Excellence in rural healthcare

NHS
United Lincolnshire Hospitals
NHS Trust

Quality & Safety Improvement Programme
Key Performance Indicator Dashboard (Quantitative Measures)

Please Note:
Whilst Key Performance Indicators (KPI's) have been aligned to a majority of the Quality & Safety projects, there are additional KPI's to be added once project leads are in post/identified and following conversations with stakeholders. The dashboard is made up of qualitative and quantitative measures. These has been split into two groups accordingly.

Project	Key Performance Indicator (KPI)	Baseline	Threshold	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
				ULHT	ULHT	ULHT	ULHT	ULHT	ULHT	ULHT	ULHT	ULHT
QS01 Developing the Safety Culture	Percentage of Specialty Clinical Governance Meetings taken place and quorate	Data to be captured from 1st October										
	Numbers of people completing the in-house Quality Improvement (QI) course	First QI course commenced in September 2018	Next QI course scheduled for January 2019		32							
	Numbers of pieces of improvement work ongoing/generated from the QI course	First QI course commenced in September 2018	Next QI course scheduled for January 2019		32							
	Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (KF 28)	2017 Survey 32	National Median 31									
	Percentage of staff reporting errors, near misses or incidents witnessed in the last month (KF 29)	2017 Survey 87	National Median 90									
	Fairness and effectiveness of procedures for reporting errors, near misses and incidents (KF 30)	2017 Survey 3.5	National Median 3.73									
	Staff confidence and security in reporting unsafe clinical practice (KF 31)	2017 Survey 3.49	National Median 3.65									
	Effective use of patient / service user feedback (KF 32)	2017 Survey 3.69	National Median 3.71									
	Percentage of incidents where feedback has been provided to the person who reported the incident		Continuous improvement	91%								
	Number of wards that have been assessed through the Ward Accreditation Programme for 2018/19	Number is an accumulative running total		40								
	Percentage of wards that are green in the Ward Accreditation Programme	Percentage is an accumulative running total	Continuous improvement	32.50%								

Project	Key Performance Indicator (KPI)		Baseline	Threshold	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
					ULHT	ULHT	ULHT	ULHT	ULHT	ULHT	ULHT	ULHT	ULHT
QS02 Governance	Percentage of Serious Incidents reported within the 72 hour target		28% December 2017 to July 2018	90% by March 2019	58%								
	Percentage of Serious Incidents completed by the Trust within 40 days		Monitored from August 2018 however first results not available until month of	90% by March 2018									
	Number of open Serious Incidents (includes completed investigations sent to CCGs for closure)		60 as of 17th September 2018	< 50 by December 2018 < 20 by March 2019	60								
	Number of open Serious Incidents over agreed timescales that are awaiting CCG sign off		49 as of 17th September 2018	< 20 by December 2018 < 10 by March 2019	49								
	Number of Serious Incidents that are approved by CCGs at the first submission		Data to be captured from 1st October										
	Percentage of risks on the corporate and operational risk registers that are overdue their scheduled review date		28% of risks (125 out of 447) overdue for review in August 2018.	< 5% by December 2018	28%								
	Duty of Candour compliance with 'in person notification' within 10 working days of reporting a notifiable incident		Baseline compliance 52% (April 2018)	85% by September 2018 100% by December 2018	60%								
	Duty of Candour compliance with written follow-up to 'in person notification' within 10 working days of reporting a notifiable incident		Baseline compliance 31% (April 2018)	80% by September 2018 100% by December 2018	64%								
	Completion rates for Duty of Candour Core Learning (clinical staff)		Monitoring to commence from January 2019	90% of clinical staff by March 2020									
	Number of attendees to the Risk / Incident Management Training		Monitoring to commence from October 2018	At least 50 attendees per quarterly round of training sessions.									
QS03 The Deteriorating Patient	National Compliance Sepsis Screening	Emergency Departments - Adult Admissions	<u>Data Source</u>: A minimum of 50 records per month after exclusions for ED and a separate 50 minimum after exclusions for Inpatients From September 2018 - Data Source: All data reported for patients that NEWS	In-Year payments indicator for 2017/18 and 2018/19. Payment based on % of eligible patients screened. - Less than 50% no payment (red) - 50 to 89.9% payment is 5% (amber) - 90% or above payment is 12.5% (green)	72.00%								
		Emergency Departments - Child Admissions			40.00%								
		Acute Inpatient Departments - Adult Admissions	As above		76.00%								
		Acute Inpatient Departments - Child Admissions			70.00%								
	National Compliance Timely Treatment of Sepsis with IV Antibiotics	Emergency Departments - Adult Admissions	As above	In-Year payments indicator for 2017/18 and 2018/19. Payment based on % of patients with sepsis treated within 1 hour. - Less than 50% no payment (red) - 50 to 89.9% payment is 5% (amber) - 90% or above payment is 12.5%	88.20%								
		Emergency Departments - Child Admissions			50.00%								
		Acute Inpatient Departments - Adult Admissions	As above		100.00%								
		Acute Inpatient Departments - Child Admissions			50.00%								
	Percentage of staff completed Sepsis e-learning training			90%	92.60%								

