United Lincolnshire Hospitals NHS
NHS Trust

QUALITY REPORT OCTOBER 2016

SAFE AMBITION 1 – MORTALITY 2

SAFE AMBITION 2 – HARM FREE CARE 11

SAFE AMBITION 3 – FALLS 12

SAFE AMBITION 4 – PRESSURE ULCERS 13

SAFE AMBITION 5 – MEDICATION 14

SAFE AMBITION 6 – INFECTION (INFECTION RATES) 15

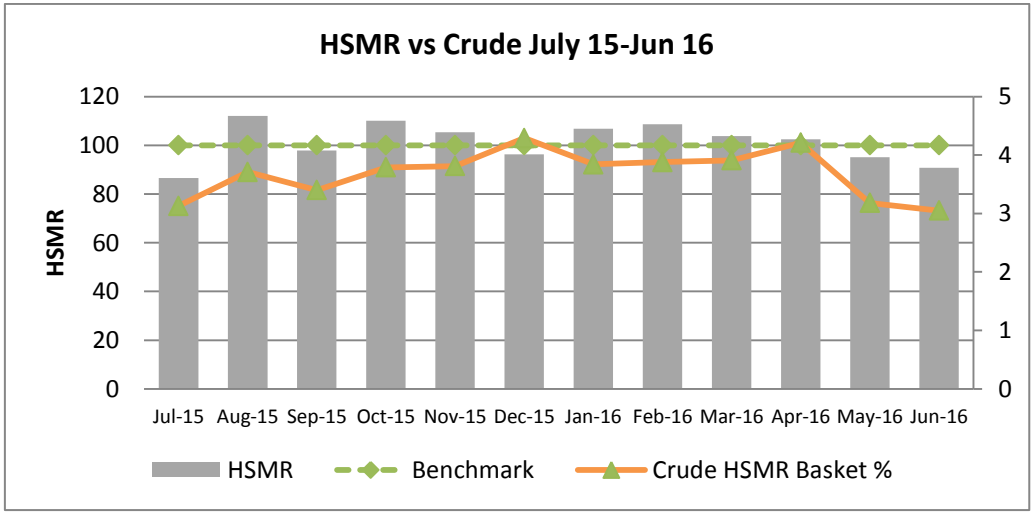
SAFE AMBITION 6 – INFECTION (CAUTI) 16

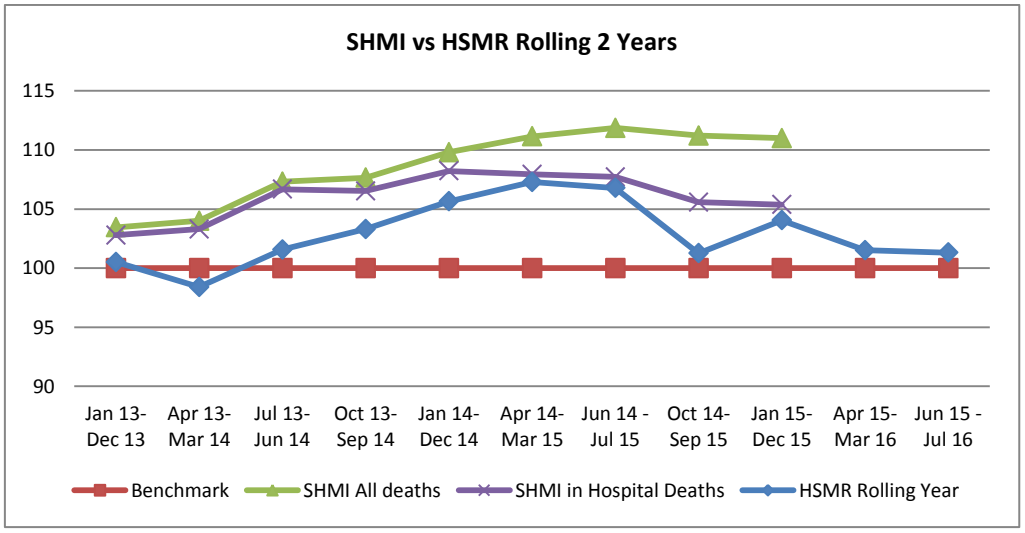
SAFE AMBITION 7– DETERIORATION (SEPSIS) 17

SAFE AMBITION 1: Reduction of Harm Associated with Mortality

Executive Summary

Trust/Site	ULHT HSMR Jul 15-Jun 16 12 month	ULHT HSMR Apr 16-Jun 16 YTD	ULHT HSMR Jun-16	ULHT SHMI Jan 15 – Dec 15	Trust Crude Mortality YTD Internal source Apr 16-Sep 16
Trust	101.31	96.45	90.79	110.99	1.62%
LCH	114.84	108.71	102.93	112.11	1.72%
PHB	91.75	89.78	81.21	110.8	1.60%
GDH	74.70	64.21	63.31	106.07	1.20%



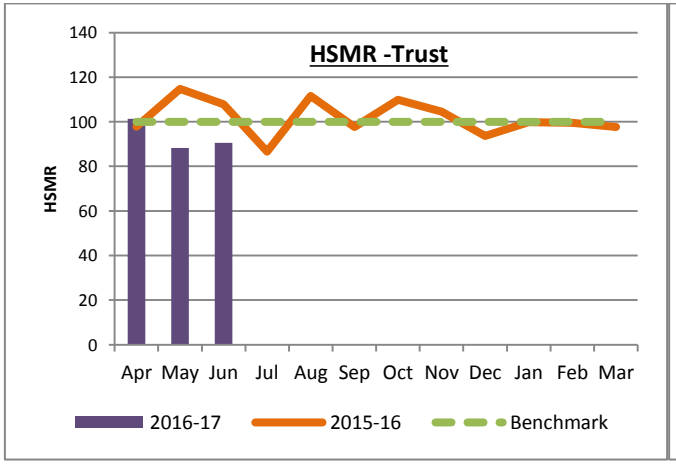


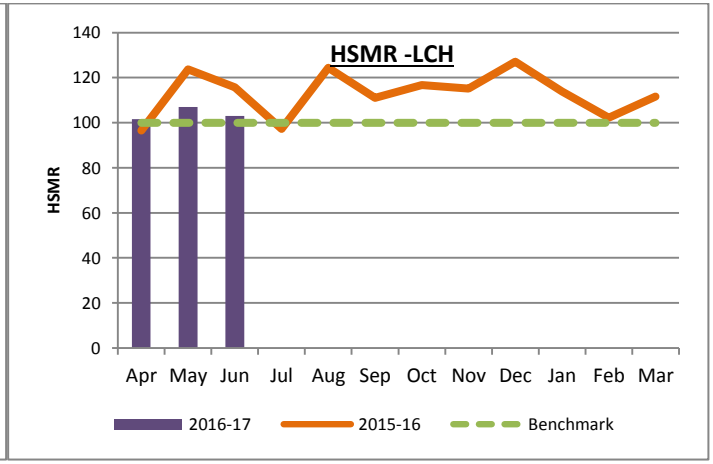
Performance Overview

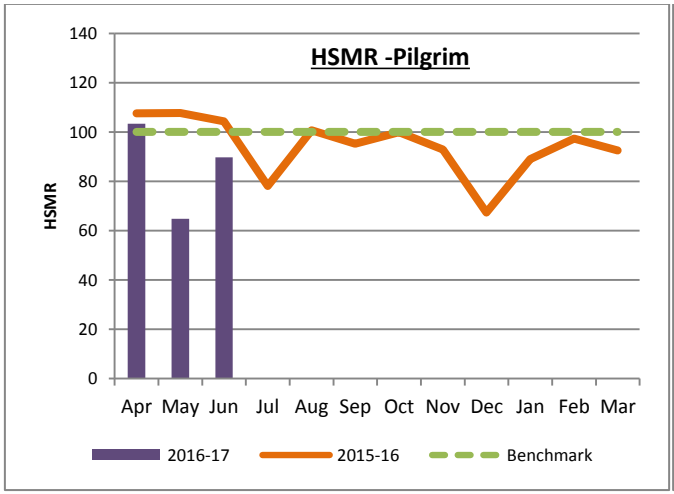
- ULHT's HSMR has decreased by 1.3 and is within expected limits. (July 15 to June 16)
- Within this time period Lincoln County Hospital is outside expected limits; this is due to historic alerts and a high HSMR in December 2015. The year to date position shows that Lincoln is within expected limits.
- HSMR Year to date position ULHT is 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.
- SHMI has decreased in line with HSMR in the reporting period of Jan 2015 to Dec 2015. NHS digital have updated the Trust SHMI but we are unable to interrogate the data in depth. Awaiting Dr Foster updates to enable us to analyse the data fully.
- Crude mortality is showing a downward trajectory in line with HSMR.

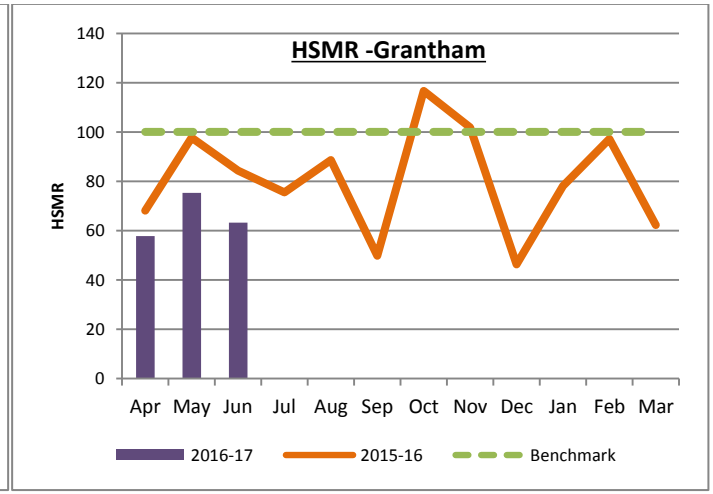
Hospital Standardised Mortality Ratio (HSMR)

Trust/Site	HSMR Jul 15-Jun 16	HSMR in year change reduction(-) Increase (+)	Trust Benchmark
Trust	101.31	-7.36	<100
LCH	114.84	-6.67	<100
PHB	91.75	-6.18	<100
GDH	74.70	-15.2	<100









HSMR-Performance Data Overview

United Lincolnshire Hospitals NHS Trust:

- HSMR is in line within expected limits. The HSMR is mirroring our decreasing crude mortality.
- In month June 16 HSMR stands at 90.51.

