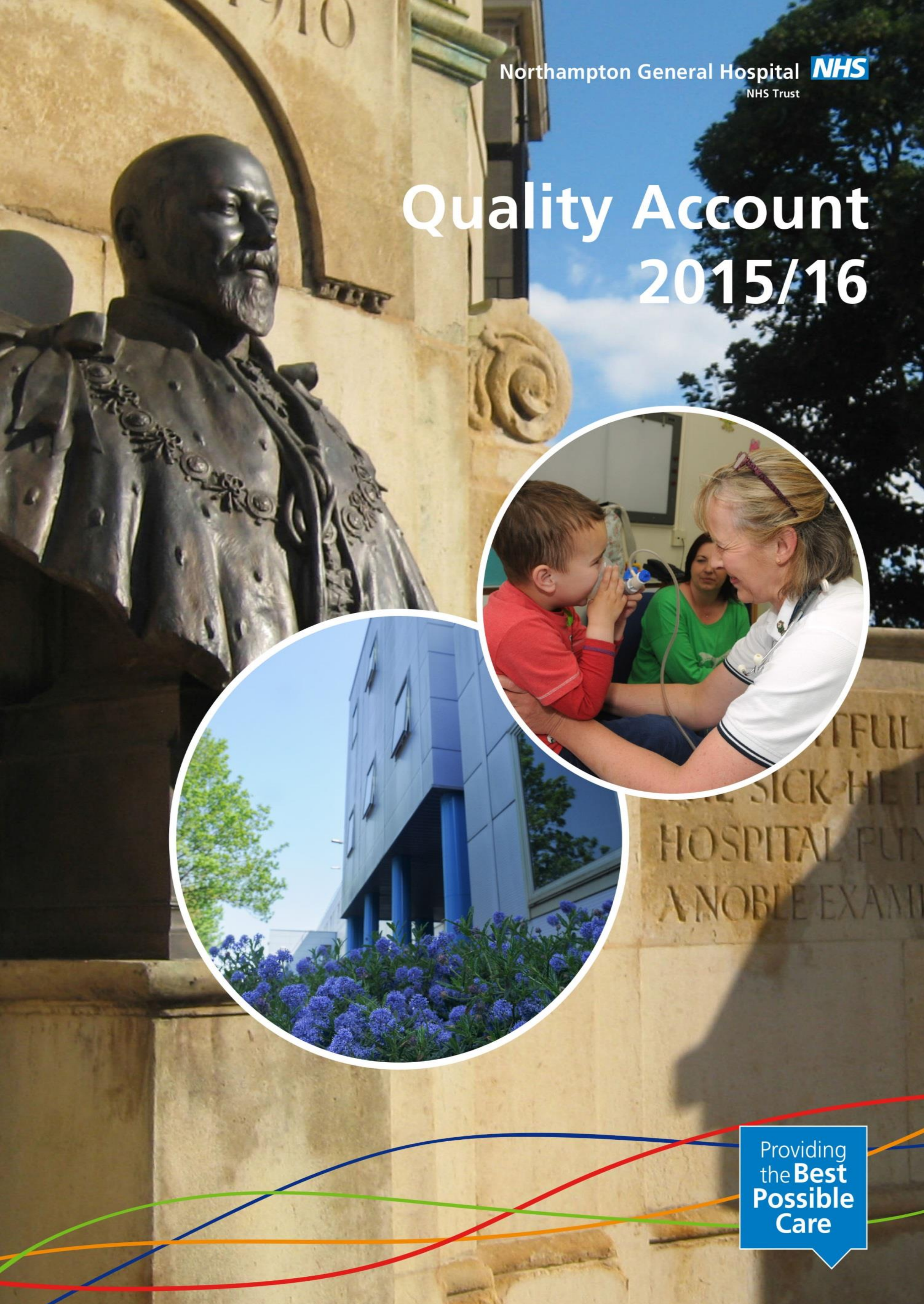

Northampton General Hospital NHS
NHS Trust
Quality Account
2015/16
HOSPITAL
A NOBLE EXAM
Providing
the Best
Possible
Care

Contents

Section	Contents
Section One	• What is a Quality Account? • Northampton General Hospital NHS Trust • Statement on Quality from the Chief Executive • Statement of Directors' Responsibilities
Section Two	• Quality at the Heart of NGH • Quality Priorities 2016/17
Section Three	• Quality Priorities 2015/16: A Review
Section Four	• Our Improvements in 2015/16 • Implementing Duty of Candour • Learning from Patient Feedback (Encompassing the Friends & Family Test, Complaints & PALS) • NHS Staff Survey • National Inpatient Survey • Care Quality Commission
Section Five	• National Clinical Audit and Confidential Enquiries • Local Clinical Audit • Participation in Clinical Research • Commissioning for Quality and Innovation • Local Quality Requirements
Section Six	• NHS Number and General Medical Practice Code Validity • Information Governance Toolkit • Clinical Coding Error Rate • Core Quality Indicators • Hospital Mortality Monitoring • Corporate Scorecard 2015/16 • Review of Performance 2015/16 • Review of Services • Review of Quality
Section Seven	• External Stakeholder Feedback
Section Eight	• Independent Auditors Limited Assurance Report
Section Nine	• Abbreviation List

SECTION ONE

WHAT IS A QUALITY ACCOUNT?

A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided.

The Department of Health requires providers to submit their Quality Account to the Secretary of State by uploading it to the NHS Choices website by June 30 each year. The requirement is set out in the Health Act 2009. Amendments were made in 2012, such as the inclusion of quality indicators according to the Health and Social Care Act 2012. NHS England or Clinical Commissioning Groups (CCGs) cannot make changes to the reporting requirements

NORTHAMPTON GENERAL HOSPITAL NHS TRUST

Northampton General Hospital NHS Trust provides general acute services for a population of 380,000 and hyper-acute stroke, vascular and renal services to people living throughout the whole of Northamptonshire, a population of 692,000.

The Trust is also an accredited cancer centre and provides cancer services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire. In addition to the main hospital site, which is located close to Northampton town centre, the Trust also provides outpatient and day surgery services at Danetre Hospital in Daventry.

The principal activity of the Trust is the provision of free healthcare to eligible patients. We are a hospital that provides the full range of outpatients, diagnostics, inpatient and day case elective and emergency care and also a growing range of specialist treatments that distinguishes our services from many district general hospitals. We also provide a small amount of healthcare to private patients.

We are constantly seeking to expand our portfolio of hyper-acute specialties and to provide services in the most clinically effective way. Examples are developments in both urological cancer surgery and laparoscopic colorectal surgery placing the Trust at the forefront of regional provision for these treatments.

We also train a wide range of clinical staff, including doctors, nurses, therapists, scientists and other professionals. Our training and development department offers a wide range of clinical and non-clinical training courses, accessed in a variety of ways through a range of media including e-learning. The Trust has excellent training facilities which were recently upgraded.

Division: Medicine & Urgent Care

Directorate	Services			
Urgent Care	A&E	Benham	EAU	Ambulatory Care
In patient Specialities	Cardiology	Nephrology	General medicine	Gastroenterology
	Endoscopy	Thoracic medicine		
Outpatient & Elderly & Stroke Medicine	Neurology	Rheumatology	Dermatology	Geriatric Medicine
	Stroke services	Rehabilitation	Main Outpatients	Neurophysiology
	Diabetes	Endocrinology	Day Case Area	Danetre Outpatients

Division: Surgery

Directorate	Services			
Anaesthetics, Critical Care & Theatres	Anaesthetics	Critical Care	Theatres	Pain Management
	Pre-operative assessment			
Head & Neck & Trauma and Orthopaedics	Audiology	ENT	Maxillo Facial Surgery	Opthalmology
	Oral Surgery	Orthodontics	Restorative Dentistry	Trauma & Orthopaedics
General & Specialist Surgery	Colorectal Surgery	General Surgery	Plastic Surgery	Upper GI Surgery
	Vascular	Urology	Endocrine Surgery	Breast Surgery

Division: Women's & Children's and Oncology / Haematology services and Cancer Services

Directorate	Services			
Women's	Gynaecology	Obstetrics	Gynaecological Oncology	
Children's	Neonatology	Paediatrics	Community Paediatrics	Paediatric Audiology
	Paediatric Physiotherapy	Community Paediatric Nursing		
Oncology / Haematology services and Cancer Services	Clinical Oncology	Medical Oncology	Haematology	Radiotherapy
	Palliative Care	Cancer services		

Division: Clinical Support Services

Directorate	Services			
Imaging	Breast Screening	Imaging Physics	Interventional Radiology	Radiology
	Nuclear Medicine	Medical Photography		
Pathology	Microbiology	Histopathology	Biochemistry	Immunology
	Infection Prevention			
Clinical Support	Therapies	Pharmacy	Medical Education	Research & Development

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

During 2015/16 Northampton General Hospital (NGH) NHS Trust has continued to focus on delivering high quality care for patients. We aim to put quality improvement at the core of all our services and this report gives an overview of some of the work done in 2015/16 and sets out the plans for improving the quality of services in specific areas for next year and beyond.

Throughout 2015/16 the Trust experienced very high levels of demand for emergency services as was the case in the wider NHS. This presented challenges for both staff and for our patients alike. It has also impacted upon our ability to deliver planned services. Despite this, our staff have remained committed to delivering the best care that they can and have continued to work towards the hospital's overall aim of 'Best Possible Care' with the values that support that ambition. We have improved the care that we give to our patients who require emergency admission over the last 2 years and we aim to continually improve urgent care in collaboration with partners in the health and social care economy. We know that if we can succeed in this collaboration in Northamptonshire, our planned services will also flourish.

Delivering high quality services requires us to constantly review the care we provide. In order to better meet the needs of our patients and to support this work, the Trust has signed up to a national campaign called Sign Up to Safety that aims to make the NHS the safest healthcare system in the world. A key component of this work centres on listening to and involving our staff, our patients and the local community we serve. It is important that all our staff understand the values of the Trust and what it means for them to aspire to excellence, to reflect, learn and improve and to respect and support each other and our patients. In order to deliver Best Possible Care, we know that we must be a learning organisation committed to developing individuals, teams and leaders to be able to put these values into practice. The simple message that all staff have a duty both to deliver care and improve care is increasingly built in to induction training.

The views of our staff, patients and their carers have been incorporated into our Quality Priorities for next year and our Quality Improvement Strategy 2015-18 which describes how we will achieve the aspirations we have for our services. Over the next 3 years we have committed to a programme of work that will ensure that our services become safer, more effective and provide those who use them with a more positive experience.

Our work to reduce avoidable harm and save more lives continues and is at the centre of our Quality Improvement work. Increasingly this work needs to involve all our partners in Health and Social Care in order to ensure we can support patient centred care in the community where possible. Getting patients home safely has been a particular focus and this work will be essential as pressure on services increases

We have strengthened the path set out in our Clinical Strategy by working closely in partnership with other hospitals including Kettering General Hospital and the University Hospitals of Leicester and with providers of community services and primary care. An example of this can be seen through our collaborative work with Kettering General Hospital covering a range of specialities and with Northamptonshire Healthcare where we have worked on solutions to improve the situation for patients who are waiting to leave the hospital

and for patients who need special care at the end of their lives. This signals our intention to focus on providing care that best meets the needs of the population of Northamptonshire and not just on the patients who have traditionally used our hospital services.

During 2015/16 year we have also continued to imbed our clinically led structure that was introduced in January 2015. Despite the acknowledged operational challenges, we are now beginning to reap the benefits of this transition with our clinical staff being at the forefront of decision making within the Trust. Our staff survey results are now starting to show a positive change in our staff's perceptions of the hospital and we are determined to build on this.

The Trust has made significant progress against the quality priorities we set ourselves in 2015/16. For example:

- Although we still have too many patients who cannot leave hospital for home as quickly as we or they would like, we have improved our discharge processes and are committed to improving this further
- End of life care continues to be a priority for us with on-going work streams building on the foundations laid through the CQUIN (Commissioning for Quality and Innovation) and our NGH quality priorities to ensure that patients who are approaching the end of their life are identified and receive the appropriate care
- The foundations for Sign up to Safety have been laid ensuring continuous reporting against agreed metrics to achieve the best possible care for our patients
- Complaint responses have improved throughout the year with all complaints being acknowledged within three working days
- We have continued to invest in our staff though programmes of leadership and development focussed on improving quality

The Trust has been recognised nationally through a number of awards including a national Award for Using Information for Improvement and Assurance, a national Award for Leadership and Innovation in Cancer Nursing and nomination for a CHKS national patient safety award. Following some very successful work involving doctors in training, medical students and student nurses in quality improvement we were invited to make national and international presentations. We have strengthened our links with both the University of Leicester and the University of Northampton and hope to develop this further in the future

We recognise that further work is needed to build upon the progress made in 2014/15 and this on-going activity will be accorded a high priority within the Trust as we go forward into 2016/17.

Providing health care is not without risk and we acknowledge that we do not get it right every time and for every patient. This quality report outlines our ambition to further reduce preventable harm across our organisation. The coming year will provide us with further opportunities to make improvements to the care that we provide to our patients and their carers. Our quality priorities for 2016/17 will again focus on delivering care to our patients that is safe, effective, reliable and compassionate.

We also recognise that a key challenge for the coming year and for the future will be to contribute effectively to planning and implementing the changes required to transform the

Northamptonshire Health and Social Care system and to ensure that patient centred, high quality care remains central to this work.

Despite the pressures we face including the unprecedented levels of emergency activity and the need for significant and transformation change, there is no doubt that many patients receive excellent care and our staff continue to show exceptional commitment day after day. I remain proud of Northampton General and of our staff who so often pull together to do the very best for our patients. It is only right that I end by thanking each and every one of them and reflect on the privilege of being able to do so.

Dr Sonia Swart
Chief Executive

STATEMENT OF DIRECTORS' RESPONSIBILITIES

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality account, directors should take steps to assure themselves that:

- The Quality Account presents a balanced picture of the trust's performance over the reporting period
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm they are working effectively in practice
- The data underpinning the measure of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with any Department of Health guidance
- The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board

30 June 2016
Paul Farenden
Chairman

30 June 2016
Dr Sonia Swart
Chief Executive

SECTION TWO

QUALITY AT THE HEART OF NGH

Quality has always been an integral component of our work at NGH. Our Quality Improvement Strategy sets our ambition and aim to provide the best possible care for all of our patients both now and in the future. Quality within the Trust focuses on three core areas:

1. *Patient safety*
    - There will be no avoidable harm to patients from the healthcare they receive.
    - This means ensuring the environment is clean and safe at all times with the aim that harmful events never happen.

2. *Effectiveness of care*
    - The most appropriate treatments, interventions, support and services will be provided at the right time and in the right place to those patients who will benefit from them.
    - Our patients will have healthcare outcomes which achieve those described in the NHS Outcomes Framework and NICE quality standards

3. *Patient experience*
    - Patients will experience compassionate, caring and communicative staff who work in partnership with them, their relatives and their carers to achieve the best possible health outcomes.

Successful organisations are also characterised by strong values and a strong guiding vision.

At NGH, our **vision** is simply stated: “To provide the best possible care for all our patients.”

The **Values** that we work by to support our vision are equally straightforward and uncompromising:

- We put patient safety above all else
- We aspire to excellence
- We reflect, we learn, we improve
- We respect and support each other

QUALITY PRIORITIES 2016/17

Quality is at the heart of everything we do. We will strive to continuously improve the quality of our services across the Trust. There are five key priorities that we will focus on in the coming year. Setting these priorities for 2015/16 involved a process of consulting staff, external stakeholders and volunteers on what should be included. The Quality Priorities that have been agreed for 2015/16 are shown below and are aimed to deliver our key goal:

- To reduce mortality
- To reduce harm
- To provide reliable care
- To improve patient experience

We will deliver our priorities through our clinically led divisional structure as part of our overarching programme of Changing Care at NGH supported by our Patient Safety Academy. It is crucial that the progress with each of these priorities is closely monitored to ensure the best possible care for our patients. Each of these Quality Priorities will be overseen by the Medical and Nursing Directors and reported to the Quality Governance Committee on a quarterly basis.

We have aligned our Quality Priorities for 2016/17 with our quality improvement portfolio, to ensure that we build upon the work of previous quality improvement strategies. This will enable us to provide the best possible care to every patient.

Our Quality Improvement Strategy is also aligned with our Quality Priorities and was developed with input from our staff and what quality means for them through the lessons learnt from complaints and serious incidents. It takes into account the recommendations of the Francis Report and Berwick Review and the principles from the Sign up To Safety Campaign that aims to make the NHS the safest health care system in the world.

The aims of this strategy are to ensure that patients and service users of NGH receive safe, effective services with a positive experience. We will aim to demonstrate a year on year improvement against baseline, within all measurable benchmarks.

Each of the six quality priorities is underpinned by a number of work streams that will enable us to deliver and measure successful outcomes.

1. Aim: Reducing Harm from Failure to Rescue

As measured by:

- Timeliness of observations
- Identification of the deteriorating patient
- Eliminating delays in investigations
- Sepsis care bundle

2. Aim: Reduce Avoidable Harm from Failures in Care

As measured by:

- Avoidable pressure ulcers
- Falls with harm

- Hospitals acquired VTE
- Omitted medicines

3. Aim: To Deliver Patient and Family Centred Care

As measured by:

- Friends and family test
- National CQC patient surveys
- NHS Choices
- Dementia carers survey

4. Aim: To Lead and Promote a Reflective Culture of Safety and Improvement

As measured by:

- Safety culture questionnaire
- Learning from errors (reduction in repeat incidents)
- Qualitative feedback from Board to ward walk rounds

5. Aim: To ensure operational processes support essential planning, delivery and record keeping

As measured by:

- Night team handover
- Time to Consultant Review
- WHO safer surgery checklist

6. Aim: To Deliver Reliable and Effective care (Care Bundles)

As measured by:

- Intentional rounding
- SSkin
- Stroke care
- Sepsis 6
- Heart Failure
- Ventilated acquired pneumonia
- Dementia (butterfly care)

In order to accomplish our aim we must continue to learn and embed a range of quality methods at all levels within the organisation.

Our clinicians and managers will need to remain focused on this agenda despite both internal and external challenges. We will build on our performance and efficiency to create a culture of continuous quality improvement. Our goal is to become a learning organisation in which every member understands their role in delivering clinical quality and works towards that goal every day. We will continue to place considerable emphasis on understanding our systems in greater detail, working towards excellence, engaging all of our employees in improvement whilst using small tests of change to build momentum and learning from mistakes.

Quality metrics around our strategic goals are agreed by the Quality Governance Committee, a sub-committee of the Board, in consultation with the clinical leads and Divisional Management teams, they will reflect the aspiration and vision of the strategy and priorities and be monitored through the Quality Governance Committee.

Primary Driver	Secondary Driver
Reducing Harm from Failure to Rescue	**Project 1-** Improving the quality and timeliness of patient observations
	Project 2 - Identifying and managing the deteriorating patient
	Project 3 - Eliminating delays in investigations and management for patients who are septic
Leadership for Safety & Safety Culture. Promoting and Leading a Culture of Reflective Learning and Improvement	**Project 4** - Leadership training & development for staff
	Project 5 - Board to ward leadership walk rounds
	Project 6 - Patient Safety Champions & Patient Safety Academy
	Project 7 - Safety culture questionnaire
	Project 8 - LFE for clinical teams
Reducing avoidable harm from failures from care	**Project 9** - Eliminate all avoidable pressure ulcers
	Project 10 - Reduce harm from patient falls
	Project 11 - Eliminate hospital acquired VTE
	Project 12 - Reduce omitted medicines
Reducing harm from essential planning of patient care ensuring that standards of record keeping and planning are accurate, timely and effectively communicated	**Project 13** - Effective night team handover
	Project 14 - Pain management
	Project 15 - Time to consultant review
	Project 16 - WHO safer surgery checklist
Patient & Family Centred Care	**Project 17** – Communication deep dive to identify key issue areas within the patient journey
	Project 18 – Implementation of Patient Beside Information Booklet and Bedside Placemat
	Project 19 – Initiate a set of Feedback Events with patients
	Project 20 – Create a repository of patient stories
Reliable Care – Deliver evidence based care via a "bundles" for particular treatments with inherent risks	**Project – 21** Myocardial infarction
	Intentional rounding
	SSKin
	Stroke Care
	Sepsis 6
	Heart failure
	VAP

SECTION THREE

QUALITY PRIORITIES 2015/16: A REVIEW

In our Quality Account 2014/15 we chose five key priorities to focus on in 2015/16. The progress and outcome of these are shown below.

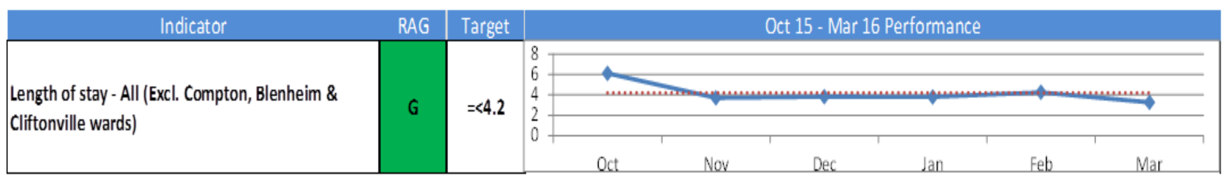
Quality Priority One – Supporting Patients in Getting Home

Why this was chosen
Our patients and staff told us about how delays in discharge from hospital impact upon them. By reviewing and improving ward based processes, including admission and discharge we can improve the patient experience. In reducing time spent in hospital, and excess bed days there would also be an increase in capacity and financial saving.

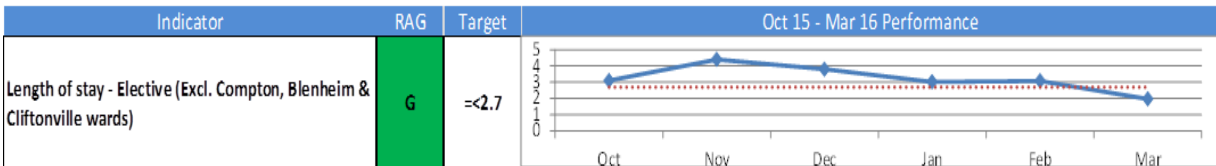
What we intended to do
Achieve greater coordination of teams and services such as pharmacy and hospital transport to ensure timely discharge. Show improved discharge planning resulting in a reduction of average length of stay and to demonstrate an increased number of patients discharged on their planned date of discharge.

How we performed

- A new patient information booklet was devised and introduced
- An in depth weekly review of all patients with a length of stay greater that 10 days
- There has been a focus on improving weekend discharges
- 91% of wards now have a full Board round before 11am
- 28% of patients have criteria led discharge
- Discharge to Assess was implemented and exceeded capacity
- A daily allocation meeting is now in place for all patients who require care following discharge



Indicator	RAG	Target	Oct 15 - Mar 16 Performance
Length of stay - All (Excl. Compton, Blenheim & Cliftonville wards)	G	=<4.2	



Indicator	RAG	Target	Oct 15 - Mar 16 Performance
Length of stay - Elective (Excl. Compton, Blenheim & Cliftonville wards)	G	=<2.7	

Quality Priority Two – Listen to Our Patients

Why this was chosen
Where things go wrong it is important we take the necessary steps to avoid a reoccurrence and in the instance of a complaint take steps to ensure it is investigated thoroughly with a timely response provided to the complainant and that any learning is shared

What we intended to do
Ensure complaints are quickly and robustly investigated with appropriate actions recorded and followed through and that any lessons learnt are shared across the organisation and embedded.

