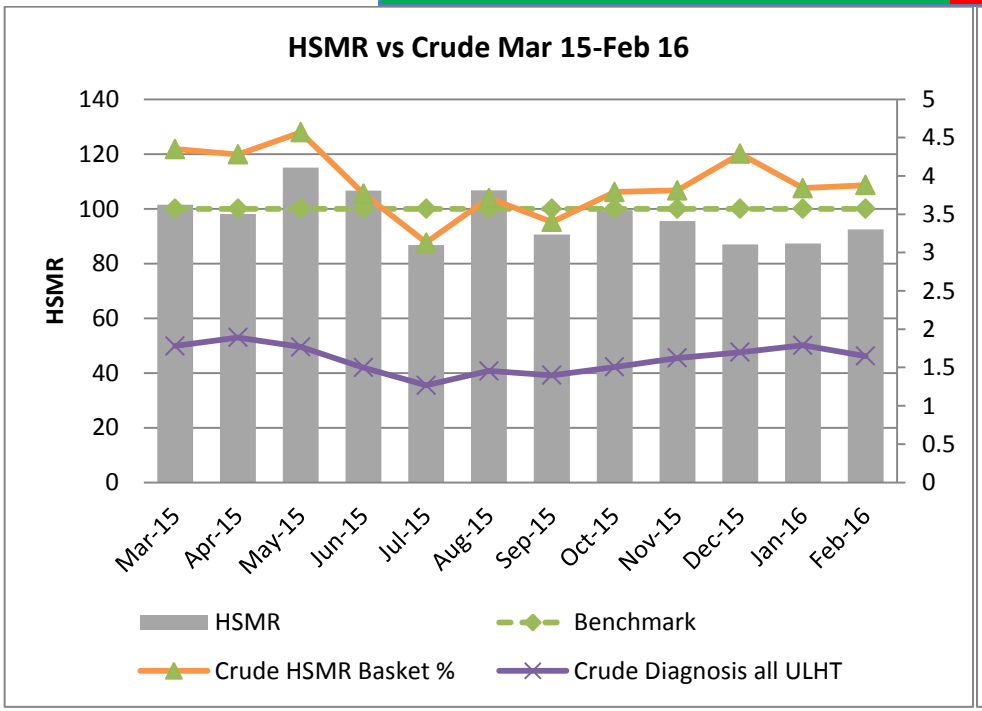
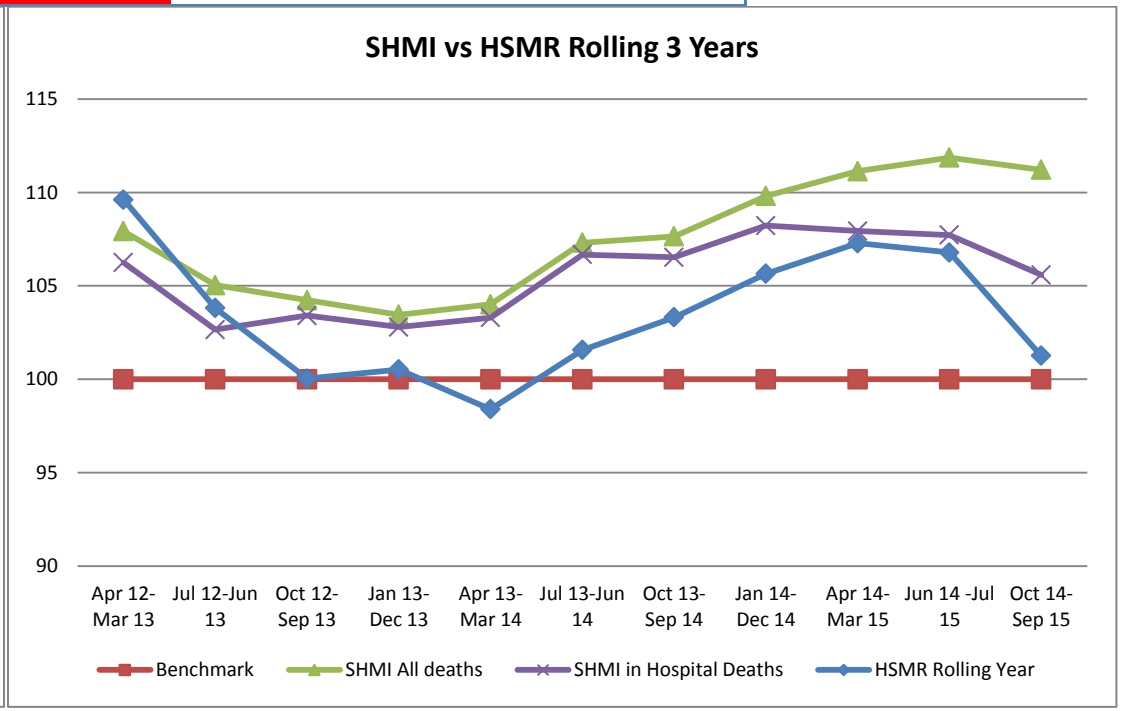
QUALITY REPORT JUNE 2016

SAFE AMBITION 1: Reduction of Harm Associated with Mortality

Executive Summary

ULHT HSMR MAR 15-FEB 16	HSMR YTD Apr 15-Feb 16	ULHT HSMR Feb-16	ULHT SHMI Oct 14-Sep 15	ULHT Crude Mortality avg % Mar 15-Feb 16 Internal Source	Crude Mortality % National Avg Diagnosis ALL Dr Foster Mar 15-Feb 16
99.88	99.78	92.49	111.21	1.63%	1.65%



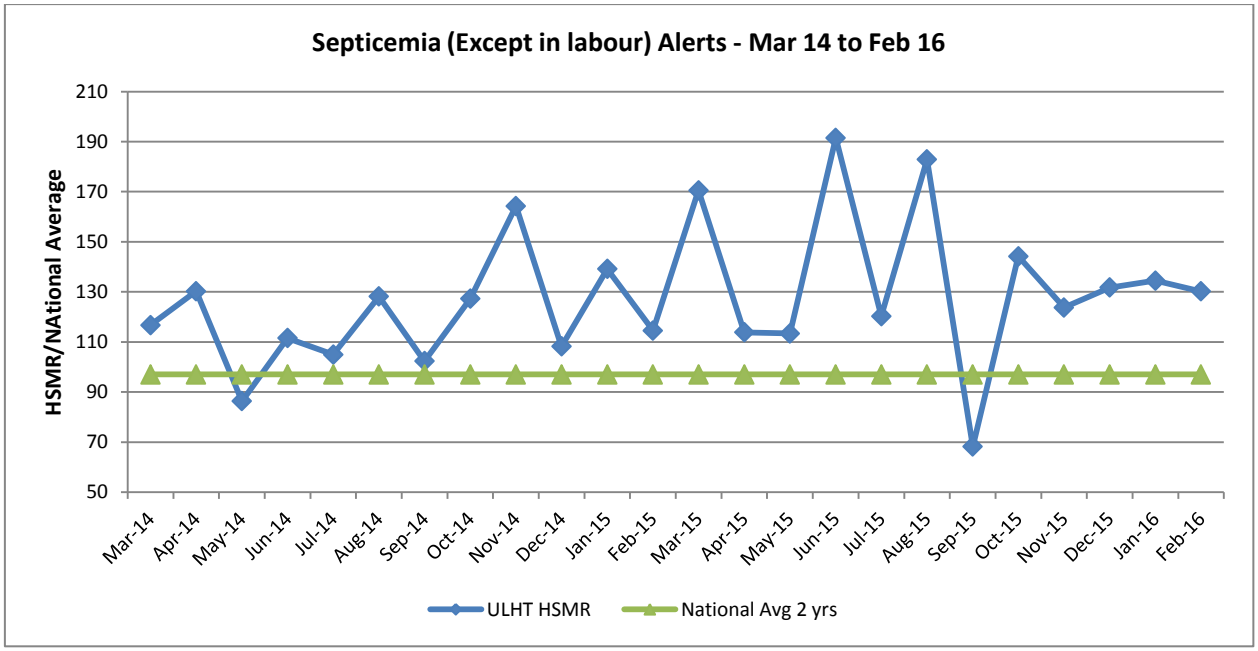


HSMR Diagnosis Groups alerting YTD April 2015 to February 2016:

