

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**

June 2015
2015/16

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

This report is based on information from June 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.

96%	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	5	0
Trust Improvement target (year to date)	14	0
Actual to date	18	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 66 category 2 - category 4 pressure ulcers were acquired during a hospital stay and there was also 55 in the community.

Severity	Number of pressure ulcers in the hospital setting	Number of pressure ulcers in our community setting
Category 2	61	49
Category 3	5	5
Category 4	0	1

The pressure ulcers include all pressure ulcers that occurred from 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:

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: 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 5 falls that caused at least 'moderate' harm.

Severity	Number of falls
Moderate	4
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:	0.17
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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 **94** % 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:	93.0%
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:	94.0%
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:	98.0%
I always had access to the call bell when I needed it:	94.0%
I feel I received the care I required when I needed it most:	97.0%

A patient's story

A patient attended our Board of Directors meeting to explain the care and treatment he received following a diagnosis of prostate cancer, the surgical procedure was carried out by robotic surgery, a relatively new technique. He commented how he thought the procedure was less invasive and how it reduced his hospital stay and aided a quick recovery. The patient was very positive about the post-operative care and treatment he had received in both the acute and community settings. The patient described that the quality of communication he had experienced had worked well and found this to be effective. He felt well informed on the potential side effects. Coupled with this he received plenty of guidance and written information regarding his options which helped him to reach a decision on his treatment. The communication between the acute healthcare setting and his GP practice was good though recognised that there was some points of clarification required because it was a new procedure. He also described how he had received pain relief when he needed it though he only had limited need. The patient felt he had a positive experience of care with high standards.

3. IMPROVEMENT

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

Together with researchers from Teesside University and the University of York, Professor Rangan, clinical professor in trauma and orthopaedic surgery at The James Cook University Hospital, secured over £1.25m funding from the National Institute for Health Research's Health Technology Assessment Programme (HTA project number: 06/404/53) in 2008 to lead the largest randomised clinical trial (ProFHER) to-date on proximal humerus (shoulder) fractures.

The results have now been published in the prestigious international Journal of the American Medical Association, (JAMA), receiving world-wide attention and could lead to considerable cost savings for the NHS as the researchers found no significant difference between having surgery – which is being increasingly used - for the more serious types of proximal humerus fracture (broken shoulder) compared with non-surgical treatment.

The current treatment for this increasingly common injury, in people aged over 65, involves either putting the arm in a sling or surgery for the more serious fracture, but clinicians were unsure which treatment had the best outcome. Professor Rangan, the chief investigator on the five-year project in collaboration with clinicians from 32 NHS hospitals across the country, recruited 250 patients into the trial.

The patients, who were randomly allocated to surgery or no surgery through a service provided by the York Trials Unit, were followed up for two years with data collected at six, 12 and 24 months.

Patients recorded and 'scored' their own progress and experiences after treatment on a specially compiled questionnaire. The trial was managed by York Trials Unit, University of York, and The School of Health & Social Care at Teesside University was the trial sponsor.

In total the data for 231 patients – 114 in the surgical group and 117 in the non-surgical group – were included in the