Northern Lincolnshire and Goole Hospitals NHS
NHS Foundation Trust

NLG (13) 323

DATE	**24 September 2013**
REPORT FOR	**Trust Board of Directors**
REPORT FROM	**Karen Dunderdale, Chief Nurse** **Wendy Booth, Director of Clinical and Quality Assurance/Trust Secretary**
CONTACT OFFICER	**Kathryn Helley, Deputy Director of Clinical and Quality Assurance/Assistant Trust Secretary**
SUBJECT	**Monthly Quality Report**
BACKGROUND DOCUMENT (IF ANY)	**2012/13 Annual Quality Account**
REPORT PREVIOUSLY CONSIDERED BY & DATE(S)	**On this occasion, this report has not been considered by the Quality & Patient Experience Committee (QPEC) and the first presentation of this is to the Trust Board on the 24th September 2013.**
EXECUTIVE COMMENT (INCLUDING KEY ISSUES OF NOTE OR, WHERE RELEVANT, CONCERN AND / OR NED CHALLENGE THAT THE BOARD NEED TO BE MADE AWARE OF)	**The Monthly Quality Report outlines progress towards meeting the quality indicators agreed by the Board.**
HAVE THE STAFF SIDE BEEN CONSULTED ON THE PROPOSALS?	**N/A**
HAVE THE RELEVANT SERVICE USERS/CARERS BEEN CONSULTED ON THE PROPOSALS?	**N/A**
ARE THERE ANY FINANCIAL CONSEQUENCES ARISING FROM THE RECOMMENDATIONS?	**N/A**
IF YES, HAVE THESE BEEN AGREED WITH THE RELEVANT BUDGET HOLDER AND DIRECTOR OF FINANCE, AND HAVE ANY FUNDING ISSUES BEEN RESOLVED?	**N/A**
ARE THERE ANY LEGAL IMPLICATIONS ARISING FROM THIS PAPER THAT THE BOARD NEED TO BE MADE AWARE OF?	**N/A**
WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO THE NHS CONSTITUTION IN ANY DECISIONS OR ACTIONS PROPOSED?	**N/A**

Directorate of Clinical & Quality Assurance

Quality Report

August 2013

Board Report – Quality Summary

August 2013

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1.0 INTRODUCTION

This, the latest monthly edition of the Trust's Quality Report, outlines performance against the quality priorities agreed for 2013/14 and reports on these indicators to the Quality & Patient Experience Committee (QPEC) and ultimately the Trust Board. For the 2012/13 indicators wherever possible data is provided outlining the Trust position for the previous year to allow for comparison.

2.0 BOARD ACTION

The Board is asked to:

- Review the performance against the range of targets/indicators included within the report.

3.0 RECOMMENDATIONS

There are no new recommendations or actions within this report.

4.0 AT A GLANCE SUMMARY

QUALITY INDICATORS AT A GLANCE: August 2013

2013/14 Indicators

Indicator			Change	Time period	Comparator	Target
CLINICAL EFFECTIVENESS				**Most recent data**	**Previous**	
CE1	Deliver mortality performance within 'expected range' and improving quarter on quarter, until reported SHMI is 95 or better	Official' SHMI (Jan 12 - Dec 12)		115	115	95
		HED data (May 12 - Apr 13)		111	112	95
		Position vs peers		Within expected range	Higher than expected	Within expected range
Indicator			**Change**	**Jul-13**	**Dec - Mar 2013**	**Threshold**
CE2	2.1) NEWS - NEWS score completed	DPoW	✔ 1.5%	99.0%	97.5%	95.0%
		SGH	✘ -5.0%	88.0%	93.0%	
		GDH	✔ 1.0%	95.0%	94.0%	
CE2	2.2) NEWS - Appropriate action taken	DPoW	✔ 0.5%	100.0%	99.5%	95.0%
		SGH	✔ 1.5%	99.0%	97.5%	
		GDH	✔ 1.8%	100.0%	98.3%	
				Jul-13	**Previous**	Threshold
CE3	3.1) Screened for Dementia	DPoW	✔ 7.0%	44.0%	37.0%	90.0%
		SGH	✘ -10.0%	52.0%	62.0%	
CE3	3.2) Dementia - screened, appropriate assessment	DPoW	✔ 0.0%	100.0%	100.0%	90.0%
		SGH	✔ 0.0%	100.0%	100.0%	
CE3	3.3) Dementia - appropriate referral to specialist services	DPoW	✔ 7.0%	7.0%	0.0%	90.0%
		SGH	✔ 7.0%	7.0%	0.0%	
CE4	NICE - Compliance with All NICE Guidance		✔ 0.6%	69.0%	68.4%	90% by March 2014
CE4	NICE - Compliance with ALL NICE TAGs assessed		✔ 0.6%	84.5%	83.9%	

Indicator			Change	Time period	Year to date	Threshold
PATIENT SAFETY				**Jul-13**		
PS1	MRSA Bacteraemia Incidence			0	1	0
PS2	C Difficile Incidence			3	8	No more than 30
				Jul-13	**Jun-13**	**Threshold**
PS3	Safety Thermometer (Acute)	DPoW	✘ -4.0%	83.0%	87.0%	90%
		SGH	✘ -2.0%	86.0%	88.0%	
		GDH	✔ 13.0%	100.0%	87.0%	
PS4	Safety Thermometer (Community)		✘ -1.0%	91.0%	92.0%	95%
				Jun-13	**May-13**	**Threshold**
PS5	Number of Avoidable Repeat Fallers	DPoW	✔ 0	2	2	50% reduction
		SGH	✔ -1	2	3	
		GDH	✔ 0	0	0	
PS6	Number of Avoidable Pressure Ulcers	DPoW	✔ -1	1	2	50% reduction
		SGH	✔ 0	1	1	
		GDH	✔ 0	0	0	

Indicator			Change	Time period	Prev 12 mths	Threshold
PATIENT EXPERIENCE				**Jul-13**		
PE1	Recommending the Trust to family and friends	Inpatient	no data	Bottom 50%	no data	Top 50%
		A&E	no data	Bottom 50%	no data	
PE2	Reduction in the number of re-opened complaints		✔ -2.5	3	5.5	To be agreed
PE3	Complaints - action plans implemented within agreed timescales		no data	14%	no data	90%
PE4	Complaints - 10% reduction in complaints received by end of March 14		✘ 7	50	43	10% reduction (max. 39)
PE5	Nursing care indicator	DPoW	✔ 6.7%	95.0%	88.3%	95.0%
		SGH	✔ 7.6%	95.0%	87.4%	
		GDH	✔ 11.6%	100.0%	88.4%	

4.0 At A Glance

This Section…

→ 5.0 CLINICAL EFFECTIVENESS

→ CE1 Mortality

→ CE2 National Early Warning Scores (NEWS)

→ CE3 Emergency Admissions (Dementia)

→ CE4 Evidence Based Practice (NICE)

6.0 Patient Safety

7.0 Patient Experience

8.0 Glossary

5.0 CLINICAL EFFECTIVENESS

Clinical Effectiveness

CE1 – Mortality

SHMI: Deliver Mortality Performance within 'expected range' and improving quarter on quarter, on a Moving Annual Total (MAT) basis at each quarterly publication date until our reported SHMI is 95 or better

The quality indicator for 2013/14 around mortality is focussed on the Summary Hospital-Level Mortality Indicator (SHMI). In previous years the Trust's performance against the Risk Adjusted Mortality Index (RAMI) has been monitored and progress against this indicator tracked. Whilst this has been effective in the past, the RAMI, in the way it is calculated, differs significantly to the 'official' NHS measure – SHMI. However, in its current reported format is difficult to track continuous progress against due to the delays in reporting this indicator by the Health & Social Care Information Centre (mainly due to its inclusion of community mortality data).

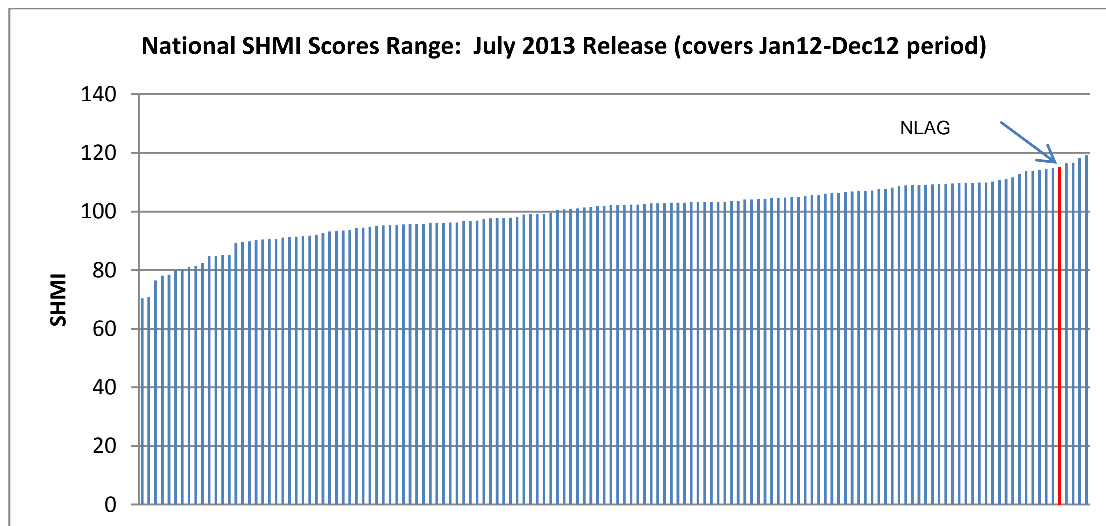
The Trust with the aid of a product purchased from the University of Birmingham is now able to provide the Trust's 'provisional' SHMI position within a more recent timeframe in the interim of the 'official' quarterly publication of SHMI by the Health & Social Care Information Centre.

The following information is an excerpt from this month's Mortality report which contains more detail on this and the other work underway within the Trust regarding mortality.

The Trust's SHMI in National Context

The most recent Summary Hospital Level Mortality Indicator (SHMI) was published on the 24th July 2013. The Trust's SHMI score was 115 – the 5th worst national SHMI score. In the previous quarter's SHMI release NLAG was the 5th worst national performer, with a score of 115. The SHMI includes all deaths in hospital and those deaths that occurred within thirty days of discharge. The indicator uses data that is normally around six months out of date, for example the July 2013 release covered the period January 2012 – December 2012.

The following chart illustrates the Trust's SHMI score, covering the period of January 2012 – December 2012 and benchmarks the Trust against other Trusts.



Source: Information Services based on the Health & Social Care Information Centre's data

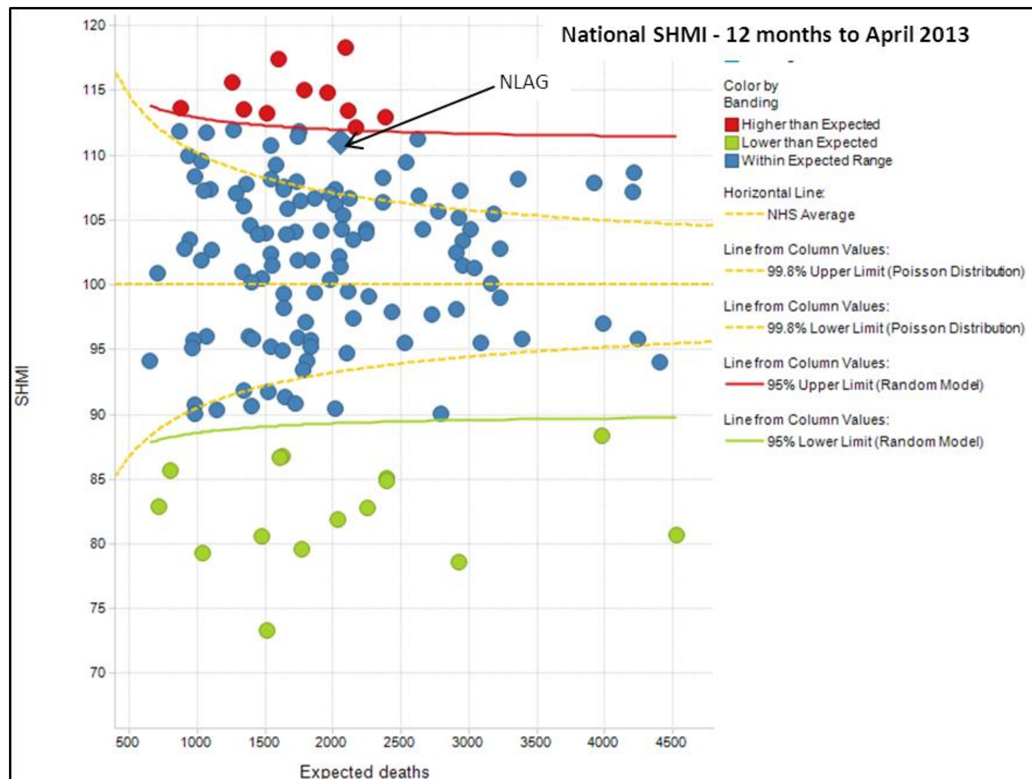
Summary Hospital-Level Mortality Indicator (SHMI) – H.E.D. Provisional Data

Following the acquisition of the University of Birmingham Hospitals' Healthcare Evaluation Data (HED) reporting product in May 2013, we can now report on more up to date SHMI data. You will note that the July 2013 nationally published SHMI contained data up to December 2012. The HED data currently shows data to the end of April 2013.

