NHS
Northampton General Hospital
NHS Trust

Quality Account 2016/17

Providing the **Best Possible Care**

Contents

Introduction

What is a Quality Account?

A Quality Account is a report about the quality of services we provide. The report is published each year and made available to the public. We believe our quality account is important because it provides us with a way of letting people know about the improvements we have made to our services as well as their overall quality. We measure the quality of services by looking at patient safety, the effectiveness of the care and treatment we provide and, importantly, the feedback we receive from our patients.

The Department of Health requires organisations like Northampton General Hospital to submit their quality account to the Secretary of State by uploading it to the NHS Choices website by 30th June each year.

Northampton General Hospital NHS Trust (NGH) – about us

NGH is an 800-bedded hospital providing general acute services for a population of 380,000 and hyperacute stroke, vascular and renal services to people living throughout the whole of Northamptonshire, a population of 692,000. There are approximately 713 general and acute beds with 60 maternity beds, and 18 critical care beds. We employ 4, 800 staff, which includes 496 doctors, 1,074 nursing staff and 2,587 other healthcare professionals and non-clinical staff.

Our principal activity 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 an accredited cancer centre, providing 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, we provide outpatient and day surgery services at Danetre Hospital in Daventry and have dedicated beds at the Cliftonville Care Home, Spencer Care Home and Angela Grace Care Home for patients who no longer require acute inpatient care. We are responsible for the medical care of patients transferred to those care homes, whilst all nursing care and management is the responsibility of the home.

We are constantly seeking to expand our portfolio of acute specialties and to provide services in the most clinically effective way. Examples are developments in vascular surgery and laparoscopic colorectal surgery, which place us 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 within our own excellent training facilities which were recently upgraded.

Division: Medicine & Urgent Care

Directorate	Services			
Urgent Care	A&E	Benham Assessment	Emergency Assessment	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

Part One

A statement on quality from our Chief Executive

At Northampton General Hospital we are committed to providing the very best possible care for each of our patients. This is underpinned by a focus on our key values, all of which have a critical role in providing high quality care. As we build a culture where patient safety stands out as our overarching concern and where every member of staff understands their role in improving this, we have also made a commitment to continual quality improvement in an atmosphere of respect and support.

Our Quality Account gives an overview of the Trust's performance in providing high quality care for our patients and their families and also sets out our priorities for improvement.

The experience that our patients and visitors have however goes well beyond the things we can measure in terms of outcomes of treatment. We are proud of the motivation our staff show for the delivery of the care and compassion they would like a member of their own family to receive.

Whilst the pressures on the NHS are obvious and the demand for our services continues to grow, our staff have continued to provide the best care they can and have increasingly worked towards a 'team NGH' approach to support ambitious programmes of work which will support better care for our patients and a better working environment for staff.

The views of our staff, patients and their carers have been brought together in our Quality Improvement Strategy which forms the basis of our quality priorities over each of the next three years. On the understanding that better quality care is better value for patients and the taxpayer, we have committed to support a culture where quality improvement drives programmes of change to ensure the care we provide is better for patients, better for staff and are resources are used most efficiently.

We have made significant progress against the priorities we set ourselves for 2016/17 which was year one of our Quality Improvement Strategy. For example:

- We have improved the safety of our patients through a reduction in falls which result in harm and the number of patients who develop a pressure ulcer whilst we are caring for them.
- Infection prevention is an important issue for us and we have seen a further reduction in the number of patients who develop and infection as a result of the care they receive at NGH.
- We have improved the timeliness of treatment for those patients who have developed a serious infection (sepsis) where any delay can adversely affect the outcome.
- We have continued to invest in our staff though programmes of leadership and development focussed on improving quality. This has contributed to the positive work that we have done on the safety culture in key areas of the Trust.

The Trust has been recognised nationally through a number of awards and continues to actively support our doctors in training, medical students and student nurses in quality improvement with many being invited to make national and international presentations. This is part of our plan to extend our role in education and training, understanding that it not only has a positive impact on patient care but is also an investment in the workforce of the future. We recognise the need to continue the work to ensure that quality improvement priorities underpin all of our change programmes and that in these and other endeavours, we remain focussed on the things that matter most to patients and staff.

Dr Sonia Swart
Chief Executive

Statement from the Director of Nursing & Midwifery and the Medical Director

The cornerstone of Northampton General Hospital NHS Trust's philosophy is to provide the best possible care for all our patients, underpinned by our values:

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

We have successfully delivered Year 1 of our three year Quality Improvement Strategy with programmes aligned to our Quality Priorities to make our care safer, more effective and to improve the experience of our patients and families.

We have achieved the majority of our key performance indicators including the Referral to Treatment Time but did not achieve the national access standard of 95% for patients being treated within four hours in the Accident and Emergency Department. Although this was disappointing, our patients have rated their experience highly and we were assured that patient care was not adversely affected.

The focus on patient safety remains a priority for all our staff and this culture is embedded throughout the Trust. We continued to make significant progress in reducing the numbers of hospital-acquired pressure ulcers and consistently improved the delivery of harm free care as measured by the "Safety Thermometer".

We continue to encourage our staff to report incidents so that we are able to improve the care given to our patients as a result of learning from incident reports and investigations. During the year, we focussed our work in infection prevention and control on reducing the number of patients contracting C Difficile and MRSA.

Our improvements in patient experience have been recognised nationally with a prestigious award from the Patient Experience Network. Our patients are telling us the care we are providing is improving, with 92.3% recommending our services to their family and friends in comparison to 89.2% last year.

The results of the National Staff Survey were exceptionally positive this year which continues to build on the year improvements that we have made since 2013. The survey showed 12 statistically significant improvements including overall levels of staff engagement with no areas of deterioration. There were significant improvements in staff recommending the Trust as a place to work, staff agreeing that their role makes a difference to patients and their carers and the satisfaction of staff with the quality of the work that they are able to deliver. Overall, we were in the top 5 most improved Trusts in the country.

One area of concern that has come through from the survey is that not all of our staff are consistently living our Trust value of 'we respect and support each other'. This will be an area of focus for us in the coming year.

We welcomed the sustained improvement in the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) which are among the lowest in our peer group and reflect our aim to place patient safety above all else. Building on our work in this area we are

further improving engagement with bereaved families and carers and extending reviews to all patients who have died to ensure that we are capturing learning wherever possible.

In March 2017 the Board reaffirmed its commitment to the Trust values which ensure that behaviours underpin the strong patient-centred culture at Northampton.

We would like to pay tribute to the hard work and dedication of staff at Northampton General Hospital and the invaluable assistance provided by our many supporters, including volunteers, and support groups. The improvements our staff continue to make to ensure that patients receive the care they deserve are inspiring. The Director of Nursing and Medical Director are fully committed to the delivery of the improvements described in the Trust's Quality Strategy and this Quality Account describes those achievements and our plans for next year.

Ms Carolyn Fox
Director of Nursing, Midwifery & Patient Services

Dr Michael Cusack
Medical Director

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 have taken 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 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

29 June 2017
Paul Farenden
Chairman

29 June 2017
Dr Sonia Swart
Chief Executive


Northampton General Hospital
NHS
Maiken Hvild
Midwife

Part Two

Priorities for Improvement 2016/17

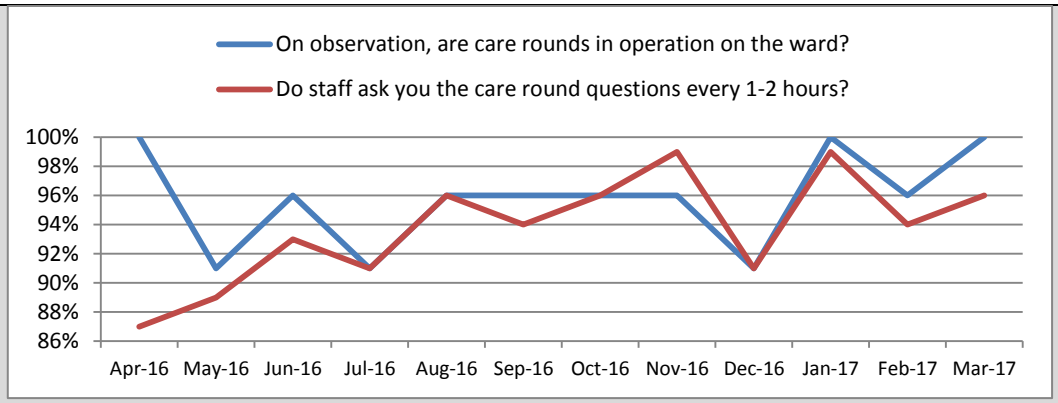
Patient safety is the cornerstone of our philosophy at Northampton General Hospital - it is at the heart of everything we do. Our Quality Improvement Strategy sets out our ambition and aim to provide the best possible care to all our patients. Our quality priorities are focused on improving the safety, efficiency and effectiveness of the care we provide, as well as improving our patients' experience.

The information presented within this report summarises the progress made on the priorities we set ourselves in the first year of our Quality Improvement Strategy.

We said we would: *Provide care that is clinically effective by delivering reliable care by increasing compliance with Intentional Rounding. Intentional rounding (also known as essential care rounds) are regular, planned 'nursing care rounds', to check on patients and ensure that their essential care needs are met.*

What we achieved:

What:	Improving compliance in key process measures for Intentional Rounding
How Much:	Greater than 90% as measured on a monthly basis via Quality Care Indicators (QCI's)
When:	March 2017
Outcome:	All inpatient adult wards use the Intentional Rounding tool which incorporates the main questions asked to patients around pain, the need for food/ fluid and their toileting needs, plus safety checks within the environment such as having call bells to hand, and moving aids available. As well as repositioning checks, our charts also allow staff to plan and record the delivery of care given for personal hygiene, patient moving, prevention of pressure damage, and checking of equipment and aids. We monitor compliance by asking our patients the following questions: • **Are care rounds in operation on ward?** • **Do staff ask you the care round questions every 1-2 hours?** The results during 2016/17 show that care rounds are in operation on our adult wards and that staff ask the care round questions with a high degree of consistency. Further data has been obtained from direct observation of ward practice. A snapshot of the data from 2016/17 Quarter 4 shows a compliance rate of 98.6% with Intentional Rounding against a target of 90%. We also asked our patients whether Intentional Rounding is undertaken 1-2 hourly and our compliance with this was 96.3% as shown in the following graph:



The key actions in place to support further improvements in the reliable completion of Intentional Rounding are:

- A task and finish group for Intentional Rounding (essential care rounds) has been established. A revised Intentional Rounding tool is being developed using Quality Improvement methodology.
- An Intentional Rounding Best Practice Guideline is being developed, incorporating guidance for completion.
- Placemats are on each Adult in-patient bed table with information for patients and carers on Intentional Rounding.
- A patient bedside booklet including information on Intentional Rounding has been developed.