How we performed

KPI	Q4
3 working days acknowledgement	Achieved
5% reopened	0.9%
Local response rate target of 90%	Average response time = 90% (Apr-Jan)
Complaints information monitoring	• Quarterly reporting presented to QGC • ECLIPSS inspections in place for 2015/16 • Monthly meetings taking place for all areas of Patient Experience (PE, Complaints, PALS) to monitor and identify areas of concern at the earliest opportunity. • Bi-Monthly meetings to review the action plan from the Clwyd Hart report (incorporating other high level publications) • Directorate / divisional governance (dashboard) reporting remains ongoing - information is available Trust wide through a shared Governance drive • Audit undertaken in September covering complaints handling, reporting and learning - Action plan remains ongoing at present.
Development / Learning plan	• All information is entered onto the Health Assure system • The Complaints Team are recording all the learning on Health Assure • An action plan was prepared and submitted in each instance • All learning is included within quarterly reporting

Quality Priority Three – Invest in our Staff

Why this was chosen
Genuine leaders understand that they have a direct impact on the motivation and engagement of their staff. Employee engagement is a workplace approach designed to ensure that employees are committed to their organisation's goals and values, motivated to contribute to organisational success, and are able at the same time to enhance their own sense of well-being thereby feeling valued, supported and listened to

What we intended to do
Develop an effective culture and way of working through the implementation of the Employee Engagement Strategy. Develop a continuous improvement culture and equip staff to lead service improvement in their own area. Roll out of leadership programmes. Support the development of an environment for a healthy culture with values shared across the trust. Improve staff engagement

How we performed

Success	Metric	Outcome
Enrolment of staff in leadership programmes	Enrolment of 50 participants on Francis Crick Programme	50
	Enrolment of 15 participants on Consultant Development Programme	15
	Enrolment of 24 participants over 2 cohorts on Ward Sister Leadership Programme	
	Enrolment of 36 participants over 3 cohorts on First Steps in Team Leadership	
Improved staff survey results	Improvement in overall Staff engagement score from Staff Survey in comparison to 2014	2014 = 3.61 2015 = 3.75
Improved staff FFT results	Improvement in Staff recommending NGH as a place for treatment and as a place to work across all areas	
Completion of in the box session	150 staff completed ‘in the box' workshop	335
Improved staff FFT results	Reduction in rollover negative feedback trends from qualitative data captured on Staff Friends and Family test.	↓
Staff completed Rainbow risk	1500 staff completed Rainbow risk	1240
Street talk	8 street talk events	4
DoOD network	100 NGH DoODs in network	67
Appraisal completion	Achievement of corporate appraisal compliance target of 85%	81.89%
Staff turnover	Improvement towards corporate target of 8% for turnover	11.40%
Sickness absence	Improvement towards corporate target of 3.8% sickness absence	4.08%
Attendance on mandatory and role specific training	Achievement of corporate mandatory training compliance target of 85%	84.50%
	Achievement of corporate role specific training compliance target of 85%	74.04%
Involvement in local innovation events	200 people involved in six hat thinking tool in local areas.	238
Participation in Making Quality Count programme	Enrolment 100 participants in Making Quality Count Development Programme	148
Number of improvement projects undertaken	25 Improvement projects undertaken using D5 methodology	29

Staff step up to the challenge

Well done to our 147 employees who took part in the Global Corporate Challenge in a bid to get active and healthy.
The 21 teams of seven aimed to rack up 10,000 steps every day for 100 days.

Easily beating that target, NGH participants recorded a grand total of 176,848,326 steps – the equivalent of travelling the length of Great Britain 81 times. At the heart of the challenge is the health and wellbeing of our employees.

Quality Priority Four – Sign up to Safety

Why this was chosen

Our pledges were composed using awareness of our performance against qualitative and safety KPI`s and feedback received from our staff and patients. We have focussed on areas where we know we can make improvements and have included areas for change where work may have already begun. Being part of Sign up to Safety will provide additional focus and drive for achievements of our goals and a platform to share with the wider NHS our Safety improvement work.

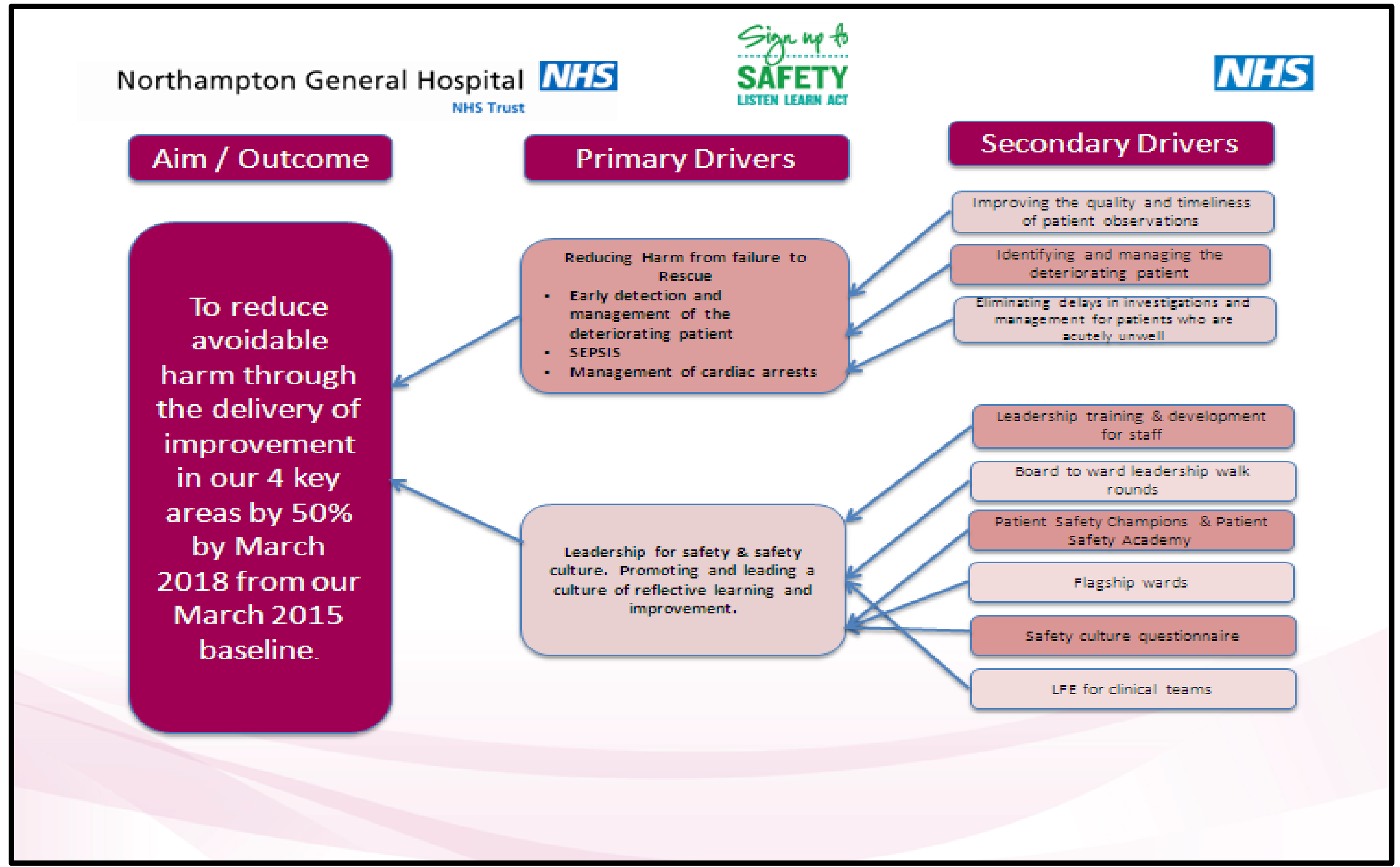
What we intended to do

Commit to NHS England's patient safety improvement quest to reduce avoidable harm by 50 per cent in three years**.** Develop and implement a safety improvement plan to meet the five Sign Up to Safety Pledges: putting safety first; continually learn; being honest; collaborating; and being supportive.

How we performed

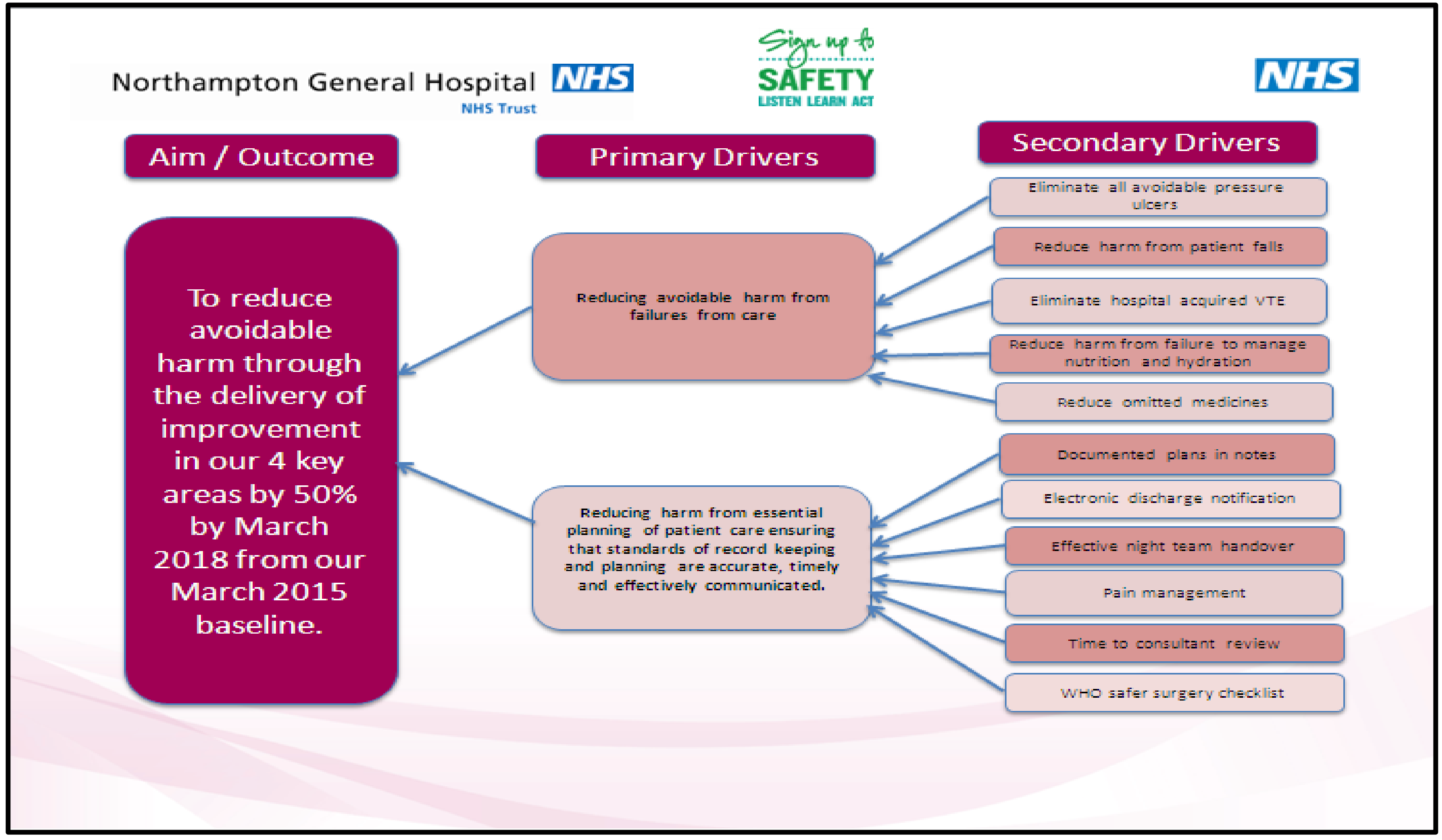
Sign Up To Safety Improvement Aim and Drivers

2015 - 2018



Sign Up To Safety Improvement Aim and Drivers

2015 - 2018



Sign Up to Safety 2015 – Progress to Date

Primary Driver	Secondary Driver	Year 1 2015/16	Year 2- Q1 2016/17	Year 3 2017/18	Year 4 2018/19
Reducing Harm from Failure to Rescue	**Project 1**- Improving the quality and timeliness of patient observations				
	Project 2 - Identifying and managing the deteriorating patient				
	Project 3 - Eliminating delays in investigations and management for patients who are septic				
Leadership for Safety & Safety Culture. Promoting and Leading a Culture of Reflective Learning and Improvement	**Project 4** - Leadership training & development for staff				
	Project 5 - Board to ward leadership walk rounds				
	Project 6 - Patient Safety Champions & Patient Safety Academy				
	Project 7 - Flagship wards				
	Project 8 - Safety culture questionnaire				
	Project 9 - LFE for clinical teams				
Reducing avoidable harm from failures from care	**Project 10** - Eliminate all avoidable pressure ulcers				
	Project 11 - Reduce harm from patient falls				
	Project 12 - Eliminate hospital acquired VTE				
	Project 13 - Reduce omitted medicines				
Reducing harm from essential planning of patient care ensuring that standards of record keeping and planning are accurate, timely and effectively communicated	**Project 14** - Effective night team handover				
	Project 15 - Pain management				
	Project 16 - Time to consultant review				
	Project 17 - WHO safer surgery checklist				
Project 18 To reduce the number of stillbirths and undiagnosed small for gestational age babies					

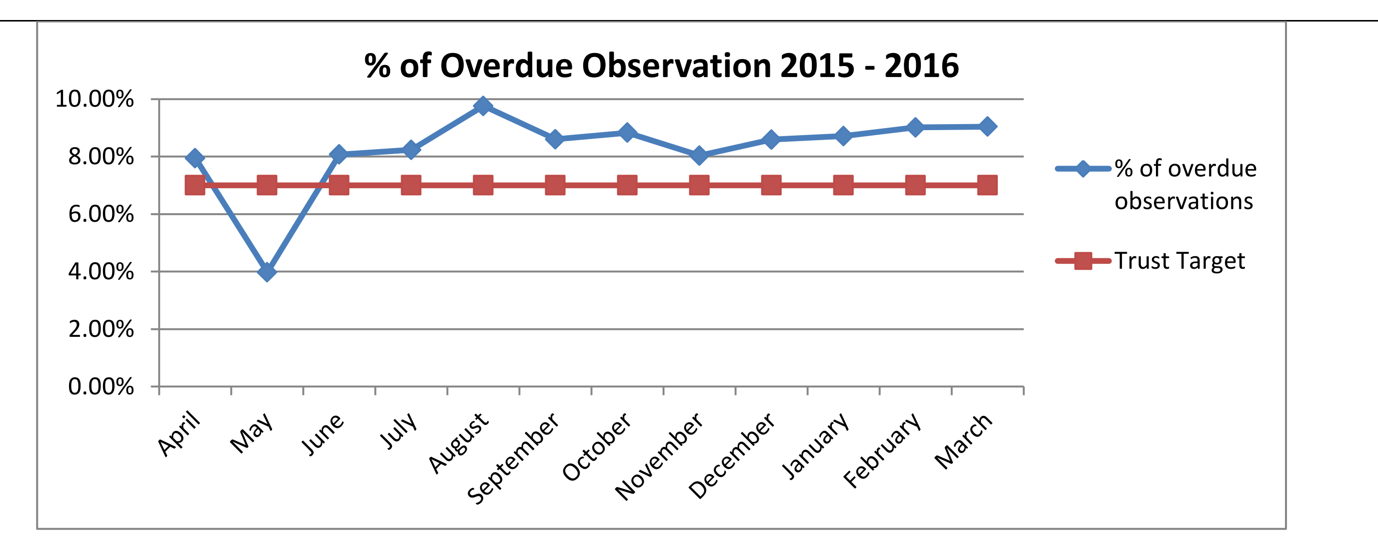
Safety Improvement Project – 1 - Aim: To reduce late observations by 30% by March 2018.

Goal Statement	Measure	2014/15 Outturn	Target Performance
Improve the quality and timeliness of patient observations	Late observations data via VitalPac across all adult general wards.	>10% of adult in patient observations were recorded late	Reduce baseline by 30% = <7% late observations Trust wide

Action Plan:

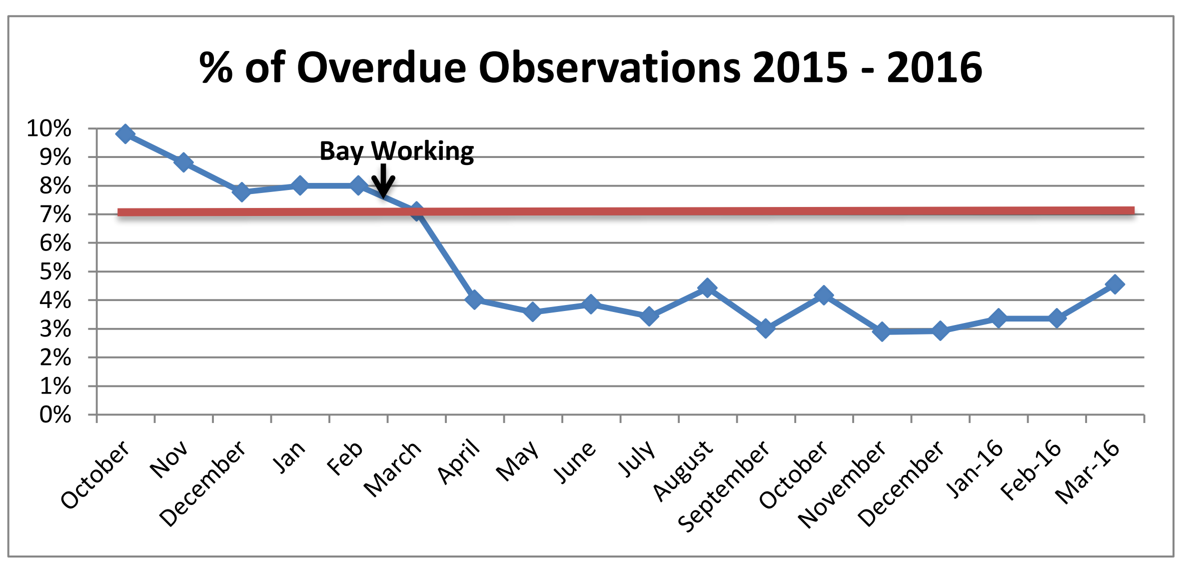
Action	By When	**Progress at a Glance:** Blue = Data/Progress preview in place Green = Achieved Amber = on track Red = Not met/not in trajectory
Circulate audit data monthly to all wards	April 2015 then monthly	Green
Monitor acuity data against late observations	September 2015 – March 2019	Amber
Regular agenda item for review by the Resuscitation Committee quarterly reflecting progress	Ongoing	Amber
Targeted support for the wards scoring the highest % of overdue observations	End 2016	Red

Q4 Progress Update
Late Observations: Late observation data is collected via VitalPac and circulated to all adult wards as part of a monthly EWS audit analysis. NGH has placed a threshold of acceptance at 7%. Any ward that is consistently above that level is required to have an action plan in place. This data is also monitored as a regular agenda item at the Resuscitation Committee and CQEG. The 2014 – 2015 outturn was 10% and the mean for 2015 – 2016 was 8.23% which represents a 10% improvement towards the 2018 target.



Targeted Support:

Current improvement work is focusing on standardisation of local minimum timeframe for observations and set instructions for recorders of observations via an algorithm. Low performing areas have been given a tablet for the co-ordinator to monitor and remind staff when observations are due. This has yielded demonstrable improvement in these areas. This work has been coupled with the introduction of bay working. The graph below demonstrates a sustained improvement in timeliness of observations since bay working was introduced in a test ward.



Safety Improvement Project – 2 - Aim: To reduce cardiac arrest calls by 15% by March 2019.

Goal Statement	Measure	2014/15 Outturn	Target Performance

Improve early identification and management of the deteriorating patient	1. Data evidencing critical risk patients >7 EWS on Vital Pac 2. Data evidencing time from referral to patient review 3. Reduction in cardiac arrests calls	38 coded preventable cardiac arrest calls following review	Reduce cardiac arrest calls by 15% by 2018 Resulting in < 32 preventable cardiac arrests calls per year

Action Plan:

Action	By When	Progress at a Glance: Blue = Data/Progress preview in place Green = Achieved Amber = on track Red = Not met/not in trajectory
1. Monthly point prevalence audit to review critical risk >7 EWS patients	Ongoing	
2. Identify all the issues in relation to the deteriorating patient and provide the Trust with an options appraisal	December 2016	
3. Monitor time from referral to medical review	September 2015 – March 2018	
4. Resuscitation Committee standard agenda item to review all data pertaining to the deteriorating patient	Ongoing	
5. All cardiac arrest reviews to be awarded coding following further review by clinical members of the Resuscitation Committee	April 2016	
6. Share learning from cardiac arrests pan Trust	September 2015	
7. Introduce patient & relative escalation system	End 2016	

Q4 Progress Update

1 <u>Monthly EWS Audits:</u>

For the year 2015 – 2016 the focus of the audit was to identify the number of patients scoring within the critical level (EWS >7) and of those how many had an appropriate level of escalation in place. Where there are no patients scoring at a critical level, data is captured for patients identified as being at high risk (EWS >5). This data is circulated to all adult wards on a monthly basis and discussed as a standing agenda item at the Resuscitation Committee and CQEG.

EWS Audit – Whole Hospital	April	May	June	July	August	Sept.	October	November	Dec.	Jan	Feb	March
% Monthly Compliance	80%	66%	60%	58%	67%	100%	67%	50%	80%	57%	67%	36%

Ensuring an appropriate plan is in place is multi-faceted, from correct level medical review through to ceilings of care and DNACPR. The Resuscitation Officers are working with clinical teams to give point of care education including simulation in the ward environment.

2. **Identify all the issues in relation to the deteriorating patient and provide the Trust with an options appraisal:**

A group met within Q4 to identify all of the issues and possible solutions. A VitalPac usage audit was also undertaken within this period that has identified insufficient usage on ward rounds to identify patients at high risk. A relaunch is underway and the introduction of a MET / Rapid response style team is being considered.

3. **Monitoring time from referral to medical review:**

Due to transitional problems VitalPac 'closing the loop' module is temporarily suspended.

4/5. **Resuscitation Committee:**

The Resuscitation Committee review all data pertinent to the deteriorating patient. The committee will also review each cardiac arrest case to ensure the coding given to each review is robust.

6. **Sharing learning from Cardiac arrest calls:**

Feedback continues to be given on each cardiac arrest call to the clinical teams involved with the call and the patient care. This is also discussed at the appropriate M&M meeting within the division. Coded preventable cardiac arrest calls are presented monthly at CQEG where there is also divisional representation.

Safety Improvement Project – Project 3 - Aim: To improve the screening of potentially septic patients & time to administration of antibiotics in severe sepsis.

Goal Statement	Measure	2014/15 Outturn	Target Performance
Eliminate delays in administration of antibiotics to septic patients, by ensuring that patients with deranged early waning scores (EWS) are screened for sepsis at entry to the hospital. In severe sepsis, to increase antibiotic administration within the first	Percentage with raised EWS presenting to the hospital screened for sepsis. Time to administration of antibiotics from diagnosis of severe sepsis. Sepsis 6 bundle	Q1 -29% screened for sepsis. Severe sepsis baseline end Q2	Increase screening and time to antibiotics to 90% by end of quarter 4. Incremental raise in line with CQUIN

hour from diagnosis to 90%.	compliance of those patients treated for sepsis in A&E		

Action Plan:

Action	By When	Progress at a Glance: Blue = Data/Progress preview in place Green = Achieved Amber = on track Red = Not met/not in trajectory
Design CQUIN part A audit and establish baseline	June 2015	
Design CQUIN part B audit and establish baseline - Agree coding for severe sepsis - Audit design - Establish a process for clinical notes	September 2015	
Establish sepsis group and meetings	Q2	
Refresh sepsis screening tool across Trust to align with UK sepsis trust document.	September 2015	
Sepsis group output Feed into antibiotic stewardship group	Ongoing	
Establish sepsis pathways, refine / check in Paeds, Oncology and maternity.	September 2015	
Relaunch sepsis campaign Text alert - Education at BLS for all trust members - Education at grand rounds - Education at induction - Education at division or directorate level - Nursing meetings - And infection prevention meeting	Sept 2016	
Ensure sepsis 6 sticker is in all clinical areas	Q1	
Ensure sepsis boxes are in place in clinical areas.	August 2015	

Q4 Progress Update
CQUIN complete for 2015/16 all targets met. Project lead support has started. Planning work for 2016/17 CQUIN, introducing maternity and paediatric sepsis pathways. Antimicrobial stewardship group work closely to ensure all elements of CQUIN align and are achieved throughout the year. The new sepsis screening tools are being disseminated currently across appropriate clinical areas. Sepsis guideline has been re written. NCEPOD sepsis audit report and gap analysis underway.

Safety Improvement Project – 4 - Aim: To develop a safety improvement culture as part of the roll out of the NGH Leadership model, producing leaders who are; Trusted, Motivate staff & Committed to excellence.

