

## 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**

September 2016

This report is based on information from August 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.

	August 2016
The % of patients that received harm free care whilst an inpatient	99.2%
Total % of harm free care - admitted with and whilst an inpatient	94.31%

In August 2016 NGH achieved 99.2% harm free care, with 0.79% 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: 0 falls with harm, 0 VTE, 1 CRUTI's and 4 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>
<b>August 2016</b>	3	0
Annual improvement target	21	0
Actual to date	9	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.

<b>August 2016</b>	18	Category 2 - Category 4 pressure ulcers were acquired during hospital stays
--------------------	----	---

<b>Severity</b>	<b>Number of pressure ulcers</b>
Category 2	10
Category 3	8
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.

<b>August 2016</b>	3	fall(s) that caused at least 'moderate' harm
--------------------	---	--

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.

<b>August 2016</b>	5.24	Rate per 1,000 bed days
--------------------	------	-------------------------

## 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?***'

**August 2016**

Inpatient, Day Cases & Paediatric FFT	91.6%	% Recommended
A&E FFT	86.4%	% Recommended
Maternity FFT	97.7%	% Recommended
All Outpatient Areas	91.6%	% 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

A patient raised concerns that following their discharge from hospital the appropriate referrals were not made to allow the patient to receive adequate support in relation to their mobility. The patient also raised a concern that they were not provided with advice in relation to the removal of sutures and clips.

On investigation it was identified that whilst the referrals were appropriately made there was no process in place to ensure receipt of the referral by community services. In view of the patients experience a new process is being devised whereby referrals are hand delivered to ensure receipt.

With regard to postoperative advice, this has been addressed with the ward team and bespoke advice is being provided to those patients who are ambulant and those who are not. This may involve a visit from a community nurse where appropriate.

---

## NGH is a baby-friendly hospital - and that's official!



Our maternity team hosted a celebratory tea party in June with some of our new parents and babies to mark becoming an accredited baby-friendly hospital. UNICEF's Baby Friendly award is given to hospitals who have best practice standards in place to strengthen mother-baby relationships and to support mothers in their feeding.

Kate Bates, NGH infant feeding co-ordinator, said: "The award means we've been recognised as giving a very good standard of care in terms of breastfeeding and support for all mums whether they've chosen to breast or bottle feed.

"In Northampton, just under 80 per cent of mothers choose to breastfeed their babies. We know that breastfeeding helps protect babies from a range of illnesses like gastroenteritis, chest infections and ear infections.

"We support mums and babies in spending time just getting to know each other; we suggest lots of skin-to-skin contact and we help mums to understand how their babies communicate so they can respond because that's so important for babies' development and for relationship building."

Baby Friendly Initiative programme director Sue Ashmore said "We are delighted that Northampton General Hospital has achieved full Baby Friendly status. Surveys show us that most mothers want to breastfeed but don't always get the support they need.


Mothers at Northampton General Hospital can be confident that their maternity team will provide high standards of care

## Supporting Information

---

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**