AN EVALUATION OF THE OPEN AND HONEST CARE: DRIVING

IMPROVEMENT PROGRAMME IMPLEMENTED WITHIN NHS TRUSTS IN THE

NORTH OF ENGLAND

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FINAL REPORT

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EXECUTIVE SUMMARY

The Open and Honest Care: Driving Improvement Programme is a central part of NHS England's commitment to improve transparency about the quality of care in the NHS. It promotes the use of measurement and openness to understand and improve care. NHS England (North) commissioned an evaluation of the Programme which was conducted between June and November 2014. The aim of the evaluation was to examine how the Open and Honest Care Programme had been implemented across a range of Acute NHS Trusts; to understand how Programme information had been shared with Trust staff, patients and the public and to explore the extent to which it was driving improvements in patient safety, patient experience and staff experience. The evaluation identified the challenges Trusts encountered during the implementation phase, how these were overcome and areas of the programme that required further improvement.

The evaluation utilised a mixed method study design which included a self-administered questionnaire distributed via the Survey Monkey computer package to a range of Trust staff including Executive and Non-Executive members of the Board, nursing managers and specialist nurses; staff at ward level including wards managers, staff nurses and health care assistants. Qualitative data was collected through semi-structured telephone interviews undertaken with senior nurses and ward managers.

The evaluation demonstrated that OHCP is a highly valued part of the NHS improvement strategy. It can facilitate ward based staff to identify areas for improvement and can energise and empower them to act on these indicators contributing to a culture of learning across the organisation. The study identified a number of key challenges that Trusts had encountered and to some extent resolved throughout the process of establishing the Open and Honest Care Programme. These challenges related to four different domains: implementation of the Programme; sharing of OHCP information with staff; sharing of OHCP information with patients and the usefulness of the Programme as a vehicle for continuous improvement.

The first challenge concerns the way in which the Programme is implemented in the Trusts. The Programme requires sufficient standardisation of definitions of indicators across clinical settings and ongoing verification of results. While NHS England provides a Standard Operating Procedure (SOP) for the reporting of patient safety issues, there was concern that NHS Trusts had interpreted this guidance differently. The evaluation revealed that consistency and verification of reporting requires some further improvement. A varied impact of the programme on staff and patients was also found to be a potential concern. Continuous and effective feedback to staff and patients is seen as essential to maximise the impact of the Programme. The evaluation demonstrated that additional strategies need to be developed to effectively engage staff and the public with the Programme. In particular, it was

found that the Programme was most effective when meaningfully translated into tangible actions at a local level. Key recommendations that emerged from the evaluation included:

1 Engage with Trusts to ensure that the metrics within the Standard Operating Procedures are consistently applied across Trusts;

2 Improve pro-active engagement of staff at ward level to increase ownership and engagement with the programme;

3 Develop more effective approaches to engage patients and public with the programme.

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1. INTRODUCTION

1.1 Background

The Open and Honest Care: Driving Improvement Programme is a central part of NHS England's commitment to making more information available about the quality of care in the NHS. The overarching aims are to ensure every patient gets high-quality care and to build improved services for the future. The programme forms part of the key actions of the Nursing Midwifery and Care Staff Strategy: Compassion in Practice (DH 2012). Implementation plans are detailed in 6 action areas relating to the strategy to ensure it is a dynamic vehicle for positive change. NHS England North leads on initiatives that will deliver the outcomes required in Action Area 3; Delivering High Quality Care and Measuring Impact, as well as ensuring that local commissioners and providers are facilitated to deliver improvement in all areas of the strategy. The Open and Honest Care: Driving Improvement Programme is aligned to Action Area 3 and is intended to support organisations to become more transparent and consistent in publishing safety, patient and staff experience and improvement data, with the overall aim of driving improvements in practice and creating a culture of compassion, dedicated to learning and improvement.

1.2 Overview of the Open and Honest Care Programme

Open and Honest Care: Driving Improvement Programme (OHCP), promotes the use of measurement and openness to understand and improve care. It builds on the evidence that organisations with a high reporting culture can be safer and deliver higher quality care consistently. At the start of the programme the Action Area 3 Team worked with stakeholders to agree a set of metrics and information that both Acute Trusts and the public would find useful, using existing metrics wherever possible to reduce the burden of data collection. From November 2013, 16 Acute Trusts in the North of England commenced publication of similar information. By the end of 2013, 23 Acute NHS Trust in the North of England had signed up to a Board Compact with NHS England to participate in the programme, endorsing their organisation's involvement and making a commitment to transparency and openness.
The Board Compact contains 7 key principles including a commitment to;

- The utilisation of common data definitions and a reporting template in agreed formats at agreed times

- A monthly review of the Open and Honest Care: Driving Improvement Programme data and report at Board level or an appropriate sub-board committee

- The proactive sharing of their published data and Open and Honest reports internally and externally

- The creation and maintenance of a culture of openness and honesty at their organisation

- A focus on the capacity and capability of improvement, not to apportion blame

- A commitment to publish further metrics as they are developed and agreed, including metrics for other specialities such as Community, Maternity and Mental Health

- The mentoring of organisations new to the Open and Honest Care: Driving Improvement Programme.

1.3 Information published within the Open and Honest Care reports

The intention of the OHCP is to support NHS Trusts to bring together into one report, safety, staff and patient experience and improvement data that is routinely collected and which may be reported singularly within other publications. The aim is to publish this in a way that is understandable and meaningful for staff and patients and proactively share it with both Trust staff and the public through publication on the Trust internet and intranet and on the NHS England website.

The information that Trusts are publishing in their OHCP monthly reports comprises both metric and narrative data and includes;

- NHS Safety Thermometer data
- Friends and Family Test data
- Information on healthcare associated infection (MRSA and C Diff)
- Pressure ulcers category 2-4
- Falls causing moderate harm or above
- Staff experience questions
- Patient experience questions
- A patient story
- An improvement story describing what the Trust has learnt and what improvements they are making.

While the information in the OHCP reports is not intended to make direct comparisons about the safety or quality of healthcare across different organisations, it is anticipated that access to this locally derived information will act as a catalyst to improve clinical practice, patient experience and contribute to a culture of safe compassionate care.

The first community services Open and Honest Care: Driving Improvement report was published in April 2014 followed by the first maternity services publication in September 2014. Currently there are 31 Trusts in the North of England publishing data and this includes Acute, Community, and Integrated (Acute and Community)

Trusts. Plans to implement the programme in Mental Health services and for scale and spread nationally are currently underway.

2. STUDY DESIGN

2.1 The aims and objectives of the evaluation

This study sought to evaluate the Open and Honest Care; Driving Improvement Programme, implemented within 23 participating Acute NHS Trusts who had been publishing reports for six months from November 2013. Key Questions the study sought to address included;

- How has the Open and Honest Care Programme been implemented across a range of Acute NHS Trusts?
- What challenges have participating NHS Trusts experienced in implementing the Open and Honest Care Programme and how have these challenges been overcome?
- How has the Open and Honest Care Programme information been shared with Trust staff, patients and the public?
- What perceived impact has the Open and Honest Care Programme had on patient safety, patient and staff experience and improvement efforts within participating Trusts?
- How can the Open and Honest Care Programme be enhanced?

2.2 Introduction to study design

An evaluative research approach to study design was used incorporating a combination of quantitative and qualitative methods of data collection (Creswell, 2003; Patton, 2002). Evaluation research seeks to answer questions about programme implementation, outcomes and impact and as such is well suited to the purpose of the study (Fink, 2014). Combining quantitative and qualitative methods was intended to provide a more in-depth and contextual understanding of the programme and its reported impact in practice (Parahoo, 2006; Greene 2007).

Quantitative data was collected through a self-administered questionnaire designed for online administration via the Survey Monkey computer package. Qualitative data was collected through semi-structured telephone interviews to complement survey data and to explore participants' perceptions of the programmes processes, outcomes and impact (Fink 2014).

Table 1: Areas for evaluation and methods of inquiry

Question areas	Methods of inquiry
How has the Open and Honest Care Programme been implemented within participating NHS Trusts?	Survey Questionnaire Telephone interviews
What challenges have participating NHS Trusts experienced in implementing the Open and Honest Care programme and how have these been overcome?	Telephone interviews
How is the Open and Honest Care report shared with NHS Trust staff, patients and the public?	Survey Questionnaire Telephone interviews
What perceived impact has the Open and Honest Care Programme had on patient safety, patient and staff experience and improvement efforts?	Survey Questionnaire Telephone interviews
In what ways can the Open and Honest Care Programme be enhanced?	Survey Questionnaire Telephone interviews

2.3 Research ethics

The study was compliant with the Research Governance Framework (DH 2005) and all standard ethical processes were adhered to including recruitment, consent, confidentiality and storage of data considerations. In addition to Faculty Research Ethics Committee (FREC) approval, Research & Development (R&D) approval was sought from each participating NHS Trust. The process for seeking R&D approvals commenced in June 2014 when an initial email was sent to respective R&D contacts at each of the 23 Trusts to both inform them of the study and to request the research team be informed as to the documentation required to secure the relevant permissions.

Documentation requirements varied greatly between each Trust and included copies of the study protocol, a completed Integrated Research Application System (IRAS) R&D form, completed IRAS Site-Specific Information (SSI) forms, Good Clinical Practice certificates for all research team members, study information sheets, the consent form, drafts of all data collection tools, project registration forms and research team CVs. Following ethical approval from Edge Hill University's Faculty of Health and Social Care Research Ethics Committee (FREC) on 25th July 2014 the requested documentation began to be forwarded and the reviewing process began. The time to confirm R&D approval from Trusts varied significantly between one week and ten weeks. Despite this, it was necessary in only two cases to withdraw our application, one because of time limitations and one because of a prohibitive fee (see Table 2).

Table 2: R&D approvals by NHS Trust

Trust	Approval date
Aintree University Hospital NHS Foundation Trust	4.9.14
Barnsley District General Hospital Trust	30.7.14
Blackpool Teaching Hospitals NHS Foundation Trust	11.9.14
Bolton NHS Foundation Trust	5.8.14
Calderdale and Huddersfield Foundation Trust	25.9.14
Clatterbridge Cancer Centre NHS Foundation Trust	Withdrawn (30.9.14)
Hull & East Yorkshire NHS Trust	15.9.14
Leeds Teaching Hospitals NHS Trust	16.7.14
Liverpool Heart and Chest Foundation Trust	7.10.14
Northern Lincolnshire & Goole Hospitals NHS Foundation Trust	1.10.14
Pennine Acute Hospitals NHS Trust	2.10.14
Royal Liverpool and Broadgreen University Hospitals NHS Trust	12.8.14
Rotherham NHS Foundation Trust	3.10.14
Salford Royal NHS Foundation Trust	1.8.14
South Tyneside NHS Foundation Trust	6.8.14
Southport & Ormskirk NHS Trust	8.9.14
St Helens & Knowsley Teaching Hospitals Trust	29.9.14
Stockport NHS Foundation Trust	10.9.14
Tameside Hospital NHS Foundation Trust	1.8.14
University Hospital of South Manchester NHS Foundation Trust	1.8.14
Walton Centre for Neurology and Neurosurgery NHS Trust	4.8.14
Warrington and Halton Hospitals NHS Foundation Trust	Withdrawn (6.10.14)
Wrightington, Wigan and Leigh NHS Foundation Trust	30.7.14

2.4 Questionnaire development and distribution

The electronic survey was a structured, self-report document designed for online administration via the Survey Monkey computer package. The use of an online survey was deemed appropriate as potential participants were located at a number of NHS Acute Trusts that were geographically widespread across the north of England. It was designed to facilitate data collection relating to the study questions and consists mostly of closed or fixed response questions, as well as two free text questions. Section A of the questionnaire sought demographic information; section B sought to capture participants' knowledge; while section C explored participants' understanding and perceptions. The final section was structured to illicit participants' views on ways in which the Open and Honest Care Programme could be enhanced or improved. Questions were pre-tested for face and construct validity through an initial small scale pilot with qualified health care professionals (Bryman, 2008).

The study targeted approximately seventy six staff members within each identified NHS site. Each NHS Trust participating in the Open and Honest Care: Driving Improvement Programme had a senior Trust member who acted as project lead. The project lead within each site assisted in the identification of potential key

participants. This purposive sampling strategy was intended to maximise a good correspondence between the population sample and the questions to be answered (Bryman, 2008). Potential participants were sent an email forwarded via the project lead inviting them to complete the online questionnaire. This was forwarded to a range of Trust staff as follows:

- 6 members of the Board both Executive and Non-Executive
- 20 nursing managers below Executive Board and including specialist nurses
- 50 staff at ward level including wards managers, staff nurses and health care assistants.

This recruitment strategy avoided personal details of potential participants being divulged to the research team. The email that was sent contained a hyperlink to the online survey and information letter which described the study in detail. A follow up reminder email was sent to potential participants at two further points in the data collection process until the survey was closed on 24th October 2014.

