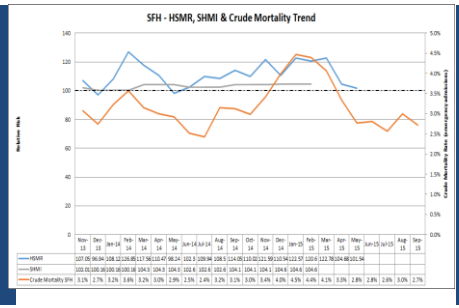
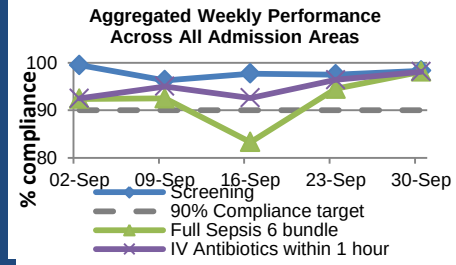
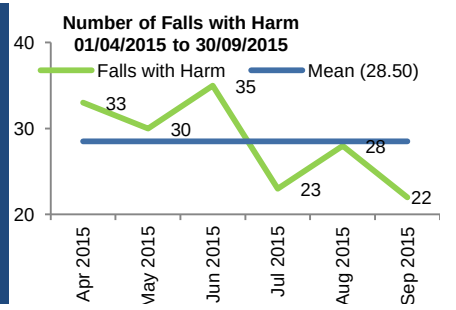
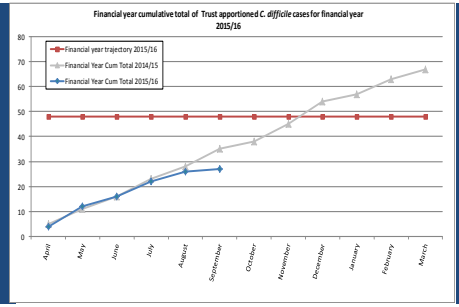
Sherwood Forest Hospitals NHS
NHS Foundation Trust

Board of Directors Scorecard (September 2015)

Quality & Safety (Executive Lead – Victoria Bagshaw, Acting DON)

	Description	Aggregate Position	Historical	Variation
Mortality	HSMR (Hospital Standardised Mortality Ratio) is a nationally reported statistic based upon a Trust's crude mortality (actual number of deaths) with multiple other factors applied eg Demographics & Co-morbidities. The SHMI is calculated similarly.	A focused piece of work has been taking place around the management of Patients and record keeping over many months. Data is now available via Dr Foster intelligence up to May 2015 which shows an encouraging reduction in HSMR. Analysis shows that we have improved our expected mortality figure to be a truer reflection of our patient population.		Septicaemia, Pneumonia and UTI are our highest areas where observed deaths exceed expected. There is continuing audit concerning Sepsis. An audit of deaths where Pneumonia was the primary diagnosis has taken place and will be reported in the next Trust Mortality Group. Further investigation into deaths with primary diagnosis UTI will be carried out.
Sepsis Screening	Improve the management of sepsis and reduce sepsis related mortality. To implement a recognised local protocol / screening tool within emergency department / other units that directly admit emergency patients. Administer intravenous antibiotics to patients presenting with severe sepsis within one hour of presentation.	During July- September 2015 a sepsis screening tool was introduced in all emergency admissions areas and subsequently across all wards to aid identification of patients that requiring review and timely delivery of the sepsis treatment bundle. A random sample of notes from all admission areas across all the shifts worked shows compliance with screening and the bundle is above 90%. Ward audits start week commencing 26/10/2015.		There is a compliance target of 90% in all admission areas included in the screening. The following are the average over the 5 week period for: Screening 97.86% Full Sepsis 6 Bundle 92.16% IV Antibiotics within 1 hour 94.92%
Falls	Reduce the number of inpatients falling in hospital with harm. Reduce the number of inpatients reporting severe and catastrophic harm as a result of a fall in hospital	Clear focus on a falls improvement plan is underway with a priority to investigate links between the times falls occur in relation to staffing numbers and numbers of patients at risk. September performance indicates a decrease in overall number of falls. There were 3 severe Harms recorded.		Q2 has shown that falls with harm have decreased. The performance for September is encouraging.
C Diff Actual numbers	The organisation is required to report externally on all cases of Clostridium Difficile toxin identified in patients post 72 hours (3days). These are deemed trust attributable	The Trust was provided with an externally identified performance measure of no more than 48 cases during this year 2015/2016. This equates to an average of no more than 4 per month. During September there was 1 cases identified.		The organisation came under its monthly target during August bringing the total for the year to 27, compared to 35 during the preceding year.