We said we would: *Provide care that is safe by reducing in-patient falls with harm.*

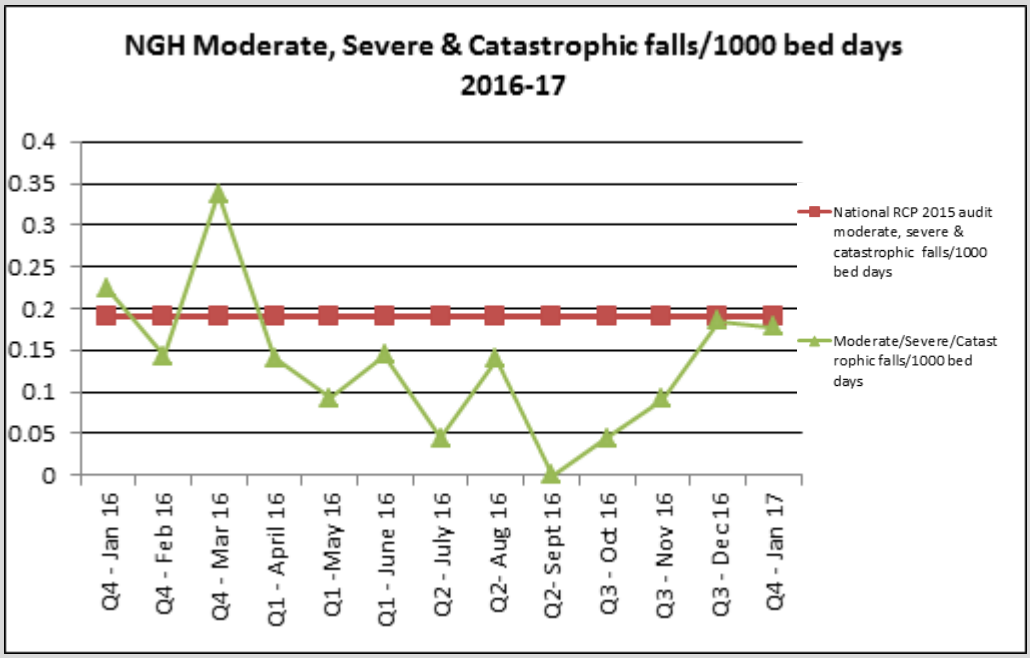
What we achieved:

What:	To reduce the number of in-patient falls with harm compared with 2015/2016
How Much:	The falls assessments will be completed within 12 hours of admission for 92% or more of our patients. Falls care plans will be completed within 12 hours of admission for 87% or more of our patients. We will review and improve the current process for post-fall reviews. We will develop a delirium policy to improve the management patients with confusion. We will improve the medication review process for patients who are admitted with a fall and those at risk of falls. We will ensure that more than 85% of relevant staff have had Falls Prevention Training. Examples of harm occurring from falls includes: Low harm – a graze or a bruise Moderate harm – a fracture of a wrist or a laceration that requires sutures Severe harm – a fracture of the hip Catastrophic – death as a direct result of the fall

When:	March 2017
Outcome:	There were 306 inpatient falls with harm in 2016/17 compared to 354 in 2015/16. This is a reduction of 13.6%. In the year to date we have achieved the target for Falls Risk Assessment completion with an average of 93% recorded. A new post-fall medication form to support patient assessment was developed and trialled in quarter 2. This has since been reviewed and further changes made in response to feedback. A further trial is planned which will coincide with the rotation of our junior doctors. The Delirium Policy has been developed and is progressing towards ratification. Pharmacy processes to undertake medication reviews for those who are at risk of falling have been reviewed. The process has been embedded on each ward and makes use of specific stickers, documentation and verbal handovers. Adjustments have also been made to the electronic prescribing system so that high risk medications are highlighted. The compliance with falls training has improved during 2016/17. It remains below our target of 83% and we have work underway to address this: . We remain on a continual improvement journey in the reduction of patient harm from falls which we are working on through: • Working with NHS Improvement as part of a National Collaborative • A review of the falls risk core care plan that has been ratified and awaiting launch • Development of a multifactorial/multidisciplinary risk assessment document • Key targeted support for areas of high incidents of falls • Supporting wards to develop tests of change using quality improvement methodology • Working collaboratively with the frail and elderly team • Review of bedrail risk assessments • Introduction of quarterly bedrail compliance audits • Monitoring of training compliance with bespoke training delivered as required • Development of role specific training • Relaunch of the falls Multidisciplinary Team Meetings with increased input from clinical areas A Falls Collaborative has been planned to take place in Quarter 2 (2017/18)

We said we would: Reduce Avoidable Harm from Failures in Care: Falls with Harm

What we achieved:

What:	To reduce moderate, severe and catastrophic falls/1000 bed days
How Much:	Reduction of 0.02 moderate, severe and catastrophic falls/1000 bed days and maintain rates below the Royal College of Physicians (RCP) national threshold of 0.19 moderate severe and catastrophic falls/1000 bed days
When by:	31st March 2017
Outcome:	In the year to date: • The Trust has reduced the rate of moderate, severe and catastrophic falls/1000 bed days by a mean average of 0.03. • The Trust has consistently remained below the RCP national threshold up to the year to date.  Over the last year the Inpatient Falls Prevention Team have focussed on best practice and developing care plans to reduce each patient's risk of a fall. A trust-wide quality improvement project on Lying and Standing Blood Pressure was commenced which included: • A trust wide audit of availability of manual sphygmomanometers and stethoscopes - all wards now have these. • Lying Standing Blood Pressure guidelines have been reviewed, updated and new laminates are available on all wards as part of the SilverLinks folder and are available on the intranet. • A Lying Standing Blood Pressure workshop was held as part of a Frailty seminar as well as continuing ward based training. To improve Staff knowledge and practice with Neurological observations a training programme has commenced and been delivered in conjunction with the Simulation Suit. A new head injury poster and neurological observations poster has been completed and has been circulated to all ward areas and is available on the intranet.

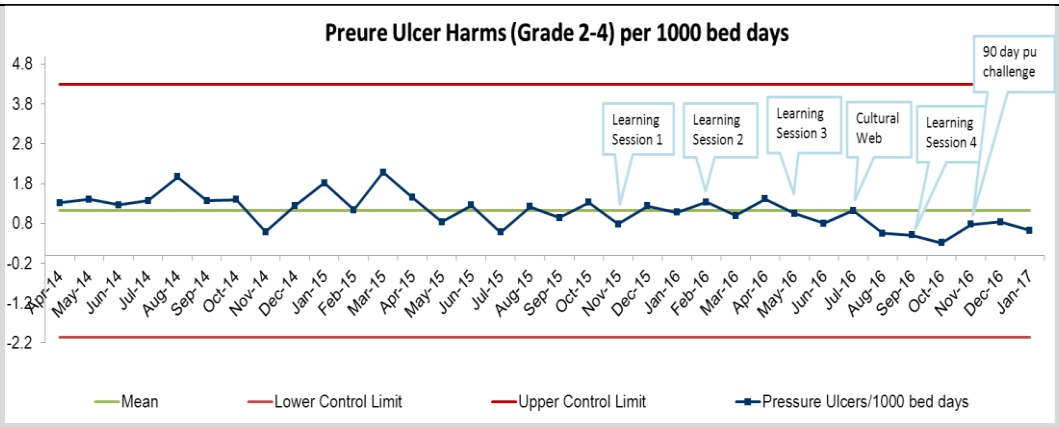
	A new Falls Care Plan has been trialled and continues to be developed across the Trust. The Bed Rails care plan has also been updated and reviewed. This continues to be trialled across inpatient ward areas. A 'Top Six' task and finish group established in September 2016 has involved the six wards across the Trust with the highest number of falls. Each of these ward areas has developed action plans and initiated 'Tests of Change'. Positive results have resulted from this approach with a reduction in falls on three of these wards during this period. Specific Health Care Assistant and International Nurse Training has been commenced alongside the Trust wide training programme with work underway to support areas to identify their role specific training needs. Ward level information is analysed for trends to focus further improvement work to reduce the future risk of falls. Quarterly Bed Rail Audits have commenced allowing practice to be reviewed, informal teaching and learning to commence, and areas for improvement to be identified.

We said we would: Reduce harm from hospital acquired pressure ulcers

What we achieved:

What:	To reduce the number of Hospital Acquired Grade 2 & 3 Pressure Ulcers. The Trust will have no Hospital Acquired Grade 4 Pressure Ulcers
How Much:	A reduction on 2015-2016 incidence
When By:	By March 31st 2017
Outcome:	From April 2016 to March 2017 there were a total of 164 grade 2 hospital acquired pressure ulcers. When compared to the same time period for 2015/2016 this represents a reduction of 22%. Between April 2016 and March 2017 there have been a total of 31 grade 3 hospital acquired pressure ulcers. When compared to the same period for 2015/2016 this represents a reduction of 45%. There have been no grade 4 pressure ulcers since May 2013. Overall the Trust has achieved a 28% reduction in pressure ulcers in 2016/2017

Hospital Acquired Pressure Ulcers	Grade 2	Grade 3	Total
2015-2016	210	59	265
2016-2017	164	31	194
% reduction	22%	45%	28%



We achieved this reduction in harm by:

- A change in culture. Openly acknowledging the challenges we faced in relation to the harm caused to our patients through the development of a pressure ulcer.
- Quality Improvement session led by the Director of Nursing was designed to challenge well-established cultural norms with the express purpose of re-establishing patient focused care by creating new norms and a fundamental belief that zero harm can be achieved. This included the removal of terminology such as avoidable/unavoidable pressure ulcers and focused on lapses in care.
- Development of a grade 2 pressure ulcer post incident report (PIR) tool to identify the reasons why the pressure ulcer developed and to identify lessons learnt.
- Sharing and learning from incidents at the Pressure Ulcer Prevention Group.
- Increased training for all nurses and allied health professionals, including simulation suite work.
- Development of a 'SWOT' team to provide prompt targeted support for areas of increased incidence of pressure ulcers.
- Successful tests of change developed from the pressure ulcer collaborative are being implemented across the Trust.
- 90 day rapid improvement model has been commenced to support teams to develop changes using quality improvement methodology
- The Practice Development Team is undertaking a review of training in relation to continence management and skin care.
- Raised awareness through a monthly newsletter.
- Compliance with positional changes for at risk patients as part of Intentional Rounding.
- Trust wide SSKIN compliance audit with learning from the results shared across the Trust.

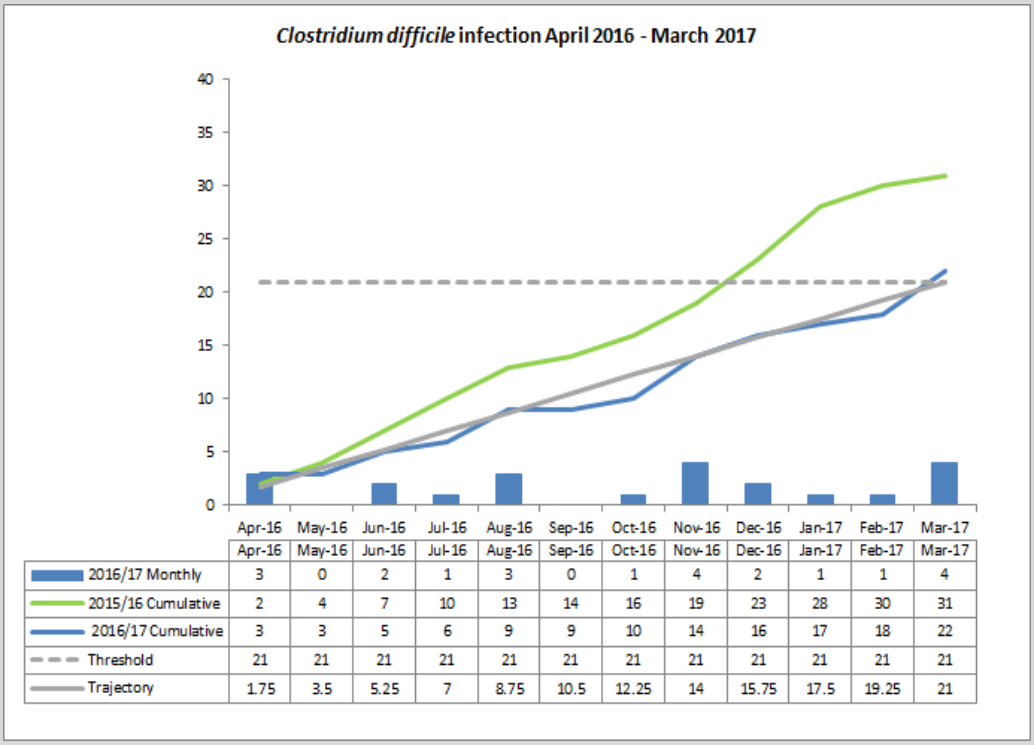
Whilst there has been a reduction in the overall number of patients developing pressure ulcer harms over the last 6 months, we are clear there is still work to do.

A Pressure Ulcer Collaborative using a 'Breakthrough Series Model' commenced in October 2015 with representation from relevant clinical professional groups and most wards. A series of learning sessions have been held through the year and the work will culminate in a pressure ulcer prevention summit in spring 2017.

