DATE OF MEETING 31 January 2017

REPORT FOR Trust Board of Directors – Public

REPORT FROM Tara Filby, Chief Nurse
Wendy Booth, Director of Performance Assurance/Trust Secretary
Jeremy Daws, Head of Quality Assurance

CONTACT OFFICER

SUBJECT Monthly Quality Report

BACKGROUND DOCUMENT (IF ANY) Annual Quality Report

REPORT PREVIOUSLY CONSIDERED BY & DATE(S) QPEC Meeting – 11 January 2017

EXECUTIVE COMMENT (INCLUDING KEY ISSUES OF NOTE OR, WHERE RELEVANT, CONCERN AND / OR NED CHALLENGE THAT THE BOARD NEED TO BE MADE AWARE OF)

From this month’s Quality Report, the Board are asked to note the following key points:

- Page 8: HED provisional SHMI for the period to August 16 the Trust remains within the ‘as expected’ banding, but features on the border line between the ‘as expected’ and ‘higher than expected’,
- Page 10: 100% of inpatients received antibiotics within 90 minutes, during November,
- Page 13: NICE Guidance compliance 96.0% for TAGs and 82.6% for CG/GNG,
- Page 18: 0 MRSA and 3 C Diff (0 due to a lapse in care) during November,
- Page 22: 3 falls resulting in harm during November (1 moderate, 2 severe),
- Page 25/26: 0 falls/pressure ulcers deemed to be avoidable,
- Page 30: Fluid management chart compliance deteriorating,
- Page 37: Increase above target threshold of re-opened complaints,
- Page 38: Significant increase in new complaints received.

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

WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO SUSTAINABILITY IMPLICATIONS (QUALITY & FINANCIAL) & CLIMATE CHANGE? N/A

THE PROPOSAL OR ARRANGEMENTS OUTLINED IN THIS PAPER SUPPORT THE ACHIEVEMENT OF THE TRUST OBJECTIVE(S) AND COMPLIANCE WITH THE REGULATORY STANDARDS LISTED N/A

ACTION REQUIRED BY THE BOARD The Board is asked to note the contents of the Quality Report
Directorate of Performance Assurance

Quality Report

December 2016
Board Report – Quality Summary

December 2016

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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 2016/17 and reports on these indicators to the Quality & Patient Experience Committee (QPEC) and ultimately the Trust Board. For the 2016/17 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 contained within this report.
### QUALITY INDICATORS AT A GLANCE: Nov-16

#### PATIENT SAFETY

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Time period / RAG</th>
<th>Comparator</th>
<th>Trending</th>
<th>Trust Stretch</th>
<th>National Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS1</td>
<td>VRSA Bacteraemia incidence</td>
<td>VTD: (6)</td>
<td>R</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PS2</td>
<td>C Difficile incidence (IAI cases)</td>
<td>VTD: (6)</td>
<td>R</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PS3</td>
<td>Safety Thermometer (Community)</td>
<td>VTD: (6)</td>
<td>R</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PS4</td>
<td>Wards focused pressure ulcer reductions</td>
<td>VTD: (6)</td>
<td>R</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PS5</td>
<td>Reduction in number of avoidable pressure ulcers (Grades 2, 3 &amp; 4)</td>
<td>VTD: (6)</td>
<td>R</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PS6</td>
<td>Elimination of avoidable repeat falls</td>
<td>VTD: (6)</td>
<td>R</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PS7.1</td>
<td>Nutrition care pathway was followed</td>
<td>VTD: (6)</td>
<td>R</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PS7.2</td>
<td>The food record chart completed accurately and fully in line with care pathway</td>
<td>VTD: (6)</td>
<td>R</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PS8</td>
<td>The fluid management chart was completed accurately and fully in line with care pathway</td>
<td>VTD: (6)</td>
<td>R</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

#### CLINICAL EFFECTIVENESS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Time period / RAG</th>
<th>Comparator</th>
<th>Trending</th>
<th>Trust Stretch</th>
<th>National Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>CE1</td>
<td>Deliver mortality performance within expected range and improving quarter on quarter, until reported SHMI is 95 or better</td>
<td>Most recent data</td>
<td>R</td>
<td>95</td>
<td>100</td>
</tr>
<tr>
<td>CE2.1</td>
<td>Patients screened for sepsis on presentation (Adults)</td>
<td>Nov-16</td>
<td>0</td>
<td>90.0</td>
<td>0.0</td>
</tr>
<tr>
<td>CE2.2</td>
<td>Patients screened for sepsis whilst already in hospital</td>
<td>Nov-16</td>
<td>0</td>
<td>100.0</td>
<td>0.0</td>
</tr>
<tr>
<td>CE2.3</td>
<td>Patients screened for sepsis whilst already in hospital</td>
<td>Nov-16</td>
<td>0</td>
<td>100.0</td>
<td>0.0</td>
</tr>
<tr>
<td>CE3</td>
<td>Screened for Dementia</td>
<td>Nov-16</td>
<td>0</td>
<td>88.0</td>
<td>0.0</td>
</tr>
<tr>
<td>CE4.1</td>
<td>Technology Appraisal Guidelines (TAGs) to be fully compliant within 3 months of release</td>
<td>Nov-16</td>
<td>0</td>
<td>100</td>
<td>0.0</td>
</tr>
<tr>
<td>CE4.2</td>
<td>Clinical Guidelines (CGs) / NICE Guidelines (NGs) to be fully compliant within 3 years</td>
<td>Nov-16</td>
<td>0</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>CE5</td>
<td>Transfer of patients for non-clinical reasons (capacity) to not exceed 10% of total</td>
<td>Nov-16</td>
<td>0</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

#### PATIENT EXPERIENCE

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Time period / RAG</th>
<th>Comparator</th>
<th>Trending</th>
<th>Trust Stretch</th>
<th>National Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE1</td>
<td>Feedback from the friends &amp; family tests positive</td>
<td>Nov-16</td>
<td>0</td>
<td>7.4</td>
<td>98.0</td>
</tr>
<tr>
<td>PE2</td>
<td>Re-opened complaints to not exceed 10% of total closed complaints</td>
<td>Nov-16</td>
<td>0</td>
<td>10.0</td>
<td>90.0</td>
</tr>
<tr>
<td>PE3</td>
<td>Complaints relating to communication</td>
<td>Nov-16</td>
<td>0</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>PE4</td>
<td>Patients feel that medical and nursing staff did everything they could to help control pain</td>
<td>Nov-16</td>
<td>0</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>PE5</td>
<td>Patients received pain relief when they needed it in a timely manner</td>
<td>Nov-16</td>
<td>0</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
4.0 At A Glance

This Section…

5.0 CLINICAL EFFECTIVENESS (CE)

→ CE1 Mortality
→ CE2 Sepsis Detection and Treatment
→ CE3 Dementia
→ CE4 Evidence Based Practice (NICE)
→ CE5 Transfer and Discharge
5.0 CLINICAL EFFECTIVENESS

CE1 – Mortality

TARGET: 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

Key points - context:

- SHMI (Summary Hospital Level Mortality Indicator) is the ‘official’ NHS mortality measure. It is reported quarterly. It measures in and out of hospital mortality (deaths within 30 days of hospital discharge).

- The indicator uses data that is normally around six months out of date, for example the December 2016 release covered the period July 2015 – June 2016.

- The Trust uses HED ‘provisional’ SHMI, purchased from the University Hospitals Birmingham NHS Foundation Trust. Enables a more recent timeframe in the interim of the ‘official’ quarterly publication.

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.

Key points – performance:

- Most recent Summary Hospital Level Mortality Indicator (SHMI) was published in December 2016 and covers the July 2015 – June 2016 time period.

- The Trust’s SHMI score is 110.5 – ranking 117 out of the 136 NHS provider organisations included in the data set.

- This is officially in the “as expected” range.

- The previous quarters SHMI for NLAG was ranked 111 out of 136, with a score of 108.9

NLAG’s SHMI in National Context

The following chart illustrates the Trust’s most recent SHMI score in relation to those of all Trusts nationally.

Source: Information Services / HSCIC
NLAG’s Provisional SHMI in National Context

- Using the HED (Healthcare Evaluation Data) ‘provisional’ SHMI we can now report on more up to date information.

