Cover page	
Meeting	**Trust Board**
Agenda Item No.	**Public Agenda Item 14**
Paper Title	Quality Governance Report
Date of meeting	Wednesday 24 July 2019
Date paper was written	Wednesday 17 July 2019
Responsible Director	Barbara Beal, Director of Nursing, Midwifery and Quality
Author	Peter Jeffries, Associate Director of Quality, Governance and Risk
Previously considered by	N/A

The Board is asked to:			
☐ Approve	☑ Receive	☐ Note	☑ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☐ Responsive	☐ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☐ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☐ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☑ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	**BAF 1134:** We need to deliver plans jointly agreed with the local health and care system so our admission and discharge processes ensure patients are receiving safe and effective care in the right place **BAF 1533:** We need to implement all of the 'integrated improvement plan' which responds to CQC concerns so that we can evidence provision of outstanding care to our patients **BAF 1204:** Our maternity services need to evidence learning and improvement to enable the public to be confident that the service is safe

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)

Freedom of Information Act (2000) status	(•) This document is for full publication ( ) This document includes FOIA exempt information ( ) This whole document is exempt under the FOIA
Financial assessment	N/A

Main Paper

Situation

The purpose of this report is to provide the Quality and Safety Committee with assurance relating to our compliance with quality performance measures during June 2019.

Background

This report covers our performance against contractual and regulatory metrics related to quality and safety during the month of June 2019. The report will provide assurance to the Quality and Safety Assurance Committee where we are compliant with key performance measures and outline areas where further assurance may be required.

Assessment

Key points to note by exception:

- There were seven reported cases of C-Difficile in June 2019;
- Non-elective MRSA screening was just below the 95% target for June 2019 with compliance of 94.3% (this is the first time the 95% target has not been achieved since February 2018);
- In April 2019 (latest available validated data) VTE assessment was below the 95% target at 93.7%;
- The percentage of patients who would recommend the area where they were treated to friends and family (FFT) decreased in both outpatients (from 97.5% in May to 97.3% in June) and ED (from 95.7% in May to 92.1% in June);
- There were three serious incidents raised in June 2019. Two related to patient deaths (a delayed diagnosis of myocardial infarct in ED and an unexpected neonatal death) and one related to delayed diagnosis of a sub-dural haemorrhage in ED where the patient was transferred to the care of Neurosurgery in another regional provider;
- Four patients waited for > 104 days for cancer treatment in May (latest validated figures).

Recommendation

Quality and Safety Committee are asked too:

- Receive and take assurance from the Quality Governance report

Quality Governance Report July 2019

INTRODUCTION

This report covers our performance against contractual and regulatory metrics related to quality and safety during the month of June 2019. The report will provide assurance to the Quality and Safety Committee where we are compliant with key performance measures and that where we have not met our targets that there are recovery plans in place.

The report will be submitted to the Quality and Safety Committee as a standalone document and will then be presented to Trust Board as part of the integrated reports for consideration and triangulation with performance and workforce indicators.

This report relates to the Care Quality Commission (CQC) domains of quality – that we provide safe, caring, responsive and effective services that are well led, as well as the goals laid out within our organisational strategy and our vision to provide the safest, kindest care in the NHS.

CONTENTS

Section one: Our Key Quality Measures – how are we doing?

Measure	July 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	June 19	Year to date 19/20	Monthly Target 2019/20	Annual Target 2019/20
CDI due to lapse in care (CCG panel)	0	1	2	1	1	1				1			1	2	43
Total CDI reported	0	2	2	1	1	2	1	2	1	2	3	7	12	2	43
MRSA Bacteraemia Infections *Contaminant	0	1*	0	0	1*	1*	0	0	0	0	1	0	1	0	0
MSSA Bacteraemia Infections	2	4	3	1	2	1	5	0	0	0	1	3	5	None	None
E. Coli Bacteraemia Infections	6	4	3	7	8	5	2	3	3	3	9	3	11	None	None
MRSA Screening (elective) (%)	95.6%	95.4%	97.6%	95.4%	95.9%	95.2%	96.5%	96.1%	95.6%	95.9%	91.8%	95.9%	94.6%	95%	95%
MRSA Screening (non elective) (%)	96.2%	96.8%	96.7%	96.5%	97.1%	97.0%	96.8%	96.5%	96.4%	96.4%	95.9%	94.3%	95.5%	95%	95%
Cat 2 Confirmed	10	12	15	6	11	7	10	11	17	12	5	4	21	None	None
Cat 2 Reported	10	12	15	7	12	10	13	14	19	21	17	18	56	None	None
Cat 3 HRCR	2	0	4	0	4	3	6	9	3	2	2	0	4	None	None
Cat 3 Serious Incident	0	0	0	0	0	0	0	0	0	0	0	0	0	None	None
Cat 4 HRCR	0	0	0	0	0	0	0	0	0	1	0	0	1	None	None
Cat 4 Serious Incident	0	0	0	1	0	0	0	0	1	0	0	0	0	None	None
Falls reported as serious incidents	0	1	0	0	0	0	0	0	2	0	1	0	1	None	None
Number of Serious Incidents	1	2	2	3	4	3	1	1	8	3	2	3	8	None	None
Never Event	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0
Catheter Associated UTI (number of patients on prevalence audit)	1	3	3	2	6	0	*	1	0	*	3	1	4	None	None
WHO Safe Surgery Checklist (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Measure	July 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	June 19	Year to date 19/20	Monthly Target 2019/20	Annual Target 2019/20
VTE Assessment	95.9%	95.6%	96.0%	97.3%	95.9%	95.1%	94.4%	94.2%	94.2%	93.7%			93.7%	95%	95%
ITU discharge delays>12hrs	36	36	46	40	30	42	30	24	26	37	27	43	107	None	None
No of MSA breaches other areas	1	0	0	0	0	0	0	0	0	0	0	0	0	None	None
Complaints (No)	60	54	58	55	82	40	53	50	64	59	65	55	179	None	None
Friends and Family Response Rate (%)	20.8%	20.8%	16.5%	14.6%	16.7%	11.4%	11.3%	11.5%	9.3%	10.5%	11.5%	11.3%	11.1%	None	None
Friends and Family Test Score (%)	95.6%	93.3%	97.1%	97.2%	97.6%	97.4%	97.1%	97.5%	97.5%	97.6%	97.8%	97.8%	97.8%	95%	95%

Section Two: Key Messages by exception

Infection Prevention and Control

Clostridium Difficile (C Diff)

This financial year there have been changes in the CDI reporting algorithm.

The changes that affect SaTH as an acute Trust are as below:

A reduction in the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.

Therefore Acute provider objectives have been set using two categories:

- Hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission
- Community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks

Following the changes SaTH's CDI yearly target has been increased to 43 from 24 the previous year. Any patient that has been an inpatient in the reporting Trust in the previous four week is now attributed figures. Unsurprisingly due to the changes the trust have been reporting an increased number of CDI cases

This has resulted in an increase in the amount of root cause analysis (RCA) meetings needed. Any non-compliance regarding attendance has been escalated to the Associate Director of Nursing and Medical Director.

There were 7 incidents of C diff attributed to the Trust in June 2019. Two of these cases were post 48 hour cases, and five had been inpatients in the 28 days prior to their positive sample. These are now attributed to the Trust following the recent changes in the reporting guidelines from PHE to be applied as of April 2019.