We said we would: Reduce the number of patients with hospital-attributable *Clostridium difficile* infection

What we achieved:

What:	Reduce the number of *Clostridium difficile* infection (CDI)
How Much:	Less or equal to 21 cases 2016/2017
When:	March 2017
Outcome:	Between April 2016 and March 2017 there have been 22 patients with CDI infection (this figure includes 1 patient who had a false positive result – they were subsequently found to have a negative result CDI result on external review). The 22 patients have been reviewed by the Trust local Clinical Commissioning Group (CCG) and there were no lapses in care identified. In 2015 /2016 there had been 31 patients with CDI. The outcome in 2016/17 represents a 32% compared with the previous year.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
2016/17 Monthly	3	0	2	1	3	0	1	4	2	1	1	4
2015/16 Cumulative	2	4	7	10	13	14	16	19	23	28	30	31
2016/17 Cumulative	3	3	5	6	9	9	10	14	16	17	18	22
Threshold	21	21	21	21	21	21	21	21	21	21	21	21
Trajectory	1.75	3.5	5.25	7	8.75	10.5	12.25	14	15.75	17.5	19.25	21

We have progressed this priority by:

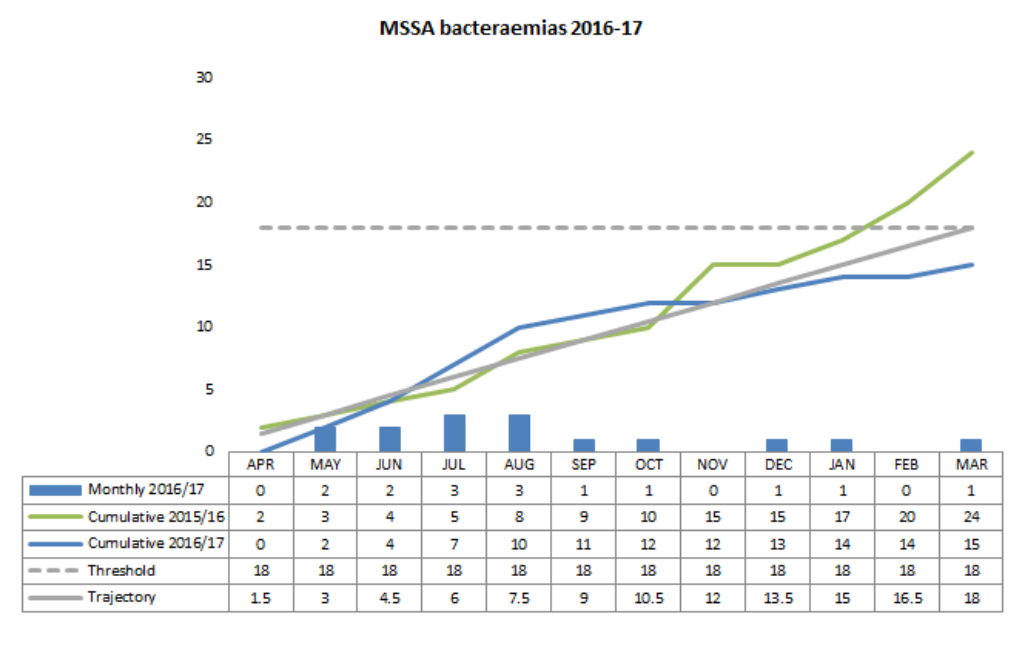
- Development of a *Clostridium difficile* infection improvement plan which has also been monitored through IPSG.
- NGH Trust became part of the NHS Improvement 90 day Healthcare Associated Infection (HCAI) reduction collaborative with 22 other trusts from across the country.
- The weekly C.diff round continues where patients with C.diff acquisition are reviewed by the Consultant Gastroenterologist, Consultant microbiologist, Antimicrobial pharmacist, a member of the Infection Prevention Team and now in addition our newly appointed Nutritional Nurse Specialist.
- In January 2016, the Infection Prevention Team and in collaboration with the domestic services team commenced enhanced cleaning. This procedure ensures that when a ward has a patient or patients who present a high risk of cross-infection, enhanced environmental cleaning support is implemented to reduce the risk.

We said we would:

Provide care that is safe by reducing harm by reducing hospital acquired methicillin sensitive Staphylococcus aureus (MSSA) bloodstream infections.

What we achieved:

What:	Reduce the number of patients with MSSA
How Much:	In 2015/2016 24 patients developed a trust-attributable MSSA bacteraemia. For 2016/2017 the Infection Prevention forward plan was to have no more than 18 patients with Trust attributable MSSA bacteraemia.
When:	March 2017
Outcome:	Between April 2016 and March 2017 there were 15 patients with trust-attributable MSSA bacteraemia, which represents a reduction of 38% on the previous year:



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Monthly 2016/17	0	2	2	3	3	1	1	0	1	1	0	1
Cumulative 2015/16	2	3	4	5	8	9	10	15	15	17	20	24
Cumulative 2016/17	0	2	4	7	10	11	12	12	13	14	14	15
Threshold	18	18	18	18	18	18	18	18	18	18	18	18
Trajectory	1.5	3	4.5	6	7.5	9	10.5	12	13.5	15	16.5	18

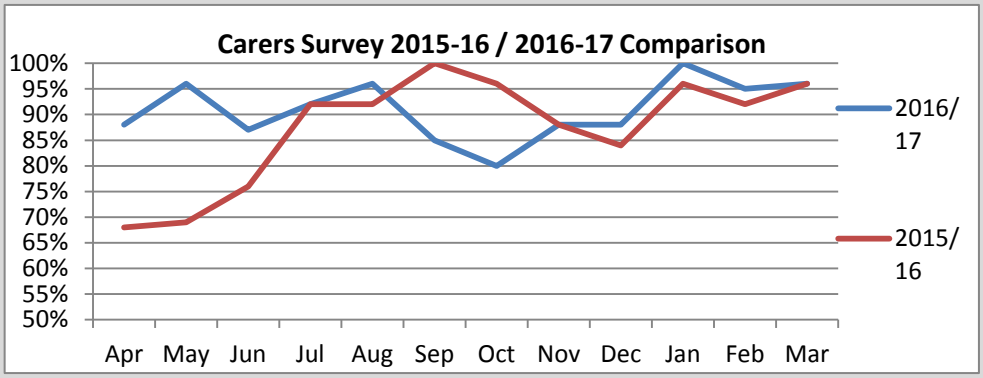
We progressed this priority through:

- The implementation of the MSSA bacteraemia reduction plan for 2016/2017.
- Post Infection review meeting within 48 hours for every case of NGH Trust attributable MSSA bacteraemia.
- Discussion of all incidents at the monthly Infection Prevention Operational Group.
- Lessons learnt and MSSA patient cases shared across the Trust through Infection Prevention Team patient safety alerts and ward huddle sheets.
- ANTT(Aseptic Non-Touch Technique) refresher training for any ward that has a line-related MSSA bacteraemia

We said we would:

Aim to Deliver Patient and Family Centred Care Using the Dementia Carers' Survey Results.

What we achieved:

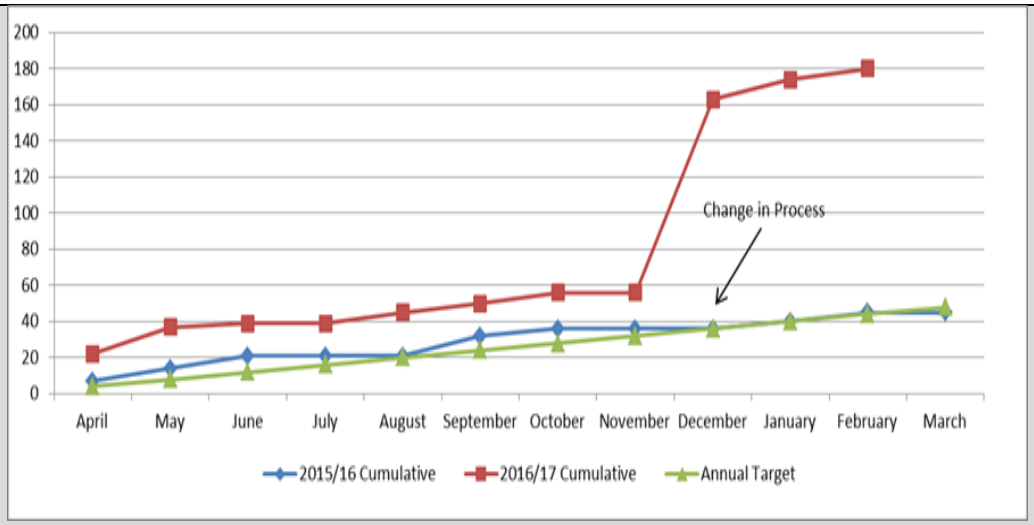
What:	Understand the needs and improve the experience of carers of those living with Dementia when they are admitted to hospital. A minimum of 25 carers of patients living dementia are asked each month if they feel supported and involved with the care of their loved ones.
How Much:	Continuous improvement
When:	March 2017
Outcome:	 A snap shot of the Quarter 4 data shows that in 2016/2017 97% of carers felt supported and involved in the care of their loved ones compared to 94.6% in 2015/2016. We are improving the care of people living with dementia by: • Developing survey feedback mechanisms to the clinical areas. • Incorporating the feedback into teaching plans. • Share the feedback in Dementia awareness sessions, inside and outside of the Trust. • Review of the patient profile/passport to improve communication. • Developing relationship/communication channels with care homes. • Carers and outside agencies are an integral part of the Dementia steering group. • Support of John's campaign, which is based on a simple belief that carers of patients living with dementia should be welcomed into our hospital, and that collaboration between the patients and all connected with them is crucial to their health and their well-being.

We said we would:

Support and monitor the provision of safe care and reduction of harm through increasing the number of Executive Safety rounds.

What we achieved:

What:	Executives and Non-Executive Board Members will visit clinical and non-clinical areas speaking with staff and patients. Speaking with patients and their carers during the safety rounds provides a timely opportunity to capture real time patient and carer feedback, capturing good practice and areas for improvement. Executive Safety rounds have been shown to have a positive effect on the safety climate and are a promising tool to improve the broader construct of safety culture.
How much:	Monthly as part of Trust Board Business. In 2014/15 there were 40 Board to Ward visits. The target set for 2015/16 was for a minimum of 48 executive safety visits. We undertook to: • Monitor the number of areas visited per month. • Provide Divisional feedback via patient safety and quarterly report. • Demonstrate progress via improved safety climate results.
When:	Executive safety rounds have been in progress from January 2009. A revised format was introduced in July 2012 to include all Executives and Non-Executive Board Members to visit clinical and non-clinical areas as part of monthly Trust Board Business. Target date was April 2016 – March 2017 inclusive.
Outcome:	Where regular Board to Ward visits have occurred, the operational staff and directorate management boards have acknowledged the benefit of senior leaders regularly spending time with them. They welcome the opportunity to discuss the safety issues which concern them and receiving feedback on action that would be taken forward to address these. The purpose of the safety round has allowed us to send a message of commitment to a culture for change focused on patient safety. When all executives commit to regular visits (walk rounds), it creates a shared insight into organisational safety issues. **During 2016/17 180 executive safety rounds were completed**:



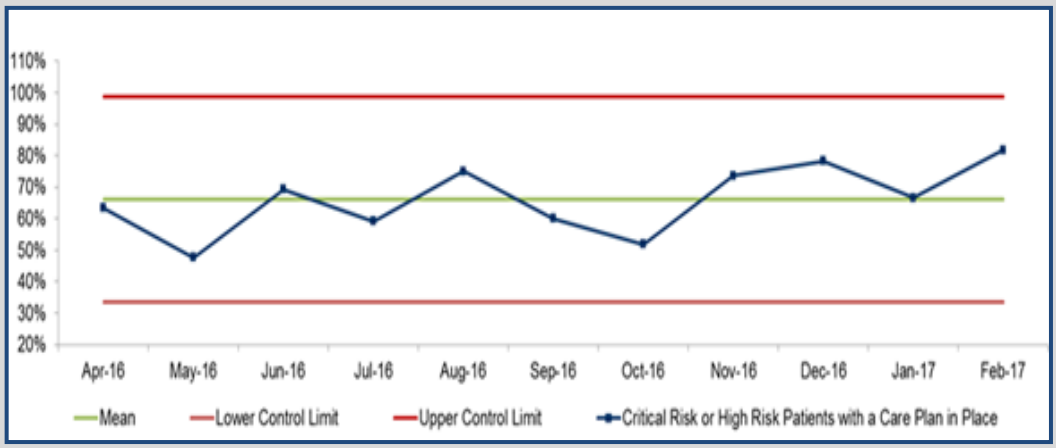
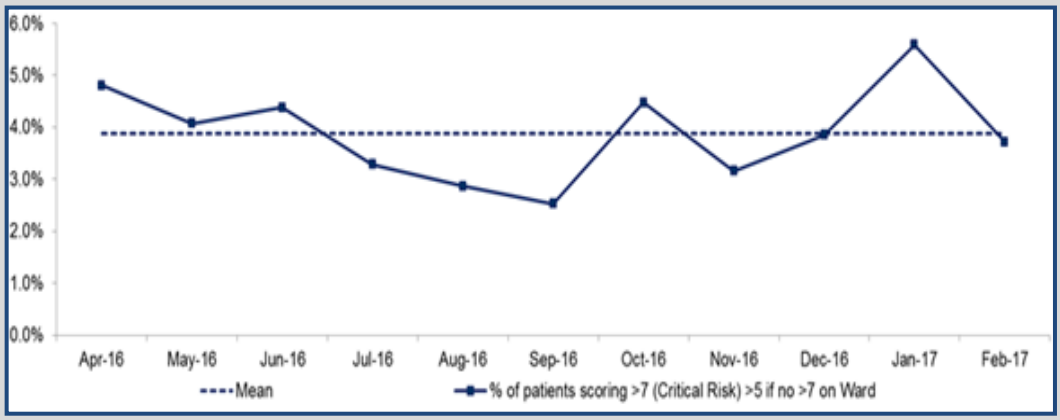
In December 2016 a change to the process was adopted whereby each member of the Bard made a ward visit on a monthly basis.