Data in this analysis should be treated as provisional. However, from reconciliation work, we know that this data source reflects previous SHMI publications.

NLAG's SHMI in National Context

Using the provisional data for the twelve months to April 2013, the Trust is the 18th worst performer nationally, with a score of 111. This takes the Trust into the "within expected range" banding. The following funnel plot graphically represents this.



Source: Information Services

Greater detail, including trend performance, for this indicator and full details regarding the Trust's work on Mortality is reported on in the monthly mortality report.

CE2 – National Early Warning Score (NEWS)

Target –

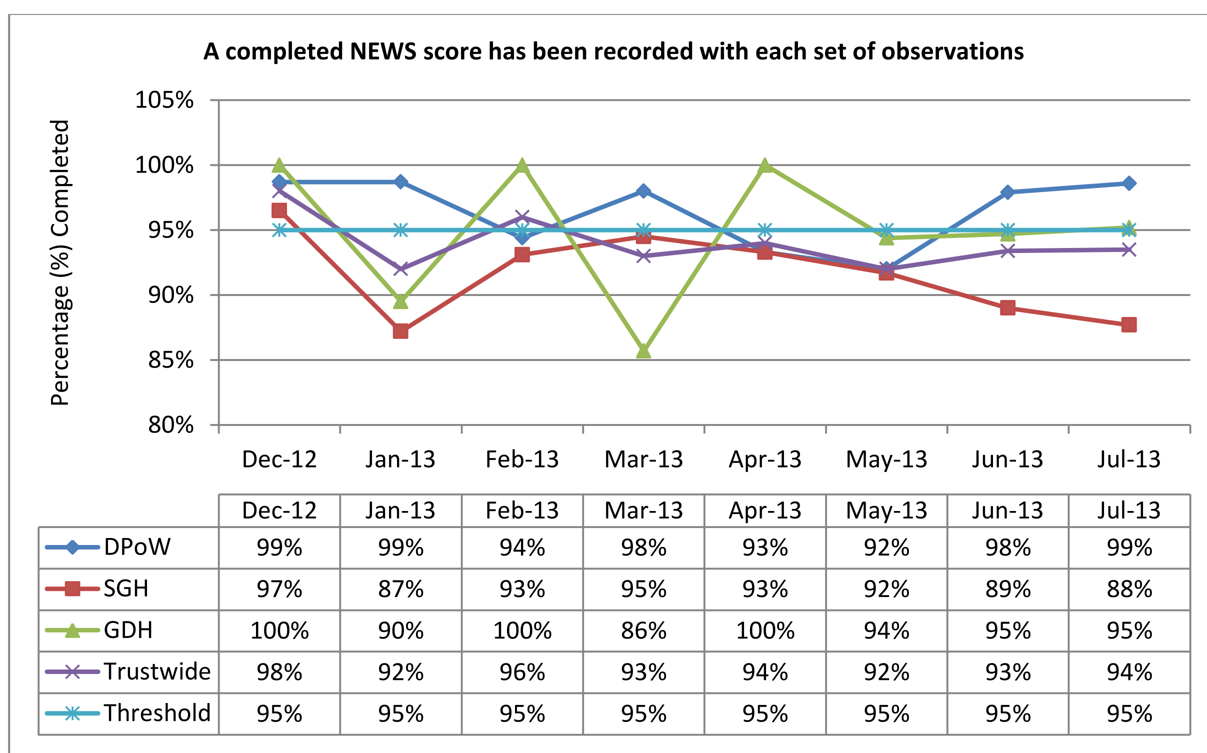
- **(CE2.1) 95% of eligible patients have had a NEWs score,**
- **(CE2.2) in 95% of cases with a NEWs score, appropriate action was taken**

Trust performance against these individual component parts is outlined over the following sections, clearly labelled for ease of interpretation.

CE2.1: 95% of eligible patients have had a NEWs score

Nursing staff randomly undertake a snapshot audit of 10 patients per ward each month and from this assessment, the following information regarding compliance with NEWs scoring is made available. The following chart measures whether patients have had a completed National Early Warning Score (NEWS) recorded with each set of observations. The NEWS scoring system aims to recognise patients that are at risk of deteriorating in order to proactively change treatment as necessary.

The target for 2013/14 is for a completed NEWS score to have been recorded with each set of observations in 95% of cases. This is demonstrated in the following chart:



	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13
DPoW	99%	99%	94%	98%	93%	92%	98%	99%
SGH	97%	87%	93%	95%	93%	92%	89%	88%
GDH	100%	90%	100%	86%	100%	94%	95%	95%
Trustwide	98%	92%	96%	93%	94%	92%	93%	94%
Threshold	95%	95%	95%	95%	95%	95%	95%	95%

Source: Information Services, Nursing Dashboard

NB: As Trust performance with this indicator has been consistently high, for optimal viewing of this information, the above charts axis starts at 80%.

The Trust attained 94% performance with NEWS being recorded.

A dual system of data collection has been running in July from both paper and electronic systems therefore the data quality is not as accurate as it should be. Work is underway at present to ensure any data quality issues are identified and appropriate action taken to ensure this information report is fully accurate going forward.

To ensure compliance with this indicator, much work has been undertaken since NEWS was rolled out in November and the focus is still on this important area. An audit of NEWS has

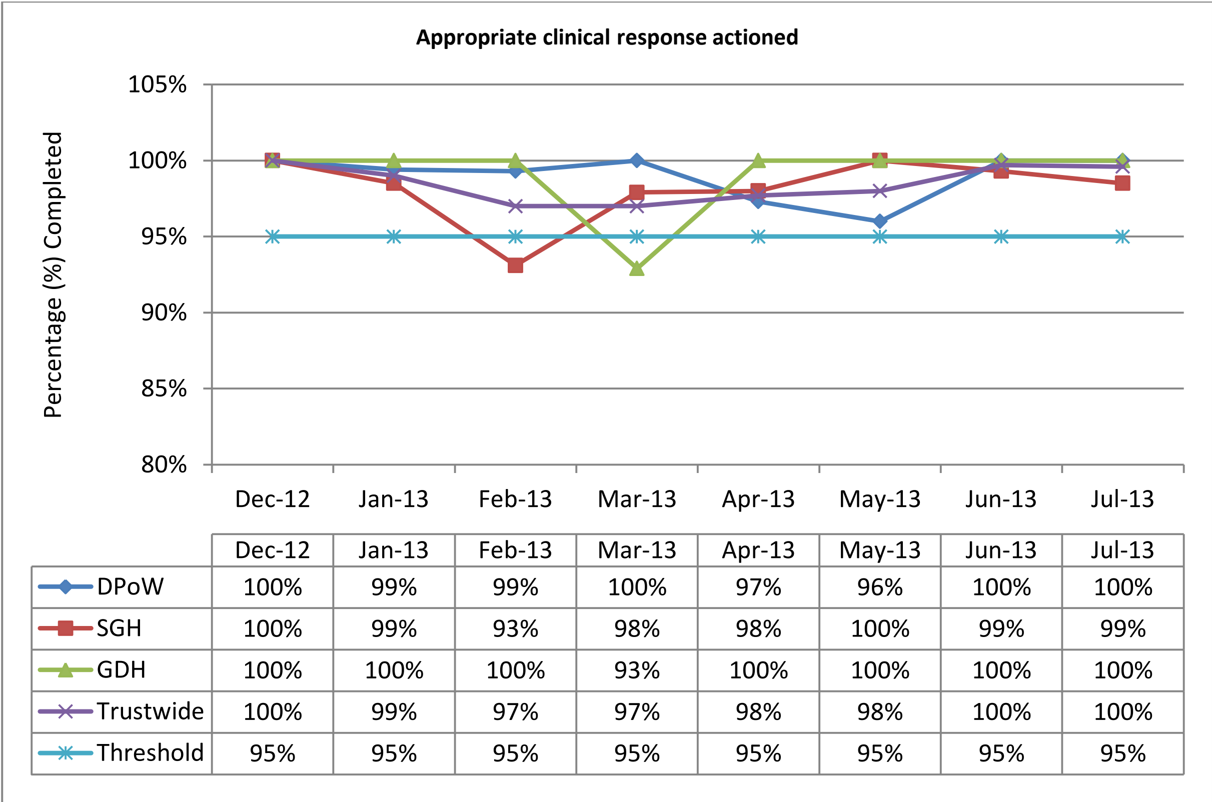
recently been undertaken and as a result of this an action plan developed. A repeat of this Trust wide project is planned to take place during November 2013 to provide regular clinical intelligence to the Trust around performance in this area.

Another project undertaken to assess performance against NEWS was a local audit assessing compliance on medical wards at Scunthorpe. The audit evaluated whether training had resulted in improved outcomes. The findings illustrated that in 100% of cases NEWS scores are being recorded and that when indicated by an abnormal score appropriate care was provided in the majority of cases.

Another initiative in this area is the current work underway to move nursing documentation and records onto the Electronic Patient Record (EPR). This electronic system will automatically calculate the NEWS score which is then displayed on the electronic white boards available on ward areas for staff to be able to see at a glance and therefore prompt appropriate action as a result. The recorded score on the white board also alerts staff to when the next set of observations are due to be undertaken. A roll out plan has been developed to ensure this is a Trust Wide initiative.

CE2.2: In 95% of cases with a NEWs score, appropriate action was taken

For the Trust's use of the NEWs score to be effective, appropriate action needs to be taken as a result to ensure that patients identified as deteriorating receive the most appropriate care or escalation. The following chart summarises the number of cases where appropriate action was taken as a result of the NEWS score assessment. The appropriateness of this assessment is judged by nursing staff undertaking this audit on a monthly basis.



	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13
DPoW	100%	99%	99%	100%	97%	96%	100%	100%
SGH	100%	99%	93%	98%	98%	100%	99%	99%
GDH	100%	100%	100%	93%	100%	100%	100%	100%
Trustwide	100%	99%	97%	97%	98%	98%	100%	100%
Threshold	95%	95%	95%	95%	95%	95%	95%	95%

Source: Information Services, Nursing Dashboard

NB: As Trust performance with this indicator has been consistently high, for optimal viewing of this information, the above charts axis starts at 80%.

Comment: The above chart demonstrates that performance with this indicator at all sites achieved the 95% target. The information is monitored on an on-going basis with ward areas and so this information will inform the consistent quality improvement aspirations in these clinical areas.

The results from the local audit undertaken on Medical wards at Scunthorpe provides encouraging validation of this snapshot audit data.

All the wards are currently undertaking a rolling programme to move over to paperless NEWS observations. All NEWS scores will then be displayed on the Electronic boards situated in prominent positions in the ward areas. This enables Clinicians, Central ops teams including matrons to be highlighted to, that a patient has a high NEWS score and they can then ensure that the appropriate escalation has occurred.

CE3 – Dementia

Target – 90% of patients aged 75 and over admitted as an emergency for more than 72 hours who have been screened for dementia and where patients are identified as potentially having dementia ensuring that at least 90% are appropriately assessed and where appropriate referred on to specialist services.

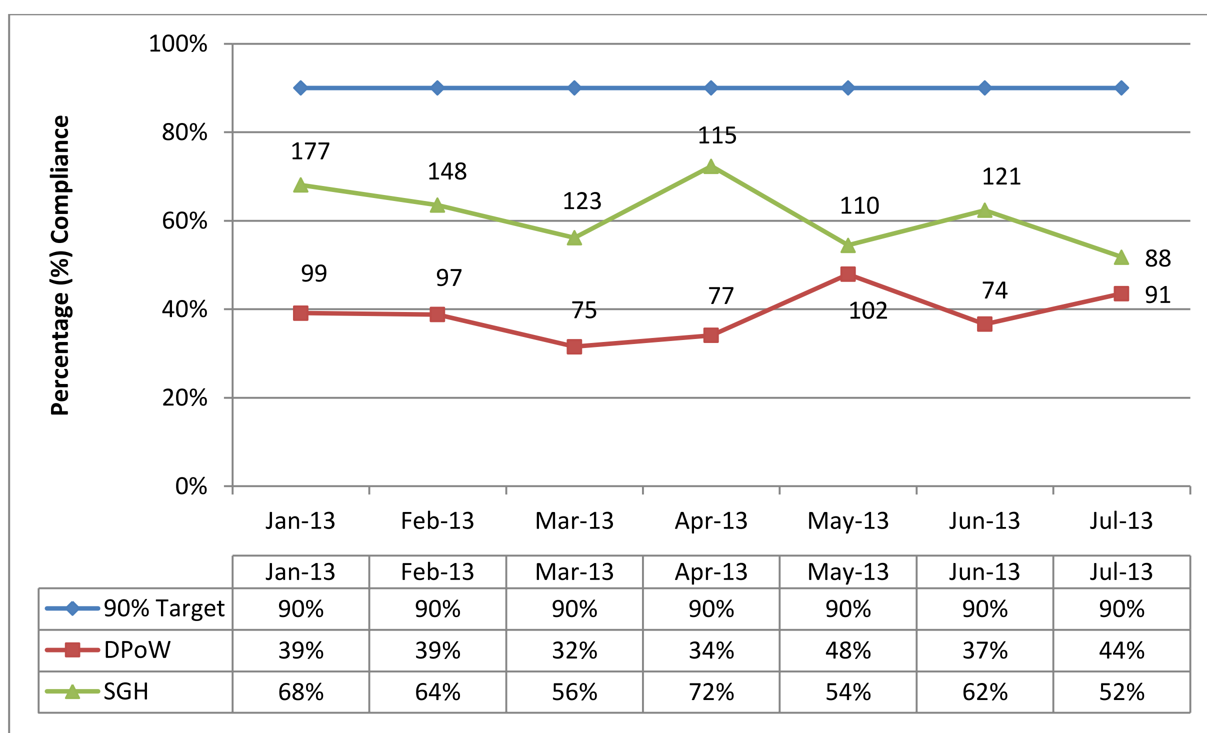
This is a new indicator for the 2013/14 financial year. To measure this indicator, it has been broken down into 3 component parts, to mirror the way this CQUIN (Commissioning for Quality & Innovation) goal is monitored/reported within operational groups.

