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

March 2014

Open and Honest Care at South Tees Hospitals NHS Foundation Trust : March 2014

This report is based on information from March 2014. 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.

96.0% **of patients did not experience any of the four harms whilst an in patient in our hospital**

97.0% **of patients did not experience any of the four harms whilst we were providing their care in the community hospitals and community nursing teams**

Overall 96.5% **of patients did not experience any of the four harms whilst in the care 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 methicillin-resistant staphylococcus aureus (MRSA) bacteremia are the most common. C.difficile is a type of bacterial infection that can affect the digestive system, causing diarrhoea, fever and painful abdominal cramps - and sometimes more serious complications. The bacteria does not normally affect healthy people, but because some antibiotics remove the 'good bacteria' in the gut that protect against C.difficile, people on these antibiotics are at greater risk.

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.

Patients in hospital setting	C.difficile	MRSA
This month	3	2
Trust Improvement target (year to date)	37	0
Actual to date	57	2

For more information please visit:
www.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 grades, with one being the least severe and four being the most severe.

Number of pressure ulcers	Grade 2	Grade 3	Grade 4	Total
Acute hospital Setting	67	4	0	71
Community Hospital Setting	12	3	0	15
Total	**79**	**7**	**0**	**86**

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 1000 bed days:

Acute hospital Setting	2.38
Community hospital setting	3.34
Total	**2.51**

Falls

This measure includes all falls in the hospital that resulted in injury, categorised as moderate, severe or death,

This month we reported fall(s) that caused at least 'moderate' harm.

Severity	Number of falls
Moderate	1
Severe	1
Death	0

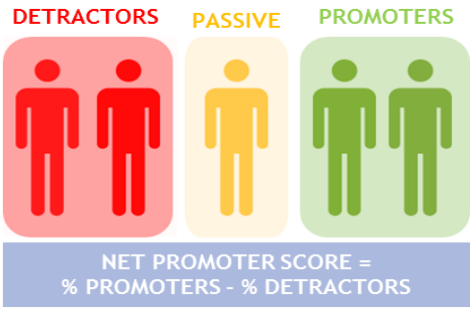
So we can know if we are improving even if the number of patients we are caring for goes up or down, we also calculate an average called 'rate per 1,000 occupied bed days'. This allows us to compare our improvement over time, but cannot be used to compare us with other hospitals, as their staff may report 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:	0.06

2. EXPERIENCE

To measure patient and staff experience we use a Net Promoter Score.

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.



From the answers given 3 groups of people can be distinguished:
Detractors - people who would probably not recommend you based on their experience, or couldn't say .
Passive - people who may recommend you but not strongly.
Promoters - people who have had an experience which they would definitely recommend to others.

This gives a score of between -100 and +100, with +100 being the best possible result.

Patient experience

The Friends and Family Test

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

The hospital had a score of 77 for the Friends and Family test in February 2014*.
This is based on 2,264 responses.

*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/

We also asked patients the following questions about their care:

	% positive responses
Were you involved as much as you wanted to be in the decisions about your care and treatment?	91
If you were concerned or anxious about anything while you were in hospital, did you find a member of staff to talk to?	81
Were you given enough privacy when discussing your condition or treatment?	95
During your stay were you treated with compassion by hospital staff?	97
Did you always have access to the call bell when you needed it?	92
Did you get the care you felt you required when you needed it most?	93

Staff experience

As part of the National NHS staff survey 838 staff across the organisation were required to answer a number of questions including:-

	% positive responses
How satisfied are you with the quality of care you give to patients /service users ?	81
Do you feel your role makes a difference to patients?	88
How happy are you with the standard care provided to recommend South Tees to friends or relatives?	76

To find out more go to:-
http://www.nhsstaffsurveys.com/Page/1019/Latest-Results/Staff-Survey-2013-Detailed-Spreadsheets/

3. IMPROVEMENT

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

Fall, falls-related injuries and fear of falling are responsible for four million hospital bed days in England every year, are t he commonest cause of accidental death in the over 75s and a death occurs every five hours as a consequence of a fall. There will always be a risk of falls in hospital given the nature of the patients that are admitted, and the injuries that may be sustained are not trivial. Whilst achieving zero falls is not realistic, because rehabilitation involves risk, there is much that can be done to reduce the risks of falls and minimise harm, whilst at the same time properly allowing patients freedom and mobilisation during their stay.

With the integration of community services into South Tees in 2011, we've developed a consistent approach towards this key patient safety – and patient experience – priority.

As a result, the quality of falls incident reporting has improved (through updating the Datix incident report form to include specific mandatory drop down fields), and we've taken forward a robust action plan through a specialist group dedicated to improving falls management.

Patient pathways and policies have been streamlined and a new falls risk assessment tool developed, which includes a bed rails risk assessment and dementia screening.

Each ward now has an identified falls lead – an advocate who ensures falls information and training is routinely cascaded and assesses practice through regular audits.

Relatives expect hospitals to be places of safety and are devastated if their family member is injured in a fall in hospital. Equally for staff, trying to keep vulnerable patients safe from falls can become a constant source of anxiety. Our improvements in reporting, coupled with falls leads audits, have clearly prioritised the actions needed to reduce patient harm from falls, while patients and staff stories, which share the devastating effects of falls, have helped commit all staff to improving safety.

The outcome has been some significant changes in falls practice and, importantly, a subsequent reduction in falls and injuries related to falls. The numbers of inpatient falls have dropped from 2508 to 2047 in the last year, and even more importantly the number of patients who sustained a hip fracture following a fall whilst in our care has gone down by 60%. On top of this, 98% of patients now undergo a cognitive screen (compared to a 30% baseline) and all our progress is shared quarterly with everyone in the hospital falls strategy group, plus all falls leads and senior nursing staff, and the Trust bo ard so we can continue to promote this important work, raise awareness and galvanise staff.

The basis of this work can be shared across other patient safety initiatives and work is underway across the trust to do so i n pressure ulcer management and medication errors.

Supporting information