North Somerset
Clinical Commissioning Group

Reference Guide to CCG Quality Dashboard
**Introduction**

North Somerset Clinical Commissioning Group (CCH) has designed quality metrics for the services it commissions, and there will be three separate dashboards: one for each of the acute trusts, Weston Area Health Trust and North Bristol Trust, North Somerset Community Partnership and Avon Wiltshire Partnership Mental Health Trust. They are structured under the headings of the NHS Outcomes Framework with the addition of a set of staff well-being measures.

The dashboards comprise the quality requirements of the Trust’s 2013/14 contract, including CQUINs (Commissioning for Quality Indicators) and national and local quality premium indicators. A narrative report has been drafted to provide an analytical view of the data available in the dashboards.

**North Somerset CCG Quality Dashboard**

These are measures at CCG level and will include combined quality measures of all acute Trusts.

**A.1/A.2 Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)**

This measure is one of the local quality premium indicators identified by North Somerset CCG 2013/14 and relates to the aim of reducing the time spent in hospital by patients with long-term conditions. The results will be a composite figure from the NHS Information Centre and it is anticipated that data will be available from July 2013.

**B.1/B.2/C.1/C.2 Number of unplanned admissions for children with lower respiratory tract infections, Number of unplanned admissions for asthma in children, Number of unplanned admissions for diabetes in children & Number of unplanned admissions for epilepsy in children**

These measures are local quality premium indicators identified by North Somerset CCG 2013/14 and relate to the aim of reducing the time spent in hospital by children with specific long-term conditions. The results will be a composite figure from the NHS Information Centre and it is anticipated that data will be available from July 2013.

**D Summary hospital mortality indicator**

This is the new hospital-level indicator which is reported from the NHS Information Centre and Dr Foster Intelligence. Like the HSMR, it is the ratio of the observed number of deaths to the expected number of deaths, and also like HSMR, a SHMI of above 100 is below average performance for an NHS acute Trust.

The observed deaths are the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days of discharge. The expected number of deaths is calculated from a risk adjusted model with a patient case-mix of age, gender, admission method (elective/emergency), year, Charlson Comorbidity Index and Diagnostic Grouping.

**E.1 Percentage of patients with diabetic foot ulceration referred to multidisciplinary team with 24 hours**

Diabetes is one of the biggest health challenges facing the UK today, and as the longevity of the population increases, the incidence of diabetes-related complications also increases. Among the complications of diabetes are foot problems, the most common cause of non-traumatic limb amputation. The feet of people with diabetes can be affected by neuropathy, peripheral arterial disease, foot deformity, infections, ulcers and gangrene. Diabetic foot problems have a significant financial impact on
the NHS through outpatient costs, increased bed occupancy and prolonged stays in hospital. In addition, diabetic foot problems have a significant impact on patients’ quality of life; for example, reduced mobility that may lead to loss of employment, depression and damage to or loss of limbs. Diabetic foot problems require urgent attention, as any delay in diagnosis and management increases morbidity and mortality and contributes to a higher amputation rate.

Clinical Guideline 119, was published by NICE in March 2011, but has since been incorporated into the Diabetes pathway. It recommends that each hospital should have a care pathway for patients with diabetic foot problems who require inpatient care and have a multi-disciplinary foot care team with the specialist skills and competencies necessary to deliver inpatient care for patients with diabetic foot problems. This is a locally decided indicator and the thresholds will be set based on the first six months’ data.

E.2  Percentage of diabetic amputations against total number of admissions for diabetic patients
To be completed.

Domain 1 - Preventing people from dying prematurely

1.1  Summary hospital mortality indicator
This is the new hospital-level indicator which is reported from the NHS Information Centre and Dr Foster Intelligence. Like the HSMR, it is the ratio of the observed number of deaths to the expected number of deaths, and also like HSMR, a SHMI of above 100 is below average performance for an NHS acute Trust.