Goal Statement	Measure	2014/15 Outturn	Target Performance
Develop Leaders at all levels of the organisation to build a safety improvement culture within their areas of work	1. No of leaders enrolled in FCP and other Leadership programmes 2. No of MQC improvement programmes 3. No of Improvement projects undertaken 4. No of staff involved in Values in Practice workshops	1. 65 enrolled leaders in FCP and CDP 2. 83 participants enrolled in MQC programme 3. 21 improvement projects undertaken 4. 76 members of staff involved in VIP workshops	1. 125 by March 2017 2. 200 by March 2017 3. 50 by March 2017 4. 250 by March 2017

Action Plan:

Action	By When	Status at a Glance: Blue = Data/Progress preview in place Green = Achieved Amber = on track Red = Not met/not in trajectory
Complete FCP for top 50 leaders	10/2016	
Define next level FCP to roll out across the Trust	03/2017	
Complete Consultant Development programme	07/2016	
Develop the MQC product to speed access to further project development	09/2016	

Develop the MQC Graduates to provide further divisional capability	12/2016	
Develop a tool for measuring how the Trust performs against living our values	11/2016	
Implement values approach into Patient Journey	03/2017	

Q4 Progress Update
IQE update: Currently on track to meet all MQC targets. The engagement from the teams has been encouraging and is reflected in the results we are seeing. We are currently recruiting further projects for consideration in the next Cohort of MQC commencing in June. **OD update**: Currently on track to meet OD targets. Values session is now included on corporate induction programme and Values are now referenced as part of all OD interventions. A 'heat map' is currently being developed that will identify priority areas for Values into practice delivery within teams. The Consultant Development Programme is nearing completion and the next cohort is being planned along with the roll out of a buddy programme. The FCP is being delivered with sessions on Finance and Quality being planned for 2016. Planning of the roll out of FCP to the next cohort is underway.

Safety Improvement Project – 5 - Aim: The purpose of the safety round is first to send a message of commitment and it also fuels a culture for change pertaining to patient safety

Goal Statement	Measure	2014/15 Outturn	Target Performance
Trust Board Members will complet monthly Executive Safety Rounds visiting Clinical and non- clinical areas.	Numbers of areas visited monthly.	40 visits	Minimum of 48 executive safety visits per year

Action Plan:

Action	By When	**Status at a Glance:** Blue = Data/Progress preview in place Green = Achieved Amber = on track Red = Not met/not in trajectory
Develop a plan to facilitate clinical and non-clinical areas to be visited	April 2015	
Allocate Board members to complete safety rounds on a monthly basis	April 2015	
Provide areas visited and divisional teams with feedback from safety rounds	June 2015	
Develop screensavers to raise profile and promote Board to Ward rounds	June 2015	

Identify Board to Ward themes for discussion with staff and patients	June 2015	

Q4 Progress Update
During Q4 19 Executive Safety Visits were completed. During January and February operating theatres and areas that completed invasive procedures were visited with board members discussing the WHO Safer Surgery Checklist. The overarching feedback confirmed that board members were encouraged with the positive assurance that they received with regard to all stages of the WHO Checklist compliance and how it is an integral part of the teams work and practice. It is recognised that surgical Never Events are relevant to all clinical settings where invasive procedures are undertaken and therefore during the Board to Ward visit, the executive team also discussed National Safety Standards for Invasive procedures (NatSSIPs) and Local Safety Standards for Invasive procedures (LocSSIPs) compliance. During March 2016 the Board to Ward theme focused on the support for operational staff due to the pending British Medical Association industrial action and this resulted in the executive members visiting clinical areas and informally discussing resilience planning and offering support. The resilience plans that were in place addressed many of the concerns raised with extra safety huddles and rounding by senior staff planned.

Safety Improvement Project – 6 - Aim: To increase year on year the number and activity of safety champions within the Hospital – Currently under review see Progress update.

Goal Statement	Measure	2014/15 Outturn	Target Performance
To increase the number and activity of safety champions within clinical areas in the Hospital	1. Numbers of safety champions within each clinical area 2. % activity of champions	112 safety champions currently on the system following a data cleanse	250 minimum

Action Plan:

Action	By When	Status at a Glance: Blue = Data/Progress preview in place Green = Achieved Amber = on track Red = Not met/not in trajectory
Data base of champions to be updated as a baseline & reported within the Patient Safety, Clinical Quality & Governance quarterly reports.	November 2015	

All areas under the minimum to be contacted	January 2016	
Safety science induction session to be developed	June 2016	
Monitoring of new champions access & attendance on safety training induction sessions	December 2016	
Newsletter to be developed and disseminated bi-annually	December 2016	

Q4 Progress Update
The Quality Improvement Strategy (2015-2018) has been developed and is currently in draft. A strategy delivery plan will influence the revised role of Safety Champions. Baseline and trajectory will be identified for Q1, along with a new action plan for this SU2S improvement project.

Safety Improvement Project – 7 - Aim: To roll out QI initiatives across all wards that have proven sustainability from the Flagship test bed

Goal Statement	Measure	2014/15 Outturn	Target Performance
To roll out Quality Improvement (QI) initiatives with proven sustainability from the Flagship test bed. Implement appropriate 'bay working' principles across the general ward areas	General Wards work to the principle of 'bay working' appropriate for their area	1 ward utilised as the test bed for all QI initiatives, multiple treatments trialled and sustained.	All wards will put into practice the concept of 'bay working' that is appropriate for their area

Action Plan:

Action	By When	Status at a Glance: Blue = Data/Progress preview in place Green = Achieved Amber = on track Red = Not met/not in trajectory
To undertake a gap analysis of all general ward areas outlining the principles and barriers to 'bay working'	April 2016	
ADN's to discuss principles and methodology of 'bay working' with	Qtr. 2 2016	

their ward teams		
Roll out agreed and appropriate 'bay working' principles throughout the directorates	Qtr. 3 2016	
Review effectiveness of roll out and evaluate improvement outcomes against original test ward results	Qtr. 4 2016	

Q4 Progress Update
The principle of 'bay working' was decided upon as the successful measure to roll out from the trial on Holcot ward. Each divisional associate directors of nursing were requested to review the principles and implement the appropriate methodology for their wards against those principles, this project will be undertaken across the course of 2016

Safety Improvement Project – 8 - Aim: Increase staffs perception of safety culture across four key areas: general safety: individual performance: team and job satisfaction and incidents and concerns.

Goal Statement	Measure	2014/15 Outturn	Target Performance
Increase staff awareness and engage everyone in the organisation to understand how safety is perceived across the organisation	1. Safety culture and safety climate questionnaire 2. Safety culture questionnaire undertaken by all participants Learning from Error (LFE) sessions	August 2016	10% increase year on year from baseline

Action Plan:

Action	By When	Status at a Glance: Blue = Data/Progress preview in place Green = Achieved Blue = on track Red = Not met/not in trajectory
Approve patients safety climate and culture questionnaires	Q4	
Introduce safety culture questionnaire within LFE sessions which will inform 2014/15 outrun	Q3	
Deliver QI training	Q2	
Record QI projects in place	Q1	
Confirm if NGH agree to be part of Pascal metrics via EMAHSN	Q4	

Confirm if NGH agree to be use MaPSF	Q4	

Q4 Progress Update
During Q4 the preparatory work for a 4 year commitment to measure safety culture and climate was actioned. During May 2016 the patient's safety culture survey in eight acute trusts in the East Midlands will commence with online safety attitudes/climate surveys for the workforce in emergency departments and maternity units in all acute trusts. The surveys will be organised and analysed by Pascal Metrics. A US based company who have delivered a number of similar projects in the NHS. Pascal Metrics will also support the delivery of strategies to improve the culture of patient safety in these services based on the results of the surveys. The programme of culture assessment provides diagnostic and actionable insights into organisational and unit level cultures which enable the development of data driven training programmes to address areas of risk and opportunity. This includes a single culture survey using the safety attitudes questionnaire and a range of other surveys including for example engagement, burn out and resilience. The project period is for four years with culture measurement in year 1 and repeated in year 3 with follow-up work in the intervening years focusing of ED and maternity. NGH results in ED and maternity will be benchmarked regionally and will be presented as organisational case studies evaluating the impact of safety interventions during the project. As far as possible we will ensure that the structure and "fit" of any improvement programme dovetails into our current patient safety and quality improvement programmes within the Trust and a fairly formal project team approach for each service will be planned

Safety Improvement Project – 9 - Aim: 50% of all ward & clinical teams to attend Learning from Error (LFE) sessions within the Simulation Suite.

Goal Statement	Measure	2014/15 Outturn	Target Performance
Improving learning from error within ward teams	Ward teams accessing LFE sessions within the Simulation Suite	5% of ward teams have attended an LFE session	50% of ward teams attending an annual LFE session by 2018

Action Plan:

Action	By When	**Status at a Glance:** Blue = Data/Progress preview in place Green = Achieved Amber = on track Red = Not met/not in trajectory

LFE attendance data to be included within the Patient Safety, Quality & Governance quarterly reports.	Q1 2015/2016	
Implement a practice change agreement with all participating staff.	July 2015	
Follow up on practice change agreements and report to ward managers & quarterly report	Q1 2016	
Monitor attendance growth with changes in practice (based on bespoke session input)	December 2015 – March 2018	

Q4 Progress Update
LFE design and attendance data: LFE training has now been implemented for wards and clinical teams. Meetings set with matrons and sisters to explain the importance of the sessions and how we can make them bespoke to wards/teams. Promotion through Screen savers will be utilised throughout 2016. All wards booking for simulation training are booked onto the LFE training days; the session is then designed around common themes and incidents that have occurred on their ward. Discussions are currently ongoing as to how best to encourage medical staff attendance. To discuss further with DME how to encourage consultants to teach on LFE days and for this to be acknowledged as learning from their Governance SI report. **LFE staff trained so far – 36% of relevant Trust staff.** **Practice change agreements:** As of December 2015 all participants are asked to agree to take one thing back into their practice. This will be further developed and refined throughout 2016 with themes explored and reported upon.

Safety Improvement Project – 10 - Aim: To reduce the number/percentage of pressure ulcers by 10% by March 2019

Goal Statement	Measure	2014/15 Outturn	Target Performance
Reduce avoidable hospital acquired grade 2, 3 and 4 pressure ulcers by 10% by March 2019. Grade 2 – 25 % Grade 3 – 20% Grade 4 – maintain 0% baseline	Number of avoidable pressure ulcers grade 2, 3 & 4	181 grade 2 PUs 50 Grade 3 PUs	Reduction by: 25% in year 1 Grade 2 20% in year 1 Grade 3 Maintain 0 baseline for Grade 4

Action Plan:

Action	By When	Status at a Glance: Blue = Data/Progress preview in place Green = Achieved Amber = on track Red = Not met/not in trajectory
Agree % projection with TV Lead, DoN & DDoN through Pressure Ulcer Steering Group	July 2015	
Confirm project management structure through Pressure Ulcer Steering group	July 2015	
Review & update action plan to reduce the number of pressure ulcers across the trust to reflect recent thematic review	July 2015	
Maintain confirm & challenge meetings with Associate Director of Nursing through performance framework	Monthly – on-going	
Develop pressure ulcer strategy	November 2015	
Pressure Ulcer collaborative QI program	November 2016	
Implement and monitor Pu strategy providing staff and public with regular updates		

Q4 Progress Update
The Trust seeks wherever possible to prevent the occurrence of HAPU's by taking a proactive approach. The use of a collaborative model will provide a framework to optimise the likelihood of success for the organisation. It is most effective when there is a deficit in quality which can be identified by teams as "unacceptable" and when there are pockets of excellence which can be used to promote learning. An example of the effectiveness of this multidisciplinary framework is seen in the work undertaken by two junior Doctors working within the Collaborative who are undertaking a "Retrospective study of routine blood results in patients who have acquired a pressure ulcer during their inpatient stay at Northampton General Hospital". The interim results have identified some patterns in routine blood results that exist for patients who develop a pressure ulcer, and raise the question of whether they could be predicted in advance rather than retrospectively. This work has been shortlisted for the Patient Safety Congress 2016 in Manchester. Although there was an overall 22% decrease in the number of ulcers when compared with the same period the previous year Whilst it appears the number of grade 2 pressure ulcers has reduced by 25% when compared to the previous year and grade 3's have reduced by 28%, it is important to note that suspected Deep Tissue Injuries (sDTI) were not reported on the last financial year 2014-2015 and these account for 14 ulcers (6% of total number of ulcers) in 2015-2016. Areas for improvement work include redressing Device Related Pressure Ulcers (DRPU's) and poor moving & handling practices. Utilising the Department of Health Productivity Calculator

(2008/2009) it has been estimated that the reduction this year has saved the whole Northampton NHS economy in the region of £560,000.

The reporting of pressure ulcers continues to increase, demonstrating a positive reporting culture within the organisation. Once identified as a HAPU each clinical area where the damage originated is invited to the 'Share & Learn' meeting where a discussion is had about that patients episode of care, in a non-threatening environment, any omissions in assessment/documentation, any deviation from the designed treatment plan and any areas of good practice. As a group a decision, is made as to whether there has been a lapse in care that had led to the harm occuring. This forum allows that learning is shared across the organisation and actions taken to reduce the risk of recurrence.

The data demonstrates that patients are at greater risk of developing pressure damage within the first two weeks of their admission to Northampton General Hospital. As stated before this trend is reflective of previous data and requires further exploration.
The training of clinical staff will be monitored and the Trust aims to achieve over 90% compliance by October 2016. In order to achieve this Tissue Viability will identify new methods of delivery and work closely with colleagues in Practice Development. The team has already:

- Piloted new simulation suite cluster day session in collaboration with Falls, Safeguarding and VTE.
- Personalised Simulation Suite Training to ward issues,
- Provide enhanced support for wards RAG rated Red in pressure ulcer incidence.

Another trend identified, is a potential lack of patient involvement in their care, in particular the patient who is independent in repositioning, this leads to a lack of supporting evidence of frequency of repositioning. In order to rectify this we must ensure our patients are educated about pressure ulcers and ways in which they can help prevent them.

The Tissue Viability Team together with the QAI Matrons have identified improving processes and compliance as well as the efficiency of resources in the implementation of sound evidence based care.

Safety Improvement Project – 11- Aim: To reduce harm from (in-patient) falls by 15% by March 2019

Goal Statement	Measure	2014/15 Outturn	Target Performance
Reduce Harm from Patient Falls by 15% by March 2019	Harmful Falls/1000 bed days	1.16	0.99

Action Plan:

Action	By When	**Status at a Glance:** Blue = Data/Progress preview in place Green = Achieved Amber = on track Red = Not met/not in

		trajectory
1. Falls prevention action plan developed for current financial year	May 2015	
2. a. Falls assessment will be completed within 12 hrs of admission in 90% or more patient	June 2015	
b. Falls assessment will be completed within 12 hrs of admission in 95% or more patient	December 2015	*see below
3. a. Falls care plan will be completed within 12 hours of admission in 80% or more patients	December 2015	*see below
b. Falls care plan will be completed within 12 hours of admission in 90% or more patients	June 2016	
4. Review current process for post falls review and make appropriate changes	September 2015	
5. Develop a delirium policy to manage patients with confusion	December 2015	
6. A. Introduce a process to review medication that may lead to increased falls for patients sustaining an in-patient fall	September 2015	
B. Introduce a process to review medication that may lead to increased falls for patients admitted with a fall	September 2016	
c. Introduce a process to review medication that may lead to increased falls for patients at risk of a fall	February 2018	

Q4 Progress Update

Targets Achieved (all internally set):

- Trust's falls rate is below the (internally set) maximum of 5.5 falls/1000 bed days.
- The Trust's harmful falls rate/1000 bed days are below the internally set maximum of 1.6.
- The Trusts' falls/1000 bed days and harmful falls rate is below the national average as measured by the Safety Thermometer (point prevalence) and the RCP in patient falls audit (incident data).

Targets Not Achieved

- **Falls assessment will be completed within 12 hrs of admission in 95% or more patients.**

This target was achieved in Q3 (95%) but not in Q4 (90%). Further work in underway to address this.

- **80% or more of patients have all components of the falls care plan completed**

This target was achieved in Q3 (85%) but not in Q4 (76%). This is thought to be in part due to the sustained winter pressures. Again, further work is targeting this area.

- **Target: 85% or more of staff trained – compliant with mandatory training.**

76% of staff are currently trained. This is being targeted through the clinical divisions

- **Review current process for post falls review and make appropriate changes**

A review of the current paperwork and processes is on-going and will be completed by the end of April 2016.

Develop a delirium policy to manage patients with confusion

The policy was completed by the Dementia Steering group and waits ratification.

Safety Improvement Project – 12 - Aim: To reduce harm to patients admitted to NGH by eliminating avoidable VTE events by 2019 (excluding maternity). The trust is below the national average, hence we aim to maintain and marginally improve year on year.

Goal Statement	Measure	2014/15 Outturn	Target Performance
To eliminate all preventable VTE events (excluding maternity)	Percentage of preventable VTE events at NGH compared with non-preventable VTE events which is collated annually by VTE lead	Q1 2016/17	Sustain current incidence of preventable VTEs and improve year on year. i.e. 2% in 2016, 4% in 2017 and completely eliminate all preventable HATS by 2018 (excluding maternity)

Action Plan:

Action	By When	**Status at a Glance:** Blue = Data/Progress preview in place Green = Achieved Amber = on track Red = Not met/not in trajectory
Ensure every patient has a documented risk assessment for VTE and this is documented in the eDN	ongoing	
Provide formal and informal VTE education and learning	ongoing	
Anticoagulant nurses will provide appropriate follow up and deliver education whilst the patient is in hospital	In place	
Discuss all HATS at the thrombosis committee meeting, to be held bi-monthly and assign the responsibility of incidence reduction to the appropriate Directorate representative at these meetings	ongoing	

Q4 Progress Update
Refreshed Thrombosis Committee has commenced and Consultants informed of the need to attend to discuss RCA's of any HATS. Thromboprophylaxis nurse continues to deliver VTE teachings. Both Clinical and project lead are working together to refresh the teaching sessions and devise an assessment to be completed at the end of each session. The anticoagulation department is planning to hold an education day in 2016 to raise the profile of the service and the work it carries out. This will also provide an opportunity for more informal teaching and find out from nurses what educational needs they have in relation to VTE. Further review during Q1 is required to refine data collection for VTE assessment.

Safety Improvement Project – 13 - Aim: To reduce omitted doses of medicines* by 10% in Year 1 and thereafter by 20% Year on Year to March 2019.

Goal Statement	Measure	2014/15 baseline	Target performance
Reduce omitted doses of medicines by 10% in Year 1 and thereafter by 20% year on year by March 2018	Omitted doses of medicines	9% (Based on data from September 2014)	Reduce by 10% in Year 1 and thereafter by 20% Year on Year

Action Plan

Action	By when	Status at a Glance: Blue = Data/Progress preview in place Green = Achieved Amber = on track Red = Not met/not in trajectory
Implementation of the audit tool Medication Safety Thermometer across the Trust to match implementation of EPMA	March 2017	
Implementation of electronic prescribing [ePMA] across the Trust according to project plan:	Jan 2015 -2019	
Medicine – complete roll out, including upgrade to allow EPMA to be started in A&E	July 2016	
Orthopaedics (+ relevant pre-op assessment and theatres)	October 2016	
Surgery and Head & Neck / Gynae	February 2017	

Design report which can be produced by EPMA to populate the MST audit.	August 2016	
Medication Safety Group (MSG) to produce strategy and plan for reducing omitted doses of medication (not documented and unavailable). This will include implementation of Medication Safety Thermometer and ePMA across the Trust.	August 2016	
Implementation of strategy and monitoring using the Medication Safety Thermometer plus additional tools as agreed by MSG	March 2017	

Q4 Progress Update
For Q4 the Medication Safety Thermometer (MST) was utilised for data collection (following Pharmacy & DCASE reviewed plan). During Q4 MST was conducted on 5 wards (2 EPMA wards) on one month. Future plan by DCASE is to continue to support & match implementation of EPMA across wards until EPMA team are able to produce reports from EPMA which will be used for the MST audit. It is anticipated that implementation of EPMA across the trust will reduce omitted doses (not documented). EPMA went live on Holcot and Eleanor in February 2015. For 2015/16, the MST measured that there has been a reduction in Omitted doses (not documented) on the EPMA wards, Holcot and Eleanor of 14% and 6% respectively. As the EPMA becomes more embedded on these wards we would expect this to reduce further. In Dec 2015 and March 16 when these wards were audited using MST there were no omitted doses (not documented) recorded for patients on EPMA. The plan to reduce Omitted medicines (not available) will be formalised at Medication Safety Group (June 2016). This will be included in the medication safety plan which includes a work stream for omitted doses.

Safety Improvement Project – 14 - Aim: Patients requiring an internal transfer will have a documented transfer plan in place and appropriate staff escort. Patient transfers out of hours will be risk assessed. Deteriorating patients or patients with a EWS >7 will be discussed at night team handover

Goal Statement	Measure	2014/15 Outturn	Target Performance
Eliminated harm from poor documentation and poor transfers/handover of care	Number of attendance at night team handover Number of Transfers with >EWS 7 with Plan in place Number of wards using Patient transfer checklist	Q1 2016/17	All on call specialities represented 100% 100%

Action Plan:

Action	By	Status at a Glance:

	When	Blue = Data/Progress preview in place Green = Achieved Amber = on track Red = Not met/not in trajectory
Patient risk assessment to be completed for all out of hour transfers	June 2015	
Relaunch night team handover	Q4 15/16	
Record and follow up Night team handover attendance via directorate -	September 2015	
Monthly point prevalence audit for patients with EWS>7 to confirm management plan in place	April 2015	
Roll out of patient transfer checklist	July 2016	

Q4 Progress Update
Internal audit are being undertaken and discussed in the monthly patient moves meeting. Each move is risk assessed. Handover is now well led and uses VitalPac to inform of those patients who are triggering or Code Red status overnight. There is a patient transfer checklist in place and patient moves leaflet. Discussions currently ongoing as to how this is audited on a regular basis. On-going meetings with Corporate nursing, likely to use the SBAR tool for this. Symphony being scoped out for electronic handover from ED to EAU/ BENHAM. Monthly meeting now set up with the Associate Director of Nursing for Medicine to progress this work. The point prevalence EWS audit for the quarter and whole year 2015 - 2016:

EWS Audit - Whole Hospital	April	May	June	July	August	September	October	November	December	January	February	March
% of patients scoring >7 (critical risk)	2%	1%	2%	2%	2%	2%	3%	1.37%	1%	1%	3%	2%
% Critical risk patients with plan in place	80%	66%	60%	58%	67%	100%	67%	50%	80%	57%	67%	36%

Safety Improvement Project – 15 - Aim: To increase the number of ward based nurses competent to complete a pain score and timely reassessment

Goal Statement	Measure	2014/15 Outturn	Target Performance
Staff to respond appropriately to patients pain and to reassess interventions in a timely manner	Pain Management scores on monthly Quality Care Indicators; 1. Is pain evaluated and documented each shift 2. Did staff return after administering pain relief 3. Are you satisfied with your overall pain management during	Overall mean pain score for Trust from August to December 2015 (90.5%) 37.5% pain scores on referral to acute team reflect pain	95% patients receive appropriate pain management at Northampton General

	this admission Acute Pain team evaluation of accuracy of pain scores in visited post-operative patients	team scores to within 1 point (Dec 2016)	Hospital

Action Plan:

Action	By When	Status at a Glance: Blue = Data/Progress preview in place Green = Achieved Amber = on track Red = Not met/not in trajectory
Produce gap analysis for pain score training on acute wards	March 2016	
Plan training schedule	June 2016	
Monitor Pain Management QCI data monthly • Is the pain evaluated and documented on each shift • Did staff return after administering pain relief to ask if it was effective • Are you satisfied with your overall pain management during this admission	October 2015 onwards	
Acute Pain Team to audit accuracy of pain scores on patients they review	To start 19/10/2015	

Q4 Progress Update

1. **Produce gap analysis for pain score training on acute wards**
   18/25 clinical areas responded to the request for a Gap analysis.

2. **Plan Training Schedule**
   Pain Team are undertaking ward based training.

3. **Monitor Pain Management QCI Data**
   Data has been collected for all adult inpatient areas for January, February, and March 2016 and recorded as results for medical wards, surgical wards and the Trust as a whole. For Q4 the mean overall pain score is 93.13%
4. **Acute Pain Team to Audit accuracy of pain scores on patients they review**
   Data collection was suspended by the pain team on 31st January 2016 and resumed on 1st April 2016. January 2016 data suggests that only 37.5% of ward pain scores on referral to the pain team reflect the acute pain team scores to within 1 point. Further comparison of data will occur once ward based training takes place.