- HED SHMI currently shows data to the end of August 2016. Data in this analysis should be treated as provisional. Whilst from reconciliation work, we know that this data source reflects the ‘official’ SHMI publications, the numerical value of the HED SHMI can be subject to change. This is due to a number of reasons (1) the quarterly publication of the ‘official’ indicator provides the HED model with rebased data (representing the national picture/changes) and (2) more complete data is available from hospital episode statistics (HES) data and Office for National Statistics (ONS) each successive month, therefore, both local and national changes (including deaths post hospital discharge) are an emerging picture and become more complete the further away we move from the months covered within the data release.

- Using the provisional data for the twelve months to August 2016, the Trust is ranked as 123 out of the 136 NHS provider organisations included within the mortality data set, with a score of 109.6. This is a decrease on the last HED SHMI to the end of July 2016 of 110.5.

- The Trust is within the ‘as expected range’ banding. The following funnel plot graphically represents this.

![HED SHMI - 12 months to August 2016](source)

Source: Information Services based on the Healthcare Evaluation Data (HED)

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 – Sepsis Detection and Treatment

Background:

- During 2015/16, a national CQUIN (Commissioning for Quality and Innovation) scheme was instituted to help Trusts across the NHS focus on sepsis.
- The 15/16 methodology was judged to be weak in terms of the sample of patients included. For 2016/17 therefore the national CQUIN remains with an amended methodology to increase the sample size and process through which patients are identified and included. Whilst an improvement for data quality, the increased rigour will have significantly more impact on the time needed to collect the required information.
- Other changes for 16/17 see the inclusion of sepsis screening and antibiotic commencement for patients who are already an inpatient. This results in the 16/17 CQUIN indicator including 4 component parts:
  1. Sepsis screening on presentation to hospital
  2. Antibiotic commencement for patients presenting to hospital with severe sepsis
  3. Sepsis screening whilst already an inpatient
  4. Antibiotic commencement for patients already an inpatient with severe sepsis
- As the CQUIN indicator has changed from that used in 15/16, no historic comparison data is available. Performance against these 4 elements is demonstrated as follows.

Key points – performance in 16/17 – Patients PRESENTING to hospital:

TARGET: CE2.1: 90% of patients who meet the criteria of the local protocol for sepsis screening and were screened for sepsis

TARGET: CE2.2: 90% of patients with severe, red flag sepsis or septic shock receive IV antibiotics within 1 hour of presentation

![Graph showing performance for presentation and IV antibiotics within 1 hour]

Source: Northern Lincolnshire & Goole NHS Foundation Trust CQUINS Data Collection

Comments:

- Whilst the Trust stretch target for sepsis screening is 90% the CQUIN payment trajectory, for each quarter is:
  - 90% or above: 10% of payment
  - 50% - 89.9%: 5% of payment
  - <50%: no payment
- Full achievement each quarter, exceeding 90% compliance with sepsis screening, would guarantee 40% of the CQUIN monetary value being awarded.
**Indicator CE 2.1:** The above chart illustrates that the number of patients being screened for sepsis has exceeded 90% at the end of November. To obtain a sample of 50 patients, 508 records had to be reviewed.

Of this sample of 50 patients, 48 were adult and for the first time 2 paediatric patients met the criteria for inclusion within CE 2.1, both were fully assessed and screened for sepsis.

**Indicator CE 2.2:** Relates to antibiotic commencement and the sample for this was drawn from a random identification of patients who were identified through clinical coding with a sepsis diagnosis (ICD 10 codes, A40 and A41). The results of this review identified that in November, 87% of patients were administered with antibiotics within 1 hour of arrival and there was evidence of review within 72 hours. 3 patients in total did not meet this indicator, 2 did not get antibiotics within 60 minutes, and the 3rd patient received antibiotics but did not have a review at 72 hours.

Indicator 2.2 with regard to severe sepsis demonstrates the management of adult patients only in the Emergency Department. No children reviewed for the purposes of the audit have met the criteria for severe sepsis and therefore none have been included in the admission element of this CQUIN.

It should be noted that the 90% target is that set for achievement by Quarter 4, 16/17. The CQUIN is designed to help drive quality improvement, so the agreed performance targets for each quarter change over time.

**TARGET: CE2.3:** 90% of patients ALREADY IN hospital who meet the criteria of the local protocol for sepsis screening and were screened for sepsis

**TARGET: CE2.4:** 90% of patients ALREADY IN hospital with severe, red flag sepsis or septic shock receive IV antibiotics within the appropriate timeframe and had an empiric review within 3 days of the prescribing of antibiotics

- Whilst the Trust stretch target for commencement of IV antibiotics and reviewing within 3 days is 90% the CQUIN payment trajectory, for each quarter is designed to support continuous improvement:
  - Quarter 1 trajectory: 60% compliance is awarded 15% of CQUIN value
  - Quarter 2 trajectory: 70% compliance is awarded 15% of CQUIN value
  - Quarter 3 trajectory: 80% compliance is awarded 15% of CQUIN value
  - Quarter 4 trajectory: 90% compliance is awarded 15% of CQUIN value

- Full achievement each quarter, meeting the above compliance thresholds, would guarantee 60% of the CQUIN monetary value being awarded.

Adult patients:

<table>
<thead>
<tr>
<th>Month</th>
<th>Screened for sepsis whilst an INPATIENT - Adults (%)</th>
<th>IV antibiotics within 90 mins (INPATIENT) Adults (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-16</td>
<td>25%</td>
<td>100%</td>
</tr>
<tr>
<td>May-16</td>
<td>28%</td>
<td>100%</td>
</tr>
<tr>
<td>Jun-16</td>
<td>25%</td>
<td>100%</td>
</tr>
<tr>
<td>Jul-16</td>
<td>30%</td>
<td>100%</td>
</tr>
<tr>
<td>Aug-16</td>
<td>67%</td>
<td>75%</td>
</tr>
<tr>
<td>Sep-16</td>
<td>42%</td>
<td>60%</td>
</tr>
<tr>
<td>Oct-16</td>
<td>46%</td>
<td>46%</td>
</tr>
<tr>
<td>Nov-16</td>
<td>46%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Northern Lincolnshire & Goole NHS Foundation Trust CQUINS Data Collection

Comments:
The above chart illustrates that the number having antibiotics prescribed for sepsis within 90 minutes has remained at 100%.

The number of inpatients having sepsis screening however has remained constant at 46%.

Children:

Source: Northern Lincolnshire & Goole NHS Foundation Trust CQUINS Data Collection

Comments:

- **Indicator CE 2.3:** The methodology used involves a review of 50 patients, split between adults and children, and then presented separately within the preceding charts.

- **Indicator CE 2.4:** The methodology used in connection with the use of IV antibiotics, included identification of patients coded as having sepsis. These cases were then reviewed to ascertain if they had markers of severe, red flag sepsis or septic shock. Again the results are presented separately split between adults and children.

Action being taken:

- The Trust’s Web V system has been expanded to include for patients with an elevated NEWS score an automated prompt to alert staff that this patient is at risk of sepsis and should be screened using the sepsis screening tool. This process has been developed as an electronic system and it is hoped will support the continued work to identify patients at risk whilst in hospital already, not simply on admission. This system is to be piloted on the DPoW site on surgical wards alongside increased guidance and availability of key equipment in a ‘sepsis box’ to help clinicians on with next steps including investigation and treatment.
CE3 – Dementia

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

The following chart summarises performance over time with this indicator.

Source: NLAG Dementia Dashboard, Intranet, Information Services Team

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

For full details as to how compliance with this indicator is measured, see glossary.

**Comments:**

- Dementia screening has achieved the target of 90% for twelve consecutive months. During November 2016, the Trust’s performance is 92% at SGH and 89% at DPoW.