2.5 Telephone interviews

Data collection for this component of the study utilised semi-structured telephone interviews deemed to be a valid data collection approach when attempting to access busy health care staff dispersed across multiple organisations (Smith, 2005). Telephone semi-structured interviews were intended to facilitate the capture of qualitative narrative data relating to participants' perceptions and experiences of the programmes' impact and outcomes.

Within identified sites only, the email accompanying the online survey also included a separate link whereby Trust staff could volunteer to participate in an interview. Respondents were asked to provide contact details and to agree to a member of the evaluation team contacting them directly to arrange a convenient interview time. This aspect of recruitment to the study was not as successful as anticipated and the opportunity to participate in telephone interviews was opened up to staff across all sites. An email invitation was sent to all project leads who distributed this within their Trusts. Interviews were undertaken with all participants who responded. The interviews were scheduled at agreed times at participants' convenience and were approximately twenty minutes in duration. An interview guide was developed, informed by data collected via the questionnaire, and was used to enable emergent issues to be explored in more detail. Questions were open-ended and respondents were prompted to expand on salient points raised. Interviews were undertaken by three team members (AC, AB, TB) and were digitally recorded following verbal consent from participants.

2.6 Data analysis

Following the closure of the survey, responses were exported to Microsoft Excel and frequencies were analysed using Excel. Some data were exported to the statistical package SPSS to conduct cross tabulations. Exported data were subject to simple descriptive analyses and some cross-tabulations. Likert scale data were simplified, where appropriate, from five to three levels. Categorical data were used to cross-tabulate responses with professional categories to obtain a more detailed picture on select issues.

The digitally recorded interview data were anonymised and transcribed in full. Responses to the two open survey questions and interview data were analysed using a thematic analysis approach informed by the main research questions. To ensure rigour this was undertaken independently by two members of the research team, who subsequently met to agree key themes (Polit & Beck, 2010).

3. MAIN FINDINGS FROM THE QUESTIONNAIRE SURVEY

3.1 Introduction

In this chapter the quantitative finding from the survey questionnaire are presented. The questionnaire was designed to ascertain the views and opinions of staff in four distinct, yet interrelated, domains. The survey also collected some demographic data relating to the professional role of the respondent to assist analysis. The survey did not contain any forced questions, i.e. respondents could choose not to answer and proceed with the survey regardless and it took about ten minutes to complete. Qualitative data that were collected through open response facilities of the survey were analysed separately and are integrated into the following chapter. Results are reported below in four sections. First, demographics and survey utilisation data; second, data relating to knowledge and dissemination of the OHCP; third, data on staff views on the usefulness of the programme; and fourth, views of staff on the relevance of the OHCP for improving clinical practice and suggestions for improvement.

3.2 Survey utilisation data and respondent demographics

The survey link was sent to 21 NHS Trusts for whom R&D had been confirmed. Three Trusts declined to distribute the questionnaire although one of these Trusts agreed to participate in telephone interviews. The questionnaire was therefore distributed within 18 Trusts to approximately 76 staff per Trust (n=1368). The actual number of responses was 387 (n=387). Respondents did not answer all questions. The resultant approximate response rate was 28.3%.

Table 3: Number of respondents per participating Trust

Which NHS Trust are you working for?		
Answer Options	Response Percent	Response Count
Barnsley District General Hospital Trust	9.3%	36
Blackpool Teaching Hospitals NHS Foundation Trust	6.5%	25
Bolton NHS Foundation Trust	4.1%	16
Calderdale and Huddersfield Foundation Trust	3.6%	14
Leeds Teaching Hospitals NHS Trust	2.6%	10
Liverpool Heart and Chest Foundation Trust	5.4%	21
Northern Lincolnshire & Goole Hospitals NHS Foundation Trust	7.8%	30
Pennine Acute Hospitals NHS Trust	3.4%	13
Royal Liverpool and Broadgreen University Hospitals NHS Trust	4.1%	16
Salford Royal NHS Foundation Trust	11.4%	44
South Tyneside NHS Foundation Trust	4.1%	16
Southport & Ormskirk NHS Trust	5.2%	20
St Helens & Knowsley Teaching Hospitals Trust	2.3%	9
Stockport NHS Foundation Trust	4.9%	19
Tameside Hospital NHS Foundation Trust	12.1%	47
University Hospital of South Manchester NHS Foundation Trust	5.2%	20
Walton Centre for Neurology and Neurosurgery NHS Trust	1.6%	6
Wrightington, Wigan and Leigh NHS Foundation Trust	6.5%	25
Total	100%	387

The survey also asked respondents to identify their main professional role against a number of identified categories. The largest numbers of respondents (n=181) were ward based staff including staff nurses and health care assistants, followed by nurse managers including matrons and specialist nurses (n=117) and Non-Executive and Executive Board members (n=25). 49 respondents identified their role title as 'other'. Specific roles within this category were varied but included specialist lead roles, heads of services, doctors, ward clerks, midwives and physiotherapists.

Table 4: Professional role of respondents

What title best describes your role within the Trust?		
Answer Options	**Response Percent**	**Response Count**
Executive Member of the Board of Directors	3.7%	12
Non-Executive Member of the Board of Directors	4.0%	13
Director of Nursing	0.9%	3
Deputy / Assistant Director of Nursing	3.8%	12
Matron	17.0%	55
Specialist Nurse	16.4%	53
Ward Manager, Sister or Charge Nurse	32.2%	104
Staff Nurse	13.7%	46
Senior Nurse	5.3%	17
Healthcare Assistant	5.9%	19
Other (please specify)		49
Answered question		**323**
Skipped question		**64**

During the analysis stage, the above respondents were assigned to one of four categories;

- Executive and Non-Executive Board members

- Nurse managers below Executive Board including specialist nurses

- Staff at ward level including ward managers, staff nurses and healthcare assistants.

- Other

Table 5: Respondents assigned to one of four categories of professional roles

Number of responses

- 1 - Trust Board - Executive and Non-executive members
- 2 - Nurse managers below Executive Board including specialist nurses
- 3 - Staff at ward level including ward managers, staff nurses and healthcare assistants
- 4 - Other
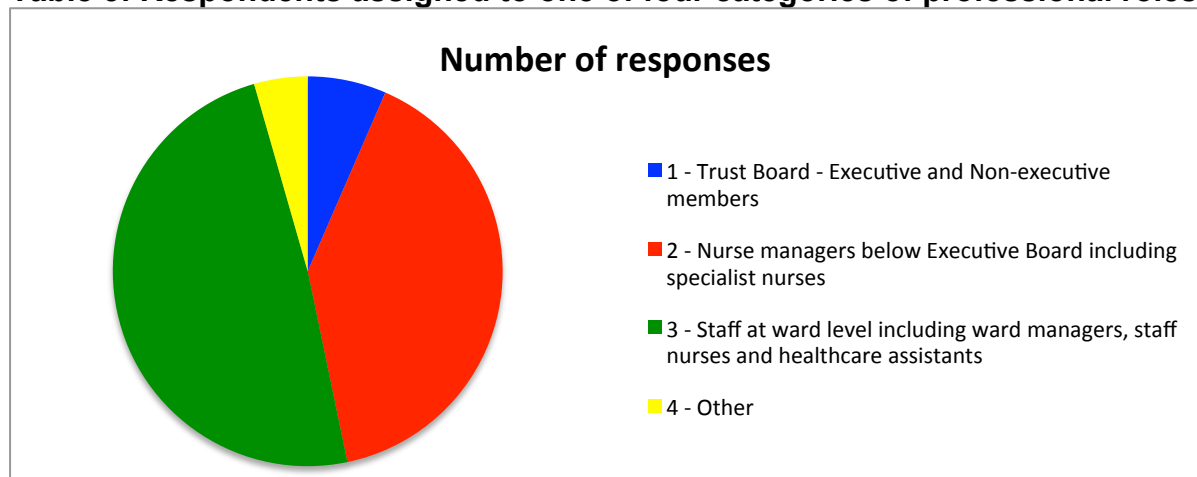
3.3 Knowledge and dissemination of the OHCP

The next domain of questions related to how much Trust staff knew about the OHCP and how widespread, in their opinion, knowledge of the programme was amongst staff. The overwhelming majority of respondents (85%) indicated that they had knowledge of the programme and this was reflected in all categories of staff i.e. Board members, nurse managers and ward based staff. Less than 15% of respondents had not heard of OHCP and one respondent declined to answer the question (Table 6).

A similarly high number of respondents indicated that the information contained in OHCP was shared with them (78%). About a fifth (20%) of all respondents said it was either not shared or they did not know if it was shared with them (Table 7).

Table 6: Awareness of the OHCP within identified Trust staff categories
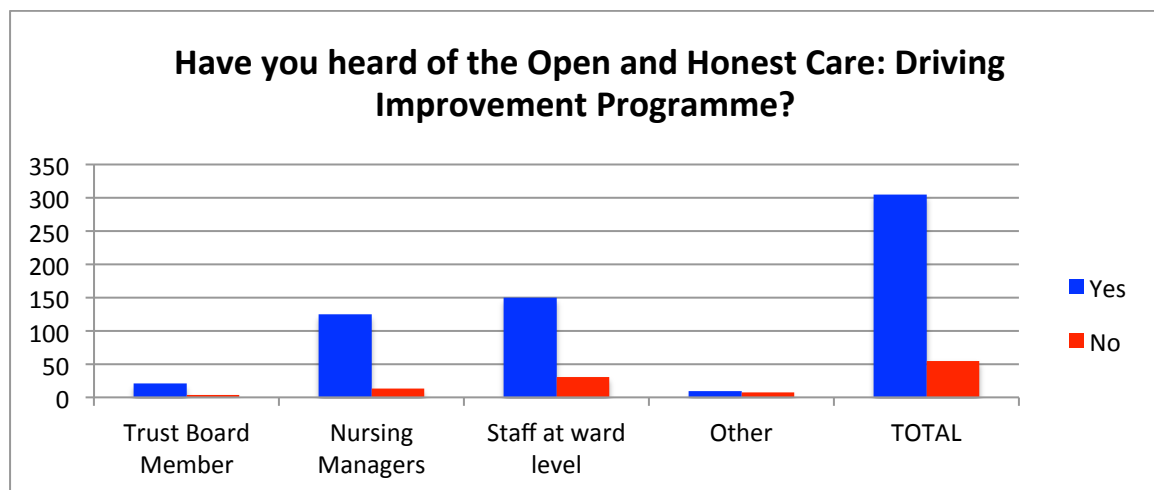
Table 7: Are results of the OHCP shared with you?
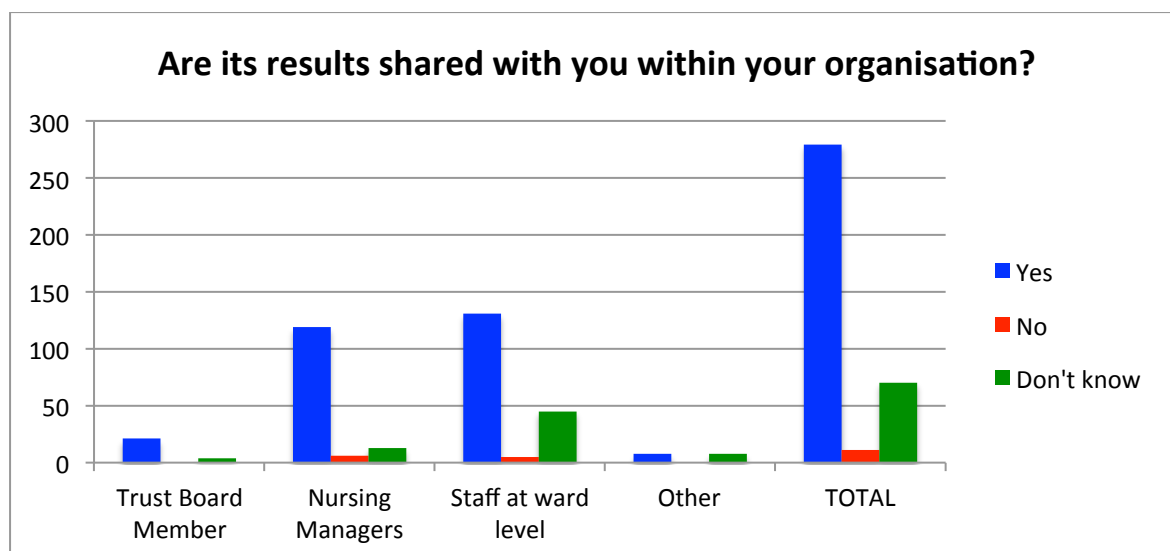
Table 8 presents the responses to this question as a percentage for each category of staff. There were 84% of Trust Board members, 86% of nursing managers and 72% of ward staff who confirmed that information within the OHCP was shared with them. Whilst this represents a high proportion of respondents, it is notable that 13.9% of ward based staff indicated that OHCP information was not shared with them or they were unsure if it was shared with them.

Table 8: Are results of the OHCP shared with you?

