

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:

**Tameside and Glossop Integrated
Care NHS Foundation Trust**

April 2017



Open and Honest Care at Tameside and Glossop Integrated Care NHS Foundation Trust : April 2017

This report is based on information from April 2017. The information is presented in three key categories: safety, experience and improvement. This report will also signpost you towards additional information about Tameside and Glossop Integrated Care 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.

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

99.2% of patients did not experience any of the four harms whilst we were providing their care in the community

99.2% 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.

A rigorous Root Cause Analysis is in place to determine whether a 'lapse in care' occurred for the 7 Cdifficile cases during April 2017 and as a result this number may be subject to change.

	Total Cases		Avoidable Cases - April 2017	
	C.difficile	MRSA	C.difficile	MRSA
This month	7	0	0	0
Annual Improvement target	46	0		
Actual to date	7	0		

For more information please visit:

<https://www.england.nhs.uk/patientsafety/associated-infections/>

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 7 pressure ulcers were acquired during hospital stays.

This month 0 pressure ulcers were acquired in the community however there are a number still awaiting confirmation.

Severity	Number of pressure ulcers in our Acute setting	Number of pressure ulcers in our Community setting
Category 2	2	0
Category 3	5	0
Category 4	0	0

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

In the hospital setting, 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.

Rate per 1000 bed days:	0.62
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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
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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 4 fall(s) that caused at least 'moderate' harm.

Severity	Number of falls
Moderate	4
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:	0.36
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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.



The Friends & Family Test

Patient experience

The Friends and Family Test

The Friends and Family Test (FFT) 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?* We ask this question to patients who have been an in-patient or attended A&E (if applicable) in our Trust.

In-patient FFT score*	97.5%	% recommended	This is based on 872 responses.
A&E FFT Score	79.4%	% recommended	This is based on 737 responses
Community FFT Score	94.7%	% recommended	This is based on 75 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 14 patients the following questions about their care in the hospital:

	% Recommended
Were you involved as much as you wanted to be in the decisions about your care and treatment?	71
If you were concerned or anxious about anything while you were in hospital, did you find a member of staff to talk to?	79
Were you given enough privacy when discussing your condition or treatment?	93
During your stay were you treated with compassion by hospital staff?	100
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?	86
Did you get the care you felt you required when you needed it most?	86

A patient's story

Eileen's story

<https://vimeo.com/208096445>

Staff experience

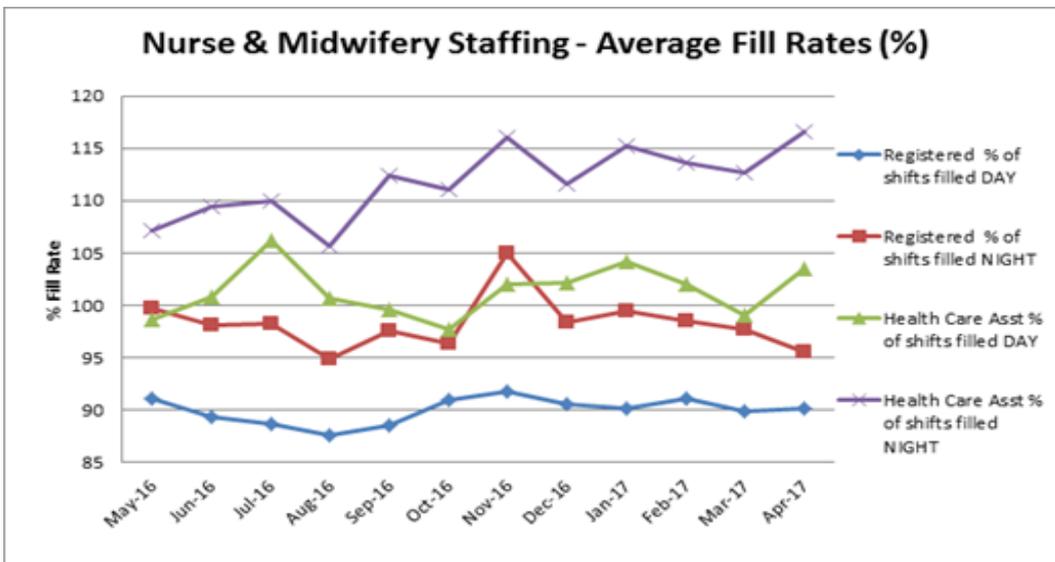
We asked 28 staff in the hospital the following questions:

I would recommend this ward/unit as a place to work	% Recommended
I would recommend the standard of care on this ward/unit to a friend or relative if they needed treatment	88
I am satisfied with the quality of care I give to the patients, carers and their families	57
	89

Nurses/Midwives and Health Care Assistants (Care Staff) working on our in-patient wards.

Each month the data compares the number of staff hours 'Planned' against the number of staff hours used 'Actual'. This is collected by ward, by shift, and is reported by calendar month as a % fill rate by day and by night.

An overview of Tameside hospitals current position is given below:



To view our detailed reports, which provide a breakdown by ward and to access the monthly Trust Board Reports relating to Safer Staffing information at Tameside, please use the link below:

[Internal Links](#)

[Safer Staffing](#)

3. IMPROVEMENT

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

Digital Health

Here at Tameside & Glossop Integrated Care NHS Foundation Trust, we are developing new ways of working with our patients and families along with the wider health care teams and economy.

One of our newest transformational schemes is 'Digital Health'.

Digital Health is based on the Airedale Telemedicine model which was successfully implemented with the prison service, after its success it was introduced into nursing and community care homes, which in turn had a positive effect on ED attendances with a 30% reduction.

Our service utilises Skype for business, this meets all the NHS data protection and governance requirements. Care home staff are able to skype into the Digital Health Centre where trained registered Senior Nurses can assess patients, accessing medical records, offering tailored individual advice.

We are able to sign post to other services, arrange GP visits, refer to specialist services, involving teams from the acute and community to provide joined up care. This will allow us to manage people within their own home where ever it is possible, improving patient experience whilst helping reduce demand on the Emergency Department and GP time.

The service has received calls from the 4 homes involved in the pilot, helping to avoid unnecessary ED attendances and admissions. We have now offered this service to some of our community-based inpatient beds.



Peter Grace, Clinical Lead for Clinical Health