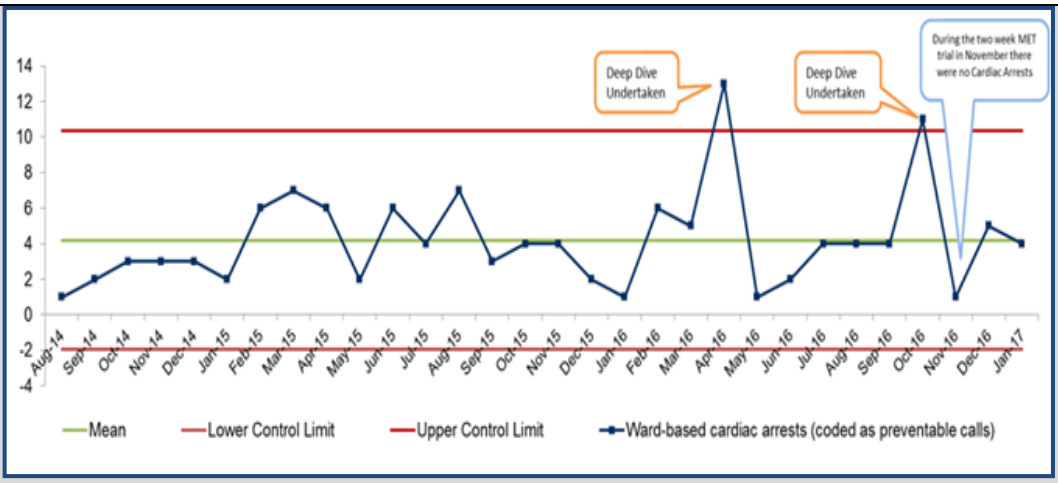
We said we would:

Provide care that is safe by reducing harm through improving the early identification & management of the deteriorating patient.

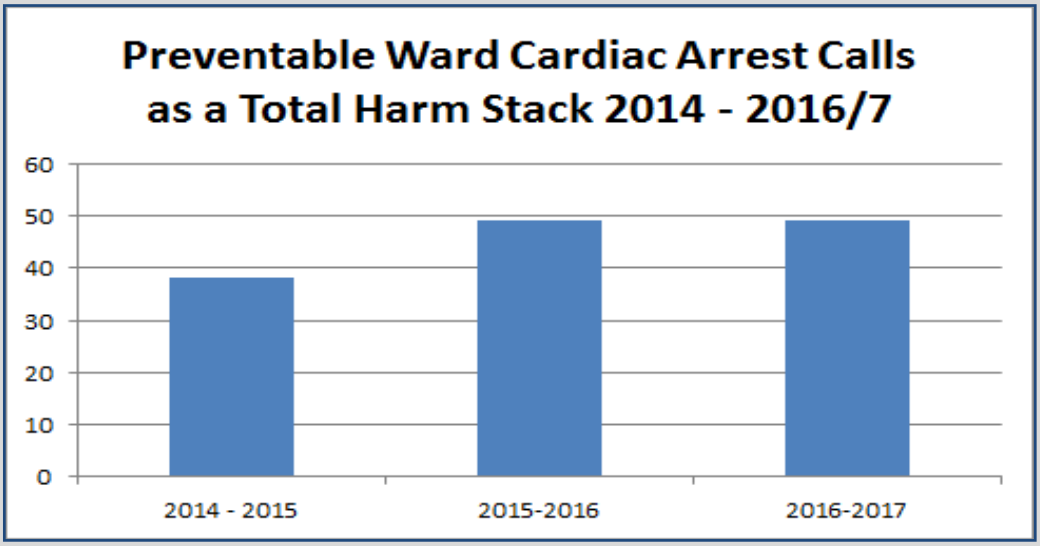
What we achieved:

What:	Failure to identify areas of deterioration in patient observations can potentially lead to delayed or missed escalation and treatment. The 2012 report "Time to Intervene", published by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) indicated that for many acutely ill people better assessment and action early in their hospital admission may have led to: • Intervention that may have prevented progression to cardiorespiratory arrest, or • Recognition that the person was dying and that attempted resuscitation would be inappropriate The NCEPOD report also states that in a substantial number of cases a patient's condition was not 'escalated' appropriately for assessment by a senior doctor. That assessment may have led to intervention to try to reverse deterioration, or may have led to recognition that the treatment would not result in recovery and to a decision that attempted CPR would be clinically inappropriate.
How much:	The NCEPOD report reflects that many in-hospital cardiac arrests are predictable events, often following a period of slow and progressive physiological derangement that is often poorly recognised and treaded. Therefore it was recommended that each hospital should set a local goal for reduction in cardiac arrests leading to CPR attempts. It has been reported that up to a third of hospital cardiac arrests could be preventable. We have aimed to reduce the number coded preventable cardiac arrest calls by 15% from the previous year.

When:	Monthly point prevalence audit data continues to be collected and circulated. The audit measures: • % of patients scoring within the critical risk category with an appropriate plan in place (if no critical risk patients at time of audit the high risk category are used). • Numbers of cardiac arrest calls that have been coded as preventable following full clinical review
Outcome:	1. Monthly EWS audits: The focus of the monthly audit and compliance awarded is based upon identifying patients scoring within the critical level >7 EWS and of those how many have received an appropriate level of escalation and management plan. During the audit, if no patients are scoring in this critical risk category then the high risk category is reviewed instead (5>).   2. Preventable Cardiac Arrest Calls: Members of the Resuscitation Committee review all data pertinent to any ward based cardiac arrest. Each cardiac arrest is coded via the review responses and a final code of a preventable or non-preventable call is awarded.



When there has been an increase in the number of cardiac arrests coded as preventable we have undertaken a detailed review to determine the specific causes and identify learning.



We have not seen a decrease in the absolute number of preventable cardiac arrests that we sought to achieve. Between 2014 and 2016 there was a significant increase in the number of patients admitted non-electively and in the acuity which has had a direct effect on the numbers shown.

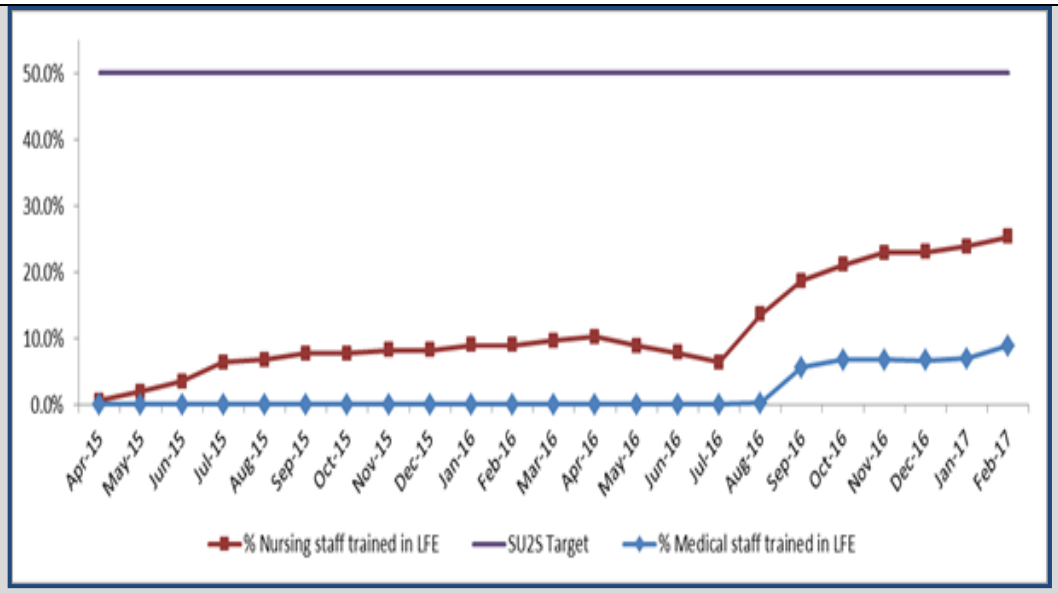
We continue to make a determined effort to reduce both the absolute and relative number of preventable cardiac arrests through our Resuscitation Group and the clinical Divisions.

We said we would:

Provide care that is safe by reducing harm through learning from errors within clinical teams.

What we achieved:

What:	The Chief Medical Officers report (CMO 2008) explained in detail how simulation in all its forms would be a vital part of building a safer healthcare system. Literature reviews frequently inform practice describing how well simulation training has worked in high risk organisations because it allow staff to practice difficult scenario's an learn technical and non-technical skills in relation to safety and team work, providing the safest environments for their workers and public. Whilst delivering simulation speciality training programmes since the Simulation Suite in NGH has opened it has become apparent there were common themes especially involving human factor skills. A programme has been developed working closely with the wards to create a bespoke session for each area that addressed human and system errors relating to their individual issues addressed through Datix incident reports and any serious incidents. The objectives of each session include communication, decision making, situational awareness, task focus, escalation and challenging behaviours.
How Much:	We will measure the amount of ward staff attending an annual learning from errors (LFE) session within the Simulation Suite. We aim for 50% of all ward teams to attend LFE by 2018. 2014-2015 Outturn – 5% of ward staff have attended an LFE session
When:	LFE was designed and implemented in April 2015. Attendance is collated quarterly and ward managers are informed of attendance levels.
Outcome:	The LFE sessions have now been running for nearly two years and showing a gradual increase in attendance, however medical staff attendance remains low. Point of care simulations were developed within Q2 of 2015-2016 with the aim of addressing the theory from LFE in the classroom to practice in the ward situation. These have been well received and the project has been further extended to a collaborative piece of work with Northampton University to assess the difference that LFE makes to practice. Our aim by the end of 2018 is to undertake one Point of Care simulation each week. The 2014–2015 outturn was recorded as 5% of ward staff had attended LFE. In 2015–2016 - 33% of staff had attended LFE, which is a 28% increase from the baseline During 2016–2017 - 43% of staff have attended LFE (excluding March 2017), which is a 43% increase above the baseline measurement. Staff are encouraged to attend annually and the below graph is refreshed each year to take this into account.