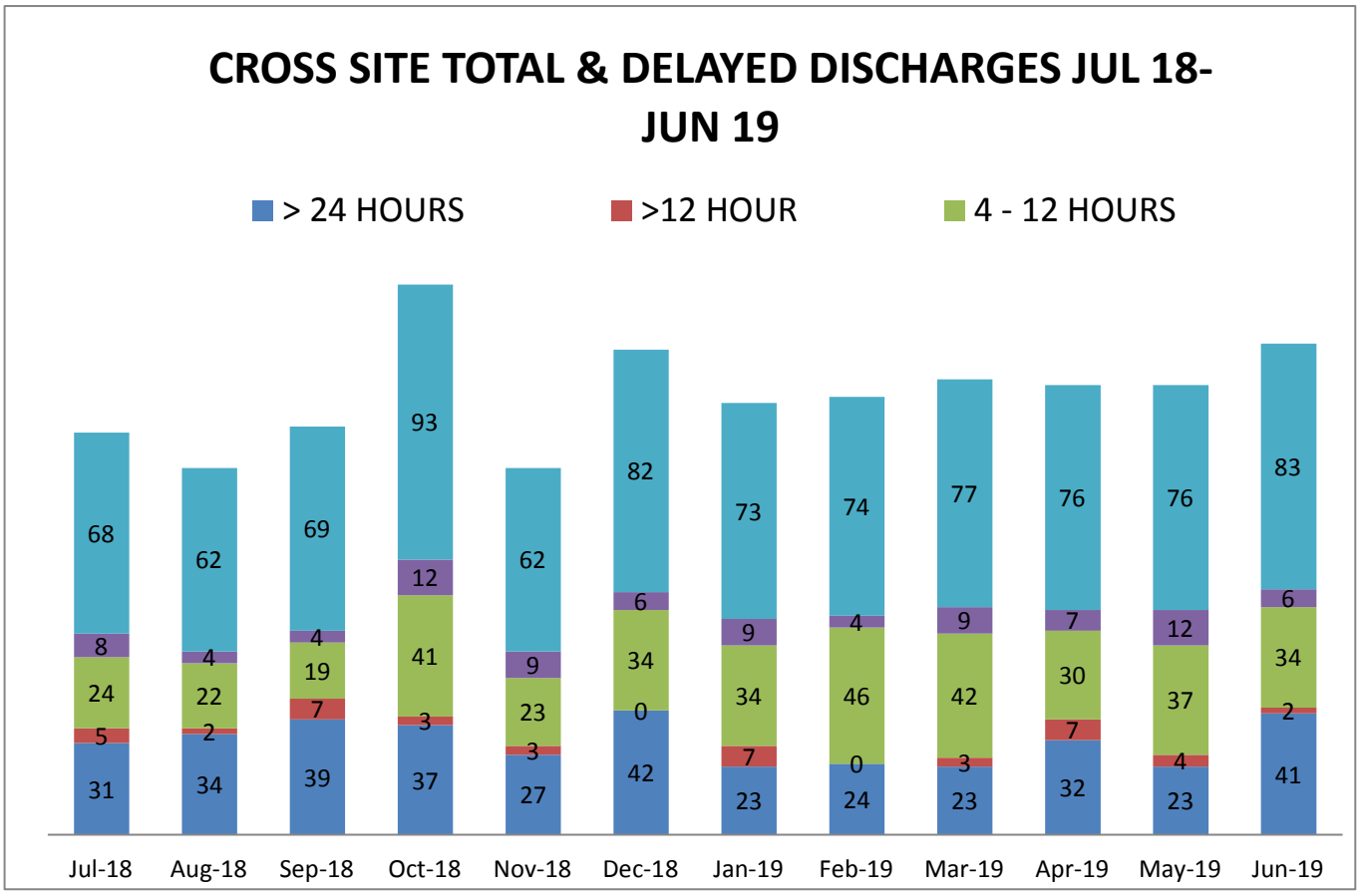
MRSA Screening (non - elective) (%)

The Trust was just below the 95% target for June 2019 with compliance of 94.3%. This is the first time the 95% target has not been achieved since February 2018.

Complaints & PALS

55 formal complaints were received in June 2019, in line with expected variation. 33 related to RSH and 22 related to PRH. No new trends were noted in relation to subjects or location. 165 PALS contacts were received.

Delayed Discharges from ITU and Mixed Sex Accommodation Breaches



There were 43 patients who experienced a delayed discharge >12 hours from Critical Care out of a total 83 patients transferred in June 2019. Of these delays, 21 patients experienced a mixed sex accommodation breach – 9 patients from ITU/HDU at The Royal Shrewsbury Hospital and 12 patients from ITU/HDU The Princess Royal Hospital.

Friends and Family Test

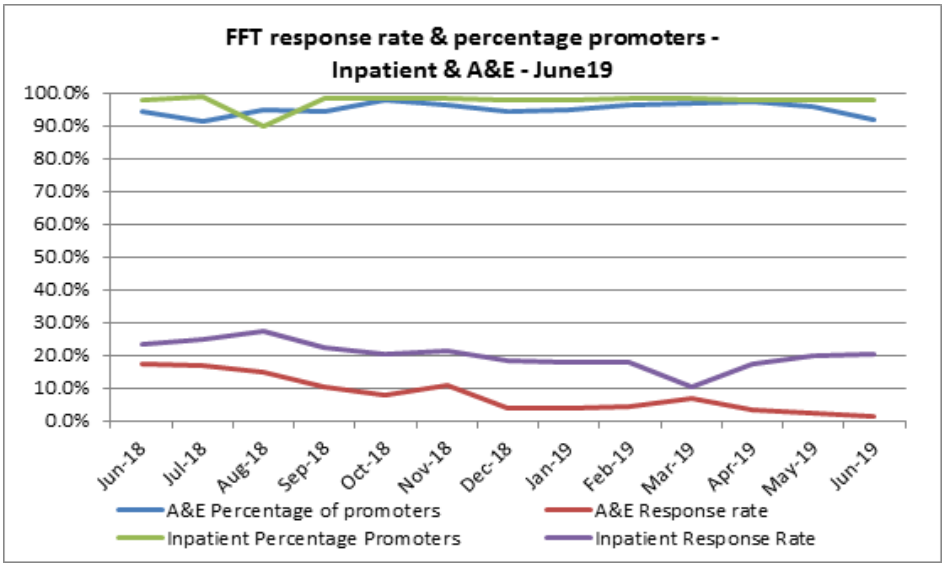
The overall percentage of patients who would recommend the ward they were treated on to friends and family, if they needed similar care and treatment, was 97.8% which was the same as May. Individually, Inpatients remained at 98.1% and Maternity increased from 99.4% in May to 100% in June. Outpatients saw a very slight decline from 97.5% in May to 97.3% in June and A&E decreased from 95.7% to 92.1% in June.

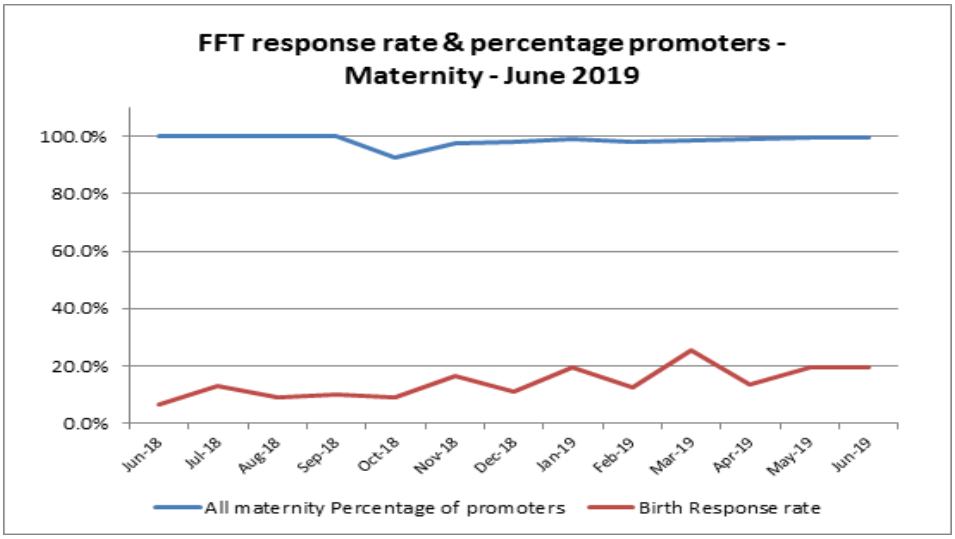
The overall response rate this month was 11.3% which a slight decrease of 0.2% on May. Birth saw a great increase of over 17% compared to May; reaching 37% in June. Inpatients also saw an increase from 19.7% to 20.5%. A&E however did drop from 2.5% to 1.2% response rate in June.