Diagnosis group	Observed	Expected	Obs. - Exp.	Crude (%)	Exp. (%)	HSMR	Low CI	High CI
Septicemia (except in labour)	176	133.61	40.39	27.44	21.07	130.23	111.60	151.08
Other perinatal conditions	18	9.32	8.68	2.82	1.46	193.16	114.42	305.29
Pulmonary Heart Disease	20	12.07	7.93	7.07	4.27	165.67	101.15	255.88
Liver disease. Alcohol related	23	14.02	8.98	21.5	13.1	164.04	103.96	246.16

HSMR Alerting Diagnosis

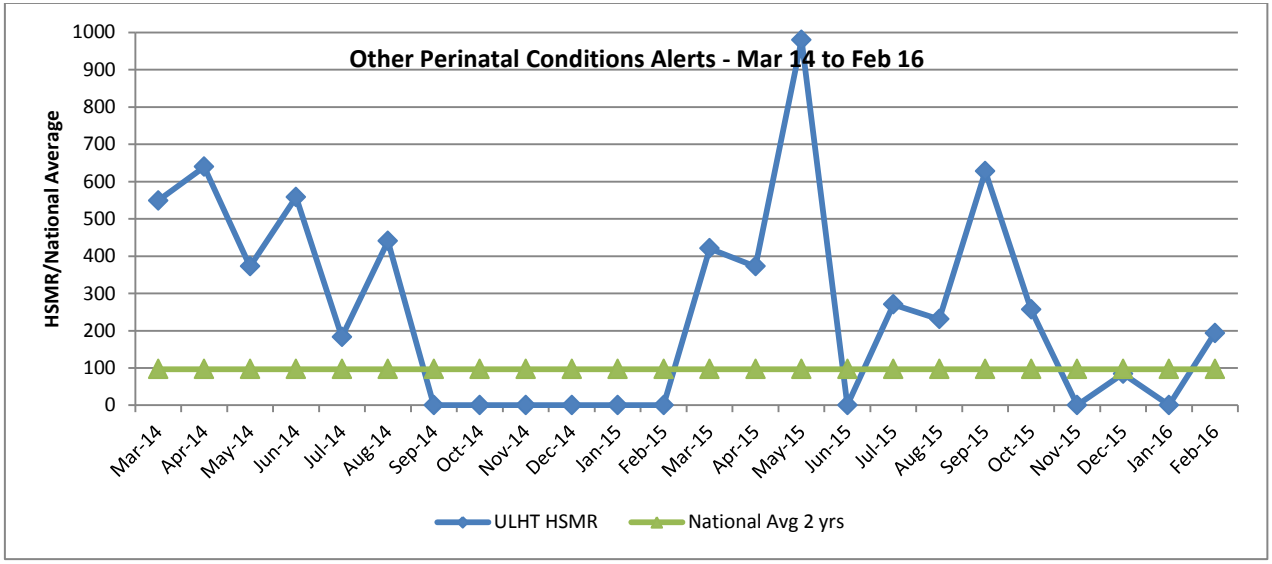
Septicemia (except in labour)



HSMR Septicemia alert overview

- Within the past 2 years sepsis has been sporadically alerting. ULHTs current HSMR YTD is 130.23 against National average of 97.02.
- 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.
- The sepsis task and finish group have facilitated an ongoing audit of sepsis patients.
- Quality governance also facilitate a weekly audit with published results.

Other Perinatal Conditions

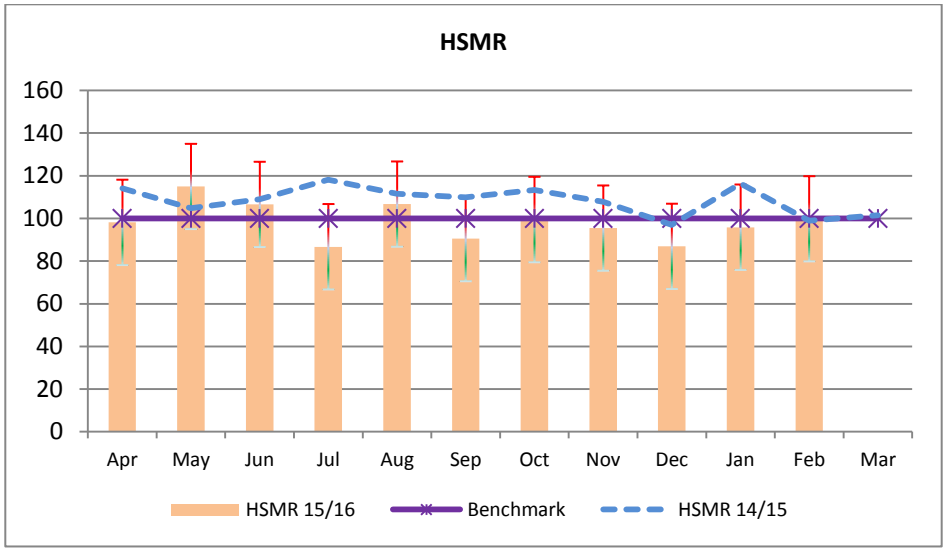


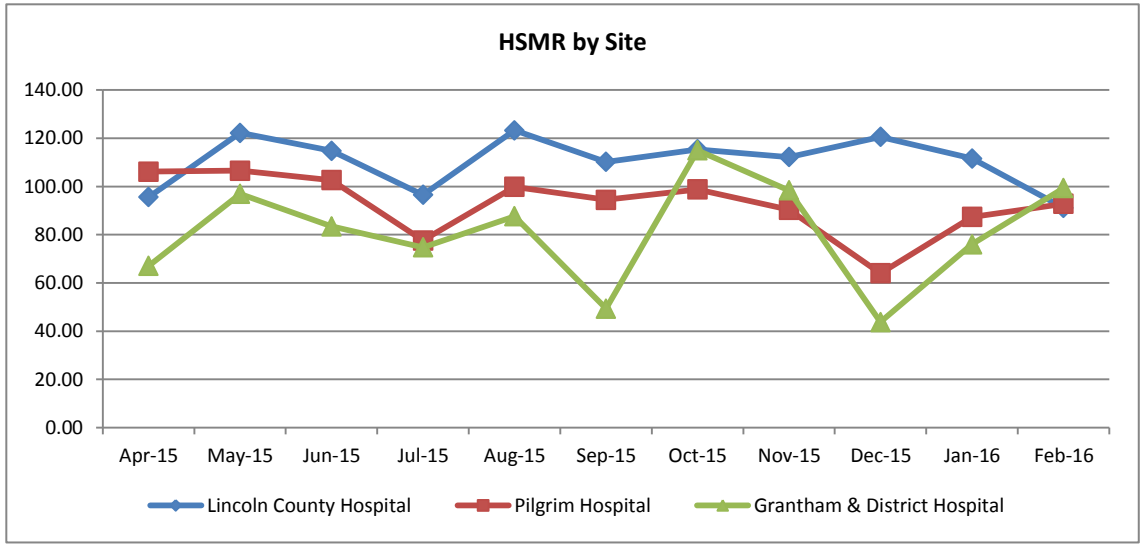
HSMR Other perinatal conditions alert overview

- Other perinatal conditions have been alerting infrequently over the past 2 years. ULHTs current HSMR YTD is 193.16 against a National average of 96.67
- ULHT have conducted casenote reviews on previous alerts.
- 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. 13/18 deaths are coded with P95X.
- Pilgrim Hospital is alerting and Quality Governance have commenced improvement work with the team.

Hospital Standardised Mortality Ratio (HSMR)

HSMR Apr 14- FEb15	HSMR Apr 15- Feb 16	HSMR reduction(-) Increase (+)	Trust Benchmark
109.91	99.78	-10.13	< 100





Performance Data Overview:

United Lincolnshire Hospitals NHS Trust:

- The current year to date HSMR (April 15 to February 16) is 99.78 which is in line with the Trust and National Benchmark.
- Rolling year HSMR (March 15 to February 16) is 99.88; which is within expected range.
- In month for February 2016 HSMR has decreased to 92.49. A slight reduction from last year's February position which stood at 99.30.

Lincoln County Hospital:

- HSMR YTD (April 15 to February 16) for LCH is 110.13, which is outside of expected range.
- Rolling year HSMR (March 15 to February 16) for LCH is 110.38, which is outside of expected range.
- In February 2016 has decreased by 17.64 to 91.01 which is within expected range. This is a reduction from last year's position at 115.41.