Lincoln County Hospital

- HSMR 12 month is outside of expected limits at 114.84. However the YTD position is 108.71 and is within expected limits. The position has decreased from the previous reporting period.
- In month June 2016 HSMR has decreased to 102.93

Pilgrim Hospital

- HSMR is within expected limits it has decreased from the previous reporting period.
- In month June 2016 HSMR is 89.78, which is still below expected limits.

Grantham Hospital

- HSMR is within expected limits it has decreased from the previous reporting period.
- In month June 2016 HSMR has decreased by 12.03 to 63.31
- Small numbers are the reason for such variability

HSMR Alerting Diagnosis - YTD April 16-June 16

Diagnosis group	Actual Deaths	Expected	Obs. - Exp.	Crude (%)	HSMR
Syncope	4	1.06	2.93	1.9	376.88

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: (2 months-alerting)

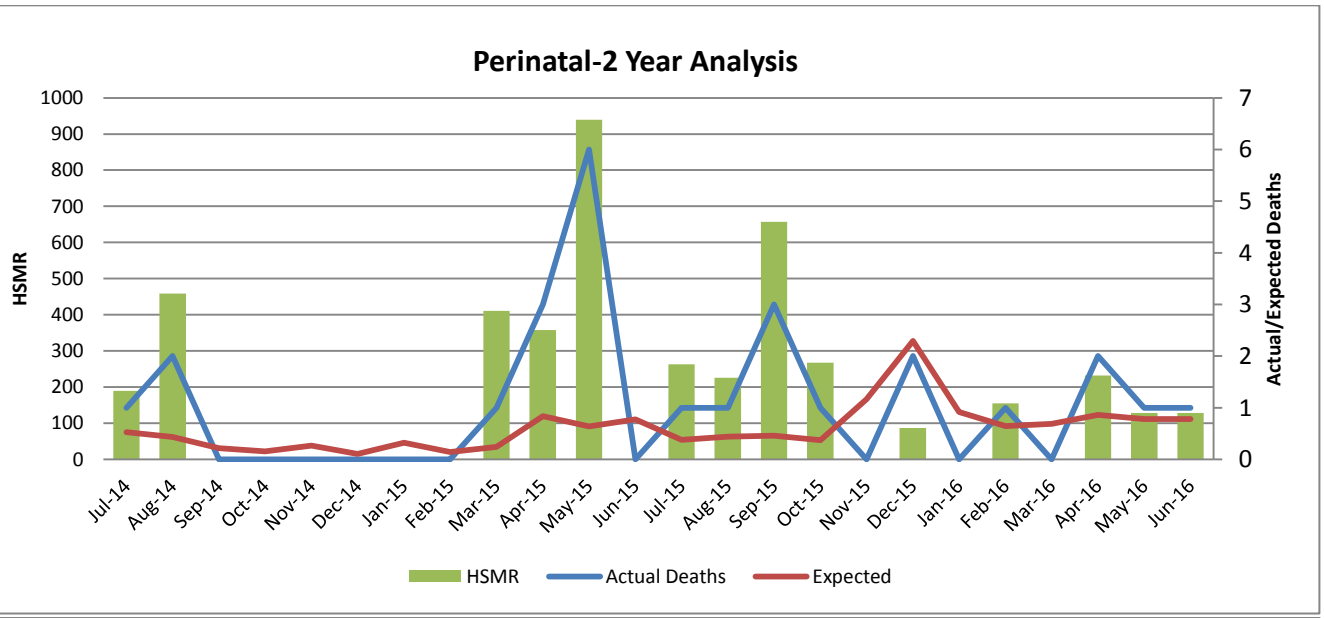
- This is a sign and symptom code there are 4 deaths that have had a primary diagnosis coded as R55X Syncope and Collapse.
- Quality Governance have checked the codes against Medway and Mortality Reviews. The Patients details have been sent to the Consultants whom the patients were under to confirm the main condition treated.
- This diagnosis group equates to 0.8% of the Actual Deaths within ULHT

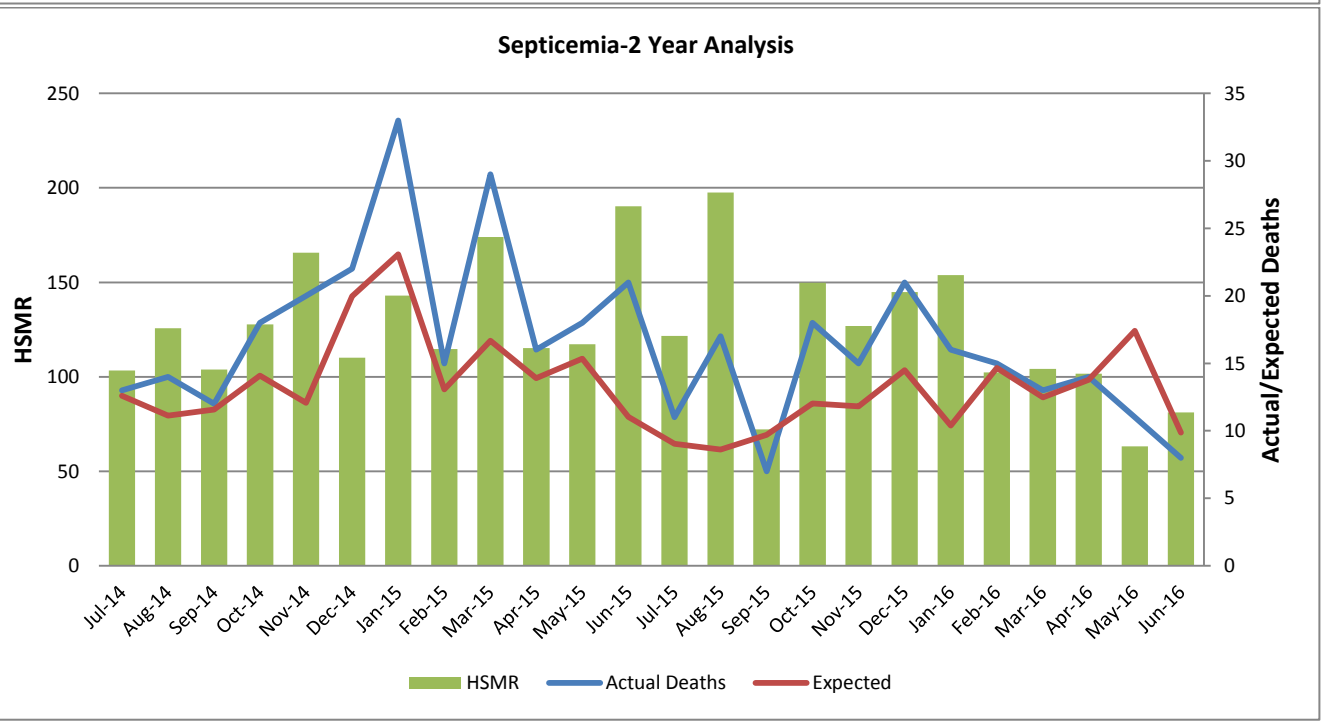
HSMR Top Observed Diagnosis Groups- April 2016 – June 2016

Rank	Diagnosis group	Spells	Actual deaths	Actual % of all deaths	Expected deaths	Obs. - Exp.	Crude (%)	HSMR
1	Pneumonia	589	101	21.1%	108.95	-7.95	17.18	92.71
2	Acute cerebrovascular disease	272	41	8.6%	43.56	-2.56	15.07	94.12
3	Septicemia (except in labour)	199	33	6.9%	41.06	-8.06	16.58	80.38
4	Acute and unspecified renal failure	176	31	6.5%	26.75	4.25	17.82	115.88
5	Urinary tract infections	550	24	5.0%	22.85	1.15	4.36	105.05
6	Acute myocardial infarction	242	18	3.8%	16.11	1.89	7.47	111.7
7	Chronic obstructive pulmonary disease and bronchiectasis	370	17	3.5%	15.21	1.79	4.61	111.75
8	Secondary malignancies	470	15	3.1%	12.03	2.97	3.21	124.71
9	Congestive heart failure, nonhypertensive	238	15	3.1%	26.00	-11.00	6.3	57.68

The above table shows the top percentage diagnosis groups which makes 62% of mortality within ULHT. All diagnosis groups are continually monitored

HSMR Alert Action Update





Alert Action Update

These are prior alerts where ongoing work is being progressed.