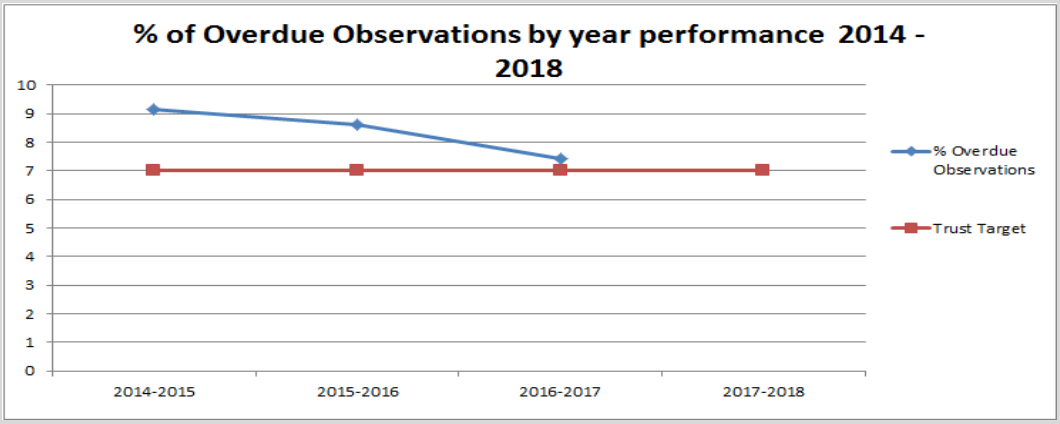
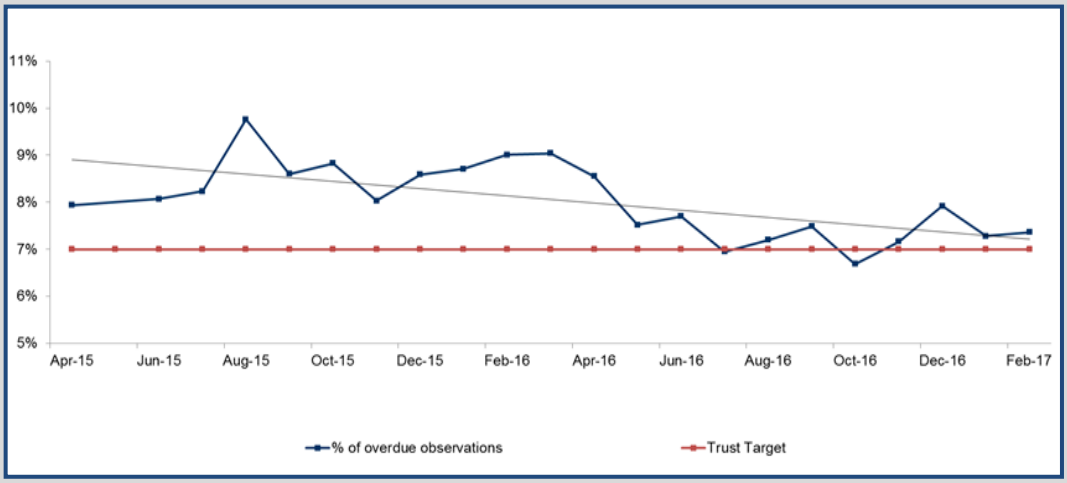


We said we would:

Provide care that is safe by reducing harm through improving the quality & timeliness of patient observations.

What we achieved:

What:	Failure to take patients observations in accordance with their planned and prescribed care can lead to delayed identification of any potential deterioration and therefore potentially delayed treatment.
How Much:	We will measure all overdue observations data using VitalPac across all adult general wards. Vitalpac is an electronic system for recording observations and other clinical data. The system uses this clinical information to alert staff to changes in the condition of our patients. We will aim to improve overdue observation rate by 3% to achieve the Trust target of no greater than 7% overdue observations. In 2014-2015 the rate of overdue observations was recorded as an average of 9.14%.
When:	Monthly point prevalence audit data has been collected since 2014 and circulated to all adult general wards.
Outcome:	We have placed a threshold of acceptance at 7%. Any ward that is consistently above that target receives targeted support with additional lessons learnt from performing wards being utilised as good practice examples. There has been a gradual improvement year on year with targeted support to those wards demonstrating non-compliance including the use of additional iPod's to allow the ward co-ordinators to keep track of when patient observations are due and prompt the appropriate staff accordingly. A gradual roll out of bay tagging as a working principle has demonstrated an improvement towards the 7% target being achieved. The 2014 – 2015 out-turn was recorded as an average of 9.14%. The mean for 2015 – 2016 was 8.61% demonstrating a 0.53% reduction from the baseline.

	The mean for 2016 – 2017 is 7.43% (excluding March 2017) demonstrating a 1.71% improvement from the baseline.  % Overdue Observations by month: 

We said we would:
Provide care that is safe by reducing harm through Improving Organisational Safety Culture.

What we achieved:

What:	In recent years there has been an increase in focus in the UK and internationally on approaches to improve safety and this has led to greater recognition of the importance of the culture of organisation and teams. NHS England launched the Patient Safety Collaborative in October 2014 following the publication of the Francis and Berwick Reports. Safety culture and leadership were identified as mandatory areas.
How Much:	The overall outcome measure for this project will be from the Pascal Survey – i.e. the operational staffs' perceptions of the safety culture in their work area. The survey will be repeated in 2018 and the following two years. The following tables show the results of the baseline assessments. The baseline position shown reflects the work of the teams over recent years in both the A&E and Maternity departments to improve the safety culture for the benefit of our patients.

Safety domain	NGH ED score	East Midlands mean score[1]	East Midlands range of scores[2]
Overall perceptions of patient safety	60%	39%	21% - 60%
Safety climate	80%	58%	41% - 80%
Teamwork	84%	63%	43% - 84%
Job satisfaction	84%	60%	37% - 84%
Working conditions	61%	39%	21% - 61%
Exhaustion / resilience	58%	36%	23% - 58%
Perceptions of senior management[3]	40%	17%	7% - 40%
Perceptions of local management[3]	61%	47%	34% - 61%
Nonpunitive response to errors	53%	39%	24% - 53%

Safety domain	NGH Maternity score	East Midlands mean score[1]	East Midlands range of scores[2]
Overall perceptions of patient safety	60%	57%	42% - 67%
Safety climate	75%	73%	58% - 86%
Teamwork	70%	67%	50% - 79%
Job satisfaction	75%	61%	47% - 75%
Working conditions	52%	49%	28% - 64%
Exhaustion / resilience	52%	45%	37% - 55%
Perceptions of senior management[3]	33%	25%	11% - 38%
Perceptions of local management[3]	66%	54%	43% - 66%
Nonpunitive response to errors	43%	34%	24% - 50%

A&E (ED)
NGH received the most favourable scores within the region.

The Quality Improvement team have supported the A&E to identify three primary drivers to support make further improvements in line with the aims described above :

- Improvement in the designated paediatric area to ensure 100% of children will receive a rapid assessment when clinically appropriate. (4 secondary drivers)
- 100% of patients will attend A&E clinical observation area adhering to the Trust and departmental policy (3 secondary drivers)
- 25% increase in the number of staff who have a favourable opinion of the work culture in A&E (6 primary drivers)

Maternity
The maternity team have identified two major work streams that will be led by community and hospital based midwives.

The teams have identified the following areas for improvement :

- An improved, transparent reporting culture (non-punitive response to errors)
- Increased senior management visibility
- Improved support and appreciate of staff
- Improved internal communication

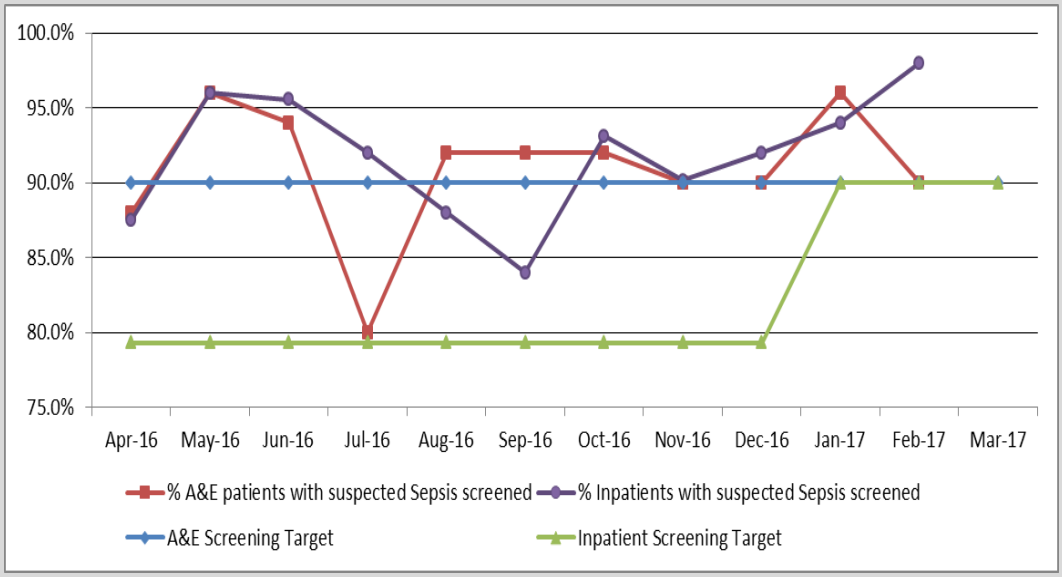
	There are also additional outcome measures for each primary driver, detailed below. **A&E** A&E Continuing Observation Area (COA) project (1): Average length of stay in the A&E COA A&E COA project (2): Compliance with the revised departmental policy on the clinical observation area. Rapid Assessment project: Time to triage paediatric 'minors' patients Rapid Assessment project: Average length of stay (LOS) for paediatric patients Staff Working culture project: Percentage of staff with a favourable opinion of the work culture. **Maternity** Response to errors: % of staff who say there is a positive reporting culture Communication: % of staff who say there is effective communication within Maternity Senior Management: % of staff with a favourable opinion of senior managers Support: % of staff who feel appreciated and supported in their role We have also agreed all relevant process, balancing, financial and patient experience factors and measures with the project leads for each work area.
When:	The project aim for both work streams, is by 2020 there will be a 50% improvement from the 2016 baseline in the number of operational staff who have a favourable opinion of the safety culture in A&E and Maternity
Outcome:	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.

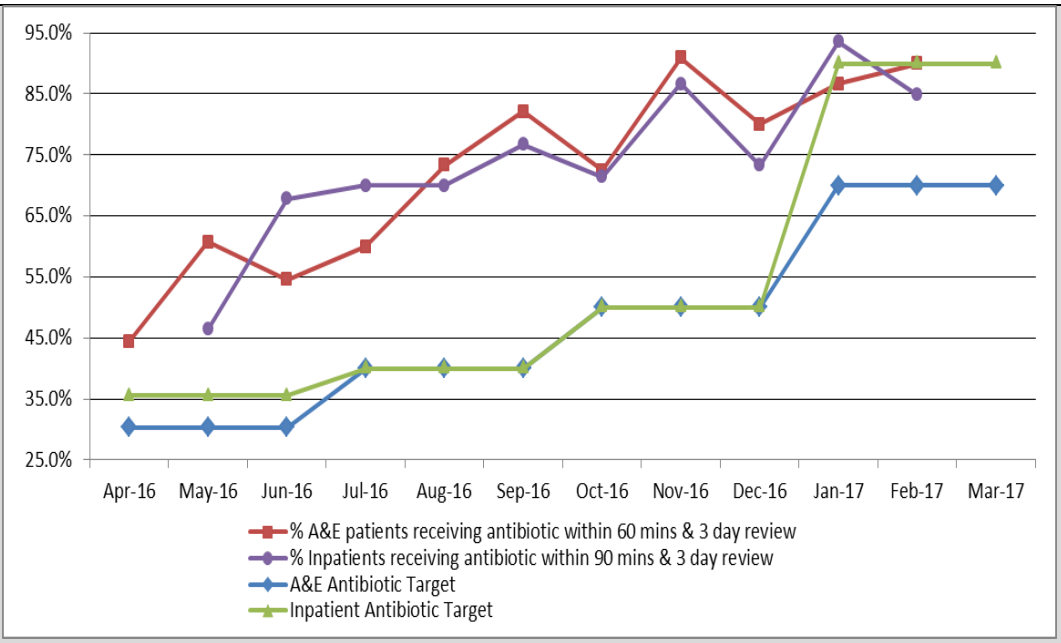
We said we would:

Provide care that is safe by reducing harm through eliminating delays in investigations and management for patients with sepsis

What we achieved:

What:	Failure to recognise symptoms of developing sepsis or red flag sepsis can lead to delayed antibiotic treatment, with a subsequent rise in morbidity / mortality and increased length of stay.
How Much:	We will eliminate delays in antibiotics administration to septic patients by ensuring that patients with deranged early warning scores (EWS) are screened for sepsis both on identification of EWS rise and at entry to the hospital. We also aim to increase antibiotic administration to 90% compliance within 60 mins (A&E) and 90 mins (inpatients), in line with national CQUIN targets, from diagnosis, for patients with red flag sepsis

When:	In 2016/17, we are measuring two groups of patients, those presenting to the Emergency Department and inpatients. For these groups, ie. A&E /inpatients , we are measuring performance against two sets of criteria: • The percentage of patients with EWS of 3 or higher, (a) on arrival in A&E, and (b) inpatients that are suspected of Sepsis that are screen for Sepsis. • The percentage of patients with red flag Sepsis (as set in UK Sepsis Trust / NICE guidelines) who are administered antibiotics within the appropriate timeframe (within 60 minutes / A&E and within 90 minutes / inpatients) **and** then had an antibiotic review within 72 hours.
Outcome:	Sepsis is a common and potentially life-threatening condition where the body's immune system goes into overdrive in response to an infection, setting off a series of reactions that can lead to widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can mean blood supply to vital organs such as the brain, heart and kidneys is reduced – potentially leading to death or long-term disability. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with an estimated 106,000 people in the UK surviving sepsis and a further 44,000 deaths attributed to sepsis annually *(source UK Sepsis Trust)*. The Parliamentary and Health Service Ombudsman (PHSO) published *Time to Act* in 2013, which found that recurring shortcomings in relation to the sepsis management included: • Failure to recognise presenting symptoms and potential severity of the illness • Delays in administering first-line treatment • Inadequate first-line treatment with fluids and antibiotics • Delays in source control of infection • Delays in senior medical input 



Considerable progress has been made in the treatment of sepsis. We will continue to focus on this area so that we can consistently achieve the in-patient target and A&E targets to ensure that patients with sepsis receive potentially life-saving treatment as quickly as possible.