The observed deaths are the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days of discharge. The expected number of deaths is calculated from a risk adjusted model with a patient case-mix of age, gender, admission method (elective/emergency), year, Charlson Comorbidity Index and Diagnostic Grouping.

1.2  Number of patients on outlying wards other than the specialist area
It is an accepted fact that patients who are cared for outside of their speciality area are likely to have a longer length of stay and are more likely to either have a less good clinical outcome or suffer unnecessary complications. This is a locally decided indicator, and as no historic data is available the threshold will be agreed based on the first six months’ data for 2013/14.

This measure is in development with Trusts.

1.3  Percentage of patients receiving thrombolysis within 30 minutes of arriving at hospital
The National Service Framework (NSF) standard is that people suffering from heart attack should receive thrombolytic therapy within 60 minutes of calling for professional help. The national target is that at least 75% of patients will be treated within 30 minutes (30 minute door to needle time) of arrival in hospital.

1.4  Survival to discharge - cardiac arrest calls
This refers to in-hospital cardiac arrests outside of the Emergency Department, and may be an indication of a failure to recognise a deteriorating patient. The data should only include those cases where no Do Not Actively Resuscitate decisions
have been formally documented. This is a locally determined indicator, based on measures used in the NHS Southwest Quality and Patient Safety Improvement Programme. The thresholds have been agreed as follows:

1.5 **Number of patients identified with high alcohol consumption offered brief intervention**

It is recognised that simply collecting data about alcohol consumption is unlikely to change the clinical outcome for this group of patients. Therefore the CCG is keen to measure how many patients identified as consuming high levels of alcohol are offered help in the form of a brief intervention. As with indicator 1.6 this locally agreed indicator is baseline data for inclusion in the quality dashboard(s) for 2013/14 and only captures information from patients undergoing elective procedures this year.

1.6/1.7 **Percentage of cancer patients waiting more than two weeks for first appointment & Percentage of cancer patients treated within 62 days from referral**

It is accepted that cancer targets are historically considered under performance targets, but they are also an indication of quality of care, hence their inclusion in the quality dashboards. This is a nationally driven indicator.

1.8 **Smoking cessation rates**

The Department of Health is committed to reducing smoking rates across England and as long ago as 1993 the National Institute for Health and Care Excellence (NICE) published a document “Meeting Department of Health smoking cessation targets: Recommendations for primary care trusts”.

More recently Public Health England has reported that the biggest individual risk factor to the burden of illness and disease in the UK is tobacco (12%), followed closely by high blood pressure and high body-mass (nine per cent each), and then physical inactivity, alcohol and poor diet (five per cent each). Compared with the other 18 countries, the UK does worse for premature mortality (years of life lost) for most conditions and its relative position has worsened since 1990.

Historically, public health has been seen to be the responsibility of Primary Care, but Secondary Care has a key role to play, especially in respect of smoking cessation. Therefore this locally decided measure has been included and it is suggested that initially data is captured from patients attending pre-assessment clinics for elective surgery regarding the number of smokers referred to the smoking cessation service.

1.9 **Enhanced access to health checks programme**

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. Learn more inside. For further information [http://www.healthcheck.nhs.uk](http://www.healthcheck.nhs.uk)
Domain 2. Enhancing quality of life for people with long term conditions

2.1 Percentage of patients aged 75 and over where dementia screening question is asked.
This is a national 2013/14 CQUIN measure and refers to the number of patients over the age of 75 asked the question “have you (or your relative) been more forgetful over the past 12 months to the extent that it has affected you (their) life?” It is aimed at early identification of dementia and subsequent early supportive intervention and treatment.

2.2 Percentage of patients with positive screening test who have formal screening assessment
As above this is part of the national 2013/14 CQUIN measures and where patients have tested positive to the initial screening question there is an expectation that they will be formally assessed for the likelihood of dementia, using a recognised assessment tool.