CE3.1 - 90% of patients aged 75 and over admitted as an emergency to be asked the dementia case finding question.

All patients who are admitted to the Trust as an emergency admission who are aged 75 or over should have an initial screening for dementia. The screening consists of the patient being asked:

> *"Have you been more forgetful in the last 12 months to the extent that it has significantly affected your daily life?"*

Patients who already have a diagnosis of dementia or who have a clinical diagnosis of delirium do not require screening. In the national guidance regarding calculating compliance, these two groups of patients are included in the numerator as patients who are determined to have had a dementia screening.



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13
90% Target	90%	90%	90%	90%	90%	90%	90%
DPoW	39%	39%	32%	34%	48%	37%	44%
SGH	68%	64%	56%	72%	54%	62%	52%

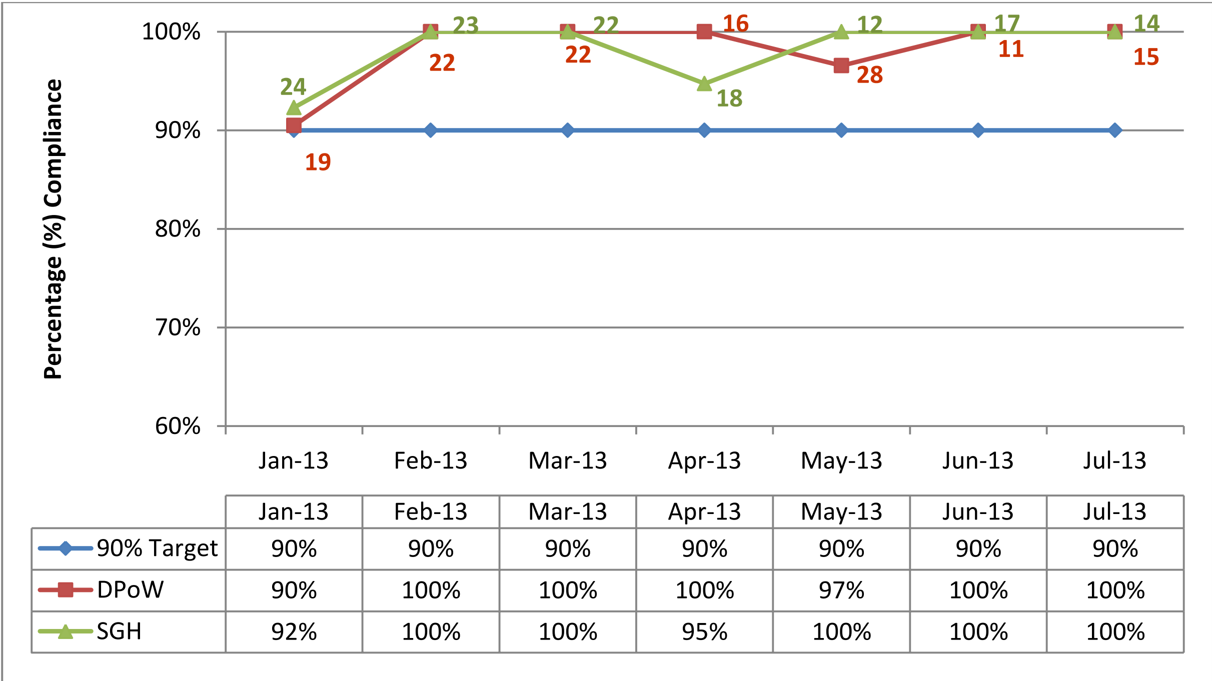
S**ource:** NLAG CQUINS Data, Intranet, Information Services Team

Comment: The above chart illustrates that compliance with all eligible patients having a dementia screening question is not meeting the 90% target set.

NB: *The above charts data labels refer the number of patients, not the percentage of patients, as illustrated in the chart axis.*

CE3.2 – 90% of the above patients scoring positive on the case finding question to have a further risk assessment.

All patients admitted aged 75 and above, who have scored positively on the case finding question, or who have a clinical diagnosis of delirium and who do not fall into exemption categories should then receive a more detailed diagnostic assessment using the 6 item Cognitive Impairment Test (6CIT).



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13
90% Target	90%	90%	90%	90%	90%	90%	90%
DPoW	90%	100%	100%	100%	97%	100%	100%
SGH	92%	100%	100%	95%	100%	100%	100%

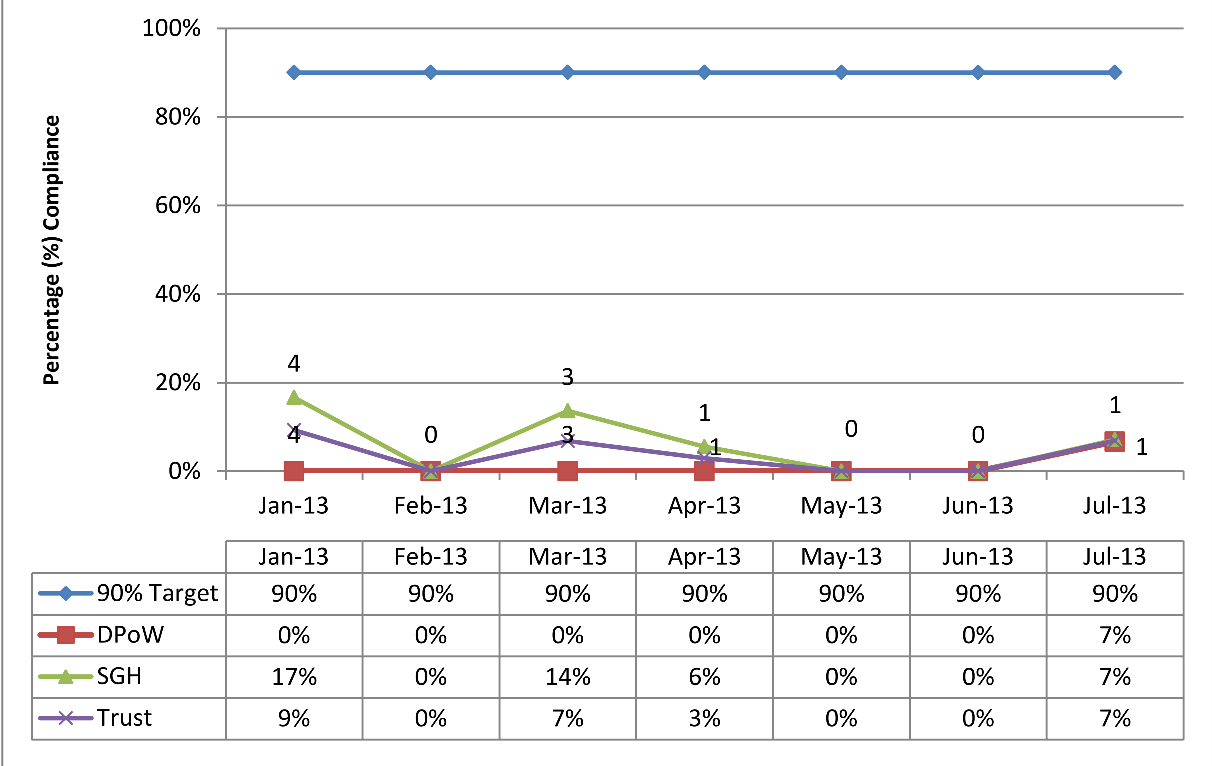
Source: NLAG CQUINS Data, Intranet, Information Services Team

Comment: The above chart illustrates that only a small number of patients were identified as having a clinical diagnosis of delirium or who answered positively to the screening question. Of those patients, the majority, therefore meeting the 90% target, had a diagnostic assessment.

***NB:** The above charts data labels refer the number of patients, not the percentage number of patients. Also, the axis starts at 60%.*

CE3.3 – 90% of the patients identified as requiring referral following risk assessment to be referred in line with local pathway

Following the roll out of the national CQUIN for dementia, it was agreed locally with Rotherham Doncaster & South Humber NHS Foundation Trust in North Lincolnshire and NAVIGO Health & Social Care Community Interest Company in North East Lincolnshire that in patients with a positive diagnostic assessment (6CIT score of 8 or above) or inconclusive should be referred to them for a specialist Mental Health Liaison Team review. The following chart illustrates the number of eligible patients referred to partner organisations.



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13
90% Target	90%	90%	90%	90%	90%	90%	90%
DPoW	0%	0%	0%	0%	0%	0%	7%
SGH	17%	0%	14%	6%	0%	0%	7%
Trust	9%	0%	7%	3%	0%	0%	7%

Following this agreement, both organisations reported an increase in the number of referrals received, however, more recently the number of referrals has fallen, as illustrated above.

On review of the CQUIN data regarding dementia screening, some questions are raised regarding next steps needed to improve the current report position. One action taken by the lead Quality Matron is to ensure that additional training has been organised to further support the rollout of the dementia screening tool. Initially this will be aimed at the joint ward manager's meetings within the Trust. Also to be considered is amending the screening tool to make it clearer in terms of guidance over next steps to be taken.

Another action having been agreed was to undertake some validation of the reported data. This is being undertaken by the Quality Matron in collaboration with the Trust's Information Team assessing a snapshot sample of cases.

An update on this CQUIN in connection with Dementia will be provided in the September Quality Report.

CE4 – Evidence Based Practice

Target – To increase compliance with NICE guidance with 90% compliance achieved by the end of March 2014.

National Institute for Health and Clinical Excellence (NICE)

Guidance Implementation

Since November 2012, NICE Guidance has been managed by the NICE / Quality Administrator and the Risk and Governance Facilitators. Each Clinical Group has a dedicated Risk and Governance Facilitator who support the Clinical Directors in the delivery of the guidance.

A bespoke system through Allocate Software is currently used to administer and log all NICE guidance for the Trust. An excel spread sheet has recently been developed to compliment this system in the monitoring process. The spread sheet monitors closely when a gap analysis is distributed, the deadline for return, the dates for reminders to be sent, and any comments as required. It is hoped that this will help to identify where any delays / issues are occurring. A summary of this will be included within future quality reports. To increase awareness of NICE guidance within the Trust, new guidance issued will be detailed on the intranet.

The Implementation of NICE Guidance Policy for the Trust has recently been revised following the Directorate of Clinical & Quality Assurance formation and has been approved at the last Trust Governance & Assurance Committee. The process for the implementation of new guidance is *summarised* below:

- NICE / Quality Administrator identifies new guidance and lead groups with Medical Director *(monthly)*
- Risk & Governance Facilitators present new guidance to governance group to establish relevance and lead clinician *(within two weeks of guidance being issued)*
- Gap Analysis / baseline assessment is distributed to lead clinicians *(to be returned within six weeks)*
- Returns are monitored and followed up by the NICE / Quality Administrator *(reminder sent after three weeks)*
- NICE database updated accordingly of compliance, action plans monitored via governance groups.

Overall Trust Compliance – NICE Technology Appraisal Guidance (TAGs)

As of the end of July 2013, Trust compliance with those NICE Technology Appraisal Guidelines that had been assessed using the Trust's gap analysis toolkit (TAGs) is as follows:

NICE Compliance Status	Numbers / Percentage (%)
GREEN - Full Compliance	**126/149 (84.5%)**
AMBER - Partial Compliance	5/149 (3.4%)
YELLOW - Non-Compliant, deviation approved by TGC	1/149 (0.7%)
RED - Non-Compliant	0/149 (0%)
BLUE - Not yet assessed – OVERDUE	17/149 (11.4%)

Overall Trust Compliance – All NICE Guidance

As of the end of July 2013, overall Trust compliance is as follows:

NICE Compliance Status	Numbers / Percentage (%)
GREEN - Full Compliance	**227/329 (69%)**
AMBER - Partial Compliance	47/329 (14.3%)
YELLOW - Non-Compliant, deviation approved by TGC	2/329 (0.6%)
RED - Non-Compliant	4/329 (1.2%)
BLUE - Not yet assessed – OVERDUE	49/329 (14.9%)

Difficulties / Issues

The following difficulties / issues have been identified when implementing new guidance within the Trust:

- Lead names to undertake GAP Analysis slow to be identified;
- GAP Analysis returned incomplete / late / not at all;
- Assessing compliance can be a lengthy process as one piece of guidance may be relevant to numerous groups;
- Guidance can be very lengthy and very complex to assess.

A review of all NICE guidance is currently being undertaken and action plans put in place in order to improve the Trusts position. Due to the large volume of guidance that has been issued, an improvement in this position may not be seen for a number of months.