General Improvements in 2016/17

Quality Improvement

We have made Quality Improvement (QI) work a key point of focus to improve the care that we provide to our patients and have described this in our Quality Improvement Strategy.

To ensure that the learning can be captured and shared across the Trust, we developed a central repository that is supported by the QI team. This provides a library of projects & ideas that may benefit from further project work/development and will reduce areas of duplication & replication. This has been an important development for our organisation as it will particularly highlight work that is sustainable and can be transferred between teams to become business as usual.

During 2016/17 we had more than 40 projects across the Trust which were supported by our QI team some examples of which are listed below:

- Improving Nurse Knowledge of Acute Kidney Injury
- Improving early Discharge by earlier engagement with family/carers
- Reducing the amount of inappropriate cannula's
- Improving the accessibility of patient observations on admission unit ward rounds
- Doctor Toolbox
- Documentation of cardiac arrest management in out of hours cardiac arrest
- Standardisation of procedure specific equipment trays
- Improving Electronic Discharge Notification (eDN) completion in Urology.
- Effectiveness of the falls assessment form
- Improving access to gynaecology equipment for emergency assessment
- Improving accessibility to common guidelines
- Introducing a discharge system for medically fit for patients who requiring four times daily intravenous antibiotics
- Improving surgical handover
- Medical Emergency Team trial
- Improving the efficiency of giving medications by 25% on Holcot ward
- Night team handover
- Care of the patients on the stroke pathway who are 'nil by mouth'
- Improving the paging system
- Rapid tranquilisation
- Support of the Trust rollout of the SAFER bundle
- Improving accessibility of bedside sharps disposal
- Situation, Background, Assessment, Recommendation (SBAR) communication tool implementation
- Improving compliance with Venous Thromboembolism (VTE) risk assessment
- Improving medical weekend handover plans
- Introducing a daily '10 minute conversation' for the emergency team
- Improving access to emergency protocols
- A multidisciplinary approach to learning from error

Reflecting the high level of QI activity, the Trust submitted 17 projects for consideration by the Patient First conference. In all, we made 49 conference submissions this year, with 18 of these being shortlisted for presentation and the Trust received 4 QI awards.

We made 25 submissions of QI work carried out by our junior doctors which were accepted for the 2017 International Forum on Quality & Safety in Healthcare.

More recently we have had 12 submissions accepted for presentation at the Patient Safety Congress:

- Introducing a '10 Minute Conversation' – Improving Communication within the Adult Cardiac Arrest Team
- Improving Nursing Knowledge of Acute Kidney Injury
- Reducing the risks associated with blood transfusion: the experience of implementing patient blood management at Northampton General Hospital
- Easing the stress of rotation through the development of the Dr Toolbox mobile app and the introduction of a formal handover
- Improving Access to Emergency Protocols
- Improvement of Service Provision through the Introduction of Gynaecology Emergency Bags at Northampton General Hospital
- Improving intravenous Fluid Prescribing
- Learning from Errors - A Multi-disciplinary Approach within the Simulation Suite
- Improving the Efficiency of the Administration of Medication on an Acute Medical Ward
- Introducing Point of Care Simulations at Northampton General Hospital
- Improving the disposal of sharps
- Improving VTE re-assessment compliance

This work comes from across the multidisciplinary team and reflects the desire of all of our staff to seek innovative ways of improving the care we provide. Using this approach, we have improved the care for more elderly patients by making our Accident & Emergency Department "frail friendly" and improving the skills of our staff in Geriatric Emergency Medicine (GEM).

GEM in our A&E
We organised multidisciplinary GEM training on a bi-monthly basis and targeted teaching for specific groups e.g. our non-clinical staff.

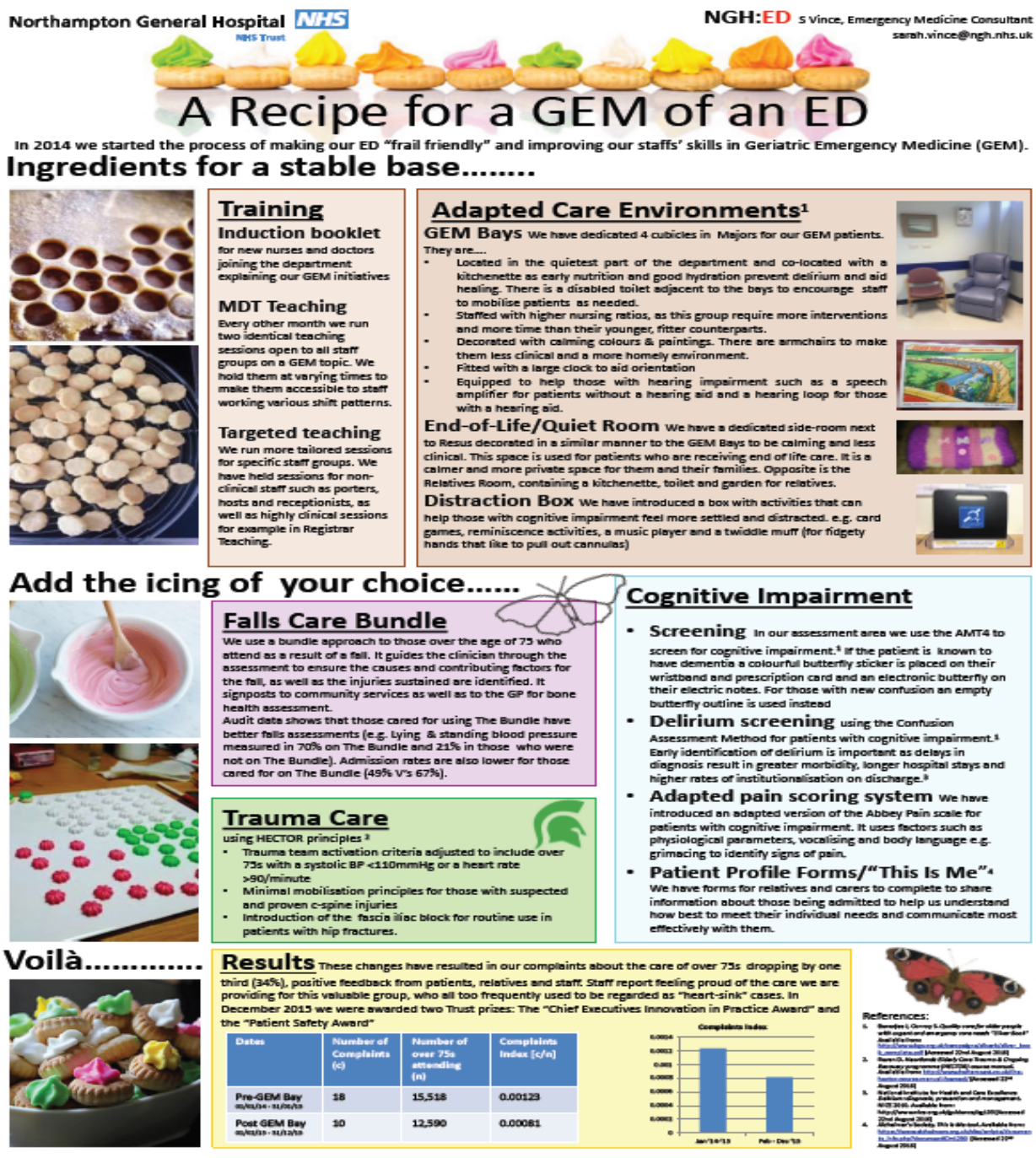
To make our clinical area more homely and calming we redecorated the four quietest bays and prioritised them for those with cognitive impairment and frailty with pastel colours. Specialised equipment such as speech amplifiers for those with hearing problems are also readily available. The nursing ratios are higher than for other Majors bays with 1 nurse and 1 healthcare assistant to 5 cubicles.

We have developed a number of specially designed care pathways for our GEM patients:

- Cognitive Impairment
- Falls Care Bundle
- Trauma Care

Since starting this programme our cognitive assessments have improved from 11-52% over 16 months. The Falls Bundle has improved the quality of falls assessments. In the year after the introduction of these changes, our complaints relating to the care of patients over 75 years of age fell by 34%.

With the right staff training, departmental processes and an adapted care environment we have been able to make our busy, A&E "frail friendly".



QI reporting

During 2016, the bi-annual Quality Improvement and Efficiency Report brings together the national focus that demands assurance for continual learning and improvement of Patient Care and supports the Quality Improvement Strategy 2016/19.

Our aim is to ensure that improvement is measured and presented using run charts and control charts to understand variation. Our view is "a picture is worth a thousand words" and is a fundamental concept for quality improvement. Rather than relying on data tables its best to make a picture of the data and let the picture do the talking. Plotting data over time can incentivise and maximise the learning from data collected by revealing patterns and improvement opportunities.

Our reporting structure provides clarity of why projects were chosen, and their interconnectivity with strategic objectives or organisational risk, the impact on patient experience, and workforce and financial efficiency and effectiveness.
All reports respond to three improvements questions:-

- What are we trying to accomplish?
- How will we know that change is an improvement?
- What changes can we make aimed at improvement?

Leadership & Safety for Doctors in training

- *JDSB* - The junior Doctor Safety Board (JDSB) is formed following each new intake of junior doctors in August of each year. This year the JDSB has been opened up to any grade of junior doctor.
- *Aspiring to Excellence Programme* – NGH have been offering this bespoke course to 5th year medical students for 6 years. The course teaches the students the fundamentals of safety science and focuses on one main theme each year for project focus. The students receive a series of lectures and interactive sessions on a number of aspects of the project theme and QI methodology as well as including patient experience.
- *Registrar Management Development Course* – This is a nine week course modular in nature and bespoke to NGH. The Registrars are encouraged to challenge and question the safety principles and processes in place and lead on a project that demonstrates their understanding of how to implement a quality improvement initiative interacting with the appropriate personnel to deliver a sustainable change.

Our aim is to encourage all junior doctors to join the various programmes on offer and be supported to undertake a quality improvement project, through to conference submission and possible publication. All participants are supplied with teaching of QI principles and methodology and guidance in submitting their work to conferences and publications.

NGH and the East Midlands Patient Safety Collaborative
The Patient Safety Collaboratives (PSC) were launched by NHS England at a national event in October 2014. East Midlands Academic Health Sciences Network (EMAHSN) held a stakeholder event to share priorities in March 2015.

The PSC commitment is to build Capability in Quality Improvement, grow Leaders for Safety and improve the Safety Culture of organisations. NGH has welcomed the new PSC operating model to support the development of system level patient safety aims in each STP footprint and are leading on this work on behalf of the county.