The overall data for June 2019 is as follows:

The FFT response rate = 11.3%
The FFT percentage of recommenders = 97.8%

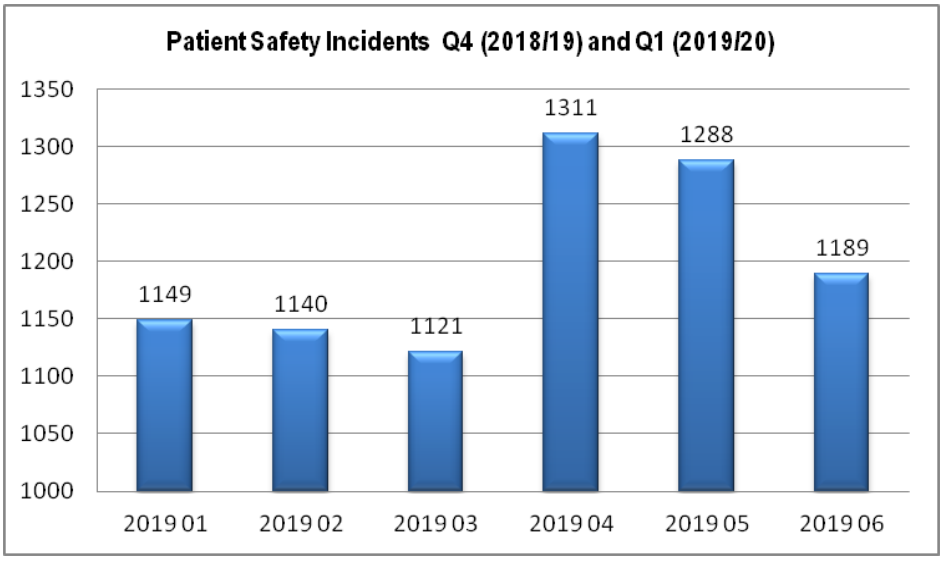
	Percentage of Recommenders	Response Rate
Inpatient	98.1%	20.5%
A&E	92.1%	1.2%
Maternity overall	100%	37% (Birth only)
Outpatients	97.3%	NA

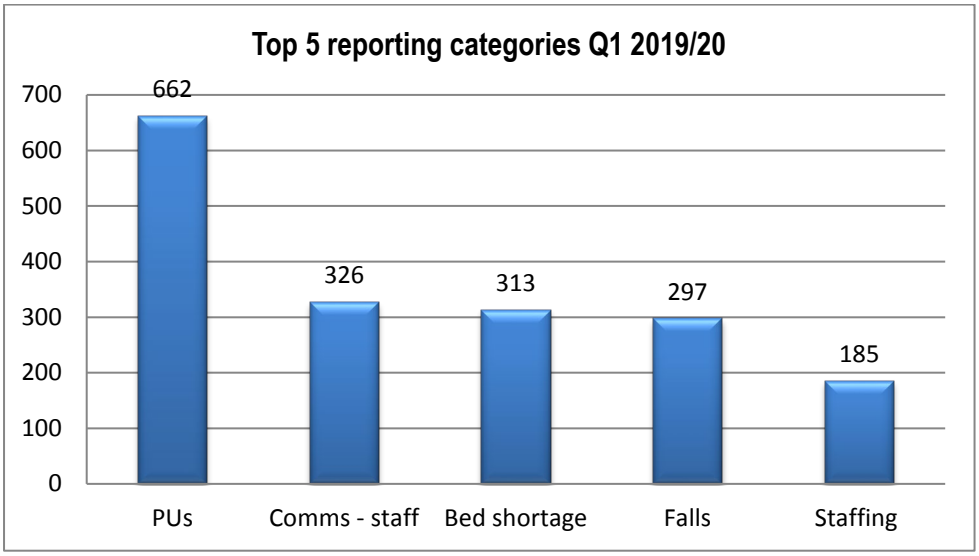


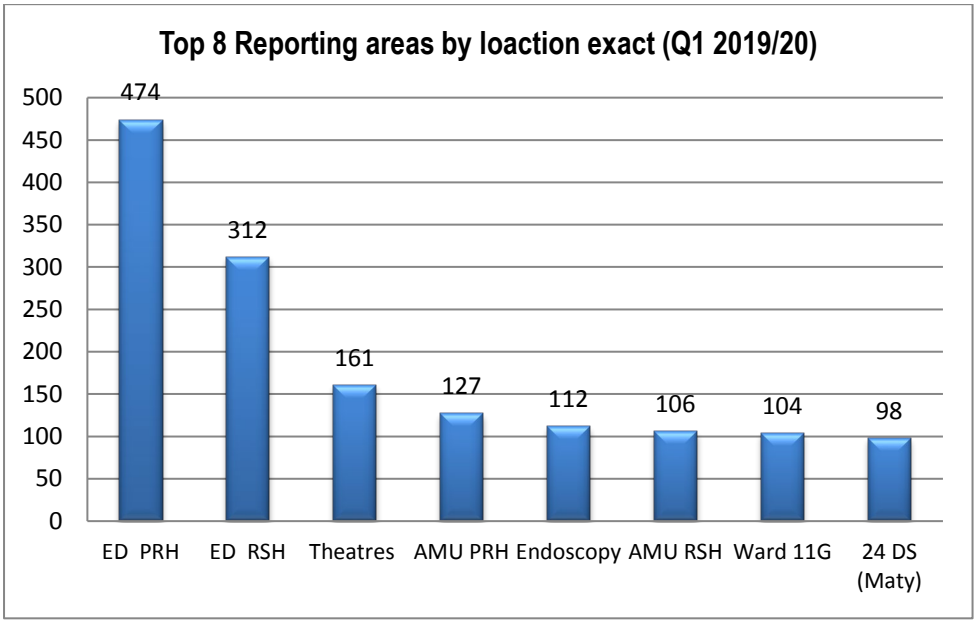


Learning from Incidents

All Patient Safety Incidents







Patient Safety Incidents

A total of 3788 PSIs were reported in Qtr 1 2019-20 across the Trust. This compares to 3675 in the same quarter of 2018/19. There has been an increase in reporting when compared to Q4 2018/19, but this correlates with changes to pressure ulcer uploads. Previously those PU's identified on admission were not uploaded as they are not a Trust harm, however, following the advice of the NHSI Pressure Ulcer recommendations (June 2018) we now upload these to the NRLS to support national monitoring.

Top Five Reporting Categories/Top Ten Areas

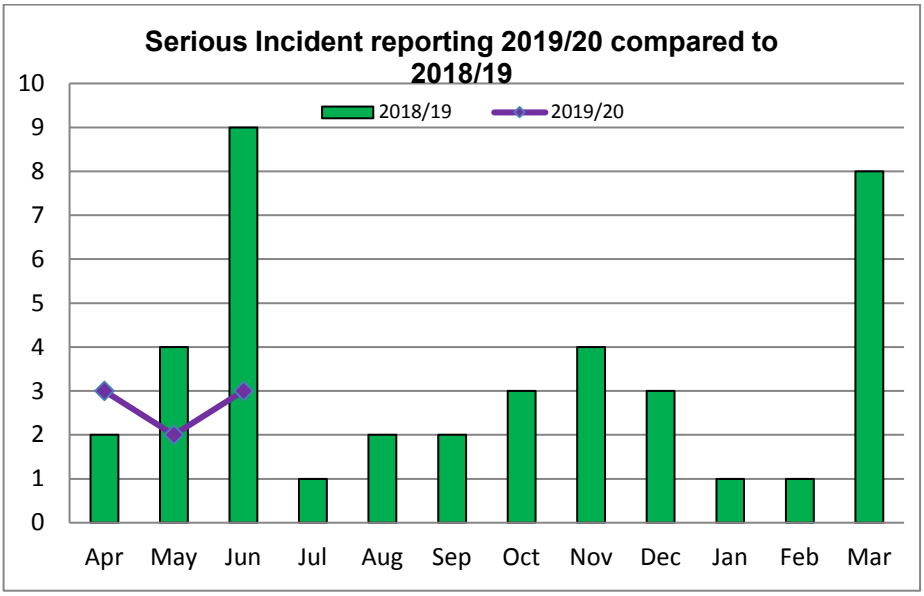
It should be noted, that of the 662 pressure ulcers reported; 492 were present on admission, 79 were skin conditions other than pressure ulcers; meaning 50 potential pressure ulcers reported were Trust acquired (12 of which were category 1). Staffing concerns were reported in the top five for the third consecutive quarter. The top 2 reporting areas remain consistent, the majority of their reporting relates to recording pre-admission skin damage.

