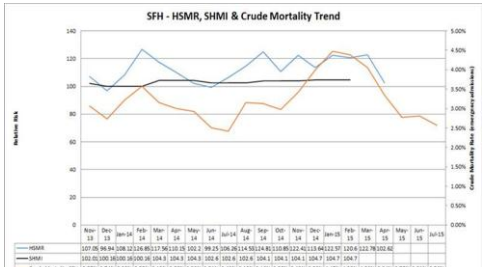
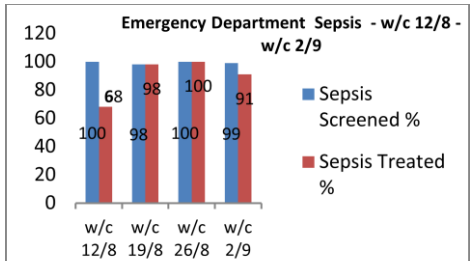
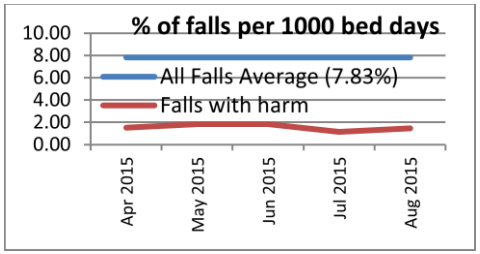
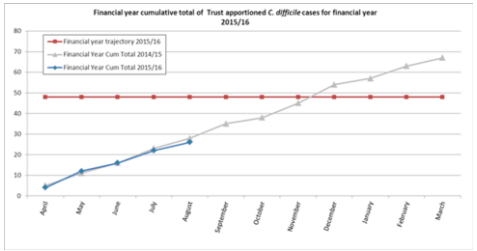
Sherwood Forest Hospitals NHS
NHS Foundation Trust

Board of Directors Scorecard (August 2015)

Quality & Safety (Executive Lead – Susan Bowler, 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 to management of Patients and record keeping over many months. However, the national data is always delayed. Te improvements in figures are only now being seen with an HSMR for April of 102 and an expected HSMR for May of less than 100.		The current alerts, ie areas where the number of deaths is above the calculated expected rate, are being investigated with the support of the Trust Mortality Group: Sepsis & Fluid & Electrolyte Imbalance
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 2015 a sepsis screening tool was introduced for emergency admissions which will aid identification of patients that will require rapid medical review and assessment for severity of sepsis and timely delivery of the sepsis treatment bundle. A sample of notes from across all the shifts worked were randomly selected and the data shows compliance with the screening tool, on average, of 90%.		The baseline audit evidenced 57.1% compliance in ED and this increased to 71% in the first week of July. From this point we can now set targets in order to reach 90% compliance by the end of 2015
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. August performance indicates an increase in overall number of falls. There were 2 severe Harms recorded.		The majority of the falls reported in August are NO Harm totalling 138. Low Harm Falls were 24. Following review of National guidance Fracture Neck of Femur harms have been regraded from moderate to severe from April 2015
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 July there were 6 cases identified.		The organisation breached its monthly target by 2 cases during July, bringing the total for the year to 22, compared to 23 the preceding year.

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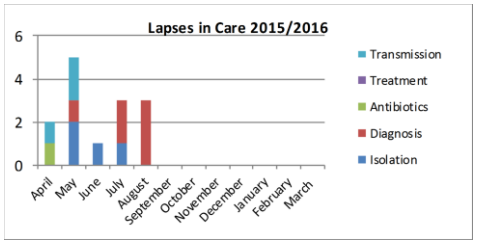
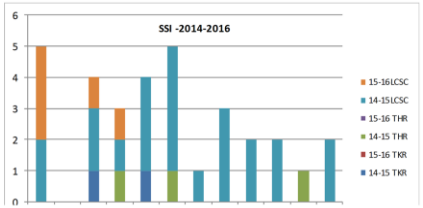
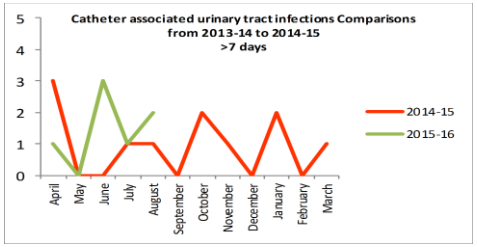
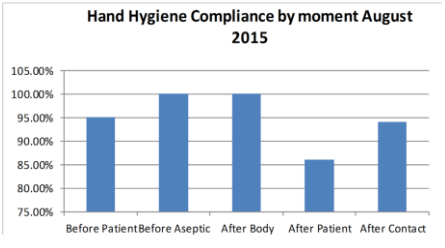
C.Diff lapses in care	C.diff is recognised to be a complex organism that can easily be transmitted to other patients. 'Lapses in care' are monitored following each case. Where I identified they must be reported externally.	Lapses in care during July occurred in 3 of the cases identified. 2 patients had a delay in samples being taken which delays diagnosis, both patients potentially had other possible causes for the delay which may have contributed and 1 patient was delayed in isolation.		Based on the data available from last year there appears to have been an increase in the delays in isolation, and delays in diagnosis due to delayed sampling. Though antimicrobial prescribing has improved.
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 for preceding month. This is June 2015 data. 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 June 2015, identifies no infection found within the 2 areas, total hip replacements and total knee replacement. The discharge surveillance for caesarean section suggests no change compared to last year
Catheter Acquired UTI (CAUTI)	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 are completed in all BSI where a device is present. In July 2015, there was 1 CAUTI BSI identified; bringing year total to 5. RCA completed showed no clear reason for initial infection or themes.		Compared to previous 2 years there has been little change in CAUTI BSI, suggesting a change in approach is required to improve practice during insertion and reduce risk of an adverse event. A business case to introduce Integrated catheter packs is in progress.
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 95% across all areas. The graph shows where compliance is most compromised, at moment 3 after contact with bodily fluids and moment 5 after contact with patient environment. Training is being adjusted to emphasise those elements. Training compliance overall is that 85% 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. In addition the overall training compliance must be mitigated against a change in the mandate to include all non clinical staff . This group are now at 54%, medical staff are at 82%, and non-medical clinicians are 91% compliant.