Are results of the OHCP shared with you?			
Answer Options	Percent of category	Percent of category	Percent of category
Trust Board Member	84.0%	0.0%	16%
Nursing Managers	86.3%	4.3%	9.4%
Staff at ward level	72.4%	2.8%	24.8%
Other	50.0%	0.0%	50.0%
Answered question	360		*Skipped question 27*

A follow up question asked respondents to clarify *how* information of the OHCP was shared with them. The survey questionnaire offered several choices as well as an 'other' option to respondents. Only those who had answered positively to the previous question were invited to respond to the follow up question. The answer options included 'pro-active' and 'passive' dissemination options, distinguishing between 'face to face' dissemination events and simple display options at the workplace. Respondents could select multiple options and a large number of respondents indicated that both 'pro-active' and 'passive' dissemination options were used in the Trusts (Table 9).

Table 9: How is the OHCP information shared with you?

If YES, how are they being shared?
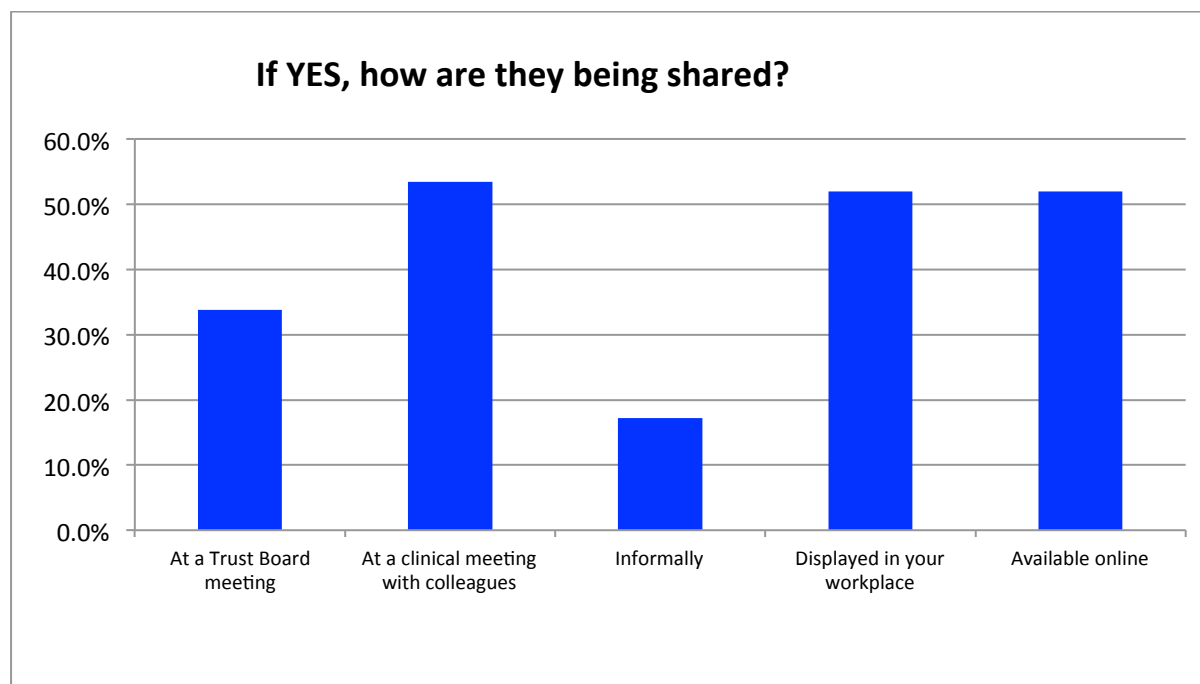
If YES, how are they being shared?		
Answer Options	**Response Percent**	**Response Count**
At a Trust Board meeting	33.8%	100
At a clinical meeting with colleagues	53.4%	158
Informally	17.2%	51
Displayed in your workplace	52.0%	154
Available online	52.0%	154
Other (please specify)		23
Answered question		**296**
Skipped question		**91**

The next question probed the extent to which information sharing was complemented by discussion amongst staff. This is an important aspect of dissemination practice as available data can only inform practice if and when its content and relevance for clinical practice is discussed. The question was intended to ascertain whether the OHCP information was used to stimulate debate and discussion. A large majority of

respondents (68%) indicated that discussions about the content of OHCP information took place at different levels of the organisation.

The questionnaire also inquired under which circumstances these discussions took place. The survey offered several options which included informal and formal work related occasions. Respondents could select several options to reflect the fact that discussions about OHCP data could take place at various settings. The results indicate that staff discuss OHCP information mainly at formal settings, such as clinical meetings with colleagues.

Table 10: Where is the OHCP information discussed with you?
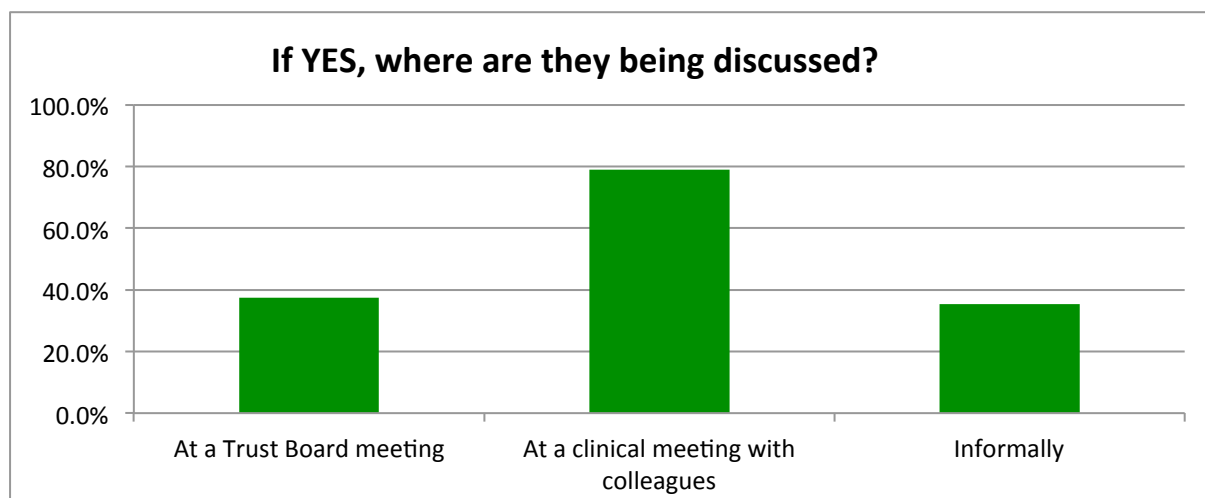
The next set of questions investigated the ways in which OHCP information was displayed at the workplace, if at all. A majority of respondents (53%) said that information about the OHCP was displayed in the clinical area where they work. Approximately 18% said that information was not displayed there and the remainder of respondents either did not know or selected non-applicable. This question completed the survey section on knowledge and dissemination of OHCP amongst staff.

3.4 Staff views on the usefulness of the OHCP and its impact on practice

The next section asked questions about how respondents perceived the usefulness of the programme for staff, patients and the public. When asked if respondents found the information within the OHCP useful approximately 59% of respondents confirmed that the information was useful, with 22% indicating they were unsure of its usefulness and 18% suggesting it was somewhat useful. It was noted that 0.5% indicated they did not think it was useful.

Table 11: Does the OHCP contain useful information?

Do you think it contains useful information?

22.0%

18.5%

59.0%

0.5%

- Yes
- No
- Somewhat
- Don't know
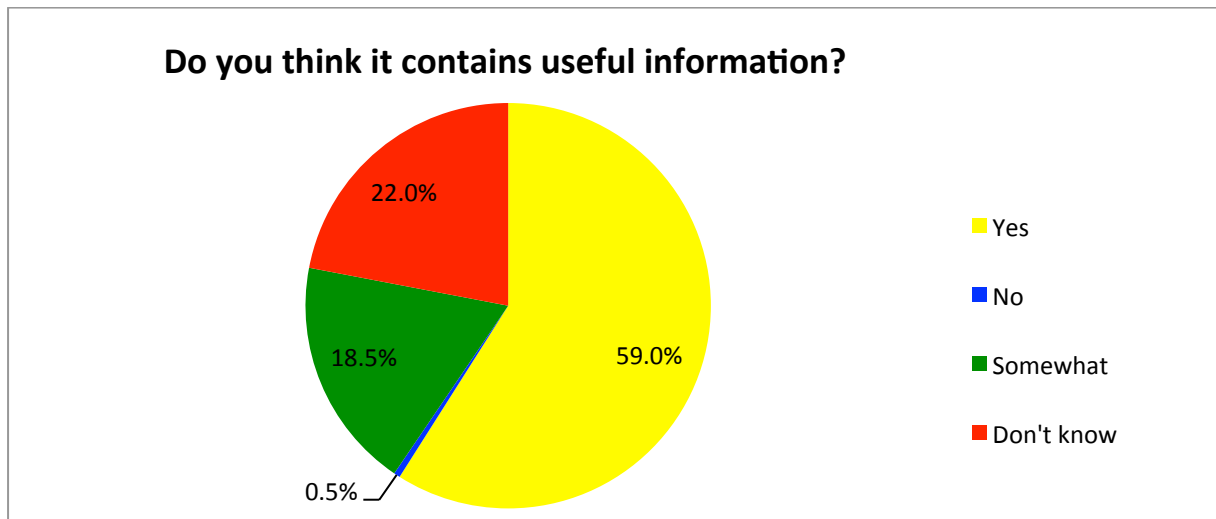
The survey then distinguished between different types of information to offer a more complete picture of the usefulness of the information brought together within the OHCP report. Respondents were asked to rate, using a five point Likert scale, the degree to which they agreed that each of the data sets was useful for their clinical practice (Table 12).

The majority of respondents strongly agreed that all data was useful to them and to their clinical practice, although it is worth noting some variations. The most useful information was deemed to be metrics relating to health care associated infections (HCAI's) with approximately 95% of respondents strongly agreeing or agreeing that this information was useful to them. The patient experience questions followed closely behind, with 94% agreeing or strongly agreeing that this information was useful to them, followed by staff experience data and patient story both with 91% positive responses and 90% for pressure ulcer rates. The 'NHS Safety thermometer' is thought slightly less useful than others, with 78% of respondents indicating it was useful to them compared to 6.8% who disagreed and 1.3% who strongly disagreed that it was useful to them. This may indicate that usefulness is dependent on the type of clinical area respondents are located or may suggest the need for future improvement of either the presentation or familiarity of staff with these items.

Table 12: Do you think the following data is useful to you?
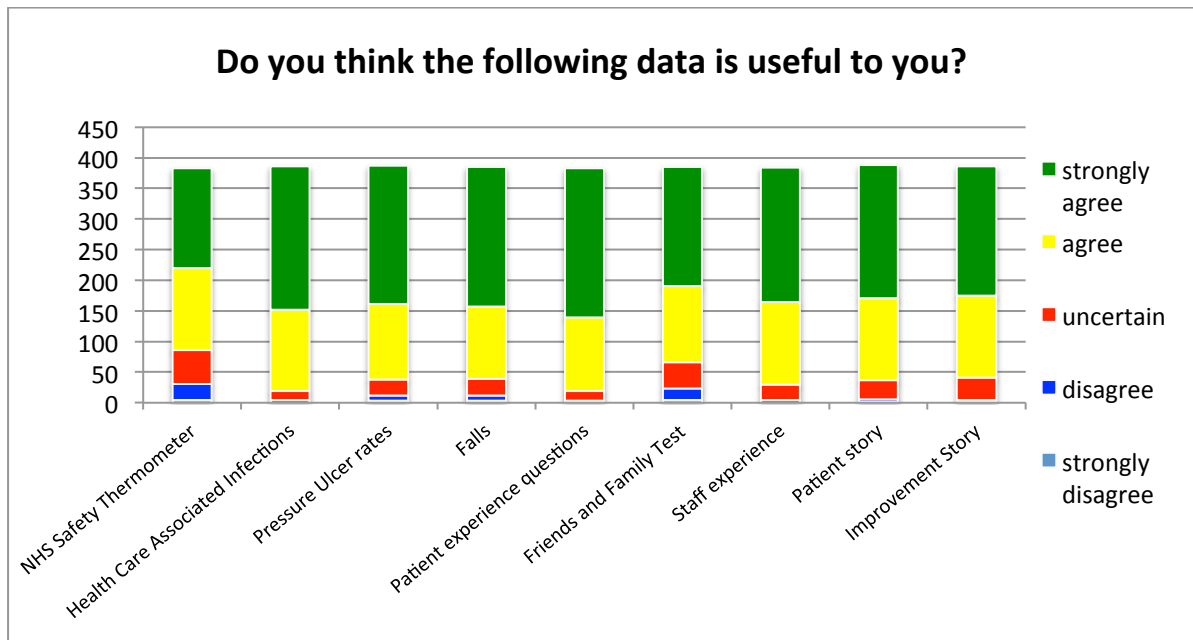
The survey also asked whether staff thought that the programme enabled the Trust to be open and honest with patients about the quality of care in the Trust. It is important to note that the responses reflected the perceptions and opinions of staff on this issue, not whether or not the OHCP actually increases transparency with patients. The responses were however positive, with 82.5% of respondents strongly agreed or agreed that the programme increased transparency with the public about the quality of care.

