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

March 2014

Open and Honest Care at Salford Royal NHS Foundation Trust : March 2014

This report is based on information from February 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.

97.6% **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	1	0
Improvement target (year to date)	35	0
Actual to date	18	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

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	0.251

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 0 fall(s) that caused at least 'moderate' harm.

Severity	Number of falls
Moderate	4
Severe	0
Death	0

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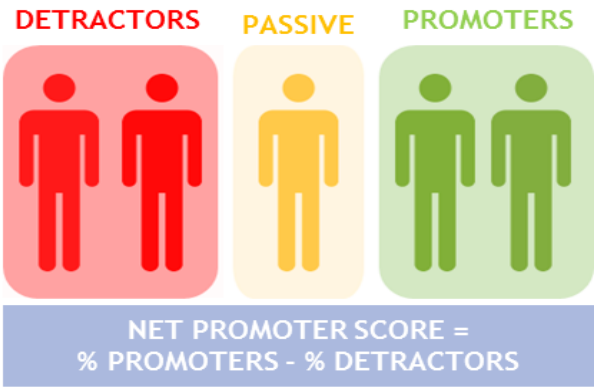
Rate per 1,000 bed days:	0.04

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 70 for the Friends and Family test*. This is based on 778 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 1032 patients the following questions about their care:

We also asked 922 patients the following questions about their care:

	% recommend	
	Yes always	Yes to some extent
When you have important questions to ask a doctor, do you get answers that you understand?	68	28
Do you have confidence and trust in the doctors treating you?	81	18
When you have important questions to ask a nurse, do you get answers that you could understand?	74	22
Do you have confidence and trust in nurses treating you?	82	15
Are you involved as much as you want to be in decisions about your care and treatment?	66	28
Did we deliver what matters most to you during your stay?	75	19
Overall, how would you rate the care received on this ward?	70	18

A patient's story

Following the recent publication of the Berwick Review, 'A promise to learn – a commitment to act: improving the safety of patients in England', there has been a widespread focused Trust wide consultation as to how we respond to the specific challenges contained within the report. One of the key challenges has been how does the Trust further improve its ability to learn from patient incidents? Feedback from this consultation has resulted in the development of short case studies presented as videos rather than written reports that combine three key elements.

- Over view of the harmful incident
- Staff reflection and presentation of key learning outcomes
- The patient and or family describing their thoughts and feelings in relation to the incident.

The first video has now been completed and a second one is currently being produced. We will seek feedback from staff as to how this change has impacted on them and continue to measure improvements as we continue to reduce harmful patient events.

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	92%
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

The Trust has successfully achieved its key infection control targets for the financial year 2013/14. There have been zero MRSA bacteraemia cases and 18 Clostridium Difficile infections against a target of 35. The Trust has realised a year on year reduction in the incidence of these healthcare acquired infections and this is something we know is of critical importance to the patients we serve.

We are committed to see on-going reductions in healthcare infections and will continue to report through this honest and open publication the progress we are making.

Supporting information

Pressure ulcers

This month 5 patients have acquired a grade 2 pressure sore during their admission to Salford Royal in March. Three of these have been attributed to the use of medical device equipment. The wards and departments are as follows; B6, L4, Emergency Admissions Unit, Theatre, H1. We can assure the public that each of these harms are thoroughly investigated and the lessons learned are shared across the Trust. We are committed to continue to see the on-going reduction in the numbers of pressure sores that are developed. We will continue to report our progress in an open and honest manner.

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/