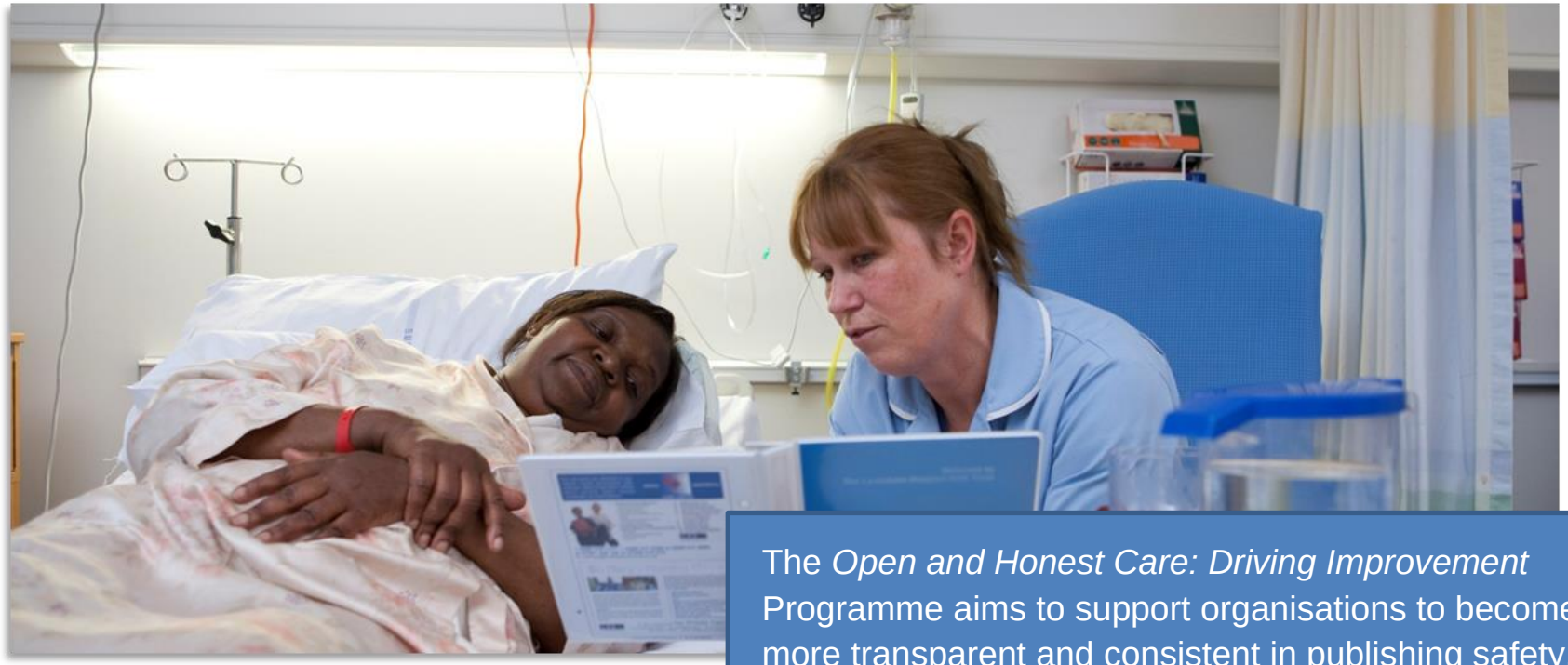
Open and Honest Care in your Local Hospital



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:

The Christie NHS Foundation Trust

April 2015

This report is based on information from **April 2015**. The information is presented in three key categories: safety, experience and improvement. This report will also signpost you towards additional information about **The Christie NHS Foundation 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 NHS 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 harms.

97.96%	**of patients did not experience any of the four harms**

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 nationally monitored as we are trying reduce the incidence of these infections. 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 MRSA bacteraemia infections and are working towards reducing C Difficile infections; 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**
Annual Improvement target	**19**	**0**
Actual to date	**3***	**0**

*Zero cases of C-Diff so far this year have been classified as avoidable

We have recorded a small number of Clostridium difficile infections so far this year - it is important to note that none of the three cases have been deemed avoidable by external committee. Patients with a diagnosis of cancer are more vulnerable to getting C-diff infection due to treatment with high dose chemotherapy and increased use of opiate based analgesia that can affect gut motility.

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	**3**	**Category 2 - Category 4 pressure ulcers were acquired during hospital stays**

Severity	Number of pressure ulcers
Category 2	**3**
Category 3	**0**
Category 4	**0**

The pressure ulcer numbers include all pressure ulcers that occurred from	**72**	**hours after admission to this Trust**

In order to 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.

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Rate per 1,000 bed days	**0.65**

Falls

This measure includes all falls in the hospital that resulted in injury, categorised as moderate, severe or death, regardless of cause.
This includes avoidable and unavoidable falls sustained at any time during the hospital admission.