Table 13: Does the OHCP enable transparency with the public about the quality of care in the Trust?

The programme enables us to be open and honest with the public about the quality of care in our Trust.		
Answer Options	**Response Percent**	**Response Count**
Strongly agree	41.0%	157
Agree	41.5%	159
Uncertain	15.7%	60
Disagree	1.6%	6
Strongly disagree	0.3%	1
Answered question		**383**
Skipped question		**4**

It is clear from responses in Table 13 that the majority of staff believe that the OHCP enabled transparency with the public about the quality of care in the Trust. Yet the results displayed in Table 14 below, show that more than a third of respondents indicated that they were uncertain about the role of OHCP in improving decision making for the public. It appears, therefore, that staff believe that the OHCP increases transparency but does not equip the public to act on that transparency. It is also noteworthy that the question did not define who belongs to the public. Only a more detailed attitudinal study can ascertain whether 'the public' may be synonymous with patients in this context for staff.

Table 14: Does the OHCP help the public to make informed decisions about their care?

It enables the public to make informed decisions in relation to their care.		
Answer Options	**Response Percent**	**Response Count**
Strongly agree	28.1%	108
Agree	40.9%	157
Uncertain	24.5%	94
Disagree	5.2%	20
Strongly disagree	1.3%	5
Answered question		**384**
Skipped question		**3**

A key aim of the OHCP is to facilitate understanding and raise awareness of where harm reduction and improvements are needed and can be made. The survey asked whether respondents thought the programme would enable the Trust to understand where improvements can be made. The questionnaire offered several options and an opportunity to identify additional areas. The majority of respondents agreed or strongly agreed that access to the OPCP information helped the Trust to understand where action could be taken to; reduce harm to patients or improve patient safety (87%); and improve the experience of patients (87%). However there was considerable uncertainty (18%) amongst respondents that OHCP data were facilitating improvement for staff experiences at work.

Table 15: Does the OHCP enable the Trust to understand where improvements can be made?
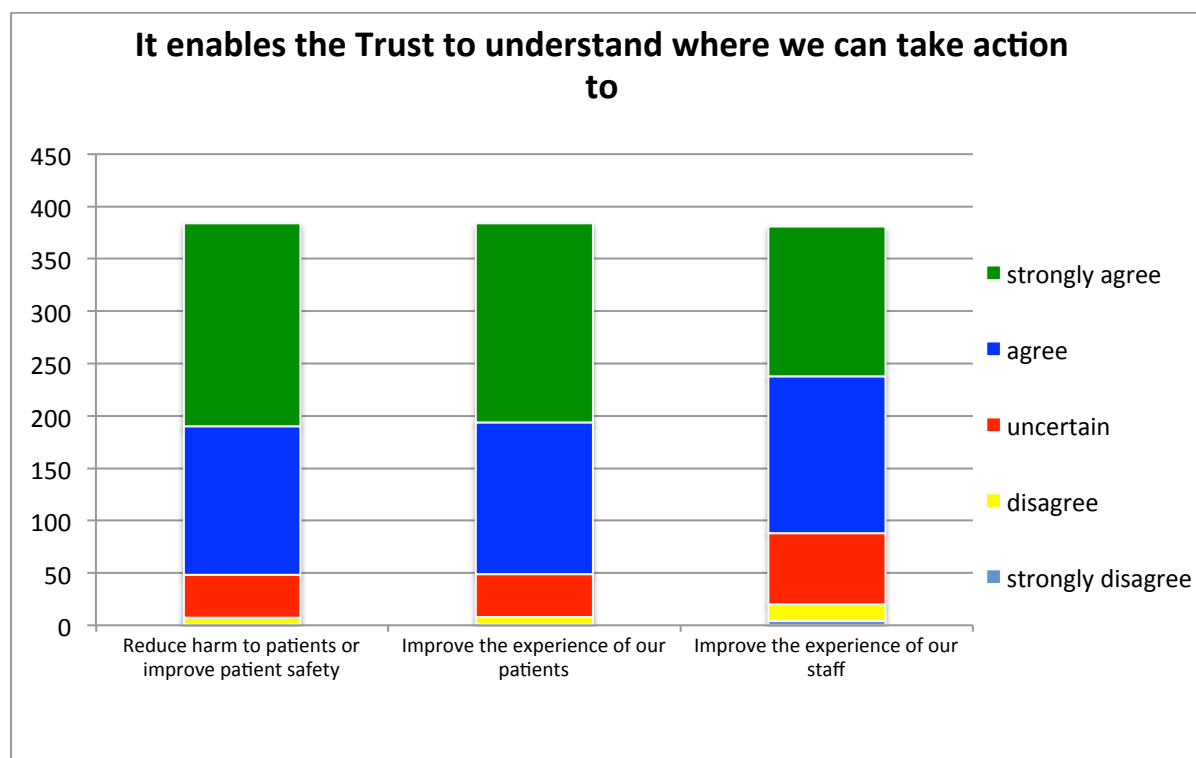
A similar picture emerged when respondents were asked whether or not OHCP data enabled ward based staff to identify areas for improvement (Table 16). This question aimed to gauge views of staff on the probability that the programme data would enable them to translate information into tangible action. The majority of respondents agreed or strongly agreed that access to the OPCP information helped ward based staff to understand where action could be taken to; reduce harm to patients or improve patient safety (86%) and improve the experience of patients (83%). Again, whist 72% agreed that OHCP information helps to improve the experience of staff 24% remained certain.

Table 16: Does the OHCP enable the ward based staff to understand where improvements can be made?

It helps ward based staff to understand where we can take action to
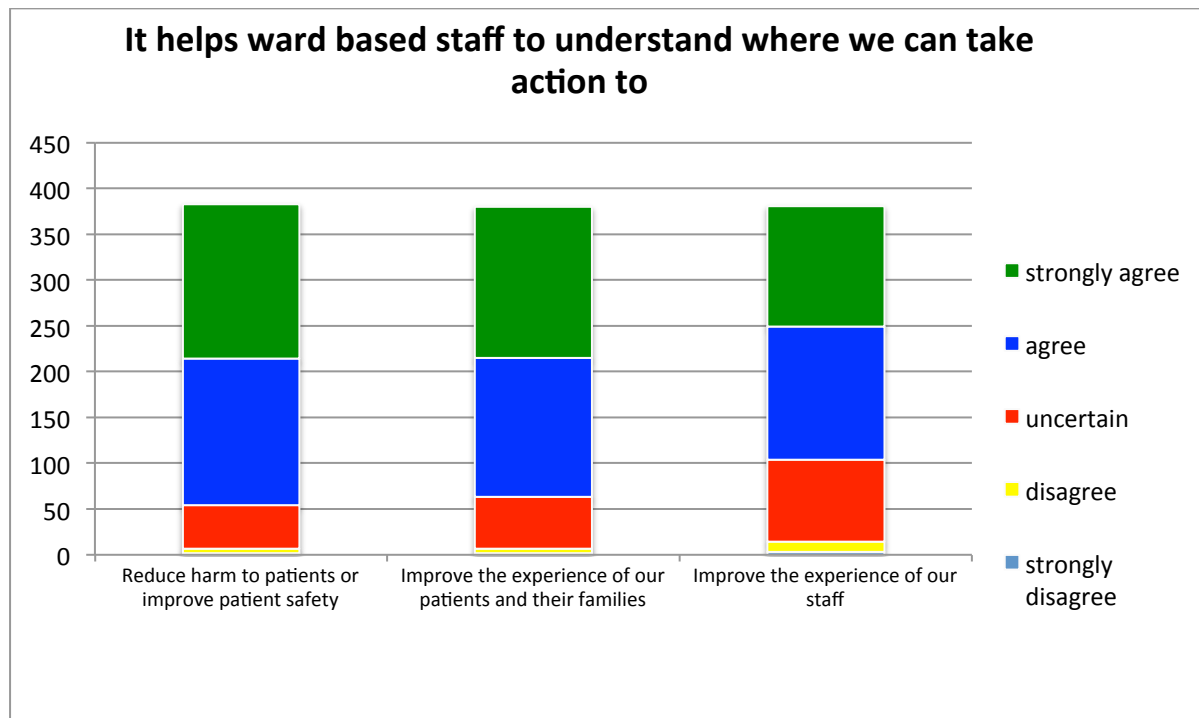
Whilst the previous questions probed the attitudes and views of staff on the potential of the programme to lead to improvements, the next question asked whether or not respondents perceived that the OHCP had already led to improvements. The aspect in which the OHCP was perceived to have impacted most highly was in improvements to pressure ulcer prevention and management, with 70% agreeing or strongly agreeing with the statement. This was followed by improvements to the experience of patients and their families (67%), prevention of falls causing moderate to severe harm (64%) and prevention of healthcare associated infections (56%). In terms of improvements to the experience of staff 51% indicated that the OHCP had led to improvements. It is worth noting the high level of uncertainty responses across all categories.

Table 17: Has the OHCP led to improvements?
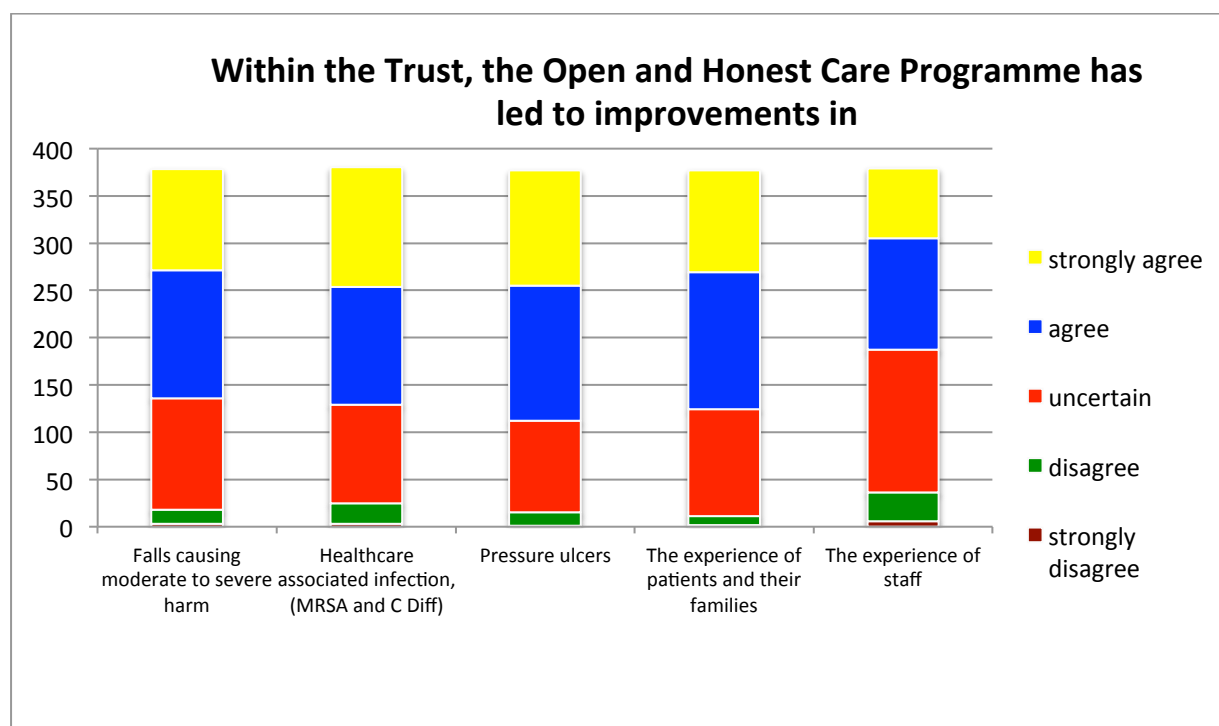
Within the Trust, the Open and Honest Care Programme has led to improvements in

Answer Options	Agree	Uncertain	Disagree	Response Count
Falls causing moderate to severe harm	242	118	18	377
Healthcare associated infection, (MRSA and C Diff)	251	104	25	379
Pressure ulcers	265	97	15	377
Experience of patients and their families	253	113	11	377
Experience of staff	192	151	36	379
Answered question				**381**
Skipped question				**6**

3.5 Suggestions for improving the impact of the OHCP

To identify what would help Trust staff, including ward based staff, to make more effective use of the information available through the OHCP, the survey respondents were given a range of options and asked to select any that they thought would assist them in making better use of OHCP data. There was a strong preference of respondents to be given more formal opportunities to discuss relevant OHCP information and to involve other clinical and non-clinical professions in those discussions.