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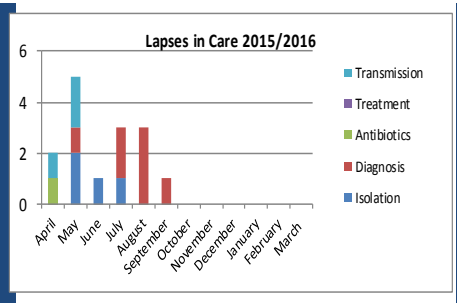
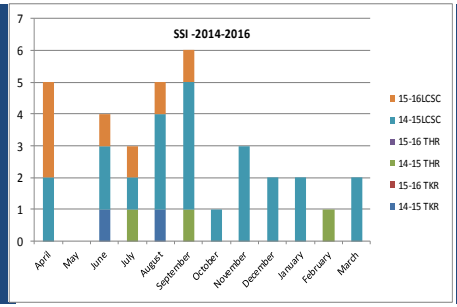
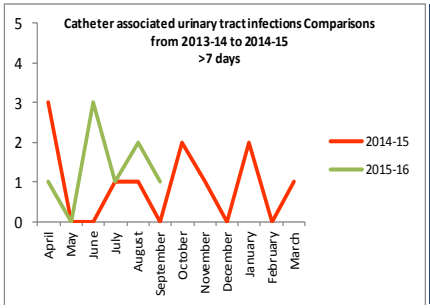
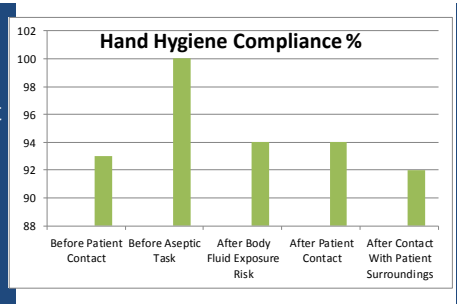
C.Diff lapses in care	C.diff is recognised to be a complex organism that can easily be transmitted to other patients. 'Lapses in care' are monitored following each case. Where identified they must be reported externally.	Lapses in care during September occurred in 1 of the cases identified. 1patient had a delay in samples being taken though they had been isolated at the onset of symptoms.		Based on the data available from last year there appears to continue to be delays in diagnosis due to delayed sampling. The stool proforma designed to improve practice is finally achieving compliance rates between 70-100% in areas.
Surgical Site Infections	The Organisation is mandated to report data externally on specific groups of orthopaedic surgery. We also voluntarily perform surveillance on discharged caesarean sections	The process for identifying surgical site infections is devised by the PHE. This requires surveillance to be deemed completed 30 days after the date of surgery means that data provided will be not be fully validated . Surveillance is undertaken on Total hip Replacement and Total Knee replacements. Post discharge surveillance of caesarean section surgery is collected.		The orthopaedic surveillance data up until the end of September 2015 identifies no infection found within the 2 areas, total hip replacements and total knee replacement. The discharge surveillance for caesarean section identifies one infection which suggests no change compared to last year
Catheter Acquired UTI	Invasive devices are recognised to be a major source of blood stream infections (BSI). Urinary bladder catheters (UBC) are nationally recognised as a major source of infection, that may lead to a bacteraemia..	Surveillance of BSI potentially caused by a UBC are collected monthly. RCA's completed in all BSI where a device is present. In September 2015, there was 1 CAUTI BSI identified; bringing year total to 7. RCA completed showed no clear reason for initial infection.		Compared to previous 2 years there is a slight indication that CAUTI BSI rates are increasing, confirming the need for improving practice and overall management of catheters during insertion and on-going care. Progress to implement integrated catheter pack remains slow due to procurement processes.
Hand Hygiene compliance	Hand hygiene is internationally recognised to be the most effective method of reducing cross infection. Hand hygiene training is mandatory across all staff groups and compliance audits are completed monthly and are measured against the 5 moments for hand hygiene.	The overall compliance with hand hygiene was 94% across all areas. The graph shows where compliance is most compromised, at moment 1, before patient contact, and moment 5 after contact with patient environment. Training is being adjusted to emphasise those elements. Training compliance reports 84% of all staff have attended their hand hygiene mandatory update.		The IPCT can now drill further into the compliance data and provide the information to guide training. This enables the IPCT to better understand the non-compliance data, and potential causes. Main non-compliances are around prolonged glove use