- To strengthen the focus on dementia, the Trust has recently recruited two new Dementia Clinical Nurse Specialists who will work to oversee this indicator as well as support other dementia focused initiatives. To support their role, the previously used patient level daily monitoring processes will be reinstated.
CE4 – Evidence Based Practice

TARGET: CE4.1 100% of Technology Appraisal Guidelines (TAGs) to be fully compliant within 3 months of publication

As at the 21 December 2016, Trust compliance with those NICE Technology Appraisal Guidelines (TAGs) that had been assessed using the Trust’s Gap Analysis toolkit is as follows:

<table>
<thead>
<tr>
<th>COLOUR</th>
<th>COMPLIANCE STATUS</th>
<th>COMPLIANCE NUMBERS</th>
<th>COMPLIANCE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GREEN</td>
<td>FULL COMPLIANCE</td>
<td>242</td>
<td>96.0%</td>
</tr>
<tr>
<td>AMBER</td>
<td>Partial compliance</td>
<td>2</td>
<td>0.8%</td>
</tr>
<tr>
<td>BLUE</td>
<td>Not yet assessed – OVERDUE  (Published&gt;3 mths)</td>
<td>7</td>
<td>2.8%</td>
</tr>
<tr>
<td>RED</td>
<td>Non-Compliant</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>252</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: NICE Assurance System, Quality Assurance Team

TARGET: CE4.2 90% of Clinical Guidelines (CGs) / NICE Guidelines (NGs) to be fully compliant within 3 years of publication

As at the 21 December 2016, overall Trust compliance is as follows:

<table>
<thead>
<tr>
<th>COLOUR</th>
<th>COMPLIANCE STATUS</th>
<th>COMPLIANCE NUMBERS</th>
<th>COMPLIANCE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GREEN</td>
<td>FULL COMPLIANCE</td>
<td>128</td>
<td>82.6%</td>
</tr>
<tr>
<td>AMBER</td>
<td>Partial Compliance</td>
<td>16</td>
<td>10.3%</td>
</tr>
<tr>
<td>BLUE</td>
<td>Not yet assessed – OVERDUE  (Published&gt;3 mths)</td>
<td>11</td>
<td>7.1%</td>
</tr>
<tr>
<td>RED</td>
<td>Non-Compliant</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>155</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: NICE Assurance System, Quality Assurance Team

Comments:

- For NICE Technology Appraisal Guidelines (TAGs), the target is for 100% compliance within 3 months of publication. The top table illustrates that there are still some TAGs outstanding initial assessment.

- The second table illustrates current compliance with the larger Clinical Guidelines/NICE Guidelines. Due to the size of the recommendations contained, the Trust within its policy allows for 3 years for full compliance to be attained.

- Compliance with NICE guidance is overseen monthly at the Trust Governance & Assurance Committee, a sub-committee of the Board.
CE5 – Transfer and Discharge

TARGET: Transfer of patients for non-clinical reasons (capacity) to not exceed 10% of the total transfers.

Key points – Context:

- Transfer and Discharge continues to remain a crucial area of focus for both patient experience and also bed stock efficiencies and flow. The transfer and discharge group continue to:
  - The Transfer and Discharge Group encompassed membership from all operational groups, and has recently been revised to include representatives from strategy and planning, Chief Nurse and Medical Director, with partners invited such as Core Care Links as required.

A focus for the group has been as follows:

- To review the data compendium to provide information to drive clinical change*
- Secure clinical leadership to drive the changes
- Recognise the impact of multi-agency action on realising discharges
- Identify the opportunities to learn from best practice elsewhere
- Focus on feedback received from colleagues in primary and community care regarding the quality of discharge communication

* This work is guided by a compendium of data on these various aspects of transfer and discharge, provided by Information Services. The dashboard is summarised each month in the QPEC Quality Report.

Progress April 2016- to present day:

1. A full review of the compendium and work so far has been undertaken within the Directorate of Operations, with the support of Strategy and Planning.

2. Observational work was undertaken in ward, operations centres, and the newly develop FEAST and RATL services.

3. A time-out session was held for all ACOO’s to undertake a SWOT analysis utilising the compendium data and the outcomes of the observational work.

4. A work programme identifying prioritised workstreams to enable change to be driven through building on the objectives identified originally has been formulated.

5. This has enabled an informed discussion to be held with community partners and contributed to the development of a community wide plan, and fed into the Urgent and Emergency Care Network Strategy at a local and STP level.

6. An internal mitigation plan for DPoW has been developed to mobilise as a minimum 15 additional community care beds sub-contracted by NLaG for patients who are medically fit and require arrangements to be made at home before they are transferred, or who are choosing a care home. A second phase is being developed which could lead to an expanded cohort of patients who require therapy input and a business case in progress to identify the funding required for this additional therapy input.
Key Points – Performance:

Patient transfers with reason for capacity – Target 10%
- Whilst Scunthorpe and Goole meet this, as does the Trust overall. DPoW is an outlier although has been reducing overall since January 2016. However, as we approach winter this is expected to increase again, albeit mitigated with additional community beds sub contracted.

Length of Stay – Target 4%
- The average length of stay has reduced to just above 4%, and is within the range of our peers. However Medicine, DPoW is circa two days longer than peer average.

Specialty Outliers
- Specialty outliers has continued to reduce since a peak in March 2016, and the work operationally on a daily basis remains a focus. Goole has seen an increase due to the focus on flexible site use according to patient need, which has helped with flow between sites, but this will continue to be monitored.

Next Steps:
- To establish the identified work streams, with a focus on DPoW site initially.
- Complete the go live for Phase 1 of patients at DPoW to sub contracted community beds.
- Monitor the success of Phase 1
- Develop the business case for Phase 2 of community beds in DPoW
- Continue in collaboration with the Chief Nurse a review of bed configuration of existing staff.
- Continue in collaboration with Strategy and Planning involvement in service reviews
- Operational groups continue to initialise revised job plans which enable morning ward rounds to facilitate discharge.

Source: Transfer and Discharge Working Group Report, Trust Information Services
Source: Transfer and Discharge Working Group Report, Trust Information Services
This Section…

6.0 PATIENT SAFETY (PS)

→ PS1 MRSA Bacteremia Incidence
→ PS2 C Difficile
→ PS3 Community Safety Thermometer
→ PS4 Ward Focused Pressure Ulcer Reductions
→ PS5 Trust Focused Pressure Ulcer Reductions
→ PS6 Avoidable Repeat Falls
→ PS7 Nutrition
→ PS8 Hydration
4.0 PATIENT SAFETY

PS1 – MRSA Bacteraemia Incidence
TARGET: 0 MRSA Bacteraemia developing after 48 hours into the inpatient stay (hospital acquired).

Trust Performance (April 2016 to date): 0 cases

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of MRSA Bacteraemias</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>8</td>
</tr>
<tr>
<td>2011/12</td>
<td>4</td>
</tr>
<tr>
<td>2012/13</td>
<td>2</td>
</tr>
<tr>
<td>2013/14</td>
<td>5</td>
</tr>
<tr>
<td>2014/15</td>
<td>1</td>
</tr>
<tr>
<td>2015/16</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Trust Infection Control Database, Information Services Team

Key points – previous performance: Hospital acquired MRSA (post 48hrs)

PS2 – C. Difficile Incidence (Lapses in care)
TARGET: Achieve a level of no more than 10 hospital acquired C. Difficile cases linked with a lapse in the quality of care, over the financial year 2016/17.

Key point – Performance (April 2016 to date): 2 cases
- November 2016: 0 cases reported at Diana Princess of Wales
- November 2016: 0 cases reported at Scunthorpe General Hospital
- November 2016: 0 cases reported at Goole District Hospital

Comments:
- A decision as to if this was as a result of a lapse in care (in other words avoidable) is made during the Director of Infection and Prevention Control (DIPC) review of the case. There can be a short delay in undertaking the review.
- From April 2016 the target of no more than 10 C Diff cases due to a lapse in care commences, note the decreased threshold of 0.83 per month.
CONTEXTUAL INFORMATION: ALL cases of hospital acquired C. Difficile

Trust Performance (April 2016 to date): 16 cases (ALL cases)
- November 2016: 2 cases reported at Diana Princess of Wales Hospital
- November 2016: 1 case reported at Scunthorpe General Hospital
- November 2016: 0 case reported at Goole District Hospital

![Graph of ALL Hospital Acquired Clostridium Difficile Infections]

Source: Trust Infection Control Database, Information Services Team

Comments:
- The above chart illustrates the trend since April 2012 for reported hospital acquired Clostridium Difficile cases. The blue line in the chart illustrates all reported infections. Added, for clarity, since April 2015 are those within each month deemed to be as a result of a lapse in the quality of care (or where the DIPC review has not yet been held).

Key points – previous performance: Hospital acquired C Diff (post 48hrs, ALL cases)

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<tbody>
<tr>
<td>C Diff Incidence</td>
<td>43</td>
<td>41</td>
<td>37</td>
<td>24</td>
<td>20</td>
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</table>
PS3 – 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

Key Points – Context:

- The NHS Safety Thermometer methodology is used to monitor the incidence of harm as a result of acute and community care (Community care in North Lincolnshire area only, which became a part of the Trust from April 2011).
- For details and methodology used by the Safety Thermometer, see the glossary.

Key points – Performance:

- The following chart illustrates the overall percentage of harm free care (‘old’ and ‘new’ harms) within Community & Therapy Services provided by the Trust in North Lincolnshire since April 2013.