Table 18: What would help you to make better use of the OHCP information?
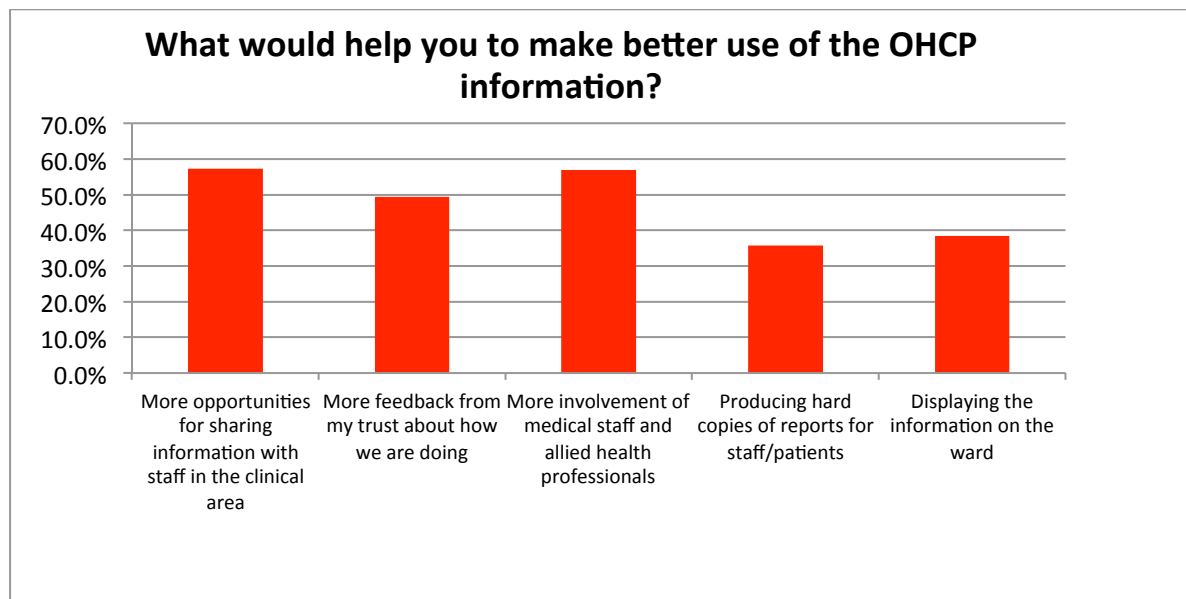
One critical element of improving the usefulness of OHCP is to assess the familiarity of the programme amongst the public and to identify ways to effectively disseminate knowledge of the programme to patients. This next section asked respondents several questions about whether or not members of the public were consulting OHCP information, whether they thought it useful, and whether or not it is currently presented in the best location and the best way for the public and patients to access.

Despite some significant optimism of staff about the potential role of OHCP for improvements in the future, the picture emerging from this section is more varied. The first question asked whether staff thought that OHCP information was viewed by the public. The overwhelming majority of respondents said that they either did not know or thought this not to be the case.

Table 19: Have members of the public asked you about this information?

Have members of the public asked about this information?

- Yes
- No
- Don't know
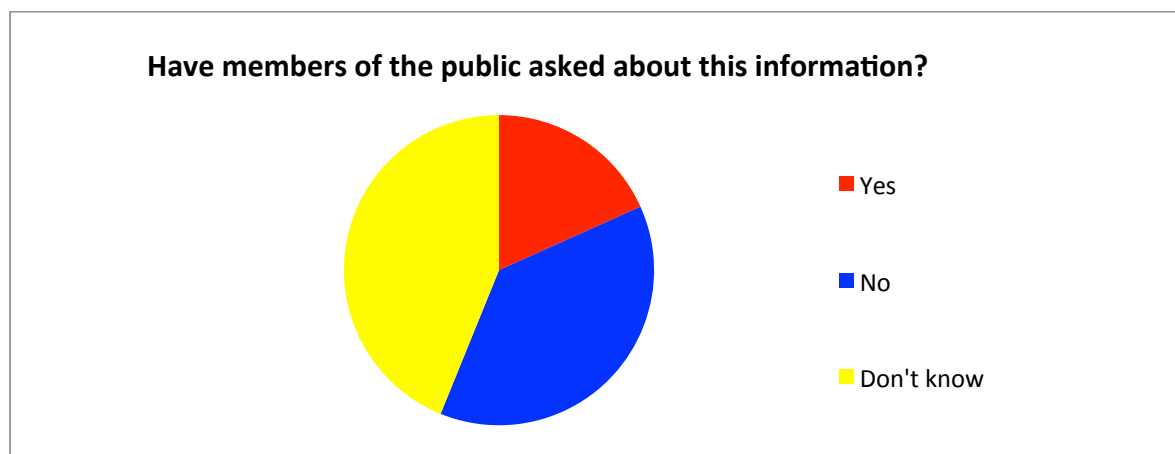
There was also some significant uncertainty with respect to whether the programme offered useful information to the public. Although about a third of respondents answered in the affirmative, another third indicated that they did not know. Around 30% of respondents thought that the public may find the information 'somewhat' useful which may echo some uncertainty amongst staff as to the effect of OHCP on the public, reflected in responses to previous questions.

Table 20: Do you think members of the public will find this information useful?

Do you think members of the public find this information useful?		
Answer Options	**Response percent**	**Response count**
Yes	30.6%	117
No	5.0%	19
Somewhat	28.5%	109
Don't know	35.9%	137
	Answered question	**382**
	Skipped question	**5**

Part of the uncertainty amongst staff about the effects of the programme on the public may be a reflection of dissemination strategies. The survey asked staff whether or not the data is displayed in the best location for the public to access it and many respondents were not sure that was the case.

Table 21: Do you think the information within the OHCP is displayed in the best location?

Do you think the information within the OHCP is displayed in the best location?
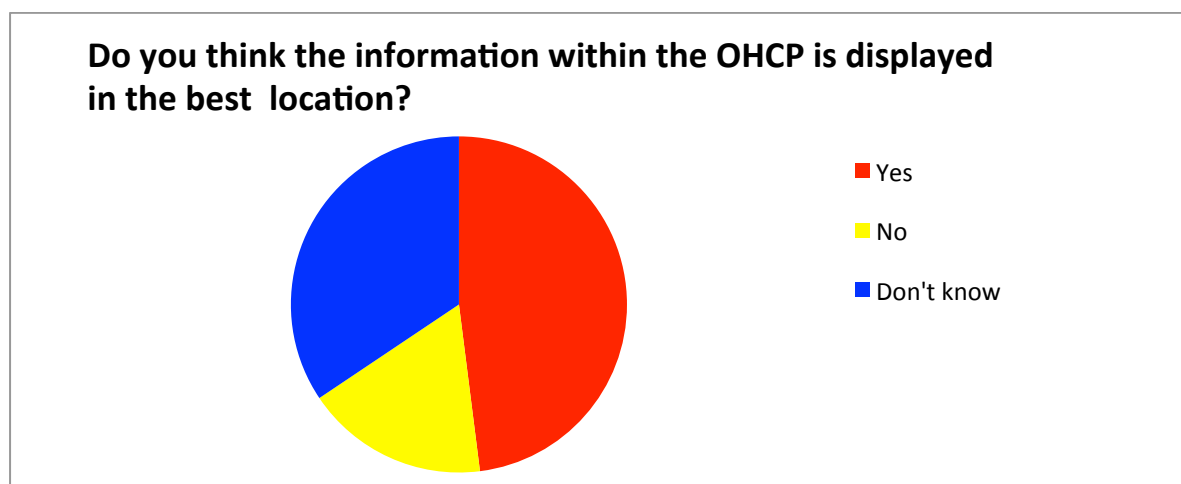
Do you think the information is displayed in the best location?		
Answer Options	**Response Percent**	**Response Count**
Yes	48.0%	180
No	17.6%	66
Don't know	34.4%	129
Answered question		**375**
Skipped question		**12**

Staff were equally doubtful about the way in which the information was presented. More than two thirds of respondents either did not know how to answer this question or said that it was not displayed in the best way. This indicates some important issues about presentation and accessibility of OHCP information for patients and the public. This may not just pertain to displaying programme information in clinical settings, but be related to accessibility of OHCP data in general for the public, including as an electronic resource on the internet.

Table 22: Do you think the information is displayed in the best way?

Do you think the information is displayed in the best way?

- Yes
- No
- Don't know
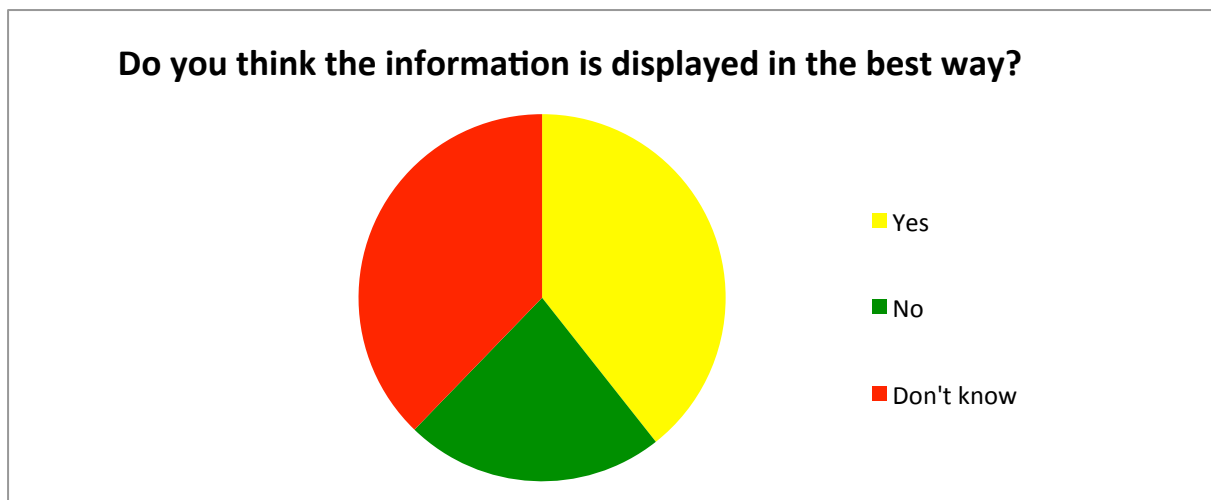
Do you think the information is displayed in the best way?		
Answer Options	**Response Percent**	**Response Count**
Yes	39.4%	148
No	22.9%	86
Don't know	37.8%	142
Answered question		**376**
Skipped question		**11**

4. MAIN FINDINGS FROM THE TELEPHONE INTERVIEWS AND OPEN QUESTIONNAIRE RESPONSES

4.1 Introduction

In this chapter the findings from the qualitative data are presented. This is derived from two sources. Firstly, the questionnaire contained two open questions, one which invited respondents to state how the OHCP had impacted on an aspect of patient safety within their Trust. There were 190 individual statements made in response to this question, with 78 people responding to the second question which invited any other comments.

Secondly, thirteen senior nurses, matrons, specialist nurses and ward managers volunteered to participate in semi-structured telephone interviews. Participants were employed within nine different NHS Trusts across the north of England. They were asked questions relating to their experience and perceptions of the programme. Many of the participants were in the role of project lead for the Open and Honest Care Programme within their Trust. Five participants had been involved in the programme since its initial inception in 2011, while others worked in Trusts who signed up to the programme subsequently.

All qualitative data were subject to a thematic analysis. A summary of the key themes arising are reported here. Themes are illustrated using verbatim quotations. To protect participant anonymity quotations are labelled with an interview number or QR to represent questionnaire response.

4.2 Involvement with the OHCP

Interview participants were asked to describe their role in relation to the programme and they reported that they were involved in a variety of ways. Some participants were involved in working groups prior to the launch of the pilot in 2011, the purpose of which was to agree with NHS England the aim of the programme; the criteria for reporting and the reporting templates. Those in project lead roles described the key activities that this role involved including; overseeing data capture including collection of patient stories and improvement stories; gathering feedback from staff and patient questionnaire; the collation of all data; overseeing its import into the OHCP reporting template and publishing report on the Trust websites. Project leads also worked with others such as the patient experience team or nurse specialist to analyse the information and identify trends and variability in the data and set priorities for improvement. While most participants in the role of project lead, also ensured that ward based teams received feedback each month about the actions that had been taken in response to the data provided, this was not always the case.

Specialist nurses and matrons described their involvement as the gathering of data within their area or speciality, the reporting of data at key meetings, the identification of problems and the development of action plans to address emerging areas of

concern. Specialist nurses also indicated that the availability of timely and continuous data provided evidence of the effectiveness of their preventative and educational intervention;

> '*Reporting of data at performance meetings*' and production of '*an action plan identifying the problem and to be able to evidence what we're doing about the difficulties that we have with pressure ulcers*' (Interview 9).

Ward managers described their involvement with the OHCP as the collection of ward based information, ensuring that care protocols are followed particularly in relation to initial patient assessments, the reporting of incidents of harm and subsequent root cause analysis to identify and understand the root cause of the event to take action to prevent it recurring. Ward managers also described their role in the interpreting all the information to be able to communicate its relevance to ward staff. The following comment is illustrative here:

> '*The involvement that I have as a ward manager is doing our monthly audits…making sure from a safety point of view that we're doing what we should be doing. Make sure appropriate care assessments have been carried out in appropriate time scale* (Interview 10).