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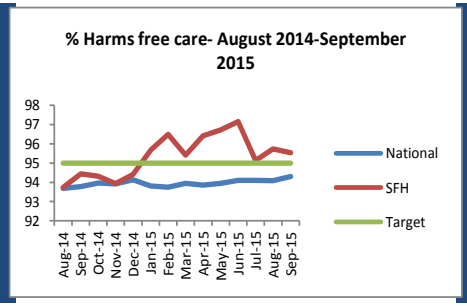
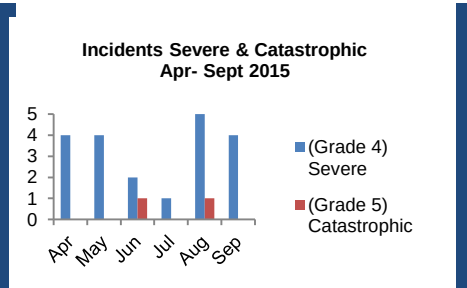
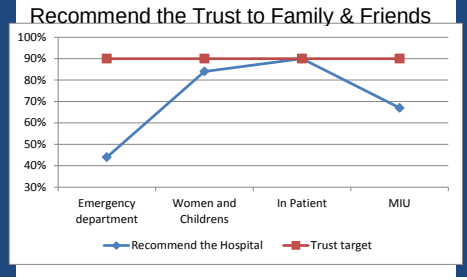
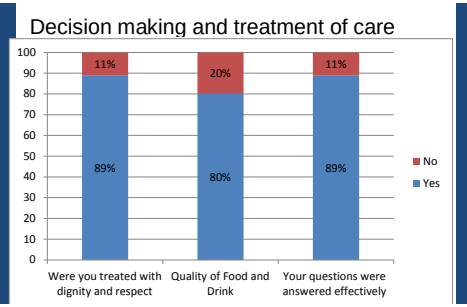
Safety Thermometer	Measures percentage of patients that received 'harm free care' – defined by the absence of; pressure ulcers, falls, catheters, UT Is and VTEs	This measure only includes new harms. Our Trust aim for this measure is for 95% of our patients to be harm free. During September we were 95.54% harm free, the national figure is 94.30%		Last average three months harm free: Trust – 95.46% EC &M – 93.86% PC & S – 98.91% Newark – 98.90%
Actual Harm	Patient safety Incidents as reported on the integrated Risk Management System (Datix) are initially severity graded to help determine Trust appointed harm and the level of investigation required.	All potential serious incidents are reviewed in the Executive lead SI scoping meeting. The outcome of the investigation may change the severity of harm and the numbers demonstrated may change due to this. Serious incidents are also raised following moderate harms.		Jul 2015 and August 2015 have shown an increase of two catastrophic incidents from zero in previous months. These catastrophic coded incidents are currently being reviewed. An increase in severe incidents is reflected due to the realignment of moderate # NOF incidents.
Friends and Family Test	The DoH have recently changed how this measure is reported. The Net-Promoter Score is no longer used. Instead we report the % of respondents recommending the Trust to family and friends	The figure is the % of inpatients, Emergency department, Women's and Children's & MIU who would recommend the Trust to Family and Friends. The Trusts internal target is 90%.		The wards with the highest response rates are: 23 (Cardiology), 52 (Dementia) and Sconce Ward. The lowest response rates are: Minor Injuries Unit, Antenatal Clinic and Emergency Department. The current construction in the Emergency Department has impacted the response rates due to the temporary relocation of reception desk.
Trust local Inpatient Survey	The Trust surveys 10 inpatients per month: "Were you involved in decisions relating to your care" & "treated with care & dignity" A number of response options are provided.	The stretch for this measure is for 80% of patients to respond "yes", the chart indicates the current position		The PE team are redesigning the survey to include new questions from October 2015. With a stretch aim of surveying at least 10 patients from each ward, every month when the system becomes electronic in January.

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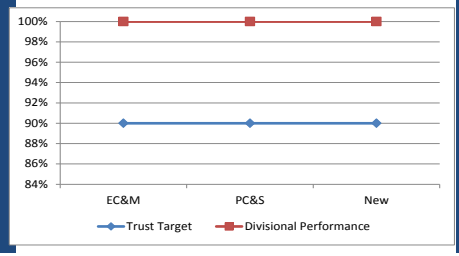
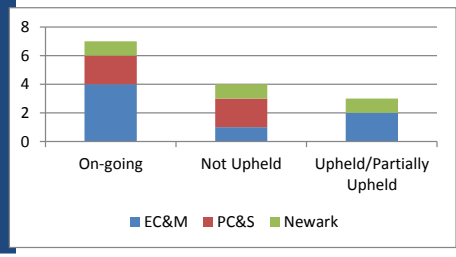
Complaint Management	The Trust manage all formal complaints are acknowledged within 3 working days , and responded to within 25 working days or agreed timescales with complainants when complex responded to within 25 working days or agreed timescales with complainants when complex	The national legislation requires all acknowledgments 100% AND the Trust response internal target is 90%	Response to formal complaints 	The Trust continue to respond to complaints within the internal trust target of 90%. Dialogue with Complainants during the complaints management, all extensions are agreed in accordance with regulations.
Lessons learnt	All upheld complaints develop an action plan to support the changes required as a result of the complaints investigation.	Current action plans are tracked within division and reported to the Patient Experience Committee	Complaints Outcome 	The Trust investigated a total of 14 complaints during August 2015, 21% were upheld which related to EC&M and Newark. 29% were investigated and not upheld. A total of 7 complaint investigations are currently on-going of these 3 were received in late August 2015 therefore not due until September 2015.