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

Comments:

- For the month of November 2016, performance was 96%.
- The trend since July 13 demonstrates an improving trend.
CONTEXTUAL INFORMATION: Open and Honest Initiative: Increase in harm free care (Acute)

Harm free acute care to 95% or more patients – as measured by the ‘Open and Honest Care: Driving Improvements’ Publication

Key Points: Context

- The NHS Safety Thermometer is based on a point prevalence analysis of the care provided to patients on a given date each month. This point prevalence audit provides a ‘snapshot’ view of harm on that given day each month. It focuses on harm in four key areas. For details and methodology used by the Safety Thermometer, see the glossary.

Key Points: Performance to date – Safety Thermometer:

- The charts below show the percentage of patients not experiencing any harm.

Source: NLAG NHS Safety Thermometer, as reported within the open and honest initiative, NHS England

Comments:

The charts above illustrate that whilst 89.7% of patients included in this snapshot did not experience any harm (new or old), a proportion of those patients presented to the acute hospital setting with a pre-existing harm i.e. an ‘old’ pressure ulcer, or in other words, a pre-existing pressure ulcer already afflicting them prior to hospital admission.

- The chart on the right hand side illustrates those patients with ‘new’ harms only – those developing at least 72 hours after admission. For November, 94.6% of patients had harm free care. The trend line demonstrates a slight deterioration over time.

- The proportion of patients receiving harm free care therefore should be interpreted with caution, recognising that some harm is not preventable by the Trust.

- During November, the percentage of new harms was partly driven by the number of new pressure ulcers, 2.0% at DPoW, 0.3% at SGH and 5.0% at Goole. It should be noted that the 5.0% illustrated at Goole was for 1 patient with a grade 2 pressure ulcer.

Directorate of Performance Assurance, December 2016 Page 21 of 46
**CONTEXTUAL INFORMATION: Open and Honest Initiative: Falls & Pressure Ulcers**

**Key Points: Headline figures – Performance as a Trust (NEW harm only):**
The following charts illustrate the number of falls and pressure ulcers, identified from all reported incidents, since October 2013, including the level of harm and the falls rate per 1000 bed days. The chart also illustrates the trend over time.

**Falls**

![Falls Chart]

**Pressure Ulcers**

![Pressure Ulcers Chart]

**Source:** NLAG Specific Findings from Open and Honest Initiative, NHS England

**Comments:**
- The above chart reports the harm classifications following falls, specified by the Open and Honest Initiative, specifically resulting in moderate, severe harm, or harm leading to death.
- The trend line demonstrates a slight increasing number falls resulting in harm.
- During November a total of 3 falls resulting in harm were recorded, 2 of these resulting in severe harm. All 3 were deemed to be unavoidable
  - Moderate harm: admitted following a fall at home, suspected as having bleeding on the brain, so under neuro observations. Patient fell whilst on the ward, and it was felt that this fall potentially caused further changes in the patient’s condition: as such it has been rated as moderate harm.
  - Severe harm (1): due to clinical condition patient mobilised hurriedly, without calling for assistance. Following this, patient suffered a fall resulting in fracture neck of femur. Deemed to be unavoidable.
  - Severe harm (2): patient was independent with a walking aid, mobilised and fell with a nurse in attendance. The circumstances of this fall were felt to be unavoidable, but due to the nature of this fall, it has been escalated as a Serious Incident for further review of the incident via the SI investigation route.

**Action now being taken:**
- For ease of reference regarding the work underway to improve the quality of care for these patients, please see sections PS4, PS5 and PS6 of this report.
PS4 – Ward focused pressure ulcer reductions

TARGET: Pressure Ulcer prevalence on 6 selected wards to demonstrate a reducing trend over time

Key Points – Context:

- Pressure ulcers have been a priority for the Trust and the focused work has led to an overall reduction in the incidence of hospital acquired pressure ulcers.
- The bulk of the Trust’s focus to date has been Trust and site specific monitoring of the incidence of pressure ulcers. To aid further improvements, this section features for the first time, ward based data to aid specific wards with higher incidences of pressure ulcers to focus on further quality improvements.
- It must be stressed that the following ward based information is presented to aid and support these wards existing quality improvement efforts and to ensure that any further support needed from these areas is available.

Rationale for specific ward area selection

- A retrospective analysis was undertaken assessing the incidence of pressure ulcers during the 2015/16 financial year. This established a baseline understanding.
- From this baseline, a ‘blended’ approach was used to identify 6 ward areas, this approach looked at both the number of ‘avoidable’ pressure ulcers and the total incidence of pressure ulcers.
- In total, the number of avoidable pressure ulcers was low, so the 6 ward areas selected had a combination of factors, a relatively high number of pressure ulcers (in total, when compared to other ward areas) and at least 1 avoidable pressure ulcer.

Performance for the 6 ward areas against the quality improvement target for 16/17:

The following charts illustrate the incidence of pressure ulcers since January 2015 and are designed to enable trends in the incidence to be seen on an ongoing basis throughout 2016/17.

Comment:
- The trend for Ward B6 at DPoW is static over time.
- In November, 3 pressure ulcers reported.

Comment:
- The trend for ward B7 at DPoW is gradually decreasing over time.
- In November, 1 pressure ulcer reported.

Comment:
- The trend for ward C6 at DPoW is increasing over time.
- In November, 4 pressure ulcers reported.
Comment:
- The trend for ward 18 at Scunthorpe General Hospital is **increasing** over time.
- This ward replaces ward 11 for monitoring within this report. In November, 1 pressure ulcer reported.

Comment:
- The trend for ward 22 at Scunthorpe General Hospital is **increasing** over time.
- In November, 2 pressure ulcers reported.

Comment:
- The trend for ward 24 at Scunthorpe General Hospital is **decreasing** over time.
- In November, 2 pressure ulcers reported.

Comment:
- Three of the six wards focussed upon are currently demonstrating an **increasing** trend over time. This is currently based over a 23 month time frame.

- Those wards identified as having an increasing trend are Ward C6 at DPoW, Ward 18 at SGH and Ward 22 at SGH.

  - Ward C6 at DPoW is likely an area that will naturally have a higher propensity for skin damage due to those patients being cared for on the ward having renal and GI problems which will see them with an increased range of trigger factors for pressure damage. From a review of the 4 grade 2 pressure ulcers during November, no care quality concerns were identified and appropriate care plans were already in place. All 4 were classified as unavoidable. It may be appropriate to set some wards, given the case mix of the patients being cared for, individualised goals for quality achievement.

  - While Ward 18 at SGH does not have huge numbers its incidence has increased over time. In the first instance the bulk of the ward mattress stock has been changed to hybrid types to support what is unquestionably a vulnerable group.

  - Ward 22 at SGH has had increasing operational support designed to address staffing levels that the ward has experienced and providing additional support from the tissue viability nurses to oversee assessment processes. The Quality Matron for the area has been closely involved in this work.
PS5 – Trust focused pressure ulcer reduction

TARGET: a 50% reduction in avoidable grade 2, 3 & 4 pressure ulcers (as measured via the Root Cause Analysis undertaken for every grade 2, 3 & 4 pressure ulcer)

Key points – Context:

- Following the reporting of a grade two, three or four pressure ulcer, a root cause analysis process is undertaken to understand if this was avoidable or unavoidable. These records are kept by the lead Quality Matron.

- In total for Quarter 1 14/15, of the 87 grade 2, 3 and 4 pressure ulcers, 12 were deemed to be avoidable following the root cause analysis work undertaken. Based on this, setting a 50% reduction target, equates to no more than 6 pressure ulcers per quarter. 6 per quarter, divided by 3 months, equates to no more than 2 avoidable pressure ulcers per reported month.

Key points – Performance:

- The following chart demonstrates the split between avoidable and unavoidable grade two, three and four pressure ulcers.

![Chart showing the split between avoidable and unavoidable pressure ulcers]

Source: RCA Records kept by lead Quality Matron

Comments:

- There were zero avoidable pressure ulcers in November.

Action now being taken:

- The Tissue Viability Nursing (TVN) team continue to ensure a standardised and consistent approach is taken to the classification of avoidable and unavoidable ulcers as part of staff education and the validation process. This provides consistency and assurance, as well as supporting understanding of the context around pressure ulcers. In future any learning will also be discussed at the Skin Integrity Board to support collaborative working between community and acute areas.

- Continued focus on themes arising from pressure ulcer RCA as a driver for change and improvement. As a consequence the TVN team is to trial a discharge pack for patients to support their ongoing community based care. Feedback from community colleagues via the Skin Integrity Board supports this approach.