4.3 Challenges encountered and resolved

Participants reported a number of challenges they had encountered and to some extent resolved throughout the process of establishing the Open and Honest Care Programme within their Trusts.

4.3.1 Establishing robust data verification processes

A key challenge identified by many participants related to the difficulty of consistently defining what is and what is not hospital acquired, particularly in relation to pressure ulceration detection and classification. It was suggested that the need to ensure collected data was valid, robust, reliable and consistent was a challenge many Trusts recognised when first participating in the Open and Honest Care Programme. The need to ensure consistency of reporting was seen as particularly important given that the data was intended for sharing with patients and the public as suggested here:

> '*The major challenge was making sure that data verification was in place, especially when you're reporting harm in a domain which is accessible to the general public and others. We needed to put really strong verification processes in place especially for falls reporting and pressure ulcer verification*' (interview 5)

To resolve these challenges many Trusts had developed operational processes to ensure data collection was as accurate and robust as possible. Examples given

included the establishment of a standard operating procedure that required all reported pressure ulcers to be photographed and graded at a pressure ulcer verification meeting attended by specialist nurses. This assured senior nurses that reporting was reliable and consistent and enabled them to target educational interventions.

There was also concern that different organisations could apply the criteria for reporting of patient safety issues, such as falls and hospital acquired pressure ulceration inconsistently, which would suggest more incidents occurring in some Trusts rather than more accurate reporting. This concern is expressed as follows:

> *'I think it is very useful but it would be more useful if we were really clear about what it is that we're supposed to be reporting (in terms of the time) because until we've got that its making some areas look like they've got more of a problem than other areas'* (Interview 9).

4.3.2 Bringing data together and making connections

Uploading data into the OHCP template in the early stages of the programme was described as cumbersome, although it was acknowledged that the process had been improved and organisations had become more adept at streamlining process as the following comments illustrate:

> *'Gathering the data is very time consuming but worthwhile'* (Interview 9).

> '*The challenge initially was getting the IT to work a little bit better in terms of getting the information into the template. It was quite lengthy and unwieldy'* (Interview 6).

Participants also described the processes through which the OHCP information was brought together into one report and some of the challenges that they encountered. Collating the data internally was described as time consuming with responsibility for data management often residing with different people situated within different areas of the organisation. Importantly many participants suggested that efforts to bring disparate information together brought into focus internal organisational silos, which once recognised, could be aligned more effectively to enhance improvement efforts as reported here;

> *'The challenge has been to marry up the data correctly. Linking the patient's stories to the service improvement stories because our service improvement is a different department but going forward hopefully those links will be much better'* (Interview 6).

4.3.3 Ensuring staff engagement with the OHCP

Ensuring staff understood the purpose of the OHCP information collection and engaged with it in a meaningful way, was identified a key challenge. This was seen as essential to get the buy in of staff and patients, prevent 'questionnaire fatigue' and

ensure the OHCP was effective as a driver for safer, high quality care. This risk was mitigated to some extent by creating local ownership and by streamlining data collection and feedback processes. This is illustrated by the following:

> *'It needs some work still, but we are all motivated to try and make it a useful tool because, it's alright us having this information but we need to be able get it to the grass roots level really, ward managers, cleaners, sister's on wards need to understand what we're doing and how useful this information can be to improve care'* (Interview 7)

This concern was reflected in the questionnaire respondents' comments who suggested that feedback strategies could be more effective in some areas:

> *'I don't feel that the changes made as a result of being Open and Honest get fed back effectively to shop floor staff'* (QR)

> *'At present to some staff working on the shop floor it feels that information is collected but nothing is done with it'* (QR)

> *'The Trust needs to publicise the programme more effectively and involve front line staff'* (QR).

4.4 Sharing of OHCP information with staff, patients and the public

Participants were asked how the OHCP information was disseminated within the Trust and how it was shared with staff, particularly those at ward level. There was considerable variation in the processes used to facilitate widespread dissemination. The OHCP report was shared at Board level and reported at a variety of Trust committees. There was a perception that the longer the Trust had participated in the OHCP the more the processes for sharing OHCP information had become embedded, while those relatively new to the programme had still to establish robust processes.

Dissemination strategies that engaged a wider group of staff were described including monthly email distribution to Executives, nursing staff, doctors and allied health professionals (AHP), health care assistants and non-medical staff such as cleaners and porters within the Trust. A number of approaches were identified that facilitate more local ownership of data collection, analysis and feedback as illustrated by the following comment:

> *'It's getting better I think as we get further into the programme. I used to coordinate everything for all the wards but now matrons are responsible for their own areas. It needs to be owned by the ward team and by the matrons at a local level'* (Interview 8)

At ward level, ward managers described how the OHCP was shared with ward based staff and made meaningful and relevant as illustrated by the following:

'As a manager how I get this information to the staff is vital. The challenge is to pull all the information together and make it relevant to what we're doing on the unit. Mostly that's through my monthly ward meetings; we also have a lessons learned meeting where this information is shared and discussed' (Interview 10).

4.4.1 Sharing OHCP information with patients and the public

While all participants confirmed that the OHCP report was publicised on the Trust website there was uncertainty as to how many people accessed this information. At ward level many participants suggested that some of the information within the OHCP was visually displayed on boards in all ward areas for patients and visitors to read. These were variously described as 'Open and Honest boards', 'Transparency boards' and 'Knowing How You're Doing boards.'

Some participants described more active internal dissemination strategies used to engage the public or public and patient representatives, as the following comment illustrates:

'It gets shared every month at the patient and staff experience Executive-led group so that we can get some scrutiny from our health watch colleagues' (Interview 5).

4.5 Usefulness of the OHCP as a vehicle for continuous improvement

This theme has been divided into a number of sub-themes to reflect the various ways in which respondents and participants perceived the OHCP had impacted on practice.

4.5.1 Useful as an integral part of wider quality improvement efforts

Many participants acknowledged that their Trusts had seen significant improvements in key aspects of care but they varied in the degree to which they attributed this solely to the OHCP. Some participants suggested the OHCP was an integral part of a range of patient safety and improvement strategies that contributed to safer care within their Trust as illustrated by the following comments:

'It's difficult to say whether it's that one specific element, there's been a huge amount of work within this organisation looking at staff experience and Trust behaviours and values, but they do link in with Open and Honest Care. It all fits together. So I do think it has helped, but I think it's in conjunction with a number of other things that we're doing' (Interview 2).

'Very useful component of the wider quality improvement programme' (QR)

For others the OHCP was described as an evolving process that had played a key role in driving continuous improvement efforts as illustrated here:

> *'I think we've embraced the concept, I think we've developed it as we've gone along; we've made some changes to how we use the information and we're trying very hard to ensure that it drives our improvement strategy'* (Interview 2).

4.5.2 Helping to identify where improvements can be made

While participants identified the OHCP as a valued component of wider improvement activities and strategies, many acknowledged that the uniqueness of the OHCP was the bringing together of both metric data and narrative stories in a way that was accessible and meaningful. While much of the information contained within the OHCP is reported independently and interrogated individually, combining different types of data and various data sources enabled Trust managers and nurse specialists to gain a more complete picture of the safety and quality of care within the Trust.

The information was made more meaningful when effort was taken to bring related information together by linking the improvement and patient story for example. This process enabled the interrogation and triangulation of different data which could reveal patterns within and across in the data and changes over time. This facilitated a clearer understanding of the areas where improvement should and could be made as illustrated by the following;

> *'It's good for me to see it consolidated in one place, because it's information that we report elsewhere, but it isn't always necessarily easy to capture in one area'* (Interview 11).

> *'It enables triangulation of data, including patient and staff experience and enables the Trust to identify trends in pressure ulcers and falls'* (QR)

> *'It has enabled us to look at how we're doing, organisationally, with regards to 'harm free care', not just looking at things individually. We were able to triangulate our patient story with some of our complaints and feedback from friends and family test'* (Interview 5).

The tangible, locally derived intelligence helped Trusts leaders to identify variations in care within the organisation. This enabled targeted action and the development of strategies to address specific aspects of care, safety or staff experience:

> *'I know this piece of work's been really valuable for us as an organisation. I think it has really helped us to focus on what we're trying to do'* (Interview 2).

> *'Sharing information regarding patient experience has shown the areas in which we need to improve'* (QR)

> *'Monthly transparency data drove strategies planning for reducing pressure ulcers'* (QR)

> *'It has enabled targeted intervention by the falls specialist nurse in identified 'hot spot' areas'* (QR)

4.5.3 Humanising healthcare; bringing back the connection to patients

The OHCP patient story and improvement story were described as particularly powerful vehicles for positive change that ensured patients were at the centre of improvement efforts, as illustrated here:

> *'I think the patient story is the element that is really powerful, because listening to what patients say enables staff to hear things they wouldn't necessarily have heard if it's written down'* (Interview 2).

> *'Yes, I think it does* (improve care)*; particularly the patient story. I think it's about capturing hearts and minds, reminding us that it's a person with a life outside of this hospital, It's about bringing back that connection to patients and what our care means to them'* (Interview 13).

4.5.4 Energising improvement efforts

It was suggested that the OHCP raised awareness both organisationally and at ward level of key aspects of patient safety and energised efforts to improve outcomes particularly in the areas of fall and pressure ulcer prevention, as illustrated by the following comments:

> *'I think the open and honest work has raised the profile of pressure ulcers and their prevention. I think we're seeing less deterioration of pressure ulcers and more pressure ulcers going the right way'* (Interview 9)

> *'I think for me it's around ulceration and the falls and bringing peoples' attention very clearly onto the numbers and being able to say this is the number of falls we have, this is the number of patients that have come to our Trust with a pressure ulcer'* (Interview 7).

> *'Staff are more aware of the importance of reducing pressure ulcers rather than just accepting their development as inevitable'* (QR)

4.5.5 Fostering local ownership of improvement practices

The OHCP information was seen to stimulate discussions and foster local ownership of improvement efforts. It was suggested that monitoring and external reporting

mobilised staff to work together to ask questions and agree how best to address areas ameliorable to improvement;

> *'I think the biggest factor is it's monitored and reported externally. It's looked at and we sit down as a team and have a real sense of ownership. They don't want to let the Trust, themselves or their team down, so it has really helped to drive improvement in that way. As a result I do think we've seen a reduction in things like falls and pressure ulcers, so I do think it has made a difference'* (Interview 2).

> *'Transparency programme gives us real time feedback from nurses and patients regarding the standard of care delivery enabling real time discussion and enabling staff to embrace small changes'* (QR)

> *'The incidence of pressure ulceration is decreasing in our area due to constant scrutiny of their causes and what can be done to improve our preventative measures'* (QR)

> *'Using for example the pressure ulcer we bring the sisters in and they learn from each other any changes that can be made within their own area but also question themselves around did they do the right thing at the right time and what could they do differently'* (Interview 1)

It was astutely recognised however that the OHCP was only effective in reducing harm or improving experiences when it was translated into tangible actions and preventable measures. This was not seen to be an inevitable outcome of the OHCP but rather was contingent on interpretation, effective leadership and adequate education and training. The following comment illustrate these points:

> *'In the end it's not about what we publish it's about what we do, what we are doing internally'* (Interview 7).

> *'It has enabled some wards to put together a business case for additional staffing. Think sometimes we can collect all this data but it's actually doing something about it which is the important bit'* (interview 8).

> *'Pressure ulcers and infection control are two good examples of how things have vastly improved because they're such a high focus and we have to submit and display'* (Interview 10).

> *'I think sharing the information helps to improve care for patients, I think it makes staff more aware of where they can focus, but I don't think it does it on its own, you've got to follow it up with leadership and management from a senior level'* (Interview 3).

4.5.5 Provides feedback about the effectiveness of improvement efforts

It was stated that the OHCP information not only helped to identify areas for improvement but also enabled Trusts and wards to appraise the effectiveness of their improvement efforts, based on the feedback of robust data, as suggested here:

'I think it's really positive, it really makes you think about how we've progressed and you've got that build in every month. It helps us to know where we're going and allows us to look at things a bit more objectively. It's quite evident that each month we're making progress.' (Interview 13).

It was also suggested that positive feedback to ward areas confirming that their improvement efforts had been successful gave staff a sense of achievement, as illustrated here:

'We can actually see all the things we've put into place, all the training and education that we've done, we can see improvements being made' (Interview 8)

'It's about that pride as well, isn't it, of thinking, you know this is what we've managed to achieve' (Interview 13)

4.6 Participants views on how the OHCP could be improved

When asked how the OHCP programme could be improved participants focused on issues internal to the Trust and issues relating more directly to the programme itself. The concern about standard definitions was identified by one participant who suggested:

'I think we need to clarifying those definitions, because we've got (NHS Safety) thermometer definitions and then we've got Open and Honest definitions, and ideally they really need to be the same' (Interview 13)

The need for the programme to be more effectively embedded within their Trust processes to ensure more comprehensive staff engagement at ward level was identified by some, as suggested here:

'I think we need to have link people within teams or within localities, because you need to get the people on the ground engaged in it' (Interview 12).

'I just think that having more ownership, more people involved so it comes up to from grassroots level rather than coming down from the top' (Interview 8).