Reporting

Due to the nature of the timescales involved in guidance implementation, it is proposed to update QPEC on a monthly basis of progress against NICE guidance using the monthly Quality Report as the vehicle to inform and assure. In addition to this, the Trust Governance and Assurance Committee receive a comprehensive update on a quarterly basis. As a result of these reporting mechanisms, the Trust is provided assurance that compliance with NICE guidance and specifically NICE Technology Appraisals is being monitored and appropriate action taken as necessary.

4.0 At A Glance

5.0 Clinical Effectiveness

This Section…

➔ 6.0 PATIENT SAFETY

→ PS1 MRSA Bacteremia Incidence

→ PS2 C Difficile

→ PS3 Safety Thermometer (Acute)

→ PS4 Safety Thermometer (Community)

→ PS5 Falls

→ PS6 Pressure Ulcers

7.0 Patient Experience

8.0 Glossary

6.0 PATIENT SAFETY

PS1 – MRSA Bacteraemia Incidence

Target – 0 MRSA Bacteraemias developing after 48 hours into the inpatient stay (hospital acquired).

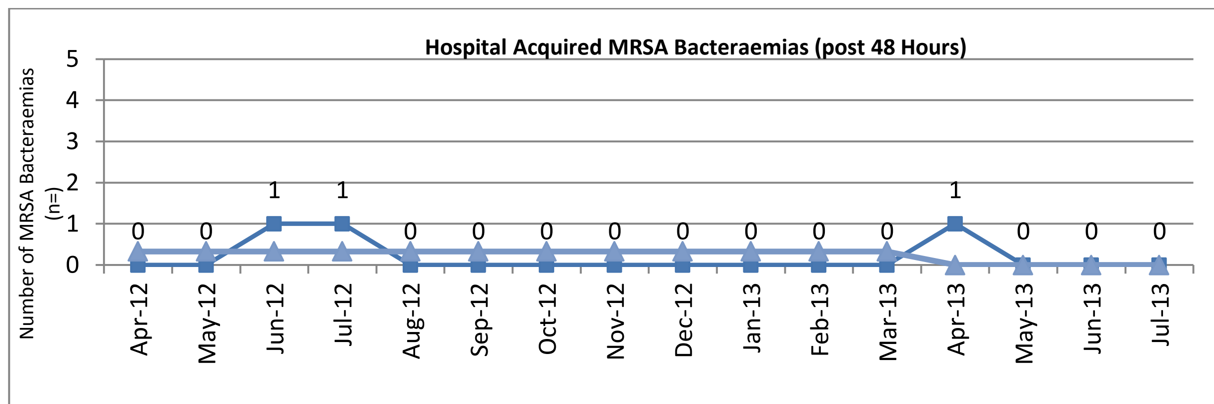
Trust Performance (April 2013 to date): 1 case

- July 2013: **0** cases reported at Diana Princess of Wales Hospital
- July 2013: **0** cases reported at Scunthorpe General Hospital

In 2012/2013 the Trust had **2** cases of hospital acquired MRSA bacteraemia (post 48 hours)

In 2011/2012 the Trust had **4** cases of hospital acquired MRSA bacteraemia (post 48 hours)

In 2010/2011 the Trust had **8** cases of hospital acquired MRSA bacteraemia (post 48 hours)



Source: Trust Infection Control Database, Information Services Team

PS2 – C.Difficile

Target - Achieve a level of no more than 30 hospital acquired C. Difficile cases over the financial year 2013/14.

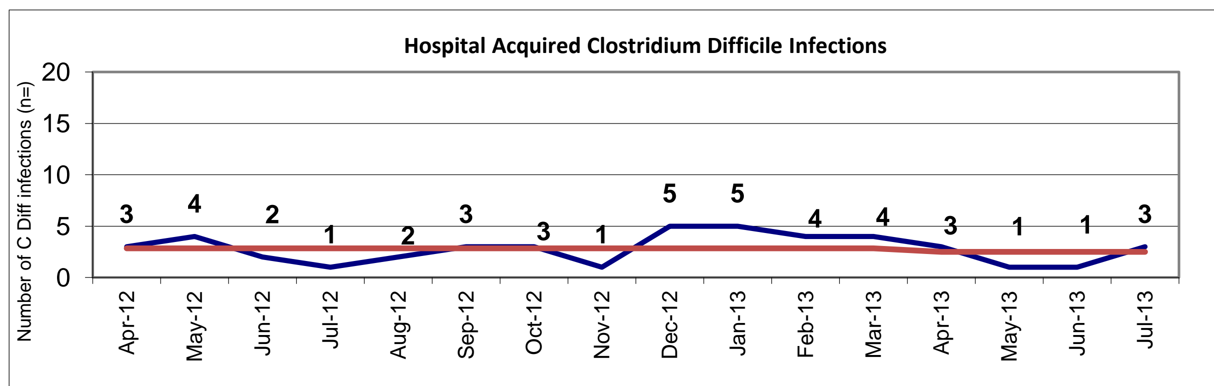
Trust Performance (April 2013 to date): 8 cases

- July 2013: **1** case reported at Diana Princess of Wales Hospital
- July 2013: **2** cases reported at Scunthorpe General Hospital

In 2012/2013 there were **37** cases of hospital acquired Clostridium Difficile Infections.

In 2011/2012 there were **41** cases of hospital acquired Clostridium Difficile Infections.

In 2010/2011 there were **43** cases of hospital acquired Clostridium Difficile Infections.



Source: Trust Infection Control Database, Information Services Team

New for the 2013/14 Quality Report is the analysis of the number of potentially preventable C. Difficile cases. During 2012/13 the Trust exceeded the target set for this area, and the target set for the 2013/14 financial year has been lowered still further to a maximum number of 30 cases. To support the Trust's focussed work around adhering to this quality indicator, the following tables detail the number of C.Difficile cases by site that were not preventable, possibly preventable, and preventable.

This assessment and categorisation is based on the Director for Infection Prevention and Control (DIPC) review of the case and the evidence recorded, from this the preventability of the case is decided. Due to the timescales involved for these DIPC reviews, there will be a delay in reporting the outcomes when compared with the monthly data provided within this report, therefore the numbers below may differ from the total number of cases detailed on the graph on page 16. Where data is unavailable, this will be reported at the earliest opportunity in subsequent quality reports.

DPoW	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Total
No of cases eligible for DIPC review	3	0	0	1	1	3	1	1	5	2	2	1	1	0	1	22
No of DIPC reviews outstanding	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	3
Not Preventable	3	0	0	1	0	2	1	1	2	1	2	0	0	0	0	13
Possibly Preventable	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	2
Preventable	0	0	0	0	1	1	0	0	2	0	0	0	0	0	0	4

Source: Trust Infection Control Database, Information Services Team

SGH	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Total
No of cases eligible for DIPC review	1	2	1	1	2	0	0	4	0	2	2	2	0	1	2	20
No of DIPC reviews outstanding	0	0	0	0	0	0	0	0	0	0	0	1	0	1	2	4
Not Preventable	1	1	0	1	2	0	0	3	0	2	1	1	0	0	0	12
Possibly Preventable	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Preventable	0	0	1	0	0	0	0	1	0	0	1	0	0	0	0	3

Source: Trust Infection Control Database, Information Services Team

NB: It should be noted that the numbers in the above tables show a site specific breakdown of the same information reported on the previous page for C Difficile at Trust level. In some months, i.e. June, only 1 C Difficile was reported, this case was at the Scunthorpe site.

PS3 – Safety Thermometer – Increase in harm free care (Acute)

Target – Provide harm free acute care to 90% or more patients – as measured by the Safety Thermometer

The NHS safety thermometer provides 'a temperature check' on harm resulting to patients receiving care within NHS organisations. It allows organisations to quickly and simply determine rates of patient harm, analyse these in more detail and use the measure to set improvement trajectories. From July 2012, this became a part of the Commissioning for Quality & Innovation (CQUIN) payment programme.

The NHS safety thermometer is used both for acute admissions and also for community care provision in North Lincolnshire Community Services, a part of the Trust.

Most importantly the Safety Thermometer is a national improvement tool allowing us a real opportunity to review the proportion of patients that pass through our services (acute and community) harm free.

The four main harms are:

- Pressure ulcers grades 2,3 & 4
- Falls – all falls reported, even if no harm occurred
- Catheter associated UTIs – those treated with antibiotics
- VTE – risk assessment, prophylaxis and treatment of DVT or PE

The data gained from it is used to drive improvements in patient safety across both the hospitals and the community.

The data is collected electronically within the hospitals at ward level on 1 day each month. A paper system is used to collect data in the community and the data then input on to the electronic system. Ward staff are involved with the data collection and are supported by the Quality Matrons, Information Team and the Quality and Audit department.

The following table illustrates the total acute trust cumulative percentage of harm free care by month since April 2013. The target being aimed for is 90%.

	Cumulative % of Harm Free Care				
Site	**Quarter 4**	**Apr-13**	**May-13**	**Jun-13**	**Jul-13**
DPoW	87%	**85%**	**85%**	**87%**	**83%**
SGH	85%	**90%**	**87%**	**88%**	**86%**
Goole	81%	**87%**	**87%**	**87%**	**100%**
Acute Trust Total	**84%**	**87%**	**86%**	**87%**	**89%**

Source: NLAG Safety Thermometer Data, Intranet, Information Services Team

To enable further action to be taken, the above tables cumulative percentage for the acute Trust has been broken down into the 4 component parts that comprise this indicator:

Pressure ulcers (grades 2, 3 and 4) – both old and new:

	Pressure Ulcers % - Harm Free Care			
Period	Apr-13	May-13	Jun-13	Jul-13
Acute Trust Total	97%	97%	97%	97%

Source: NLAG Safety Thermometer Data, Intranet, Information Services Team

Falls:

	Falls % - Harm Free Care			
Period	Apr-13	May-13	Jun-13	Jul-13
Acute Trust Total	97%	98%	99%	98%

Source: NLAG Safety Thermometer Data, Intranet, Information Services Team

Catheter associated UTIs:

	Catheter associated UTIs % - Harm Free Care			
Period	Apr-13	May-13	Jun-13	Jul-13
Acute Trust Total	98%	96%	94%	98%

Source: NLAG Safety Thermometer Data, Intranet, Information Services Team

VTE:

The VTE indicator is broken down into 3 elements:

1. % of patients identified as having had a risk assessment within the sample assessed during the point prevalence data collection,
2. % of patients at risk of VTE having been commenced on VTE prophylaxis, and
3. % of patients being treated for VTE who developed this following their admission.

VTE: % of patients having a risk assessment

	VTE - % of patients having a risk assessment			
Period	Apr-13	May-13	Jun-13	Jul-13
Acute Trust Total	95%	95%	93%	95%

Source: NLAG Safety Thermometer Data, Intranet, Information Services Team

VTE: % of patients at risk of VTE having been commenced on VTE prophylaxis

	VTE - % of patients at risk commenced on prophylaxis			
Period	Apr-13	May-13	Jun-13	Jul-13
Acute Trust Total	74%	81%	78%	74%

Source: NLAG Safety Thermometer Data, Intranet, Information Services Team

A working group consisting of the Medical Director and representatives from Nursing and Operations Directorate will look into this and determine where improvements are needed.

VTE: % of patients being treated for VTE who developed this following their admission

	VTE - % of patients with 'new' VTE			
Period	Apr-13	May-13	Jun-13	Jul-13
Acute Trust Total	5%	8%	4%	3%

Source: NLAG Safety Thermometer Data, Intranet, Information Services Team

PS4 – Safety Thermometer – Increase in harm free care (Community)

Target – Provide harm free community care to 95% or more patients – as measured by the Safety Thermometer

The following table illustrates the cumulative percentage of harm free care within Community & Therapy Services provided by the Trust in North Lincolnshire since April 2013.