Safety Improvement Project – 16 - Aim: All emergency admissions will be seen and have a thorough clinical assessment by a suitable consultant. The standard applies to emergency admissions via any route, not just the Emergency Department.

Goal Statement	Measure	2014/15 Outturn	Target Performance
All emergency admissions must be seen and have a through clinical assessment by a suitable consultant as soon as possible but at the least within 14 hours from the time of arrival at hospital.	The time taken for patients admitted as an emergency to be reviewed by a consultant.	67% compliance within 14 hours from admission	100% of emergency admissions will be seen by a consultant within 14 hours from the time of arrival to hospital

Action Plan:

Action	By When	Status at a Glance: Blue = Data/Progress preview in place Green = Achieved Amber = on track Red = Not met/not in trajectory
1. All patients to have a National Early Warning Score (NEWS) established at the time of admission.	April 2015	
2. All patients admitted during the period of consultant presence on the acute ward (normally at least 08.00-20.00) will be seen and assessed by a doctor, or advanced non-medical practitioner with a similar level of skill promptly, and seen and assessed by a consultant within six hours.	June 2015	
3. Consultant involvement for patients considered 'high risk' (defined as where the risk of mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected) should be within one hour.	April 2015	

Q4 Progress Update
1. NEWS at time of admission is consistently 90% Recent NHS England survey showed 71.5% patients reviewed by a consultant within 14 hours on a weekday, 70% on a Saturday and 62.5% on a Sunday 2. Improvement work to address this is being undertaken through the clinical divisions with support from the 7 day working group.

Safety Improvement Project – 17 - Aim: Never Events are Serious, largely preventable patent safety incidents that should not occur if the available preventative measures have been implemented.

Goal Statement	Measure	Q4 2015/16 Outturn	Target Performance
Surgical Never events will be eliminated - WHO Safer Surgery Checklist will be used for every patient undergoing a surgical procedure	Numbers of operations versus number of completed checklists Number of surgical never events	Throughout the quarter, 90% of procedures performed across all areas had a completed WHO paper checklist form available for audit	Patients will have all stages of the a WHO safer checklist completed resulting 100%

Action Plan:

Action	By When	Status at a Glance: Blue = Data/Progress preview in place Green = Achieved Amber = on track Red = Not met/not in trajectory
Develop audit template to differentiate between the 5 stages of the WHO checklist and the signatures required.	Q2 2016	
Following on from the Perioperative, Safety and WHO checklist meeting in March 2016, a redesigned audit proforma will be designed and piloted. The separate stages of the checklist with the requirement for a three stage signature are aimed at promoting focused responsibility and accountability for the checklist.	Q2 2016	
WHO Teaching DVD to be updated and a simulation version of how not to do the WHO checklist as well as a gold standard version to be designed. VG to liaise with Communications Team	Q2 2016	
Theatre managers will continue recording all staff trained in WHO by documenting all members of staff who join the theatre team and the date they were trained in WHO.	ongoing	

Q4 Progress Update
• Monthly WHO checklist audits have been completed by Clinical audit staff throughout the quarter and will continue in 2016/17. • Experience with using the WHO checklist has suggested that the benefits of a checklist approach can be extended beyond surgery towards all invasive procedures performed in hospitals. As part of the local implementation plan to demonstrate compliance before 14th September 2016 a gap analysis will be completed in order to identify all invasive procedures that the NatSSIPs are applicable to. This piece of work has commenced in Q1 2016/17 and will be reviewed at the next Perioperative, Safety and WHO checklist meeting.

Project 18

Aim / Outcome	Primary Drivers	Secondary Drivers
To reduce the number stillbirths and undiagnosed small-for-gestational age babies by 50% by March 2018	Training	• Improving training and education of staff in relation to smoking cessation and carbon monoxide monitoring
	Resources	• Improving links with Northamptonshire Stop Smoking service
	Leadership for Safety	• Improving and standardising information regarding risks of smoking on unborn baby and maternal and long term family health
		• Procuring handheld Carbon Monoxide breath monitors
		• Increasing the availability of midwifery led ultrasound slots and additional ultrasound machine
		• Ongoing multidisciplinary case reviews of all stillbirths and sharing of lessons learnt
		• Improving training and education of staff in relation to smoking cessation and carbon monoxide monitoring
		• Effective policy and pathway for the detection, investigation and management of small-for-gestational age babies

Safety Improvement Project - 18

Goal Statement	Measure	2014/15 Outturn	Target Performance
To reduce the number stillbirths and undiagnosed small-for-gestational age babies by 50% by March 2018	1) Number of stillbirths > 37 weeks	1) 9 Stillbirths > 37 weeks gestation	50% reduction by 2018
	2) Number of babies born > 37 weeks with a birthweight below the 10th customised centile (not detected during antenatal period)	2) Unable to collate this data for 2014/15 as birthweight below the 10th customised centile was not recorded. Baseline to be established in Q1 (2016/17)	Reduce baseline by 50% by 2018

How will progress be measured?

Outcome Measure	Data Source	Numerator	Denominator	Frequency of monitoring	Goal
Carbon Monoxide measurements will be taken at the booking appointment	Medway	Number of women who had a carbon monoxide measurement recorded at booking	Total number of women booked	Monthly	50% increase in Year 1
Women with a CO of >7 ppm will have a uterine artery Doppler scan at 28 weeks	Medway Audit	Number of women with a CO reading of > 7 ppm who have a uterine artery Doppler scan	All women with a CO reading of > 7ppm	Monthly	50% increase in Year 1
Women with a CO of > 11 ppm will have serial growth scans	Medway Audit	Number of women with a CO reading of > 11 ppm who have serial growth scans	All women with a CO reading of > 11 ppm	Monthly	50% increase in Year 1

Outcome Measure	Data Source	Numerator	Denominator	Frequency of monitoring	Goal
Stillbirths > 37 weeks gestation	Medway	Number of stillbirths (>37 weeks)	Total number of babies born	Quarterly	50% decrease by 2018
Number of babies born > 37 weeks with a birthweight below the 10th customised centile (not detected during antenatal period)	Medway Audit Datix	Number of babies not identified until birth as small-for-gestational age	Total numbers of babies born with a birthweight below the 10th customised centile	Quarterly	50% decrease

Action Plan:

Action	By When
Procure handheld Carbon Monoxide monitors	End Q4 – 2015/16
Explore charitable funding opportunities to procure Ultrasound machine	End Q4 – 2015/16
Establish baseline – number of babies with a birthweight below the 10th customised centile which was not detected during the antenatal period.	Q1 (2016/17)
Develop pathway for detection, investigation and management of small-for-gestational age babies	End Q1- 2016/17
Improve links with Northamptonshire Stop Smoking service	End Q1- 2016/17
Review of Midwife Ultrasonographer services to ensure adequate capacity to implement pathway	End Q1 – 2016/17
Multi-disciplinary review of all term stillbirths using the adapted NPSA Review of Intrapartum Stillbirths proforma and ensure lessons learnt are shared	Ongoing
Establish a rolling audit programme to monitor performance, through - the SGA rate (proportion of babies born with a birthweight below the 10th customised centile) - the rate of antenatal referral for suspected SGA and antenatal detection/diagnosis of SGA - regular case-note audit of SGA / FGR cases that were not antenatally detected, and action plans in response to system failures	End Q2 – 2016/17
Implementation of the Stillbirth Care Bundle	End Q2 – 2016/17

Quality Priority Five – Improve End of Life Care

Why this was chosen
Wards find difficulty in identifying patients at the immediate end of their life. If this were improved, patients would be placed on the end of life register and receive better care as a result

What we intended to do
All wards to identify patients who are imminently dying and to notify through the safety huddle so the patient is placed on the end of life register. Improved uptake of end of life care

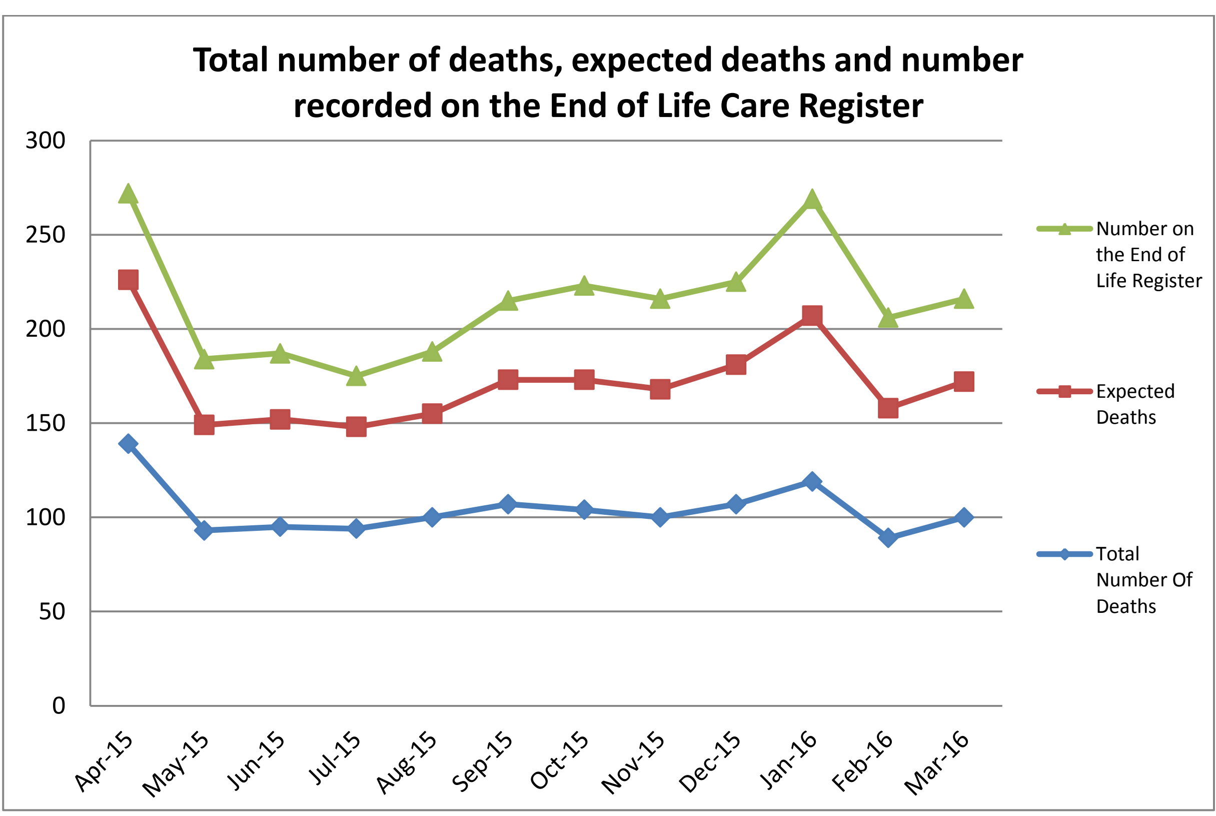
How we performed

- Specialist Palliative Care/End of Life Care Team to maintain the trust End of Life Care register
- Specialist Palliative Care/End of Life Care Team support clinical teams in the development and implementation of Personalised Care Plans for patients identified as imminently dying
- Increase in the use of the dying person care plan for patients who were recognised to be in the last hours/days of life
- The table below shows the figures for the year

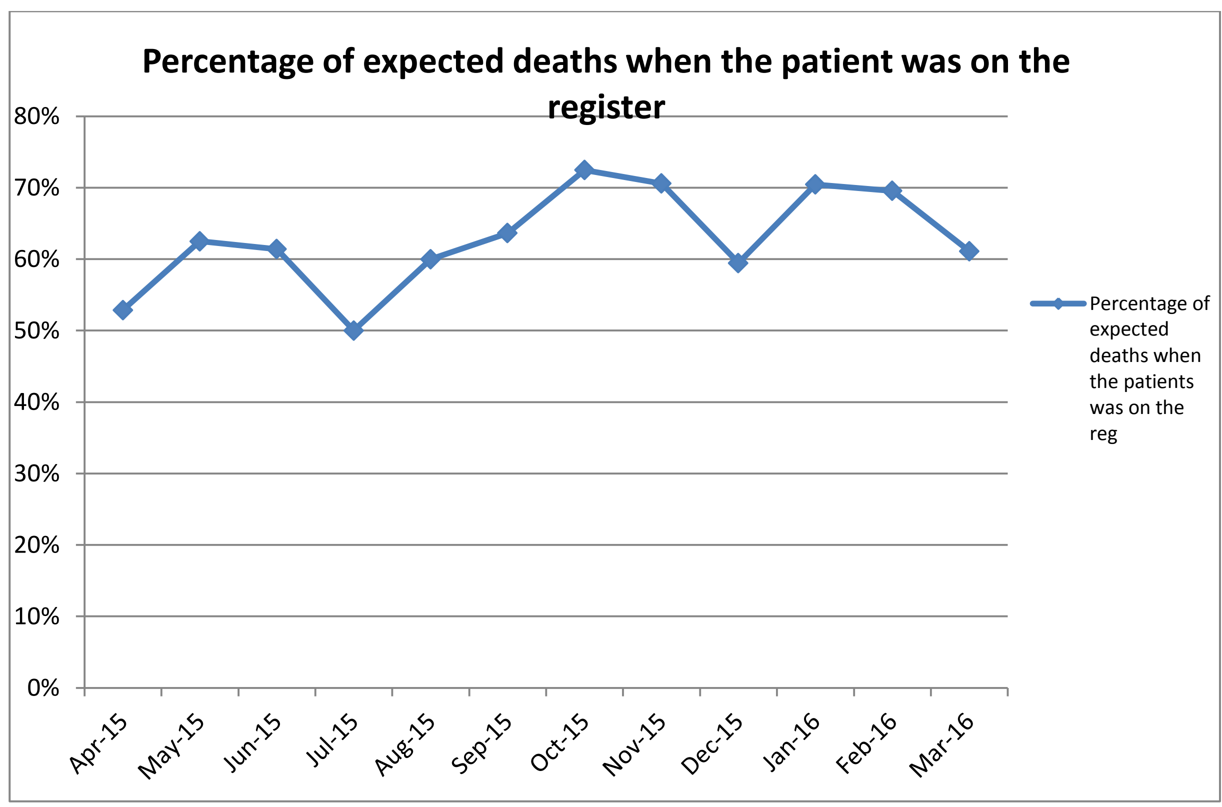
	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Total Number Of Deaths	139	93	95	94	100	107	104	100	107	119	89	100
Expected Deaths	87	56	57	54	55	66	69	68	74	88	69	72
DPCP										60	48	40
Number on the End of Life Register	46	35	35	27	33	42	50	48	44	62	48	44
Percentage of expected deaths when the patients was on the register	53%	63%	61%	50%	60%	64%	72%	71%	59%	70%	70%	61%

Percentage of patients on EOL register	33%	33%	40%	34%	45%	46%	43%	57%	50%	50%	54%	40%

The two graphs (graph 1 and graph 2) below demonstrate an upward trend in identifying patients who are likely to die in the next few hours/days within the trust.

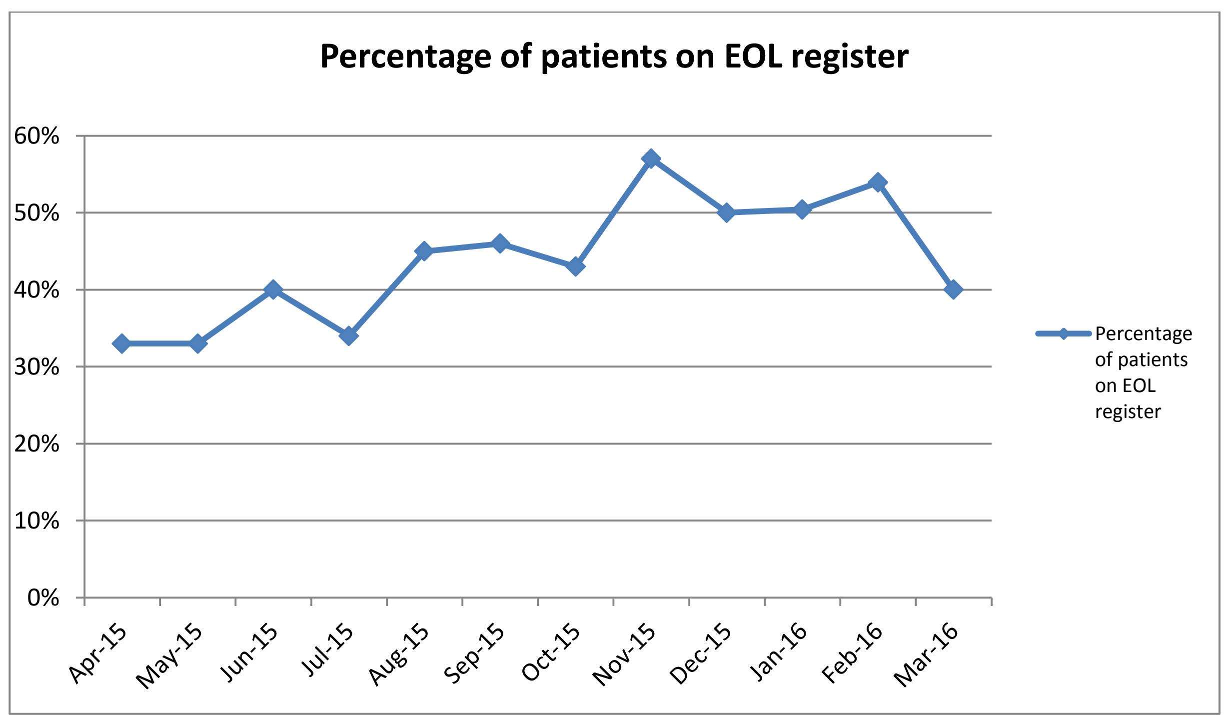


Graph 1



Graph 2

Graph 3 below demonstrates the percentage of patients who died at NGH with a Dying Person Care Plan (measured against total deaths)



Graph 3

SECTION FOUR

OUR IMPROVEMENTS IN 2015/16

During 2015/16 NGH continued to aim to deliver best possible care supported by a number of improvements throughout the year. In addition to some of the specific improvements, the senior team has worked with staff to develop an aligned programme of work to ensure that quality improvement and efficiency of services receive the emphasis required and that all energy and resources are centred on these.

The underpinning governance structures to monitor quality have been improved. The organisation has continued to develop a clinically led divisional structure underpinned by a supportive culture and a formal development programme. It is not possible to include all the improvements made by NGH in 2015/16. Therefore a representative sample is presented here:

Domain/s - Patient Experience, Effectiveness of Care
Project - Reduce the waiting times for all patients that attend the pre-operative assessment service to 30 minutes maximum wait.
Change / Outcomes

- Reduced waiting times from 3 hours to 30 mins max
- 220 additional patients seen between December 15 to February 16
- Previously up to 10 patients a day were being turned away, now this is zero
- Visual management implemented to aid managing the performance and sustainment of the department.

Domain/s - Patient Safety, Patient Experience
Project - Geriatric Emergency Medicine (GEM): providing excellent care to older people in ED.
Change / Outcomes

- Improved falls assessments and consequently targeted intervention
- Introduced and embedded cognitive impairment screening
- Improved the care environment by setting up new quiet GEM bays, supported by NGH charitable funds. Of patients coded as having dementia or confusion, 81% were cared for in a GEM Bay and of patients coded as frail, 44% were cared for in a GEM Bay.
- Improved pain management in hip fractures; introduced new processes for timeliness and fascia-iliaca blocks to A&E
- Patient complaints decreased by 34%
- Visual management – wall mounted filing system in GEM Bays to act as visual prompt, introduced Butterfly's to A&E, stickers for wristbands & notes, alerts on our IT system Symphony.

Domain/s - Patient Experience, Effectiveness of Care
Project - Improving patient and staff experience in the Diabetes department
Change / Outcome

- Significant reduction in backlog of letters from 460 to 5
- Sustained efficiencies, typing waiting fallen from 45 days to 3 days

- Reduction in patient enquiries and complaints
- Important improvements for patients care pathway and safety.

Domain - Effectiveness of care
Project - Increasing utilisation of Ophthalmology theatres
Change / Outcome

- Change in rosters has seen a steady increase in theatres starting on time. In December 2014, late starts were costing nearly £2000 and by November 2015 the cost dropped to below £250.
- Improved process for obtaining patient consent; saving time
- Ring fencing pre-op slots for cataract patients; improved quality and saved time
- Increased numbers of cases (from 4 to 8) being added to some consultants lists.

Domain/s - Patient Experience, Effectiveness of Care
Project - Reduce hospital acquired pressure ulcers.
Change / Outcomes

- Have achieved overall reduction in avoidable pressure ulcer harms from 2014/15
    - 18% reduction overall
    - 22% reduction in Grade 3
    - 21% reduction in Grade 2
- Focused training from Tissue Viability Service with wards where pressure ulcers have been identified as a problem
- 60 Pressure Reducing Mattress overlays Repose Companion) purchased for A&E , for all GEM patients admitted to department
- Pressure Ulcer Collaborative -The use of this model will provide a framework to optimise the likelihood of success for the organisation (in reducing harm caused by Pressure damage). It is most effective when there is a deficit in quality which can be identified by teams as "unacceptable" and when there are pockets of excellence which can be used to promote learning.
- All inpatient areas have action plans in place to ensure the reduction in pressure ulcers and learning continues
- Work ongoing with Matrons for Improvement and Assurance, Moving and Handling Team and Tissue Viability to reduce the harms caused by poor moving and handling practices

Domain/s - Patient Experience, Effectiveness of Care
Project – Inpatient falls
Change / Outcomes

- On a monthly basis
    - 90% or more of patients receive a falls risk assessment on admission
    - Trust's falls rate/1000 bed days are below 5.5 falls/1000 bed days.
- On a quarterly basis
    - Trust's harmful falls rate/1000 bed days is below 1.6 each
    - Trust's Harmful falls rate is below the national average as measured by the Safety Thermometer (point prevalence).
- Roll out of post fall neurological observation simulation suite session for Nursing staff trust wide
- Creation of different methods of training; e.g. workbook and new simulation suite training sessions

- Bespoke falls training has been devised for the specialist nurses for older people
- ‘FRAX’ bone health assessment tool has been added to all iPads
- Review of the Trust’s falls care plan with input from members of the NICE guideline and quality standards committee
- Pilot of bay working on flagship ward

Domain/s - Patient Experience, Effectiveness of Care
Project – Maternity
Change / Outcomes

- The Trust were successful in securing partial funding from the Department of Health to implement an innovative midwife led pathway which aims to improve the detection, investigation and management of small-for-gestational-age babies in women who smoke during pregnancy
- The maternity and neonatal services are working together to develop a new Transitional Care ward on Robert Watson Ward.
- A new and innovative weekly support group has been implemented by the Midwifery Safeguarding team. It is aimed at supporting women with a learning disability/difficulty or requiring additional support (Hidden Voices of Maternity

Domain/s - Patient Experience, Effectiveness of Care
Project – Bereavement Service
Change / Outcomes

- As part of the ‘Kings Fund Enhancing the Healing Environment’ project that a team from NGH took part in, a facility was identified to create a dedicated bereavement care service and now forms part of the Trust Patient Advice & Liaison Service (PALS)/Bereavement Service
- Designated an early national ‘Gold Standard Bereavement Service’ pilot site
- Development of the ‘What happens now’ making arrangements following a death information booklet for relatives & next of kin
- Provision of a single central point and dedicated office for medical staff to complete the medical certificate of cause of death (MCCD) and discuss with coroner if required.
- All adult deaths referred to the Service

Domain/s - Patient Experience, Effectiveness of Care
Project – Infection Prevention
Change / Outcomes

- We have achieved an overall reduction of 67% in C.Diff cases since 2009
- Sustained compliance with hand hygiene practices to minimise infection
- SIGHT campaign in January 2016 across trust
- 98.5% compliance with correct antibiotic prescribing procedures
- We have achieved an overall reduction in MRSA bacteraemias since 2009
- Sustained compliance with hand hygiene practices to minimise infection
- Sustained achievement in MRSA screening for both emergency and elective admissions

Domain/s - Patient Experience, Effectiveness of Care
Project – Stroke
Change / Outcomes