We are leading a countywide improvement plan working with other care providers across teams to identify aims, measures and adoption of QI methodology in order to make the quality interventions as successful as possible focussing on the ‘deteriorating patient’. The overarching aim of the collaborative is to reduce avoidable harm through the delivery in improvement in three key areas:

- Reduce avoidable harm from failures or omissions in care
- Prevent incidents in healthcare by sharing and learning
- Working collaboratively to improve patient safety

To do this we are employing QI methodology at a system level. In collaboration with our partners we have made management of sepsis our focus and are developing a county wide improvement plan which has the full support of the UK Sepsis Trust.

The PSC has commissioned NGH to deliver bespoke Quality Improvement coaching for the STP, which is planned to be replicated in other STP footprints.

Capturing QI at NGH
A central repository has been developed to capture QI work that is supported by the QI team. This repository provides a library of projects & ideas that may benefit from further project work/development but should reduce areas of duplication & replication. This has been an important development for the organisation as it will highlight work that is demonstrating sustainability and can be transferred to teams and become business as usual.

All new projects are required to have a project proposal template completed which highlights the identified problem and maps with strategic fit. The project will then be supported by members of the QI team, through to completion, and to conference submission.

Making Quality Count
Our flagship programme "Making Quality Count" is designed to engage our staff in a user-friendly and systematic method of improvement. Over a 3 month period we take teams through the programme, coaching them and training them to be able to lead and deliver change independent of our support. Some examples of our work in Making Quality Count include the following areas

Supporting main theatres to change the way they work to start theatres on time to more effectively utilise all our theatre time.

- How: Empowered and coached our staff to gather data on late starts and supported them to analyse the root causes of starting late.
- What changed: Improved rostering of staff and skill mix, refocused the teams efforts and focus 1st thing in the morning to create more time and get ready for our 1st patient faster, built a new quality assurance framework to ensure patient safety and quality were guiding our actions
- The results: There was a 50% reduction in late starts and an 8% increase in theatre productivity which created 45 minutes extra preparation time per theatre through redesigning the morning huddle.

Reduced patient waiting by improved flow of patients attending the Diabetic Obstetric Outpatient Clinic to improve both patients and staff experience?

- How: Worked with staff and clinicians to understand the true demand and capacity of the clinic. Mapped the clinic flow and layout. Redesigned how clinicians worked together to take steps out of the patient pathway
- What changed: We worked with NHFT and changed when they delivered their sessions. We eliminated the queue at the start of the clinic. We created three pathways through the clinic and booked patients specifically these pathways. We agreed to deliver joint clinical Consultations, Additionally, we improved flow by putting patients in clinic rooms and clinicians went to them rather than clinicians waiting in a room.
- The results: Significant reduction in patient waiting time – average 47 minutes reduction, with more efficient use of clinical resources and happier patients – the reduced waiting and improved patient flow also resulted in happier staff.

Some of our other projects include:

- Reducing the time taken to respond to patient complaints
- Improving the theatre scheduling process for elective surgery
- A trial to reduce the demand on the pre-operative assessment unit by streaming ASA1 patients safely
- Improving the start of day and equipment requirement processes in day case surgery
- Supporting our nurses with service improvement methodology on the RCN leadership course

Electronic Prescribing and Medicines Administration

Across the Health Service there many instances where medication is given incorrectly or may be missed altogether. We recognised that medication safety could be improved by using and electronic prescribing system. In April 2015 we started to implement an e-prescribing and medicines administration system (EPMA). Since this time we have worked with the system developer (EMIS) to refine it and have gradually rolled it out across our Trust.

The EPMA system is now being used in our A&E and across all of our medical specialties. We have also made progress in using the system in our surgical areas including the operating theatres. During 2017 the EPMA will be rolled-out across the remainder of the Trust.

In those areas which are using the EPMA system we have seen a significant reduction in the number of incidents which are related to medication. As we develop the system further we expect this to improve quality and safety of services for our patients.

Our Nursing & Midwifery Strategy

We created a unique collaboration resulting in a truly shared vision for nursing and midwifery, by nurses and midwives. This strategy is the beginning of a three year journey which we embark on with the support of our Pathway to Excellence partners. The success of the journey is dependent on all the factors set out in our strategy.

Nursing & Midwifery Professional & Practice Development

We are supporting our nurses and midwives to develop degree and masters level education in partnership with our learning beyond registration academic partners. In addition, we are working on developing our nursing and midwifery workforce with specialist advanced practice.

Instrumental in the delivery of our Nursing & Midwifery Strategy the team support leadership through the delivery of preceptorship through to band 6 & 7 development programmes and the RCN Clinical Leadership Programme.

Supporting our nursing & midwifery workforce currently and for the future includes a comprehensive international preceptorship programme taking our new international colleagues through the required objective structured clinical examination (OSCE) assessment. We are currently in the top three Trusts nationally for our first time pass rate.

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Trainee Nursing Associates

The new nursing associate role is a key part of national plans to create a strong, sustainable nursing workforce for the future. The nursing associates will work alongside existing health care support workers and registered nurses to deliver hands-on care for patients.

The Trust is part of a wider East Midlands collaborative of NHS Trusts and universities and one of only 11 pilot sites in the UK training the first wave of nursing associates. 18 trainee nursing associate students have been recruited to this landmark pilot scheme, and the group began their 2 year programme in January 2017. The trainees were recruited from our existing healthcare assistant workforce, investing in our own staff for our future workforce.

NGH & the University of Northampton

Reflecting our desire to look for more ways to improve the quality of the services we provide to our patients we are collaborating with the University of Northampton to develop a number of areas where we can work together. Both organisations have a clear interest in biological, medical and health related research. Together are working towards a common goal of engaging in and delivering research for the benefit of the wider health economy population.

MSc– Patient Safety & Quality Improvement

Building on this collaborative model we are developing a Masters Degree programme in Quality Improvement & Patient Safety with the University of Northampton.

The course is aimed at healthcare professionals and managers who wish to develop a greater understanding and expertise in patient safety and quality improvement with a strong emphasis on practical application. This will be supported by developing the candidates' level of expertise by undertaking a project supported by both academic and clinical mentorship at NGH.

The development is progressing well and we are on track for the validation process which should see the first cohort start in January 2018. The course will be classed as a premium level course which, as such, should attract international students as well as those from the UK.

Collaboration with Health Education England (HEE)

Northampton General Hospital has been delivering a bespoke modular course for medical Registrar development since 2012 which aims to provide our doctors with a sense of the wider issues facing the NHS and the local issues related to hospital medicine.

As part of this course our registrars are asked to lead and deliver a patient safety, patient experience or clinical outcome based quality improvement project utilising the Institute for Healthcare improvement (IHI) approach "science of Improvement" which is a unique approach on improving quality, safety, and value in health care.

Building on our experience in this area we have been awarded funding to deliver the training across the county for Specialist trainees in both acute and general practice.

Dare to Share Learning Events

We have a number of methods for sharing learning following a clinical incident in order to keep our patients safe. This year we developed a new meeting to spread important safety information among a wide multidisciplinary audience and this has recently been shortlisted for has been shortlisted in the Clinical Governance & Risk Management in Patient Safety category of the Patient Safety Awards

There have been four of these 'Dare to Share' events held which have each focused on learning from adverse events which have occurred within the Trust, supporting us on our journey to deliver the best possible care. The staff involved in the incident share their own experiences and there has been an open dialogue about factors which contributed to the incident.

The events have been organised by our governance department and supported by the Medical Director. Each event consists of presentations and we have focused on a wide range of topics including:

- Unexpected admission to ITU
- Use of an alarm system for monitoring patients' heart rate
- Never Events
- Care of the patient treated with Non-Invasive Ventilation
- Safer sharps
- MRSA bacteraemia
- Mental Capacity, Deprivation of Liberty and Medication

To date, the events have been attended by over 200 members of staff from a variety of disciplines all of who have been encouraged to share their thoughts on the trusts learning tree.

During the meeting all attendees are encouraged to document the learning that they will take away and share with their colleagues. At the following meeting those who attend are asked to describe how they have change practice and what they have done differently as a result of the meeting.

Urgent Care

As with many Trusts we have experienced considerable pressure on our urgent care pathways. Patients are increasingly likely to present more acutely unwell with more complex medical problems. Right across the organisation our multidisciplinary teams have worked hard to improve the effectiveness of urgent care.

To support this work, we completed the final phase of improvement works within the A&E. This was part of a phased re-development programme which has taken place over the last four years, during which time the whole area has been brought up to the latest standards, capacity has been increased considerably, additional clinical facilities such as a new ambulatory care centre, state of the art resuscitation area and clinical observation unit have been developed, whilst at the same time maintaining 'business as usual'. Our patients can now benefit from new triage, general practitioner and resuscitation areas. We have also created a dedicated area for children in the A&E department where they can be seen and assessed by our staff.

Some of the key changes we have made in the last year are described in this section.

In-house Primary Care Streaming

We recognise that many patients will present to our A&E with problems that in the past would often have been reviewed by a General Practitioner. To ensure that patients are directed to see a General Practitioner when it is right to do so we have introduced a Primary Care Streaming service into our A&E. This builds upon our previous experience working in partnership with an independent GP service. The service ensures that patients who can be managed by a General Practitioner are seen in a timely way and avoid the main A&E.

Due to the success of this service we will extend it further in 2017/18. Our Primary Care Streaming service will be relocated to Springfield House once redevelopment work there has been completed. This has been made possible as we have successfully bid for £858,000 of central funding which was announced in the Budget.

Consultant Connect

During 2016/17 we introduced the Consultant Connect system into the Trust. This allows GPs to quickly access our senior doctors for advice and guidance through a specialised phone system. Once rolled-out across the Trust the system has allowed patients to be directed toward appropriate investigations, clinics and other services avoiding the need for attendance at the A&E. This has undoubtedly improved the quality of the service we provide to our patients and made sure we continue to make the best possible use of our resources.

SAFER Bundle

To improve the care that we provide and minimise waiting and so help our patients to be discharge we have introduced the SAFER bundle in the Trust. This is a standardised way of managing patient flow through the hospital. It ensures that our patients are seen by a senior doctor as early as possible in their stay when clear treatment plans are made and discharge arrangements agreed.

We have a dedicated project team support the roll out of the SAFER bundle and have begun to see the benefit that it brings our patients.

Red2Green
The Red2Green approach is a visual system to assist in identifying any time that does not contribute to a patient's journey whilst they are in hospital. A 'green day is one where a patient has had treatment or an investigation which will move them along their treatment plan. A 'red' day is one where this has not happened and the time has not been used effectively. Our wards have adopted the Red2Green approach to ensure that time in hospital is used as effectively as possible and now make every effort to minimize 'red' days.

90 Day Discharge Collaborative
The aim of our 90 collaborative discharge work is to ensure that our ward processes are as efficient as possible. We are reviewing processes on a number of our wards and making targeted tests of change. In some of our clinical areas we have achieved a reduction in the length of stay for our patients by as much as 50%. Once we have demonstrated that a practice or process change is effective these are rolled out to other areas.

New Ways of Working
We are continuously seeking new or better ways of working. In the last year we have developed a new medical model to increase senior medical capacity in the acute assessment areas. We have also developed a 'consultant of the week' model in Oncology and Cardiology.

This has meant that our patients are seen more quickly be senior medical staff who are best placed to quickly decide on the treatment plan. For patients that do not need to remain in hospital we have been able to discharge them more quickly improving their experience of our services.

There have been changes to the way we work across the multidisciplinary team which ensure that we can quickly get the right professional to see each patient every time.

Bringing staff together

Feedback from our staff is vitally important in helping us to deliver the best possible care for our patients. We have a number of ways of getting feedback which includes the staff survey and the Board to Ward visits which are described elsewhere in this account. During 2016/17 we introduced several further meetings and engagement events to improve communication within the Trust and to ensure that the views of staff could be heard and acted upon.

Compass Check
Our compass check events were informal meetings where representatives from across our management team provided staff with a wide ranging update on the activity and progress within the Trust during the last year. These have been well received with highly positive feedback.

Listen & Learn
The feedback from these meetings identified that there were specific of areas where our staff would like to have more detailed information. In response we introduced Listen and Learn meetings which to date have focused on:

- Operations
- Human Resources
- Finance

Each of these meetings has been presented by the Director responsible for the area moving to a 'Question Time' style section chaired/hosted by the Chief Executive. These meetings have produced a lively discussion and very positive feedback with requests for further events.

CEO Engagement Events

Alongside these meetings we have established unscripted meetings with senior management team and our clinical divisions which are hosted by our Chief Executive. These informal meetings have provided opportunities for more informal conversations. Staff are invited to participate from across the Trust and the feedback has been very encouraging.