2.3 Percentage of patients with a new positive dementia screening question, referred for specialist diagnosis
This element of the national 2013/14 CQUIN expects patients who have been positively screened and assessed for dementia are referred for formal diagnosis by an expert in dementia diagnosis and care. This can be in the form of inclusion in the discharge letter back to the GP asking for onward appropriate referral for formal diagnosis.

Domain 3 - Helping people recover from episodes of ill health or following injury

3.1 Emergency readmissions within 30 days of discharge from hospital
This locally decided indicator measures the percentage of patients discharged from one of the Trust’s hospitals in the month, that were readmitted as an emergency within 30 days of the original discharge date. The target is for the rate of readmissions to be lower than in 2011/12. The figures follow the national rules for reporting emergency readmissions, and exclude certain categories of patients, that by the nature of their condition are more likely to be re-admitted as an emergency (e.g. patients with cancer).

3.2 Unplanned return to theatre within same episode of care
Patients occasionally need to have more than one operation whilst an inpatient, but if a return to theatre is required it should ideally be a planned situation. The need for a patient to go back to theatre for an unplanned second operation in the same episode of care should be an exception rather than a rule. It may be an indication of poor surgical technique during the first operation, a failure to recognise a deteriorating patient or incomplete/inaccurate assessment of the patient before the first operation. This is a locally decided indicator and as data has not previously been captured the thresholds will be agreed after the first six months of data capture.

3.3 Unplanned transfer to higher level of care
This measure is similar to 3.2, in that if a patient is assessed as being high risk or in need of high dependency of intensive care this should be a planned transfer. Unplanned transfers to a higher level of care, such as but not exclusively, HDU, ICU or Coronary Care Unit or a tertiary centre may be an indication of poor clinical care, a failure to recognise a deteriorating patient or incomplete/inaccurate assessment of
the patient. This is a locally decided indicator and as data has not previously been captured the thresholds will be agreed after the first six months of data capture.

3.4, 3.5 and 3.6  Patient reported outcome measures - hip replacement, total knee replacement and groin hernia repair
Since 1 April 2009 all providers of care funded by the National Health Service (NHS) in England have been required to provide Patient-Reported Outcome Measures (PROMs) in four elective surgical procedures: hip replacement, knee replacement, varicose vein surgery and hernia surgery. Patients are asked to complete a questionnaire before undergoing the surgical procedure; a follow-up questionnaire is then sent to the patient some weeks or months later. It should be noted that patient participation is, however, not compulsory.

PROMs national-level headline data is published every month with additional organisation and record-level data made available each quarter and data is provisional until a final annual publication is released each year. This is a national programme, but the decision to include the results in the performance dashboards is a local one.

3.7  Emergency admissions for acute conditions that should not usually required hospital admissions
This measure is one of the CCG Outcome Indicators for 2013/14 and relates to a specific group of acute conditions that should usually be managed in the community. The data is reported by the Health and Social Care Information Centre annually on a rolling quarterly basis. It is relevant all emergency admissions where the initially ICD 10 code is included in the following list as defined by the Department of Health:

Respiratory conditions including;
- influenza,
- pneumonia (due to Streptococcus, Haemophilus Influenza, Streptococcus B, mycoplasma pneumonia, bacterial pneumonia, pneumonia due to other infectious organisms, lobar pneumonia, and other non-specific pneumonia)
- diphtheria
- whooping cough

Viral infections of the skin including:
- measles
- rubella

Other viral diseases including;
- acute hepatitis A
- mumps

Infectious arthropathies including:
- rubella arthritis, excluding people with sickle cell disorders
Metabolic diseases including;
  - Volume depletion
  - Dehydration
  - Hypovolaemia

Gastro-intestinal diseases including;
  - Non-infective gastro-enteritis
  - Non-infective colitis
  - Salmonella enteritis
  - Other bacterial intestinal infections
  - Unspecified bacterial foodborne intoxication
  - Cryptosporidiosis
  - Viral and other specified intestinal infections
  - Other gastroenteritis and colitis infections of unknown origins

