

## Open and Honest Care in your Local Hospital



*The Open and Honest Care: Driving Improvement* programme aims to support organisations to become more transparent and consistent in publishing safety, experience and improvement data, with the overall aim of improving care, practice and culture.



Report for:

**Northampton  
General Hospital  
NHS Trust**

**July 2016**

This report is based on information from April, May and June 2016. The information is presented in three key categories: safety, experience and improvement. This report will also signpost you towards additional information about our performance.

# 1. SAFETY

## Safety Thermometer

The NHS Safety Thermometer is used nationally but is designed to be a local improvement tool for measuring, monitoring, and analysing patient harms and developing systems that then provide 'harm free' care. The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a 'snapshot' of harm once a month from pressure ulcers, falls with harm, urinary infection in patients with catheters (CRUTI) and treatment for blood clots (VTE). These are harms are measured in two ways, harms which are old and sustained prior to admission and new harms which occurred whilst the patient was in hospital. The data is used alongside other outcome measures to help us understand themes, analysis findings and plan improvements in care delivery.

The scores below show the percentage of patients who received harm free care whilst an inpatient with the second score shows the percentage of patients who did not sustain any harm both prior to and after admission.

	April 2016	May 2016	June 2016
The % of patients that received harm free care whilst an inpatient	96.8%	97.8%	98.2%
Total % of harm free care - admitted with and whilst an inpatient	90.53%	92.86%	93.43%

In April 2016 NGH achieved 96.8% harm free care, with 3.21% of patients on the day recorded in the category of 'new' harm (sustained whilst they were in our care). Broken down into the four categories this equated to: 3 falls with harm, 0 VTE, 3 CRUTI's and 14 incidents of pressure ulcer development.

May 2016 NGH achieved 97.8% harm free care, with 2.22% of patients on the day recorded in the category of 'new harm'. Broken down into the four categories this equated to: 0 falls with harm, 1 VTE, 0 CRUTI and 13 incidents of pressure ulcer development.

In June 2016 NGH achieved 98.2% harm free care, with 1.76% of patients on the day recorded in the category of 'new harm'. Broken down into the four categories this equated to: 2 falls with harm, 0 VTE, 1CRUTI and 8 incidents of pressure ulcer development.

Progress is monitored through the Trusts Quality Governance Committee.

For more information, including a breakdown by category, please visit:

<http://www.safetythermometer.nhs.uk/>

## Health Care Associated Infections (HCAIs)

HCAIs are infections acquired as a result of healthcare interventions. Clostridium difficile (C. difficile) and methicillin-resistant staphylococcus aureus (MRSA) bacteraemia are nationally monitored as we are trying to reduce the incidence of these infections. C. difficile is a type of bacterial infection that can affect the digestive system, causing diarrhoea, fever and painful abdominal cramps - and sometimes more serious complications. The bacteria do not normally affect healthy people, but because some antibiotics remove the 'good bacteria' in the gut that protect against C .difficile, people on these antibiotics are at greater risk.

The MRSA bacteria are often carried on the skin and inside the nose and throat. It is a particular problem in hospitals because if it gets into a break in the skin it can cause serious infections and blood poisoning. It is also more difficult to treat than other bacterial infections as it is resistant to a number of widely-used antibiotics.

We have a zero tolerance policy to MRSA bacteraemia infections and are working towards reducing C Difficile infections; part of this process is to set improvement targets. If the number of actual cases is greater than the target then we have not improved enough.

The table below shows the number of infections we have had this month, plus the improvement target and results for the year to date.

	<b>C. difficile</b>	<b>MRSA</b>
April 2016	3	0
May 2016	0	0
June 2016	2	0
Annual improvement target	21	0
Actual to date	5	0

Each incident of infection is reviewed and a thematic analysis undertaken. This is monitored through the Trusts Quality Governance Committee.

## Pressure Ulcers

Pressure ulcers are localised injuries to the skin and/or underlying tissue as a result of pressure. They are sometimes known as bedsores. They can be classified into four categories, with one being the least severe and four being the most severe. The pressure

ulcers reported include all validated pressure ulcers that were obtained at any time during a hospital admission that were not present on initial assessment.

April 2016	37	Category 2 - Category 4 pressure ulcers were acquired during hospital stays
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Severity	Number of pressure ulcers
Category 2	25
Category 3	12
Category 4	0

May 2016	27	Category 2 - Category 4 pressure ulcers were acquired during hospital stays
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Severity	Number of pressure ulcers
Category 2	20
Category 3	7
Category 4	0

June 2016	26	Category 2 - Category 4 pressure ulcers were acquired during hospital stays
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Severity	Number of pressure ulcers
Category 2	15
Category 3	11
Category 4	0

## Falls

This measure includes all falls in the hospital that resulted in injury, categorised as moderate, severe or death, regardless of cause. This includes avoidable and unavoidable falls sustained at any time during the hospital admission.

