NHS England

Open and Honest Care in your Local Hospital

East Lancashire Hospitals NHS Trust

July 2018

Open and Honest Care at East Lancashire Hospitals NHS Trust : July 2018

This report is based on information from July 2018. The information is presented in three key categories: safety, experience and improvement. This report will also signpost you towards additional information about East Lancashire Hospitals NHS Trust's performance.

1. SAFETY

NHS 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 harms.

98.8% **of patients did not experience any of the four harms whilst an in patient in our hospital**

99.1% **of patients did not experience any of the four harms whilst we were providing their care in the community setting**

Overall 98.9% **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.

Patients in hospital setting	**C.difficile**	**MRSA**
This month	1	0
Trust Improvement target (year to date)	2	0
Actual to date	10	0

For more information please visit:
www.website.com

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 avoidable pressure ulcers that were obtained at any time during a hospital admission that were not present on initial assessment.**

This month 2 Category 2 - Category 4 validated pressure ulcers were acquired during Acute hospital stay and 0 in the community.

Severity	Number of Pressure Ulcers in our Acute Hospital setting	Number of pressure ulcers in our Community setting
Category 2	2	0
Category 3	0	0
Category 4	0	0

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:	0.07	Hospital Setting

The pressure ulcer numbers include all pressure ulcers that occured from hours after admission to this Trust

In the community setting we also calculate an average called 'rate per 10,000 CCG 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:	0.00	Community

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.** Falls within the community setting are not included in this report.

This month we reported 0 fall(s) that caused at least 'moderate' harm.

Severity	Number of falls
Moderate	0
Severe	0
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:	0.00

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.

Staff experience

Between July - September 2016 we asked 1766 staff in the Trust the following questions:

	% recommended
I would recommend this ward/unit as a place to work	76
I would recommend the standard of care on this ward/unit to a friend or relative if they needed treatment	85

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? We ask this question to patients who have been an in-patient and/or attended Acccident & Emergency (A&E). Both scores (if applicable) are below;*

In-patient FFT % recommended *	96.66%	This is based on 2456 patients asked
A&E FFT % recommended*	81.09%	This is based on 1824 patients asked

We also asked 436 patients the following questions about their care in the hospital:

	Score	Score
Were you involved as much as you wanted to be in the decisions about your care and treatment?	94	
If you were concerned or anxious about anything while you were in hospital, did you find a member of staff to talk to?	89	
Were you given enough privacy when discussing your condition or treatment?	96	
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?	98	
Did you get the care you felt you required when you needed it most?	98	
How likely are you to recommend our ward/unit to friends and family if they needed similar care or treatment?	97	

We also asked 238 patients the following questions about their care in the community setting:

Were the staff repectful of your home and belongings?	98
Did the health professional you saw listen fully to what you had to say?	98
Did you agree your plan of care together?	97
Were you/your carer or family member involved decisions about your care and treatment as much as you wanted them to be?	96
Did you feel supported during the visit?	99
Do you feel staff treated you with kindness and empathy?	99
How likely are you to recommend this service to friends and family if they needed similar care or treatment?	100

A patient's story

About 4 weeks ago Dad became unwell, we were not really sure why but he was having symptoms including arthritic joints, immobility and pain.

Mum and Dad have care services at home. The carers know my parents very well, and obviously as a family we know them very well also.

We were worried that there was something not quite right and so I sent for the family GP who knows him well. The GP thought it was an arthritic flare up in one of his knees. Within 2 days it became apparent that it was not going to improve so they facilitated a bed at Clitheroe Community Hospital for Dad thinking that if they could get the pain under control they would be able to rehabilitate him to walking over a few days and he would be able to return home quickly.

We have worked with Clitheroe Community Hospital physios before with both Mum and Dad where they have come out to the house. Consistency is really important; that Mum and Dad know who they are going to see. When it is the same people it means they are aware of the patient and what the patient's needs are.

From the various Physio and Occupational Therapy visits, Mum and Dad have every aid they could possibly need at home, and there is a community physio number that you can ring. Therefore, if I feel that Mum or Dad's mobility is dropping, they will do a home visit and this in turn can prevent a hospital admission. Therefore I think working with the community is vitally important so that they get that integrated care throughout the whole system.

I think it would be useful that, once these things are in place at home (items including walking aids, bath aids, bed aids etc.), that there would be a system to record them on. This way if a patient does ever become admitted to hospital, upon discharge it is already known what aids they have and it is already documented what there is in their home. You would know that the patient already has in place certain aids and this would prevent having to revisit the same information again and again and again.

