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:

Salford Royal NHS Foundation Trust

December 2013

Open and Honest Care at Salford Royal NHS Foundation Trust : December 2013

This report is based on information from December 2013. 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.

97.7% **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 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.

	C.difficile	MRSA
This month	3	0
Improvement target (year to date)	26	0
Actual to date	15	0

For more information please visit:
http://www.srft.nhs.uk/for-patients/infection-prevention/

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.

This month 0 Grade 2 - Grade 4 pressure ulcers were acquired during hospital stays.

Severity	Number of pressure ulcers
Grade 2	5
Grade 3	0
Grade 4	0

* See supporting information section

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 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:	0.23

Falls

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

This month we reported 1 fall(s) that caused at least 'moderate' harm.

Severity	Number of falls
Moderate	1
Severe	0
Death	0

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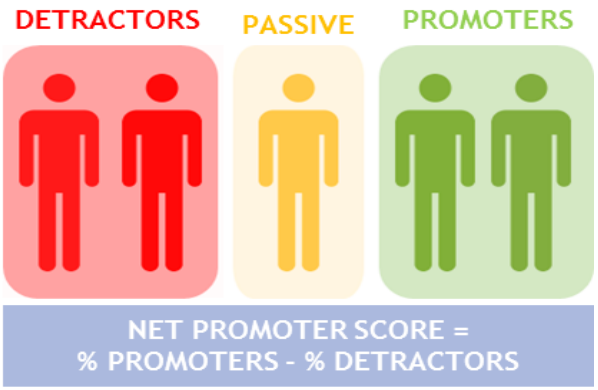
Rate per 1,000 bed days:	0.05

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 72 for the Friends and Family test*. This is based on 637 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 658 patients the following questions about their care:	% recommend
When you have important questions to ask a doctor, do you get answers that you understand?	74%
Do you have confidence and trust in the doctors treating you?	82%
When you have important questions to ask a nurse, do you get answers that you could understand?	79%
Do you have confidence and trust in nurses treating you?	86%
Are you involved as much as you want to be in decisions about your care and treatment?	66%
Overall, how would you rate the care received on this ward?	72%

A patient's story

The Board of Directors in 2007 committed to opening their monthly meeting with a patient story. The main principle for this was to ensure that all decisions prioritised patient experience and safety above any other criteria. In 2014 patient stories are integral to many meetings across the organisation. The latest story to be shared concentrates on the end of life care experience of a patient and his family. The key message from the story is that every single intervention between, patients, their families and healthcare workers matter. That one negative experience can have a dramatic effect of the overall views of a patient and their family.

Our patient experience collaborative will continue to devise new ways of working to ensure we continually improve the experience of patients and their families here at Salford Royal.

Staff experience

We asked staff the following questions:

I would recommend this ward/unit as a place to work	94%
I would recommend the standard of care on this ward/unit to a friend or relative if they needed treatment	94%
I am satisfied with the quality of care I give to the patients, carers and their families	96%

3. IMPROVEMENT

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

Infection control has been a top priority for both the NHS and Salford Royal. Over the last six years significant reductions have been achieved in MRSA blood stream infections. Annual targets for reductions in these infections have been set and we are proud to say in 2012/13 we achieved these. This means that fewer patients are acquiring this type of infections.

This type of improvement activity has also realised significant improvements over the last six years;
These include

• A 96% reduction in MRSA blood steam infections;

• Patients who are known to carry MRSA and a higher risk of infection due to wounds or invasive devices are followed up after discharge with MRSA treatments.

• Because aseptic non touch technique is so important when carrying out certain procedures we have included an identifier on staff name badges to show they are trained and assessed annually.

Supporting information

Pressure ulcers

This month two pressure sores have been acquired by patients who have undergone very long surgical procedures, two Intensive Care patients (device related) and one patient on our neurosurgical ward.

Further information

Board Papers:	http://www.srft.nhs.uk/about-us/board-meetings/
Council of Governors' (CoG) Papers:	http://www.srft.nhs.uk/for-members/council-of-governors/governors-meetings/
Membership Engagement Events:	http://www.srft.nhs.uk/for-members/membership-news-events/upcoming-events/
Our Values:	http://www.srft.nhs.uk/about-us/values/
Videos, Films:	http://www.srft.nhs.uk/media-centre/films/
Friends and Family Test Overview:	http://www.srft.nhs.uk/for-patients/fft/
Friends and Family Test Reporting:	http://www.srft.nhs.uk/media-centre/publications/fft/