	Cumulative % of Harm Free Care				
Site	Quarter 4	Apr-13	May-13	Jun-13	Jul-13
Community Care Total	92%	93%	93%	92%	91%

Source: NLAG Safety Thermometer Data, Intranet, Information Services Team

Pressure ulcers (grades 2, 3 and 4) – both old and new:

	Pressure Ulcers % - Harm Free Care			
Period	Apr-13	May-13	Jun-13	Jul-13
Community Care Total	98%	97%	98%	96%

Source: NLAG Safety Thermometer Data, Intranet, Information Services Team

Falls:

	Falls % - Harm Free Care			
Period	Apr-13	May-13	Jun-13	Jul-13
Community Care Total	99%	100%	99%	98%

Source: NLAG Safety Thermometer Data, Intranet, Information Services Team

Catheter associated UTIs:

	Catheter associated UTIs % - Harm free Care			
Period	Apr-13	May-13	Jun-13	Jul-13
Community Care Total	99%	100%	99%	99%

Source: NLAG Safety Thermometer Data, Intranet, Information Services Team

VTE – risk assessment, prophylaxis if at risk and percentage of 'new' VTEs:

As outlined in the acute Trust safety thermometer section, the VTE indicator is divided into 3 elements. These elements, due to the differences between the acute and community service, are not applicable to community services. For example, in community patients are not routinely risk assessed for VTE, any concerns regarding a patient in this matter would be referred to the patient's GP or to the acute Trust via A&E attendance. In the same way, prophylaxis, unless prescribed by a doctor, would not routinely be commenced by community staff. Due to these differences, the individual elements of this indicator have been classed as not applicable to the community care safety thermometer results. Based on these factors, the

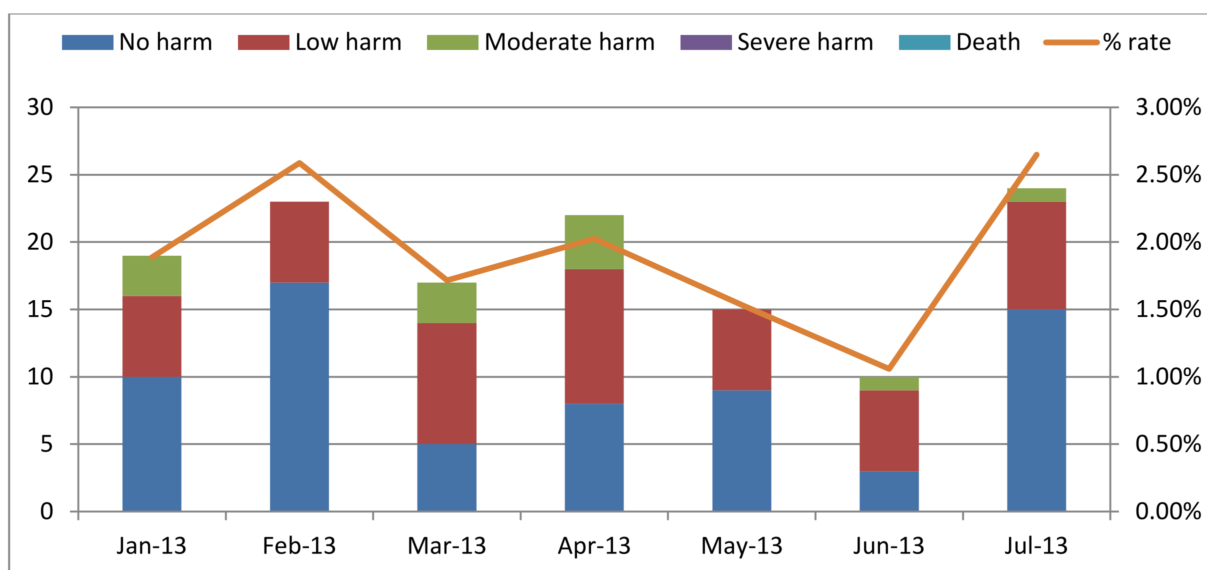
data providing the community cumulative percentage of harm free care is under review to ensure that indicators that are not applicable are duly recorded this way.

PS5 – Patient Falls – a 50% reduction in avoidable repeat falls (as measured via the Root Cause Analysis undertaken for every repeat faller)

Context – Incidence of patient falls and harm resulting

One of the elements of the NHS Safety Thermometer is patient falls. The indicator breaks down degrees of harm resulting from a patient falling within the Trust. Using this information, the Trust is able to discern both the rate of patient falls including trends over time, whilst also being able to determine if the work being undertaken to reduce falls and repeat falls is making a difference to the degrees of harm resulting.

To reflect this information, the following chart has been compiled. This is based on the style of reporting used within the Keogh data pack.



Source: NLAG Safety Thermometer Data, Intranet, Information Services Team

Comment: The above chart illustrates that the level of falls has been steadily reducing since January 2013, from 1.89% to 1.53% in June 2013. However, an increase to 2.65% can be seen for July 2013. This percentage is calculated by comparing the number of patients identified as having fallen with the total number of patients audited each month as part of the NHS safety thermometer methodology.

Also noticeable is the lack of serious harm resulting from those patients who fell within the organisation.

Repeat Fallers – RCA Outcomes – 50% reduction in avoidable falls

Falls has been an area of focus for some time within the Trust. The Lead Quality Matron for falls is supporting proactive work to prevent falls occurring within the acute Trust. To achieve this, for every repeat fall a Root Cause Analysis (RCA) is performed to identify lessons that can be learnt to prevent future patients falling. As part of the RCA work undertaken, each fall is determined to have been either avoidable or unavoidable.

Based on Q4 performance, an average of 6 avoidable repeat fallers were identified per month. Based on this, a planned 50% reduction equates to a target of no more than 3 avoidable falls per month, commencing April 2013. The following table provides a summary of performance per month against this target.

	Jan	Feb	Mar	Apr	May	Jun
Number of Repeat Fallers	24	19	30	20	20	25
Avoidable	6	4	9	5	5	4
	25%	21%	30%	25%	25%	16%
Unavoidable	18	15	21	15	15	21
	75%	79%	70%	75%	75%	84%

Data Source: RCA Records kept by lead Quality Matron

Comment: This table illustrates that the target of no more than 3 avoidable repeat falls per month is not currently being met, however, a positive reduction can be seen. 16% of all repeat falls during June were considered to be avoidable. These and the learning available from these, become the focus of the Quality Matron with the lead for falls. Ward specific learning points and interventions are determined with ward staff. Themes and trends identified from the RCA work informs the Trust Wide Falls action plan.

PS6 – Pressure Ulcers – a 50% reduction in avoidable grade 3 & 4 pressure ulcers (as measured via the Root Cause Analysis undertaken for every grade 3 & 4 pressure ulcer)

Context – Incidence of pressure ulcers and grade resulting

Another element of the NHS safety thermometer is pressure ulcers. This indicator is broken down into two categories:

- ‘Old’ pressure ulcers i.e. those developed within 72 hours of admission to the Trust and,

- ‘New’ pressure ulcers i.e. developed 72 hours or more after the patient was admitted.

To provide further clarity on the above definitions, the Health and Social Care Information Centre list a useful definition of what constitutes an ‘old’ or ‘new’ pressure ulcer for the purpose of data collection:

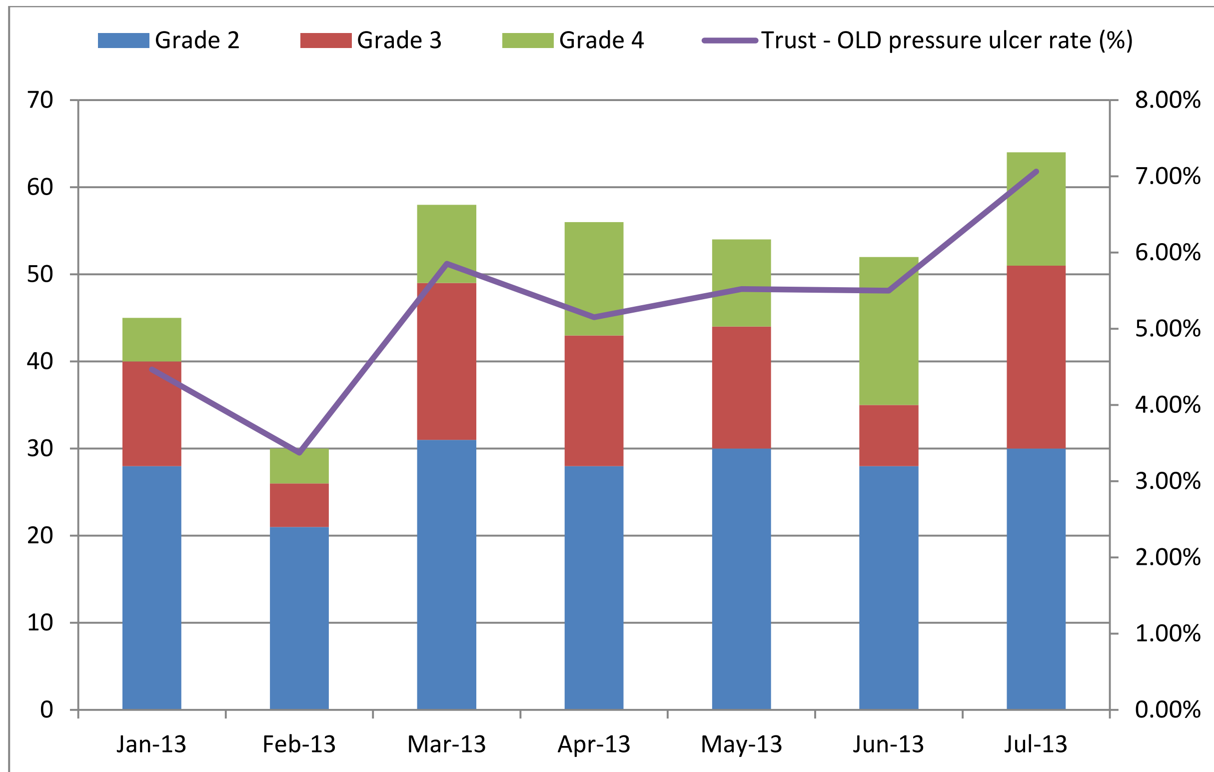
> *“An 'old' pressure ulcer is defined as being a pressure ulcer that was present when the patient came under your care, or developed within 72 hours of admission to your organisation.*
>
> *A 'new' pressure ulcer is defined as being a pressure ulcer that developed 72 hours or more after the patient was admitted to your organisation. To collect the data, you should examine the patient for any skin damage and ask them about any skin damage they have experienced as well as consulting their notes or handover documents.”*

Therefore, based on both definitions, a ‘new’ pressure ulcer which developed 72 hours or more following admission can with some degree of accuracy be defined as a hospital acquired pressure ulcer. An ‘old’ pressure ulcer developing within 72 hours could not be categorised as a community acquired pressure ulcer, as this could also be hospital acquired. The root cause analysis work, outlined later on in this section, concentrates in more detail on this distinction between hospital and community acquired.

The NHS safety thermometer data allows the Trust to examine both the rate of pressure ulcers and the grade of ulcer.

To reflect this information, the following chart has been compiled. This is based on the style of reporting used within the Keogh data pack.

'Old' (developed within 72 hours of admission) pressure ulcer incidence and grade resulting

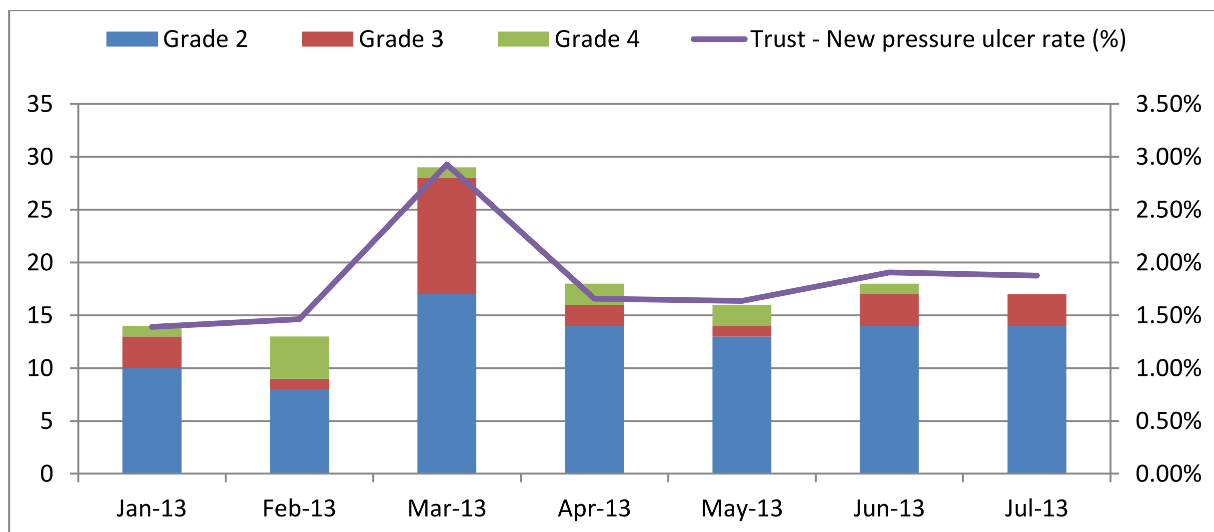


Data Source: NLAG Safety Thermometer Data, Intranet, Information Services Team

Comment: The above chart illustrates that the rate of 'old' pressure ulcers remained constant between March 2013 and June 2013, however in July 2013, an increase can be seen.

The following data reports the incidence of 'new' pressure ulcers, those developed 72 hours or more following the patient's admission.