I know that is difficult, but if we were to have a truly integrated service where everybody could access the same information then I think the discharge process could become much more seamless and even prevent failed discharges, or people being discharged home who possibly are medically fit, but medically fit does not always mean fit to be at home. My worry is that if patients are sent home because they are medically fit and it is deemed that they are OK, the full picture is not known about what their home is actually like and I worry about readmissions and failed discharges.

Having said that, because I know who to contact for Mum and Dad it works well. I have a good relationship with people that are working in the system and I know who to contact.

Dad was admitted to Clitheroe Community Hospital where he was an inpatient for a week before he became extremely unwell quite quickly. Dad needed IV treatment and unfortunately the community hospital does not support patients who need IV. Even for something like IV fluids the patient would need to be taken to Royal Blackburn.

Dad was transferred via ambulance from Clitheroe Community Hospital and directly admitted onto the Acute Medical Unit B (AMU B) at Royal Blackburn, which I also thought was wonderful as I did worry that Dad would have to go via A&E to get there, but he was a direct transfer onto AMU B which I thought was fantastic.

Within 1.5 hours Dad was on IV fluid, received IV anti biotics, had been seen by a consultant and the Doctor on duty. Dad was not admitted until 5pm, it was also a Friday and you hear many things about Friday's and weekends, but the service was incredible.

The treatment that Dad received on AMU B was faultless and flawless. I arrived obviously extremely anxious, having Mum at home who is not very mobile so was not able to be at the hospital. I was reassured immediately that they were looking after Dad and knew what they were doing.

Dad stayed on AMU B for over 48 hours before he was transferred to ward B4. On being transferred to the ward the care was seamless. There was no repeating of questions that we had already answered, there was no need to go through all his history and the medication he was on, he had been seamlessly transferred from AMU B to ward B4, and everybody was aware what Dad's needs were.

We were immediately reassured by the ward staff, and I am sure if I had requested to speak to the doctor I would have been able to, but the staff on this ward are extremely aware of all their patients' needs and that goes from the ward sister / matron, down to the healthcare assistants, they are absolutely aware of the needs.

They operate a tag system on the ward which I think is fantastic. My Dad is in a bay of 7 beds, and there is always a member of staff in the bay. I have never heard a buzzer ringing on the ward and this is because it is unnecessary, the staff are so aware of what is going on with the patients that they are on top of any situation that arises. From delivering drinks, to filling in charts, the food charts, to an hourly rounding which is checked and signed off, and all this is very reassuring for family members who come to visit. I do pick Dad's file up and I can see what he has eaten, how much he has eaten, how much fluid he has taken during the day, and what his meal choices have been. Even down to things like toileting, washing etc. that is all documented on a very regular basis.

Dad has his drugs chart at the bottom of his bed, I am aware of all the medication he takes and so if a medication has been changed for any reason I can ask and get the answers. I have been able to ask, I have never been told 'we will come to you in 10 mins, or we will get round to doing that', there is none of that at all, they have been able to answer immediately. If the person that you happen to ask that question to does not know the answer, they will immediately go and find someone that can answer it, and every question that has been asked has been answered without any difficulty whatsoever.

Although the ward staff work extremely hard they never give the impression that they are too busy for you, they are never too busy to help patients, families, anybody. They give time, and it does not matter what colour the uniform is, if a patient needs turning and there is one healthcare assistant and the sister, they will always help to turn a patient, stand a patient, even empty catheter bags, there is no differentiation on this ward that 'this is not my job', everybody takes responsibility for every body and I think that proves that this ward provides wrap around personal care for every patient, and member of their family, they provide personal care.

The care that they provide is effective, it is not lip service, it is absolutely effective because I have been here, witnessed it, seen it in operation and it is incredibly effective. I cannot praise this ward and the staff enough.

If there was something that may improve things on this ward, it may be that occasionally there are bank staff on duty, and I am not decrying the work that bank staff do, because they are also professional people, providing a professional job, but as a family member and patient, when someone has to come to the bed to deal with the patient and they have to ask what the patients name is, and they have a piece of paper and are reading things off a piece of paper, that does not instil you with confidence that you normally have on the ward.

I am acutely aware of the national situation within the NHS and care in the community and all these other things, but I do feel as a nation and a community we should be trying to promote employment and training for local people.