Others acknowledged the need to engage more effectively with the public:

'Yes we know we have it on the website and it's only two clicks away from the, the home page, but actually most people don't look that far unless they've got a specific reason or a specific interest, so how can we disseminate it better to the general public' (Interview 13).

'I think probably we could engage our health watch colleagues who go to our patient and staff experience group and actually at our next meeting I'm going to ask them what they will do with the Open and Honest Care report' (Interview 5).

One participant suggested that OHCP should have a higher national profile with patients and patient groups:

'There needs to be a much wider campaign to say that this information is out there and a bit more signposting of patients to that information' (Interview 6).

The need to engage with a wider body of Trust staff such as medical, non-medical and therapy staff was seen as a way of enhancing the programme:

'I think there are challenges engaging other professions in the programme, especially medical staff. If we started including harms related to medical care in the reporting for instance I think that would be something that we could really work on in a collaborative way' (Interview 5).

'Domestics on the unit have got responsibilities around cleaning and infection control but whether they're linked into this is probably debatable' (Interview 10).

Overall participants suggested they would benefit from learning from other Trusts and sharing learning and best practice.

4.7 Learning participants would like to share with others new to the OHCP

A number of factors were identified that could support the introduction of the OHCP to new areas. Having a clear understanding of what Trusts were trying to achieve and communicating that effectively to all Trust staff was seen as a key factor in the success of the programme. Ensuring that ward staff understood the programme and engaged with it effectively was identified as something that should be put in place prior to the launch of the programme:

'I think if you do the building blocks first then you've got the true divisional engagement, whereas I think for us, we ran with it, but then now we're trying to gain the divisional engagement and I think that's more tricky' (Interview 2).

It was suggested that existing internal process that could be aligned to the OHCP should be identified and effort should be taken to '*bring it altogether under one umbrella*' (Interview 1). This was reiterated by others who suggested:

'It's building into your programme what processes you've already got in place so that you don't have to re-invent the wheel. We had to make sure that definitions where aligned to what we were already reporting' (Interview 6).

'I think it's a really positive step in the right direction really in terms of moving care services forward. It's about thinking about the services that you currently have and working together to get a robust system in place' (Interview 9).

Finally, participants advised that Trusts new to the programme should not see participation as unduly arduous, should recognise it as a process that takes time to embed and one that people become more skilled at after a time. Participants suggested that embedding the OHCP processes resulted in significant organisational learning which could be shared across organisations. This is illustrated by the following comments:

'Keep it easy, don't make it hard, it isn't hard, just be honest and really use it as a tool to measure your progress towards your goals' (Interview 13).

'It seems very complex when you start and it was but the process has refined an awful lot. I would say use your 'buddy up' colleagues. And I would say, don't expect to get everything perfect the first time that you start completing one of the reports. I think it takes experience before you're able to actually show how you are improving as a result of what you are reporting. You know, it's linking it all together. That's the bit I think that's the bit that takes a while to finesse' (interview 5).

5. DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS

5.1 Introduction

The intention of the OHCP is to drive improvements in practice and contribute to a culture of compassion, dedicated to learning and improvement. It supports NHS Trusts to bring together into one report, safety, patient and staff experience and improvement data that is routinely collected and which may be reported singularly within other publications. While the information in the OHCP reports is not intended to make direct comparisons about the safety or quality of healthcare across different organisations, it is expected that access to this locally derived information will act as a catalyst, driving improvements in clinical practice, patient experience, and contribute to a culture of safe compassionate care.

Within this study we have explored the reported impact of the Open and Honest Care: Driving Improvement Programme, implemented within Acute NHS Trusts in the North of England. The study identifies the challenges and opportunities participation in the programme provides and reports on participants perceptions of the impact of programme on patient safety, patient experience and staff experience. Insights into how the programme could be enhanced during the process of adoption and spread are also provided.

5.2 Limitations of the study

Before considering the findings of the evaluation, it is important to recognise the limitations of the study which are particularly relevant to the generalisability and transferability of the findings. Firstly, it is important to note that the findings are based on the study participants self-reported perceptions of the usefulness and impact of the programme and cannot therefore easily be independently verified. While we did not examine Trust data in relation to key metrics we have captured the understanding, language and embodied actions of those who have experience of the programme (Shaw et al, 2006).

There are some limitations associated with the study design to be noted. The response rates for the questionnaire survey need to be considered (Bryman, 2008). Those who responded to the questionnaire invitation may not hold the same views as those who did not. The sampling strategy relied on project leads within NHS Trusts to forward the invitation link to potential respondents. This was intended to protect respondents' identity and capture those best placed to answer the study questions but this may also have influenced the characteristics of respondents. Finally the sampling strategy for the telephone interviews was purposeful and many participants in this aspect of the study had key responsibilities in relation to the Open and Honest Programme. However despite these caveats the study provides important insights into how the programme has been implemented and the extent to which it is driving improvements in care.

In this section the key findings of the study will be discussed in relation to the study questions and conclusions will be drawn.

5.3 Implementation of the OHCP within participating NHS Trusts

NHS Trusts participating in the study had previously signed up to a Board Compact with NHS England in which they agreed to;

- use common data definitions and a reporting template in agreed formats at agreed times

- review the Open and Honest Care: Driving Improvement programme data monthly and report it at Board level or an appropriate sub-board committee

- proactively share their published data and Open and Honest reports internally and externally.

While all NHS Trusts had been reporting OHCP data to NHS England for at least 6 months, some Trusts had been participating in the programme since its initial piloting in 2011. Other Trusts had joined at various times subsequent to this. It was evident, particularly from the qualitative findings, that as a consequence, some Trusts had well established and embedded processes for the collection and dissemination of OHCP information, while others were less advanced and had evolving processes. In addition project leads for the OHCP identified the need to align the OHCP data collection and reporting processes with operational mechanisms and procedure already existent within the Trust. The outcome of this is considerable variation in how the OHCP programme has been implemented within participating Trusts.

Within the study findings, this variation is reflected in the degree to which Trust staff had knowledge of the OHCP and how widespread, in their opinion, knowledge of the programme was among staff. While 85% of respondents indicated they had knowledge of the OHCP, 15% said they had not heard of the programme. Similarly 78% of respondents indicated that the OHCP information was shared with them but at least a fifth said it was either not shared with them or they did not know if it was shared with them. Of the respondents who had no knowledge of the OHCP approximately 1% were members of the Executive Board, 8% were nursing managers and 16% were staff at ward level. This suggests that some Trusts are more effective at using the OHCP as a vehicle for improvements through the creation of ward based engagement and ownership, while others are yet to establish effective engagement and dissemination strategies.

5.4 Implementation challenges and how have these been overcome

The study identifies a number of key challenges that Trusts had encountered and to some extent resolved throughout the process of establishing the Open and Honest Care Programme. The consistent use of operational definitions both internally and across organisations was identified as challenging. The importance of establishing

valid and consistent definitions of technical specifications has previously been noted (Griffiths et al, 2008) as has the need to ensure reliable case detection systems are in place (Streed, 2011). Standardisation of definitions of indicators is essential to enable valid comparisons within organisations and to enable identification of changes over time (Burston et al 2013). While NHS England provide a Standard Operating Procedure (SOP) for the reporting of patient safety issues, such as falls and hospital acquired pressure ulceration, there was concern that NHS Trusts had interpreted this guidance differently. The need to ensure consistency of reporting was seen as particularly important given that data was used to benchmark further progress within Trusts and was intended for sharing with patients and the public. There was concern that implementation of different reporting criteria invalidated cross Trust comparisons

It is recognised that the reliability of these data sources and processes are affected by the skill and assiduousness of the health care staff who complete the documentation and reporting (Burston et al, 2013). In terms of internal consistency and accuracy of reporting many Trusts had established robust verification procedures that enabled senior nurses and nurse specialists to contribute to the verification process. Further work to clarify Standard Operating Procedures and definitions within the OHCP and aligning these to other common definitions such as the NHS Safety Thermometer was seen as important to the ongoing success of the programme.

Collating key information and bringing it together in one report was also described as challenging particularly at the commencement of participation in the OHCP. This was exacerbated when responsibility for data management resided within different departments within the Trust, such as the patient experience team or service improvement team. However in these circumstances the OHCP was seen as a valuable tool to facilitate organisational collaboration across departmental silos. Aligning the improvement functions of various departments and establishing effective collaborative processes was seen as instrumental to the success of an integrated report and an embedded process.

The study findings suggest supporting ward based staff to engage meaningfully with the OHCP was essential to ensure the programme was used effectively as a driver for improvement and safer care. Some Trusts had actively taken steps to generate local ownership by involving ward based staff more effectively in the process. While findings suggest these efforts have been successful in many Trusts it is evident that some Trusts need further work to effectively embed the programme at ward level. Indeed the success of the programme is likely to be significantly influenced by efforts taken to ensure ward based staff understand the value of information collection and receive regular feedback about any changes made as a consequence of the OHCP. It has previously been reported that lack of feedback provided by organisations may exacerbate nursing perceptions that data collection and measurement only increases nursing workload rather than energising improvements in patient care. More effective

feedback mechanisms are likely to lead to broader understanding of the value and usefulness of the data collection to improve the safety and experience of patients (RCN 2012). A well-established communication strategy that clarifies to all staff what Trusts are trying to through participation in the Open and Honest care Programme, put in place prior to the launch of the programme was seen as essential.

5.5 Sharing the OHCP information with NHS Trust staff

The study looked at how OHCP information was shared with Trust staff from Board to ward within participating NHS Trusts. The OHCP Board Compact requires Trusts to publish the monthly report on their Trust website for the public to access and their Trust intranet for staff to access. The reports are also published on the NHS England website. However many Trusts had developed more structured internal dissemination strategies. The study did not ascertain the format in which the information was shared but sharing at clinical meetings with colleagues was the most common dissemination mechanisms identified, followed by visual displays in the workplace, availability of the information on Trust websites, at Trust Board meetings and informally. While many of these occurred simultaneously, it is worth noting that they include 'passive' and 'pro-active' approaches. It is reasonable to assume, that available data can only stimulate debate and discussion and energise remedial action if and when its content and relevance for clinical practice is interpreted and acted on. The majority of respondents (68%) confirmed that discussions about the content of OHCP information took place at different levels of the organisation including ward level. Interestingly, the need to engage with a wider body of Trust staff including as medical, AHP and other non-medical care staff was seen as a way of enhancing the programme and facilitating collaborative improvement efforts.

5.6 Sharing the OHCP information with patients and the public

A key purpose of the OHCP is to share information with the public. It is increasingly emphasised that availability of healthcare information can enable the public to make informed decisions about their care based on measures that are important to them (Griffiths et al 2008). The study confirmed that to facilitate public access, the OHCP report is published on Trusts external website. However while the majority of staff (82%) believed that the OHCP enabled transparency with the public about the quality of care in the Trust, there was uncertainty as to whether the public actually engaged with this information or that it was presented in such a way that the public would find useful.

The displaying of OHCP information on a ward boards was identified by just over half of the study respondents, as a way of sharing information with patients and visitors. However only one fifth of respondents said that the public had asked them about this information and more than a third of respondents indicated that they were uncertain

about the role of OHCP in improving decision making for the public. It appears, therefore, that staff believe that the OHCP increases transparency but does not equip the public to act on that transparency. Part of the uncertainty amongst staff about the effects of the programme on the public may be a consequence of limited dissemination strategies.

This indicates some important issues about presentation and accessibility of OHCP information for patients and the public. This may not just pertain to displaying programme information in clinical settings, but may be related to accessibility of OHCP data in general for the public as an electronic resource on the internet. Given the age demographic of the public, reliance on the Trust internet may not be the most effective means of dissemination. It is worth noting however that some Trusts had established more active dissemination strategies to engage the public, such as sharing and discussion with health watch and other public representative groups.

When publishing information, consideration should be given to the intended audience as this should drive selection of both the means of communication and the format of the report (Burston et al 2013). The need to revisit the format of the OHCP report to ensure it is user friendly for the public; the identification of more effective dissemination approaches that engage the public in open and constructive conversations about improving safety and experience and a campaign to raise awareness among the public that this information is available, were all identified by participants as ways in which the programme could be enhanced.

5.7 Usefulness of the Open and Honest Care Programme as a vehicle for continuous improvement

It has been argued that to be useful, quality indicators in healthcare must be obtainable in a timely manner, with a demand on resources that is proportionate to the benefits (DH. 2012). They should provide intended audiences with results which are meaningful and which inform decision-making (Griffiths et al 2008). Nurse-sensitive indicators are those that reflect aspects of care that nurses are recognised as able to influence through their practice (Griffiths et al 2008; McCance et al 2011; Burston et al 2013). Study finding suggest that most respondents strongly agreed that all OHCP information was useful to them and to their clinical practice. The most useful information was deemed to be metrics relating to health care associated infections (HCAI's) with approximately 95% of respondents strongly agreeing or agreeing that this information was useful to them. The patient experience questions followed closely behind, with 94% positive responses, followed by staff experience data and patient story both with 91% positive responses and 90% for pressure ulcer rates. The 'NHS Safety Thermometer' was thought slightly less useful than others, with 78% of respondents indicating it was useful to them. The NHS Safety Thermometer may be thought to be less useful as it is a measure of prevalence as opposed to incidence. Alternately it may indicate that usefulness is context specific

or may suggest the need for future improvement of either the presentation or familiarity of staff with the NHS Safety Thermometer.