Genito-urinary diseases including;
  - Acute tubulo-interstitial nephritis
  - Pyelitis
  - Pyelonephritis
  - Chronic tubulo-interstitial nephritis
  - Chronic constructive pyelonephritis
  - Non-specific pyelonephritis
  - Pyonephrosis
  - Unspecified renal tubulo-interstitial disease
  - Urinary tract infection
  - Unspecified proteinurea
  - Stress incontinence
  - Overflow incontinence
  - Reflex incontinence
  - Urge incontinence
  - Cystitis

Diseases of the digestive system including;
  - Gastric ulcer with perforation or haemorrhage (excluding acute peptic erosion)
  - Duodenal ulcer with perforation or haemorrhage
  - Unspecified site peptic ulcer (excluding peptic ulcer of the newborn)
  - Gastrojejunal ulcer (excluding primary ulcer of the small intestine)
  - Oesophagitis, (excluding erosion of the oesophagus and reflux oesophagitis)
  - Gastro-oesophageal reflux disease

Diseases of the skin including;
  - Cellulitis
  - Acute lymphadenitis
  - Pyoderma
  - Specified and unspecified local infections of the skin
- Pyoderma gangrenosum
- Impetigo
- Cutaneous abscess

Diseases of the ear, nose and throat including:
- Suppurative and unspecified otitis media
- Otitis media
- Acute pharyngitis
- Acute tonsillitis
- Acute upper respiratory infections of multiple and unspecified sites
- Chronic nasopharyngitis
- Acute laryngitis

Other conditions including:
- Necrotising ulcerative stomatitis
- Dental caries
- Other diseases of hard tissue of teeth
- Diseases of pulp and periapical tissues
- Gingivitis and periodontal diseases
- Other disorders of gingiva and edentulous alveolar ridge
- Other diseases of teeth and supporting structures
- Cysts of oral region
- Stomatitis and related lesions
- Diseases of the lip and oral mucosa
- Febrile convulsions
- Unspecified convulsions
- Eclampsia
- Myoclonus
- Crush injury of shoulder and upper arm

3.8 Number of “zero hours” emergency admissions
This is a locally decided indicator. In 2011 the Kings’ Fund suggested that the NHS could save at least £1 billion if it used hospital beds more efficiently. There has been an increasing trend in emergency admissions with approximately 50% of all patients admitted as an emergency staying less than 24 hours. This may be due to a number of factors; for example:
- the patient could have been managed in the community, but was unable to access appropriate advice or care
- lack of senior clinical advice for junior medical staff making the initial assessment in hospital, resulting in a potentially unnecessary admission
- lack of support to allow the patient to be discharged home (including care home reluctant to accept patient back after assessment)

3.9 Percentage of patients with fractured neck of femur operated on within 36 hours
This is a locally decided indicator, based on the Best Practice Tariff (BPT) for hip fractures which requires all of the following to be achieved:
- a) Surgery within 36 hours from admission to hospital
- b) Orthogeriatric review within 72 hours of admission to hospital
c) Joint care of patients under a T&O Consultant & Orthogeriatrician Consultant
d) Completion of a Joint Assessment Proforma
e) MDT rehabilitation led by an Orthogeriatrician
f) Falls Assessment
g) Bone Health Assessment
h) Abbreviated Mental Test done on admission & pre-discharge

The key to a good clinical outcome is the speed with which a patient has surgery following admission; therefore the threshold set is as follows:
Fractured neck of femur patients treated within 48 hours: 60 -79 % = Red, 80-99% = Amber and >99% = Green

3.10 Percentage of non-essential surgery not performed within working hours
Evidence suggests that the outcome is better if non-elective surgery is performed within normal working hours, when full support services and optimum number of senior clinicians are available. It is accepted that emergency surgery, by its nature may need to be performed out of normal working hours. This measure reviews the percentage of non-essential surgery performed outside normal working hours and may be an indication of poor organisation of operating lists or over-running lists or pressure to meet waiting times. This is a locally decided indicator and as data has not previously been captured the thresholds will be agreed after the first six months of data capture.