We use Care providers who employ really good care staff. We have just had a lovely carer who has worked with mum and dad for over a year, who is now coming here to train as a healthcare associate, a new training program which started last year. She has just been accepted on to this cohort and because of the experience that she has had in the community, this has enabled her to get onto the course and I am sure that she will go on to do well. Programs like this should be positively encouraged, if they get candidates like our carer, she will hopefully go on to be a qualified nurse or practitioner of some description.

I think that this grass roots training for people who work in the community has been spotted by the Trust and recognised that by providing training programmes that accommodate a pathway for local people to progress into a healthcare profession will promote and improve the Trust. Social care in the community needs to be given higher priority and a higher profile. This is a valued profession and it can also lead to you promoting yourself, your further development and lifelong journey as a learner and I think this hospital is embracing that and taking this on board which is wonderful.

Dad has felt cared for, he has felt loved, and he has also appreciated that consistency of staff. He has become a little upset and agitated at night sometimes; he has had a couple of nights that he said he did not know anybody. This week one of the day staff is on night duty and I know it is very difficult to keep consistency of staff and I am sure that you have to move staff around, but the biggest thing for my dad who has short term memory difficulties is familiarity and familiar faces help to build his confidence that he is being looked after by people that know him and know what his needs are.

My parents live in a very small village with extremely lovely views, the bay and bed that my Dad is in has windows that are quite high up on the opposite side, which do not open very much and the temperature has been extremely high. The only thing he can see is a brick wall, he cannot see the sky. With it being so hot, the curtains have been closed and the lights have been kept off to try and keep the temperature down within the bay, so he has been a bit confused at times as to whether it is day or night. I know not everybody can have a view but because he has been here for 3 weeks in the same bed, his words are 'I think I have become Jack Horner in the corner', but that does not mean that he has been neglected in any way at all, it is just that if we could have a wish, he would wish to be able to see the sky, he would wish to have been kept at a cooler temperature because in the corner that he is in, it has been extremely hot. We have had fans at either end of the bay, yesterday we had 2 fans, but I do appreciate that we can only do what we can do without air conditioning.

The other thing is that the drinks get really hot, even the cold drinks, they get really hot quite quickly; there is no ice on this ward. Somebody thought that ward C1 had ice, would ask them if this ward can have some, but of course because of infection control there is no ice being brought from one ward to another which is absolutely quite right, but it would be nice, and I know it is not as hot as this all the time, but it has been extreme and if ice could have been kept in the kitchens somewhere, in the morning just to make the drinks in the jugs cooler because the water is virtually hot in the jugs. They are changing them regularly but they are warming up so quickly.

When visiting I have been in a few times on a Sunday morning and the staff have said we think Dad might benefit from a little trip outside. One of my bugbears, are the amount of patients stood underneath the no smoking signs, right in the doorway, and we have to walk through their disgusting and horrible smoke. The new car park is absolutely amazing but halfway down that road I presume it is deemed to be off hospital grounds, and I have to walk past staff in uniforms every day and they are also smoking, and so I do not want to take my dad through the main door full of smoke.

The staff on the ward have been amazing, they allow us to come in early if I have an appointment elsewhere, or late. Yes, they do have dedicated visiting times, and they try to protect that, and we always try to come at these times where possible. If we have come outside, it has never been a problem.

Most of the patients on this ward, especially in my Dad's bay are not able to come and access the quiet room with the TV. Perhaps the quiet room could be the physio room with some bars and the physios can say 'we will aim to walk down to the target room' and get more people into the quiet room, and have a little table maybe so they can go and eat or have a drink or something together. There is not much conversation between patients in the bay as there is no walking about between beds etc. so anything that can promote them being more active would help and this room would be ideal as the room is mainly empty.

My dad has not always understood how poorly he has been, and he keeps asking "why can I not go to Clitheroe today", and I think that the fact that he is on IV anti biotics is preventing that happening, but his words are "but why does it say hospital at the end of Clitheroe if the nurses there have the same qualifications as the nurses here, and they are being paid the same, why can they not put an IV line in my arm", which brings you right down to practicalities, he is saying 'why am I taking a medical bed up here'. I have asked this also. You would think that where practical it would be better to take up the community hospital beds, and I wonder if it was a truly integrated care system across the community whether there could be some sort of doctor who is ready to come out to do IV. This would be a massively

community hospital beds, and I wonder if it was a truly integrated care system across the community whether there could be some sort of doctor who is ready to come out to do IV. This would be a massively good experience for them as there is a wide range of patients there. Not to make big clinical decisions as I can understand litigation and all that kind of thing, but it would relieve some of the demand on beds in Blackburn. My dad is here, he is obviously not medically fit because he needs IV antibiotics, but do those antibiotics need to be delivered in Blackburn?