- Hybrid stocks of beds have been installed across the sites and has had very positive feedback. Training in the clinical areas has commenced and is ongoing. The Trust supported a ‘Stop the Pressure’ event at the SGH site. This was well attended and was used as a focus for education, which included as session on improvements.
themes as identified at RCA. CQC attended the last RCA review meeting and were very positive about the degree of scrutiny and challenge applied within the process.

- A theme identified from some of the recent RCAs undertaken for pressure ulcers has identified communication to be a theme following admission to the Trust’s admission units and then the onward transfer of patients to other wards. In response to this, during September 2016 a trial of a specific SBAR (Situation, Background, Assessment and Recommendation) handover tool has been developed to aid in improving communication and learning lessons from the themes identified.

- Following further discussion, although working within the same financial envelope we hope to shortly recruit additional staff to join the tissue viability team. The roles will work across both acute and community and augment the excellent work already carried out by our nurse specialists.

PS6 – Avoidable Repeat Falls

TARGET: Eliminate all avoidable repeat falls (as measured via the Root Cause Analysis undertaken for every repeat faller)

Key points: Repeat Fallers – RCA Outcomes – Eliminate all avoidable repeat fallers

- For every repeat fall a Root Cause Analysis (RCA) is performed to identify lessons that can be learnt to prevent future patients falling.
- Each fall is determined to have been either avoidable or unavoidable.
- The following chart provides a summary of performance per month against this target.

Data Source: RCA Records kept by lead Quality Matron

Comments:
- There were zero avoidable repeat falls during November.

Action now being taken:
- Targeted input to wards that are experiencing higher numbers of falls. This mirrors the approach being taken around pressure ulcer incidence and is designed to support the wards to reduce incidence and support change.
- This targeted work has already identified some issues around how patients at risk of falls are communicated on transfer and this will be the focus of further Quality Matron work.
- Trial of the use of a ‘falls pause’ in one clinical area to assess impact. This would see the ward team stop for a brief pause to check all correct process are in place for patients identified at risk of falls, check if any new at risk patients require review and discuss how best to deploy resources to facilitate the current clinical picture.
• There is good evidence from RCA that once a fall has occurred staff are putting the full package of interventions in place to prevent reoccurrence. A good example is the Stroke Unit at SGH who still have a number of single falls but are managing to prevent recurrence in a group where a high proportion are inevitably fall risks.

CONTEXTUAL INFORMATION: Total number of SINGLE falls

• The Quality report has focussed on the Quality Priority target assessing the aspiration to have zero avoidable repeat fallers.

• As additional context to this important area, the following chart presents, for background purposes, the total number of single falls, or more specifically, the total number of patients identified as having had one fall during their hospital stay, since May 2015.

Data Source: DATIX, Performance Assurance Team

Comment:
• The chart above illustrates that the number of single falls occuring within the Trust during November was 104.

Action now being taken:
• An option appraisal has been requested by the Non-Executive Director from the Quality Matron to support the introduction of further low profile beds. The trial of alarm products on Ward C6 has been very positive and we will take the potential recommendations forward to the Non-Executive Director (NED) challenge and falls steering group for potential escalation.
PS7 – Nutrition
TARGET: PS7.1: Nutrition: 100% of patients had the Nutrition management pathway followed

Key points – Context:

- In September 2013 the Trust adopted a nationally validated tool – the Malnutrition Universal Screening Tool (MUST).
- The MUST screening Tool is used to identify those patients who are at risk of malnutrition – depending on the MUST score – a management plan is then followed for the duration of the patients stay.

Key points – Performance:

- The following chart illustrates current levels of compliance with using the care pathway following roll-out of the MUST scoring system in September 2013.

![In 100% of patients the Nutrition management pathway was followed](chart)

Source: Information Services, Nursing Dashboard

NB: The above charts axis starts at 90%.

Comments:

- During November the Trust achieved 96.3% compliance. The chart illustrates performance since April 2015 and note the trend over time demonstrates a slight improvement.
- Non-compliance may be as a result of non-commencement of a food chart, or a non-referral to dieticians – any areas of concern are always highlighted at the time of the audit to the respective Nurse.

Action now being taken:

- Any areas of concern are highlighted by the Quality Matrons at the time of audit both with the Nurse responsible for the patient’s care (to ensure the concern is rectified) and the Senior Nurse on duty (to ensure the concern is cascaded amongst the Nursing team).
- Where there are continued concerns, these are discussed in a meeting with the Assistant Director of Nursing, Head of Quality the Ward Sister / Charge Nurse, Operational and Quality Matrons. Agreed actions are then formulated and may be prioritised according to each area. Whilst this report focuses on Nutrition and Hydration indicators taken from the Nursing Dashboard, it is worth noting that areas of concern cover multiple indicators.
TARGET: PS7.2: Nutrition: 100% of patients the food record chart was completed accurately and fully in the line with the care pathway

Key points – context:
- Those patients who are identified as moderate to high risk (MUST score >1) need to have a food record chart commenced and completed fully in line with the management plan.

Key points – performance to date:
- The following chart illustrates the current compliance with ensuring the food record chart was used fully and appropriately.

![Chart Illustrating Compliances](chart.png)

Source: Information Services, Nursing Dashboard

NB: The above charts axis starts at 80%.

Comments:
- During November the Trust achieved 93.2% compliance. The trend line demonstrates improvement over time.
- During November a slight deterioration is seen at all three sites. Where the Nursing Dashboard information has raised concerns, this has been escalated with Ward Sisters/Charge Nurses and supportive meetings have been convened.

Action now being taken:
- As part of the monthly Quality Matron visits and audit work, ward staff are encouraged, to review and discontinue food record charts that have been commenced when not clinically indicated.
- Any areas of concern are raised at the time of the audit both with the Nurse responsible for the patient’s care (to ensure the concern is rectified) and the Senior Nurse on duty (to ensure the concern is cascaded amongst the Nursing team).
- Work is to be undertaken to ensure that wards are using the salmon coloured trays appropriately for patients who require assistance with eating, or who are on a food chart.
- Where there are continued concerns, these are discussed in a meeting with the Assistant Director of Nursing, Head of Quality the Ward Sister / Charge Nurse, Operational and Quality Matrons. Agreed actions are then formulated and may be prioritised according to each area. Whilst this report focuses on Nutrition and Hydration indicators taken from the Nursing Dashboard, it is worth noting that areas of concern cover multiple indicators.
PS8 – Hydration

TARGET: Hydration: 100% of patients the fluid management chart was completed accurately and fully in line with the care pathway.

Key points – Context:

- Effective and consistent fluid management is recognised nationally as being an area of weak practice as demonstrated in the National Patient Safety Agency (NPSA) (2008) and the National Reporting and Learning System (NRLS) (2008) evidence.
- Accurate fluid balance monitoring is an essential tool in the early identification of a patient whose condition is deteriorating.
- Monitoring the hydration status of patients by using fluid management charts is imperative to reducing the risks of dehydration and the associated complications it can bring.

Key points – performance to date:

- The following chart illustrates the current compliance with ensuring the fluid management chart was used fully and appropriately.

![Graph showing compliance with fluid management chart usage]

Comments:

- The chart illustrates performance since April 2015. Note the trend over time is now a deteriorating one.

Action now being taken:

- Supportive challenge is offered at the time of audits if it is felt that the patient does not require a fluid chart.
- Where there are continued concerns, these are discussed in a meeting with the Assistant Director of Nursing, Head of Quality the Ward Sister / Charge Nurse, Operational and Quality Matrons. Agreed actions are then formulated and may be prioritised according to each area. Whilst this report focuses on Nutrition and Hydration indicators taken from the Nursing Dashboard, it is worth noting that areas of concern cover multiple indicators.
This Section…

7.0 PATIENT EXPERIENCE (PE)

→ PE1 Friends & Family Test
→ PE2 Reduction in Re-Opened Complaints
→ PE3 Complaints Relating to Communication
→ PE4 Pain Management
7.0 PATIENT EXPERIENCE

PE1 – Friends and Family Test

TARGET: 98% of feedback from the Friends and Family Test is positive

Background:

- The Trust has been focusing within its quality priorities on the Friends and Family Test (FFT) since 2013/14. The focus to date has been on the response rate, the participation in the Family and Friends test by patients recently accessing Trust services.

- Whilst response to surveys is critical, the Trust, in combination with other mechanisms of service user feedback, are keen to look at the actual responses from the FFT and ensure we understand key issues of patient experience from this. With this in mind, then, for 2016/17, the Trust has refocused its quality priority in relation to the FFT to focus on the actual feedback from the survey, not merely the response rates.