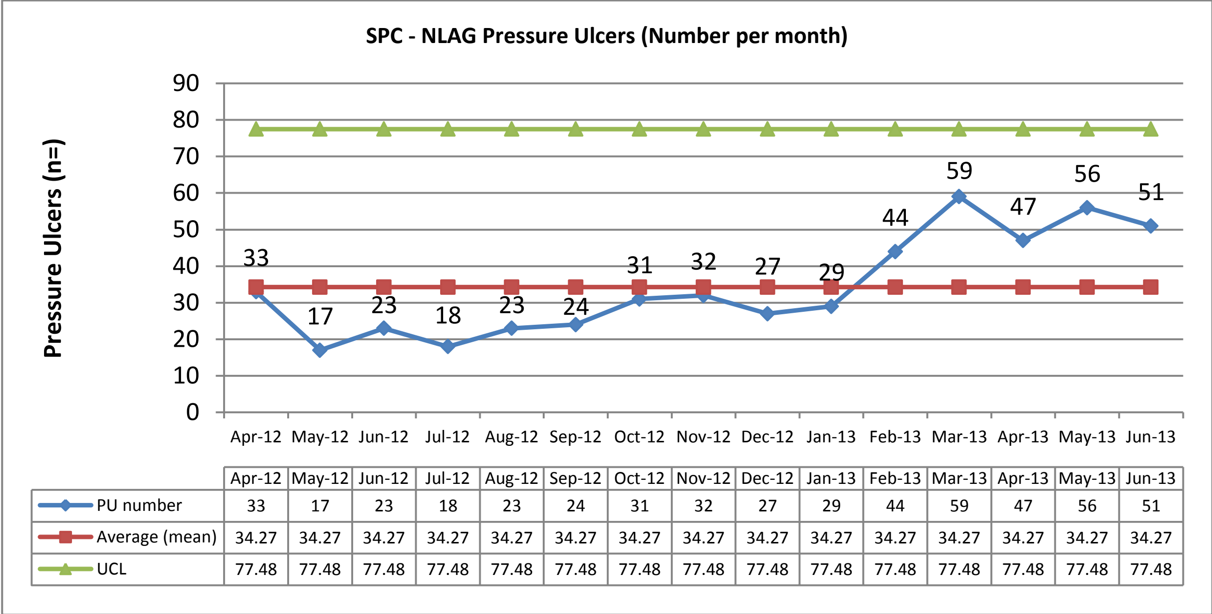
'New' (developed 72 hours or more following admission) pressure ulcer incidence and grade resulting



Data Source: NLAG Safety Thermometer Data, Intranet, Information Services Team

Comment: The above chart illustrates that the rate of 'new' pressure ulcers has remained constant over the last 4 months and also demonstrates encouraging levels of reduction in grades 3 and 4 pressure ulcer.

Context – Pressure Ulcers per month (Grade 2-4 pressure ulcers)



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
PU number	33	17	23	18	23	24	31	32	27	29	44	59	47	56	51
Average (mean)	34.27	34.27	34.27	34.27	34.27	34.27	34.27	34.27	34.27	34.27	34.27	34.27	34.27	34.27	34.27
UCL	77.48	77.48	77.48	77.48	77.48	77.48	77.48	77.48	77.48	77.48	77.48	77.48	77.48	77.48	77.48

Data Source: April 2012 – January 2013: Information Services Team, Intranet collated data,
February 2013 onwards: DATIX, Clinical & Quality Assurance Team

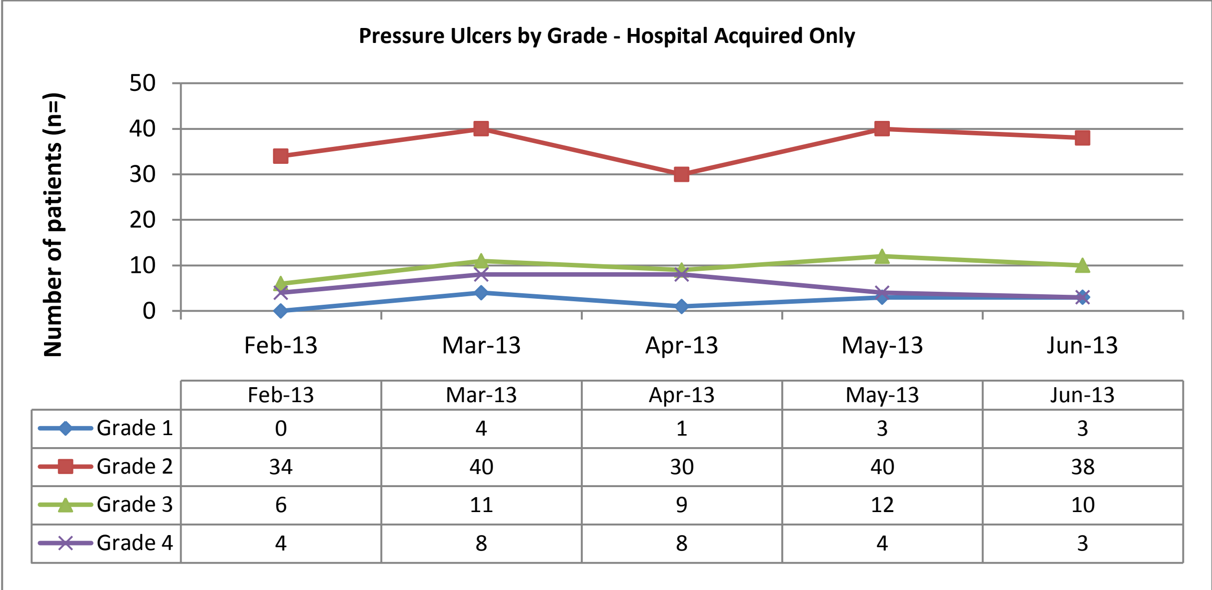
The reporting mechanisms for pressure ulcers have been reviewed and as a result all pressure ulcers information is now collated in one place – the DATIX Incident Reporting System. This centralised data was reported for the first time in February 2013. The move to this data source enables the lead quality matron to oversee the numbers of hospital acquired pressure ulcers on an on-going basis, due to DATIX being accessible throughout the Trust via a web link and take appropriate action.

The move to reporting and monitoring this area from one source, DATIX, has resulted in a higher than previously reported incidence of hospital acquired pressure ulcers. From a review of this most recent data and previously reported positions it appears that these inconsistencies may have been a result of previously under reporting hospital acquired pressure ulcers. As a result of this work on the data from DATIX and the monitoring processes that have now been established, the Trust is confident that the figure as reported in DATIX is the correct one allowing for proactive work to be undertaken in an attempt to improve the reported position in future months.

Additional benefits to the Trust from centralising the data source used for pressure ulcer monitoring and reporting is to focus on reducing the number of avoidable pressure ulcers. This is being accomplished in two ways. Firstly as a result of the pressure ulcers now being systematically reported via DATIX, this provides the Tissue Viability Nurses (TVNs) with timely notifications of patients with a pressure ulcer, this therefore speeds up the TVNs review of such a patients' skin integrity to within 12 hours of the pressure ulcer being reported ensuring the patient receives expert assessment much quicker than in the past. This also allows for a more robust judgement to be made in determining whether the pressure ulcer is hospital or community acquired. Secondly, at present the distinction between avoidable and un-avoidable pressure ulcers is being made as a result of the root cause analysis work for grade 3 and 4 pressure ulcers only. This is only the first step, with plans being made to assess all hospital acquired pressure ulcers and determine if they were avoidable or not. In future once the process for grades 3 and 4 ulcers is sustained, this will be replicated for grade 2. At that point, the reporting within the monthly quality report will

focus on those pressure ulcers considered to be avoidable and an improvement trajectory will be used to measure this area on an on-going basis.

Context – hospital acquired pressure ulcers by grade (grades 1–4)



	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Grade 1	0	4	1	3	3
Grade 2	34	40	30	40	38
Grade 3	6	11	9	12	10
Grade 4	4	8	8	4	3

Source: DATIX, Clinical & Quality Assurance Team

The above chart indicates all hospital acquired pressure ulcers according to the grade recorded. Due to the aforementioned changes in systems used to monitor the incidence of pressure ulcers, this information is only available from February 2013, when this information was centralised on the DATIX system.

Avoidable grade 3 and 4 hospital acquired pressure ulcers – RCA outcomes – 50% reduction in avoidable grade 3 and 4 pressure ulcers

The Trust has actively been focussed on reducing hospital acquired pressure ulcers. The following table focusses on the number of potentially avoidable grade 3 and 4 pressure ulcers with a view to refocusing all the hospital acquired pressure ulcer data within this report to be presented in this format. At present data for other grades is not yet available but this is planned for the future.

The information below is taken from records kept by the lead Quality Matron as a result of the RCA work taking place for patients with grades 3 & 4 pressure ulcers. This data is made available through close collaboration between the lead Quality Matron and the Tissue Viability Team.

Based on Q4 performance, an average of 4 avoidable grade 3 and 4 pressure ulcers per month were identified. Therefore, a 50% reduction equates to a target of no more than 2 avoidable grade 3 and 4 pressure ulcers per month, commencing April 2013.

	Jan	Feb	Mar	Apr	May	June
Number of Grade 3 & 4 Pressure Ulcers	12	13	16	10	13	11
Avoidable	3	3	5	3	3	2
	25%	23%	31%	30%	23%	18%
Unavoidable	9	10	11	7	10	9
	75%	77%	69%	70%	77%	82%

Source: RCA Records kept by lead Quality Matron

Comment: The above table illustrates that in June, this target was reached with only 2 pressure ulcers being considered as avoidable.

4.0 At A Glance

5.0 Clinical Effectiveness

6.0 Patient Safety

This Section…

➔ 7.0 PATIENT EXPERIENCE

→ PE1 Friends & Family Test

→ PE2 Complaints (re-opened)

→ PE3 Complaints (action plans)

→ PE4 Complaints (reduction)

→ PE5 Nursing Care Indicator

→ PE6 Staff Satisfaction

8.0 Glossary

7.0 PATIENT EXPERIENCE

PE1 – Friends and Family Test

Target – To have a response rate that achieves a response rate in the top 50% which also improves on the Quarter 1 response rate.

The Trust introduced the new friends and family test in April, when it was launched across the country. Within 48 hours of receiving care or treatment as an inpatient or visitor to A&E, patients are given the opportunity to answer the following question:

> ***"How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?"***

Service users are then asked to answer how likely or unlikely along a six-point scale they would answer the above question. There is also an opportunity to elaborate on the reasons for their answer and all feedback will be encouraged whether positive or negative.

Service users are asked to respond to the question on a postcard on discharge from hospital which they can place it in a box on the ward, or take it home and post it back to the freepost address provided.

The results are designed to give patients an easy to understand evaluation of their local hospitals and help them make decisions about their care.

The 'net promoter score' can range from -100 to +100. The overall scores for the Trust are as follows for the period April to June, Quarter 1:

- April: A&E +57; inpatients +81
- May: A&E +72; inpatients +74
- June: A&E +38; inpatients +74
- Quarter 1 averages: A&E +56; inpatients +77

When compared to the England average the Trust outperformed for April and May and equalled the England average in June.

Whilst the above feedback from service users was very positive, this target measures the response rate for quarter 1 patient and service user feedback. When comparing the Trust to the national landscape, the following table illustrates for quarter 1, the response rate compared to that of other NHS providers.

	A&E		In-patient	
	NLAG Trust position	Number of participating Trusts	NLAG Trust position	Number of participating Trusts
Apr-13	127	144	140	167
May-13	127	144	163	169
Jun-13	134	133	162	170
Position (Average)	**129**	**140**	**155**	**169**
Placement	Bottom 50%		Bottom 50%	

Source: NHS Choices

Patient Experience

The above table illustrates that for quarter 1, the Trust is not yet meeting the quality indicator set for this area and currently places in the lower half of all NHS organisations in both the A&E and inpatient indicators.

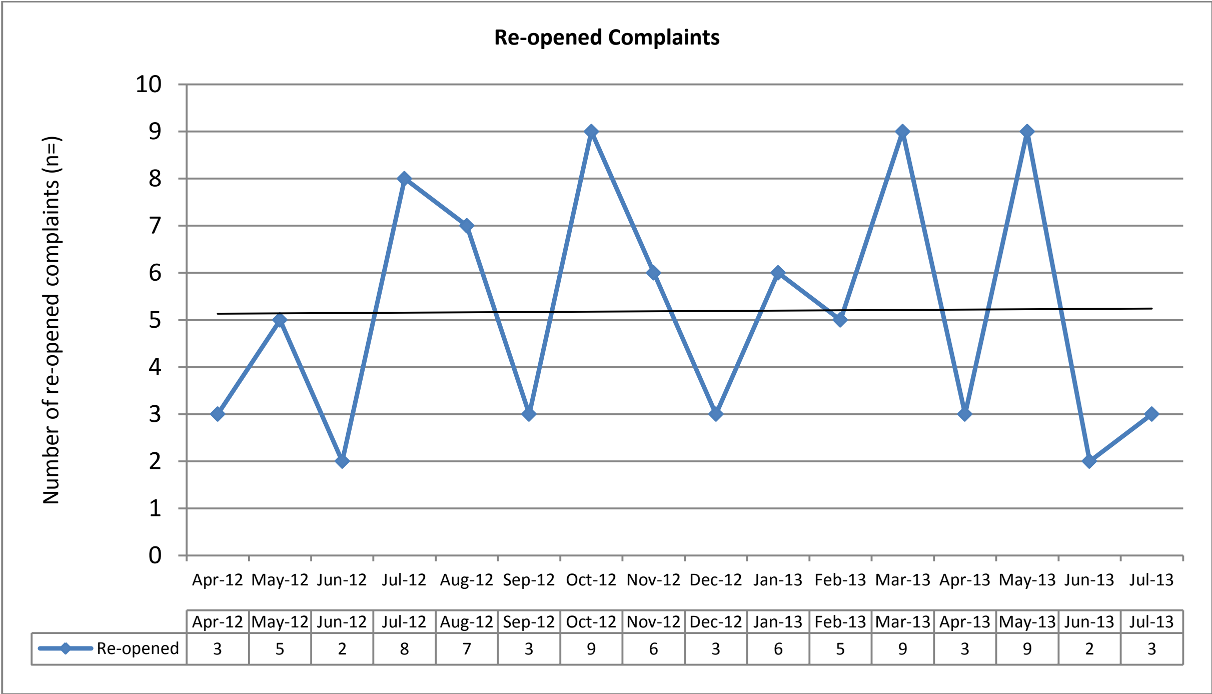
The percentage of eligible patients who responded to the friends and family test for the Trust is outlined as follows:

	April	May	June	July	August
A&E	0.9%	1.2%	1.5%	1.1%	0.8%
Inpatients	11.8%	7.7%	9.9%	8.7%	9.6%

All wards and A & E have been asked to further promote the family and friends cards. As a trust we are also exploring using other methods of data collection to compliment the postcards and increase our response rate. The feasibility of using on line surveys, automated telephone calls, and SMS are options being looked in to. A proposal is being drawn up for consideration and funding.