Project	Key Performance Indicator (KPI)	Baseline	Threshold	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
				ULHT	ULHT	ULHT	ULHT	ULHT	ULHT	ULHT	ULHT	ULHT
QS04 Pilgrim Emergency Department	Percentage of patients who are triaged within 15 minutes of arrival	Manage triage performance to achieve 15 minute targets										
	Percentage of patients that are fast tracked who clinically present as unwell, unstable, deteriorating or have a recognised early warning trigger scores											
	Percentage/numbers of qualified, skilled and experienced nurses and healthcare assistants to support the care and treatment of patients.											
QS06 Safe Care	Compliance with NG Tube Policy			93%								
	Number of NG tube related Serious Incidents with harm			0%								
	Number of nurses presented with a Daisy Award	Daisy Awards launch on 25/09/2018										
	The number of SI's that have positive patient ID errors			0								
QS07 Safeguarding	Percentage of cases audited that evidence the use of least restrictive options prior to administration of chemical sedation / restraint	**Audit currently being undertaken for August and September**										
	Number of cases audited where medication and dose are in line with policy	**Audit currently being undertaken for August and September**										
	Clinical Holding / Restraint Level 4 training compliance	This is an accumulative total	Target of 12 members of staff per session	33								
	Clinical Holding / Restraint Level 3 training compliance	This is an accumulative total	Target of 12 members of staff per session	25								
QS08 Medicines Management	Percentage of medicines reconciliation completed within 24 hours		80% or above - Green 79.9% - 55% - Amber 54.9% or below - Red	71%								
	Percentage of all prescriptions containing one or more missed doses	Data produced bi-monthly	0-10% - Green 11-15% - Amber 16-100% - Red	17%								
	Prescribing Quality Audit compliance against standards in Trust Policy	Data produced bi-monthly	80% or above - Green 79.9% - 70.1% - Amber 70% or below - Red									
	Medication incident report rate (Datix) per 1000 bed days	National average is 3.9	Continuous improvement in line with national average	4.11								
	Percentage of medication incidents reported as causing harm or death / all medication errors	National median is 10.3%	Continuous improvement in line with national median	13.7%								
	Number of medicines related Serious Incidents with harm	Standard zero		0								

Project	Key Performance Indicator (KPI)	Baseline	Threshold	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
				ULHT	ULHT	ULHT	ULHT	ULHT	ULHT	ULHT	ULHT	ULHT
QS09 Mortality Outliers	**SHMI Reporting Period**			**Jan 17-Dec 17**	**Jan 17-Dec 17**	**Jan 17-Dec 17**						
	HSMR Reporting Period			**Apr-18**	**May-18**	**Jun-18**						
	Elective depth of coding SHMI Reporting Period	National average is 3.9		2.8	2.8	2.8						
	Non-elective depth of coding SHMI Reporting Period	National average is 4.4		3.9	3.9	3.9						
	Co-morbidities with zero Charlson score HSMR Reporting Period	National average of co-morbidities with zero Charlson score for spells is 48.99%		65.97%	65.52%	49.68%						
	Palliative care coding HSMR Reporting Period	National rate of 42.78% for palliative care coding for deaths		26.47%	31.90%	19.50%						
	Initial notes screened within 7 days (will commence with ME in October)	Target is for 100% to have an initial screen within 7 days										
	HSMR for Sepsis	National - 100 or less		106.7	70.6	91.3						
	HSMR other Perinatal	National - 100 or less		226.2	410.7	237.4						
	SHMI - Data is 6 months in lieu	National level 100		114.87	114.87	114.87						
	HSMR - Data is 3 months in lieu	National level 100		91	87.9	79.03						
QS11 Hospital at Night	Patient safety Incidents moderate and above which occur during the defined H@N period	Data to be captured from 1st October										
	Numbers of gaps in H@N rota medical	Data to be captured from 1st October										
	Numbers of gaps in H@N rota nursing	Data to be captured from 1st October										
	Number of issues or concerns raised Related to H@N service, team, and processes	Data to be captured from 1st October										
	Completion rate of immediate and urgent jobs	Data to be captured from 1st October										