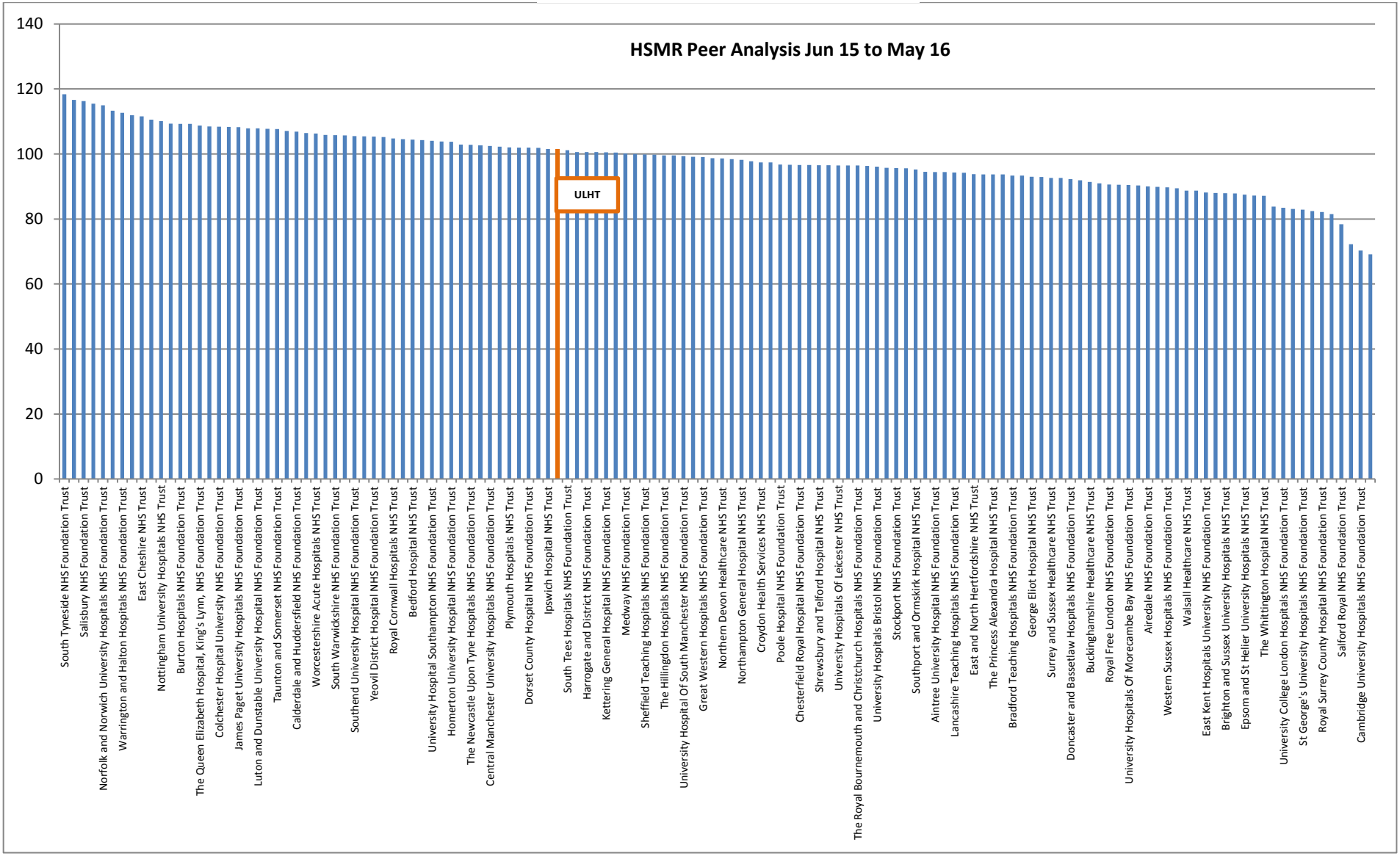
Other Perinatal Conditions:

- A review was conducted to ensure the processes that were originally set up were sustained. Which the meeting confirmed.
- As a result of these process being put into place from January 2016; HSMR is within expected limits and no longer alerting.

Septicemia (Except in labour):

- Sepsis is no longer alerting year to date.
- Sepsis has been within expected limits and the expected mortality is higher than actual since February 2016.
- The ongoing work being completed by the Task and Finish group and Quality Governance is showing a reduction in mortality.
- Sepsis Nurse business case has been approved..
- Ongoing audit work by the outreach team and Quality governance.

HSMR – Peer analysis



Summary Hospital-Level Mortality Indicator (SHMI)

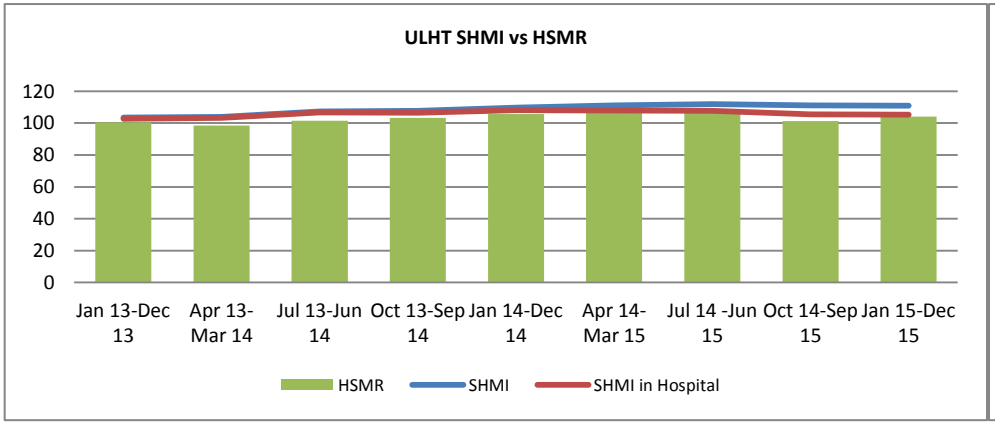
Death I/O Hospital Jan 15-Dec15	SHMI Spells	SHMI/ HSMR	Actual Deaths	Expected Deaths
SHMI All deaths	82545	110.99	3591	3235.3
SHMI In hospital deaths	82545	105.38	2436	2311.71
HSMR	51873	104.05	2131	2048.06

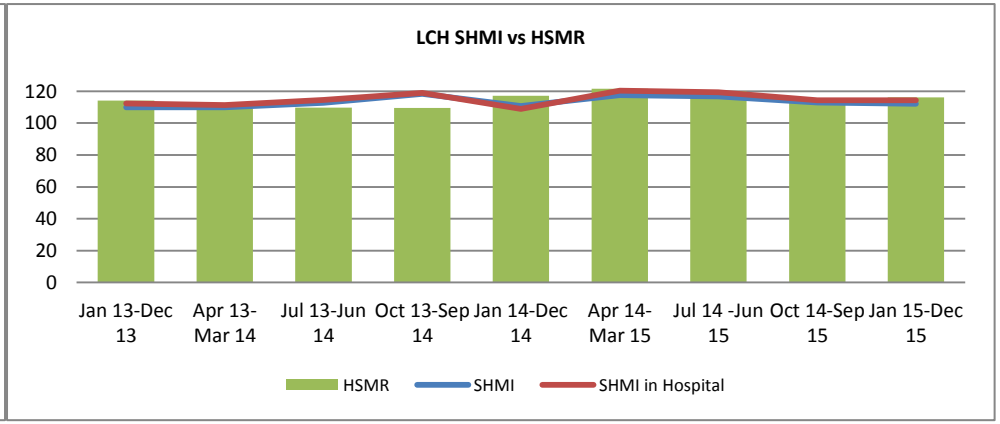
SHMI Graphs by Trust and site-In and out of hospital deaths:

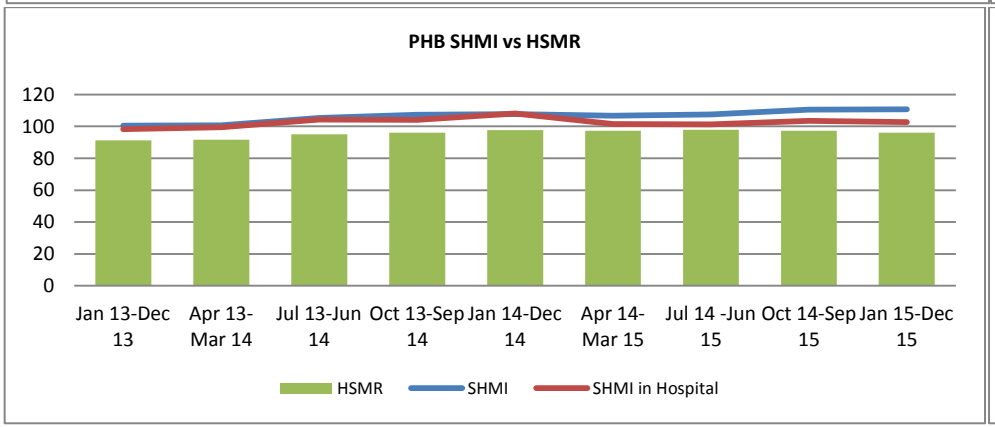
Trust/Site	ULHT SHMI Jan 15-Dec 15 (Current)
ULHT	110.99
LCH	112.11
PHB	110.8
GDH	106.07

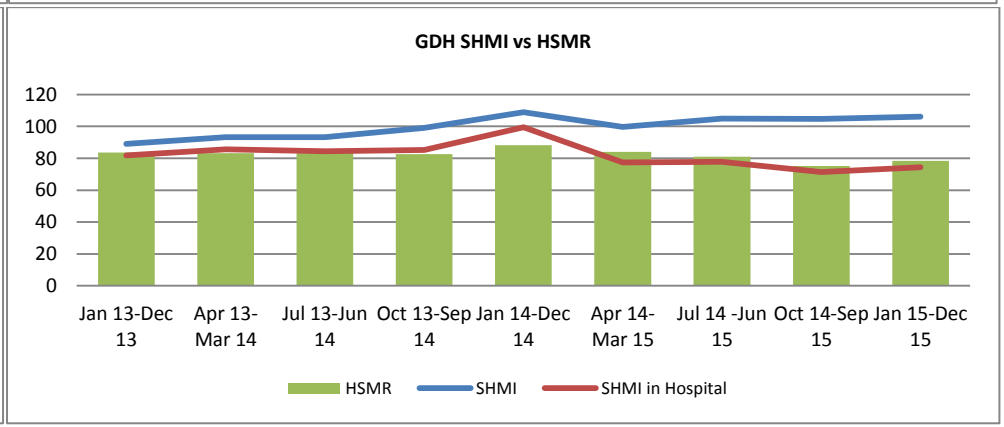
SHMI Performance Overview

- Current SHMI reporting period (Jan 15-Dec 15) show that ULHT has decreased to 110.99 . 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.
- 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.