Pilgrim Hospital:

- HSMR YTD (April 15 to February 16) for PHB is 92.48, which is within expected range.
- Rolling year HSMR (March 15 to February 16) for PHB is 92.75, which is within expected range.
- In February 2016 HSMR has increased to 92.41 which is below expected range. A increase from last year's position at 87.95

Grantham Hospital:

- HSMR YTD (April 15 to February 16) for GDH is 80.23, which is within expected range.
- Rolling year HSMR (March 15 to February 16) for GDH is 79.43, which is within expected range.
- In February HSMR has increased significantly to 99.23; this is within expected range. A increase from last year's position at 66.49

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

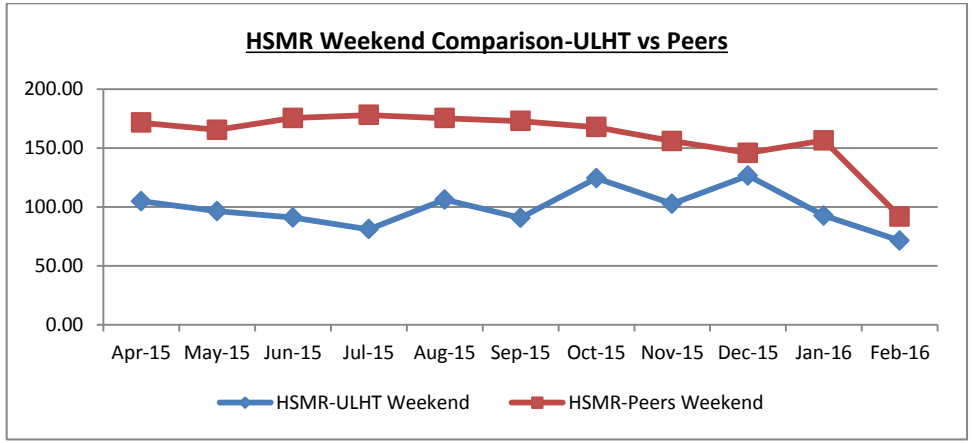
Diagnosis group	Spells	Spells (%)	Observed Deaths	Expected Deaths	Obs. - Exp.	Crude Rate (%)	Exp. (%)	HSMR	Low Confidence Interval	High Confidence Interval
Pneumonia	1736	3.7	329.00	345.24	-16.24	19.01	19.94	95.3	85.27	106.17
Septicemia (except in labour)	636	1.36	174.00	133.61	40.39	27.44	21.07	130.23	111.6	151.08
Acute cerebrovascular disease	1001	2.12	145.00	164.57	-19.57	14.65	16.62	88.11	74.35	103.67

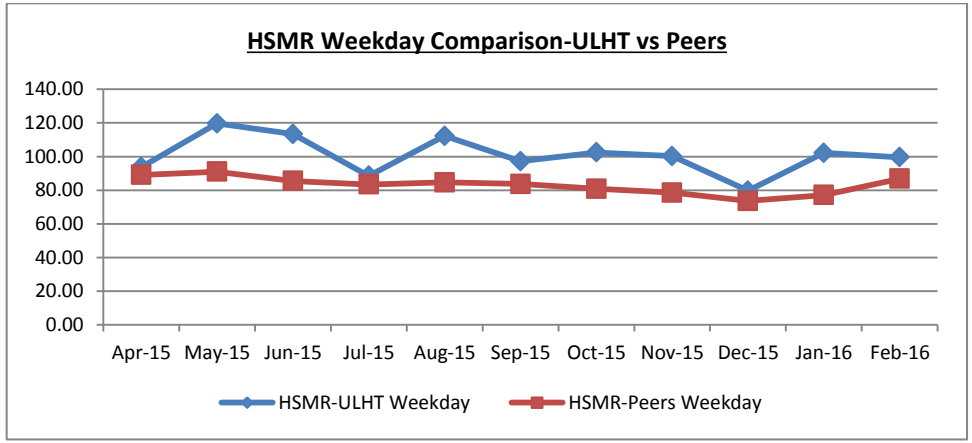
HSMR Top 3 observed Diagnosis Group Action Plan

- 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 as per action plan on page 3.
- 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. Dr Leach is reporting the results 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.

HSMR-Weekend Weekday analysis ULHT vs DR Foster Peers

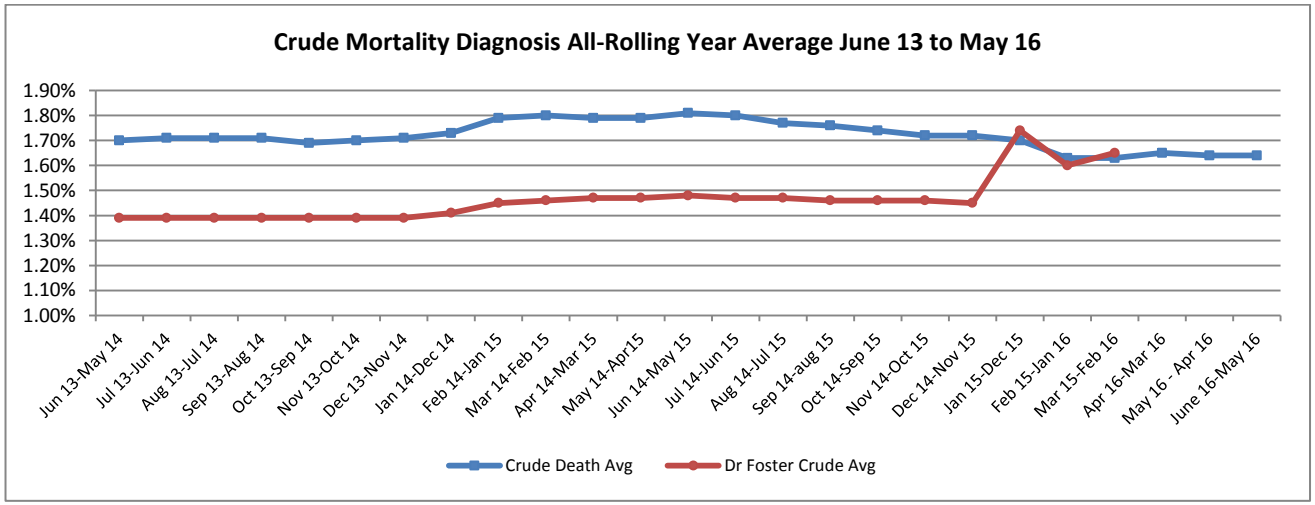
- The below comparison is a year to date analysis of ULHT HSMR weekday and weekend comparison with the 136 non specialised acute trusts within Dr Foster. In comparison with our peers; ULHT are in line with our peers trends for weekday admissions. For weekends ULHT are showing similar trend line however HSMR is showing lower than our peer average.





Crude Mortality

Dr Foster Crude National Average Mar 15 – Feb 16	ULHT comparison to Dr Foster Mar 15-Feb 16	Crude Mortality Apr 15 – Mar 16	Crude mortality YTD Apr 16-May 16	Crude Mortality May 16
1.40%	1.63%	1.65%	1.76%	1.70%