PE2 – Complaints

Target – A reduction in the number of re-opened complaints – target still to be set



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13
Re-opened	3	5	2	8	7	3	9	6	3	6	5	9	3	9	2	3

Data Source: DATIX, Clinical & Quality Assurance Team

Comment: The above chart illustrates the increasing trend (see trend line) of re-opened complaints during 2012/13. In future reports an improvement target will be set based on previous performance in this area.

As complaints is a key issue being focussed on by the Trust, careful consideration has been given to setting an improvement target for the number of re-opened complaints. The number of re-opened complaints can be used as a proxy measure of the wider complaints handling and response procedures within an organisation. Due to this, the Trust's Complaints Manager is working with peer NHS organisations to determine the systems they operate with regard to this important area with a view to embedding any components that would improve the quality of the complaints handling procedure across the organisation. As part of this work,

peer comparators will be consulted as to the trend of re-opened complaints they have. Based on this peer feedback and our own trends in this area, an improvement trajectory will be submitted for approval within the September Quality Report.

PE3 – Complaints

Target – 90% of action plans following a complaint to be implemented within agreed timescales.

This is a new indicator for 2013/14. To ensure this can be accurately monitored during the year, an extra field has been added to the DATIX system to enable this to be monitored in a time efficient manner for all complaints in the system from the 1st April 2013.

The policy for the operational management of this area states that where remedial action is identified, an action plan, which records timescales and responsibilities, will be prepared by the relevant Operational Group on the closure of a concern or no later than 3 months after closure of the complaint and will be monitored regularly by the Operational Group until fully implemented. Whilst this is not a new requirement, the electronic recording of completed actions on DATIX has not been consistent. Now that 3 months have elapsed, the following is the first data available with which to monitor this target.

Period	Number of complaints which required an action plan	Number of action plans completed		Target
		n=	%	
April 2013	19	10	**53%**	90%
May 2013	21	3	**14%**	90%

Data Source: DATIX, Clinical & Quality Assurance Team

Key to aid interpretation of the above information:

Number of complaints which required an action plan:

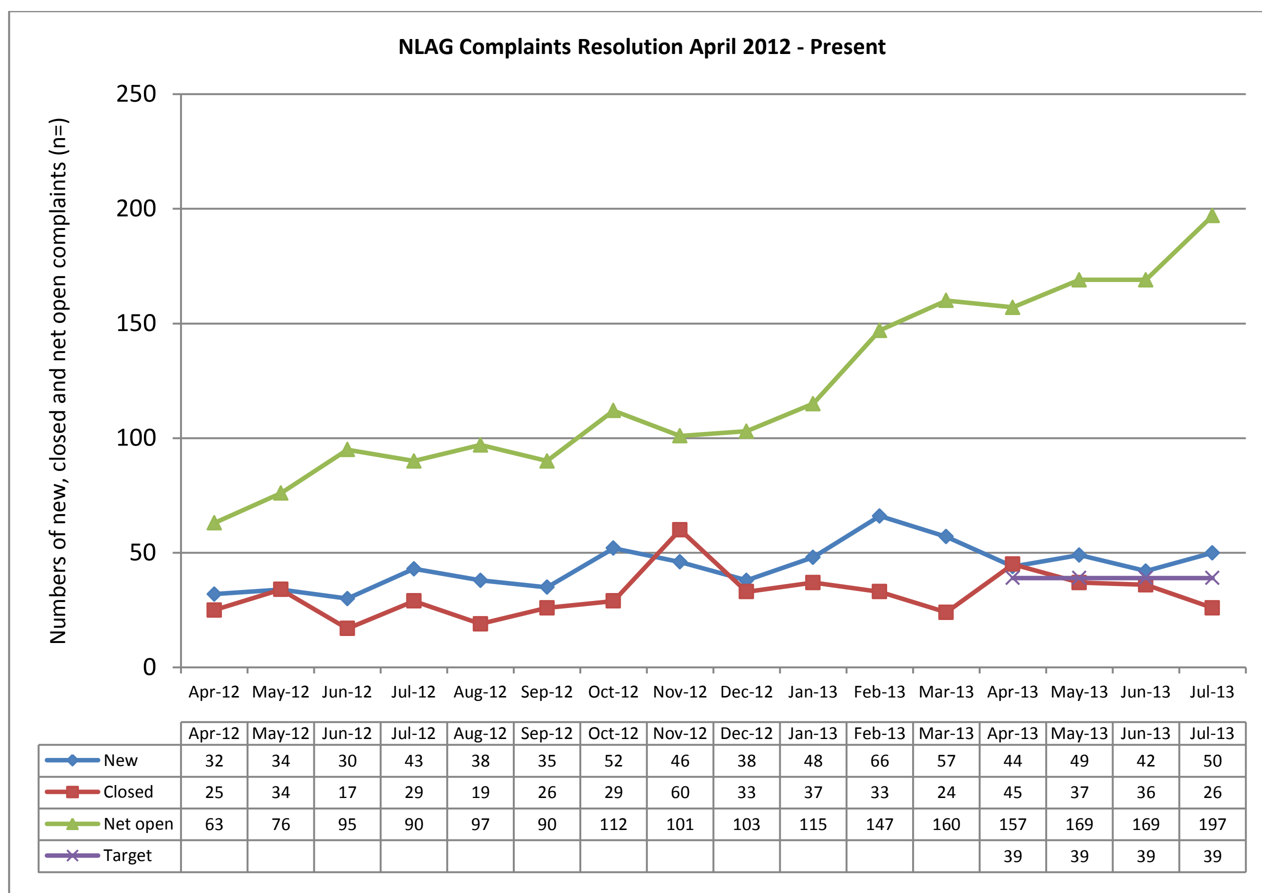
As the nature of each complaint are very different, most complaints that are upheld (or in other words justified on review of the individual circumstances involved in the case) require an action plan, in some cases those not upheld also require action. Due to the different circumstances in the case of each complaint/complainant, the DATIX system is used to record in each circumstance which complaints require action and which don't.

Action being taken to meet 90% target

Over the last few months, as illustrated by the next section – PE4 Complaints, the number of net open complaints has been steadily on the increase. Whilst additional resource has now been made available to reduce this backlog, the focus has been on responding to the complaint, which has resulted in a number of action plans not being formally agreed within the timescales aimed for. It is planned that the additional resource in this area will support this target being met in future months. All staff working in this area are aware of the importance of this issue and that this is now monitored within the monthly quality report. This requirement has been reinforced with both the central and operational teams.

PE4 – Complaints

Target – To achieve a 10% reduction in the number of complaints received by the Trust by the end of March 2014



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13
New	32	34	30	43	38	35	52	46	38	48	66	57	44	49	42	50
Closed	25	34	17	29	19	26	29	60	33	37	33	24	45	37	36	26
Net open	63	76	95	90	97	90	112	101	103	115	147	160	157	169	169	197
Target													39	39	39	39

Data Source: DATIX, Clinical & Quality Assurance Team

Comment: The above chart illustrates the number of new complaints received by the Trust. For 2012/13 the total number of complaints received was 519, the monthly average being 43.25. Therefore, a 10% reduction in this would be 4.32, making a new monthly target for 2013/14 of 39 new complaints received by the Trust per month.

- During June 2013, the actual number of new complaints received was 42, only 3 above the target of 39 being aimed for. However, in July, the number of new complaints received increased to 50.

PE5 – Nursing Care Indicator

Target – For the Overall Nursing Care Indicator to be 95%

Nursing and Midwifery is fundamental to high quality healthcare. High Quality Care for All, the final report of the NHS Next Stage Review, brings the nursing contribution to the fore, the resulting commitment to measure the compassion, safety and effectiveness of nursing care provides a challenge and an opportunity for the profession.

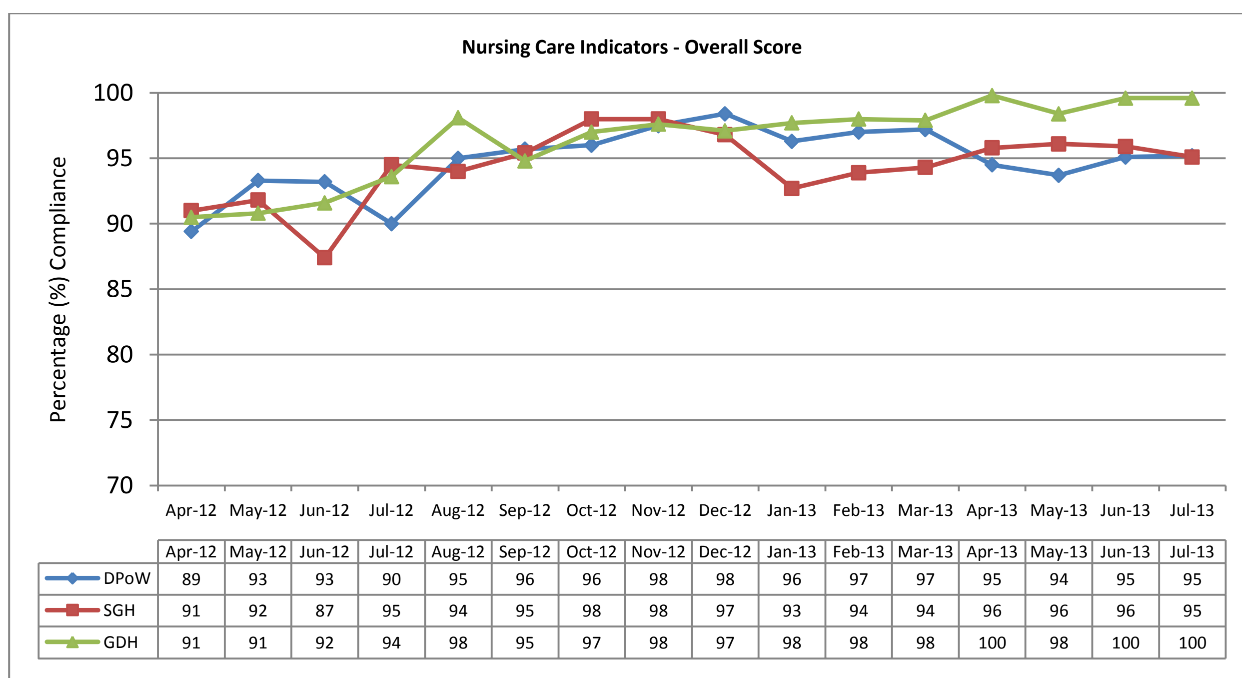
The Trust is already using a large number of indicators and there is a wealth of information available.

Feedback on performance that is based on important measures of nursing can improve nursing care quality by providing frontline staff with information on trends, emerging problems and successes. Such metrics and indicators can empower the public to choose between care options which matter to them as much as it matters to the nursing and midwifery profession.

The Nursing Dashboard will allow us to:

- Refresh the current set of nursing indicators (ward standards/ward dashboards) to ensure they reflect current evidence regarding valid indicators
- Collect data on a more regular basis so that it is live
- Ensure that that data is actively used to drive performance improvement rather than being just 'monitoring'.
- Ensure that the metrics feed into the Board quality reports/accounts to assure the Board (and our commissioners) of the quality of nursing care

The Nursing Dashboard will ensure the nursing contribution will be visible and measurable at all levels from ward to Board. The Matrons will be responsible for providing the information for the dashboard on a monthly basis.



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13
DPoW	89	93	93	90	95	96	96	98	98	96	97	97	95	94	95	95
SGH	91	92	87	95	94	95	98	98	97	93	94	94	96	96	96	95
GDH	91	91	92	94	98	95	97	98	97	98	98	98	100	98	100	100

Source: Information Services, Nursing Dashboard

***NB** Please note the graph axis starts at 70%.*

PE6 – Staff Satisfaction: Culture change and the Morale Barometer

Culture Change – Vision & Values launch plan

The Vision & Values was formally endorsed and committed to by the Trust Board on 26 March 2013.

Since then work to launch plan and operational processes to embed the V&V are being worked up. This work is nearing completion and includes:

- Behavioural indicators
- The review of committees and forums to support the V&V Group
- Review of operational policies and processes
- Employer brand development

Behavioural indicators

April/May 2013 saw the development of the V&V supporting behavioural indicators which are aligned to each of the value statements. The behavioural indicators build on the culture plan, strategic priorities and national priorities such as the Francis recommendations. The behavioural indicators were endorsed by the Trust Board in June 2013.

Reporting Committees

A new Vision & Values Group will be formed and will report directly into QPEC. The purpose of the V&V Group (subject to ratification) are:

1. To ensure that the Trust has a co-ordinated and effective approach to understanding the content and delivery of services against the agreed Vision and Values (V&V) statement.
2. To ensure that appropriate actions are taken to embed the V&V and its associated behavioural indicators, leadership style and quality, safety and innovation drivers into all Trust activities.
3. To identifying areas where V&V can support quality and safety improvements, opportunities to improve patient experiences, and to stimulate increased workforce motivation, performance and satisfaction.
4. To ensure that delivery of services through the V&V activity supports the strategy and operation plans of the Trust and the Trust's Patient Experience Strategy and Quality Strategy.

