectory remains the same as 2015-16. Clostridium difficile – 24 cases for year to date (Trajectory is 59) MRSA bacteraemia- o cases to date (Trajectory 0) Hand hygiene- overall trust compliance is at 90%	Monthly hand hygiene drop in sessions undertaken trust wide Hand hygiene awareness carried out in May 2016 trust wide Hand hygiene awareness week being carried out in September 2016 trust wide Messages communicated via twitter Compliance assessment tool/review is undertaken for each patient RCA undertaken for each hospital acquired case and an action plan put into place which is discussed at site meeting Post infection review undertaken for all cases and an action plan completed and discussed at site and committee meetings

SAFE AMBITION 6 Reduction of Harm Associated with Infection







Safety Quality Dashboard Aug 2015 – Aug 2016 Trust data

Metric Title	Aug-2015	Sep-2015	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	May-2016	Jun-2016	Jul-2016	Aug-2016
Number of urinary catheters in-situ	52	65	93	87	57	65	73	72	74	75	81
Urinary catheter record demographics correct	96.20%	89.20%	90.30%	85.20%	89.50%	90.90%	87.70%	90.10%	84.90%	90.40%	95.00%
Urinary catheter record completed &signed daily	83.00%	71.90%	59.60%	72.40%	63.20%	54.50%	64.40%	72.20%	57.50%	57.50%	72.20%
TWOC occurred within 3 days for acute retention	83.30%	70.00%	34.80%	47.10%	50.00%	14.30%	25.00%	100.00%	50.00%	36.40%	40.00%
Documented evidence why catheter needed	96.20%	87.50%	90.30%	84.10%	89.50%	83.30%	83.60%	87.30%	87.30%	89.00%	91.10%
Urinary catheter bags secure	100.00%	100.00%	100.00%	98.90%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Urinary catheter care plan activated	96.20%	84.60%	77.40%	83.00%	91.10%	74.20%	78.10%	83.30%	82.20%	87.50%	88.60%

Performance Data Overview

There were 1 CAUTI at Pilgrim for August 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.

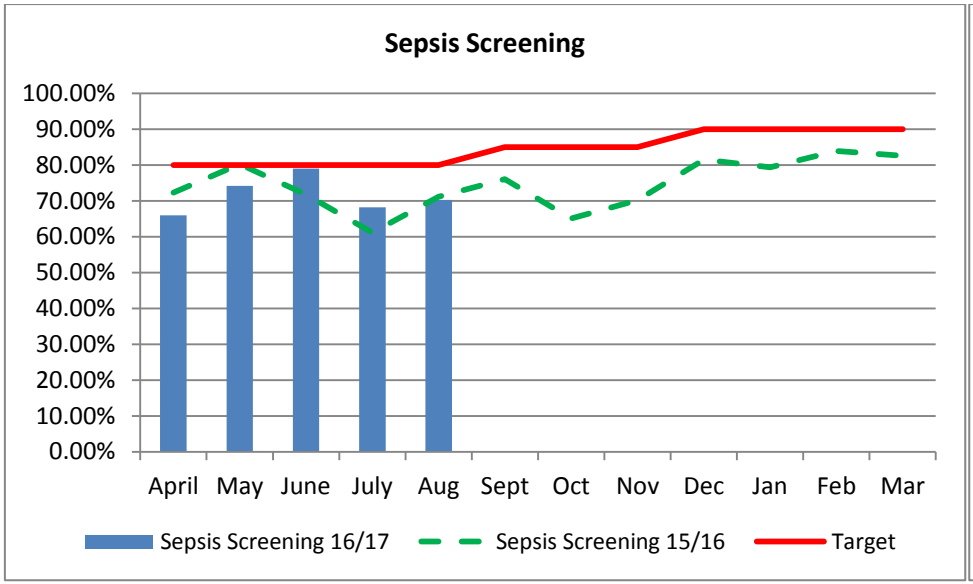
Compliance with catheter processes is still showing us as an outlier however there is improvement for reviewing catheters daily and removing catheters on day 3 for acute retention.

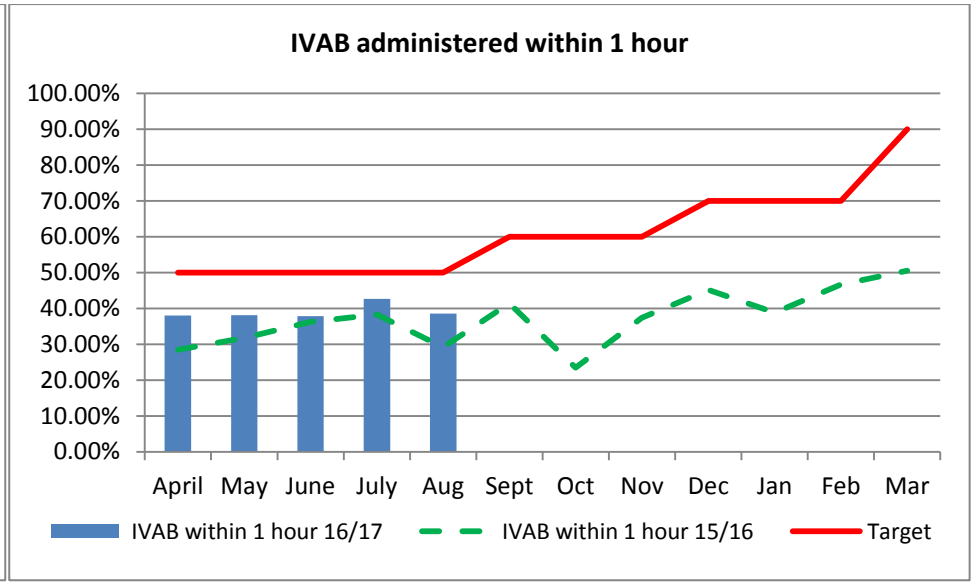
Action Plan

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.

SAFE AMBITION 7 Reduction of Harm Associated with Deterioration





Safety Quality Dashboard Aug 2015 – Aug 2016 Trust data

Metric Title	Aug-2015	Sep-2015	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	May-2016	Jun-2016	Jul-2016	Aug-2016
Patient demographics correct	95.00%	95.90%	96.50%	98.30%	98.50%	99.00%	98.00%	98.10%	98.80%	99.50%	98.00%
Patient observations on time and complete	77.40%	66.40%	71.80%	75.00%	76.70%	72.90%	77.60%	79.20%	79.10%	80.00%	78.20%
NEWS score added correctly	94.50%	96.10%	95.00%	98.30%	98.80%	95.80%	96.20%	97.10%	98.30%	98.10%	97.50%
Evidence of escalation if required	77.30%	90.00%	74.10%	66.70%	94.40%	92.00%	81.50%	91.20%	78.00%	78.30%	76.10%

Performance Data Overview

The compliance for screening has improved somewhat at Trust level . Lincoln achieved 81% for screening and 42.3% for administration of IVAB within 1 hour. Grantham achieved 89.47% for screening and 56.25% for administration of IVAB. Pilgrim site is still struggling to improve their compliance achieving 53.33% for screening and 29.27% for IVAB within 1 hour.
Observations on time and correct has also deteriorated slightly to 78% 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 4 months for sepsis.

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 for 2 sepsis nurses has been approved.
PGD has been approved and plan to roll out the boxes to A&E and admission wards initially..
Sepsis bundle being incorporated within eCOBS.
Numerous publicity campaigns are also occurring.