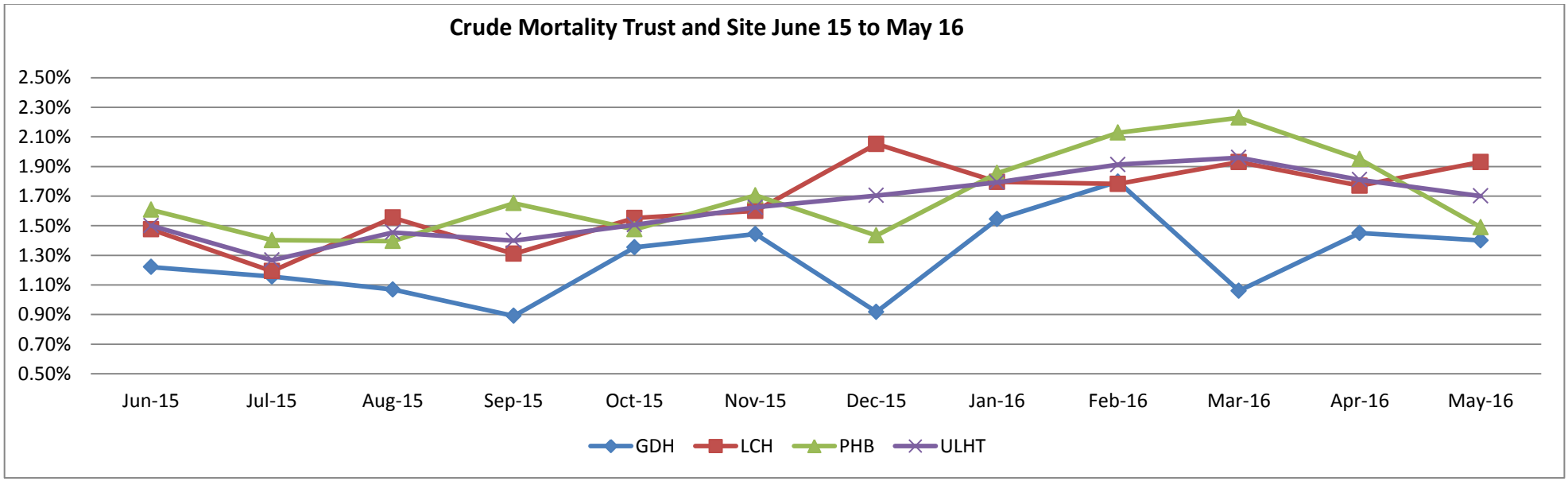


Performance Data Overview:

- Against National average (Mar 15 – Feb 16) ULHT is higher by 0.23%. ULHT's average is 1.63%.
- ULHT's crude mortality for year to date is 1.76%.

May 2016 crude mortality by hospital:

- Grantham: 1.40% ↓
- Lincoln: 1.93% ↑
- Pilgrim: 1.49% ↓



Mortality Reviews

Reviews (Jan 2016-May 2016):

Review compliance is as follows:

Site	Deaths	Notes Sent for Review	Review Complete	Review completion Compliance	Total Death % Reviewed
ULHT Total	1188	794	460	58%	39%
Lincoln Total	642	474	241	51%	38%
Pilgrim Total	461	262	183	70%	40%
Grantham Total	85	58	36	62%	42%

ULHT Review Grading:

From the completed reviews the following grading's were applied by the reviewing consultants:

Grading	Review Count
Grade 0-Unavoidable death, no suboptimal care	343
Grade 1-Unavoidable death, suboptimal care but different management would NOT have affected outcome	54
Grade 2- Suboptimal care, but different care MIGHT have affected the outcome (possibly avoidable death)	12
Grade 3- Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome (probable avoidable death).	1
Grading not completed by reviewer	11

Lessons Learned:

Actions and Lessons

Issues identified/Lessons to be learned:

- No end of life care planning in the community.
- Lack of Senior Review
- Coding/Cause of death inaccuracy
- Sepsis bundle not completed
- Adverse events during stay
- Documentation missing and illegible; Drug Charts, Emergency Admission Proforma-time of arrival and referrals missing, Duty of Candour not documented
- Inappropriate admissions management.
- Inappropriate early discharge
- Failure to escalate deteriorating patient and not put on a palliative care pathway within a timely manner.

Action plan:

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 within 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. Quality Governance are working with the alerting site to drive improvement

Explanatory Notes

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 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.

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.

HSMR is a complex statistical tool used by Dr Foster 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. We use HSMR to point us to possible areas of concern and, when they are identified, we actively review them through case note reviews.

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.

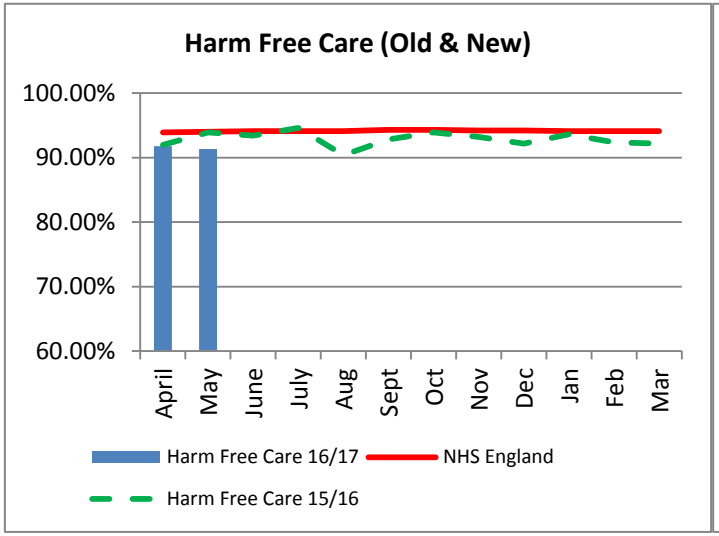
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

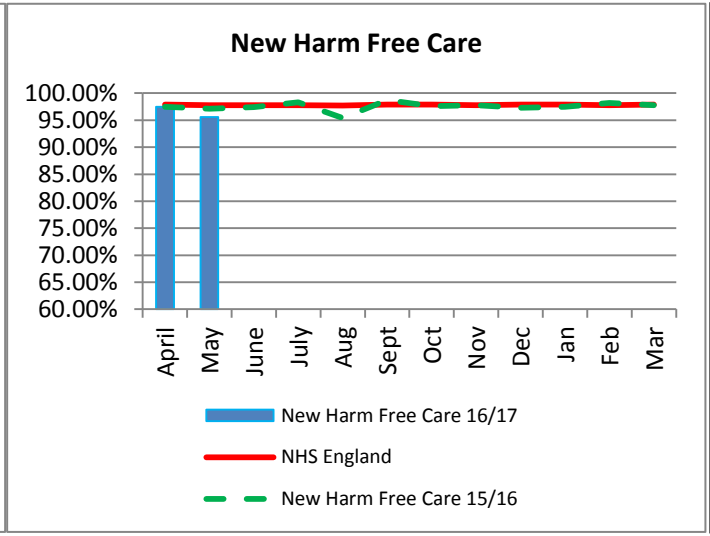
SAFE AMBITION 2 Reduction of Harm Associated with Harm free Care

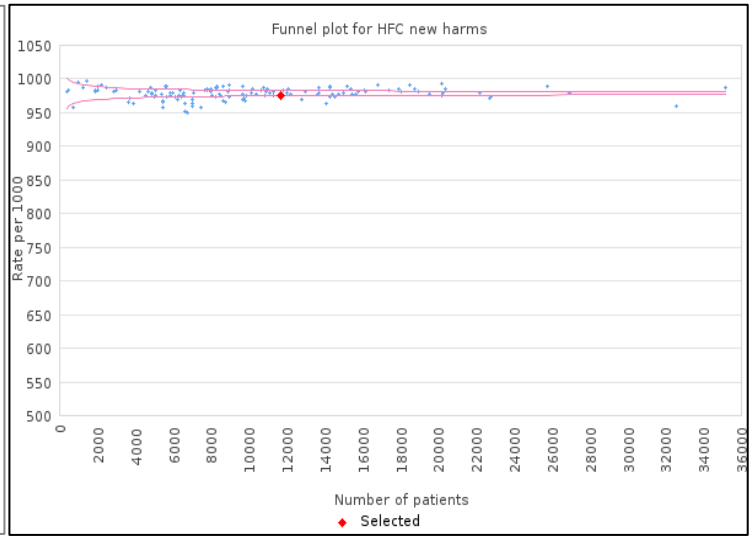
The NHS Safety Thermometer records the presence or absence of four harms:

- 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 95.61%







Performance Overview - Overview for May 2016

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		**93.9%**	**97.8%**	**4.5%**	**1.0%**	**0.6%**	**0.7%**	**0.3%**	**0.4%**
Grantham	44	88.6%	97.7%	9.1%	0%	2.3%	0%	0%	0%
Lincoln	469	92.8%	95.1%	4.1%	1.9%	2.8%	1.3%	0.4%	0.2%
Louth	3	100%	100%	0%	0%	0%	0%	0%	0%
Pilgrim	322	89.4%	96%	8.1%	3.1%	0.3%	1.9%	0%	0.6%
UHT Total	838	91.3%	95.6%	5.8%	2.3%	1.8%	1.4%	0.2%	0.4%