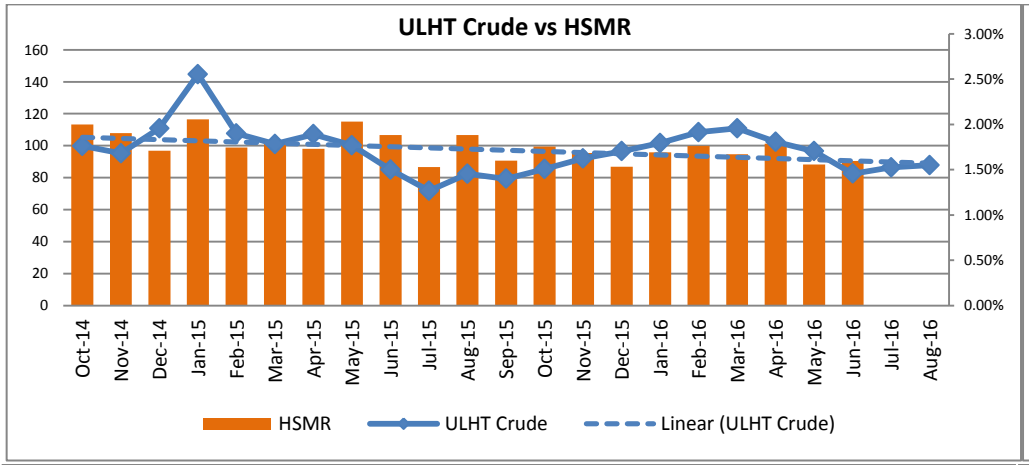


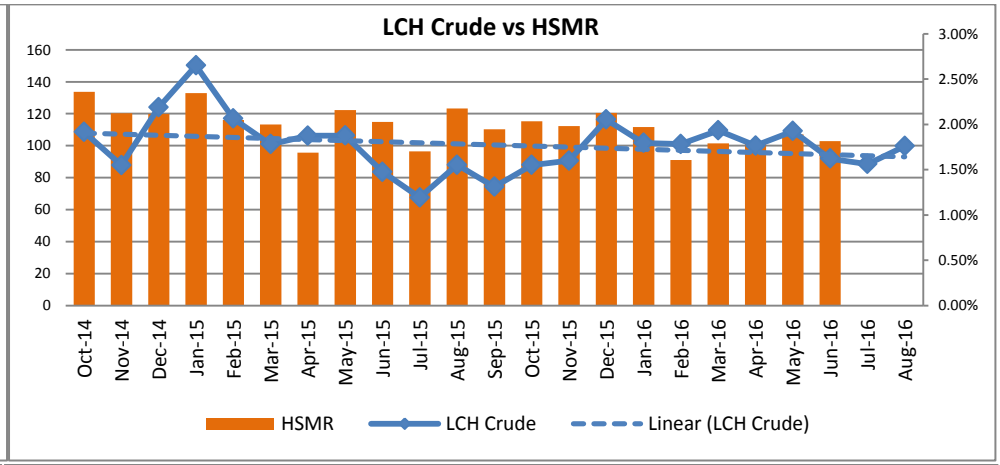
Crude mortality

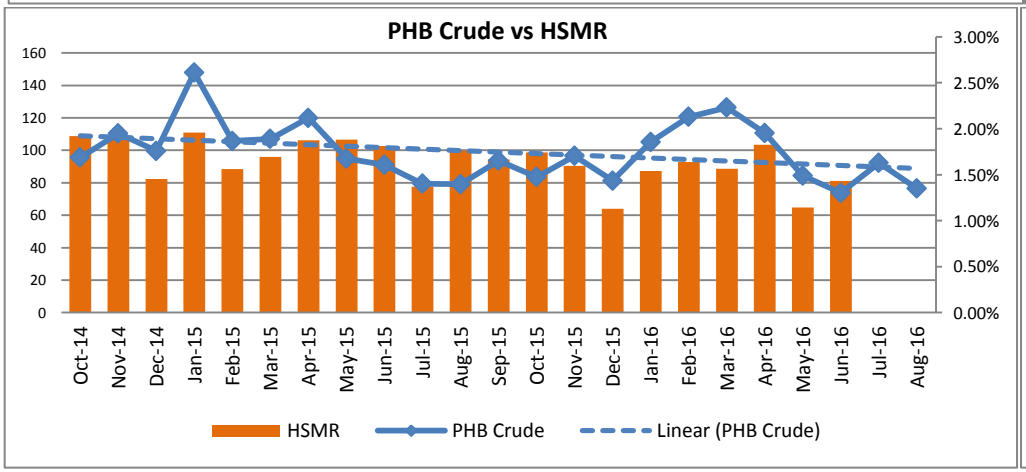
Trust Site	Dr Foster Crude National Average Jul 15 – Jun 16	ULHT data Crude mortality YTD Apr 16-Sep 16	ULHT data Crude Mortality Sep 16
Trust	1.40%	1.62%	1.68%
LCH	-	1.72%	1.66%
PHB	-	1.60%	1.88%
GDH	-	1.20%	1.04%

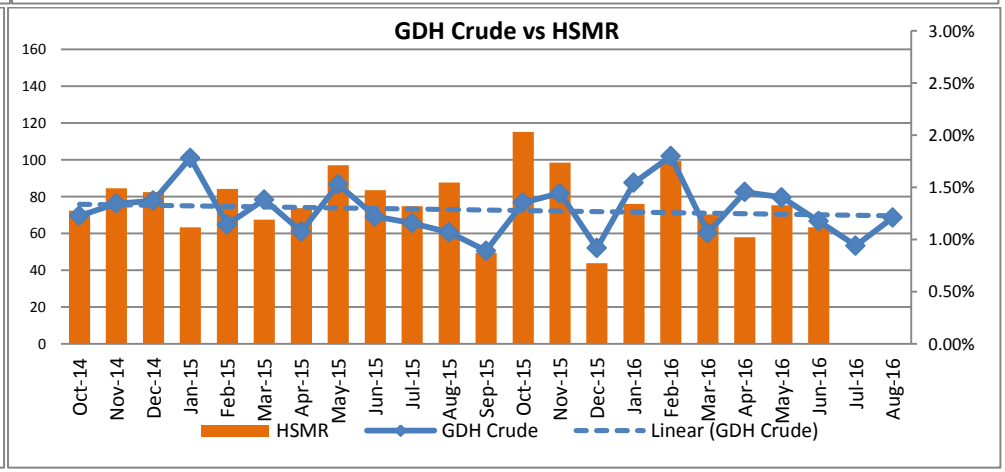
Crude mortality overview

- Against National average (time period: Jul 15 – Jun 16) ULHT crude mortality is 1.63%, 0.23% higher than the national average.
- ULHT's crude mortality for year to date has increased by 0.01% to 1.62%
- ULHT's Crude Mortality shows a slight downward trajectory over the past two years this is an indication that HSMR will shadow.









Mortality Reviews

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

Site	Deaths	Awaiting notes/Notes in Quality Governance	Notes Sent for Review	Review Complete	Review completion Compliance	Review Completion Target	Total Death % Reviewed
ULHT Total	2060	542	1518	1057	70%	75%	51%
Lincoln Total	1124	229	895	576	64%	75%	51%
Pilgrim Total	785	267	518	393	76%	75%	50%
Grantham Total	151	46	105	88	84%	75%	58%

Mortality Actions

- A review compliance trajectory has been put into place and expected 75% completion compliance by December.
- Working with the CCG for all mortality within 48 hours of admission to assess inappropriate admissions and disseminate shared learning.
- Working with the CCG to assess mortality post 30 days of admissions and Sepsis this report is currently being assembled by Quality Governance.
- MoRAG actions are escalated and actioned in a timely manner actions included; case notes presentations and sharing learning at specialty governance meetings, writing to clinical teams and individuals to communicate issues and improvements. Devolving community learning to the CCG.
- Alerting and top observed diagnosis groups are being closely monitored and improvement works are ongoing; with the sepsis task and finish group.
- Quality Governance are working with the Quality Safety Officers to ensure learning is shared at specialty governance.
- Quality Governance are currently working on a Mortality reduction strategy.
- Quality Governance are working towards review completion compliance targets, chase reports are sent out by Quality Governance.
- Quality Governance will review top 3 themes from the reviews and allocate to appropriate committee.
- Mortality newsletters to disseminate learning to a wider audience.

E

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.