A key aim of the OHCP is to facilitate understanding and raise awareness of where harm reduction and improvements are needed, and can be made. The majority of respondents agreed or strongly agreed that access to the OHCP information helped the Trust to understand where action could be taken to; reduce harm to patients or improve patient safety (87%); and improve the experience of patients (87%). A similar picture emerged when respondents were asked whether or not OHCP data enabled ward based staff to identify areas for improvement. The majority of study respondents felt strongly that access to the OHCP information helped ward based staff to have a more acute awareness and understanding of where action could be taken to reduce harm to patients, improve patient safety (86%) and improve the experience of patients (83%).

While participants identified the OHCP as a valued component of wider improvement activities and strategies, many acknowledged that the uniqueness of the OHCP was the bringing together of both metric data and narrative stories in a way that was accessible and meaningful. This enabled a comprehensive focus not only on safety outcomes but also effectiveness of care interventions and patients' experience of compassionate care. While much of the information contained within the OHCP is reported individually, combining different types of data and stories enabled senior nurses to interrogate disparate evidence and gain a more complete picture of the safety and quality of care within the Trust. The information was made more meaningful when effort was taken to identify a common theme by linking the safety data, improvement story and patient story for example.

This process enabled the triangulation of different data which could reveal patterns within and across in the data and changes over time. The tangible, locally derived intelligence helped Trusts leaders to identify variations in care within the organisation. This enabled targeted action and the development of strategies to address specific aspects of care, safety or staff experience. The OHCP patient story and improvement story were described as particularly powerful vehicles for positive change, adding a dimension to the data that ensured that patients were at the centre of improvement efforts. Alternatively, the tangible nature of metric information was seen to be particularly effective at raising awareness and focussing attention on aspects of safety ameliorable to remedial preventive measures such hospital acquired infections, falls and pressure ulcers.

It was recognised however that the OHCP was only effective in reducing harm or improving experiences when it was meaningfully translated into tangible actions at a local level. It is increasing recognised that patient safety and patient experience information should primarily be collected for learning, and actively interrogated and used at the front line of care services (DH. 2013). Indeed Burston et al (2013) notes

how a wealth of data may be collected in healthcare but this may not be interpreted and acted on to influence clinical practice. Within the study, at its most effective, access to objective data with local relevance and the immediacy of real time feedback regarding care delivery, was seen to stimulate real time questioning and discussions and to foster local ownership. Similarly, subjecting key patient safety outcomes to continuous internal and external scrutiny were seen to energise improvement efforts contributing to continuous improvement efforts and the establishment of safer care practices. This was not seen to be an inevitable outcome of the OHCP however but rather was contingent on support with interpretation, effective leadership and adequate education and training to ensure staff have the capability, capacity, support and motivation to continuous improve care and the processes in which they work.

Study findings suggest that OHCP information not only helped ward based staff to identify areas for improvement but also enabled and empowered them to act on these indicators and appraise the effectiveness of their actions however this was dependent on the availability of robust and effective feedback mechanisms. Indeed it is argued that effective feedback of data can be used to identify where teams are performing well and can be used to highlight the positive impact staff have on patients' experience of health care (DH. 2012). This can lead to improvements in job satisfaction and staff morale. Indeed it is suggested that that the NHS should embrace an ethic of learning and staff should celebrate and take pride in successful improvement efforts (DH. 2013). Findings suggest that Trust managers and ward based staff alike used OHCP information to evaluate whether various training, education and improvement strategies had been effective. Confirmation that their intervention had led to improvements gave staff a real sense of achievement and an enhanced knowledge of what interventions were most effective. It also gave staff a powerful tool to make a case for increased resources to improve care across all domains.

5.8 Recommendations

Based on the findings presented in this report the following recommendations are made.

Recommendation 1: Engage with Trusts to ensure that the metrics of the Standard Operating Procedures (SOP) are consistently applied across Trusts.

- Where deviation from Standard Operating Procedures occurs the opportunity to provide contextual information within the Open and Honest report would provide greater clarity.

- Engage with Trusts to clarify the metrics in particular for pressure ulcer reporting to enable Trusts to consistently benchmark improvements over time.

Recommendation 2: NHS Trusts should consider pro-active approaches to facilitate and support ward based engagement and ownership of the Open and Honest Care Programme as a vehicle for continuous improvement.

- Local ownership is likely to increase when there is clear communication about the purpose of the programme and regular feedback to identify actions taken as a consequence of information collection and interrogation.

- Support should be provided to ensure ward staff understand the relevance of OHCP information for their practice and education and training to ensure they have the necessary improvement capabilities

- Opportunities to engage a wider range of staff in the OHCP, including medical, non-medical and AHPs, should be considered to foster collaborative improvement efforts.

- Use of the programme to engender important learning and foster a sense of achievement and pride when improvements have been successfully implemented should be considered

Recommendation 3: Explore more pro-active approaches for sharing information and engaging patients and the public with the Open and Honest Care programme.

- Consider reviewing the format of the Open and Honest Report to ensure it is user-friendly for the public

- Consider more effective dissemination strategies such as the availability of hard copies or visual display of the report in patient waiting areas

- Consider engagement with patient representative groups to provide opportunities for more constructive conversations with the public about the information in Open and Honest Programme report.

- Consider ways to raise awareness among the public that this information is available.

5.9 Conclusion

Overall the study findings suggest that the Open and Honest Care Programme is highly valued as an integral part of continuous improvement in practice and is recognised as contributing to a culture of learning and improvement. The combination of metric and narrative information relating to patient safety and patient and staff experience enables NHS Trusts to bring into sharp focus areas where patient centred improvements are needed and can be made, facilitating them to target specific interventions or resources. Combined with effective feedback

strategies, support, education and training, the Open and Honest Care Programme not only helps ward based staff to identify areas for improvement but also energises and empowers them to act on these indicators and helps them to celebrate the effectiveness of their actions. It enables transparency with the public about the quality of care in NHS Trusts but further work is needed to equip the public to engage more actively and more meaningfully.

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Appendix A: Questionnaire Survey

Your Trust is currently participating in NHS England's Open and Honest Care; Driving Improvement Programme. Edge Hill University has been commissioned to evaluate the programme. You have been sent this questionnaire because you may have experience of the programme and we are interested in hearing your views.

The Open and Honest Care Programme (previously piloted as the Transparency Project) supports your Trust to collect and share with staff and the public a monthly report containing information about the quality of care in your Trust. This report includes information relating to patient safety, patient and staff experience, a patient story and an improvement story. As part of our evaluation we want to know what you think about this programme.

The responses you give will be anonymised and your answers will not be shared in identifiable form with others.

1. SECTION A

This section will ask you questions about yourself

1. Which NHS Trust are you working for?

- ◯ Aintree University Hospital
- ◯ Barnsley District General Hospital Trust
- ◯ Blackpool Teaching Hospitals NHS Foundation Trust
- ◯ Bolton NHS Foundation Trust
- ◯ Calderdale and Huddersfield Foundation Trust
- ◯ Clatterbridge Cancer Centre NHS Foundation Trust
- ◯ Hull & East Yorkshire NHS Trust
- ◯ Leeds Teaching Hospitals NHS Trust
- ◯ Liverpool Heart and Chest Foundation Trust
- ◯ Northern Lincolnshire & Goole Hospitals NHS Foundation Trust
- ◯ Pennine Acute Hospitals NHS Trust
- ◯ Royal Liverpool and Broadgreen University Hospitals NHS Trust

- ◯ Rotherham NHS Foundation Trust
- ◯ Salford Royal NHS Foundation Trust
- ◯ South Tyneside NHS Foundation Trust
- ◯ Southport & Ormskirk NHS Trust
- ◯ St Helens & Knowsley Teaching Hospitals Trust
- ◯ Stockport NHS Foundation Trust
- ◯ Tameside Hospital NHS Foundation Trust
- ◯ University Hospital of South Manchester NHS Foundation Trust
- ◯ Walton Centre for Neurology and Neurosurgery NHS Trust
- ◯ Warrington and Halton Hospitals NHS Foundation Trust
- ◯ Wrightington, Wigan and Leigh NHS Foundation Trust

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2. What title best describes your role within the Trust?

◯ Executive Member of the Board of Directors

◯ Non-executive Member of the Board of Directors

◯ Director of Nursing

◯ Deputy Director of Nursing

◯ Matron

◯ Specialist Nurse

◯ Ward Manager, Sister or Charge Nurse

◯ Staff Nurse

◯ Senior Nurse

◯ Healthcare Assistant

Other (please specify)

[   ]

3. SECTION B

This section will ask questions about your knowledge of the Open and Honest Care: Driving Improvement Programme and what you think about it.

Have you heard of the Open and Honest Care: Driving Improvement Programme?

◯ Yes

◯ No

4. Are its results shared with you within your organisation?

◯ Yes

◯ No

◯ Don't know

5. If YES, how are they being shared?

☐ At a Trust Board meeting

☐ At a clinical meeting with colleagues

☐ Informally

☐ Displayed in your workplace

☐ Available online

Other (please specify)

[   ]

6. Are its results discussed with you within your organisation?

◯ Yes

◯ No

◯ Don't know

7. If YES, where are they being discussed?

☐ At a Trust Board meeting

☐ At a clinical meeting with colleagues

☐ Informally

Other (please specify)

[   ]

8. Is the information displayed somewhere in the clinical area you work in?

◯ Yes

◯ No

◯ Don't know

◯ Not applicable (I am not working in a clinical area)

9. Do you think it contains useful information?

◯ Yes

◯ No

◯ Somewhat

◯ Don't know

10. Do you think the following data is useful to you?

	strongly agree	agree	uncertain	disagree	strongly disagree
NHS Safety Thermometer	☐	☐	☐	☐	☐
Health Care Associated Infections (HCAI's) (MRSA &C.Diff)	☐	☐	☐	☐	☐
Pressure Ulcer rates	☐	☐	☐	☐	☐
Falls	☐	☐	☐	☐	☐
Patient experience questions	☐	☐	☐	☐	☐
Friends and Family Test	☐	☐	☐	☐	☐
Staff experience	☐	☐	☐	☐	☐
Patient story	☐	☐	☐	☐	☐
Improvement Story	☐	☐	☐	☐	☐

11. SECTION C

We will now ask you what you think about the Open and Honest Care Programme and how it may impact on practice. Please rate the following statements below.

The programme enables us to be open and honest with the public about the quality of care in our Trust.

○ strongly agree

○ agree

○ uncertain

○ disagree

○ strongly disagree

12. It enables the public to make informed decisions in relation to their care.

○ strongly agree

○ agree

○ uncertain

○ disagree

○ strongly disagree

13. It enables the Trust to understand where we can take action to

	strongly agree	agree	uncertain	disagree	strongly disagree
reduce harm to patients or improve patient safety	☐	☐	☐	☐	☐
improve the experience of our patients	☐	☐	☐	☐	☐
improve the experience of our staff	☐	☐	☐	☐	☐

14. It helps ward based staff to understand where we can take action to

	strongly agree	agree	uncertain	disagree	strongly disagree
reduce harm to patients or improve patient safety	☐	☐	☐	☐	☐
improve the experience of our patients and their families	☐	☐	☐	☐	☐
improve the experience of our staff	☐	☐	☐	☐	☐

15. Within the Trust, the Open and Honest Care Programme has led to improvements in

	strongly agree	agree	uncertain	disagree	strongly disagree
falls causing moderate to severe harm	☐	☐	☐	☐	☐
healthcare associated infection, (MRSA and C Diff)	☐	☐	☐	☐	☐
pressure ulcers	☐	☐	☐	☐	☐
the experience of patients and their families	☐	☐	☐	☐	☐
the experience of staff	☐	☐	☐	☐	☐

16. Can you please give an example of one of the above?

17. SECTION D

This section will ask you questions about how the Open and Honest Care Programme could be improved.

As far as you are aware have members of the public asked about this information?

○ Yes

○ No

○ Don't know

18. Do you think members of the public find this information useful?

○ Yes

○ No

○ Somewhat

○ Don't know

19. Do you think the information is displayed in the best location?

○ Yes

○ No

○ Don't know

20. Do you think the information is displayed in the best way?

○ Yes

○ No

○ Don't know

21. Would any of the following help you to make better use of the data?

☐ More opportunities for sharing information with staff in the clinical area

☐ More feedback from my trust about how we are doing

☐ More involvement of medical staff and allied health professionals

☐ Producing hard copies of reports for staff/patients

☐ Displaying the information on the ward

Other (please specify)

[ ]

22. Would you like to make any other comments about the Open and Honest Care Programme?

[ ]

Many thanks for taking the time to complete the survey!