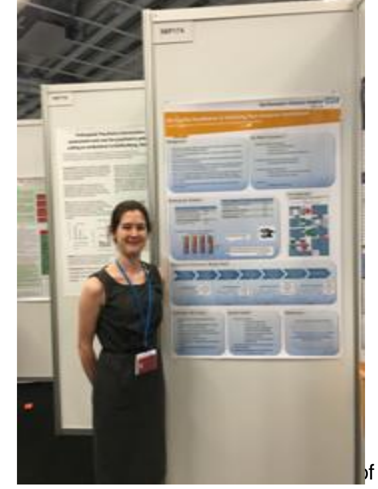
- An exercise group, run in collaboration with the gym's own instructors and personal trainers, was set up after a successful pilot showed that patients made huge physical and psychological gains by attending the group.
- The results show that all patients increased the speed they were able to walk 10 metres with and without a walking aid
- All patients increased the distance they were able to walk in 6 minutes by at least 50 metres
- Our balance assessments show that any patient who attended the group at a medium to high falls risk moved to a low falls risk post completion of the group.
- All participants felt their mood either stayed the same or improved over the course of the 10 weeks and everyone felt that their quality of life, function, confidence and general wellbeing had improved significantly

Domain/s - Patient Experience, Effectiveness of Care
Project – Vascular
Change / Outcomes

- Vascular Nurse Specialist participates on diabetic foot round at KGH
- Nurse led Vascular Clinic at Corby Diagnostic Centre
- Exercise programme for patients with Intermittent Claudication, at Corby Physiotherapy Department Corby Diagnostic Centre

Junior Doctor Safety Board
The Junior Doctor Safety Board 2015/2016 (JDSB) was formed following the new intake of Junior Doctors in August 2015. This year the JDSB is open to both FY1 & FY2 grades. There are currently 20 members all of whom have chosen a project and are being supported through the process by mentors and have received introductory QI & Safety Science taster sessions. During Q4 there was progress demonstrated in the following projects:

- *Confidence and ability of Doctors and Nurses to manage End of Life care* - this project is being undertaken by 1 FY2 and 2 FY1's and reporting into the End of Life Strategy Group. The predominant aim is that by April 2016 the group will a) identify 50% of medical patients as dying prior to death & b) implement a PDPCP (personal dying patient care plan) for 100% of those patients identified to promote optimal palliative care and communication.
    - Poster presentation at Gothenburg International Forum on Quality & Safety April 2016

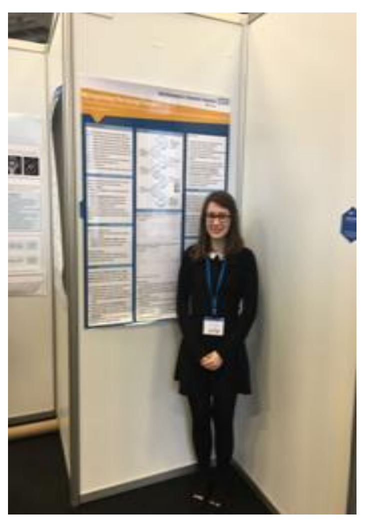


- Accepted for poster presentation at International Forum on Quality & Safety, Singapore September 2016
  - Accepted for Poster presentation at Patient Safety Congress, Manchester 2016
  - Abstract submitted for East Midlands Quality Improvement Forum June 2016

- *Standardisation of clinical equipment rooms (including access codes) on all wards across the hospital* - this project is being undertaken by 1 CT2 and 2 FY1's. At the outset of the project NGH had no standardised access to equipment in treatment rooms leading to time wasted finding access codes, difficulty locating essential equipment and inappropriate selections. The project had undergone a number of PDSA cycles which has led to all juniors having access codes to all wards via Dr Toolbox on their IPad devices and a variety of clearly labelled prepared procedure specific trays containing all the equipment required in one readily accessible compartment.
  - Presented at QGC with agreement to provide an options appraisal for potential rollout
  - Poster presentation at Gothenburg International Forum on Quality & Safety April 2016
  - Accepted for poster presentation at International Forum on Quality & Safety, Singapore September 2016
  - Accepted for presentation at Medical Women's Federation Spring Conference 2016
  - Accepted for Poster presentation at Patient Safety Congress, Manchester 2016
  - Abstract submitted for East Midlands Quality Improvement Forum June 2016
  - Poster WINNERS at Cambridge QI Conference 2015 & NUH Patient Safety Conference 2015 - RUNNER UP

- *Pressure Ulcer Collaborative* - one FY1 is involved with the PU Collaborative with a specific interest in causative factors of tissue damage. The project is a retrospective study of routine blood results in patients who have acquired a pressure ulcer during their inpatient stay at NGH.
  - Presented at the PU collaborative in March 2016
  - Accepted for Poster presentation at Patient Safety Congress, Manchester 2016
  - Abstract submitted for East Midlands Quality Improvement Forum June 2016

- *Managing and Developing Doctor Toolbox (Gatekeeper role)* - Doctor Toolbox is a website and app originally developed by a team of junior Doctors in London. It is now freely available to any NHS Trust. NGH launched the app in October 2014 by a couple of juniors within the auspices of the JDSB. Now the baton changes hands at each August intake to ensure that the system continues to be developed and championed. This work has been presented at four different forums since its launch, most recently:
  - Poster presentation at Gothenburg International Forum on Quality & Safety April 2016
  - Accepted for poster presentation at International Forum on Quality & Safety, Singapore September 2016
  - Accepted for Poster presentation at Patient Safety Congress, Manchester 2016
  - Abstract submitted for East Midlands Quality Improvement Forum June 2016



- *Improving Satisfaction in patients with Learning Disabilities* - this project is being undertaken by 2 FY1's and the LD team at NGH. The project was initially run as part of the BaSIS course and further supported by the JDSB. The aim was to improve the patient experience and increase staff knowledge of the needs of patients with Learning Disabilities.
    - Accepted for Poster presentation at Patient Safety Congress, Manchester 2016
    - Abstract submitted for East Midlands Quality Improvement Forum June 2016

- *Improving Documentation for Rapid Tranquilisation* - following a serious incident (SI) which involved a patient having inappropriate rapid tranquilisation (RT), one of our current FY1's found that there was no appropriate documentation for the pathway of RT. The numbers for the project are small hence this piece of work is still ongoing, however it is believed that the introduction of a proforma will highlight the areas to focus on with regards to RT, appropriate escalation if required and make it easier to trace which patients have received RT.
    - Accepted for Poster presentation at Patient Safety Congress, Manchester 2016
    - Abstract submitted for East Midlands Quality Improvement Forum June 2016

- *Falls* - Effectiveness of the Assessment Form - project being undertaken by an FY1 supported by Dr Shah and the fall's team. The aim is to revise the current proforma and promote the use of an eLearning package 'CareFall'. The project has been presented at the Falls Steering group twice and is still ongoing.

- *Aiming for Excellence in initiating Non Invasive Ventilation* - this project is being led by two FY2 Doctors supported by two respiratory Consultants with additional support of the JDSB. Anecdotal evidence and experience of these Doctors demonstrated that there was poor adherence to the guidelines, inappropriate use of NIV, poor understanding of the process and poor documentation. This can result in longer patient stays, delays in care and poorer outcomes.
    - Poster presentation at Gothenburg International Forum on Quality & Safety April 2016
    - Accepted for poster presentation at International Forum on Quality & Safety, Singapore September 2016
    - Abstract submitted for East Midlands Quality Improvement Forum June 2016

Projects previously undertaken and presented at other forums during Q4

- *Serious Incidents & Never Events, a technique to improve dissemination of information and learning points* – This project was run as part of the Registrar Management & Leadership course in 2015. Presented and shortlisted at the Patient Safety Congress for July 2016 at the East Midlands Quality Improvement Forum for June 2016.
- *Improvement of service provision through introduction of Gynaecology Emergency bags at Northampton General Hospital* – This project was run also as part of the Registrar course in 2015 and was a joint winner. Presented and shortlisted at the

Patient Safety Congress for July 2016 at the East Midlands Quality Improvement Forum for June 2016.
- *Aspiring to Excellence in Hospital Diabetes Care* – This project was run by the Aspiring to Excellence Medical students from 2015 cohort and won a prize for their work when presented at the NGH QI day in November 2015. This work was presented via poster presentation at the International Forum on Quality & Safety in Gothenburg in April 2016.

General Areas of Improvement

Additional Parking - The staff car park has been radically overhauled with the addition of a one-storey structure laid on top of current spaces in car park 1. This has enabled additional spaces to be available for our patients and visitors.

Outpatient Pharmacy - A new outpatient pharmacy was opened in June 2015, operated by Boots in collaboration with our existing pharmacy service. This has allowed our own highly-skilled pharmacy staff to prioritise their ward-based work.

Blood Taking Unit - Our blood taking unit has moved to new larger premises and extended its opening hours to provide an improved service for patients.

Closer Links with the University of Northampton - Northampton – NGH and the University of Northampton have initiated a programme of collaborative working, which has already yielded joint research projects. This work culminated in the signing of a memorandum of understanding between the two organisations who have both agreed to continue to work more closely together to further improve the care of hospital patients and the wellbeing of local people

The memorandum of Understanding was signed by Dr Sonia Swart, NGH chief executive and Professor Nick Petford, vice chancellor of the University of Northampton

Capital Projects - During the past 12 months the Trust has undertaken a number of capital projects which have improved the quality of the environment in which patients are treated as well as improving the facilities available for staff. These projects are part of an ongoing estate improvement strategy and have included:
- Development of a new Discharge Suite for patients awaiting transport from the hospital once discharged.
- Creation of a new Blood Taking Unit that incorporates an additional waiting area, cubicles, dedicated children’s facilities, toilets and reception.

- Installation of an additional, ‘state of the art’ Linear Accelerator in the Oncology Centre.
- Total refurbishment and expansion of Gosset Special Care baby Unit.
- Refurbishment and installation of new X-Ray equipment in the Radiology Department.
- Creation of a new ambulatory care centre (below) and clinical observation area for the A&E department

IMPLEMENTING DUTY OF CANDOUR

The introduction of the CQC Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust 1, which recommended that a statutory duty of candour be introduced for health and care providers.

To meet the requirements of Regulation 20, the Trust has to:

- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of our knowledge, is true of all the facts we know about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.
- Offer an apology.
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person.

As a Trust a significant amount of work has been undertaken to ensure we are compliant with the statutory and contractual requirements. Duty of candour training has been included in all the incident reporting/investigating and root cause analysis training given to staff.

The Trust's Clinical Risk Manager has attended departmental, directorate and divisional meetings to talk through the process with the clinicians and ensure they are aware of the expectations and their own responsibilities.

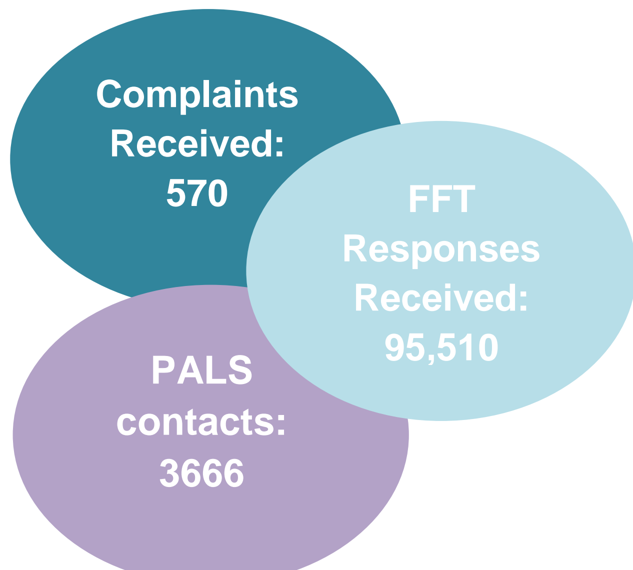
Since the introduction of the regulation, the Governance Team have audited compliance that all patients/relevant person(s) who have been involved in an incident which has resulted in moderate harm or above have received an apology.

The Trust then sends a letter following the verbal apology to the patient/relevant person(s) with the outcome of the investigation.

From feedback received from the clinicians a crib sheet/sticker was requested to support them in ensuring the correct information is documented when they make an apology. The use of the stickers will be implemented in May 2016.

LEARNING FROM PATIENT FEEDBACK

(ENCOMPASSING THE FRIENDS & FAMILY TEST, COMPLAINTS & PALS)



Complaints Performance 2015/2016

100%	Percentage of complaints acknowledged within 3 working days
90%	Percentage of responses provided to complainant by agreed deadline

Complaints Performance 2014/2015

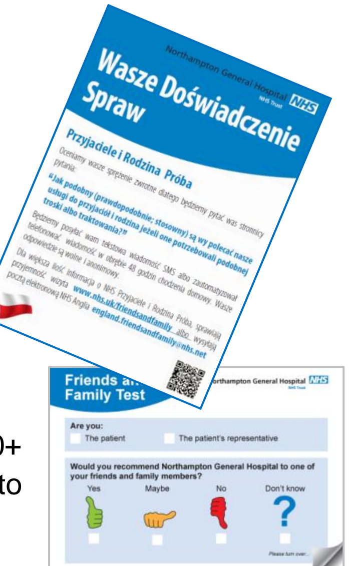
100%	Percentage of complaints acknowledged within 3 working days
Ave 81%	Percentage of responses provided to complainant by agreed deadline

What are our patient's main concerns?
The following Word Cloud has been produced from the Complaints and Friends & Family Test subjects most used throughout 15/16 Q4.

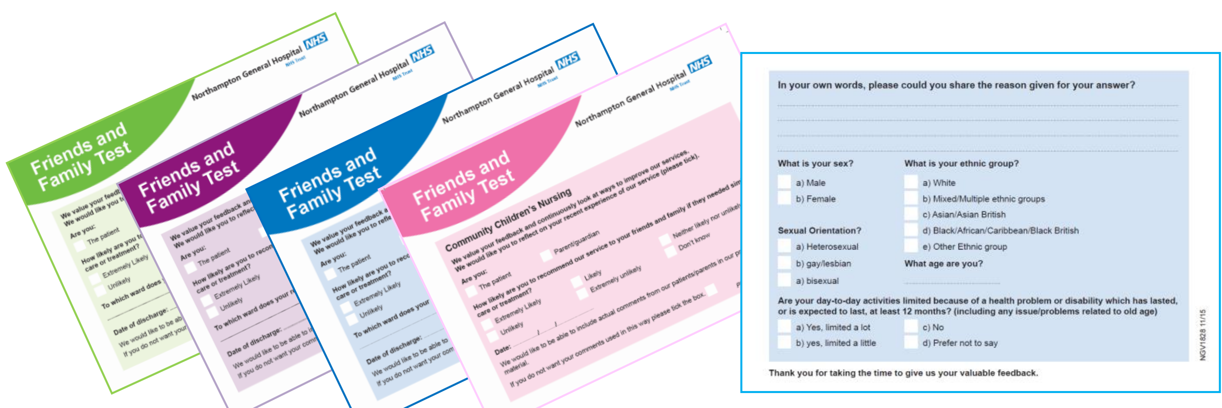
The Friends & Family Test

The Patient Experience teams within NGH spend time collating information that is received about the services that we provide, from our patients. Feedback may be received through a number of different sources including complaints, concerns, patient stories, friends and family test and surveys which may be completed during or after a patient's admission. All of this information provides the Trust with vital intelligence as to how we may improve our services.

The Friends & Family test, which is used across the NHS, is an excellent source of information for the Trust to obtain feedback by answering simple questions about the patients experience whilst they have been attending or admitted to hospital. In 2015 the methods used to collect the Friends & Family Test were expanded from collecting through SMS Text messaging and Interactive Voice Messaging, to ensure inclusivity to all patients. This includes;



- ➢ Multiple language posters giving a web link to an online survey in the patients preferred language
- ➢ A bespoke children's survey to ensure feedback is collected from children as well as parents/guardians
- ➢ The development of a suite of postcards and installation of 70+ post-boxes throughout the hospital including questions relating to equality and diversity
- ➢ Creation of an easy read FFT postcard

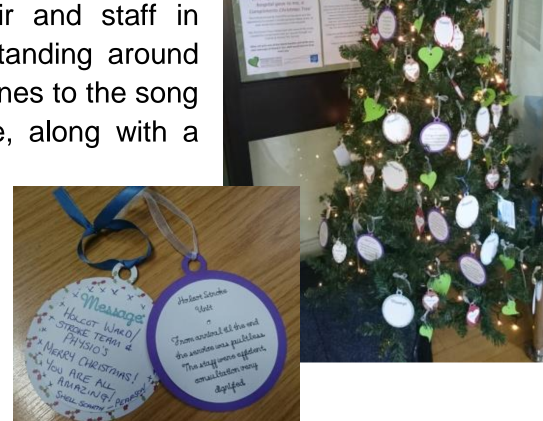


Northampton General Hospital's inclusivity has been recognised by NHS England who shortlisted the hospital for an award at the Insight Awards in March 2016.

To support the changes to the FFT, throughout December 2015 the FFT was relaunched to both the hospital and the public. As part of the relaunch, 2 Compliments Trees, funded by Northamptonshire Health Charitable Funds, were put up in the hospital displaying positive comments from the FFT responses. In addition to this, members of the public were able to

give their own compliments by writing on blank baubles. The completed baubles have been shared with the teams throughout the hospital.

In addition to this, in order to showcase some of the exciting changes that have been made throughout the hospital as a result of patient feedback, the hospital created a video of 10 improvements to the tune of ‘the 12 days of Christmas’. The track was sung by a combination of the NGH Choir and staff in Northamptonshire Health Charitable Funds, all standing around the Compliments Christmas Tree. Each of the 10 lines to the song features the improvement which has been made, along with a number of the hospitals staff. Through YouTube the video has had 160 views; however the real success was through uploading the video to Facebook. To date, the video has been viewed by over 5000 people. Many people commented on the video, including both staff and patients. Here are just some of the many wonderful comments;



‘You guys are awesome just brilliant, wishing everyone at Northampton General a very Happy Christmas and a massive Thank you for all you do. Well done everyone!’

Triangulating Feedback

Patients are able to provide their feedback to the hospital in a number of different ways including the Friends & Family Test, PALS, Complaints, Online Reviews and Social Media sites. Each of these different sources provides a wealth of information regarding the patient’s experience. To ensure the areas where patients are voicing dissatisfaction, are identified correctly, the feedback from all of these sources is triangulated quarterly. This includes;

- Combined reporting structure incorporating Complaints & Concerns produced on a quarterly basis and presented to the Trust’s Quality Governance Committee
- Introduction of a complaints survey and covering letter to obtain feedback in order to continuously improve the complaints service and the way in which complaints are handled across the Trust
- Data from Patient Experience, Complaints and PALS is themed and compared to identify commonalities and areas for improvement based upon patient experience across the organisation
- ECCLIPSS (Experience, Complaints, CCG, Legislation, PALS, Safeguarding and [Nursing] Standards) meetings held quarterly to discuss triangulation data and identify clinical areas in which to undertake an internal QuEST inspection.

The table below provides an example of the triangulated themes from 15/16 Q3.

Area	Primary Theme
Complaints	Clinical Treatment

	Communication
	Cancellations
FFT	Waiting Times
	Communication
	Care (Medical & Nursing)
PALS Concerns	Communication
	Delays
	Care (Medical & Nursing)
Online Reviews	Communication
	Care (Medical & Nursing)

Improvement Projects

Outpatient

One of the most commonly identified problem areas in Outpatients is waiting times. The Outpatient Project, managed by the Improving Quality & Efficiency team, is focusing its improvements around waiting times, within the areas that have been identified within the patient experience triangulated data as detailed previously.

Next Steps: The project was identified in 15/16 and will continue to run in 16/17. All KPI's and progress will be monitored through feedback during the next financial year.

Do it for Dementia

The Do it for Dementia (DIFD) fundraising campaign had an active year within 15/16. The main focus for this year was around identifying where expenditure would take place and fundraising. The Tea Dance held in September at Sedgebrook Hall was the main event held for the year. Everything for the day was donated by generous people and businesses throughout Northampton. The event raised £1400.

The first piece of reminiscence equipment was purchased with the money raised. The My Life equipment includes a large portable computer and a tablet. The software contains video clips, pictures, and music bites which can be played with our dementia patients within the hospital. To support the use of the software on the wards, a number of volunteers have

been trained to use the computers with our patients with dementia.

At the end of 15/16 the campaign had raised a total of **£13,591**.

Next Steps: The DIFD campaign will be taken over by Northamptonshire Health Charitable Funds during 16/17 with the aims of the campaign directly reflecting and supporting those of the strategic aims of the organisation.

NHS STAFF SURVEY

The 2015 annual National NHS Staff Survey took place during September to November 2015. A total of 4676 surveys were sent directly to all staff and 1442 members of staff returned the survey.

Of the 32 key findings this year there has been improvement in 9, no deteriorations, 13 have stayed the same and 10 could not be compared. This is again an overall improvement and continues our positive trend of improvement over the last 3 years.

The Trust has statistically improved since 2014 in:

- Overall Staff Engagement
- Staff recommendation of the organisation as a place to work or receive treatment
- Support from immediate managers
- % appraised in the last 12 months
- % feeling pressure in last 3 months to attend work when feeling unwell
- % experiencing physical violence from staff in last 12 months
- % experiencing harassment, bullying, abuse from patients, relatives or the public in the last 12 months
- % experiencing discrimination at work in the last 12 months
- % witnessing potentially harmful errors, near misses or incidents in the last month
- Staff confidence & security in reporting unsafe clinical practice

The Trust was in the top 20% for Acute Trusts in:

- % appraised in last 12 months

The Trust was above average for Acute Trusts in

- Effective team working
- % experiencing discrimination at work in the last 12 months

Key areas for improvement when comparing us to other trusts:

- Staff satisfaction with resourcing and support
- Staff satisfaction with the opportunities for flexible working patterns
- Staff experiencing physical violence from patients
- Organisation and management interest in and action on health and wellbeing
- Staff witnessing potentially harmful errors, near misses or incidents

Work is already underway on these however we are aware that a number of these areas are influenced by pressure in the system, particularly in relation to increasing urgent care

workload and acuity, compounded by national staff shortages in key areas such as doctors and nursing staff, which undoubtedly impacts on staff. We are actively recruiting new staff and providing support to staff to help them to cope with the day to day pressures they face in an ever increasingly challenging environment in which to provide high quality care.

Staffs most positive perceptions

- Staff are trusted to do their job
- Staff agree that their role makes a difference to patients and service users
- Staff know how to report concerns about unsafe clinical practice and the organisation encourages reporting of incidents
- Staff have received mandatory training in the last 12 months
- Staff have had an appraisal in the last 12 months
- Staff agree that they always know what their work responsibilities are
- The organisation takes positive action on health and wellbeing
- The organisation is fair with regards to career progression and promotion
- Staff agree that training has helped them to stay up-to-date with professional requirements
- Staff agreed that their manager has supported them to access training, learning or development

We recognise that overall the survey shows improvement however it highlights some areas of concern and the Trust continues to work to improve the results, through the work of its Organisational Development Team and the Improving Quality and Efficiency Team to bring about a fundamental shift in culture, where everyone is focused on quality, continuous improvement and meaningful staff engagement to sustainably improve staff satisfaction at work.

National Inpatient Survey

The national inpatient survey is an annual, mandatory requirement from CQC to ascertain how patients are experiencing the services provided across the country. It acts as mechanism for comparisons between:

1. Score obtained in previous years, enabling the tracking of local progress
2. Scores obtained in comparison to national data from other organisations

Improvements have been made within 29 questions since 2014, with 3 questions scoring statistically significantly better;

- Q9 From time you arrived, did you feel long wait to get a bed on a ward?
- Q24 For important questions, did doctors answer in an understandable way?
- Q25 Did you have confidence and trust in the doctors treating you?

Depreciation in scores have been seen in 25 questions, 5 of which scored statistically significantly worse in 2015 than in 2014;

- Q59 Before leaving, were you given written or printed discharge information?
- Q64 Were you told about any danger signals to watch for when you went home?
- Q66 Did doctors/nurses give family/friend all information needed to help care for you?

- Q73 During your stay, were you ever asked views on quality of care?
- Q74 Did you see/were you given any information explaining how to complain about care received?

When comparing the Trusts results with the national averages, the Trust performed ‘Better than the national average for 1 question. This is the first time in a number of years that the Trust has obtained a ‘better’ rating.

- Q8 Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?