To support the V&V Group staff will be invited to become 'Value Champions'. Value Champions will provide the critical link between the V&V Group and their respective directorates, and will get involved in the development and activities of the V&V Group. The revised QPEC and draft V&V Group terms of reference will shortly be consulted upon.

Review of operational policies and processes

To embed the V&V a review of the following processes has commenced:

1. **Appraisal process** – to consider how the V&V behavioural indicators can be reviewed and established as part of the ADR/PDP planning process
2. **Recruitment** – to consider how the desired leadership style can be incorporated into the selection process for new managers, 'patient first' can be incorporated in HCA/nursing recruitment etc
3. **Director Visits** – to review how the V&V/culture plan/behavioural indicators are impacting on operational activities, staff morale, staff engagement and quality improvement etc
4. **Ward Review Audits** – to review how the V&V/behavioural indicators are impacting on the patient experience, staff morale etc

8.0 Glossary

Glossary

Benchmark Peer Group: Calderdale and Huddersfield NHS Foundation Trust, Chesterfield & North Derbyshire Royal Hospital NHS Trust, Countess of Chester NHS Foundation Trust, County Durham and Darlington NHS Foundation Trust, Doncaster and Bassetlaw Hospitals NHS Trust, North Cumbria University Hospitals NHS Trust, North Tees & Hartlepool NHS Trust, Rotherham NHS Foundation Trust, Royal Bolton Hospital NHS Foundation Trust, The Pennine Acute Hospitals NHS Trust, University Hospitals of Morecambe Bay NHS Trust

Cardiac bundle: The new bundle is comprised of the following HRG4 subchapters:

Procedures: Catheter 19 years and over, Pace 1 - Single chamber or Implantable Diagnostic Device, Pace 2 - Dual Chamber, Percutaneous Coronary Intervention (0-2 Stents), Complex Echocardiogram (include Congenital Transoesophageal and Fetal Echocardiography), Simple Echocardiogram, Electrocardiogram Monitoring and stress testing, Percutaneous Coronary Intervention (0-2 stents) and Catheterisation, Minor Cardiac Procedures, Other Non-Complex Cardiac Surgery + Catheterisation, Pace 1 - Single chamber or Implantable Diagnostic Device and other (Catheterisation; EP; Ablation; Percutaneous Coronary Intervention), Congenital Interventions: Other including Septostomy Embolisations Non-coronary Stents and Energy Moderated Perforation, Pacemaker Procedure without Generator Implant (includes resiting and removal of cardiac pacemaker system), Percutaneous Coronary Interventions with 3 or more Stents, Implantation of Cardioverter - Defibrillator only, Percutaneous Coronary Interventions with 3 or more Stents and Catheterisation, and Intermediate Congenital Surgery.

Cardiac Disorders: Non interventional acquired cardiac conditions 19 years and over, Arrhythmia or Conduction Disorders without CC, Syncope or Collapse without CC, Actual or Suspected Myocardial Infarction, Heart Failure or Shock without CC, Deep Vein Thrombosis, Syncope or Collapse with CC, Heart Failure or Shock with CC, Hypertension without CC, Arrhythmia or Conduction Disorders with CC, Cardiac Valve Disorders, Hypertension with CC, Endocarditis, Cardiac Arrest, and Non-Interventional Congenital Cardiac Conditions.

Commissioning for Quality & Innovation Framework (CQUIN): The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. Since the first year of the CQUIN framework (2009/10), many CQUIN schemes have been developed and agreed. This is a developmental process for everyone and you are encouraged to share your schemes (and any supporting information on the process you used) to meet the requirement for transparency and support improvement in schemes over time.

Common Cause Variation: an inherent part of the process, stable and "in control". We can make predictions about the future behaviour of the process within limits. *When a system is stable, displaying only common cause variation, only a change in the system will have an impact.*

Complaints: The NHS Complaints Regulations (England) 2009 require that an offer to discuss the complaint with the complainant is made on receipt of all complaints; the discussion to include the response period (the period within which the investigation is likely to be completed and when the response is likely to be sent to the complainant). The requirement is to investigate the complaint in an appropriate manner, to resolve it speedily and efficiently and to keep the complainant informed as to progress. The response should be within 6 months or a longer period if agreed with the complainant before the expiry of that period.

The Complaints Regulations permit extensions to the agreed timescale where this becomes necessary and in agreement with the complainant. The Trust (as outlined within the Policy for the Management of Complaints) expects that any delay to the agreed response time is communicated to the complainant, the reasons explained and an extension agreed.

In respect of monitoring, the Regulations require (amongst other points) that the Trust maintain a record of the response periods and any amendment of that period and whether the response was sent to the complainant within the period or any amendment of that period.

KEY DEFINITIONS TO INTERPRET COMPLAINTS DATA:

- **NEW:** The number of new complaints received in a month regardless of whether or not they were resolved within that month.
- **CLOSED:** The number of complaints that were resolved within a month regardless of whether they were received within the month or resolved within agreed timescale.
- **NET OPEN:** The total number of complaints currently open; includes new, unresolved from previous month(s) and complaints open 'on hold'.
- **RE-OPENED:** Complaints that have been resolved which for any number of reasons require further review.

Control Limits: indicate the range of plausible variation within a process. They provide an additional tool for detecting special cause variation. A stable process will operate within the range set by the upper and lower control limits which are determined mathematically (3 standard deviations above and below the mean).

The upper control limit is displayed in blue throughout this report. The lower control limit is displayed in teal throughout this report.

Crude Mortality Rate: The crude mortality rate is based on actual numbers. Unlike the HSMR which features adjustment based on population demographics and related mortality expectations.

The local benchmarking rate for crude mortality is adjusted quarterly. The latest adjustment reflects January 2010 data.

Fall: A sudden, unintended, uncontrolled downward displacement of a patient's body to the ground or other object. This includes situations where a patient falls while being assisted by another person, but excludes falls resulting from a purposeful action or violent blow.

Unpreventable Fall: Impossible to avoid the fall(s) from happening. Recognizes that some of these events are not always avoidable, given the complexity of healthcare; therefore, the presence of an event on the list is not evidence of a systems failure or a lack of due care.

Preventable Fall: The fall(s) could have been avoided. Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure.

Harm:

- **Catastrophic harm:** Any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care.
- **Severe harm:** Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.
- **Moderate harm:** Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care. Locally defined as extending stay or care requirements by more than 15 days; Short-term harm requiring further treatment or procedure extending stay or care requirements by 8 - 15 days
- **Low harm:** Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care.Locally defined as requiring observation or minor treatment, with an extended stay or care requirement ranging from 1 – 7 days
- **None/ 'Near Miss' (Harm):** No obvious harm/injury, Minimal impact/no service disruption

Hospital Standardised Mortality Rate (HSMR): The HSMR is a method of comparing mortality levels in different years, or between different hospitals. The ratio is of observed to expected deaths, multiplied conventionally by 100. Thus, if mortality levels are **higher** in the population being studied than would be expected, the HSMR will be greater than 100. This methodology allows comparison between outcomes achieved in different trusts, and facilitates benchmarking.

Live Dataset: A live dataset is one which is continuously added to over time. This means that incidents that are reported relating to a particular point in time can be added whenever they are resolved and arrive for data entry. This means that historic figures can change over time, reflected in subsequent reports.

Mortality by Diagnosis Group: These comparisons can be and are made for a large number of conditions and operations. The three chosen are common conditions affecting many people.

Some people with acute myocardial infarction (heart attack), fractured neck of femur (broken hip) and stroke die before they can be admitted to hospital. However, there are variations in hospital death rates among those who survive long enough to be admitted. Some of these deaths may be potentially preventable through faster ambulance response times and effective early treatments, so these figures may be considered as indicative of the overall outcome of care in the Trust.

Patient Experience: This Trust has set the goal of being the hospital of choice for our local patients. Being the hospital of choice is a far different thing than being the hospital of convenience, proximity or default. We measure patient experience using methodologies employed by the NHS National Patient Experience Survey against two key indicators to help us determine that our hospitals are the ones our patients would choose if the practical factors were removed.

The Trust uses *The Menu Card Survey* which asks five questions relating to patient experience and is attached to inpatients' menu cards. It measures the patients' experience in real time. The questions asked are all derived from questions that feature in all National Patient Surveys.

The scores depicted in the graphs reflect an absolute figure generated by this methodology (in short – high score is good, 100% would be the maximum achievable score).

Patient Medication Incident: A medication incident is any preventable medication related event that could, or did, lead to patient harm, loss or damage.

All medication incidents are recorded on the DATIX Risk Management Software System, which holds a "live" data set which means that monthly figures can change if there are delays in submission of incident report forms by clinical areas. To minimise the amount of fluctuation, data is reported two months in arrears.

Pressure Ulcer: Definition of Avoidable and Unavoidable Pressure Ulcer

The Department of Health (DH) has been asked to clarify what an avoidable pressure ulcer is in regards the nurse sensitive outcome indicators. The DH researched the availability of definitions, finding that there are a limited number of definitions in existence to draw from.

The Wound, Ostomy and Continence Nurses Society of the US have produced a position paper which points to a clear definition of "avoidable" pressure ulcer (WOCNS) March 2009. However, the DH are using a modified version of the Avoidable d Unavoidable pressure ulcers definitions from the Centre for Medicare and Medicaide (CMS) 2004, to keep with the UK policy Terminology.

The modified definitions are:

AVOIDABLE PRESSURE ULCER:

"Avoidable" means that the person receiving care developed a pressure ulcer and the provider of care did not do **ONE** of the following:

- Evaluate the person's clinical condition and pressure ulcer risk factors
- Plan and implement interventions that are consistent with the persons needs and goals and recognised standards of practice within the Trust
- Monitor and evaluate the impact of the interventions
- Revised the interventions as appropriate

UNAVOIDABLE PRESSURE ULCER:

"Unavoidable" means that the person receiving care developed a pressure ulcer even though the provider of the care had done **ALL** of the following

- Evaluated the persons clinical condition and pressure ulcer risk factors
- Planned and implemented interventions that are consistent with the persons needs and goals and recognised standards of practice within the Trust
- Monitored and evaluated the impact of the interventions
- Revised the interventions as appropriate
- The individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence and this was documented.

Pressure ulcer gradings from the European Pressure Ulcer Advisory Panel (EPUAP):
Category/Grade 1: Non-blanchable redness of intact skin
Intact skin with non-blanchable erythema of a localized area usually over a bony prominence. Discoloration of the skin, warmth, edema, hardness or pain may also be present. Darkly pigmented skin may not have visible blanching.
Further description: The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons.

Category/Grade 2: Partial thickness skin loss or blister
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister.
Further description: Presents as a shiny or dry shallow ulcer without slough or bruising. This category/stage should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.

Category/Grade 3: Full thickness skin loss (fat visible)
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are *not* exposed. Some slough may be present. *May* include undermining and tunnelling.
Further description: The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

Category/Grade 4: Full thickness tissue loss (muscle/bone visible)

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often include undermining and tunnelling.

Further description: The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable.

Readmission Rate (RA): This measure shows the percentage of patients who were readmitted to hospital as an emergency within one month of being discharged. It can serve as an indicator of the quality of care provided and post-discharge follow up. A low readmission rate is an indicator of the quality of care in that it reflects a healthy care balance. Where rates are low, patients are not having to come back to the Trust for care of the same complaint. Conversely, a high readmission rate potentially signals that an organisation is releasing patients home too soon or otherwise not addressing all elements of their clinical condition.

Relative Risk (RR): The Relative Risk indicator is calculated by taking the actual number of inpatients and dividing them by the expected number of inpatients expressed as a percentage. A figure less than 100 represents better than expected performance (highlighted in green).

Sigma: A sigma value is a description of how far a sample or point of data is away from its mean, expressed in standard deviations usually with the Greek letter σ or lower case s. A data point with a higher sigma value will have a higher standard deviation, meaning it is further away from the mean.

Special Cause Variation: the pattern of variation is due to irregular or unnatural causes. Unexpected or unplanned events (such as extreme weather recently experienced) can result in special cause variation. Systems which display special cause variation are said to be unstable and unpredictable. When systems display special cause variation, the process needs sorting out to stabilise it. This report includes two types of special cause variation, trends and outliers. If a trend, the process has changed in someway and we need to understand and adopt if the change is beneficial or act if the change is a deterioration. The outlier is a one-off condition which should not result in a process change. These must be understood and dealt with on their own (i.e. response to a major incident).

Standard Deviation: Standard deviation is a widely used measurement of variability or diversity used in statistics and probability theory. It shows how much variation or "dispersion" there is from the "average" (mean, or expected/budgeted value). A low standard deviation indicates that the data points tend to be very close to the mean, whereas high standard deviation indicates that the data are spread out over a large range of values.

Valid Data Set: A minimum of 21 data points is required for a valid data set using the SPC methodology.

Identifying Special Cause Variation

- 7 or more points on the same side of a centre line
- Consecutive points going alternately up or down 13 times
- 7 successive points all going up or down
- A point widely different from all the others (such as a point falling outside control limits)
- Points following a cyclical pattern

X (centre line): The SPC charts in this report display the centre line mean in red which is used in identifying types of variation.