Grantham is better than the national average for PU's New, Catheters & all UTI, Catheters & New UTI & New VTE's.
Lincoln is performing less than the national average for all indicators besides PU's All and New VTE's.
Pilgrim is performing less than the national average for all indicators besides Falls w/harm, Catheters & New UTI.
ULHT is performing less than the national average for all indicators besides Catheters & New UTI's and New VTE'

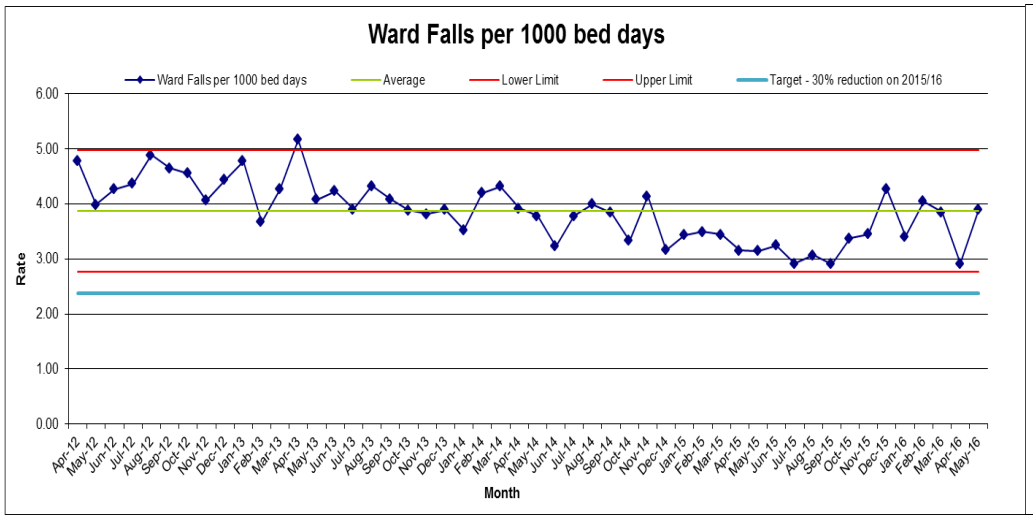
Action Plan

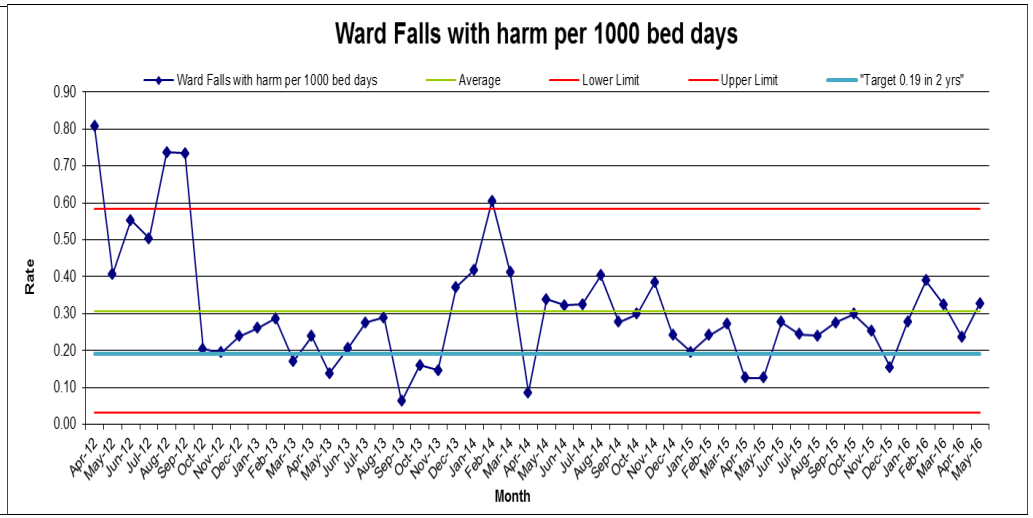
There are committees for pressure ulcers, falls VTE and catheter associated UTIs. Reports are disseminated to staff monthly

Results are also discussed as part of the HoN / matron and ward sister 1:1 meetings and a ward improvement plan is developed with all of the key areas identified as requiring improvement.

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





Safety Quality Dashboard – June 2015 – May 2016

Metric Title	Jun-2015	Jul-2015	Aug-2015	Sep-2015	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	May-2016
Patient at risk of falls	333	325	327	330	320	334	276	332	315	349
Medication review occurred	67.70%	67.10%	69.40%	69.70%	68.70%	71.00%	66.80%	71.00%	64.70%	65.10%
Lying & standing BP completed	52.10%	54.00%	56.70%	57.10%	58.60%	65.60%	61.80%	57.30%	60.10%	56.20%
Care plan 7 activated	95.50%	94.50%	97.50%	93.90%	94.60%	93.60%	94.40%	93.90%	93.50%	94.00%
Reviewed by physio	55.60%	56.10%	63.10%	68.00%	64.70%	74.20%	71.20%	71.90%	77.80%	79.90%
Referred to OT	76.30%	78.70%	83.50%	82.00%	86.50%	89.00%	85.20%	86.70%	83.20%	90.90%
Referred to physio	92.10%	88.40%	88.60%	90.40%	90.50%	92.40%	89.90%	86.30%	86.70%	86.10%
Actions completed within 4 hours	84.10%	82.70%	86.90%	86.70%	87.90%	88.90%	88.50%	87.20%	83.80%	91.40%
Actions completed within 24 hours on admission	44.20%	39.70%	41.10%	44.50%	38.90%	46.30%	42.00%	39.70%	43.80%	41.30%
Actions completed within 24 hours of transfer (if necessary)	36.80%	37.30%	39.90%	44.30%	38.70%	37.90%	37.00%	33.70%	35.90%	33.80%

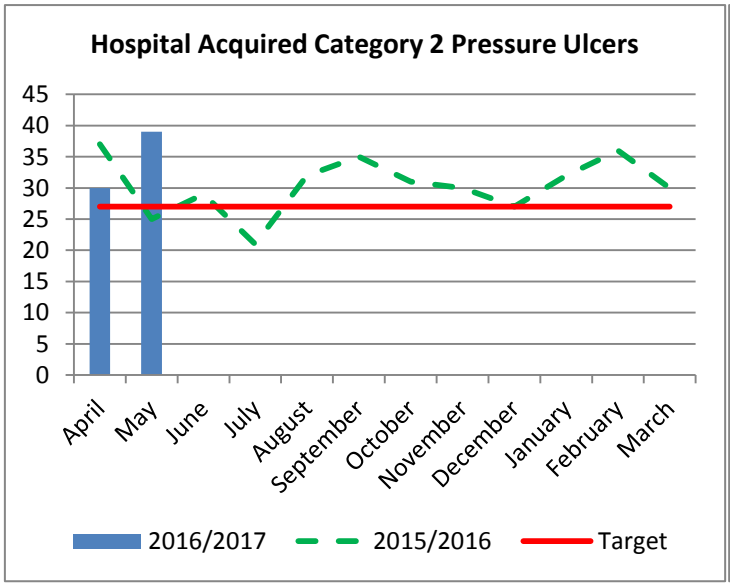
Performance Data Overview

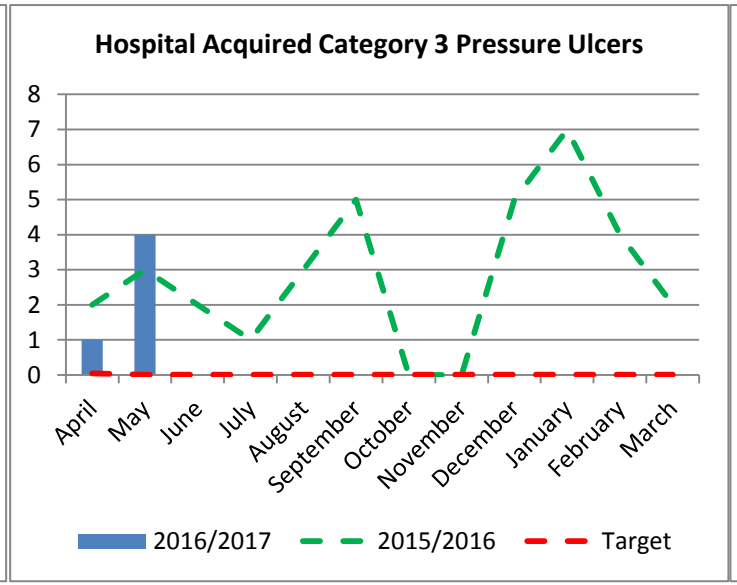
Data per site is now being collated which reports Pilgrim having the highest falls with harm rate at 0.6 which although higher than the other sites is an improvement from last month.
Grantham did not report any falls with harm this month
Falls with harm are being triangulated with staffing levels in the workforce dashboard which is submitted to Trust Board
The SQD data on process reliability of falls is improving but still has improvements to be made.
Display on graphs is currently being modified.