Patient safety incident management current status and/of Q1 2019/20	In holding area, awaiting review	Being reviewed	Awaiting final approval	Final approval	Total
Unscheduled Care Group	1353 ↑	466 ↓	952 ↑	414 ≈	3185
Scheduled Care Group	634 ≈	466 ↑	786 ↑	420 ↑	2360
Women and Children's Care Group	85 ↓	164 ↑	104 ≈	215 ↓	568
Clinical Support Services Care Group	100 ↑	78 ≈	157 ↑	19 ↓	354
Resources Directorate	48 ↑	12 ≈	16 ↑	10 ↓	86
Ambulance/ Patient first	13 ≈	11 ≈	8 ≈	0 ≈	32
Quality & Safety Directorate	22 ≈	6 ≈	29 ↑	2 ≈	59
Corporate Governance Directorate	2 ≈	3 ≈	3 ≈	1 ≈	9
Totals:	**2258** ↑	**1188** ↑	**2058** ↑	**1076** ↑	**6653**

The table above shows the detail relating to the current status of incidents and those which have been given final approval in the Quarter. The Trust Clinical Incident Management Policy requires managers to whom the incidents have been reported (the handler of the incident) to review and close the incident within specified timescales depending on the severity of the harm that may have occurred. Final approval is a process by which the relevant member of the Patient Safety Team reviews the actions and ensures that the Datix record is correct. There has been a significant increase in the number of incidents staying open when compared to Q4. Plans are being collated to consider a workable and safe solution to close off outstanding incidents but ensures that the main learning themes are not lost, this may require additional resources to make this happen.

Serious Incidents Reported in Quarter 1 2019/20

Type of Incident	Care Group	Date of incident
April:		
Surgical/invasive procedure incident	SCG	02/04/2019
Fall (sub-dural)	USCG	19/03/2019
Diagnostic delay	USCG	24/04/2019
May:		
Accident - choking	USCG	03/05/2019
Fall - #NOF	USCG	17/05/2019
June:		
Delayed Diagnosis MI	USCG	22/05/2019
Unexpected neonatal death @ day 9	W&C	12/06/2019
Diagnostic delay - Subdural haem	USCG	26/06/2019
TOTAL		**8**



Serious incidents

There have been 8 SIs reported in Q1 2019/20 compared with 15 for the same period in 2018/19. Reporting will be monitored for trends and themes, at present the themes identified relate to: complex cases where multiple MDTs contribute to confusion and lack of ownership, documentation within EDs and the reporting and reviewing of x-rays – particularly in relation to incidental findings (linked to IT issues).

June SIs

- Delayed diagnosis (MI) – Patient attended ED/AMU with a 4 day history of confusion and shut down with a possible diagnosis of Lower limb phlebitis. ECGs were performed by WMAS, ED and AMU. The patient's condition deteriorated after 22 hours in the Trust, the retrospective review of this ECG indicates that the patient may have had an MI but this was not acted upon. The investigation to date has noted that in hindsight the subtle ECG changes are evident in the ECG performed by WMAS. This patient's condition continued to deteriorate and he sadly died.
- Delayed diagnosis (sub-dural) – Patient attended ED on 25/06/2019 via ambulance with a collapse/ fainting episode, with a history of neck stiffness and headache. Impression from Ambulance team; faint-vasovagal with haematuria. On examination his EWS = 0, he was reviewed and it is noted that the patient now felt 'ok', he was noted as being orientated with no focal neurology noted, no radiology was requested. He was discharged with medication for vertigo. He returned 10 hours later following a collapse with loss of consciousness, a subsequent CT scan identified; an acute and chronic right sided haematoma; a right frontal intracerbral haematoma with acute haemorrhage. While not obviously meeting the NICE guidelines for a CT scan at his first visit, this is being raised as an SI to ensure vigorous scrutiny of the event. The patient is currently at UHNM under the care of their neurosurgery team.
- Unexpected neonatal death @ 9 days of age; baby discharged at day 7 with mother (kept in hospital for care of the mother); case reviewed, no obvious acts or omissions contributed to the outcome, it is currently believed that the patient contracted Herpes Simplex Virus. Incident reported as an SI at the request of NHSE and the DoN.

Serious Incident (SI) Reporting Status

The table below shows that there are 20 incidents open to investigation. Of these; five have agreed clock stops with commissioners due to factors affecting capacity to complete the investigation. In addition there are six investigations which have breached the external deadline due to a variety of internal and external factors. Progress on these is being managed to ensure resolution as soon as possible.

Incident Status at 09/07/2019

	New Incidents for Q1	8
	Incidents being investigated	18
	Out of internal deadline (excludes external deadline & RCAs with extensions)	1
	Out of external deadline with CCG/CSU (excludes RCAs with extensions)	7
	CCG/CSU have been asked to close incident	12

Action plan completion status

There are 21 RCA action plans out of date for 2018/19 with 0 closed since the last report. Overall the total number of RCA action plans going out of deadline has slightly increased.

Serious Incidents submitted to the Clinical Commissioning Groups in Quarter 1 2019/20 with learning identified

StEIS No	Type of Incident	Clinical Area	Learning identified
2018/26587	IG Breach	Trust Admin Hub, PRH	• Increased emphasis on ensuring that letters/envelopes are checked before sending to patients. • Use of finger cones to ensure that multiple pages separated to ensure contents of envelopes is accurate
2018/1603	Maternity/Obstetric affecting baby	W&CCG (Maternity)	• To ensure that the Latent Phase of Labour and the Intrapartum Care on an MLU or Home Birth guidelines are reviewed and updated • All sick babies should be given parental Vitamin K on admission (via feedback) • The need to prioritise actions to minimise brain injury by correcting hypoglycemia (via feedback) • Improved documentation required to ensure multi-disciplinary shared care • Multidisciplinary training on transferring sick babies from Wrekin MLU to the NNU
2018/29001	Diagnostic Delay	USCG (Medicine)	• The use of informal meetings is not reliable and does not provide a robust system for reviewing patients. • The current temporary records folders do not provide suitable instant identification that the set of notes is temporary. • Documentation and letters need date-stamping on receipt and actioning. • Clinicians must date hand-written comments on correspondence and documentation. • All administration staff should be familiar with systems and processes regarding meetings and medical records; this is particularly important when temporary staff is used. Trust-wide standardisation of systems is required. • The mixed system of paper medical records and some electronic systems present additional risks. • (The Trust is currently preparing for a full Electronic Patient Record system).
2018/30483	Treatment delay	SCG (MSK)	• Any incidental findings of aneurysms identified near to operative sites following surgery must be referred to the Vascular Team in a timely manner. If identified whilst still an inpatient, this needs to happen prior to discharge
2018/28424	Maternity/Obstetric affecting baby	W&CCG (Maternity)	• The practice of administering Pethidine to preterm women on the antenatal ward to cease effective immediately. • Development and implementation of a handover sticker following the SBAR format. To be used when care is handed over between care givers in all areas of Maternity • Development and implementation of emergency proformas for use on the Delivery Suite for common emergencies (eg: breech birth, shoulder dystocia, PPH etc) • To consider the development of standardised

StEIS No	Type of Incident	Clinical Area	Learning identified
			counseling tools to enable through and clear counseling and documentation of such discussions • To remind all staff that the most experienced practitioner available should conduct a breech birth as stated in the Trust guideline (via feedback) • Flow chart / check list to be devised and implemented detailing who should be told of a mother's transfer out of area in the event of her baby being transferred to another hospital. • Anonymised case to be used on the PROMPT training day to promote human factors awareness specifically in relation to situational awareness during the second stage.
2019/5950	Category 4 PU	USCG (Medicine)	• Patients with multiple co morbidities and bed bound are at high risk of developing pressure areas. • Accurate communication and documentation recording are essential in the monitoring of a patient at risk of pressure area deterioration to assist in preventing further deterioration.
2019/5950	Treatment Delay	SCG (Surgery)	• There is learning that has already been shared as a safety alert regarding the treatment of suspected bowel obstruction and/or pseudo-obstruction, that a naso-gastric tube should be inserted at the outset and that the patient should be kept nil by mouth until they have been personally reviewed by a surgical registrar or consultant. • The MDT co-ordinators have been informed of the case and reiterated the importance of returning the medical records of any in-patients discussed at their respective Cancer MDT meetings, to the appropriate ward. • An alert has been circulated stating that when nursing teams are experiencing difficulty contacting medical colleagues that they escalate through the senior members of the medical team.
2019/5830	Clinical Incident	SCG (Head & Neck)	• This case was originally submitted as a Never Event. The investigation has confirmed that it does not meet those criteria, or that of a Serious Incident. It was submitted for downgrade (and removal off StEIS) to the Commissioners, which has been approved.