The Trust performed within the ‘Worse’ nationally category for 7 questions;

- Q15 Were you ever bothered by noise at night from other patients?
- Q16 Were you ever bothered by noise at night from hospital staff?
- Q23 Did you get enough help from staff to eat your meals?
- Q59 Were you given any written or printed information about what you should or should not do after leaving hospital?
- Q61 Did a member of staff tell you about medication side effects to watch for when you went home?
- Q73 During your hospital stay, were you ever asked to give view on the quality of your care?
- Q74 Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

Immediate action will be taken to address some of these areas, these are as follows;

- Redesign and launch of the 4C’s process, displaying throughout the hospital how patients can raise a complaint, concern, compliment or comment
- Initiation of medication side effect reminders for patients to be included within TTO bags
- Potential initiation of a pharmacy helpline for patients looking for guidance on their medication side effects
- Inclusion of information within Pre-Op assessment packs for patients
- Information for patients available within the discharge lounge

In addition to this, the information gained through the survey has been shared with the Associate Directors of Nursing for each Division to ensure the results are localised and shared within the division.

CARE QUALITY COMMISSION

The Trust is registered with the Care Quality Commission under the Health and Social Care Act 2008. The CQC are the independent health and adult social care regulator. Their job is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care. They do this by monitoring, inspecting and regulating services to make sure they meet fundamental standards of quality and safety.

NGH currently has no conditions attached to registration and has not been required to take part in any special reviews or investigations under section 48 of the Health and Social Care Act 2008.

All NHS organisations that are obliged to publish Quality Accounts or equivalent should include in them quantitative and qualitative data describing the number of formally reported concerns in addition to incident reports, the action taken in respect of them and feedback on the outcome.

The Trusts CQC grid below shows the outcome of CQC inspections where numerous areas were categorised as “Good”. Actions are ongoing to address those areas identified as “Requiring Improvement” or “Inadequate”.

Last rated
27 March 2014

Northampton General Hospital NHS Trust

Are services

Safe?	Requires improvement
Effective?	Requires improvement
Caring?	Good
Responsive?	Requires improvement
Well led?	Requires improvement

The Care Quality Commission is the independent regulator of health and social care in England. You can read our inspection report at www.cqc.org.uk/provider/RNS

We would like to hear about your experience of the care you have received, whether good or bad.

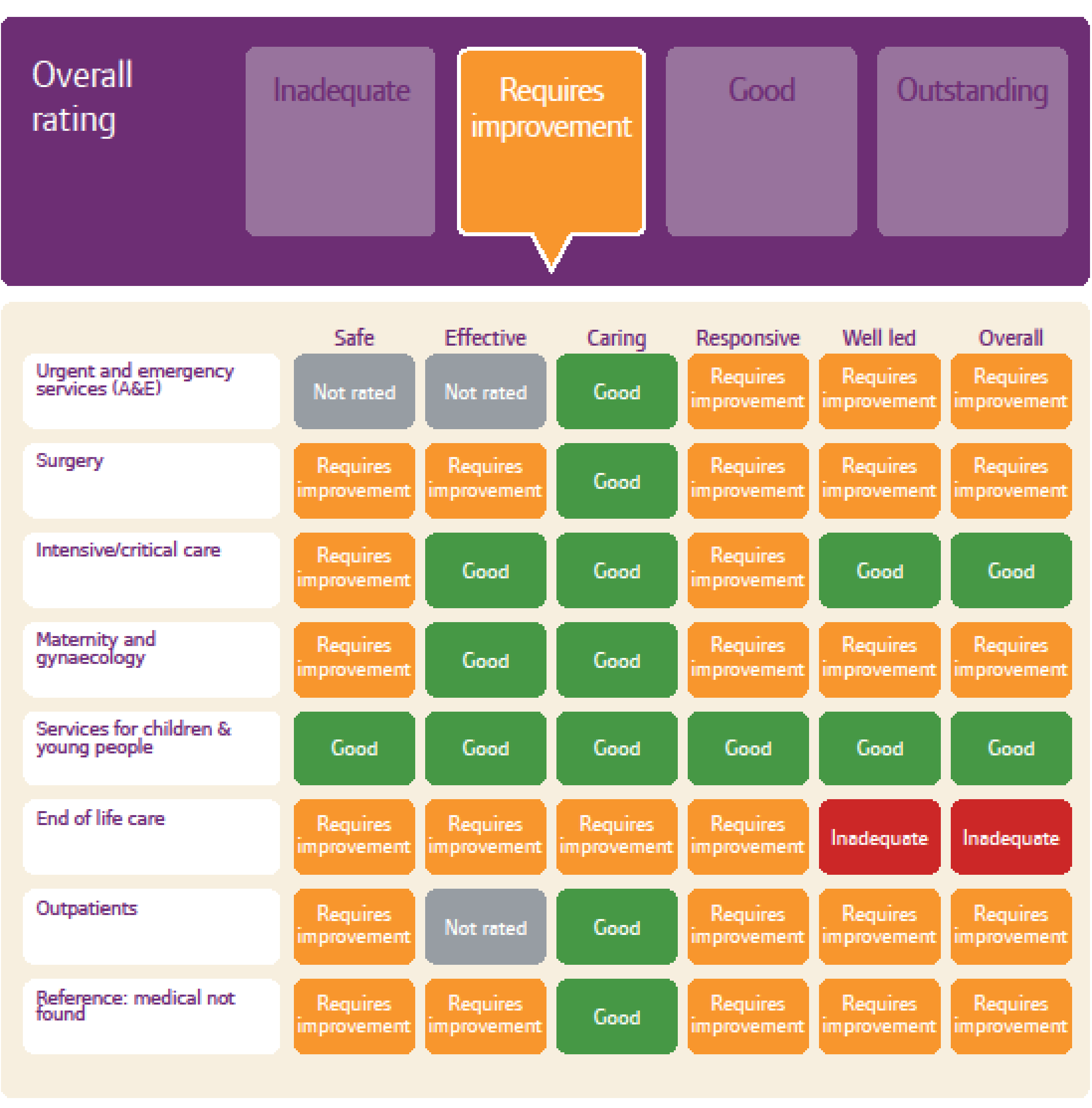
Call us on 03000 61 61 61, e-mail enquiries@cqc.org.uk, or go to www.cqc.org.uk/share-your-experience-finder

Find out what we have changed since we received this rating from CQC:

Last rated
23 June 2015

Northampton General Hospital NHS Trust

Northampton General Hospital



Overall rating: Inadequate | **Requires improvement** | Good | Outstanding

	Safe	Effective	Caring	Responsive	Well led	Overall
Urgent and emergency services (A&E)	Not rated	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Intensive/critical care	Requires improvement	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Services for children & young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Reference: medical not found	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

SECTION FIVE

NATIONAL CLINICAL AUDIT AND CONFIDENTIAL ENQUIRIES

Participation in National Clinical Audits and National Confidential Enquiries continues to be a high priority and during 2015/16, Northampton General Hospital aimed to participate in all relevant projects included in the Quality Account list.

The Quality Account list includes a variety of different topics and ways of collecting data. Some of the projects collect data for a short period of time (snapshot audits) and others collect data continually on the management of certain conditions. Some of the larger projects have developed to include several different work streams for example questions about the structure of the service provided (organisational questionnaires), questions about the process of individual patient care (case note reviews) and questions about the patient experience (patient questionnaires). NGH has achieved a very high level of participation with the only exceptions being the Core Audit of the National Diabetes Audit and the National Ophthalmology Audit (Data has not been entered to these due to IT issues that is being addressed to). The following table gives details of all Quality Account audits and confidential enquiries to which Northampton General Hospital submitted data in 2015/16. Percentage participation is included for snapshot audits. For audits that collect data on a continual basis, the local percentage participation and data quality are reviewed when reports are published and plans made for improvement if needed.

Name of Audit	Participated Y/N	Percentage Participation
Perinatal Mortality (MBRRACE)	Y	Data collection ongoing
National Neonatal Audit Programme (NNAP)	Y	Data collection ongoing
Paediatric asthma (British Thoracic Society)	Y	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	Y	Data collection ongoing
Emergency use of Oxygen (British Thoracic Society)	Y	100%
UK Cystic Fibrosis	Y	Data collection ongoing
Chronic Obstructive Pulmonary Rehabilitation (British Thoracic Society)	Y	100%
Cardiac Arrest (National Cardiac Arrest Audit)	Y	Data collection ongoing
Adult Critical Care (Case Mix Programme)	Y	Data collection ongoing
National Emergency Laparotomy Audit (NELA)	Y	Year 2 – 100% Year 3 – Data collection ongoing

Diabetes (National Adult Diabetes Audit)	Y/N	Core Audit – No data entered
		National Pregnancy in Diabetes - Data collection ongoing
		Foot Care Audit – Year 2 data collection ongoing
		Inpatient Audit – 100%
Rheumatoid and Early Inflammatory Arthritis	Y	65% (Estimate)
UK IBD Audit (Biologics)	Y	Data collection ongoing
Hip, knee and ankle replacements (National Joint Registry)	Y	Data collection ongoing
Elective Surgery (National PROMS Programme)	Y	Data collection ongoing
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Y	Data collection ongoing
National Vascular Registry	Y	Data collection ongoing
Procedural sedation in adults (CEM)	Y	100%
Vital Signs (CEM)	Y	100%
VTE risk in lower limb immobilisation(CEM)	Y	100%
Acute Myocardial Infarction and other ACS (MINAP)	Y	Data collection ongoing
Heart Failure Audit	Y	Data collection ongoing
Stroke National Audit Programme (SSNAP)	Y	Data collection ongoing
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Y	Data collection ongoing
Renal Replacement Therapy (Renal Registry)	Y	Data collection ongoing
Lung Cancer (National Lung Cancer Audit)	Y	Data collection ongoing
Bowel Cancer (National Bowel Cancer Audit Programme)	Y	Data collection ongoing
Prostate Cancer Audit	Y	Data collection ongoing
Oesophago-gastric Cancer (National O-G Cancer Audit)	Y	Data collection ongoing
Falls and Fragility Fracture Programme (Include National Hip Fracture Database	Y	NHFD - Data collection ongoing
		Inpatient Falls – 100%
		FLSDB Organisational Audit
Severe Trauma	Y	87%
National Ophthalmology	N	no data entered
UK Parkinson's Audit	Y	100%

National Confidential Enquiries (NCEPOD)	Y	Mental Health in Acute Hospitals – 100%
		Non-invasive Ventilation (early stages – patient

		identification spreadsheet submitted)
		Acute Pancreatitis – 100%
National Audit of Blood Transfusion – Audit of Red Cell and Platelet Transfusion in Haematology	Y	100%
National Audit of Blood Transfusion – Lower GI Bleeding and the Use of Blood	Y	100%

The number of national clinical audit reports published during the reporting period that were reviewed by the provider during the reporting period was 15. National reports (including hospital specific and individual consultant specific results where appropriate) are published at varying intervals. Most audits will report annually but some provide more frequent updates. The audit department monitors the publication of reports and shares them with the clinical leads. The clinical leads are asked to review the report and recommendations, share the findings with their colleagues and assess the need for changes to their practice. The recommendations made are wide ranging and some examples of changes that have been made following the review of national audit recommendations are given below.

- Clinical effectiveness
  - Review of the use of antibiotics in patients with pneumonia with a focus on increasing the number of patients who receive combination therapy when needed.
  - Review of screening (retinopathy of prematurity) for eligible babies and a change in the frequency with which Ophthalmologists visit Gosset Ward.
- Patient Safety
  - Development of a Board Level Falls Steering Group.
  - Organisation of “Protected Team Time” for the Paediatric Diabetes Team to improve the co-ordination of care.
  - Review of intubation protocol for neonates.
  - Development of a “seizure tray” for paediatric patients presenting to the Emergency Department following a seizure to ensure that treatment is in line with national guidance.
  - Development of care pathway for patients undergoing emergency laparotomy.
- Patient experience
  - Review of patient pathway to reduce the time to chest X-ray in patients with suspected pneumonia.
  - Review of the scheduling of theatre lists to improve access to theatre for patients requiring a total hip replacement following a fractured neck of femur.
- Service Improvement
  - Trust wide Quality Improvement Project for the measurement of lying and standing blood pressure as part of the approach to the management of falls.
  - Development of a dedicated clinic to monitor 2 year neurodevelopmental outcomes of babies on Gosset Ward.
- Communication
  - Revision of electronic communication between the Emergency Department and General Practitioners to include information about the patient’s cognitive state where appropriate.
  - Development of an information leaflet for carers of patients with cognitive impairment who present to the Emergency Department.

- Data quality and documentation
  - Using the recently published report from the National Prostate Cancer Audit to continue to identify areas where the quality of data entered can be improved further.
  - Creating regular time slots to capture data for the National Neonatal Audit Programme to improve data quality.
  - Local audit to improve the documentation of mental health issues and Mental State Examination in Emergency Department patients.
- Resources
  - The building of a dedicated assessment room in the Emergency Department for patients presenting with mental health conditions.
- Recruitment of Staff
  - Appointment of an additional staff member to the Falls Team.
  - Appointment of an additional Paediatric Diabetes Nurse Specialist.

LOCAL CLINICAL AUDIT

87 local clinical audits including 17 specifically against NICE guidance were registered in 2015/16. Some examples are outlined below together with actions arising to improve clinical quality, patient experience and patient safety. All leads are required to complete a registration form and are offered help and advice with planning their clinical audit and implementing changes as a result. All registered audits completed by October 15 were eligible for entry to the Trust Quality Improvement Day where the following two audits were presented:

- Audit to assess care for patients admitted with Parkinson's Disease in NGH (including compliance with NICE CG35)
  - Action Plan
  - Develop a flagging system to alert all patients admitted with Parkinson's disease in NGH.
  - Education of all ward staff and patients based on Get It on Time campaign.
  - Develop in-patient pathway and Nil by Mouth guidance for patients admitted with Parkinson's disease.

- Intravenous Cyclophosphamide: prescription and monitoring of intravenous cyclophosphamide in Rheumatology
  - Aims
  - To establish that intravenous cyclophosphamide is used by the Rheumatology department according to regional guidelines (as agreed by EMRAN).
  - Identify any areas that can be improved to raise patient safety.
  - Objectives:
  - Are we adhering to all aspects of the cyclophosphamide administration guidelines, post cyclophosphamide monitoring and care
  - Establish the type and frequency of infections and other adverse events occurred in this patient population

Local action plan implementation is part of the Trusts Divisional arrangements. DCASE inform the local divisional and/or directorate governance committee of registered audits and require evidence of action plan / improvement from clinical leads.

PARTICIPATION IN CLINICAL RESEARCH

The number of patients receiving NHS services provided by Northampton General Hospital NHS Trust from April 2015 to March 2016 that were recruited during that period to participate in research approved by a research ethics committee was around 1000. To date 658 have recruited to 58 studies on the National Institute of Health Research portfolio within this financial year.

Participation in clinical research demonstrates NGH's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research contributes to successful patient outcomes.

We have demonstrated our engagement with the National Institute for Health Research (NIHR) by participating in many clinical trials, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. Our engagement with clinical research also demonstrates NGH's commitment to testing and offering the latest medical treatments and techniques to our patients.

COMMISSIONING FOR QUALITY AND INNOVATION

NHS Nene and NHS Corby Clinical Commissioning Groups are NGHs main commissioners. We receive part of our income from them through an agreed CQUIN scheme where prior to the start of the financial year negotiations take place to agree specialist projects which bring

about innovative quality improvement for our patients. Our CQUIN agreements with them are both local agreements and part of a national agenda.

In 2015/16 NGH agreed six local CQUINs and four national CQUINs. NGH also have secondary commissioners known as Specialised Commissioners who are Leicester and Lincolnshire Area Team, NHS England. In 2015/16 NGH agreed seven specialist CQUINs.

TYPE	CQUIN INDICATOR NAME	Q1	Q2	Q3	Q4
LOCAL	Electronic Holistic Needs Assessment and Care Planning				
	AMBER Care Bundle				
	Heart Failure Rehabilitation				
	Heart Failure – single point of access				
	Psychological Support in Stroke Care				
	Improving delivery of Speech and Language therapy to Stroke patients at NGH				
NATIONAL	Acute Kidney Injury				
	Sepsis Screening				
	Sepsis Antibiotic Administration				
	Dementia and Delirium - Find, Assess, Investigate Refer and Inform				
	Dementia and Delirium - Staff Training				
	Dementia and Delirium - Supporting Carers				
	Reducing the proportion of avoidable emergency admissions to hospital				
SPECIALIST	Eligible patients receiving a NICE DG10 compliant test with provision of monitoring data				
	Vascular services Quality improvement programme for outcomes of major lower limb amputation				
	Multi-system auto-immune rheumatic diseases network				
	To reduce delayed discharges from ICU to ward level care by improving bed management in wards				
	2 Year outcomes for infants <30 weeks gestation				
	Standardising the Children's Cancer MDT decision making process				
	Neonatal Critical Care – Reducing Clinical Variation and Identifying Service Improvement Requirements by ensuring data completeness in the 4 NNAP Audit Questions identified				

For 2016/17, NGH have agreed with NHS Nene and NHS Corby Clinical Commissioning Groups five local CQUINs and three national CQUINs. NGH have also agreed three specialist CQUINs with NHS England.

TYPE	CQUIN INDICATOR NAME
LOCAL	Delayed Transfers of Care
	End of Life Care Pathways

	Dementia: John's Campaign
	Dementia Discharge Summaries
	Acute Kidney Injury
NATIONAL	NHS Staff Health and Wellbeing - Introduction of health and wellbeing initiatives - Healthy food for NHS staff, visitors and patients - Improving the uptake of flu vaccinations for front line staff within Providers
	Timely identification and treatment of Sepsis - Timely identification and treatment for sepsis in emergency departments - Timely identification and treatment for sepsis in acute inpatient settings
	Antimicrobial Resistance and Antimicrobial Stewardship - Reduction in antibiotic consumption per 1,000 admissions - Empiric review of antibiotic prescriptions
SPECIALIST	Pre-term Babies Hypothermia Prevention
	Two year follow up assessment for very preterm babies
	Multi-system Auto-immune Rheumatic Diseases MDT Clinics, Data Collection and Policy Compliance

LOCAL QUALITY REQUIREMENTS

The NHS Standard Contract contains quality requirements where NGH is required to report against certain indicators on a periodic basis. The quality requirements are set out in Schedule 4 of the NHS Contract and are collectively known as the Quality Schedule. They are split into six quality sections which include Operational Standards and National Quality Requirements. They also include Local Quality Requirements which are agreed locally with our commissioners and are derived from a variety of sources.

We report to our commissioners quarterly on all the relevant local quality requirements submitting evidence and demonstrating where we meet the requirements.

Quality Requirement for 2016/17
End of Life care
Patient Safety
Learning
Quality Care for Patients with a Learning Disability
Patient Experience
Nutrition and Hydration
WHO Surgical Checklist
National Early Warning Score
Safeguarding
Workforce
VTE

Pressure Tissue Damage
Service Specifications
Quality Assurance regarding any trust sub-contracted services (list of services to be provided by the trust)

SECTION SIX

NHS NUMBER AND GENERAL MEDICAL PRACTICE CODE VALIDITY

The trust submitted records between April 2015 and January 2016 to the Secondary Users service for inclusion in the Hospital Episode Statistics which are included in the latest published data as below and compared to the previous year's results.

Period - Apr15 to Jan16	Valid NHS Number	Valid GMPC
Inpatients	99.6%	100%
Outpatients	99.9%	99.9%
A&E	98.1%	98.8%

Period – Apr 14 to Jan 15	Valid NHS Number	Valid GMPC
Inpatients	99.7%	100%
Outpatients	99.9%	100%
A&E	97.2%	99.2%

Comparison	Valid NHS Number	Valid GMPC
Inpatients	-0.1%	0.0%
Outpatients	0.0%	-0.1%
A&E	+0.9%	-0.4%

INFORMATION GOVERNANCE TOOLKIT

The Information Governance Toolkit version 13 was completed and submitted on 31 March 2016 with an overall score of 81% and a return of 'Satisfactory'

For version 12 (2014/15) submission, the potential issue raised was the lack of a robust risk assessment processes embedded in our information risk management framework. The Information Governance team developed a risk assessment checklist to enable the Trust's Information Asset Owners (IAOs), carry out appropriate risk assessment for the different systems under their remit. This enabled the Trust to have adequate assurance not just on potential risk but increased the robustness of our information mapping (data flows) and our information asset register.

As with all risk management programmes; this is an ongoing programme, dispatched in phases to ensure all information systems within the Trust are assessed annually.

There remain 2 main areas which have seen significant improvement but have not attained the Trust's target. These are:

- 112 Information Governance Mandatory Training – the Trust is required to achieve 95% staff compliance in information governance training within a year's cycle. This has been a continuous struggle to achieve however; the information governance

team will be implementing new initiatives to improve the Trust's compliance figures. The final training figure at submission is up by 12.6% from the previous year (2015)

- 300's Information Security Assurance - further work is required to ensure that our processes are robust and are adequately maintained in identifying and managing risks. The Trust has developed an Information Asset Register with detailed system risk assessments and Information Asset Owners. Annual information governance training for Information Asset Owners will be implemented as part of the information governance specific training needs analysis.

  The Registration Authority (RA) process will be fully reviewed in line with the requirements of the IG toolkit.

An action plan, work schedule and a comprehensive confidentiality/information governance audit programme have been developed for a more proactive and robust approach to the Information Governance Toolkit, with particular attention paid to the above areas. This will be monitored through the Information Governance Group chaired by the Director of Corporate Development Governance and Assurance (the Senior Information Risk Owner- SIRO) with regular reports to the Assurance, Risk and Compliance Group.

CLINICAL CODING ERROR RATE

Objective/Method
To assess Northampton General Hospital NHS Trust Women's, Children's and Oncology coding performance against recommended achievement levels for Information Governance Toolkit Requirement 505. Exactly 200 episodes were audited using the NHS Classification Service Clinical Coding Audit Methodology Version 9.0.

NGH was not subject to a Payment by Results clinical coding audit by the Audit Commission at any time during the reporting period.

Results

	% Accuracy	IG Level 2 Requirements	IG Level 3 Requirements
Primary Diagnosis	94.00%	90.00%	95.00%
Secondary Diagnoses	88.31%	80.00%	90.00%
Primary Procedure	92.05%	90.00%	95.00%
Secondary Procedures	90.99%	80.00%	90.00%

Conclusions
The results met all of the requirements to achieve an Information Governance Level 2 rating.

The majority of errors in both the diagnostic and procedural coding were not repeated and were related to incorrect indexing or potentially lack of indexing fully. There were repeated errors around meconium in new-borns and the omission of gestational age as a subsidiary code.

As with previous audits, the highest source of error came from missed comorbidities or significant additional clinical problems. The ward based extraction may be a contributing factor here and this should be reviewed in the lead up to the implementation of HRG4+ and the altered complication and comorbidity structure.

There were a high number of unspecified ventouse and forceps deliveries coded and though no errors were attributed here, consideration should be given to improving the specificity of these codes.

Recommendations

- To develop an information report that highlights OPCS codes requiring an additional code of Y95 where it is not present.
  Timescale for completion: 1 month

- To undertake some work with midwives in order to better record the level of mid and low forceps/ventouse deliveries within the case notes.
  Timescale for completion: 3 months

- To review ward based coding and the potential for missed comorbidities leading into the new HRG4+ tariff.
  Timescale for completion: 5 months

CORE QUALITY INDICATORS

In 2009, the Department of Health established the National Quality Board bringing the DH, the CQC, Monitor, the National Institute for Health and Clinical Excellence and the National Patients Safety Agency together to look at the risk and opportunities for quality and safety across the whole health system. The National Quality Board requires reporting against a small, core set of quality indicators for the reporting period, aligned with the NHS Outcomes Framework.

Performance data for NGH is included together with the NGH data from the 2014/15 Quality Account. Where available, data has been provided showing the national average as well as the highest and lowest performance for benchmarking purposes. All information for the reporting period has been taken from the Health and Social Care Information Centre and the links provided therein.