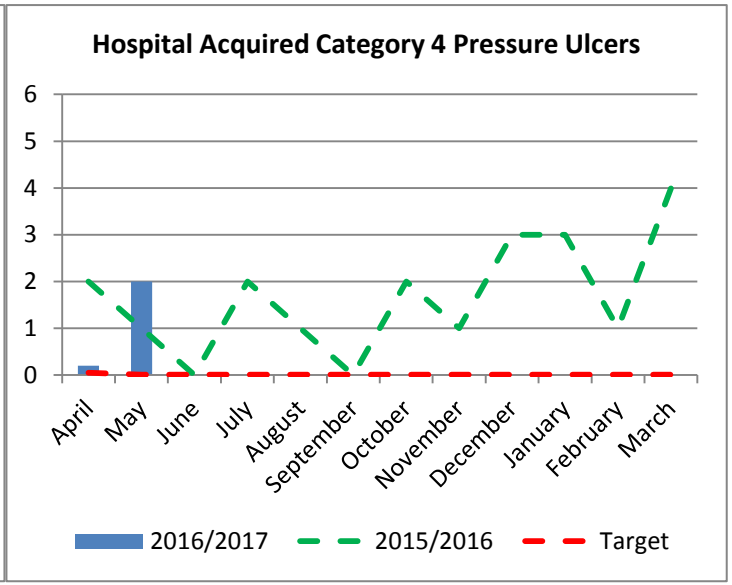
Action Plan

Lying and Standing Blood Pressure to be launched in Autumn 2016
Competency booklet now includes OT sections and is due to be launched in Autumn
Enhanced Care Project continues and will review how high risk patients are being cared for
The video for how to do a lying and standing Blood Pressure has been filmed and is currently being edited
Falls Conference arranged for November 2016
Commissioners are now attend the review panels

SAFE AMBITION 4 Reduction of Harm Associated with Pressure Ulcers







Safety Quality Dashboard – June 2015 – May 2016

Metric Title	Jun-2015	Jul-2015	Aug-2015	Sep-2015	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	May-2016
Pressure area care risk assessment completed within 24hrs	98.50%	99.30%	99.00%	98.80%	98.50%	98.30%	99.40%	97.80%	98.00%	97.90%
Pressure area care risk assessment updated weekly	80.50%	86.20%	89.40%	81.90%	85.20%	85.60%	82.50%	79.40%	86.10%	85.50%
Pressure-relieving equipment in situ if required	95.10%	97.40%	92.80%	94.30%	97.70%	96.30%	93.50%	93.40%	96.20%	93.00%
Repositioning chart commenced if required	88.40%	94.00%	94.00%	95.10%	96.00%	98.00%	98.80%	97.60%	99.00%	95.90%
Pressure area care plan activated if required	92.40%	94.90%	94.20%	92.00%	94.40%	97.30%	95.70%	90.50%	94.80%	91.40%

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 and commissioners are now attending to be involved in the discussion regarding avoidability. Where individual practice is being identified, the ward sister is requested to discuss the case with the member of staff to undertake a piece of reflection and learning.

An annual Link Nurse conference was held on the 8th June and the link nurses were charged with being Pressure Ulcer champions ensuring that their areas had good levels of training compliance

Action Plan

Job description for a pressure ulcer prevention nurse is being finalised and is hoped to be advertised over the summer

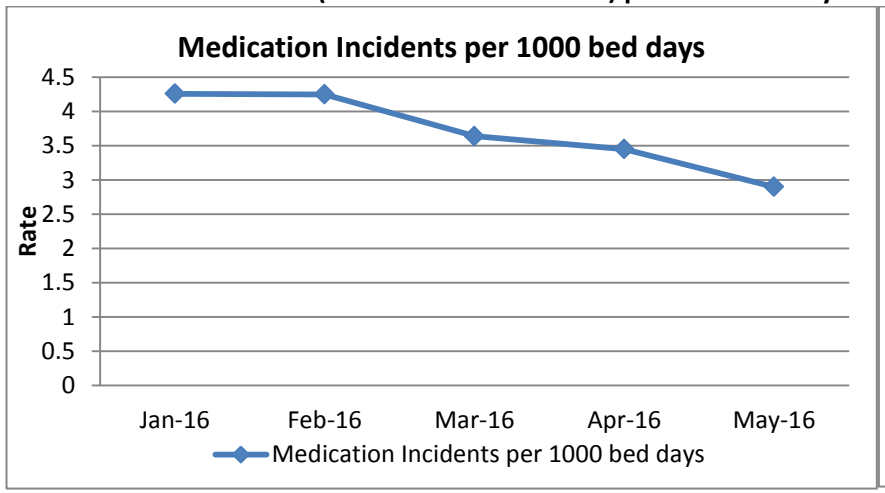
Tissue Viability documentation (within the ULHT Adult Assessment Booklet) is currently being updated as part of broader documentation review.

Ward based training has occurred in response to issues identified at the review panels including accurate categorisation of pressure ulcers and assessments

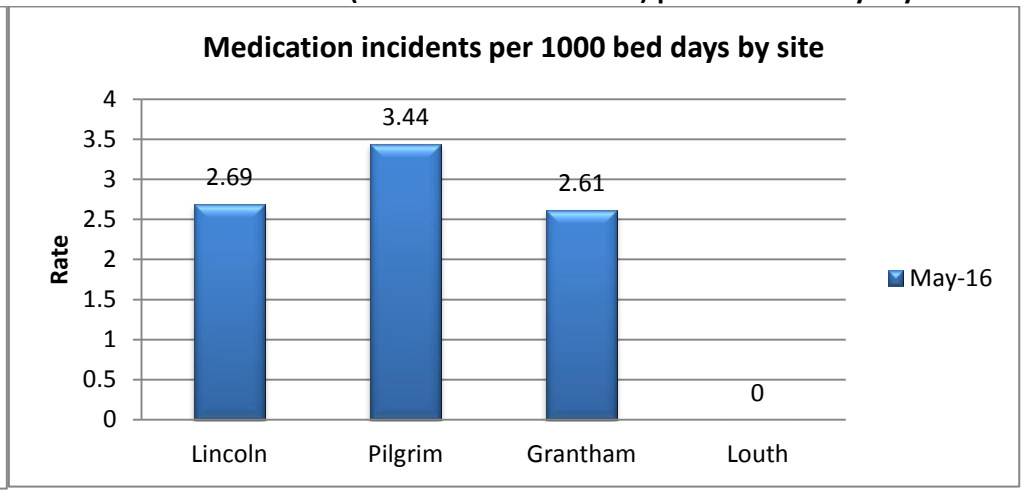
An annual work plan is also being currently formulated

SAFE AMBITION 5 Reduction of Harm Associated with Medication

All medication incidents (with and without harm) per 1000 bed days



All medication incidents (with and without harm) per 1000 bed days by site



Safety Quality Dashboard – Trust Data June 2015 – May 2016

Metric Title	Jun-2015	Jul-2015	Aug-2015	Sep-2015	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	May-2016
Medicine chart demographics correct	75.10%	77.70%	69.10%	61.80%	62.00%	67.90%	61.60%	68.30%	79.80%	73.80%
Allergies documented	99.40%	99.40%	97.00%	96.50%	96.60%	100.00%	98.40%	100.00%	98.70%	99.40%
All medicines administered on time	89.70%	92.40%	93.60%	90.90%	88.50%	90.10%	85.80%	86.00%	91.10%	88.80%
Allergy nameband in place if required	91.50%	92.60%	86.50%	83.40%	94.10%	92.00%	86.60%	90.40%	89.50%	91.20%
Identification namebands in situ	98.30%	98.60%	97.70%	99.50%	98.80%	99.30%	99.40%	98.50%	99.20%	97.90%

Performance Data Overview

Total number of medication incidents per 1000 bed days has decreased from April from 3.45 to 2.90.