I asked about physio the other day because while he is lying in bed he is losing his mobility. The staff on the ward are amazing and they get him up every day, but the chair next to his bed is totally unsuitable because it is not the right height or width. When he is assessed at home he was measured to ensure he is sitting on the right chair, but when he comes into hospital it does not seem to matter. He will go to Clitheroe and he will have rehabilitation physio which works really well, to enable him to go home. It would help if there could be more proactive physio here. He has been an inpatient for 3 weeks, and when I ask I get told he is not on their list today; he was seen once last week and once this week. They have brought some raisers for the chair but it is still unsuitable for a man of his height and femur length and I just think that if we are trying to get patients fit for home, they perhaps should be concentrating on how to keep their mobility while they are here, and then the rehabilitation care will be quicker. If he has to do another 4 weeks of IV antibiotics, we can't say for sure but I expect he will then need to go to Clitheroe for rehabilitation. If he was rehabilitated here during those 4 weeks we might not even need the Clitheroe admission because he could be discharged straight home if he was mobile and safe enough to do so.

We are extremely grateful to the hospital for the care they are providing and how he is being treated. He has received the medical treatment that anyone can wish to have.
Whatever happens, none of us are perfect, none of us can get it right all the time, and I fully understand that decisions are being made on a daily basis, that finance decisions are having to be made on a daily basis. But from a layman's point of view, coming from the outside, 'if you do that, why can't we do this?'. If we are going to provide a fully integrated care package, this needs to include NHS patient care, doctors, social workers, and with the aging population that we have, the social care and care in the community, all to provide care in the local community so that we can keep people in their home.
I think the way forward is to keep people in their own homes for as long as possible and treat people in their own homes to prevent hospital admissions. I think there could be a lot more done in the community to truly work together and to take pressures off the hospitals. There is a definite gap between what is provided in hospitals and what can be provided at home.
I do not know what the statistics are for failed discharges, and what the statistics are for readmissions to hospital not for medical reasons but for non-medical reasons. For example when the patient has not been able to access a drink to keep their fluid levels up, so have become unwell because they have then picked up a urine infection because they have not drunk enough because they cannot actually get to the tap. As practical and as ridiculous as that sounds, that is my philosophy on where we are.
These are my thoughts, I am not a medical professional, I have never worked in the NHS so I don't understand protocol, but there are some simple practicalities, like having ice to try and keep the drinks for patients cool which would make a massive difference.
This ward, this hospital, this Trust, we should all as a community be proud of each and every member of staff for the work they do, simply amazing and we thank you all.

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

Take-off for Pioneering Work Experience Scheme

Nelson and Colne College students became the first to take part in a pioneering ELHT work experience pilot.

Over the course of two weeks, a total of 20 students completed clinical or non-clinical placements working at the heart of the Trust and our fast-paced environment.

Clinical placements included working in clinics, observing consultations with specialist nurses, and observation of investigations, such as weight and blood samples. Students also experienced life on three of the Royal Blackburn Teaching Hospital's general medical wards, as well as more specialist areas such as the Ear, Nose and Throat Clinic and in Paediatrics.
Non-clinical work included Engineering through the maintenance and testing of medical equipment, accounting tasks in the Finance department, Business Administration duties in Health Records, Customer Care and Business Administration in the hospital's learning centre and Catering in the busy kitchens.

Health and Social Work Professions student Alisha Shamraiz, 17, worked in the main outpatient department.

The former Pendle Vale College student said: "I found the work experience at ELHT really interesting and very useful.

Nurses, healthcare assistants and other hospital staff made sure that we were learning at all times. It was a very inclusive environment and because there were a range of departments, I learnt a wide range of new things."

Nelson and Colne College is preparing for the introduction of T Levels in 2020 and a key component of the new qualifications is an extended work placement in industry.
NCC already has a Career College ethos and is committed to providing its students with the best education possible ensuring they are fully prepared for their future careers.
This includes making the most of successful relationships with its extensive list of employer partners, such as the East Lancashire Hospitals NHS Trust, to provide high quality work experience opportunities, leading to Apprenticeships and employment after College