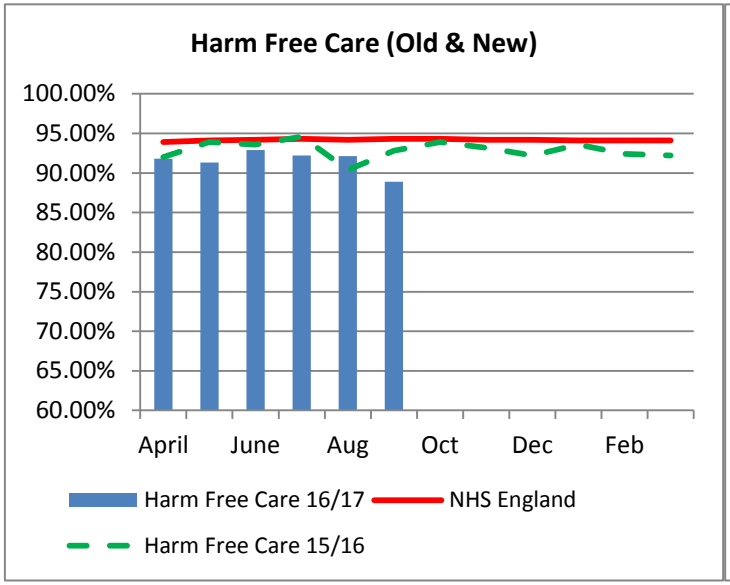
Residual codes: These are codes for all signs and symptoms written in the casenotes. The mortality reporting tools take the first primary diagnosis coded if this code is a residual code the reporting tool moves to the second episode; if this is identified as residual code the reporting tool codes the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

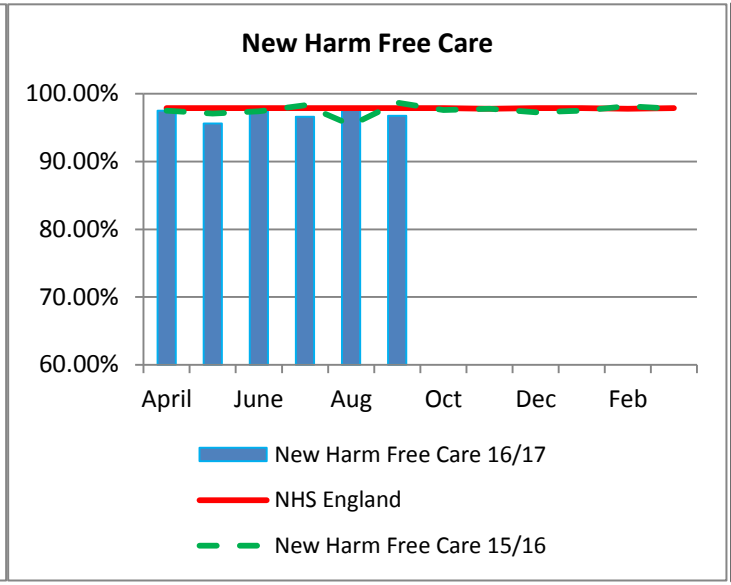
SAFE AMBITION 2 Reduction of Harm Associated with Harm free Care

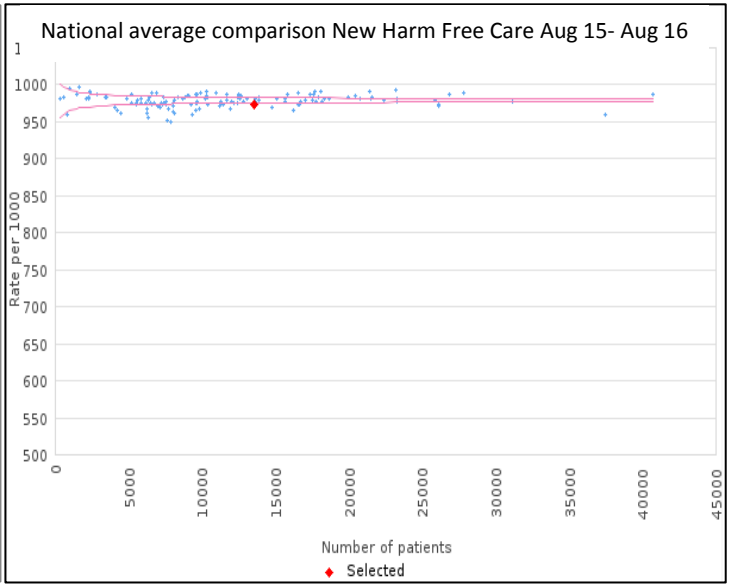
The NHS Safety Thermometer records the presence or absence of four harms:

- 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)

September New Harm Free Care 96.77%

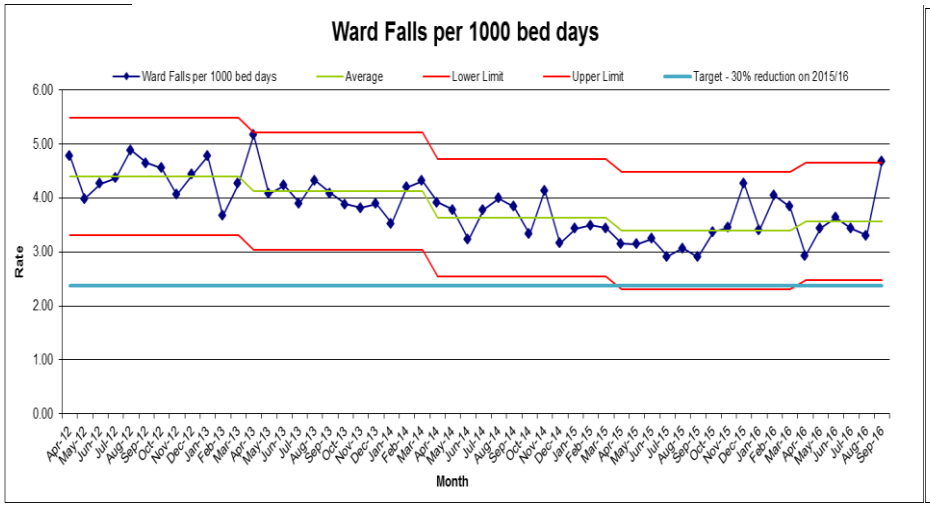


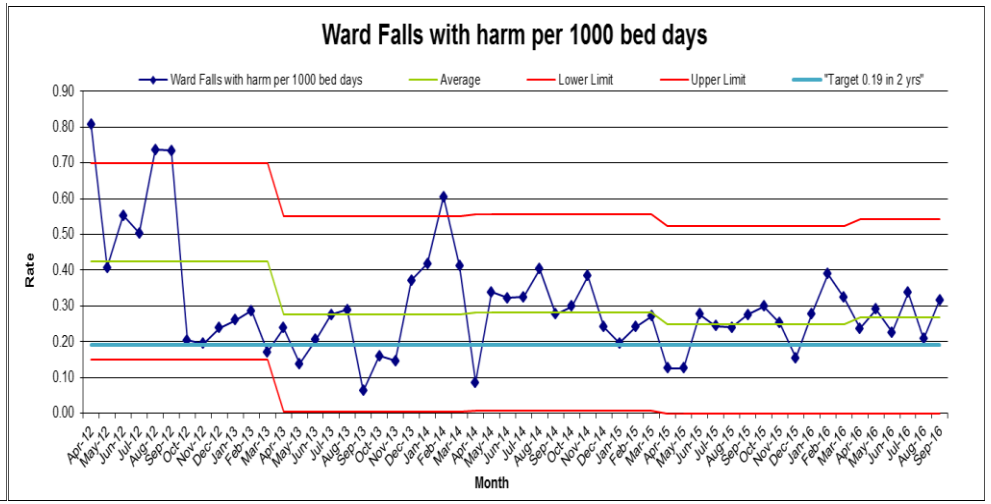




Performance Data Overview	Action Plan
There were 11 harmful falls across ULHT of which 7 were pre admission. There were 15 new pressure ulcers: 11 category 2, 2 category 3 and 2 category 4. The category 3 and 4 pressure ulcers occurred at Pilgrim. There were 0 catheters with new infection. There were 2 new VTE at Lincoln	Reports are distributed detailing where all of the harms have occurred. Nurse specialists review the harms before being uploaded Analysis of how other organisations are collecting their data is being investigated. RCAs are being completed on the VTE

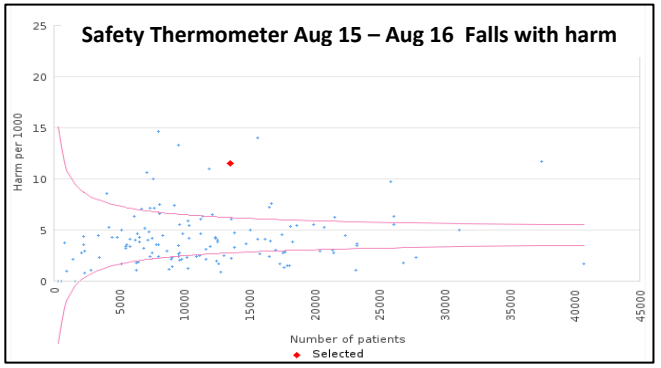
SAFE AMBITION 3 Reduction of Harm Associated with Falls





Trust Safety Quality Dashboard Oct 15 – Sept 16

Metric Title	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	May-2016	Jun-2016	Jul-2016	Aug-2016	Sep-2016
Patient at risk of falls	320	334	276	332	315	349	360	344	336	338
Medication review occurred	68.70%	71.00%	66.80%	71.00%	64.70%	65.10%	67.10%	70.90%	66.50%	73.60%
Lying & standing BP completed	58.60%	65.60%	61.80%	57.30%	60.10%	56.20%	55.60%	58.00%	62.60%	67.10%
Care plan 7 activated	94.60%	93.60%	94.40%	93.90%	93.50%	94.00%	95.50%	97.10%	96.40%	96.20%
Reviewed by physio	64.70%	74.20%	71.20%	71.90%	77.80%	79.90%	81.40%	82.40%	78.50%	83.60%
Referred to OT	86.50%	89.00%	85.20%	86.70%	83.20%	90.90%	89.80%	91.40%	80.40%	80.80%
Referred to physio	90.50%	92.40%	89.90%	86.30%	86.70%	86.10%	87.10%	88.90%	90.10%	85.00%
Actions completed within 4 hours	87.90%	88.90%	88.50%	87.20%	83.80%	91.40%	90.60%	93.00%	88.10%	87.40%
Actions completed within 24 hours on admission	38.90%	46.30%	42.00%	39.70%	43.80%	41.30%	42.40%	46.50%	42.20%	49.20%
Actions completed within 24 hours of transfer (if necessary)	38.70%	37.90%	37.00%	33.70%	35.90%	33.80%	32.10%	33.10%	39.30%	41.20%



Performance Data Overview

In September we have seen an increase in the number of falls reported on the Pilgrim site (for falls with harm and no harm) and low/ no harm falls on the Lincoln site which has led to a spike in the overall Trust figure

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 4.62 compared to 5.45 (which is lower than last month).