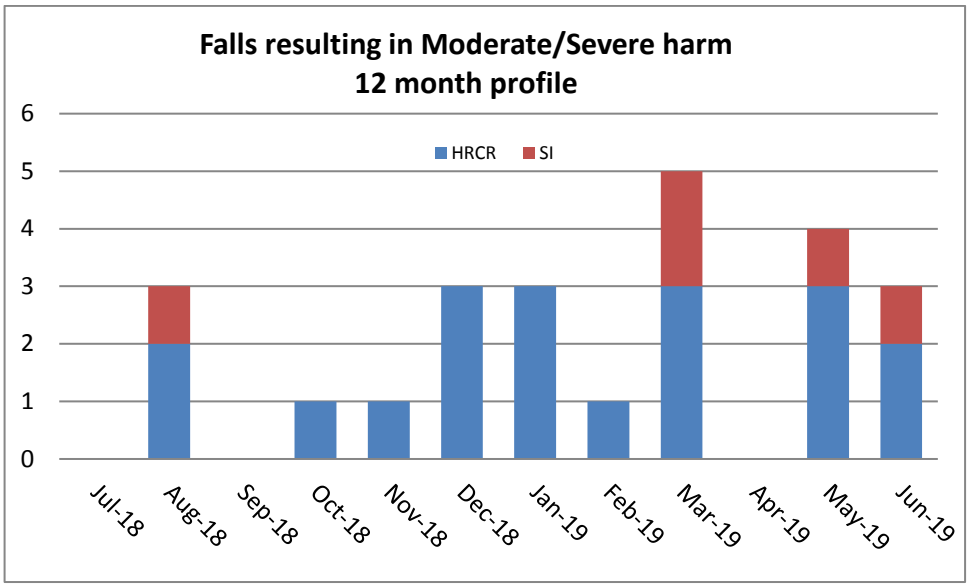
Hospital Acquired Pressure Ulcers

To date we have confirmed 20 Category 2 pressure ulcers out of a potential 56 during Qtr 1 2019/20. The learning identified from reviews of these cases identified; inconsistencies relating to accurate assessment requiring more precision, there were several relating to poor patient compliance, some with records of advice given and others which require that progression to ensure patients are aware of the risk of not taking advice. There were several with examples of very good record keeping and application of risk reduction strategies, but due to multiple co-morbidities / end of life care skin damage occurred. In such cases it can be inferred that without such input the skin damage could have been category 3 or 4.

During Quarter 1 there have been four Category 3 pressure ulcers and one Category 4 (which was a deterioration from a preadmission category 3 pressure ulcer), none of which occurred in June 2019. This is a significant reduction in reporting of either Category 3 or 4 pressure ulcers when compared to Quarter 4

2018/19 where there was an overall total of 18 Category 3 and one Category 4 pressure ulcer reported

Patient Falls

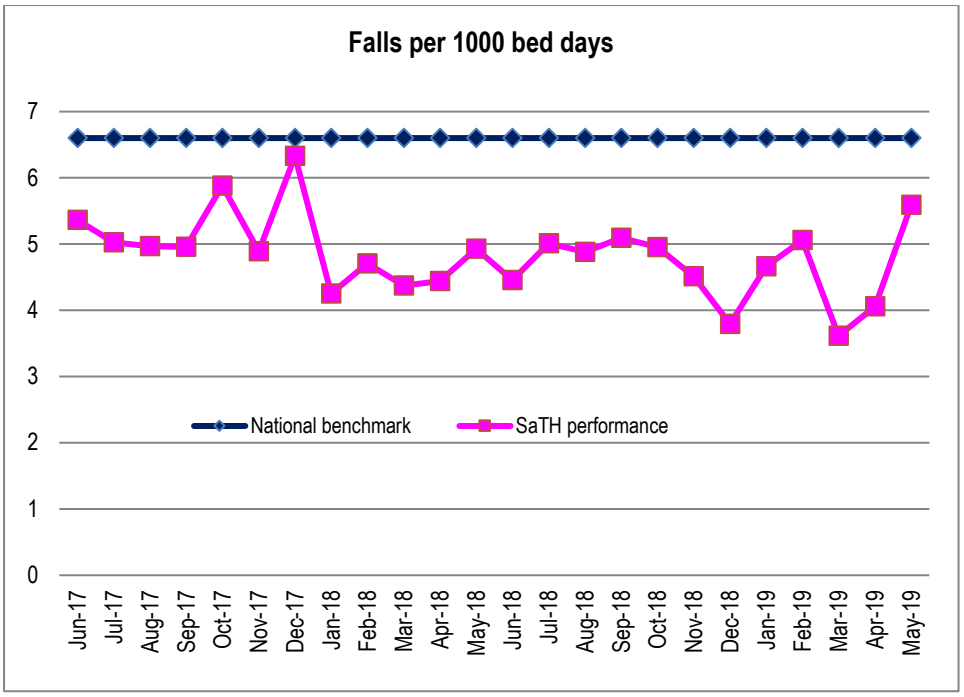


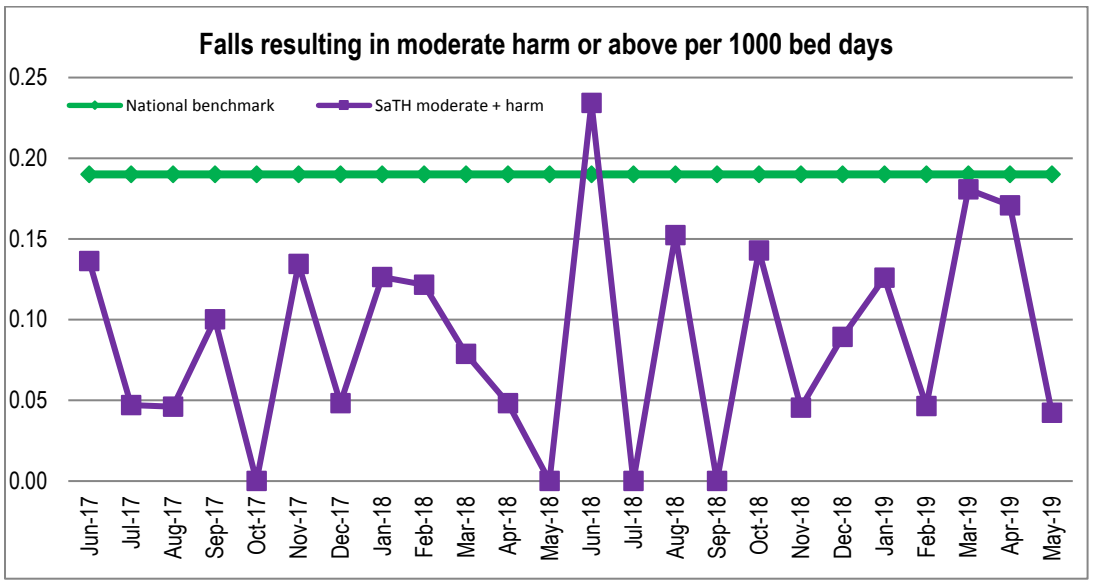
Patient falls resulting in severe harm

In Qtr 1, a total of seven patients sustained a fall resulting in moderate harm or above. Of these incidents there are two cases resulting in serious harm have been identified which are being managed as serious incidents (one reported in July's SI figures but included in the falls figures for June when the incident occurred).