- To ensure this feedback is captured for the Trust to proactively use, internal dashboards have been developed to see an overview of the responses received from the various Friends and Family Tests. The tests currently open for service user participation in are as follows:
  - Accident & Emergency / Emergency Care Centre
  - Community
  - Day case
  - Maternity
  - Inpatient

- The following chart illustrates the feedback from the Friends and Family tests currently being undertaken within the Trust, for the months April through to November 2016.

<table>
<thead>
<tr>
<th>Month</th>
<th>A&amp;E%</th>
<th>Community</th>
<th>Day Case</th>
<th>Inpatient</th>
<th>Maternity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-16</td>
<td>86.9%</td>
<td>97.4%</td>
<td>99.0%</td>
<td>96.3%</td>
<td>92.7%</td>
</tr>
<tr>
<td>May-16</td>
<td>84.2%</td>
<td>99.1%</td>
<td>97.0%</td>
<td>96.8%</td>
<td>94.9%</td>
</tr>
<tr>
<td>Jun-16</td>
<td>86.1%</td>
<td>98.8%</td>
<td>98.3%</td>
<td>97.1%</td>
<td>95.4%</td>
</tr>
<tr>
<td>Jul-16</td>
<td>85.4%</td>
<td>98.1%</td>
<td>98.3%</td>
<td>97.3%</td>
<td>95.2%</td>
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<tr>
<td>Aug-16</td>
<td>80.6%</td>
<td>98.6%</td>
<td>98.0%</td>
<td>97.2%</td>
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<tr>
<td>Sep-16</td>
<td>77.8%</td>
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<tr>
<td>Oct-16</td>
<td>70.2%</td>
<td>99.0%</td>
<td>97.3%</td>
<td>96.6%</td>
<td>94.4%</td>
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<tr>
<td>Nov-16</td>
<td>77.6%</td>
<td>98.8%</td>
<td>99.0%</td>
<td>96.0%</td>
<td>95.5%</td>
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<tr>
<td>Target</td>
<td>98.0%</td>
<td>98.0%</td>
<td>98.0%</td>
<td>98.0%</td>
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</tbody>
</table>

Source: Information Services, Friends and Family Test Dashboard

Comments:

- NB: It should be noted that in some cases patients choose to leave neutral feedback. This affects the denominator used in the calculation of the percentage of positive comments.

- Those areas reporting less than 98% positive feedback are illustrated in greater detail on the following page.
By exception: Focus on areas reporting less than 98% positive feedback:

- The following table shows in greater detail those areas, broken down by site, where possible, reporting less than 98% positive feedback to aid further understanding and to guide future work programmes.

<table>
<thead>
<tr>
<th>November 2016</th>
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<tbody>
<tr>
<td>FFT Site</td>
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<tr>
<td>-------------</td>
</tr>
<tr>
<td>A&amp;E</td>
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<tr>
<td>DPoW</td>
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<td>SGH</td>
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<td>GDH</td>
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<td>Community</td>
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<th>November 2016</th>
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<tbody>
<tr>
<td>FFT Site</td>
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<tr>
<td>-------------</td>
</tr>
<tr>
<td>Day case</td>
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<tr>
<td>DPoW</td>
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<td>SGH</td>
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<td>GDH</td>
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<td>FFT Site</td>
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<tr>
<td>Inpatient</td>
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<td>DPoW</td>
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<td>SGH</td>
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<th>November 2016</th>
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<td>FFT Site</td>
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<tr>
<td>Maternity</td>
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<td>DPoW</td>
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<tr>
<td>SGH</td>
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<tr>
<td>Community</td>
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</tbody>
</table>

Source: Information Services, Friends and Family Test Dashboard

- **NB:** It should be noted that in some cases patients choose to leave neutral feedback. This affects the denominator used in the calculation of the percentage of positive comments.

- In some instances, patients are misinterpreting the answers to the friends and family test as printed on the FFT slips. This has been identified as a result of a number of cases where the ‘free text’ comments received by patients have been glowing in praise, however, the ticked answers on the same sheet implied they were ‘extremely unlikely’ to recommend the Trust. At present, no changes are being made to these cards, however going forward a consensus will need to be agreed as to if action is taken to adjust the scores recorded on these cards in the case of such clear examples of inconsistencies.

**Comments:**

- During November 2114 pieces of FFT feedback were collected, 50 of these were rated on the negative scale which gave us an overall rating of 94.7%.

- A&E percentages are low and we are acutely aware of this. The negative shift is in direct partnership with the drop in response rates. This means that because less cards are being submitted the picture may not be representative. We may only be receiving cards of those patients who may not have had a good experience because
they are taking the time to tell us, where the other people are leaving satisfied but do not want to wait to provide feedback.

- We have explored the issues, spoken with both A&E managers and are trying to increase the response rate to ensure an accurate and representative picture is gleaned. Part of this work is looking to create a text service with a link to an online survey which we are hoping to have up and running by February 2017. In the interim both managers are re-invigorating FFT within their departments. However, we must note that A&E continues to be one of the highest pressure areas. Enabling patients to leave feedback in the quickest most convenient format is our aim going forward, this will support both staff and the public.

Thematic Analysis: From the comments left – what do we learn?

- Our focus this month is on our Inpatient areas for Children and Young People. We want our children and families to have an audible voice in the Trust, a voice that is heard and valued. Women’s and Children’s Services are committed to finding the best way possible to hear their children, young people and families.

- We have recently worked with the Paediatric Wards to create a “Tops and Pants” feedback card which is FFT based, they can rate the visit as “Tops” for a good stay and “pants” for not so good. They can colour on the cards to so that the wards can display the cards.

- Our Neonatal areas are using a simple card for parents to rate the care of their babies and them.

- Since April these areas have collected a total of 699 pieces of feedback with an overall rating of 99% - a real celebration of the excellent care given. Some of the comments are below:-

  “Scott is funny. The nurses are very kind and I like the food and you all made me feel better” – Rainforest Ward, DPoW

  “Excellent care, always helpful and take time to explain everything to the care whilst in hospital and upon leaving moving forward. Carla (HCA) has been brill! Thank you” – Neonatal Unit, DPOW

  “I am so grateful for the wonderful care that my son received whilst on Disney ward. All of the nurses were kind, caring explained everything to my child, patient, I could not have asked for more. In particular Sasha, Vicky and Laura C” – Disney Ward, SGH

  “The women that work on this unit are amazing, especially Sarah, what a woman. Total respect for all of them. The doctors are brilliant, and they make you feel like you don’t have to worry.” – Neonatal Unit, SGH

Thematic Analysis of the feedback:

Whilst we use the negative feedback to look for themes for quality improvement with ratings of nearly 100% we need to focus on what is working well, if you look below the over-riding theme across both sites is around positive behaviours of staff. This is in direct alignment of our Trust Vision and Values and should never be underestimated as the difference this can make to the experience of care is immense.

- Staff smiling and being friendly,
- Care for families,
• Care to babies,
• Support and reassurance to parents,
• Access to toys/games.

What we do find with this feedback particularly is that the rating remains high but they may suggest an improvement, those are listed below and will be fed back to the teams for discussion. Areas suggested include:

Suggestions:

• Less waiting for information,
• More information about what parents can expect,
• Availability to buy overnight products for families, such as toothbrush, comb, wash things,
• Discounted food available off menu for parents,
• Drab parents room DPOW,
• Later meal times for older children.

Action being taken to improve – Patient Feedback:

• The Patient Experience Practitioner is focusing on the areas where feedback trends illustrate that negative feedback has been left in order to identify themes and trends for these to be shared with relevant staff.

• Work is underway to bring forward some of the specific comments made by patients within the Friends and Family Test to provide this report and most importantly the improvement work underway with greater context and understanding of this valuable source of patient experience feedback.