LCH are reporting a further reduction in falls with harm at 0.18 compared to 0.22 for 2015/2016 (lower than last month) but are experiencing more falls with no or low harm suggesting that the severity of harm is continuing to reduce

Pilgrim are reporting increased number of falls in September

The SQD is demonstrating an improving picture.

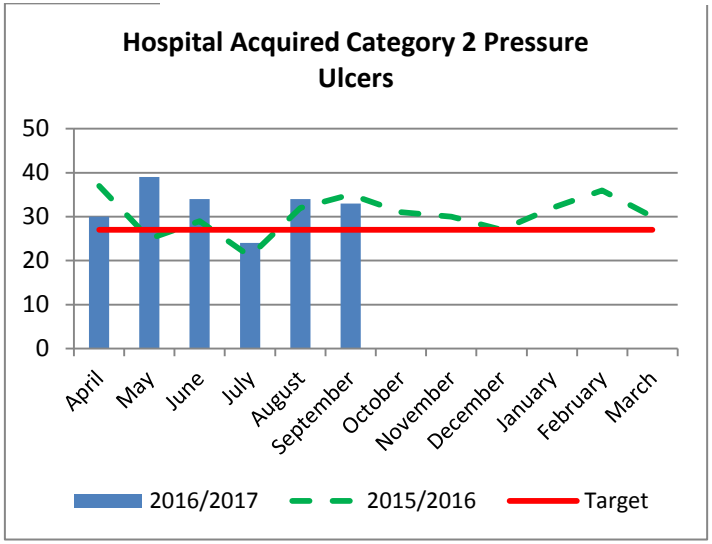
Falls is an outlier within Safety Thermometer however this incorporates falls in the community.

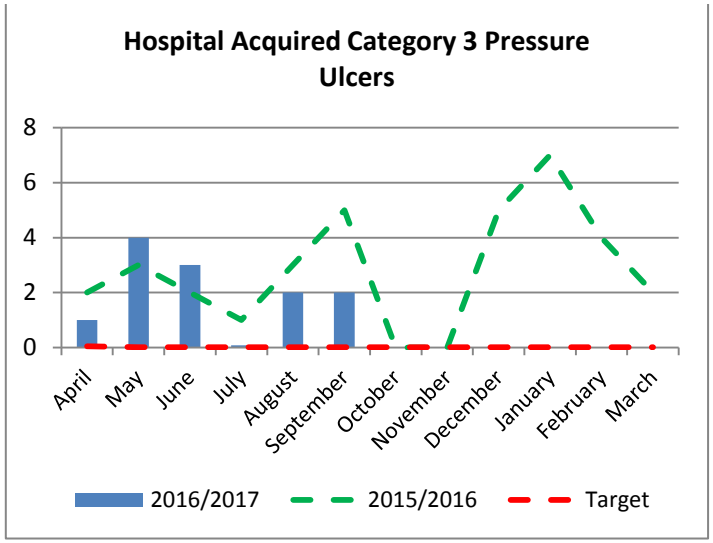
Action Plan

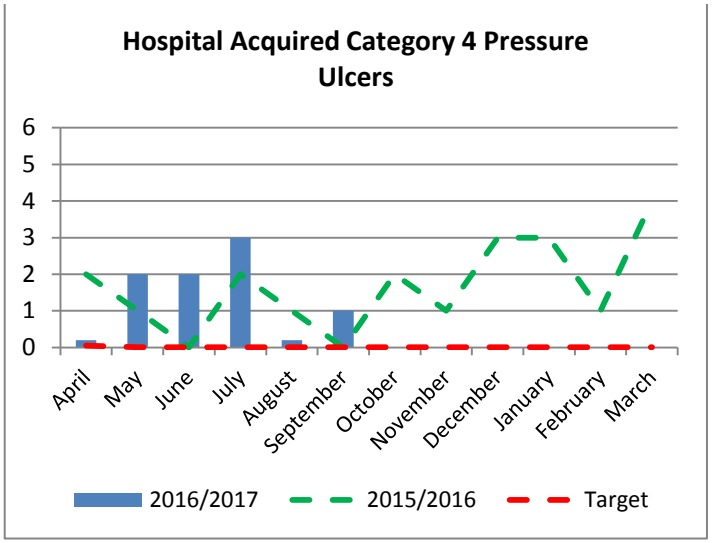
To address the variation on the Pilgrim site, contact has been made with the Heads of Nursing and Consultant Nurse for Frailty to develop a tailored plan.

Falls scrutiny panels will now review falls with moderate harm as well as severe harm in view that the number of falls to drive further improvement

SAFE AMBITION 4 Reduction of Harm Associated with Pressure Ulcers



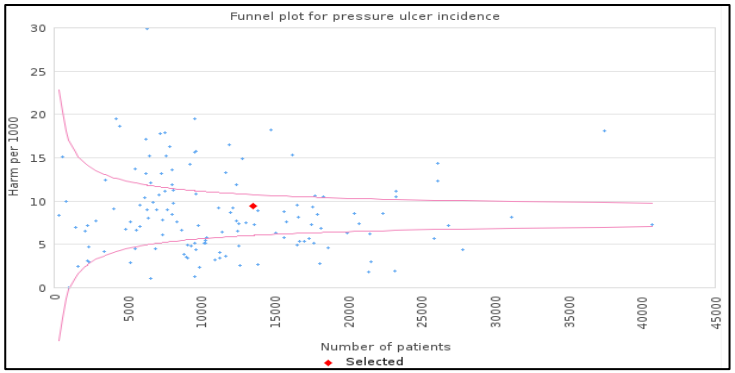




Safety Quality Dashboard – Trust Results Oct 15 – Sept 16

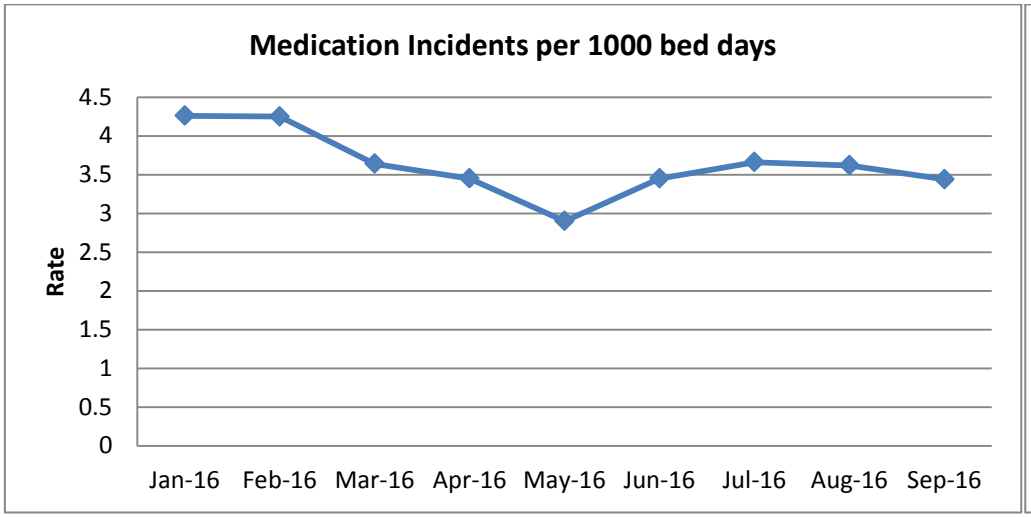
Metric Title	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	May-2016	Jun-2016	Jul-2016	Aug-2016	Sep-2016
Pressure area care risk assessment completed within 24hrs	98.50%	98.30%	99.40%	97.80%	98.00%	97.90%	98.10%	99.00%	98.80%	98.80%
Pressure area care risk assessment updated weekly	85.20%	85.60%	82.50%	79.40%	86.10%	85.50%	78.00%	75.30%	76.00%	78.90%
Pressure-relieving equipment in situ if required	97.70%	96.30%	93.50%	93.40%	96.20%	93.00%	92.30%	96.00%	93.50%	93.90%
Repositioning chart commenced if required	96.00%	98.00%	98.80%	97.60%	99.00%	95.90%	95.40%	96.10%	96.40%	98.20%
Pressure area care plan activated if required	94.40%	97.30%	95.70%	90.50%	94.80%	91.40%	93.80%	95.10%	92.10%	94.30%

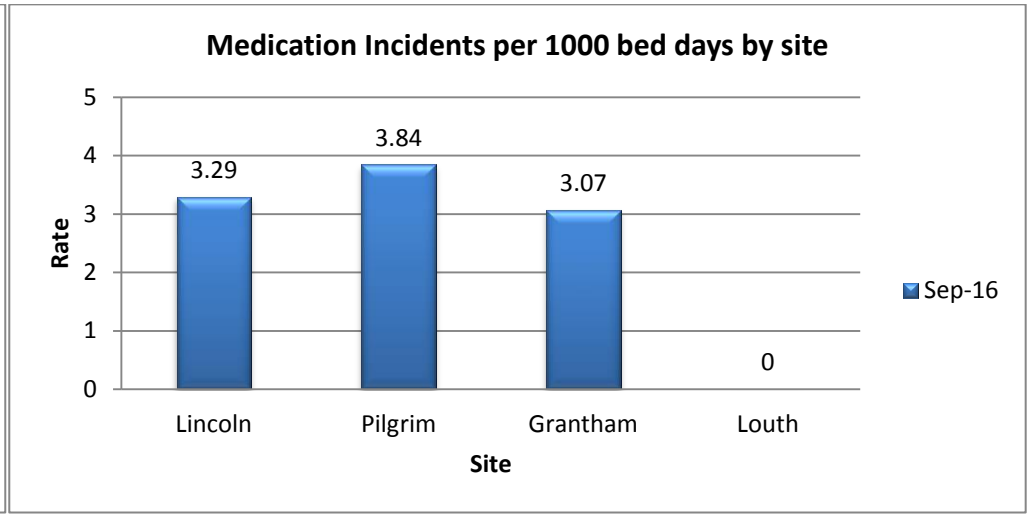
Safety Thermometer Aug 15 – Aug 16 Pressure Ulcers