During June 2019 there were two falls which have been deemed suitable to investigate as HRCR:

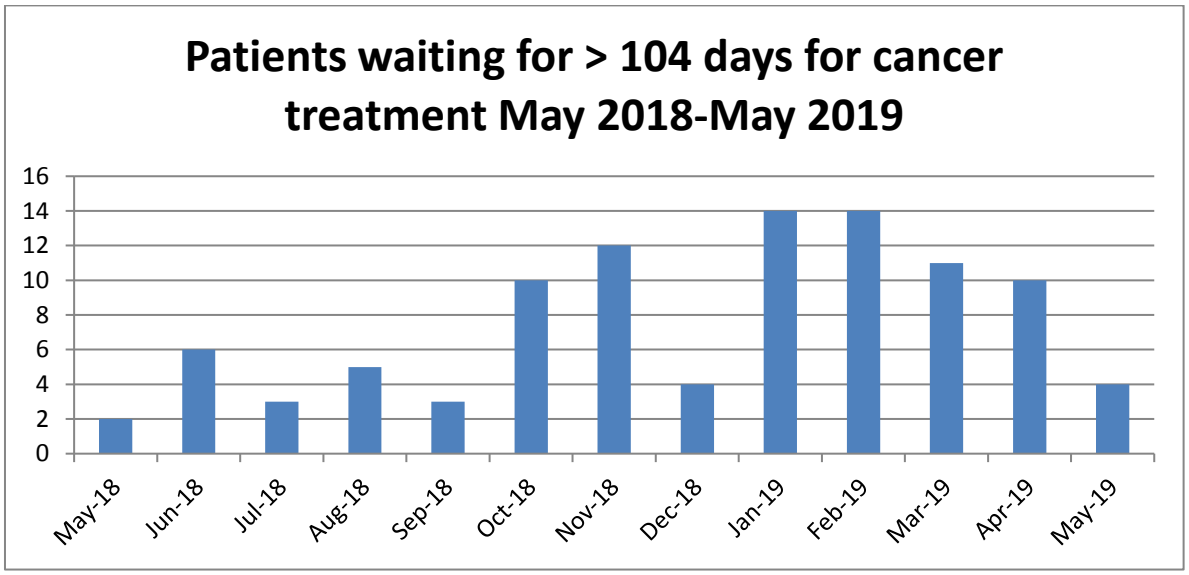
Site of injury	Rationale for not reporting as an SI
Ankle	Appropriate risk reduction strategies in place, classed as a moderate harm incident and is being managed as a HRCR.
Wrist and acetabulum	Appropriate risk reduction strategies in place, classed as a severe harm incident and is being managed as a HRCR due to no act or omission contributing to the outcome. This case has been reported under RIDDOR





*Note that information relating to bed days data is only available to the end of May

Waiting for cancer treatment for more than 104 days



Four patients waited > than 104 days for cancer treatment in May (latest available validated figures). The pathways and reasons for breach are outlined in the table below:

Pathway	Days	Reason for breach
Colorectal	120	Delay for investigations and MDT
Upper GI	109	Delay to pathway (patient had fall). Delay to discussion at partner Trust MDT. Repeated staging investigations required
Urology	154	Elective capacity/delay for diagnostics
Urology	104	Delay to diagnostics/change to treatment plan

Section Three: Mortality Review

Introduction

SaTH aspires to be an organisation delivering high quality care which is clinically effective and safe and this partly is achieved by continually monitoring and learning from mortality. These can provide SaTH with valuable insights into areas for improvement. To support that the governance around mortality is well

developed, in order to provide continued learning and improvements to the clinical pathways and to reduce unnecessary harm to patients.

1. Mortality Rate

This indicator provides a basic view of mortality: the number of deaths divided by the total spells.

SaTH Mortality Rate (March 2018 – March 2019)
SaTH 1.03% v Peer 1.26%

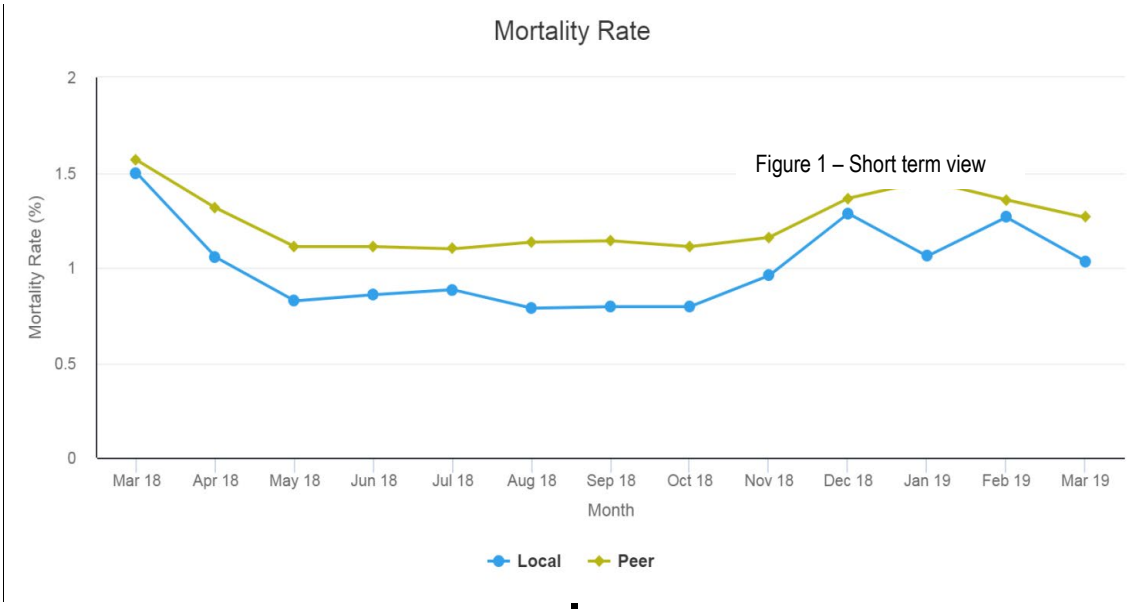


Figure 1 – Short term view

SaTH Mortality Rate (January 2014 – March 2019)

