Open and Honest Care in your Local Hospital

The *Open and Honest Care: Driving Improvement* programme aims to support organisations to become more transparent and consistent in publishing safety, experience and improvement data; with the overall aim of improving care, practice and culture.

Report for:

South Tees Hospitals NHS Foundation Trust

August 2015
2015/16

Open and Honest Care at South Tees Hospitals NHS Foundation Trust : August 2015

This report is based on information from August 2015. The information is presented in three key categories: safety, experience and improvement. This report will also signpost you towards additional information about the trust's performance.

1. SAFETY

Safety thermometer

On one day each month we check to see how many of our patients suffered certain types of harm whilst in our care. We call this the safety thermometer. The safety thermometer looks at four harms: pressure ulcers, falls, blood clots and urine infections for those patients who have a urinary catheter in place. This helps us to understand where we need to make improvements. The score below shows the percentage of patients who did not experience any new harms.

97%	**of patients did not experience any of the four harms whilst an in patient in our hospitals**
97%	**of patients did not experience any of the four harms whilst we were providing their care in the community setting**
97%	**of patients did not experience any of the four harms in this trust.**

For more information, including a breakdown by category, please visit:
http://www.safetythermometer.nhs.uk/

Health care associated infections (HCAIs)

HCAIs are infections acquired as a result of healthcare interventions. Clostridium difficile (C.difficile) and

The MRSA bacteria is often carried on the skin and inside the nose and throat. It is a particular problem in hospitals because if it gets into a break in the skin it can cause serious infections and blood poisoning. It is also more difficult to treat than other bacterial infections as it is resistant to a number of widely-used antibiotics.

We have a zero tolerance policy to infections and are working towards eradicating them; part of this process is to set improvement targets. If the number of actual cases is greater than the target then we have not improved enough. The table below shows the number of infections we have had this month, plus the improvement target and results for the year to date.

	C.difficile	MRSA
This month	7	0
Trust Improvement target (year to date)	22	0
Actual to date	29	1

For more information please visit:
http://southtees.nhs.uk/patients-visitors/infection-control/

Pressure ulcers

Pressure ulcers are localised injuries to the skin and/or underlying tissue as a result of pressure. They are sometimes known as bedsores. They can be classified into four categories, with one being the least severe and four being the most severe. **The pressure ulcers reported include all validated avoidable/unavoidable pressure ulcers that were obtained at any time during a hospital admission that were not present on initial assessment.**

This month 52 category 2 - category 4 pressure ulcers were acquired during a hospital stay and there was also 40 in the community.

Severity	Number of pressure ulcers in the hospital setting	Number of pressure ulcers in our community setting
Category 2	51	35
Category 3	1	4
Category 4	0	1

The pressure ulcers include all pressure ulcers that occurred from 0 hours after admission to this Trust

In the hospital setting, so we know if we are improving even if the number of patients we are caring for goes up or down, we calculate an average called 'rate per 1,000 occupied bed days'. This allows us to compare our improvement over time, but cannot be used to compare us with other hospitals, as their staff may report pressure ulcers in different ways, and their patients may be more or less vulnerable to developing pressure ulcers than our patients. For example, other hospitals may have younger or older patient populations, who are more or less mobile, or are undergoing treatment for different illnesses.

Rate per 1,000 bed days:	1.77

In the community setting we also calculate an average called 'rate per 10,000 population'. This allows us to compare our improvement over time, but cannot be used to compare us with other community services as staff may report pressure ulcers in different ways, and patients may be more or less vulnerable to developing pressure ulcers than our patients. For example, our community may have younger or older patient populations, who are more or less mobile, or are undergoing treatment for different illnesses.

Rate per 10,000 Population:	0.95	Community Setting

Falls

This measure includes all falls in our hospitals that resulted in injury, categorised as moderate, severe or death, regardless of cause.

This month we reported 2 falls that caused at least 'moderate' harm.

Severity	Number of falls
Moderate	1
Severe	1
Death	0

So we can know if we are improving even if the number of patients we are caring for goes up or down, we also calculate an average called 'rate per 1,000 occupied bed days'. This allows us to compare our improvement over time, but cannot be used to compare us with other hospitals, as their staff may report falls in different ways, and their patients may be more or less vulnerable to falling than our patients. For example, other hospitals may have younger or older patient populations, who are more or less mobile, or are undergoing treatment for different illnesses.

