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

December 2014

Open and Honest Care at The Christie NHS Foundation Trust: December 2014

This report is based on information from December 2014. The information is presented in three key categories: safety, experience and improvement. This report will also sign-post you towards additional information about this Trust's performance. This information relates to inpatient activity only.

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% 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	2	0
Improvement target (year to date)	20	0
Actual to date	17*	0

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

Whilst we have recorded a small number of *Clostridium difficile* infections so far this year - it is important to note that **only four** 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 does 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 grades, with one being the least severe and four being the most severe.

This month 5 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:	1.14

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

Severity	Number of falls
Moderate	0
Severe	0
Death	0

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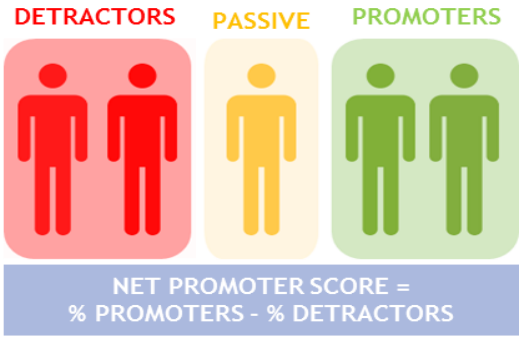
Rate per 1,000 bed days:	0.00

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 (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?*

In-patient FFT score* 87.7 This is based on 116 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/

The Trust Friends and Family test scores are now published on the ward information screens, together with patient comments and improvement stories. By the end of January all the harm free care data published in this report will also be available in real time on the ward screens

The following questions are asked as part of our monthly patient experience survey. The scores for each set of responses are calculated using the net promoter scoring methodology. In total 179 patients were asked relevant questions across all areas of the hospital.

	Net Promoter Score
Were you involved as much as you wanted to be in the decisions about your care and treatment?	68
If you were concerned or anxious about anything while you were in hospital, did you find a member of staff to talk to?	68
Were you given enough privacy when discussing your condition or treatment?	74
During your stay were you treated with compassion by hospital staff?	78
Did you always have access to the call bell when you needed it?	79
Did you get the care you felt you required when you needed it most?	72
How likely are you to recommend our ward/unit to friends and family if they needed similar care or treatment?	81

Dr Fiona Thistlethwaite

All cancer doctors deal with harrowing stories on a daily basis. Like many, I had coped during my 6 years as a consultant oncologist at The Christie, by adopting a firm belief that it could never happen to me.

Unsurprising then, my sense of shock when, a little over a year ago, I left my busy Gastric Cancer Clinic and climbed one flight of stairs to receive the results of my own biopsy, taken from a breast lump the week before.

If I am totally honest I knew what was coming. The mammograms and ultrasound scan had left me with little doubt, but I had clung onto the slim hope that it would all turn out to be just a big scare.

I have had years of training in clinical communication skills, but it is only through my experience on that day that I know how it is that patients only recall the first sentence when bad news is broken.

I remember the exact words of my surgeon: 'I have the results of your biopsy and I am afraid it is not good news'. I had been diagnosed with breast cancer. The rest of the consultation passed in a blur.

In that moment it felt like my whole identity had been turned on its head. I was no longer a cancer doctor, I was a cancer patient and along with that came all the fears and questions that everyone faced with a life-threatening diagnosis experiences; How will I cope with treatment? Who will look after the children? What will happen with my work? How will my husband cope? Will I die?

So was my journey as a cancer patient made harder or easier as a result of my profession? It never even crossed my mind to be treated anywhere other than at the hospital I work at - The Christie, the biggest single-site Cancer Hospital in Europe. And I knew, without hesitation, who I wanted to take charge of my chemotherapy - a colleague for over 10 years.

At a time of such uncertainty, the knowledge that I was in safe hands, being cared for in a hospital where I would receive gold-standard treatment was hugely reassuring. How much harder it must be for the majority of patients who have to put blind faith in those around them.

It was not just those big things that smoothed my journey, the small things mattered too; knowing where to park the car or where to find the radiology department, seeing a familiar face at the reception desk or calling a secretary I knew to check on a lost appointment. All helped ease the sense of panic that was never far from the surface in those frightening days.

But there were down-sides to being treated in my own hospital too. The loss of privacy was probably the hardest to accept. Where it could be protected it was, of course.
I received my chemotherapy in a quiet side room and the doctor came to see me there. It meant I avoided bumping into my own patients in busy waiting rooms or while I was receiving treatment.

By necessity, however, my anonymity could not be maintained in its entirety. As is standard practice, my case was discussed on several occasions at multi-disciplinary team meetings. I wonder if I walked past colleagues who knew about my diagnosis or the results of my surgery before I did.

As an oncologist I enjoy the challenge of resolving the dilemma of what is the best treatment for each of my patients. As a patient I wanted nothing more than to hand-over that responsibility and allow an expert to make the right decisions on my behalf.

Another difficulty I faced, however, was that it was impossible to completely block out my professional background and there were times when I found this knowledge encroaching into my life as a patient in a distressing way.

On one occasion I stumbled across a paper in a clinical journal about survival rates in my particular type of breast cancer. I made the mistake of reading it. I suppose I was hoping for reassurance that everything was going to be OK, but the stark facts and figures in front of me had the opposite effect.

I learnt my lesson and from then on was careful to avoid reading articles about my condition. I also learnt to avoid the temptation to over-analyse my blood test or scan results. Too many times I spent days worrying about an incidental finding on my CT scan report or made (incorrect) assumptions about the significance of a mildly abnormal blood test result.

I have completed my treatment now and have made the testing transition back to work. As I look back on my experience as a patient I can reflect on the unexpected insights I have gained; from the raw sense of shock when a diagnosis is made, to the fear for the future when treatment comes to an end.

I am eternally grateful though that, through the care of my friends and colleagues at The Christie, my case was so sensitively handled. I hope to put to good use the lessons I have learnt as a patient as I aspire to be the best doctor I can possibly be.

Staff experience

We asked 5 staff the following questions:

	Net Promoter Score
I would recommend this ward/unit as a place to work	100
I would recommend the standard of care on this ward/unit to a friend or relative if they needed treatment	100
I am satisfied with the quality of care I give to the patients, carers and their families	100

3. IMPROVEMENT

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

The Christie Medical Illustration department in collaboration with the plastic surgeons have established a 3D imaging service. By using the 3D imaging camera during the pre-operative assessment the surgeons will be enable to develop the most accurate planning of the surgery to limit the number of procedures, particularly in complex secondary surgery. It will also provide patients with a clear image of how the surgery will change the look of their body post operatively, allowing them to make much better informed decisions about their care and treatment. Initially this service will be used for facial, breast and torso surgery.

Supporting information