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

Severity	Number of falls
Moderate	**0**
Severe	**1**
Death	**0**

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Rate per 1,000 bed days	**0.22**

Safe Staffing

Guidelines recently produced by the National Institute for Health & Care Excellence (NICE) make recommendations that focus on safe nursing for adult wards in acute hospitals and maternity settings. As part of the guidance we are required to publish monthly reports showing the registered nurses/midwives and unregistered nurses we have working in each area. The information included in the report shows the monthly planned staffing hours in comparison with the monthly actual staffing hours worked on each ward and/or the percentage of shifts meeting the safe staffing guidelines.

In order to view our reports please visit: **http://www.christie.nhs.uk/openandhonest**

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 (FFT) requires all patients to be asked, at periodic points or following discharge, ***'How likely are you to recommend our ward/A&E/service/organisation to friends and family if they needed similar care or treatment?'***

In-patient FFT percentage recommended *	**96.4**	**% recommended**	**This is based on**	**283**	**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	**201**	**patients the following questions about their care**

	% Recommended
Were you involved as much as you wanted to be in the decisions about your care and treatment?	**99.4%**
If you were concerned or anxious about anything while you were in hospital, did you find a member of staff to talk to?	**100%**
Were you given enough privacy when being examined, treated or discussing your care?	**99.4%**
During your stay were you treated with compassion by hospital staff?	**100%**
Did you always have access to the call bell when you needed it?	**100%**
Did you get the care you felt you required when you needed it most?	**99.4%**
How likely are you to recommend our ward/unit to friends and family if they needed similar care or treatment?	**99.0%**

Dr Colaco, in the first meeting was able to pour oil on troubled waters and calm my aunt’s state of anxiety and upset.

Although she was facing a very bleak future, he was able to provide her with some positivity whilst being completely honest about the reality of her diagnosis and poor prognosis. This takes real skill. My aunt did not feel rushed in the consultation and he made sure that both she and my relatives had adequate time to ask any questions. Sarah Cundliffe and Alison, the specialist nurses, were also very kind and helpful.

Dr Colaco took the time to assess my aunt for her fitness for radiotherapy and decided that this would be a valid treatment option for her. She had initially been informed by previous teams that there was nothing more that could be done and although the outcome of her disease was inevitable she gained some solace in the knowledge that something was being done for her.

Dr Colaco remained constantly in contact with my aunt and our family throughout the course of her treatment and even during the last weeks of her illness when the radiotherapy course had finished. He took the time, despite presumably being extremely busy to liaise directly with me (with my aunt's consent) about her illness and treatment plans and for this I am extremely grateful. He also very kindly called and offered his condolences after my aunt's death. My mother-in-law (my aunt's twin sister) was very appreciative of this thoughtfulness.

The Friends and Family Test

The Friends and Family Test (FFT) requires staff to be asked, at periodic points: ***How likely are you to recommend our organisation to friends and family if they needed care or treatment?'*** *and* ***'How likely are you to recommend our organisation to friends and family as a place to work?'***

FFT percentage recommended care*	**96**	**% recommended**	**This is based on**	**951**	**responses**
FFT percentage recommended work*	**72**	**% recommended**	**This is based on**	**951**	**responses**

This data is collected from staff as part of the quarterly National Friend & Family Test. The data above relates to Quarter 4 2014/15

*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	**5**	**staff the following questions**

	% Recommended
Would you recommend this ward/unit as a place to work?	**100%**
Would you recommend the standard of care on this ward/unit to a friend or relative if they needed treatment?	**100%**
Are you satisfied with the quality of care you give to the patients, carers and their families?	**100%**

staff are asked in locations where a harm has occured

3. IMPROVEMENT

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

The Quality Improvement Service Launch 'The Christie CODE Quality Scheme'

The Christie
Care
Observation
Documentation
Experience
Quality Scheme

Celebrating Excellence in Care

On 20th March 2015 the Executive Director of Nursing & Quality officially launched The Christie CODE quality scheme. The Quality Improvement Service in collaboration with the wider nursing community developed an in-house bespoke quality scheme, based on The Christie Fundamentals of Care Standards initially developed to support the Quality Walk Round programme.

The principles underpinning the quality scheme are:

- To put patients at the centre of everything we do
- To celebrate excellence
- To demonstrate commitment to quality improvement
- To have methodological rigour and draw on the evidence base in the development of standards and in the process used to assess levels of performance
- To share best practice
- To be inclusive of all multi-disciplinary staff who make a substantial contribution to the delivery of clinical care
- To engage learners in the quality improvement process for better patient care
- To demonstrate The Christie Commitment

The scheme acknowledges the excellent care already provided to patients and therefore accreditation, in the form of a 'Gold Embrace' will be awarded to areas that can demonstrate outstanding practice in all areas of the 14 fundamentals of care standards.

- Care Environment & Infection Prevention and Control
- Communication
- Falls Prevention
- Leadership
- Management
- Medicines Management
- Nutrition & Hydration
- Pain
- Personal Care
- Pressure Ulcer Prevention
- Privacy & Dignity
- Record Keeping
- Safeguarding
- Sleep & Rest

The scheme has been acknowledged by the Trust as a key quality initiative and as such has been included as one of the Trusts quality objectives for the upcoming year. Phase one commenced on 1st April 2015 within the in-patient wards. Phase two, currently under development, will focus on ambulatory care areas.

Supporting information