Omitted medicines continue to be the most reported incident. Antimicrobials, opiates, anticoagulants and insulin continue to be the top four high risk medication groups that are omitted.

The CD audits for Pilgrim and Grantham have been completed for this quarter. Grantham has dropped to 67%. Pilgrim has increased to 74% which is their highest pass rate so far. Lincoln audits to be completed.

7 medication incidents were reported against Pharmacy making the error rate 0.010%.

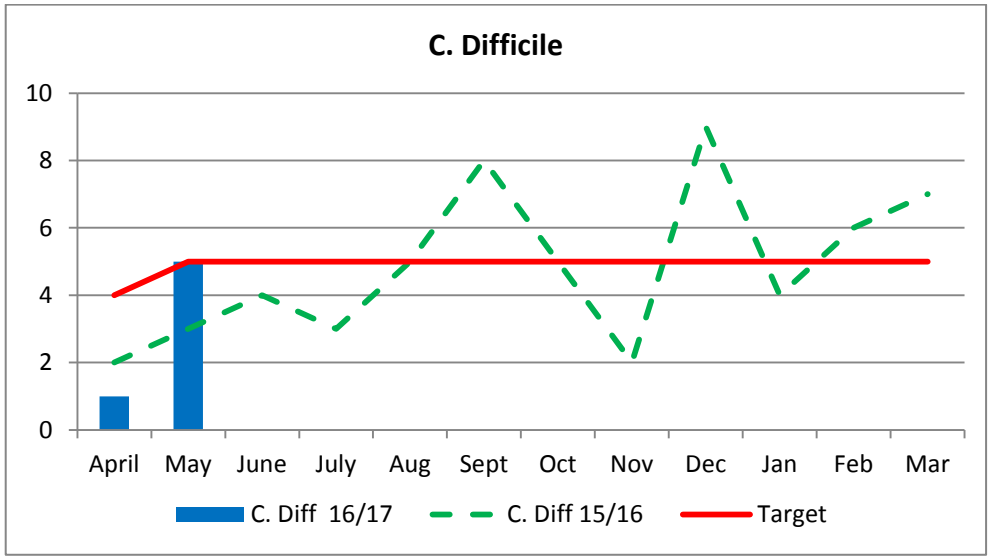
Action Plan

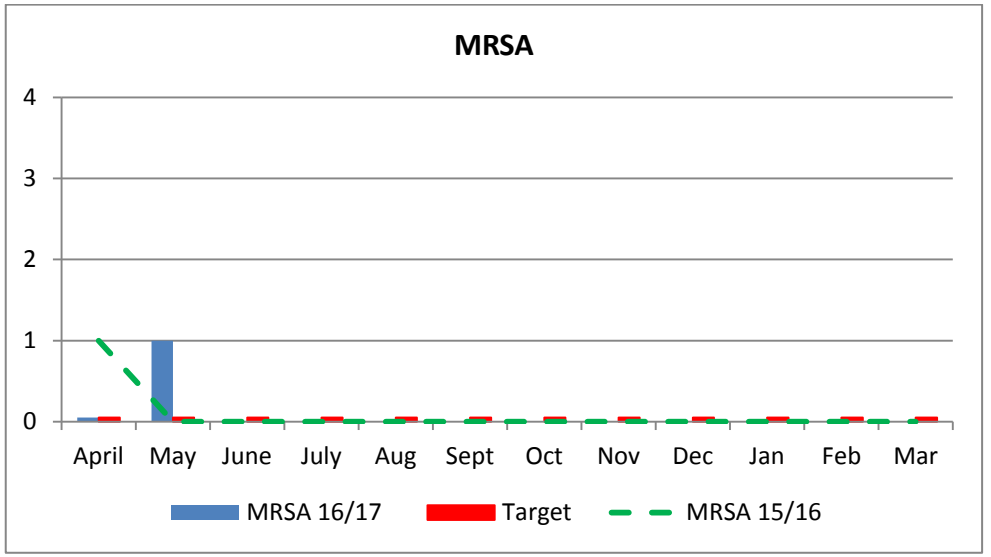
The anticoagulant chart launched in June and we will look to get feedback on the new design .

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



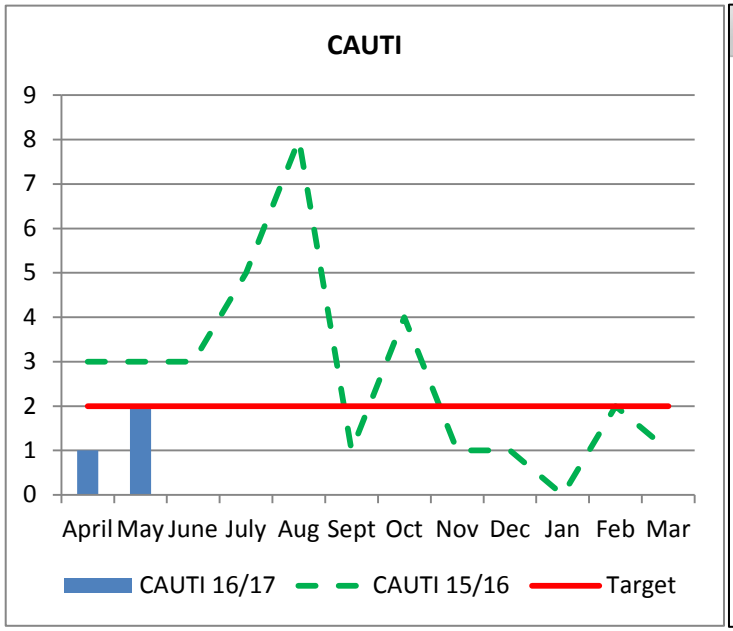


Hand Hygiene Compliance – May 2016

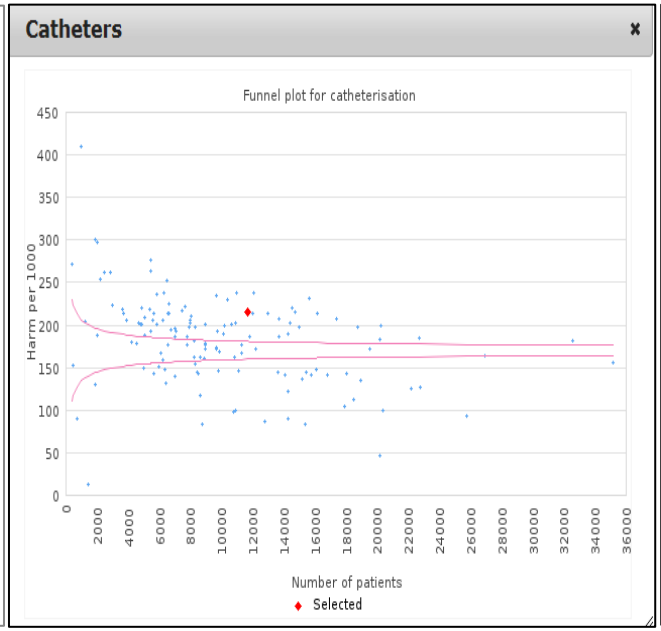
Trust	**81%**
Grantham	**89%**
Lincoln	**83%**
Louth	**88%**
Pilgrim	**64%**

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 There has been five cases of hospital attributable (trajectory 5), bringing the total of hospital attributable cases to six. There has been one case of hospital attributable (trajectory 0). The trust trajectory is zero cases. PHE have identified that this type of MRSA is not a Trust acquired case and it is actually the first case of animal to human spread, however the case will have to reported as per the usual processes and then be appealed in order to remove it from the figures. There has been improvement with hand hygiene compliance as for April 2016 ULHT scored 63% compliance.	A period of increased incidence (PII) is declared when there are 2 cases of hospital acquired cases of clostridium difficile on the same ward within a 28 day period. PII was declared on 26/05/16 for Hatton ward for 2 cases of clostridium difficile. Ribotyping results showed the same type 001. Insufficient samples for sub-typing to be carried out. Deep clean team have supported the ward and hand hygiene training carried out.