NHS Outcomes Framework Domain	NGH Performance		National Performance		
Domain 1 – Preventing people from dying prematurely and Domain 2 – Enhancing quality of life for people with long term conditions	*Reporting Period 2015/16*	*NGH Quality Account 2014/15*	*Reporting Period Average*	*Reporting Period High*	*Reporting Period Low*
Summary Hospital-Level Mortality Indicator (SHMI) Data has been made available to the Trust by the Information Centre with regard to the value and banding of the	102 Band 2* (Oct 14 – Sep 15)	98 Band 2* (Oct 13 – Sep 14)	100 Band 2* (Oct 14 – Sep 15)	117 Band 1* (Oct 14 – Sep 15)	65 Band 3* (Oct 14 – Sep 15)
	*SHMI banding: • SHMI Banding = 1 indicates that the trust's mortality rate is 'higher than				

NHS Outcomes Framework Domain **Domain 1 – Preventing people from dying prematurely and Domain 2 – Enhancing quality of life for people with long term conditions**	NGH Performance		National Performance		
	Reporting Period 2015/16	*NGH Quality Account 2014/15*	*Reporting Period Average*	*Reporting Period High*	*Reporting Period Low*
SHMI	expected' • SHMI Banding = 2 indicates that the trust's mortality rate is 'as expected' • SHMI Banding = 3 indicates that the trust's mortality rate is 'lower than expected'				
In accordance with the reporting toolkit, the Trust can confirm that it considers that the data is as described, due to it having been verified by internal and external quality checking. NGH has taken the following actions to improve this rate and quality of its services; regularly analysing mortality data and undertaking regular morbidity and mortality meetings to share learning across the Trust and externally through countywide morbidity and mortality meetings					
Palliative Care Coding Data has been made available to the Trust by the Information Centre with regard to the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	25.9% (Oct 14 – Sep 15)	26.6% (Oct 13 – Sep 14)	26.6% (Oct 14 – Sep 15)	0.19% (Oct 14 – Sep 15)	53.5% (Oct 14 – Sep 15)
In accordance with the reporting toolkit, the Trust can confirm that it considers that the data is as described, due to it having been verified by internal and external quality checking. NGH has taken the following actions to improve this rate and quality of its services; by prioritising end of life care and placing great importance on palliative care					

NHS Outcomes Framework Domain **Domain 3 – Helping people to recover from episodes of ill health or following injury**	NGH Performance		National Performance		
	Reporting Period 2015/16	*NGH Quality Account 2014/15*	*Reporting Period Average*	*Reporting Period High*	*Reporting Period Low*
Patient Reported Outcome Measures scores (PROMs) PROMs measure a patient's health status or health related quality of life from the patient's perspective, typically based upon information gathered from a questionnaire which patients complete before and after the following procedures • Hip replacement surgery • Knee replacement surgery • Groin hernia surgery • Varicose vein surgery The data made available to the Trust by the Information Centre with regard to the Trust's PROMs (adjusted average health gain) is:					
• Groin hernia surgery (EQ-5D)	0.103 (provisional Apr15 to Dec15)	0.075	0.087 (provisional Apr15 to Dec15)	0.155 (provisional Apr15 to Dec15)	0.032 (provisional Apr15 to Dec15)
• Varicose vein surgery (EQ-5D)	N/A	N/A	0.100 (provisional Apr15 to Dec15)	0.160 (provisional Apr15 to Dec15)	0.032 (provisional Apr15 to Dec15)

NHS Outcomes Framework Domain **Domain 3 – Helping people to recover from episodes of ill health or following injury**	NGH Performance		National Performance		
	Reporting Period 2015/16	*NGH Quality Account 2014/15*	*Reporting Period Average*	*Reporting Period High*	*Reporting Period Low*
• Hip replacement surgery (Primary EQ-5D)	0.528 (provisional Apr15 to Dec15)	22.491	0.449 (provisional Apr15 to Dec15)	0.543 (provisional Apr15 to Dec15)	0.270 (provisional Apr15 to Dec15)
• Hip replacement surgery (Revision EQ-5D)	N/A (provisional Apr15 to Dec15)	Not reported	0.287 (provisional Apr15 to Dec15)	0.353 (provisional Apr15 to Dec15)	0.218 (provisional Apr15 to Dec15)
• Knee replacement surgery (Primary EQ-5D)	0.328 (provisional Apr15 to Dec15)	18.535	0.331 (provisional Apr15 to Dec15)	0.404 (provisional Apr15 to Dec15)	0.215 (provisional Apr15 to Dec15)
• Knee replacement surgery (Revision EQ-5D)	N/A (provisional Apr15 to Dec15)	Not reported	0.268 (provisional Apr15 to Dec15)	0.268 (provisional Apr15 to Dec15)	0.268 (provisional Apr15 to Dec15)
In accordance with the reporting toolkit the trust can confirm that it considers that the data is as described, due to it having been verified by internal and external quality checking. NGH has taken the following action to improve the rates, and the quality of its services by further developing the work undertaken in theatres.					
Emergency re-admissions to hospital within 28 days of discharge Some emergency readmissions following discharge from hospital are an unavoidable consequence of the original treatment. There are others that could potentially be avoided through ensuring the delivery of optimal treatment according to each patient's needs, careful planning and support for self-care. The data made available to the Trust by the Information Centre (during the reporting period) with regard to:					
• The percentage of patients aged 0-15 readmitted to NGH within 28 days of being discharged from a hospital which forms part of the Trust	13.15% (2011/12)	9.3%	7.07% (2011/12)	5.86% (2011/12)	12.50% (2011/12)
• The percentage of patients aged 16 or over readmitted to hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust	11.15% (2011/12)	8.7%	10.10% (2011/12)	0.00% (2011/12)	13.55% (2011/12)
In accordance with the reporting toolkit the trust can confirm that it considers that this data is as described, due to it having been verified by internal and external quality checking. NGH has taken the following actions to improve the rates, and the quality of its services by: • Improving discharge planning with an aim to reduce readmissions • Working to improve the discharge process to ensure that early and effective planning for discharge is undertaken					

NHS Outcomes Framework Domain Domain 4 – Ensuring that people have a positive experience of care	NGH Performance		National Performance		
	Reporting Period 2015/16	*NGH Quality Account 2014/15*	*Reporting Period Average*	*Reporting Period High*	*Reporting Period Low*
Responsiveness to the personal needs of patients This indicator forms part of the NHS Outcomes Framework with patient experience being a key measure of the quality of care. The data made available to the Trust by the Information Centre with regard to the Trusts responsiveness to the personal needs of its patients during the reporting period	68.9% (2014/15)	68.6% (2013/14)	68.9% (2014/15)	86.1% (2014/15)	54.4% (2014/15)
In accordance with the reporting toolkit the trust can confirm that it considers that this data is as described, due to it having been verified by internal and external quality checking. NGH continues to review patient experience and build on the work currently being undertaken across the Trust.					
Staff who would recommend the trust to their family or friends This indicator forms part of the NHS Outcomes Framework with patient experience being a key measure of the quality of care. The data made available to the Trust by the Information Centre with regard to the percentage of staff employed by, or under contract to, the trust who would recommend the Trust as a provider of care to their family or friends	52% (2015)	52% (2014)	69% (2015)	85% (2015)	46% (2015)
In accordance with the reporting toolkit the trust can confirm that it considers that the data for these are as described, due to it having been verified by internal and external quality checking. NGH is reviewing the scores in order to improve the rates, and so the quality of its services. The data is being fed through the trusts divisional structure with the aim to join it with patient experience. The trust aims to increase staff engagement and hope to develop a triangulation between performance, experience and engagement.					
Friends and Family Test – Patient The data made available (percentage recommended) by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre for all acute providers of adult NHS funded care, covering services for:					
• for inpatients	85.1% (2015/16) 85.4%	86% (2014/15) 78%	67% (March 2016)	93% (March 2016)	38% (March 2016)

NHS Outcomes Framework Domain Domain 4 – Ensuring that people have a positive experience of care	NGH Performance		National Performance		
	Reporting Period 2015/16	*NGH Quality Account 2014/15*	*Reporting Period Average*	*Reporting Period High*	*Reporting Period Low*
	(March 2016)	(March 2015)			
• patients discharged from Accident and Emergency (types 1 and 2)	85.1% (2015/16) 85.4% (March 2015)	89% (2014/15) 85% (March 2015)	84% (March 2016)	99% (March 2016)	49% (March 2016)
In accordance with the reporting toolkit the trust can confirm that it considers that the data for these are as described, due to it having been verified by internal and external quality checking. NGH has taken the following actions to improve the percentages, and the quality of its services by encouraging a culture of reporting throughout the Trust. Information on FFT has been covered in Section Four.					

NHS Outcomes Framework Domain Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm	NGH Performance		National Performance		
	Reporting Period 2015/16	*NGH Quality Account 2014/15*	*Reporting Period Average*	*Reporting Period High*	*Reporting Period Low*
Venous Thromboembolism VTE (deep vein thrombosis and pulmonary embolism) can cause death and long-term morbidity, but many cases of VTE acquired in healthcare settings are preventable through effective risk assessment and prophylaxis. The data made available to the Trust by the Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed, for venous thromboembolism	95.2% (Q4 2015/16)	97% (Feb 15)	96% (Q4 2015/16)	100% (Q4 2015/16)	79.23% (Q4 2015/16)
In accordance with the reporting toolkit the Trust can confirm that it considers that the data for these are as described, due to it having been verified by internal and external quality checking. NGH has taken action to improve the percentages and the quality of its services, by further developing systems to ensure risk assessments are reviewed and promoted. The aim is that all patients, who should have a VTE risk assessment carried out, have one 100% of the time.					
Rate of Clostridium difficile (C.Diff) infection C.Diff can cause symptoms including mild to severe diarrhoea and	13.2 (2015/16)	12.2 (2014/15)	41 (2014/15)	0 (2014/15)	114.4 (2014/15)

NHS Outcomes Framework Domain	NGH Performance		National Performance		
Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm	*Reporting Period 2015/16*	*NGH Quality Account 2014/15*	*Reporting Period Average*	*Reporting Period High*	*Reporting Period Low*
sometimes severe inflammation of the bowel, hospital-associated C.Diff can be prevented. Data has been made available to the Trust by the Information Centre with regard to the rate per 100,000 bed days of cases of C.Diff infection, reported within the Trust amongst patients aged 2 or over.					
In accordance with the reporting toolkit, the Trust can confirm that it considers that the data for these are as described, due to it having been verified by internal and external quality checking. NGH has taken the following actions to improve the percentages, and the quality of its services by: • Sending stool samples in a timely manner • Prompt isolation of patient's with diarrhoea • Improving antimicrobial stewardship.					
Patient Safety An open reporting and learning culture is important to enable the NHS to identify trends in incidents and implement preventative action. High incident reporting should demonstrate an increasing level of awareness of safety issues amongst healthcare professionals. It should further demonstrate a more open and transparent culture across the organisation and should not be taken as an indication of worsening of patient safety. The data made available to the Trust by the Information Centre (during the reporting period) with regard to:					
• The number of patient safety incidents reported within the trust - (Acute Non- Specialist)	3,722 (Apr 15 - Sep 15)	3,738 (Apr 14 - Sep 14)	4,647 (Apr 15 - Sep 15)	12,080 (Apr 15 - Sep 15)	1,559 (Apr 15 - Sep 15)
• The rate (per 1,000 bed days) of patient safety incidents reported within the trust - (Acute Non-Specialist)	31.1 (Apr 15 - Sep 15)	32.44 (Apr 14 - Sep 14)	39.3 (Apr 15 - Sep 15)	74.7 (Apr 15 - Sep 15)	18.1 (Apr 15 - Sep 15)
• The number of such patient safety incidents that resulted in sever harm or death - (Acute Non- Specialist)	6 (Apr 15 - Sep 15)	13 (Apr 14 - Sep 14)	19.9 (Apr 15 - Sep 15)	89 (Apr 15 - Sep 15)	2 (Apr 15 - Sep 15)
• The percentage of such patient safety incidents that resulted in sever harm or death - (Acute Non-Specialist)	0.16% (Apr 15 - Sep 15)	0.4% (Apr 14 - Sep 14)	0.43% (Apr 15 - Sep 15)	0.74% (Apr 15 - Sep 15)	0.13% (Apr 15 - Sep 15)
In accordance with the reporting toolkit, the Trust can confirm that it considers that the data for these are as described, due to it having been verified by internal and external quality checking. The results show that the trust is below the national average for the level of harm. NGH has taken					

NHS Outcomes Framework Domain	NGH Performance		National Performance		
Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm	*Reporting Period 2015/16*	*NGH Quality Account 2014/15*	*Reporting Period Average*	*Reporting Period High*	*Reporting Period Low*
the following action to improve the percentages and rates, and so the quality of its services by further encouraging an open reporting culture. This is being done through regular engagement with staff via newsletters, through learning events such as Dare to Share and regular attendance at ward and department meetings.					

HOSPITAL MORTALITY MONITORING

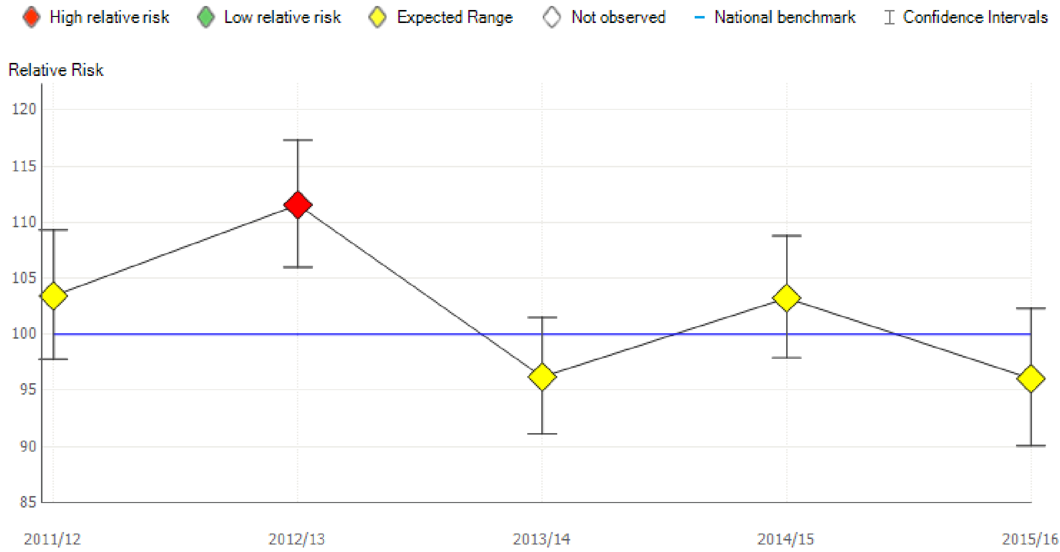
NGH uses 3 headline mortality monitoring tools which are benchmarked against all other hospitals in England and examine inpatient mortality rates. 2 indicators [HSMR and HSMR 100] are provided to the Trust by Dr Foster™ 3 months in arrears. HSMR [Hospital Standardised Mortality Ratio] measures mortality from the 56 most common and serious conditions causing >80% hospital deaths: HSMR 100 looks at all hospital deaths. Both mortality indicators are case mix adjusted, taking into account the age of each patient and their general health before their admission. These indicators can be analysed in detail to identify areas of adverse performance which require further analysis and investigation.

The information is reviewed in detail each month by the Associate Medical Director, and a structured report is presented to the Medical Director and discussed at CQEG and Trust Board Quality Governance Committee. The findings and planned actions for any areas of concern are presented monthly to the Mortality Review Group.

During 2015/16 the management of patients with biliary tract disease, pancreatic cancer, cellulitis, operations on peptic ulcer and perineal tears following instrumental and non-instrumental vaginal delivery were reviewed and action plans are in progress. CQC uses HSMR 56 as part of its assessment process when inspecting Trusts.

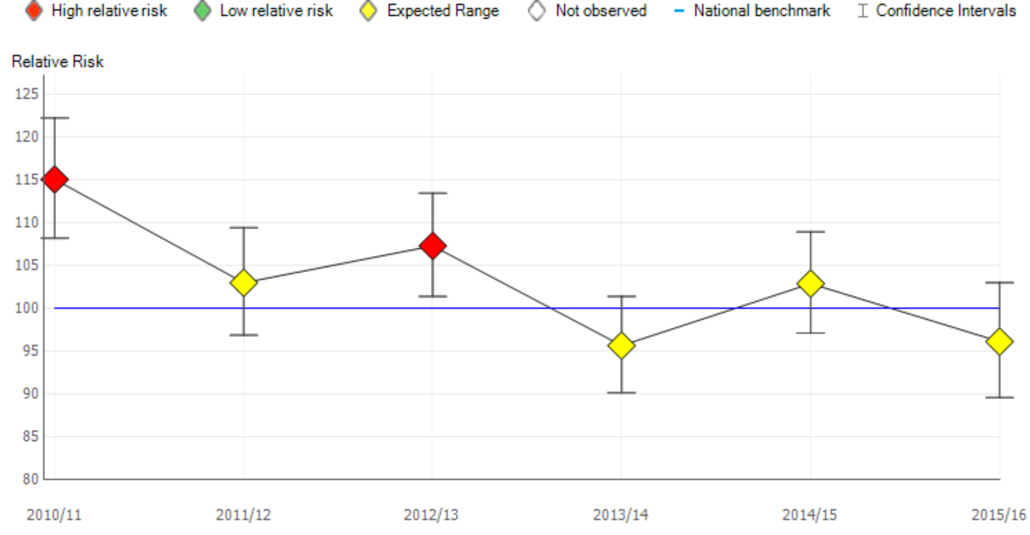
Both of the above measures (HSMR 100 and HSMR (56) show improvement since 2011. Performance during 2014/15 was as expected; performance in 2015/16 [to December 2015] remains within the expected range. HSMR 56 has seen a very good performance for the rolling year.

HSMR 100

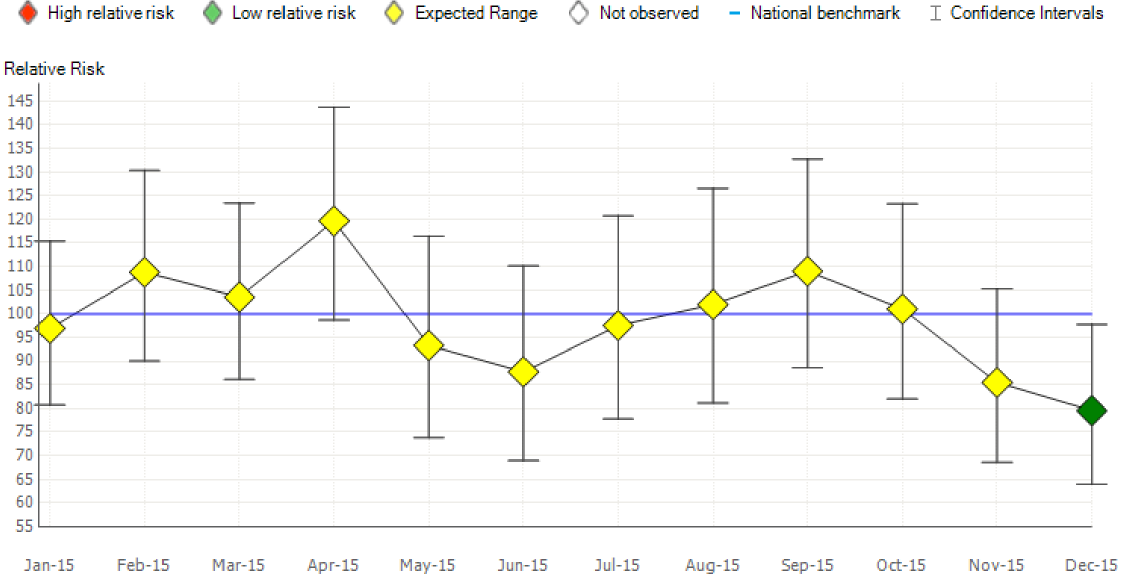


HSMR 100 year on year performance

HSMR [56]



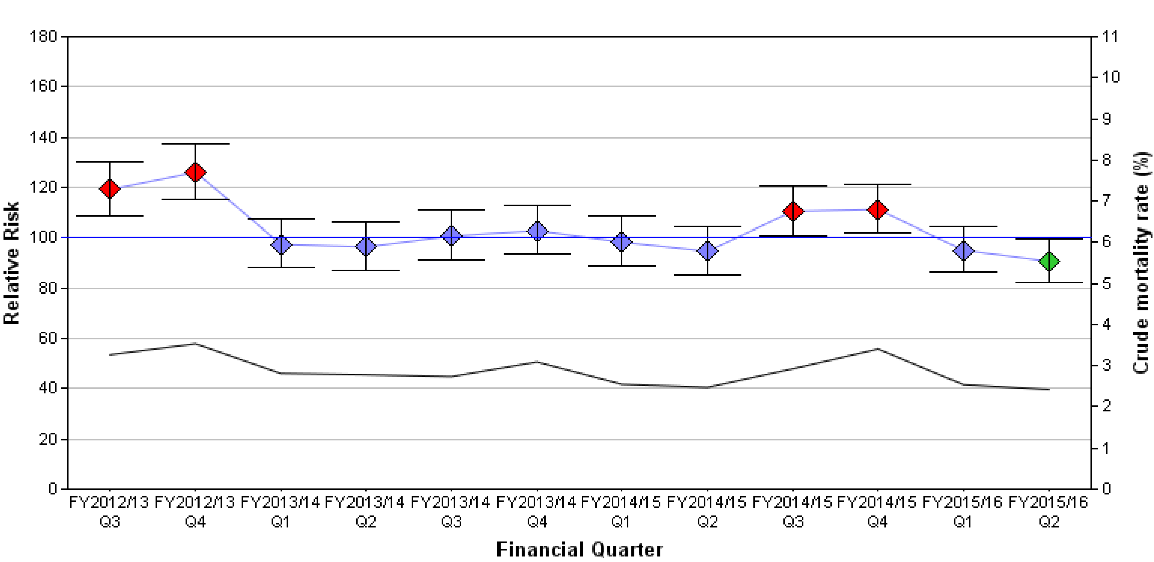
HSMR 56 year on year performance



HSMR 56 rolling year performance

A third metric, SHMI [Summary Hospital-level Mortality Indicator] is also used, provided by DH 6 months in arrears since 2010. It looks not only at hospital mortality, but also deaths that occur within a month of discharge, which may therefore reflect the care received outside the hospital. It also has a different case mix adjustment method, and so is not directly comparable to HSMR. Trust performance assessed by this method remains at expected levels in the latest published data [SHMI for the rolling year October 14 – September 15].

SHMI trend for all activity across the last available 3 years of data



NHS England has provided a framework for Mortality Governance with which the Trust is broadly compliant through the use of Dr Foster information, monthly review at Mortality Review Group, and reporting to Trust Board.

CORPORATE SCORECARD 2015/16

The following tables outline our performance against indicators we have chosen for 2015/16.