Rate per 1,000 bed days:	0.07

2. EXPERIENCE

To measure patient and staff experience we ask a number of questions.The idea is simple: if you like using a certain product or doing business with a particular company you like to share this experience with others.

The answers given are used to give a score which is the percentage of patients who responded that they would recommend our service to their friends and family.

Patient experience

The Friends and Family Test

The Friends and Family Test requires all patients, after discharge from hospital, to be asked: *How likely are you to recommend our ward to friends and family if they needed similar care or treatment?*

The hospitals had a score of **95** % for the Friends and Family test*.

*This result may have changed since publication, for the latest score please visit:

http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

Currently the Friends and Family Test is in development for community services, but we use similar questions to help us understand our patients' experience.

We also asked patients the following questions about their care in the hospital:

	% agree or strongly agree
I feel I was involved as much as I wanted to be in the decisions about my care and treatment:	94.0%
I feel my family were involved as much as I wanted them to be in the decisions about my care and treatment:	86.0%
Whenever I was concerned or anxious about anything whilst I was in hospital, I could find a member of staff to talk to:	95.0%
I feel I was given enough privacy when discussing my condition and / or treatment:	91.0%
During my stay I feel I was treated with compassion by hospital staff:	99.0%
I always had access to the call bell when I needed it:	89.0%
I feel I received the care I required when I needed it most:	92.0%

A patient's story

A daughter of a patient who had died described the care and treatment her father had received following a stroke. She spoke of a feeling of uneasiness regarding the care her father would receive whilst in an acute care ward following the realisation that he would probably not survive the stroke. She gave examples of decisions that were not followed through into the care he received and despite highlighting this to staff some of the problems continued. She highlighted an inconsistent approach to some aspects of care which caused further disturbance to her father. The patient's daughter also shared how she thought the response to pain relief was inadequate and was upset that this may have caused unnecessary suffering for her father.

In contrast the patient's daughter then spoke of the caring, thoughtful and gentle approach of staff in the area where her father did pass away, she thought that the care and the environment had met her father's wishes for the death he would have wanted but these inconsistencies at the beginning had caused additional distress and upset.

A number of improvements have been made recently, the acute stroke pathway has now been rolled out for every patient, tools for patient assessment that examine their emotions in a different way to assess their needs have been implemented. It was disappointing for staff to hear of the communication issues and on occasion lack of sensitivity and an acknowledgment that the organisation had failed to deliver optimum end of life care and this experience has been shared with the appropriate staff. Additionally this experience is now be taken forward into the End of Life Committee, so that any wider learning and further actions from this experience can be identified. Sincere apologies from the Trust have been given to the patients daughter.

3. IMPROVEMENT

Improvement story: we are listening to our patients and making changes

After an 89 year old patient was run over by a delivery van doctors feared the worst and warned that she could lose her leg.

The only chance of saving it was a major operation which the plastic surgery team at James Cook had never performed on someone of the patients age.

But the patient was extremely fit for her age – she even attended her local gym on a weekly basis and had her own personal trainer! – and she is now back on her feet following a five-hour operation and months of physiotherapy.

The patient had sustained a degloving injury to her leg and thigh (a degloving injury is when the skin and deeper layers of fat etc are scraped off the bone leaving the bone exposed) but remarkably she had not broken any bones. Rosemary's thigh could be skin grafted but she needed a much more complex operation to save her leg.

The surgeons decided that the best was to rebuild the leg was to take a healthy muscle from her back (latissimus dorsi or 'lat' muscle) and transplant this down onto her leg to cover her exposed shin bone (tibia). Using an operating microscope they joined tiny blood vessels in her leg to blood vessels in her 'lat' muscle to keep the muscle alive and help save her leg.

Chris Dunkin said: "We do this type of operation (free flap reconstruction) regularly at James Cook to help rebuild people after operations for cancer and trauma. However Rosemary is the oldest person in the region to have this type of operation. We spoke carefully to Rosemary and her family beforehand and she could have chosen to have an amputation but she is a strong lady who wanted us to save her leg if it was possible."