Performance Data Overview	**Action Plan**
In the first six months of YR. 2016/17 the Trust reported a total of 280 hospital acquired pressure ulcers YTD 2015/16 compared to 251 for the same period in the previous year– an overall increase of 11%. However it should be noted that this increase includes the improved reporting of Category 2. The SQD is demonstrating a slight deterioration in risk assessment completed weekly. The Safety Thermometer data is within expectation to national comparison.	Education is ongoing Scrutiny process being reviewed

SAFE AMBITION 5 Reduction of Harm Associated with Medication





Trust Safety Quality Dashboard Oct 15 – Sept 16

Metric Group	Metric Title	Sep-2015	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	May-2016	Jun-2016	Jul-2016	Aug-2016	Sep-2016
Medication	Medicine chart demographics correct	61.80%	62.00%	67.90%	61.60%	68.30%	79.80%	73.80%	71.90%	75.00%	78.50%	78.40%
Medication	Allergies documented	96.50%	96.60%	100.00%	98.40%	100.00%	98.70%	99.40%	95.50%	96.80%	98.10%	98.80%
Medication	All medicines administered on time	90.90%	88.50%	90.10%	85.80%	86.00%	91.10%	88.80%	89.40%	87.90%	88.00%	91.90%
Medication	Allergy nameband in place if required	83.40%	94.10%	92.00%	86.60%	90.40%	89.50%	91.20%	80.60%	91.00%	87.60%	91.80%
Medication	Identification namebands in situ	99.50%	98.80%	99.30%	99.40%	98.50%	99.20%	97.90%	97.90%	98.80%	98.00%	99.50%

Performance Data Overview

There were 123 medication related incidents reported in September. The total number of medication incidents per 1000 bed days was 3.44. A slight decrease from August.

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

There were 7 incidents reported in September that involved errors made by the Pharmacy department. The number of incidents per 100,000 items dispensed is 10.97.

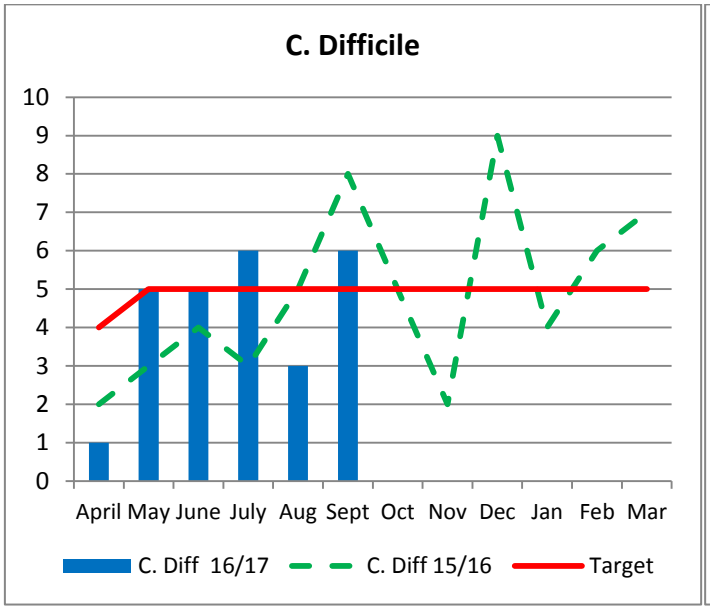
CD audits are now complete for Quarter 3. The Trust now has a pass rate of 81%. LCH has a pass rate of 82%, PHB has a pass rate of 76%, GDH has a pass rate of 93% and CHL has a pass rate of 75%.

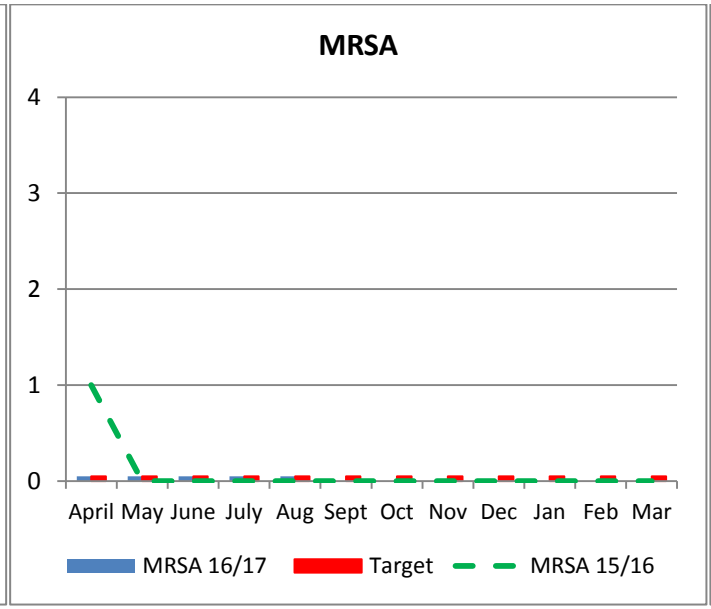
Action Plan

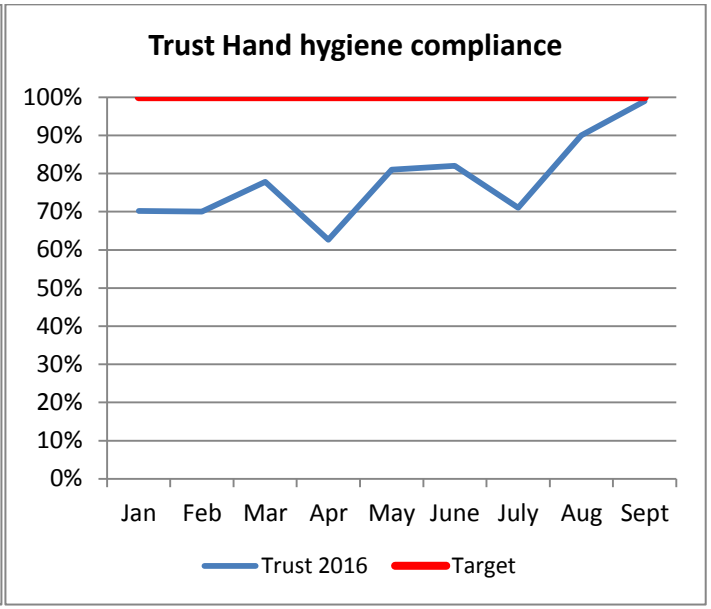
During World Antibiotic Awareness Week (14-20 November 2016) we will be running an Allergy Awareness campaign. Emphasis will be on differentiating between allergy and sensitivity.

Insulin policy is still in the development stage and is now with the diabetes team for their input.