Section	Red Rated	Amber Rated	Green Rated	None	Total
Caring	0	1	2	9	12
Winter Pressures	1	0	0	4	5
Effective	3	2	16	3	24
Safe	9	1	12	1	23
Responsive	10	0	11	0	21
Well-Led	6	4	1	2	13
Finance	4	0	4	0	8
Total	33	8	46	19	106

KEY	
↑	Improving performance over 3 month period
↓	Reducing performance over 3 month period
→	Stable performance delivery over 3 month period

Caring	Indicator		Target	Trend	Mar-16
	C.1	Written complaints rate	None	↓	46
	C.2	Complaints responded to within agreed timescales	=>90%		Awaiting
	C.3	Friends & Family Test % of patients who would recommend: Inpatient/Daycase	95.4% (Feb 16)	↓	89.3%
	C.4	Friends & Family Test % of patients who would recommend: A&E	84.9% (Feb 16)	↓	84.4%
	C.13	Friends & Family Test % of patients who would recommend: Maternity - Antenatal Community	95.3% (Feb 16)	↓	97.3%
	C.14	Friends & Family Test % of patients who would recommend: Maternity - Birth	96.3% (Feb 16)	↓	91.4%
	C.15	Friends & Family Test % of patients who would recommend: Maternity - Postnatal Ward	93.7% (Feb 16)	↑	95.8%
	C.16	Friends & Family Test % of patients who would recommend: Maternity - Postnatal Community	98.0% (Feb 16)	↑	100%
	C.6	Friends & Family Test % of patients who would recommend: Outpatients	92.4% (Feb 16)	↓	91.4%
	C.7	Mixed Sex Accommodation	0	→	0
	C.8	Total deaths where a care plan is in place	=>50%	↓	50.0%
	C.9	Transfers: Patients moved with a risk assessment completed	100%	↑	95.9%

Winter Pressures	Indicators		Target	Trend	Mar-16
	WP.1	Escalation Areas Open	0	↓	653
	WP.2	Patient Ward Moves (between 9pm & 8am) - NEL ONLY	To be agreed	↓	83
	WP.3	Cancelled Operation Numbers (Clinical & Non Clinical)	To be agreed	↑	302
	WP.4	Patient who need to be readmitted if transport arrives too late	To be agreed	↓	15
	WP.5	A&E Trolley waits 8hrs 1 min to 12hrs (DTA to admission)	To be agreed	↓	162

Responsive	Indicator		Target	Trend	Mar-16
	R.1	A&E: Proportion of patients spending less than 4 hours in A&E	=>95%	↓	81.0%
	R.2	A&E: 4hr SitRep reporting	=>95%	↓	80.6%
	R.3	A&E: 12 hour trolley waits	0	→	0
	R.4	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	=>99%	↓	99.80%
	R.5	Discharge: Number of medically fit patients awaiting discharge (average daily)	=<50	↑	106
	R.6	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	=>93%	↑	97.0%
	R.7	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	=>93%	↓	99.3%
	R.8	Cancer: Percentage of patients treated within 62 days of referral from screening	=>90%	↓	86.7%
	R.9	Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	=>85%	↓	83.3%
	R.10	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	=>85%	↑	79.5%
	R.11	Cancer: Percentage of patients treated within 31 days	=>96%	↑	96.0%
	R.12	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	=>94%	↑	100%
	R.13	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	=>98%	↑	100%
	R.14	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	=>94%	↑	100%
	R.15	Operations: Urgent Operations cancelled for a second time	0	→	0
	R.16	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	0	↑	2
	R.17	RTT for admitted pathways: Percentage within 18 weeks	=>90%	↓	78.9%
	R.18	RTT for non- admitted pathways: Percentage within 18 weeks	=>95%	↑	93.6%
	R.19	RTT waiting times incomplete pathways	=>92%	↓	93.6%
	R.20	RTT over 52 weeks	0	↑	0
	R.21	Delayed transfer of care	0	↓	105

	Indicator		Target	Trend	Mar-16
Effective	E.1	Emergency re-admissions within 30 days (adult elective)	**None**	↑	**2.5%**
	E.2	Emergency re-admissions within 30 days (adult non - elective)	**None**	↑	**10.7%**
	E.3	Length of stay - All	**=<4.2**	↑	**4.34**
	E.51	Length of stay - All (Excl. Compton, Blenheim & Cliftonville wards)	**=<4.2**	↑	**3.27**
	E.4	Length of stay - Elective	**=<2.7**	↑	**2.19**
	E.52	Length of stay - Elective (Excl. Compton, Blenheim & Cliftonville wards)	**=<2.7**	↑	**1.97**
	E.5	Length of stay - Non Elective	**=<4.7**	↑	**5.39**
	E.53	Length of stay - Non Elective (Excl. Compton, Blenheim & Cliftonville wards)	**=<4.7**	↑	**4.17**
	E.6	Maternity: C Section Rates - Total	**<26.2%**	↑	**24.6% (97)**
	E.7	Maternity: C Section Rates - Emergency	**<13.0%**	↓	**13.7% (54)**
	E.8	Maternity: C Section Rates - Elective	**<13.2%**	↑	**10.9% (43)**
	E.10	Mortality: SHMI	Within expected range	→	**102**
	E.11	Mortality: HSMR		↑	**98**
	E.12	Mortality: HSMR - Weekend		↑	**89**
	E.13	Mortality: HSMR - Week day		↑	**98**
	E.14	Mortality: Low risk conditions		↓	**89**
	E.15	Mortality: Maternal Deaths	**0**	→	**0**
	E.16	NICE Technology Appraisal Guidance compliance	**=>80%**	↑	**98.0%**
	E.17	Patients cared for in an escalation area (occ bed days)	**0**	↓	**653**
	E.18	# NoF - Fit patients operated on within 36 hours	**=>80%**	↑	**96.8%**
	E.19	Stroke patients spending at least 90% of their time on the stroke unit	**=>80%**	↑	**81.8%**
	E.20	Suspected stroke patients given a CT within 1 hour of arrival	**=>50%**	↑	**70.4%**
	E.47	% Weekend Discharges against Week Day Discharges	**=>80%**	↓	**43.5%**
	E.54	% Daycase Rate		↓	**88.3%**

Well Led	Indicator		Target	Trend	Mar-16
	W.1	Friends & Family: % of staff that would recommend the trust as a place of work	N/Applic	↓	43%
	W.2	Data quality of Trust returns to HSCIC (SUS)	=>90%	→	93.3%
	W.3	Turnover Rate	=<8%	↑	10.80%
	W.4	Sickness rate	=<3.8%	↑	3.97%
	W.5	Staff: Trust level vacancy rate - All	=<7%	↑	7.3%
	W.5	Staff: Trust level vacancy rate - Medical Staff	=<7%	↓	10.87%
	W.5	Staff: Trust level vacancy rate - Registered Nursing Staff	=<7%	↑	11.36%
	W.5	Staff: Trust level vacancy rate - Other Staff	=<7%	↑	8.44%
	W.9	Staff: Temporary costs & overtime as a % of total pay bill	None	↓	16.4%
	W.10	Percentage of staff with annual appraisal	=>85%	↑	81.9%
	W.11	Percentage of all trust staff with mandatory training compliance	=>85%	↑	84.5%
	W.12	Percentage of all trust staff with role specific training compliance	=>85%	↑	74.0%
	W.15	Medical Job Planning	100%	→	81.0%

Safe

Indicator		Target	Trend	Mar-16
S.1	C-Diff	Ave. 1.75 per mth	↑	1
S.38	C-Diff incidents apportioned to NGH care			Awaiting review
S.2	Dementia: Case finding	=>90%	↑	97.3%
S.3	Dementia: Initial diagnostic assessment	=>90%	→	100%
S.4	Dementia: Referral for specialist diagnosis/follow-up	=>90%	→	100%
S.36	Falls per 1,000 occupied bed days	=<5.5	↑	4.1
S.6	Harm Free Care (Safety Thermometer)	94.08% (Mar 16)	↑	93.3%
S.7	Medical Notes: Availability for clinics	=>99%	↑	99.1%
S.11	Medication incidents that cause significant harm	0	→	0
S.12	MRSA	0	↓	1
S.13	Never event incidence	0	↑	0
S.14	Pressure Ulcers: Avoidable grade 4	0	→	0
S.15	Pressure Ulcers: Avoidable grade 3	Max 3.4 p/mth	↓	5
S.16	Pressure Ulcers: Avoidable grade 2	Max 12.3 p/mth	↓	17
S.17	Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	0	↓	2
S.18	Overdue CAS alerts	0	→	0
S.19	UTI with Catheters (Safety Thermometer-Percentage new)	0.28% (Mar 16)	↑	0.16%
S.20	VTE Risk Assessment	=>95%	↓	95.1%
S.21	Transfers: Patients transferred out of hours	0	↑	98
S.22	Percentage of patients cared for outside of specialty	<10%	↑	18.0%
S.23	Percentage of discharges before midday.	>25%	↓	18.8%
S.24	Number of cancelled operations due to bed availability	0	↑	39
S.32	TTO's sent by Taxi	0	→	0

REVIEW OF ACTIVITY 2015/16

The table below shows a snapshot of the Trusts performance activity up to 31 March 2016 with a comparison to the previous year's activity.

Activity	2014/15	2015/16	Difference	% Difference
Emergency inpatients	40,349	43,456	3,107	8%
Elective inpatients	6,208	5,824	-384	-6%
Elective day cases	38,346	39,610	1,264	3%
New outpatient attendances – consultant led	80,037	83,474	3,437	4%
Follow-up outpatient attendances – consultant led	149,977	155,562	5,585	4%
New outpatient attendances – nurse led	38,571	42,127	3,556	9%
Follow-up outpatient attendances – nurse led	114,953	154,412	39,459	34%
Total number of outpatient DNAs	30,350	34,770	4,420	15%
Patients seen in A&E	109,305	114,179	4,874	4%
Number of babies born	4,685	4,726	41	1%
Average length of stay (in days)	3.55	4.36	0.81	23%

REVIEW OF SERVICES

During 2015/16 NGH provided and/or sub-contracted 52 NHS services.

The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by NGH for the reporting period 2015/16.

REVIEW OF QUALITY

The trust manages and monitors quality on an ongoing basis day to day through the management arrangements and formally through its committee structure.

The Assurance Risk and Compliance Group and Clinical Quality Effectiveness Group all meet monthly and receive differing assurance reports on aspects of quality and governance, both from individual divisions and directorates and on a trust-wide basis. These include reports on infection control, pathology, compliance with NICE guidance, clinical effectiveness

and audit, external reviews, risk management, incidents, complaints, PALS and claims management, CQC compliance. Both groups report and escalate any issues to the Quality Governance Committee, which is a trust board subcommittee and also meets monthly. This committee reviews other information including the quarterly Patient Safety, Clinical Quality & Governance Progress Report. This comprehensive report incorporates an overview of quality and performance across the trust in nine key sections: Introduction and executive summary, ongoing trust-wide priorities, failure to plan, failure to rescue, failures of care, learning from error, emergency care, assurance with national standards, directorate reports and quality scorecards. The Quality Governance Committee reports and escalates any issues to the Trust Board.

SECTION SEVEN

EXTERNAL STAKEHOLDER FEEDBACK

Northamptonshire County Council

FAO: Simon Hawes
Quality Assurance Manager
Governance Department
Northampton General Hospital
Cliftonville
Northampton
NN1 5BD

Please ask for: Jenny Rendall
Tel: 01604 367560
Our ref:
Your ref:
Date: 18 May 2016

Dear Simon

Re: Quality Account 2015-16

The NCC Health, Adult Care & Wellbeing Scrutiny Committee formed a working group of its members to consider a response to your Quality Accounts 2015-16. Membership of the working group was as follows:

- Councillor Sally Beardsworth
- Councillor Eileen Hales
- Councillor Sylvia Hughes
- Mr Andrew Bailey (Carers Voice Representative)

The formal response from the Health & Social Care Scrutiny Committee based on the working group's comments is as follows:

In relation to all quality accounts the Working Group noted that page 6 of the Nene CCG Quality Contract for GP practices stated:

> *At present services in the community are not able to meet demand and are not well integrated and co-ordinated. In particular there is insufficient intermediate care and domiciliary care provision and an over reliance on bedded solutions to healthcare. There are enormous budget pressures facing health and social care which have to be managed whilst large scale transformation of services is undertaken.*

In view of this comment the Quality Account Working Group would have liked to have seen in quality accounts this year how the NHS Trusts would be supporting primary care through this transformation process whilst acknowledging that the social care sector has much to contribute as well.

The formal response from the Health, Adult Care & Wellbeing Scrutiny Committee to your quality account based on the working group's comments is as follows:

- It was felt more information on partnership work was required. For example how was NGH engaging with professional and voluntary carers? What was the relationship between the NHS and NCC Social Services.
- There was data missing that the working group would have liked to have seen. For example the percentage of patients who returned to the service.
- The working group would have liked to have seen information on how you achieved targets and where possible exceeded the targets in effectiveness under Part 2.
- There was no sense from the Quality Account of how carers and families were involved when considering a package for a patient who was being discharged.
- The working group would have liked to have seen some information on how NGH would address the need for resource to be in place within the complaints team in part 3 under the learning and development plan. An organisation could not listen to complaints if there was no-one in place to listen and address them.
- The working group were also aware that many patients waited for some hours whilst medicines were mixed by pharmacists to be administered to them or when waiting for medicines before discharge. The working group would have been interested to hear how this could be improved.
- Glossaries were not complete. EG. LFE
- It was noted many services were rated as 'requires improvement' although end of life care was rated as 'good'.
- In Part 3 of the quality account it states there is an aim of helping people to get home but no information was provided regarding who they worked with and how to assist people home.
- No information was provided in terms of returning patients. There was no evidence of whether strategies to return people home worked or did not work.
- It would have been nice to have seen a paragraph regarding staff survey results.
- Progress with staff appeared positive and the working group noted that better support responses from staff was a step towards providing better patient care.
- The way in which staff could provide comments back to NGH was commended.
- The summary towards the rear of the document was very good. It was noted the arrows clearly denoted where the issues were.

Please do not hesitate to contact Democracy Officer, Jenny Rendall should you have any queries relating to this response, whose contact details can be found at the bottom of the first page of this letter.

Yours sincerely
On behalf of the Health, Adult Care & Wellbeing Scrutiny Committee

Sally Beardsworth

Councillor Sally Beardsworth
Deputy Chairman

NGH response:

We thank Northamptonshire County Council for their valued feedback on reviewing a draft of the Quality Account. Since the draft Quality Account was sent for review further updates have been made. We can confirm we continue to work very closely with the CCG and GP Federation to support and develop intermediate care for our patients.

Healthwatch Northamptonshire statement on Northampton General Hospital NHS Trust (NGH) draft Quality Account 2015/16

During 2015-16 Healthwatch Northamptonshire (HWN) has worked more closely with NGH and has regularly attended the Patient and Carer Experience and Engagement Group. We have seen growth of this group and an increase in triangulation of patient experience data, resulting in more and better action planning. We have also participated in two patient experience surveys for the hospital. HWN welcomes the opportunity to work more closely with NGH to support, challenge and assist them in ensuring high quality, innovative and patient-centred care.

We are glad this Quality Account demonstrates that patient experience is an integral component of quality at NGH. We thank NGH for working to produce a clear and readable Quality Account document but recommend the inclusion of an Easy Read summary and further efforts to avoid the use of jargon in places.

We believe NGH has chosen appropriate quality priorities for 2016/17 and support their aim to build on the work of previous quality improvement strategies and to align them with their overarching goals to reduce mortality, reduce harm, provide reliable care, and improve the patient experience. We appreciate that the 2016/17 quality priorities are specific and measurable and would be interested to see more details about the projects and actions planned.

It is our opinion that this Quality Account demonstrates that NGH is an open and transparent organisation and we are pleased to see evidence of learning from complaints, incidents and feedback, and the sharing of good practice.

Further comments on priorities for improvement for 2016/17

Patient and Family Centred Care:
HWN are pleased to see this included as a quality priority. We particularly support the Trust's plans to conduct a deep dive into communication issues across the patient journey. Communications issues were the most common theme to the poor experiences we heard about NGH during our 2015-16 'Make Your Voice Count' campaign. These experiences included examples of poor communication and information giving by clinicians to patients and other health professionals, poor staff attitudes, and problems with appointment booking or cancellation.

We also support the Trust’s plans to give better bedside information and have provided feedback on the draft booklet and placemat. We also look forward to supporting NGH’s upcoming patient feedback events.

Reducing avoidable harm:
We support the Trust’s aim to look at reducing harm from different angles. During Make Your Voice Count we heard eight experiences where patients or their relatives felt there had been an error made during their care at NGH.

Review of quality performance 2015/16

We congratulate NGH for the progress made against the targets set for 2015/16 and other innovative pieces of work. It would be helpful for the lay reader if the ‘how we performed’ section of each quality priority included some narrative. It would also be helpful to see a brief mention of how NGH plan to progress the targets not met that are not listed as priorities for this year.

Supporting patients in getting home:
It is not possible for us to tell from the incomplete information given in the draft Quality Account how well NGH has performed against this priority but we have heard from a few people over the last 12 months who had concerns about aspects of the discharge process. These included concerns about patients being discharged too quickly, whether enough discussion and/or checks about how patients could cope at home had been carried out before discharge, how quickly these checks could be done, communication with other services, and how any delay is communicated to the patient.

The importance of working with other organisations to improve the experience of patients waiting to be discharged has been highlighted by the Chief Executive. We recommend that all aspects of discharge remain a quality priority, particularly ensuring that patients have appropriate care in place before discharge.

Listening to our patients:
We are pleased to see the progress that has been made in this area. Two people who had made complaints told us they were satisfied with the involvement of PALS but not with the outcomes (they did not get the outcome they sought).

Invest in our staff:
We agree that valuing and supporting staff is important. Being treated by caring, compassionate and knowledgeable staff is the most common factor we hear that contributes to a ‘good’ hospital experience. Over 50 respondents to our ‘Make Your Voice Count’ survey told us about an experience of good staff care at NGH,

although 14 people told us of experiences where they felt NGH staff had poor attitudes.

Sign up to safety:
The importance of 'Sign up to Safety' to the Trust is noted and welcomed. We are pleased to see that progress has been made in most areas. HWN occasionally hear from patients who have experienced errors or delays in their care or diagnosis but these are a minority.

Improve end of life care:
We are pleased to see how NGH has worked on improving end of life care over the past year and hope this is reflected in their patient experience data. We believe that sensitive and good communication with relatives and carers of patients at the end of their lives is as important as identifying end of life patients. We heard one complaint this year relating to end of life; that of a relative who felt the deceased patient had been left in an undignified manner.

Additional HWN patient experience findings from 2015-16
308 respondents to our 'Make Your Voice Count' survey told us about an experience of NGH. Two thirds of these were good experiences and one third poor experiences. Additionally, the HWN office has received 5 positive and 20 negative pieces of feedback during the year.

The most common themes to the poor experiences were: communication and staff attitude, waiting times, appointment availability, staff errors, poor environment, food or parking, and there were concerns about staffing levels. We also heard many examples of great care and treatment, particularly about staff care and attitudes.

Kate Holt

Interim General Manager, Healthwatch Northamptonshire

Francis Crick House
6 Summerhouse Road
Moulton Park
Northamptonshire
NN3 6BF

TEL: 01604 651100
DDI: 01604 651724
Ref: AJ/EC/HS

Date: 31 May 2016

Private & Confidential
Carolyn Fox
Director of Nursing, Midwifery and Patient Services
Northampton General Hospital NHS Trust Cliftonville
Northampton
NN1 5BD

By email only: carolyn.fox@ngh.nhs.uk

Dear Carolyn

Re: Quality Account 2015-2016

The Northampton General Hospital (NGH) NHS Trust annual quality account for 2015-16 has been reviewed by NHS Nene Clinical Commissioning Group (Nene CCG) and NHS Corby Clinical Commissioning Group (Corby CCG). It is noted that the quality account was reviewed whilst in draft format.

The account does not follow the toolkit format of three sections, but instead is split into eight sections.

Whilst the account notes that NGH sub-contracted 52 services, Part 1 does not provide a view of these sub-contracted services

The account contains six key quality priorities for 2015-16. These are supported by Nene and Corby CCGs as these reflect national and local priorities. It may be useful to identify against each how they address patient safety, patient experience and effectiveness and to show a baseline position.

The trust has participated in all, except two applicable National Clinical Audits and National Confidential Enquiries. It is clear that there has been a large amount of local audit undertaken but it is not clear what the learning from this is.

Whilst the account contains details of performance to date against CQUIN schemes for 2015/16 it is suggested that it would be positive to identify the impact for patients of the CQUIN schemes achieved and ensure that the final version identifies any actions taken by the trust for CQUINs not achieved. It may be useful to include the benefits of both the 2015/16 CQUINs and the proposed 2016/17 CQUINs to patients.

Whilst data quality information is contained within the draft account it is not clear what the trusts overarching view on their data quality is and what their data quality improvement plan for 2016/17 is.

We note the positive work undertaken to triangulate learning from patient feedback.
Activity against Quality, Innovation, Productivity and Prevention is not clear within the account and there is no reference as to how any cost improvement programmes have impacted on the quality of care. It may have been helpful to include this information.

In the core quality indicators section where the trust is planning on taking actions to improve these are not all clearly articulated. The trust has not included Friends and Family test data, although this is a recommendation rather than a statutory requirement should the trust choose to include this this should be a combined percentage covering both A&E and inpatient responses.

The trust has included overarching information around the national staff survey results but in the draft report has chosen not to include the details of the results for KF21 (percentage of staff believing that the organisation provides equal opportunities for career progression or promotion) and KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) for the Workforce Race Equality Standard. The trust has also chosen not to include their CQC ratings grid alongside any plans for improvement or information about improvements undertaken. In line with gateway reference 04730 we think it would be useful for the trust to include this information.

Commissioners will continue to work closely with the trust and support ambitions to improve the quality standards of care and patient experience for people who use the service.

If you have any further questions please contact Emma Clarke, Senior Quality Improvement Manager, at emma.clarke@neneccg.nhs.uk or by telephone on 01604 651724.

Yours sincerely

pp
Peter Boylan
Director of Nursing & Quality
NHS Nene & NHS Corby Clinical Commissioning Groups

cc: Alison Jamson, Deputy Director of Quality, NHS Nene & NHS Corby CCGs
Caroline Corkerry, Deputy Director of Quality & Governance, NGH
Simon Hawes, Quality Assurance Manager, NGH

SECTION EIGHT

INDEPENDENT AUDITORS LIMITED ASSURANCE REPORT

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF NORTHAMPTON GENERAL HOSPITAL NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of Northampton General Hospital NHS Trust's Quality Account for the year ended 31 March 2016 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following indicators:

- Clostridium Difficile Infections and
- Friends and Family Test Patient Element Survey

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the Directors and the auditor

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2015 to June 2016;
- papers relating to quality reported to the Board over the period April 2015 to June 2016;
- feedback from the Commissioners dated 31/05/2016;
- feedback from Local Healthwatch dated 31/05/2016;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 08/06/2016;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey 2015;
- the latest national staff survey 2015;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 25/05/2016;
- the annual governance statement dated 26/05/2016; and
- the Care Quality Commission's Intelligent Monitoring Report dated 29/05/2016

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Northampton General Hospital NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Northampton General Hospital NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Northampton General Hospital NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Leicester Office
1 Waterloo Way
Leicester
LE1 6LP

30 June 2016

SECTION NINE

ABBREVIATIONS

	#	Fracture
A	A&E	Accident and Emergency
	AKI	Acute Kidney Injury
	ACS	Ambulatory Care Service
	ASGBI	Association of Surgeons of Great Britain and Ireland
B	BP	Blood Pressure
C	CCG	Clinical Commissioning Group
	C.Diff	Clostridium Difficile
	CEM	College of Emergency Medicine
	CIA	Cartoid Interventions Audit
	CIP	Cost Improvement Programme
	COPD	Chronic Obstructive Pulmonary Disease
	CNS	Cancer Nurse Specialist
	CT	Computed Tomography
	CQC	Care Quality Commission
	CQEG	Clinical Governance and Effectiveness Group
	CQUIN	Commissioning for Quality and Innovation
	C Section	Caesarean Section
D	DAHNO	Data for Head and Neck Oncology
	DH	Department of Health
	DNA	Did Not Attend
	DoOD	Do Organisational Development
	DTOC	Delayed Transfer of Care
E	EMRAN	East Midlands Rheumatology Area Network
	ePMA	electronic prescribing medicines administration
	ERAS	Electronic Residency Application Service
F	FFT	Friends and Family Test
	FY1	First Year 1
G	GMPC	General Medical Practice Code Validity
H	HSMR	Hospital Standardised Mortality Ratio
	HWN	Healthwatch Northamptonshire
I	ICU	Intensive Care Unit
	IGT	Information Governance Toolkit
K	KPI	Key Performance Indicators
	KGH	Kettering General Hospital NHS Foundation Trust

L	LFE	Learning from errors
M	MBRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
	MDT	Multi-Disciplinary Team
	MINAP	Myocardial Ischaemia National Audit Project
	MRI	Magnetic resonance imaging
	MRSA	Methicillin-Resistant Staphylococcus Aureusis
	MUST	Malnutrition Universal Screening Tool
N	NCC	Northamptonshire County Council
	NCEPOD	National Confidential Enquiry into Patient Outcome and Death
	NGH	Northampton General Hospital NHS Trust
	NICE	The National Institute for Health and Care Excellence
	NICOR	National Institute for Cardiovascular Outcomes Research
	NMET	Non-Medical Education and Training
	NNAP	National Neonatal Audit Programme
	NVD	National Vascular Database
P	PALS	Patient Advice and Liaison Service
	PCEEG	Patient & Carer Experience and Engagement Group
	PPEN	Patient & Public Engagement Network
	PROMs	Patient Reported Outcome Measures
Q	QELCA	Quality End of Life Care for All
	QI	Quality Improvement
R	RCPH	Royal College of Paediatrics and Child Health
	R&D	Research and Development
	RTT	Referral to Treatment
S	SHMI	Summary Hospital-level Mortality Indicator
	SHO	Senior House Officer
	SIRO	Senior Information Risk Owner
	SSKIN	Surface, Skin inspection, Keep moving, Incontinence/moisture, Nutrition/hydration
	SSNAP	Sentinel Stroke National Audit Programme
T	TARN	Trauma Audit Research Network
	TTO	To Take Out
U	UTI	Urinary Tract Infection
V	VTE	Venous Thromboembolism
W	WHO	World Health Organisation
Y	YTD	Year to Date

If you would like more information please contact:

Medical Director and Director of Nursing
Northampton General Hospital NHS Trust
Cliftonville
Northampton
NN1 5BD