• A number of initiatives are being taken to focus on this area including:
  o The web based Friends and Family reporting tool is being used by staff and they report they are pleased with being able to view their own ward feedback, print off reports and patient comments and share these with staff. Building on this there are delays in creating an action box for areas to reply about any negative feedback but the Experience Team have created an excel spreadsheet which is being sent out to leaders.

  o Community data is becoming very widespread and the system is currently not equipped to deal with the level of sub groupings which are coming through for inputting. Whilst these cards can be entered on the system under a general heading, teams being able to retrieve their data is vital. Work is now underway with the Community, Rehabilitation and Therapies leads to create a more streamlined approach.

  o The National Lead for Patient Experience, Julia Holding has shared the new Headline data tool which is currently being explored to pull feedback data into the tool for sharing.

  o Some of the new FFT boxes have been lost through bed moves, portering activity, so whilst this is disheartening we continue to work with areas to collect cards. There is currently no funding for replacements. Signs Express are working with us to repair any that are reusable.

  o A meeting with our IT and Development leads has resulted in the option of creating an in house text with a link to our external web page which hosts the FFT survey online. This is provisionally to be trialled in February 2017 in our AE and MIU departments.
Source: NHS England, Friends and Family Test Data

Comments:

- The Trust ranks 95 out of 141, placed in the bottom 50% of responding organisations.

Response Rate: Inpatient Friends and Family – broken down by site

Source: NHS England, Friends and Family Test Data

Comments:

- The Trust ranks 154 out of 172 Trusts which places the Trust in the bottom 50% of responding organisations.
**PE2 – Reduction in Re-opened Complaints**

**TARGET:** Re-opened complaints to not exceed 10% of total closed complaints

**Key points – Context:**

- To set a numerically based reduction was therefore deemed unrealistic. Instead of a numerical target, a proportional or a percentage target would seem more realistic.
- As a result of improvements in the reduction of re-opened complaints, the Quality Patient Experience Committee (QPEC) agreed a reduction in the target to 10%, including a focused root cause analysis process for any months where the target is exceeded. This revised target takes effect from September 2016.

**Key points – Performance:**

- The following chart illustrates the percentage of re-opened complaints compared with the number closed.

![Percentage of re-opened complaints compared with number closed](chart.png)

**Data Source:** DATIX, Performance Assurance Team

**Comments:**

- The percentage of re-opened complaints is **above** the 10% target at 11.1%.

- **Root Cause Analysis (RCA):** Performance exceeds the 10% target during November mainly as a result of a large increase in new complaints received (see next page for this presented graphically) and a reduction in the number of complaints closed during the same month (a result of refocussing/prioritising of complaints central team schedules to deal with the new complaints received that month). This results in the denominator for this percentage calculation (the number of closed complaints) being much reduced as compared with previous months. This is further supported when considering that the number of re-opened complaints has remained static at 3 during the month, the same numerical value as reported since June.

- It is worth noting that in an attempt to improve complainants’ satisfaction and improve their feeling of assurance, at the end of each response letter, the complainant is offered the opportunity of a meeting to discuss the findings. More and more complainants are taking up this opportunity and this has an impact on the numbers of reopened complaints reported in this section of the monthly quality report. To test out complainants satisfaction of this process, the Trust also uses service user satisfaction surveys to help gauge performance from a different perspective. The chart above illustrates that both the percentage and number of re-opened complaints are demonstrating a downward trend further implying that the complainants satisfaction in the way their complaint has been handled.

- Following benchmarking work and a recent internal audit into the complaints handling processes in place, the Trust has revised its complaint handling timescale, specifically:
o Complaint relating to a single area of concern / or single group: Maximum timescale for response: **30 days**

o Complaint relating to multiple issues relating to one group: Maximum timescale for response: **45 days**

o Complex complaint relating to multiple issues in multiple groups: Maximum timescale for response: **60 days**

- The Trust's central complaints team is actively working to streamline the process with operational groups to minimise delays in handling of complaints. The central team are also working with operational teams to ensure resulting action plans following complaints have greater ownership at group level.

**CONTEXTUAL INFORMATION: Complaints (as at 19 November 2016):**

![Graph showing number of complaints]

**Data Source:** DATIX, Performance Assurance Team

**Comments:**

- As referred to already, during November, a large increase is seen in the number of ‘new’ complaints, coupled with a reduced number of closed complaints (as a direct result of the central complaints team responding to the newly received complaints) drives the increase this month in the number of net-open complaints.

- Within previous iterations of this report, the seasonal effect of complaints has been noted and reported on. Surges in the number of new complaints have been seen over the following months in previous years:
  - November 2014,
  - July 2015,
  - March 2016,
  - November 2016.
PE3 – Complaints relating to communication

TARGET: Reduction of complaints relating to the theme of communication (Specific target to be agreed)

Mid-year review of target:

- This target was designed to aid an improved understanding. However from reviewing the themes to date and reporting these in this report, it has been difficult to ascertain the number of complaints made for the specific reason of poor communication. During the mid-year review of quality priorities the decision was taken to review this target.

- As a result the DATIX system has been refreshed to include additional and more specific categories for complaint themes to be logged at the time the complaint is received. These additional, more specific codes will enable the central complaints handlers to accurately code the exact nature of the communication theme which will enable the Trust to understand this area in much greater detail.

- Over the page, the communication related complaints have been broken down and reported on within this monthly report, now providing 3 months’ worth of data. This data is currently available for the months of November, December and January 2015/16. Using this data and that collated during early 2016, will provide an accurate baseline on which to use to set a more appropriate reduction target for the 2016/17 quality priorities and monitoring of these in this monthly report.

- On the following page this data is presented.

- **NB:** It should be noted that those complaints listed under the ‘open as at…’ table will likely include some data reported in the previous month, as in some cases complaints will remain open overlapping 2 or more reporting month periods, dependant on the nature and complexity of the complaint. Therefore this table should be interpreted with caution.

- **NB:** The table listed under the ‘closed as at…’ includes only those complaints closed, with a communication or values code within that month. Therefore no parallels can be drawn from earlier presented numbers of closed complaints as the analysis of the two data sets are different.
**Comments:**

- Communication with relatives and carers, failure keeping relatives informed and communication with the patient themselves are the top themes arising from an analysis of communication 'themed' complaints.
- This will be fed into the learning lessons sub group focussing on communication.
PE4 – Pain Management

Key points – Context:

- Following reflections within the ‘patient stories’ presented to QPEC and the Trust Board, management of pain and administration of pain relief were areas felt to require additional scrutiny.

- To ensure the Chief Nurse directorate are focussed on pain management, this refresh includes specific new questions that relate to pain management, from the patient’s unique perspective. These are as follows:

  - **Patient Experience Dashboard:**
    - PE4a: 90% of patients feel that medical and nursing staff did everything they could to help control pain.
    - PE4b: 90% of patients received pain relief when they needed it in a timely manner.

Key points – Performance:

- The following charts demonstrate performance for the months of March, April, May, June, July, August, September, October and November 2016.

**PE4a:** Patients felt that staff did everything they could to help control pain

**PE4b:** Patients received pain relief when they needed it in a timely manner

Comments:

- For the nine months’ worth of data available, responses to these new patient experience questions exceed 96%.

- At the mid-year review of the quality priorities, this target was reviewed. It was felt that the methodology (how these questions were asked of patients and by whom) needed to be changed to ensure that patients felt able to honestly provide feedback on this important issue. Therefore, the methodology for this quality priority has been amended, as follows:
  - The Voluntary Services Manager has been approached to determine if volunteers could ask these questions of patients, therefore enabling a non-nursing member of staff seek feedback on pain management experiences.
  - The data set has been expanded to include more detailed feedback to understand not only if pain management was considered and acted upon, but also to check to ensure that if analgesia was administered, was the effectiveness of this reviewed again subsequently.

- It is hoped these changes in the methodology will greatly enhance the Trust’s understanding of this area. Once these changes have been made, the look of this section of the Quality Report will be amended to reflect the changes.
This Section…

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

**Clostridium Difficile – Guidance from Monitor, received during 2015:** As part of the Trust’s obligations to Monitor, we are performance managed against this target of “no more than 21 hospital acquired cases”. However, when understanding their guidance to Trusts, this is no more than 21 cases “due to a lapse in care” or in other words, potentially preventable cases. An extract from Monitor’s guidance is reported as follows:

“For 2014/15, organisations will be encouraged to assess each CDI case they identify to determine whether the case was linked with a lapse in the quality of care provided to patients. This will increase the organisation’s understanding of the quality of the care they are providing and highlight areas where care could be improved. Where CDI cases are not linked with identifiable lapses in care, it is proposed that those cases are not considered when contractual sanctions are being calculated.”

As a result of this, the Quality report now contains an analysis of both ALL cases of hospital acquired C Diff alongside those classed as ‘preventable’ (or in other words lapses in care).

**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 complaints and those unresolved from previous month(s). This includes open ‘on hold’. This includes re-opened complaints.
- 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). These consist of an upper control limit, a lower control limit and a mean (average).