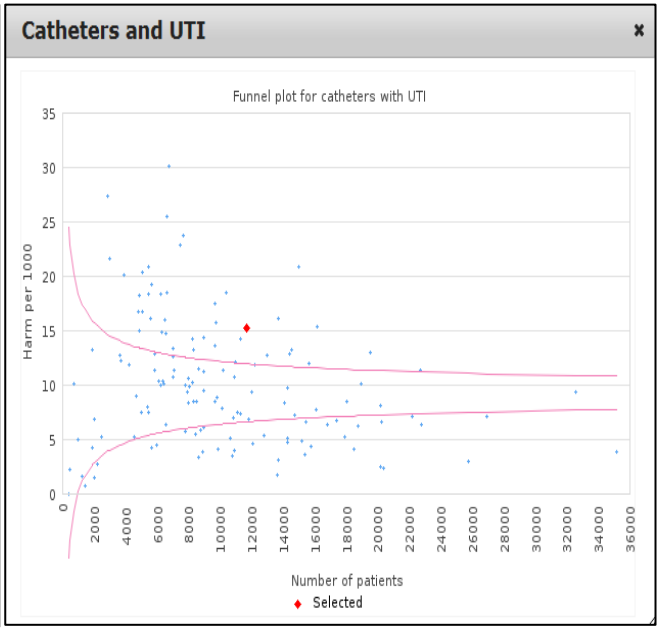
SAFE AMBITION 6 Reduction of Harm Associated with Infection



National Average of Catheterisation (April 15 - 16)



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

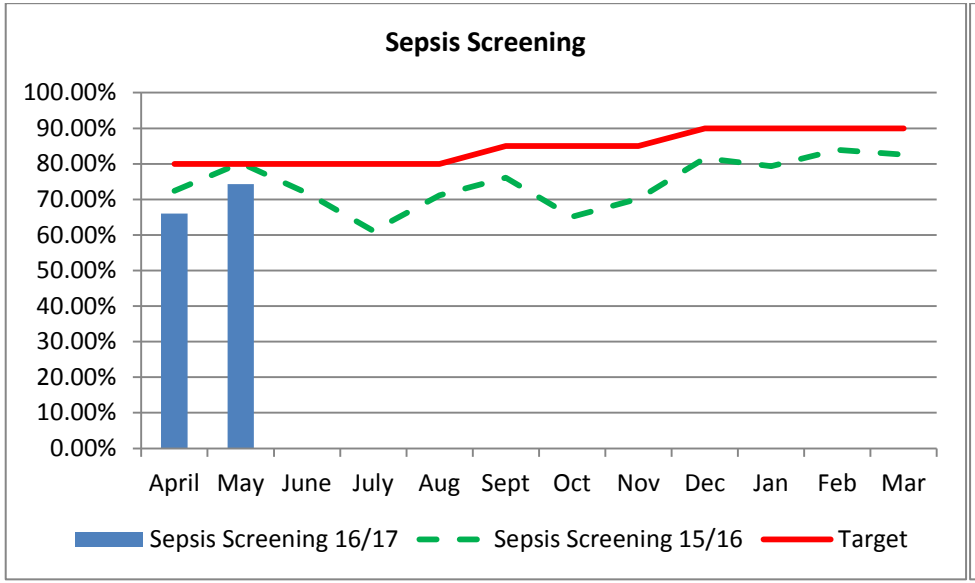


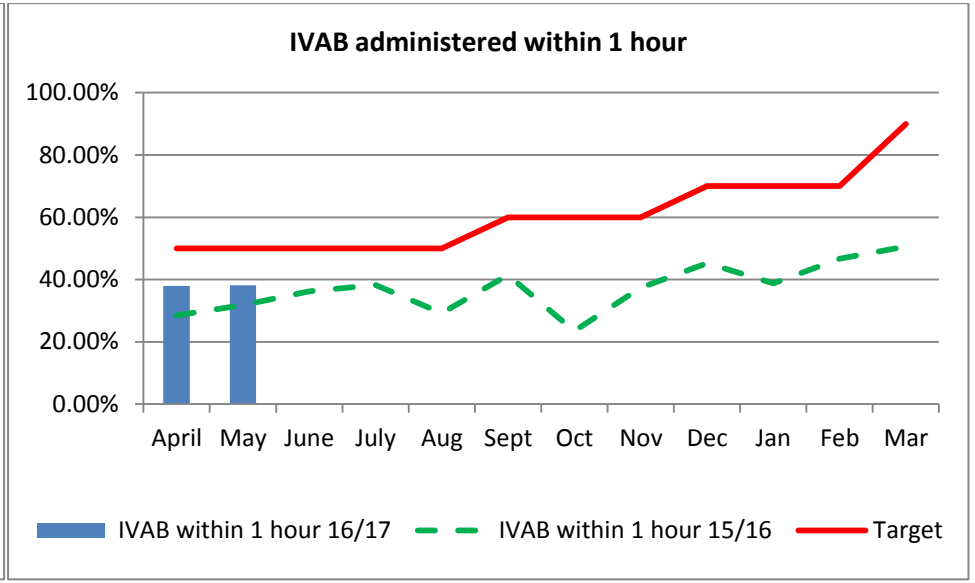
Safety Quality Dashboard – Trust Data June 2015 – May 2016

Metric Title	Jun-2015	Jul-2015	Aug-2015	Sep-2015	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	May-2016
Number of urinary catheters in-situ	85	85	52	65	93	87	57	65	73	72
Urinary catheter record completed &signed daily	68.60%	70.20%	83.00%	71.90%	59.60%	72.40%	63.20%	54.50%	64.40%	72.20%
TWOC occurred within 3 days for acute retention	38.50%	76.50%	83.30%	70.00%	34.80%	47.10%	50.00%	14.30%	25.00%	100.00%
Documented evidence why catheter needed	82.60%	92.60%	96.20%	87.50%	90.30%	84.10%	89.50%	83.30%	83.60%	87.30%
Urinary catheter bags secure	100.00%	100.00%	100.00%	100.00%	100.00%	98.90%	100.00%	100.00%	100.00%	100.00%
Urinary catheter care plan activated	89.50%	90.60%	96.20%	84.60%	77.40%	83.00%	91.10%	74.20%	78.10%	83.30%

Performance Data Overview	**Action Plan**
There were 2 new CAUTIs recorded on the Lincoln site for May. The data is demonstrating a reduction in CAUTI's. We are still an outlier on the Safety Thermometer as this data is year to date. Since the introduction of the Urology nurses validating the CAUTI's reported on the Safety Thermometer there has been a decrease in number reported. The number of catheters inserted is higher than national average. The SQD data is demonstrating an improvement in process reliability especially in relation to trial without catheter within 3 days.	The notes will be reviewed for patients who have had a CAUTI to enable lessons learnt Teaching by the Urology Nurse Specialist is ongoing especially on the reduction of insertion of catheters. The CAUTI trajectory was not discussed as the last meeting was cancelled.

SAFE AMBITION 7 Reduction of Harm Associated with Deterioration





Safety Quality Dashboard – Trust Data June 2015 – May 2016

Metric Title	Jun-2015	Jul-2015	Aug-2015	Sep-2015	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	May-2016
Patient observations on time and complete	66.90%	75.00%	77.40%	66.40%	71.80%	75.00%	76.70%	72.90%	77.60%	79.20%
NEWS score added correctly	93.80%	95.20%	94.50%	96.10%	95.00%	98.30%	98.80%	95.80%	96.20%	97.10%
Evidence of escalation if required	73.70%	84.20%	77.30%	90.00%	74.10%	66.70%	94.40%	92.00%	81.50%	91.20%

Performance Data Overview

The data is demonstrating an increase for screening and administration of IVAB. Lincoln site has seen the most improvement which was potentially due to a pilot of a Sepsis Nurse for 1 month in A&E. The trajectories are set at a staggered approach.

	April 16 Screening	May 16 Screening	April 16 IVAB in 1 hour	May 16 IVAB in 1 hour
Lincoln	70%	94.74%	28.5%	61.11%
Pilgrim	58.33%	58.70%	36.35%	30.27%
Grantham	83.33%	70.59%	66.67%	33.33%

Patient observations on time and complete has demonstrated a slight improvement but with eOBS the hope this will be improved.

Action Plan

There is a comprehensive action plan which the Sepsis Task & Finish Committee have responsibility

A report was presented to CEC and they have requested a business case to support the employment of a Sepsis Nurse at Lincoln and Pilgrim to be developed.

Sepsis boxes have been ordered and awaiting delivery

PGD has been developed and has been circulated for comments

eLearning has been supported at CEC to be mandatory and is awaiting to go to the core learning user group for discussion.

eCOBS has gone live in Pilgrim