Open and Honest Care in your local hospitals

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:

East Lancashire Hospitals NHS Trust

January 2018

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

This report is based on information from January 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.

99.2% **of patients did not experience any of the four harms whilst an in patient in our hospital**

99.4% **of patients did not experience any of the four harms whilst we were providing their care in the community setting**

Overall 99.3% **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	2	0
Trust Improvement target (year to date)	24	0
Actual to date	29	2

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 1 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	0	0
Category 3	1	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:	0.03	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	74
I would recommend the standard of care on this ward/unit to a friend or relative if they needed treatment	81

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 *	98.60%	This is based on 2426 patients asked
A&E FFT % recommended*	82.81%	This is based on 1565 patients asked

We also asked 656 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?	95	
If you were concerned or anxious about anything while you were in hospital, did you find a member of staff to talk to?	94	
Were you given enough privacy when discussing your condition or treatment?	97	
During your stay were you treated with compassion by hospital staff?	99	
Did you always have access to the call bell when you needed it?	99	
Did you get the care you felt you required when you needed it most?	99	
How likely are you to recommend our ward/unit to friends and family if they needed similar care or treatment?	98	

We also asked 321 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?	99
Did you agree your plan of care together?	98
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?	98
Do you feel staff treated you with kindness and empathy?	100
How likely are you to recommend this service to friends and family if they needed similar care or treatment?	99

A patient's story

Our teenage daughter was referred to Elcas in 2016 after exhibiting a number of troubling physical symptoms, as well as several psychological ones. The referring paeditrician told us that they felt that our daughter needed to be medicated immediately for severe depression as well as needing very specialist intervention. When we attended her initial assessment the doctor informed us that they almost never medicate children under sixteen with antidepressants, and that talk therapies would be a better option. However the doctor agreed that they needed to spend more time with her before making a recommendation.

Two weeks later the same doctor came to us and apologised. They said that they were wrong, that our daughter was extremely unwell and that as a team the decision had been made to offer her antidepressants. Our daughter was very resistant at first and refused to take them, however the doctors never once tried to force her. They talked her through exac tly what the side effects might be and how she would benefit from the medication. They also sent her for CBT.

Her CBT therapist was a godsend. They built up a rapport, never pushed or forced her to do anything, and slowly coaxed her into opening up. Then the therapist told us that he thought that our daughter was autistic. We were shocked, but agreed to her being assessed. Thank goodness we did. Our daughter was diagnosed with Aspergers Syndrome in October 2016. Suddenly so many things made sense. However our daughter struggled with the late diagnosis and continued to suffer from severe anxiety and depression. Her attendance at school was shockingly low. The staff then made the decision to offer her a place withing the Intensive Support Therapy day unit, which offers education coupled with therapies.

It was difficult at first, and there were days when she would refuse to do anything, but gradually things began to change for the better. The average time spent on the unit is twelve weeks however our daughter spent fifteen weeks there. It was a life changing experience for her. The staff never once gave up or turned their backs on her. They were unwaiveringly supportive and worked tirelessly to help our daughter learn to cope with her anxiety, depression, stress and physical symptoms. They kept us in the loop every step of the way and involved our whole family in every desicion.

Our daughter is now in a school that is better equipped to deal with her needs thanks to the staff at IST. She is more confident, has made new friends, and despite missing almost a year of education she feels able to tackle her GCSE exams in summer. She intends to go on to train as a Mental Health Nurse working with young people after being inspired by the people who helped her.

There are no quick fixes. There are therapies and treatments that take time and commitment. If you work with them then these people with give everything they have to help your child. We will never be able to thank them enough for giving us our daughter back.

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

Skin-to-skin Caesarean for Better Birth Experiences

Many of the 1,600 mothers who give birth each year via caesarean section at the Lancashire Women and Newborn Centre can now experience the magic of holding their baby skinto-skin immediately following the birth thanks to a new initiative by maternity staff.

'Immediate skin-to-skin care' is a natural process that involves placing a newborn on the mother's chest directly after the birth. Previously, mothers in East Lancashire could not benefit from immediate skin-to-skin as they were separated from their babies following a caesarean birth.

"The routine process for caesarean section births was a screen placed in front of the mother which meant she could see her baby being born," explained Consultant Obstetrician and Gynaecologist, Mrs Liz Martindale.

"For skin-to-skin care after a caesarean birth, the mother and her child must stay together."

"We received many requests from couples wishing for a 'gentler', more personal caesarean birth experience, and hospital staff have worked together to provide immediate and sustained skin-to-skin contact."

Immediate skin-to-skin contact offers many benefits including an increase in breastfeeding initiation, decreased time to the first breastfeed, increased bonding and stronger maternal satisfaction.

"Probably the biggest barrier to skin-to-skin care after a caesarean is the culture of the operating theatre," added Mrs Martindale.

"From the start, we brought everyone to the table – theatre staff, obstetricians, anaesthetists and midwives - so that the entire team took ownership of the changes."

"After understanding and seeing the benefits of this family-friendly birth, staff were more than ready to support the change."

In many other hospitals, caesarean births are followed by the baby being taken to another area in the operating room, where he/she is examined, cleaned, weighed, clothed and swaddled before being shown briefly to the parents.