Domain 4 - Ensuring that people have a positive experience of care

4.1 Friends & Family Test - Provider Response Rate
This is a national CQUIN measure for 2013/14 and requires all acute providers to offer all adult inpatients and adults not admitted from Emergency Departments the opportunity to comment on the quality of care using a standard question ('How likely are you to recommend our ward / A&E department to friends and family if they needed similar care or treatment?'). The scale of answer options must be used from extremely unlikely to extremely likely.

The first measure expects a trust-wide response rate of 15% in quarter one, increasing to a minimum response rate of 20% by quarter four, but providers will need to put in place implementation plans for rolling out the Friends and Family Test to other areas during 2013/14, with the first mandated area being maternity services by October 2013.

Two one-off returns are required from providers to local commissioners on their position at the end of October 2013 and March 2014.

4.2 Friends & Family Test – Net Promoter Score of patients who would recommend the provider to a friend or family
The Net promoter score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent

4.3 & 4.4 Total number of complaints received and as a rate per 1,000 bed days
The CCG recognises the importance of listening to and learning from patients when things go wrong or do not go as expected. There is an expectation that all providers
will meet the national requirements in respect of managing complaints and ensuring the lessons are learned. Therefore the following locally decided metrics have been selected:

- Overall number of complaints
- Overall number of complaints expressed as a percentage of activity, which is a good tool when trying to compare organisations with each other.

4.5 **Percentage of complaints responded to within agreed timescales**

It is not only important to listen to and learn from patients when things go wrong but it is equally important to provide a substantive response within the timescale agreed with the complainant. The changes made to the complaints’ legislation in 2009 allowed for a negotiation of timescales for responding to complaints. This makes allowances for the more complex complaints, involving more than one service or where an individual investigator is away from work for an extended period of time. Having agreed an achievable timescale with a complainant it is crucial that this timescale is met and only altered in exceptional circumstances. The threshold set is as follows:

- \(< 75\% = \text{Red}\)
- \(76\% - 89\% = \text{Amber}\),
- \(>90\% = \text{Green}\)

4.6 **Percentage of carers of people with dementia who feel supported**

This national 2013/14 CQUIN supplements measures 2.1, 2.2 and 2.3, but focusses on the support offered to carers of patients with dementia or cognitive impairment. Providers are required to undertake a monthly audit of carers of people with dementia and report the findings to their Board at least twice per year. The content of this audit is for local determination but must include a question on whether carers of people with dementia feel adequately supported.

4.7/4.8 **Number of local satisfaction surveys conducted, Percentage of patients rating overall care as excellent or very good & Percentage of patients rating staff attitude as excellent or very good**

It is accepted that all secondary care providers participate in the national patient satisfaction surveys, but this provides limited information about the quality of care provided and therefore providers are expected to develop a local survey for use across their services throughout the year. These locally decided measures consider the number of patients surveyed each month using a locally agreed tool, and the results of two high level questions about the quality of care and attitude of staff, which should be considered in conjunction with the results from the mandated Friends and Family test.

**Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm**

5.1 **Number of Meticillin-resistant Staphylococcus Aureus (MRSA) bloodstream (post 48 hours)**

This is the number of new MRSA bacteraemias identified post 48 hours of admission and is measured against the national trajectory. The target is based on the National Improvement Trajectory and is 0 cases. This metric also forms part of Monitor’s compliance framework for Foundation Trusts.
5.2 **Number of Clostridium difficile infections (post 72 hours)**
This is the number of new *Clostridium difficile* cases identified and includes only those apportioned to the Trust i.e. a positive sample post 72 hours of admission. The target for each acute trust is taken from the National Improvement Trajectory. This metric also forms part of Monitor’s compliance framework for Foundation Trusts.