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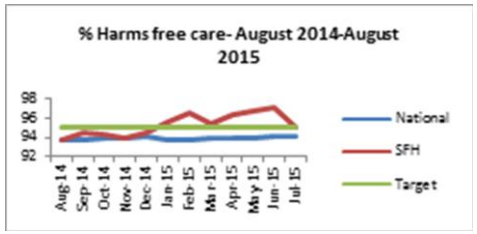
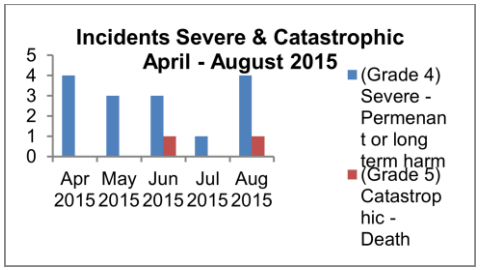
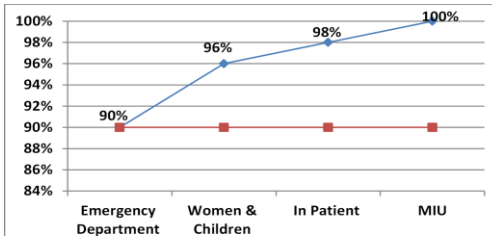
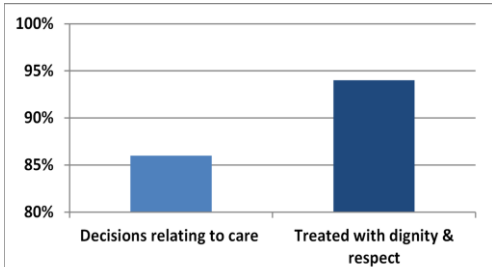
Safety Thermometer	Measures percentage of patients that received 'harm free care' – defined by the absence of; pressure ulcers, falls, catheters, UT Is and VTEs	This measure only includes new harms. Our Trust aim for this measure is for 95% of our patients to be harm free. We are currently at 95.14% harm free, the national figure is 94.10%		Last average three months harm free: Trust – 96.33% EC &M – 95.54% PC & S – 98.70% Newark – 95.83%
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.		April 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. SFHT score		The wards with the highest response rates are: 12, 22,34, 42 and Lindhurst at MCH with over 30% response rate. The lowest ward is EAU and MIU.
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 201. 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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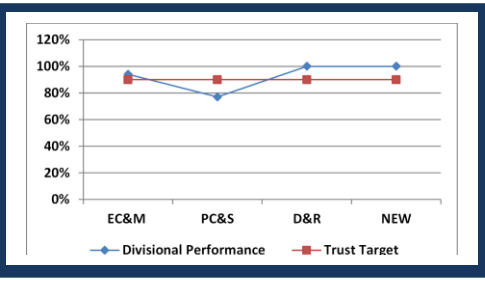
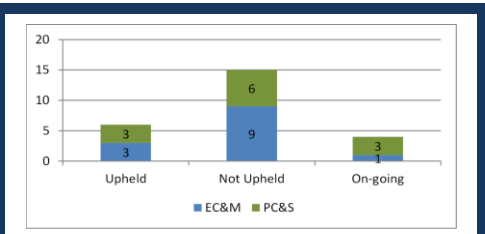
Complaint Management	The Trust manage all formal complaints are acknowledged within 3 working days , and responded to within 25 working days or agreed timescales with complainants when complex	The national legislation requires all acknowledgments 100% AND the Trust response internal target is 90%		All complainants were advised of any delays and extensions 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		The Trust investigated a total of 26 complaints during July 2015, of these 6 were upheld in both EC&M and PC&S. Actions related to administration and communication in Outpatient and staff attitude.