**Crude Mortality Rate:** The crude mortality rate is based on actual numbers. Unlike Standardised Mortality Ratios (SMRS) i.e. SHMI and HSMR which features adjustment based on population demographics and related mortality expectations. Crude mortality is calculated by using as the numerator the number of patients who have died divided by the denominator which in this case is the total population. Times this figure by 100, equals the crude mortality percentage (%).

**Dementia – methodology for determining compliance with Quality Target:**

**CE3.1 – Dementia Screening:** 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.

**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.

**Unavoidable Fall:** Impossible to avoid the fall(s) from happening. Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure.
Avoidable Fall: The fall(s) could have been avoided. Recognises 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 an a priori judgment either of a systems failure or of a lack of due care.

Friends and Family Test – Methodology: The Trust introduced the new friends and family test in April 2014, 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.

‘Positive feedback’ defined as the percentage of patients/service users answering ‘extremely likely’ and ‘likely’


H.E.D. – Health Evaluation Data: The official national data publications are released quarterly, six months after the event. The Trust therefore reports its performance to its Board every month using provisional data published by the University of Birmingham through its Hospital Evaluation Data system (HED). This is normally three months behind the current position, and has been validated as virtually identical to the official published data.

HED SHMI – Numerical value – interpret with caution: HED SHMI is referred to within this report as a ‘provisional’ indicator and should be interpreted with caution. Sometimes within this report, the numerical value of the HED SHMI is sometimes observed as changing over subsequent months reports, for the same time frame. The reason for this is multi-faceted and is explained as follows:

1. SHMI modelling information is released on a quarterly basis, alongside the ‘official’ SHMI publication. The official SHMI essentially readjusts the HED ‘provisional’ indicator so it’s in line with the ‘official’ data/statistical modelling. This modelling data when available following the publication of the ‘official’ SHMI will readjust the HED data so it is line with the official statistic. It could be reasoned from this therefore, that the further away from the quarterly release of the official data, the more scope there is for HED to be different to the next/future ‘official’ SHMI publication. When we say different, the actual difference is usually small, less than a point.

2. Hospital Episode Statistics (HES) and Office for National Statistics (ONS) data is being added to as more and more data (data completeness) becomes available. Simply put each monthly HED data includes more complete information from Trust data sources and community data (the 30 day deaths, post discharge) than the information available for the previous month. Not all deaths are reported in a timely manner, so the monthly data going into HED for the month of February, let’s say as an example, could be added to – in terms of completeness – in future monthly releases. That means that the HED data for the Trust – but most importantly – the Trust’s peers, the rest of the UK, is always being added to. HED is vulnerable to these changes as it reports a period in time much sooner to that reported by the ‘official’ SHMI. The ‘official’ SHMI looks at data 6-18 months old, so in terms of data completeness is more stable and therefore reliable.

3. All Trusts can resubmit data for previous months (during a specified window of opportunity). This can be for small data corrections or specific pieces of work to cleanse/validate data.

HED SHMI is still a useful indicator, these factors need to be borne in mind when using the information for comparing progress made with the improvement agenda.

MUST – Malnutrition Universal Screening Tool: The total MUST score for a patient is worked out from their BMI, the amount of unplanned weight loss they may have and the ‘acute disease effect’ (if the patient is acutely ill and there has been or likely to be no nutritional intake for >5 days). The MUST score triggers appropriate action, as described below:

- MUST score of 0: Low risk and require screening weekly.
- MUST score of 1: Moderate risk and require screening weekly, commencement and completion of a food record chart, to be encouraged to have fortified meals from the food menu, offered snacks from the Trust wide snack list.
- MUST score of 2 or more: High risk and require the same management as those patients scoring 1 plus a referral to the dietician for a dietetic review.

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 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).

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 Medicaid (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):**

<table>
<thead>
<tr>
<th>Category/Grade/Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category/Grade 1:</strong></td>
<td>Non-blanchable Erythema</td>
</tr>
<tr>
<td>Unstageable/depth unknown</td>
<td></td>
</tr>
<tr>
<td>Stage</td>
<td>Description</td>
</tr>
<tr>
<td>1</td>
<td>Non-blanchable erythema</td>
</tr>
<tr>
<td>2</td>
<td>Partial thickness skin loss</td>
</tr>
<tr>
<td>3</td>
<td>Full thickness skin loss</td>
</tr>
<tr>
<td>4</td>
<td>Full thickness tissue loss</td>
</tr>
<tr>
<td>Unstageable/depth unknown</td>
<td></td>
</tr>
</tbody>
</table>

**Category/Grade/Stage 1:** Non-blanchable Erythema
Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. 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” individuals (a heralding sign of risk).

**Category/Grade/Stage 2:** Partial thickness skin loss
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 blister. 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, perineal dermatitis, maceration or excoriation.

*Bruising indicates suspected deep tissue injury.

**Category/Grade/Stage 3:** Full thickness skin loss
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. 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 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/Stage 4:** Full thickness tissue loss
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. 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 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 possible. Exposed bone/tendon is visible or directly palpable.

**Unstageable/depth unknown**
Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as ‘the body’s natural (biological) cover’ and should not be removed.

**Suspected deep tissue injury: Depth unknown**
Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

**Rate per 1000 bed days:** So we can know if we are improving even if the number of patients we are caring for goes up or down, we also calculate an average called ‘rate per 1,000 occupied bed days’. This allows us to compare our improvement over time, but cannot be used to compare us with other hospitals, as their staff may report in different ways, and their patients may be more or less vulnerable than our patients.

**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.

**Safety Thermometer methodology:**

The NHS Safety Thermometer provides the ability for ‘a temperature check’ of harm to be recorded. It did this by auditing on a point prevalence basis the care provided to patients on a given date each month. This point prevalence audit provided a ‘snapshot’ view of harm on that given day each month. It focusses on harm in four key areas:

- 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

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.

Harm Free Care:

• Safety Thermometer enables the calculation of the proportion of patients who received harm free care. This is calculated by dividing the number of patients receiving harm free care (as the numerator) by the total number of patients surveyed (the denominator).
• Patients with more than one of the harms listed, will not be classified as harm free care and are thus not counted in the numerator. Patients recorded as having multiple harms are removed from the numerator in the same way as those with only one harm.

Proportion of patients with ‘harm free’ care:

• Those patients without any documented evidence of a pressure ulcer (any origin, category 2-4), harm from a fall in care in the last 72 hours, a urinary infection (in patients with a urinary catheter) or a new VTE (treatment started after admission).

Proportion of patients with ‘harm free’ care – new harms only:

• Those patients without any documented evidence of a new pressure ulcer (developed at least 72 hours after admission to this care setting, category 2-4), harm from a fall in care in the last 72 hours, a new urinary infection in patients with a urinary catheter which has developed since admission to this care setting, or a new VTE (treatment started after admission).

Community Safety Thermometer: VTE is not relevant as an indicator. In community practice, patients are not routinely risk assessed for VTE and 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. As a result, VTE is not included in the following section pertaining to community care Safety Thermometer results.

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.

Summary Hospital Mortality Indicator (SHMI): The SHMI is the NHS ‘official’ Standardised Mortality Ratio (SMR). It is a method of comparing mortality levels in different years, or between different hospitals. As a result, the SHMI is used as a performance tool to rank NHS organisations within a league table. The ratio is calculated by using as a numerator the number of deaths divided by the denominator, in this case, the number of “expected” deaths, multiplied conventionally by 100. Thus, if mortality levels are higher in the population being studied than would be expected, the SHMI will be greater than 100. This methodology allows comparison between outcomes achieved in different trusts, and facilitates benchmarking. The outcomes of the SHMI are reported in three bandings: (1) higher than expected, (2) as expected and (3) lower than expected. The SHMI includes not only in-hospital deaths, but also includes deaths within the community, occurring within 30 days of hospital discharge. As a result, it is dependant not only on in-hospital coded information, but also on Public Health data, this results in a delay in reporting. As a consequence, the quarterly data published by the Health and Social Care Information Centre reports on historic information ranging from 18 months to 6 months. To illustrate this point, the SHMI information release in April 2015 reports performance from October 2013 – September 2014.

Special Cause Variation: the pattern of variation is due to irregular or unnatural causes. Unexpected or unplanned events (such as extreme weather) 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 is most commonly reported using 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).

Identifying Special Cause Variation – agreed rules:

• Any point outside of the control limits,
• A run of 7 points all above or below the central line, or all increasing / decreasing,
• Any unusual patterns or trends within the control limits,
• The proportion of points within the middle 1/3 of the region between the control limits differs from 2/3.

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.