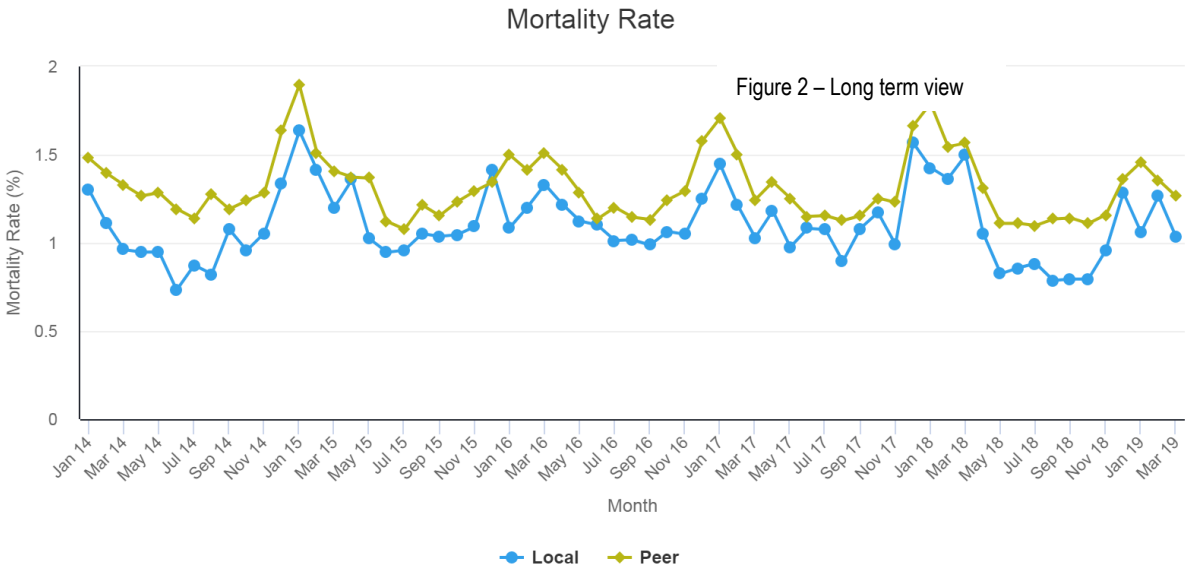


Figure 2 – Long term view

2. RAMI – Risk Adjusted Mortality Index *

RAMI (March 2018 – March 2019)
SaTH 86.29 v Peer 87.63

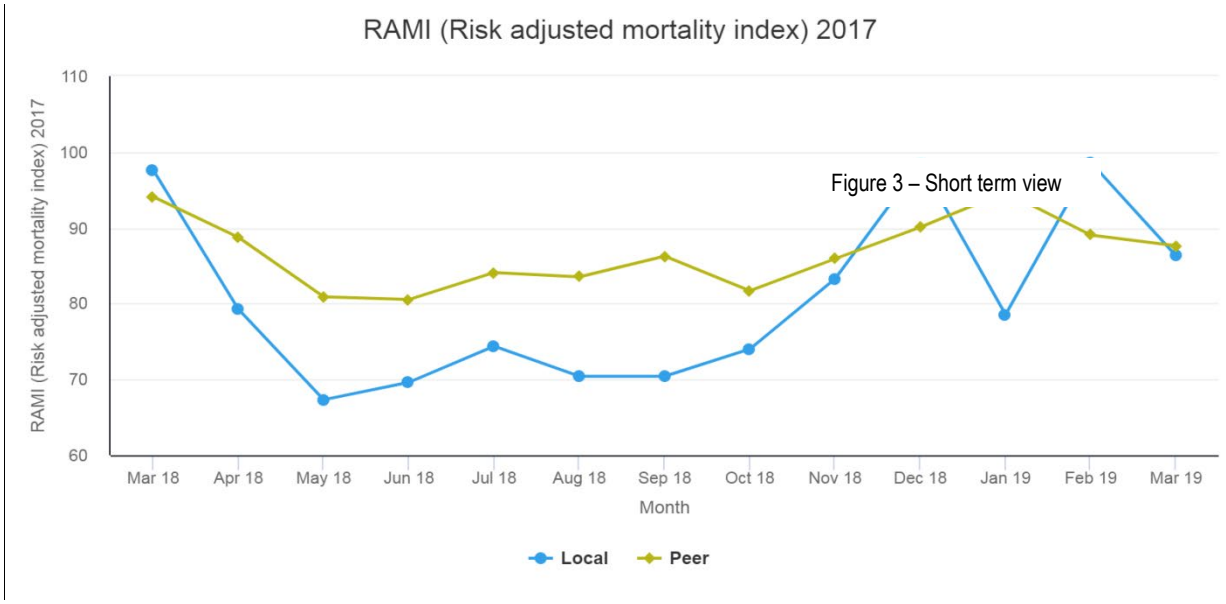


Figure 3 – Short term view

RAMI – SaTH v Trust Peer (January 2014 – March 2019)

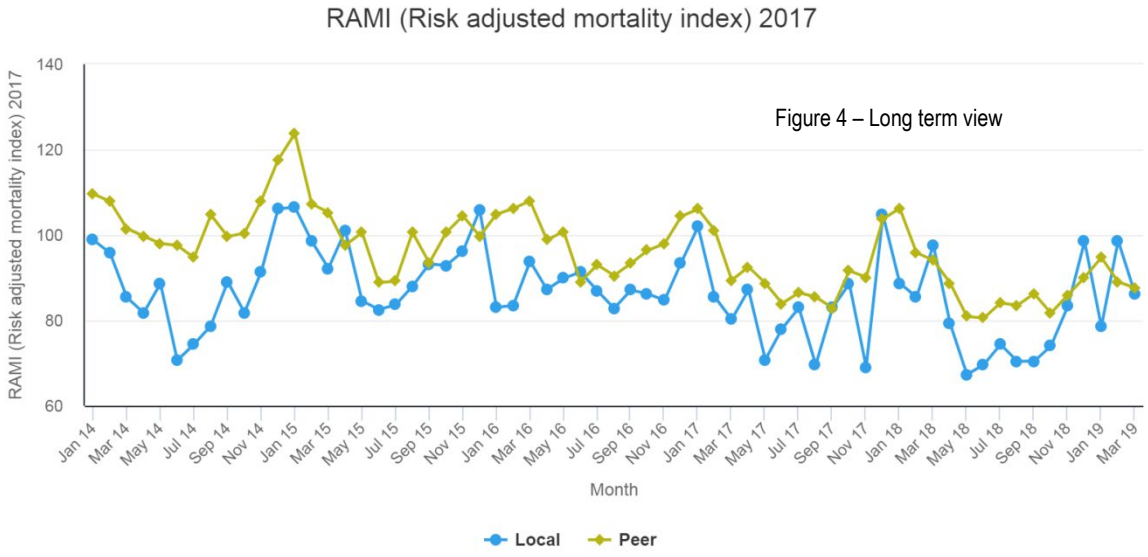


Figure 4 – Long term view

* This mortality ratio is described as the number of observed deaths divided by the number of predicted deaths. RAMI was developed by CHKS (Caspe Healthcare Knowledge System). It includes palliative care but excludes certain specialties, such as Mental Handicap, Mental Illness, Child & Adolescent Psychiatry, Forensic Psychiatry, Psychotherapy, Old Age Psychiatry.

3. HSMR – Hospital Standardised Mortality Ratio **

HSMR (March 2018 – March 2019)
SaTH 91.99 v Peer 97

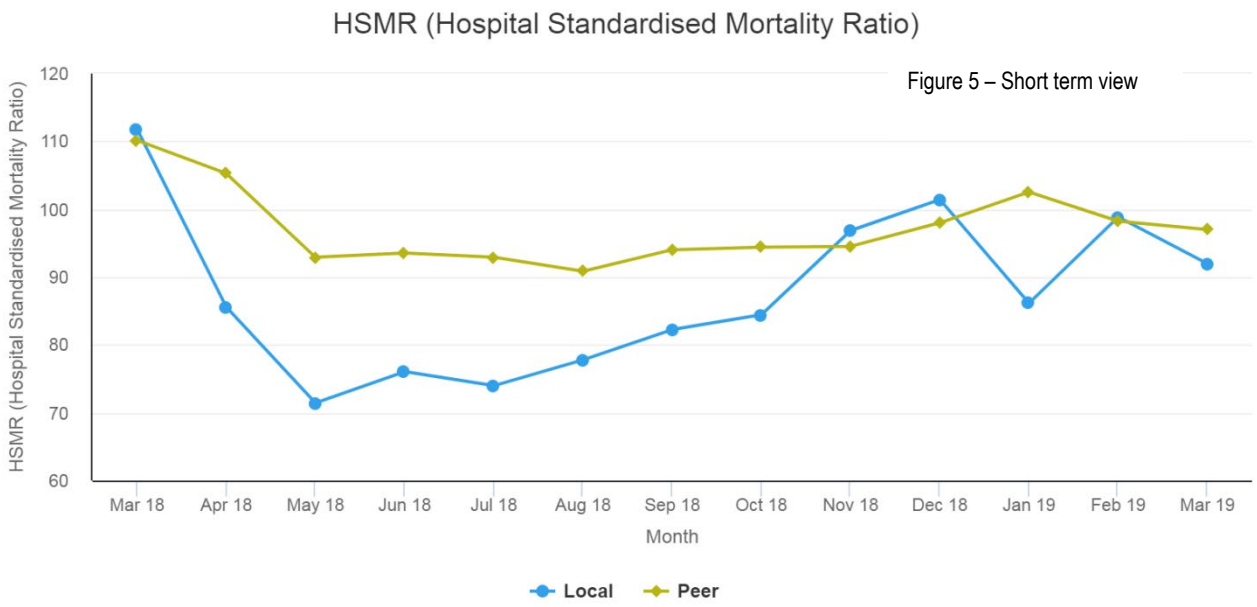


Figure 5 – Short term view

HSMR - SaTH v Trust Peer (January 2014 – March 2019)