5.3 **Number of Meticillin-sensitive Staphylococcus Aureus (MSSA) bloodstream (post 48 hours)**
This is a locally decided indicator and measures the number of new MSSA bacteraemias identified post 48 hours of admission. The thresholds are a reduction on the previous year’s out-turn as follows:

5.4 **Never Events**
Never Events are defined as events which are serious, largely preventable patient safety incidents that should not occur if available preventative measures have been implemented. The National Patient Safety Agency identifies a core list of Never Events each year. The full list of Never Events for 2013/14 is as follows:

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post-operation
4. Wrongly prepared high-risk injectable medication
5. Maladministration of potassium-containing solutions
6. Wrong route administration of chemotherapy
7. Wrong route administration of oral/enteral treatment
8. Intravenous administration of epidural medication
9. Maladministration of Insulin
10. Overdose of midazolam during conscious sedation
11. Opioid overdose of an opioid-naïve patient
12. Inappropriate administration of daily oral methotrexate
13. Suicide using non-collapsible rails (Mental Health)
14. Escape of a transferred prisoner (Mental Health)
15. Falls from unrestricted windows
16. Entrapment in bedrails
17. Transfusion of ABO-incompatible blood components
18. Transplantation of ABO or HLA-incompatible organs.
19. Misplaced naso- or oro-gastric tubes
20. Wrong gas administered
21. Failure to monitor and respond to oxygen saturation
22. Air embolism
23. Misidentification of patients
24. Severe scalding of patients
25. Maternal death due to post-partum haemorrhage after elective caesarean section

As with all incidents, Never Events are reported to the Care Quality Commission and the National Reporting and Learning Service. Never Events are automatically classed as grade 2 serious incidents requiring an in-depth root cause analysis to be completed within an agreed timescale. Although nationally reportable, this is a locally decided indicator.

5.5/5.6 **Number of Serious Incidents reported**
Serious Incidents cover a range of situations such as: incidents which result in unexpected or avoidable death or serious harm, allegations of abuse, a scenario that threatens the organisation’s ability to continue to deliver healthcare services, adverse
media coverage or public concern and “never events”. Therefore by the broad nature of definition, serious incidents reported do not necessarily correlate to patient harm.

This locally decided dashboard metric comprises the number of serious incidents reported by the trusts to the CCG in the month. Therefore there will be some inherent reporting anomalies compared to other metrics e.g. a hospital acquired grade 3 pressure ulcer identified on the last day of the month, but reported externally as a serious incident on the first day of the following month will appear in different month's figures for the two measures. There will be month on month variation of numbers of incidents reported by their unpredictable nature.

5.7 Proportion of adult inpatients who have had a VTE assessment on admission to hospital
Venous Thrombo-Emboli (VTE) is a significant patient safety issue, however outcome data on VTE is poor with post mortem studies suggesting that only 1-2 in every 10 fatal pulmonary emboli is diagnosed. Whilst work is underway to improve reliability of outcome data, the process measure of VTE risk assessment will set an effective foundation for appropriate prophylaxis. This gives the potential to save thousands of lives each year.

Risk assessment for Venous Thromboembolism (VTE) is a nationally set (CQUIN with a monthly financial reward attached to it in contracts with commissioners. The CQUIN is paid if 95% or more adult in-patients are risk assessed for VTE.

5.9 Number of confirmed cases of avoidable hospital acquired pulmonary embolism or deep vein thrombosis
This measure requires local analysis of all reported hospital acquired pulmonary emboli of deep vein thrombosis to establish whether they could have been avoided. It is deemed to be good practice to undertake a root cause analysis for all cases of avoidable hospital acquired pulmonary embolism or deep vein thrombosis. This will require clinician involvement and a retrospective review of all cases to establish whether the risk assessment was completed appropriately and the necessary prophylaxis prescribed and administered in accordance with local protocols. These are locally decided indicators and as data has not previously been captured the thresholds will be agreed after the first six months of data capture.