SAFE AMBITION 6 Reduction of Harm Associated with Infection

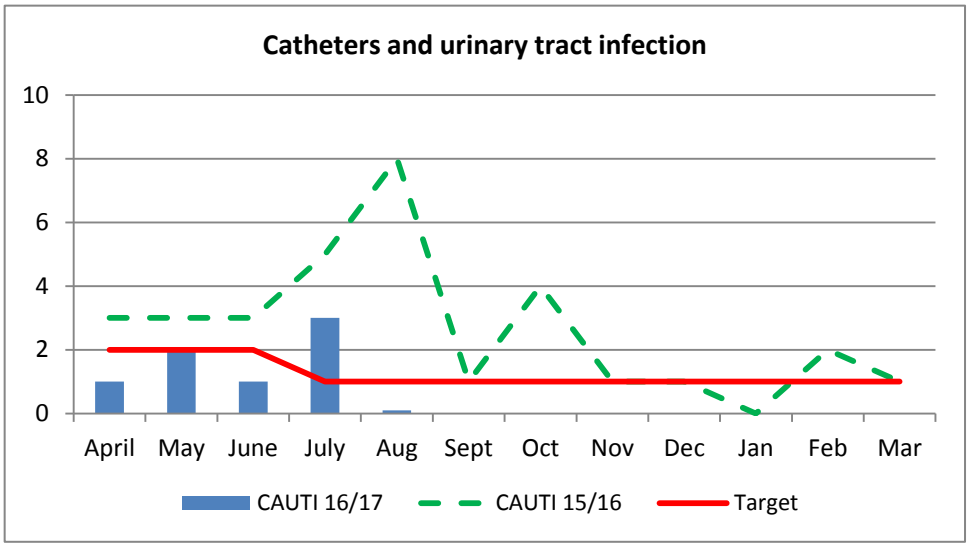


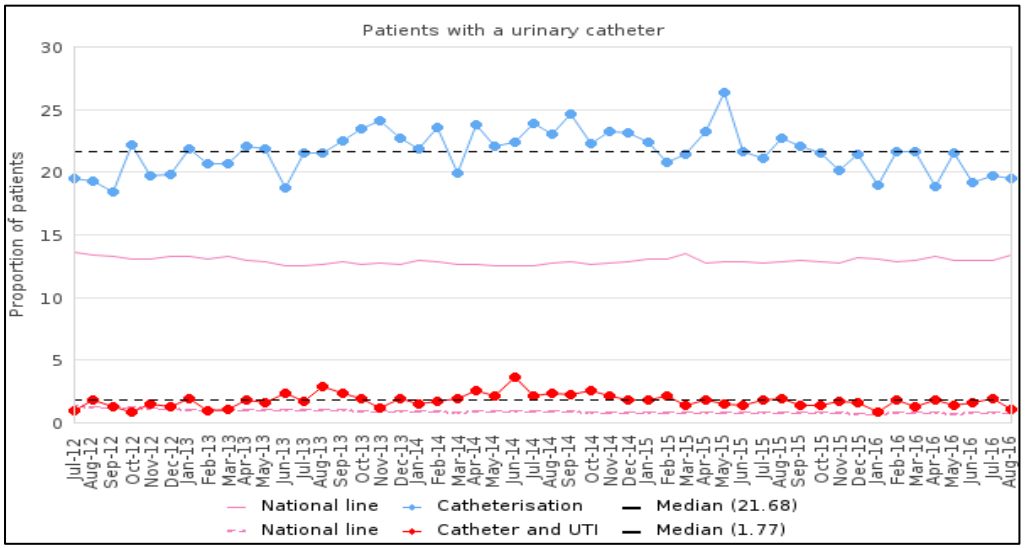




Performance Data Overview	Action Plan
Hand hygiene- overall trust compliance is at **99%** Clostridium difficile – 26 cases for year to date (Trajectory is 59) MRSA bacteraemia - 0 cases to date (Trajectory 0)	Monthly hand hygiene drop in sessions undertaken trust wide Hand hygiene awareness week being carried out in September 2016 trust wide Hand hygiene information published on the intranet Messages communicated via twitter Compliance assessment tool/review is undertaken for each patient with C.Diff RCA undertaken for each hospital acquired C.Diff and an action plan put into place which is discussed at site meeting Post infection review undertaken for all cases of MRSA and an action plan completed and discussed at site and committee meetings

SAFE AMBITION 6 Reduction of Harm Associated with Infection (CAUTI)





Trust Safety Quality Dashboard Oct 15 – Sept 16

Metric Title	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	May-2016	Jun-2016	Jul-2016	Aug-2016	Sep-2016
Number of urinary catheters in-situ	93	87	57	65	73	72	74	75	81	63
Urinary catheter record demographics correct	90.30%	85.20%	89.50%	90.90%	87.70%	90.10%	84.90%	90.40%	95.00%	96.80%
Urinary catheter record completed &signed daily	59.60%	72.40%	63.20%	54.50%	64.40%	72.20%	57.50%	57.50%	72.20%	65.10%
TWOC occurred within 3 days for acute retention	34.80%	47.10%	50.00%	14.30%	25.00%	100.00%	50.00%	36.40%	40.00%	50.00%
Documented evidence why catheter needed	90.30%	84.10%	89.50%	83.30%	83.60%	87.30%	87.30%	89.00%	91.10%	96.80%
Urinary catheter bags secure	100.00%	98.90%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Urinary catheter care plan activated	77.40%	83.00%	91.10%	74.20%	78.10%	83.30%	82.20%	87.50%	88.60%	90.50%

Performance Data Overview

The number of catheter associated urinary tract infections(CAUTI) has significantly reduced in comparison with the same period last year and the target figure. The number of patients with a urinary catheter has decreased in the last month, however it still higher than the national average figure. The main reason for catheter insertion in our trust remains monitoring output for acutely ill patients and urinary retention.

Trust Safety Quality Dashboard Oct 15 – Sept 16 indicate that although the urinary catheter record demographics, the reason for catheter insertion and elements of catheter care (eg catheter bag secure) are recorded, the catheter care plan is not signed daily and only half of the patients with catheters have a Trial Without Catheter (TWOC after 3 days).

Action Plan

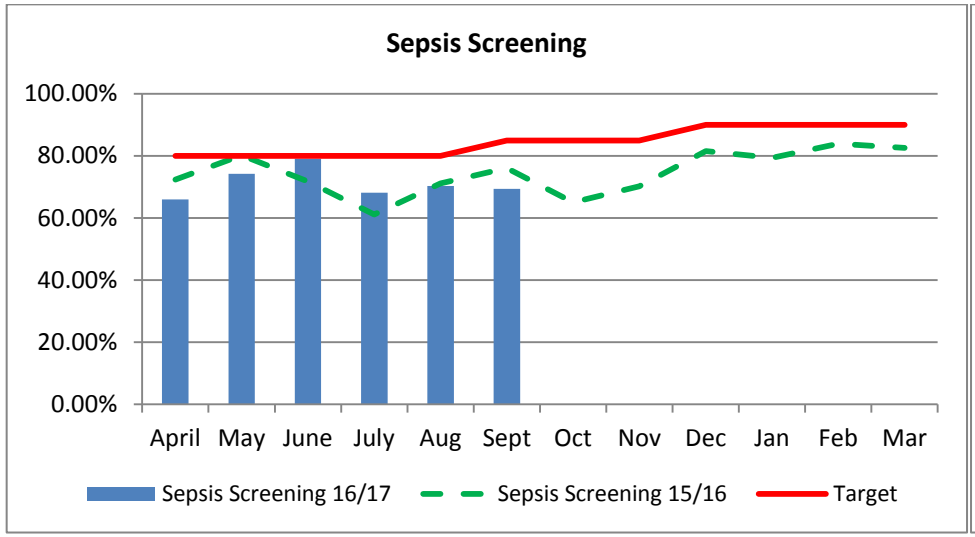
Improvement in aseptic technique through the new catheter pack from BARD which has been successfully introduced in our acute emergency wards on all sites, orthopaedic wards and theatre in Lincoln.

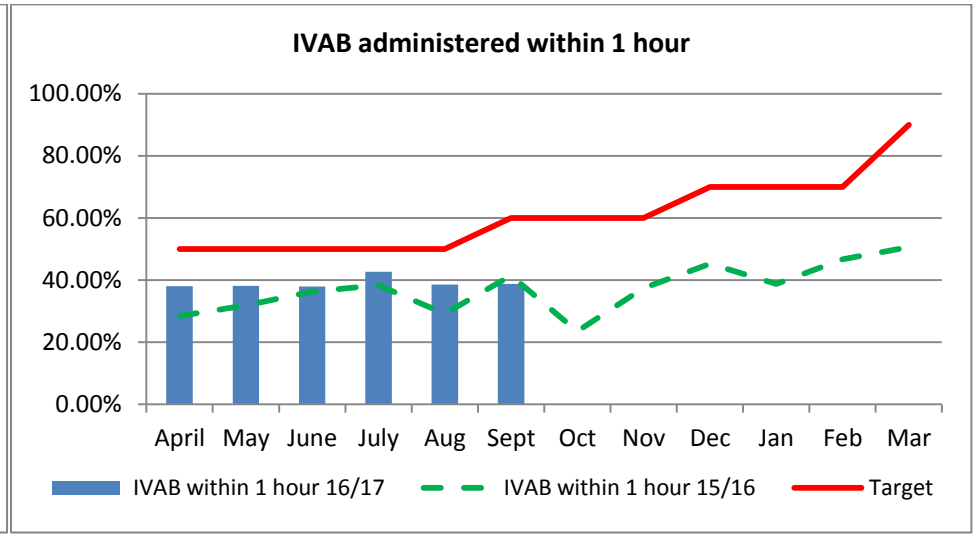
PreConect closed drainage system from BARD catheter pack, which prevent accidental bag disconnection and prevents misguided breakage of the sterile closed system.

Nurse led catheter removal protocol developed and attached to the catheter care bundle to help the nursing staff remove catheters in a timely manner.

Implement clean intermittent catheterisation as an alternative to indwelling catheters in selected group of patients – project ongoing.

SAFE AMBITION 7 Reduction of Harm Associated with Deterioration





Trust Safety Quality Dashboard Oct 15 – Sept 16

Metric Group	Metric Title	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	May-2016	Jun-2016	Jul-2016	Aug-2016	Sep-2016
Senior Review	Senior Review	90.50%	90.60%	88.70%	85.40%	92.50%	93.80%	89.50%	89.40%	91.40%	90.40%

Metric Group	Metric Title	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	May-2016	Jun-2016	Jul-2016	Aug-2016	Sep-2016
Patient Observations	Patient demographics correct	96.50%	98.30%	98.50%	99.00%	98.00%	98.10%	98.80%	99.50%	98.00%	98.80%
Patient Observations	Patient observations on time and complete	71.80%	75.00%	76.70%	72.90%	77.60%	79.20%	79.10%	80.00%	78.20%	80.50%
Patient Observations	NEWS score added correctly	95.00%	98.30%	98.80%	95.80%	96.20%	97.10%	98.30%	98.10%	97.50%	98.30%
Patient Observations	Evidence of escalation if required	74.10%	66.70%	94.40%	92.00%	81.50%	91.20%	78.00%	78.30%	76.10%	71.40%
Patient Observations	Evidence of reset baseline	89.70%	78.10%	87.00%	85.00%	96.60%	100.00%	75.00%	-	100.00%	100.00%

Performance Data Overview

Site	Bundle Commenced -Sept	IVAB within 1 hour - Sept
Grantham	88.24%	75%
Lincoln	89.74%	45.45%
Pilgrim	49.09%	26.09%

Grantham and Lincoln are consistently achieving high 80% Pilgrim site still under performing with commencement of the sepsis bundle and IVAB administrated within 1 hour.

The rollout of eOBS at pilgrim has seen a deterioration in the SQD results due to the new process and when patients are off the ward the clock does not stop.

Processes are being developed to improve compliance.

Action Plan

Workbook and competency documents being produced to support roll out of PGD

eBundle being developed and will be trialled in Pilgrim.

Due to the time required in appointing a substantive member of staff, HR are in discussion with staff side to allow a secondment of the sepsis nurses

National sepsis audit currently happening in A&E on all sites

Numerous visits by the Quality Governance team at Pilgrim A&E to discuss compliance