April 2016	3	fall(s) that caused at least 'moderate' harm
May 2016	2	
June 2016	4	

In order to know if we are improving even if the number of patients we are caring for goes up or down, we also calculate an average called 'rate per 1,000 occupied bed days'. This allows us to compare our improvement over time, but cannot be used to compare us with other hospitals, as their staff may report falls in different ways, and their patients may be more or less vulnerable to falling than our patients. For example, other hospitals may have younger or older patient populations, who are more or less mobile, or are undergoing treatment for different illnesses.

April 2016	3.99	Rate per 1,000 bed days
May 2016	4.88	
June 2016	4.29	

## Safe Staffing

In 2014 NHS England and the CQC launched 'Hard Truths Commitment'. This work complimented the National Quality Board guidance to optimise nursing and midwifery staffing capacity and capability. Each month the Trust will publish data that demonstrates the planned versus actual number of staff on each shift for each day of the month. The Hard Truths data will be available on the Trust website & NHS Choices for the public to see. The data will be presented in a format that is user/public 'friendly' and be supported by a narrative to enable an understanding of the information provided.

In order to view our reports please visit:

<http://www.northamptongeneralhospital.nhs.uk/AboutUs/Safer-staffing.aspx>

## 2. EXPERIENCE

To measure patient and staff experience we ask a number of questions. The idea is simple: if you like using a certain product or doing business with a particular company you like to share this experience with others.



The answers given are used to give a score which is the percentage of patients who responded that they would recommend our service to their friends and family.

### Patient Experience

#### The Friends and Family Test

The Friends and Family Test (FFT) requires all patients to be asked, at periodic points or following discharge, '**How likely are you to recommend our ward /A&E /service /organisation to friends and family if they needed similar care or treatment?**'

APRIL 2016

Inpatient, Day Cases & Paediatric FFT	91.6%	% Recommended
A&E FFT	86.7%	% Recommended
Maternity FFT	98.4%	% Recommended
All Outpatient Areas	92.1%	% Recommended

MAY 2016

Inpatient, Day Cases & Paediatric FFT	91.5%	% Recommended
A&E FFT	86.1%	% Recommended
Maternity FFT	97.4%	% Recommended
All Outpatient Areas	91.7%	% Recommended

JUNE 2016

Inpatient, Day Cases & Paediatric FFT	91.7%	% Recommended
A&E FFT	86.4%	% Recommended
Maternity FFT	97.5%	% Recommended
All Outpatient Areas	92.3%	% Recommended

\*This result may have changed since publication, for the latest score please visit:  
<http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/>

## A Patient's Story

### 3. IMPROVEMENT

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

**Complaint: CARE**

Concerns were raised that one of our patients who had a drain inserted into his lung (chest drain) was not cared for optimally. The issue raised was that the drain was working intermittently and they were concerned about the care given in the management of the chest drain.

**Outcome:**

The documentation regarding the management of chest drains has been reviewed and updated. We are now providing clearer guidance on monitoring how the drain is working and what action is being taken if required. Additionally a policy for chest drains in adults is going to be devised.

## Reducing Waiting Times in Pre-Op Assessment



The pre-operative assessment (POA) unit is where we check that patients are fit enough to have an anaesthetic and undergo any surgery. It's a very busy unit and staff there see between 50 and 60 patients every working day using a mixture of scheduled and drop-in appointments.

When Sharron Matthews took over the role of POA sister last year she became aware that patients were often subjected to long waits sometimes up to three hours, with a number of them each day even having to be rescheduled because they could not be assessed on the day.

To help get to the bottom of what was going wrong, Sharron enlisted the help of our in-house service improvement team. They gathered data and evidence to create a baseline of quality and patient experience. Once this was complete they worked with the staff to understand what the data was telling them and to design a new way of working.

They found that the day was not organised in a way that was focused on patient demand. The demand was uncontrolled, and there was too much variability in the system resulting in waves of activity that the staff could not forecast or manage."

Sharron said: The team were willing to try new methods and as the experts it was crucial that they were involved in the process.

"As a result we've introduced more scheduled appointments, and moved most of the drop-ins to around the middle of the day when patients are more likely to be coming straight from an appointment with their consultant. In the first three months we saw

patient waiting time reduced from up to three hours to a maximum of just 30 minutes. At the same time we saw an extra 220 patients from the previous three months.

Patient Diane Pannell was very complimentary when she came in for an assessment in May. Diane said: “As soon as I walked in the door, I was seen straight away – it was amazing. When I was here before it took a lot longer but this time I was just in and out. You get anxious when you’re waiting around, but when you’re in and out you don’t have time to think about what’s happening. It was so much better.”

Clare Bramwell, also part of the team, said: “It’s vastly improved. The long waiting times we had before made our lives much more stressful because we knew the patients were waiting for so long. So this just helps our day and I’m sure it helps the patients’ day as well.”

## Supporting Information

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Board Papers: <http://www.northamptongeneral.nhs.uk/AboutUs/Board/Board.aspx>

Safer Staffing: <http://www.northamptongeneral.nhs.uk/AboutUs/Safer-staffing.aspx>



**Carolyn Fox**  
**Director of Nursing, Midwifery & Patient Services**