5.10/5.11 Pressure Ulcers & rate per 1,000 bed days
Pressure Ulcers identified at nursing/medical assessment are graded 1-4 (Grade 1 being red discolouration, Grade 2 being a break or partial loss of skin, Grade 3 being tissue damage through the superficial layers, Grade 4 involving the most serious tissue damage). As with complaints, pressure ulcer incidence is measured per 1,000 bed days to allow for benchmarking across organisations. These are national CQUIN measures with a target of 15% reduction on the 2012/13 out-turn figures.

5.12/5.13/5.14 Number of slips, trips and falls (patient) incidents reported, rate per 1,000 bed days & number of slips, trips and falls resulting in moderate or severe harm
This metric refers to the overall number in-patient falls with the aim of reducing the falls incidence and patient harm. It is recognised that there are occasions where a patient will fall whilst in hospital, but organisations should be taking action to reduce this number, with a specific emphasis on those falls that result in harm to a patient. In-patient falls have a significant impact on patients and the service, resulting in a loss of confidence on the part of the patient, a loss of trust by the patient’s relatives an increased length of stay and an associated financial pressure either due to a longer length of stay or as a result of the additional care (and in some cases, surgical
intervention) required as a result of the fall. Commissioners are also able to recover the cost of the in-patient spell where an incident has occurred involving an in-patient fall which results in major harm.

5.15 **Number of safeguarding alerts generated by provider**
The publication of the Department of Health report into Winterbourne View identified a failure of teams to listen to concerns raised by families about the quality of care provided to vulnerable adults. It emphasised the need to promote good practice and to raise concerns about poor practice. To this end, this locally decided measure considers the number of safeguarding alerts generated by provider organisations.

5.16 **Ratio of near miss or no-harm incidents to harm incidents**
It is recognised that there are 10 “no harm” incidents or near misses for every one incident that results in harm, and significant lessons could be learned if these were reported as robustly as those incidents that result in harm. Staff are required to grade all incidents according to their likelihood and consequence so calculating the ratio of near misses to those incidents causing harm should not be difficult and will indicate an open reporting culture within organisations. This is a locally decided indicator and a threshold of 4 (no harm):1(harm) has been set.

5.17 **Percentage of harm free care reported**
The NHS Safety Thermometer is a national tool designed to detect levels of harm free care. This is measured using an audit of all eligible patients on a designated day each month and records in-patients with the following four types of harm: pressure ulcers, falls, venous thromboembolism and urinary tract infections.

Implementation of the NHS Safety Thermometer across the Trust is a national CQUIN for 2012/13 one third of which is awarded for reaching the targets in Q's 2-4. The target is 25% coverage in Q2, 75% coverage in Q3 and 100% coverage Q4. The green threshold is set at these levels for each quarter.

This is the percentage of eligible patients who have none of the four harms on the day of the audit. This measure does not distinguish whether patients with harm was hospital-acquired or not. Thresholds will be set in Q4 when sufficient national benchmarking data is available.

3. **Staff well-being**

6.1 **Percentage of staff sickness / absence**
It is recognised and accepted that staff may have unavoidable periods of sickness absence, and in the short term this can be covered either by colleagues working additional shifts or changes to the staffing rotas. In some circumstances temporary staff (Bank or Agency) may be brought in to cover the shift. However, longer periods of sickness absence or repeated short term sickness absence can have a negative impact on the team and the efficiency of the service. This is a locally decided indicator and the thresholds have yet to be agreed.

6.2 **Percentage staff turnover (rolling 12 months)**
Staff naturally change jobs during their career, and this is healthy for the individual and the service as it promotes change and prevents stagnation. However, if the turnover within a team or organisation is higher than expected or usual this can destabilise a team and as a consequence have a negative impact on patient care. It may be an indication of an unhappy workforce or a potentially failing service. This is a locally decided indicator and the thresholds have yet to be agreed.
6.3 **Number of shifts filled by temporary staff (bank or agency)**

Temporary staff are invaluable when trying to ensure continuity of service, but long-term use of temporary staff rather than substantive team members is unsettling for the team. Temporary staff are often unfamiliar with the routine of a clinical area and may need additional supervision or may only be able to undertake a limited range of roles. This situation may add extra stress to an already stretched workforce, may have a negative impact on patient care and will undoubtedly cost more than using substantive staff. This is a locally decided indicator and the thresholds have yet to be agreed.