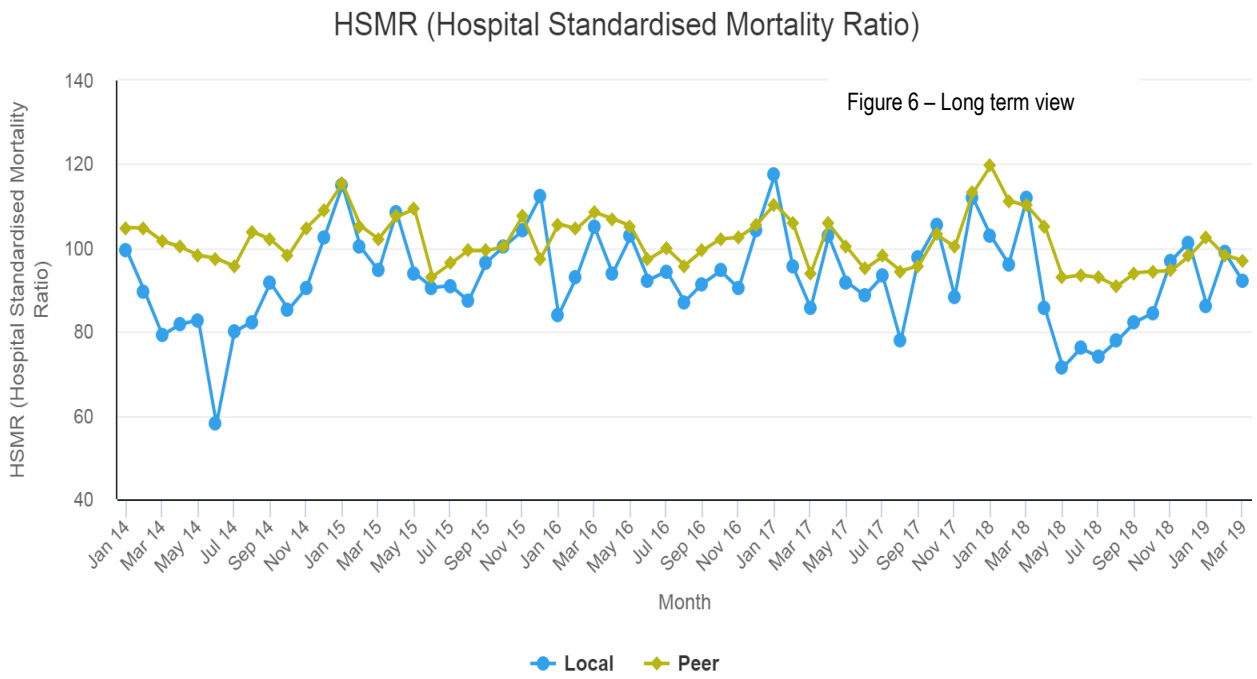


Figure 6 – Long term view

** The HSMR is the ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups. These groups contribute to over 80% of in-hospital deaths in England.

NB A value greater than 100 means that the patient group being studied has a higher mortality level than NHS average performance.

4. SHMI – Summary Hospital-level Mortality Indicator (In-hospital) ***

In-Hospital SHMI (March 2018 – March 2019)
SaTH 58.35 v Peer 62.97

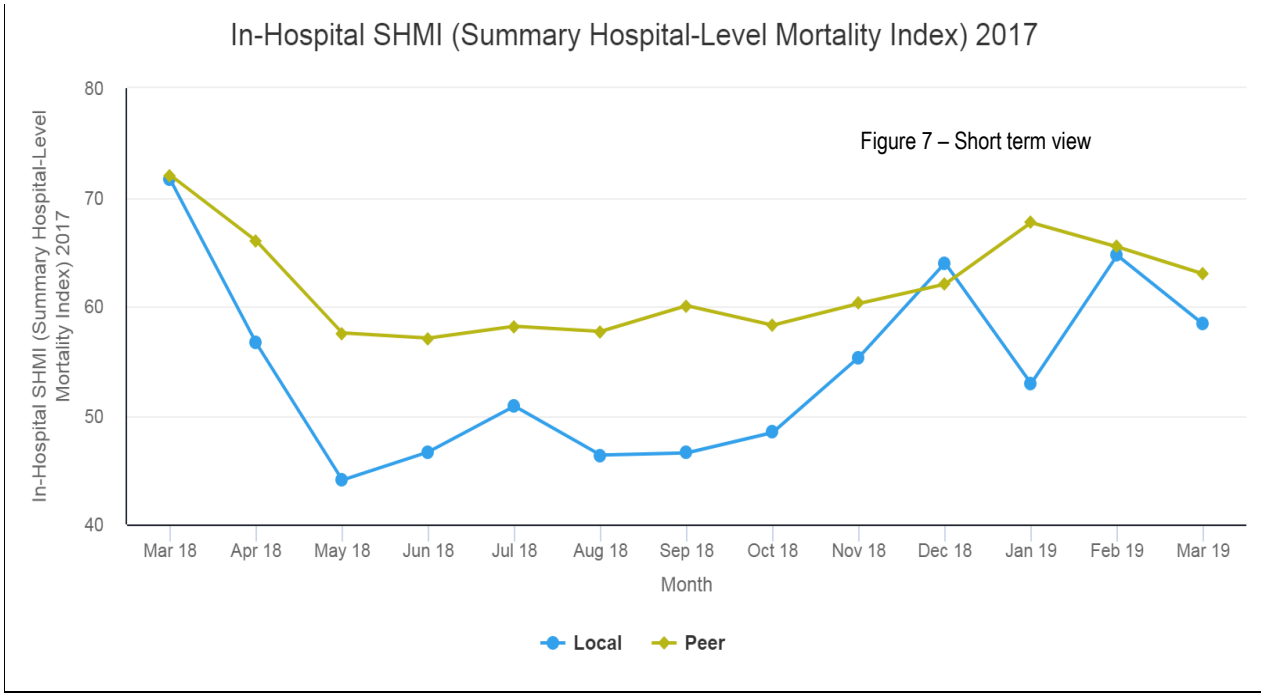


Figure 7 – Short term view

In-Hospital SHMI - SaTH v Trust Peer (January 2014 – March 2019)

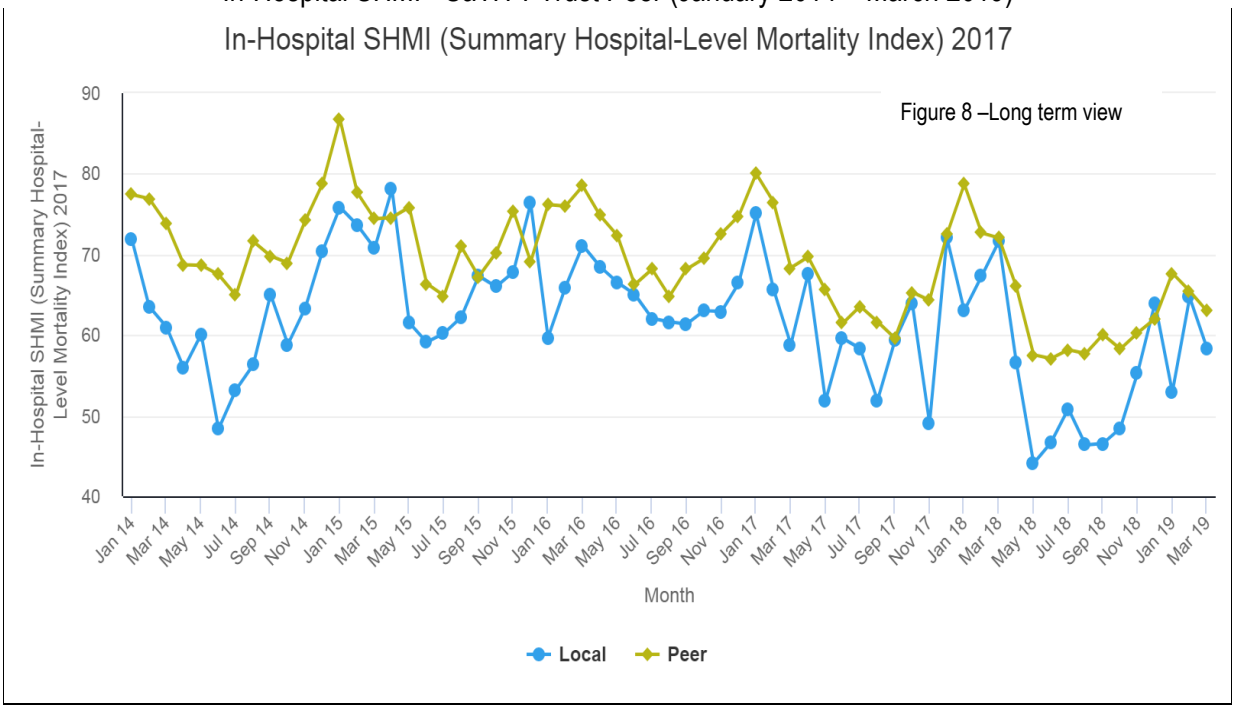


Figure 8 –Long term view

*** The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die, on the basis of average England figures, given the characteristics of the patients treated there. SHMI gives a complete picture of measuring hospital mortality by including deaths up to 30 days after discharge from hospital and is counted once against the discharging hospital. This does not exclude palliative care but does exclude day cases. It is based on 259 clinical classification system diagnostic groups.

SHMI-type indicators **cannot** be used to quantify hospital care quality directly due to the limitations of datasets in SUS and HES

Section Four: Recommendations for the Committee

The Quality and Safety Committee is asked to:

- Discuss the current performance in relation to key quality indicators as at the end of June 2019
- Consider the actions being taken where performance requires improvement
- Question the report to ensure appropriate assurance is in place