6.4 **Number of unsafe staffing incidents reported**

This measure is linked with the above measure and should record the number of times staff have completed an incident report outlining when staffing levels have been unsafe. It is accepted that this is a subjective measure, but in an organisation with a culture of openness staff should feel comfortable reporting staffing incidents as much as obvious patient safety incidents.

6.5 **Percentage of staff completing safeguarding children**

All staff are required to undertake training in respect of safeguarding children. The level of training will be dependent on their role within an organisation, but all staff must complete level 1 training on an annual basis. It is accepted that there may be occasions when a few staff are unable to complete their training within the required 12 months (for instance due to sickness absence or maternity leave), and that the percentage of compliance will fluctuate in month due to starters and leavers. Therefore this measure looks at a rolling 12 month compliance percentage.

6.6 **Percentage of staff completing safeguarding vulnerable adult training**

All staff are required to undertake training in respect of safeguarding vulnerable adults. The level of training will be dependent on their role within an organisation, but all staff must complete training to level one on an annual basis. It is accepted that there may be occasions when a few staff are unable to complete their training within the required 12 months (for instance due to sickness absence or maternity leave), and that the percentage of compliance will fluctuate in month due to starters and leavers. Therefore this measure looks at a rolling 12-month compliance percentage.

6.7 **Percentage of staff completing dementia training**

The South West Dementia Partnership agreed a set of standards for the care of patients with dementia in hospitals and introduced an annual programme of peer reviews to assess organisations’ compliance with the standards. One of the key elements of ensuring improved care for patients with dementia is specific training for staff. As with other training quality measures this should be captured as a rolling 12-month compliance figure.

6.8 **Percentage of staff having had an annual appraisal**

Staff appraisals provide an opportunity for staff members to meet with their line manager and review their performance over the previous 12 months. An appraisal also affords an opportunity to discuss objectives and any training needs for the forthcoming year. A lack of engagement in the appraisal process may lead to staff feeling under-valued, not being aware of an organisation’s objectives and not aware of the importance of their own role in the team. The measure should be captured as a rolling 12-month compliance figure.
6.9 **Staff recommendation of the trust as a place to work or receive treatment**

There is a direct link between staff satisfaction and patient satisfaction within organisations. This question is asked of staff who complete the national staff satisfaction survey and therefore is an annual figure dependent on the timing of the publication of the national survey results.

6.10 **Percentage of staff suffering work-related stress in last 12 months**

There is a direct link between staff satisfaction and patient satisfaction within organisations. This question is asked of staff who complete the national staff satisfaction survey and therefore is an annual figure dependent on the timing of the publication of the national survey results.

6.11 **Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month**

There is a direct link between staff satisfaction and patient satisfaction within organisations. This question is asked of staff who complete the national staff satisfaction survey and therefore is an annual figure dependent on the timing of the publication of the national survey results. The results should be read in conjunction with the next measure and if there is not a correlation between staff witnessing and reporting errors or incidents this may be an indication of a culture that stifles reporting of incidents or staff feeling that incidents are not taken seriously.

6.12 **Percentage of staff reporting potentially harmful errors, near misses or incidents in the last month**

There is a direct link between staff satisfaction and patient satisfaction within organisations. This question is asked of staff who complete the national staff satisfaction survey and therefore is an annual figure dependent on the timing of the publication of the national survey results.

**Version Control**

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<td>28 July 2013</td>
<td>V 01 drafted by Emma Savage, SWCS and sent to Liam Williams and Julian Simcox for information and comment</td>
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<tr>
<td>20 August 2013</td>
<td>Presented to CCG Governing Body along with Quality Report and CCG Quality Dashboard</td>
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