Channel 4 Documentary

This year we were pleased to allow the documentary maker Two Four Productions into the Trust to film our junior doctors. The documentary entitled ‘Confessions of a Junior Doctor’ followed doctors as they cared for and treated patients in the Trust. It has been widely praised for providing a very real insight into the work that juniors doctors do and the modern healthcare environment. Medical staff form part of a much wider team which provides care and the support which the multidisciplinary team provides to one another came through very strongly in the filming.

Team NGH

The ethos captured during the filming is part of a wider sense of staff being part of ‘Team NGH’ which we have seen developing in the Trust where we consistently help and support one another to provide the best possible care for our patients. We know that our staff far exceed expectations every day in striving to provide a level of care which we can be proud of. Described in the following sections are just a few examples of this.

NHS Staff Survey

We have continued to work on the development of a sustained, coherent and integrated approach to changing our culture and engaging staff in helping us to deliver long term sustainable change that results in best possible care. We have set ourselves the overall aim of introducing Best Possible Care and the Trust Values and bringing them to life over the years. A key priority from the start was to align all efforts around the quality agenda in its broadest sense. This includes a relentless focus on patient safety and key quality outcome issues from all operational, clinical and managerial staff underpinned by key programmes of work. This work has been in progress for some time but some of the key initiatives have gained significant traction over the last 2 years.

This approach was originally captured in the Trust's Organisational Effectiveness Strategy: Connecting for Quality, Committed to Excellence. This led on from the Trust's focus on strategies for patient safety and quality improvement based but took this much further by focussing on the development of staff around Quality Improvement.

Our Employee Engagement strategy was designed to facilitate cultural transformation to deliver improved sustainable staff engagement for high performance working, building capability and commitment at all levels of the organisation. This has been underpinned by providing effective and supportive leadership and implementing a clinically led structure.

We are delighted to see that the combined efforts of the cultural work can be seen through the significant improvements in the results of our staff survey.

The 2016 annual National NHS Staff Survey took place during September to December 2016. A total of 4680 eligible staff had surveys sent directly to them and 1624 members of staff returned the survey.

Of the 32 key findings this year there has been improvement in 11, no deteriorations and 21 have stayed the same. These results support the continued positive trend of improvement at the Trust over the last 4 years. In addition the Trusts overall staff engagement score has also improve since the previous survey.

The Trust has had 12 statistically significant improvements since 2015, and these were for:

- Overall staff engagement
- Staff reporting good communication between senior management and staff
- Quality of non-mandatory training, learning or development
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- Staff confidence and security in reporting unsafe clinical practice
- Organisation and management interest in and action on health and wellbeing
- Staff recommendation of the organisation as a place to work or receive treatment
- Staff satisfaction with level of responsibility and involvement
- Staff satisfaction with resourcing and support
- Recognition and value of staff by managers and the organisation
- Support from immediate managers
- Staff satisfaction with the quality of work and care they are able to deliver.

When compared against other acute trust, the Trust was in the top 20% for:

- Staff motivation at work
- Effective team working
- Percentage of staff appraised in last 12 months
- Quality of non-mandatory training, learning or development.

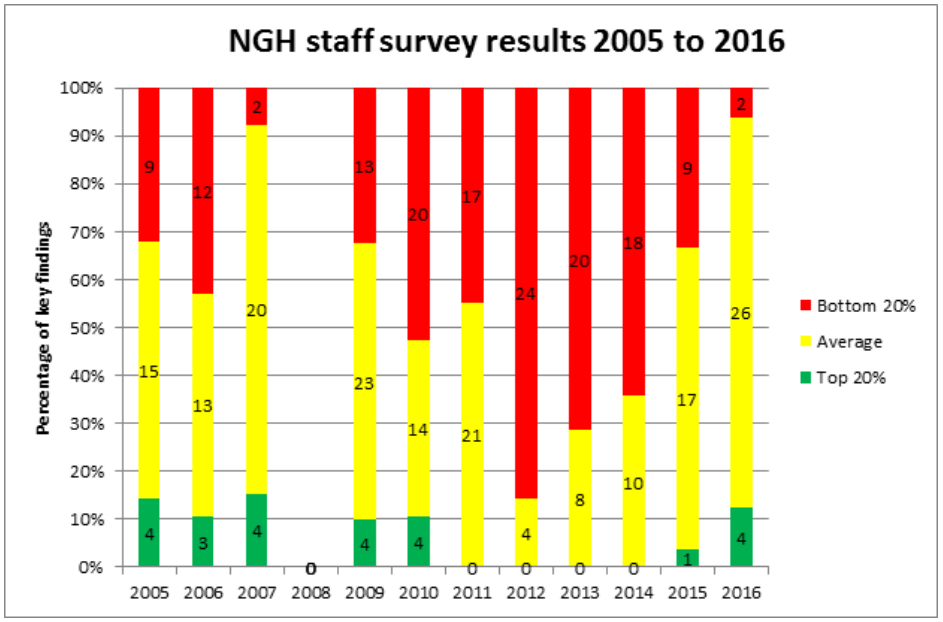
The Trust was benchmarked as above average when compared to other acute trusts for:

- Percentage of staff reporting errors, near misses or incidents witnessed in the last 12 months
- Percentage of staff working extra hours
- Percentage of staff able to contribute towards improvements at work
- Percentage of staff experiencing physical violence from staff in the last 12 months.

The Trust was benchmarked as average when compared to other acute trusts for:

- Quality of appraisals
- Percentage experiencing discrimination at work in the last 12 months
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- Percentage attending work in last 3 months despite feeling unwell because they felt pressure
- Staff recommendation of the organisation as a place to work or receive treatment
- Staff satisfaction with the level of responsibility and involvement
- Staff satisfaction with resourcing and support
- Recognition and value of staff by managers and the organisation
- Percentage reporting good communication between senior management
- Support from immediate managers
- Staff satisfaction with the quality of work and care they are able to deliver
- Percentage agreeing that their role makes a difference to patients and service users
- Effective use of patient/service user feedback
- Percentage reporting the most recent experience of violence

The following graph shows the overall picture is now continuing towards an increasingly upward trend.



There have been improvements across all areas when you compare the Trust to the others as follows:

	Lowest (worst) 20%	Below average	Average	Above average	Top 20%
2015	9	15	5	2	1
2016	2	8	14	4	4
Percentage Improvement	78%	47%	180%	100%	300%

Overall we have been recognised as being in the top 5 most improved acute Trusts in the country.

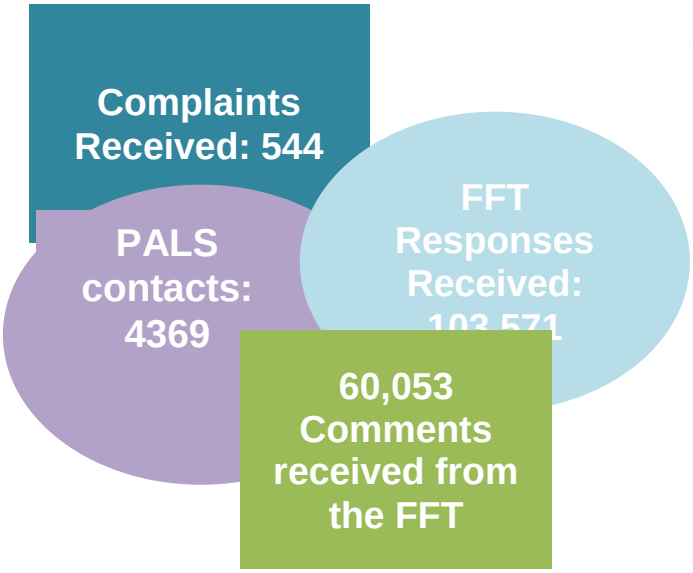
The key areas for improvement, based on our rankings against other acute trusts include:

- Flexible working opportunities
- Staff experiencing harassment, bullying or abuse from other staff or patients/relatives/public
- Staff reporting most recent experience of harassment, bullying or abuse
- Physical violence from patients/relatives/public
- Equal opportunities for career progression
- Witnessing potentially harmful errors/near misses/incidents
- Confidence and security in reporting unsafe clinical practice
- Staff feeling unwell due to work related stress
- Organisation and management interest in and action on health and wellbeing.

We recognise that overall the survey shows a lot of improvement. However, given the results on bullying and harassment we will be focussing more effort on addressing this to support our trust value of *'we respect and support each other'*. We will approach this from two perspectives; firstly to support to staff by understanding their concerns through engaging directly with staff; developing our Mental Well-Being & Resilience policy and providing resilience training as part of our Health & Well-Being strategy and secondly to send clear communications and have robust policies that make it clear that any form of bullying or harassment is unacceptable and will be dealt with.

Learning from our Patients

Our patients' views are critically important to us and the Trust has worked hard across 2016/2017 to develop the ways in which patient feedback is captured and the ways in which it is shared with the organisation and used to inform change.



Complaints Performance 2016/2017

100%	Percentage of complaints acknowledged within 3 working days
Ave 89%	Percentage of responses provided to complainant by agreed deadline

Complaints Performance 2015/2016

100%	Percentage of complaints acknowledged within 3 working days
Ave 87%	Percentage of responses provided to complainant by agreed deadline

What were our patient's main concerns during 2016/17?
The following word cloud shows the subjects most frequently raised in complaints and friends and family test feedback:

Complaints
We take learning from complaints very seriously. Any learning/action identified through the Complaints process is entered on to Health Assure, a system that enables the Trust to monitor each individual learning point. Additionally, the system also contains the details of the member of staff who has committed to take action, the timescales involved and the RAG rating assigned (i.e. green – complete, amber – on target, red – timescale exceeded). When the designated timescale has been reached, if evidence has not been received, then the RAG rating for each learning point will be revised to reflect this.

Detailed below are some examples of complaints and action taken as part of the learning process. This information relates to the top three themes for complaints for the financial year 2016/2017:

Patient care	
Complaint	Outcome
Concerns regarding different aspects of care received relating to wound care whilst an inpatient. Issues referred to the wound being unchecked, the incorrect dressing used and infection prevention concerns were raised	Complaint addressed directly with ward staff and individual concerned during the investigation. Additional wound care training has been completed and standards of care and infection prevention guidelines were reiterated to the staff. Apology and explanation was provided plus reassurance of learning taken forward
Delays in the prescribing and administering of anticoagulant medication.	Complaint was addressed directly with individual concerned in order to raise awareness and understanding of the need to ensure this type of situation is acted upon in a timely manner. Written instruction given to clinicians within the department regarding patients awaiting inpatient specialty assessments. Apology and explanation was provided plus reassurance of learning taken forward
Communication	
Level of communication experienced in relation to a surgical admission. Patient considered they were not given advice as to how to escalate any concerns that they had post-operatively.	Identified that staff must ensure patients are provided with the appropriate information both verbally and in writing to ensure they are aware of what to look for regarding post-operative complications. Apology and explanation was provided plus reassurance of learning taken forward
Level of communication regarding an outpatient appointment. Patient unable to leave a message as the telephone mailbox was full, and unable to make contact with anyone else as relevant staff were on leave and messages were cleared. Additionally a letter confirming an appointment was not dispatched, as had been advised by a member of staff.	Identified that staff must access and action voicemail messages daily and a 'buddy' system introduced when a member of staff is on leave to ensure their calls are covered. Staff were also informed they must ensure actions agreed with patients are followed up accordingly. Apology and reassurance of the learning identified expressed to the patient.
Delays/Cancellations	
Appointment was cancelled as there was not a doctor available.	Identified that this related to an administrative error whereby the clinic should have been closed on the system to prevent further patients being added. The admin team is being restructured and processes revised in light of this. An apology and explanation was provided to the patient. Reassurance was given of the learning identified and the action taken.
Delays in treatment when it was necessary to call for a more specialised member of staff from another area.	Identified more staff required training to enable them to use the equipment needed to prevent delays in treatment being administered. Training has now been undertaken, a grab box prepared to ensure treatment is administered promptly and a specific care plan is being set up for the patient as she has a relatively rare condition. An apology and explanation was provided to the patient. Reassurance was given of the learning identified and the action taken.

Learning from our patients' experience

During 2016/2017 we worked hard to develop the ways in which patient feedback is collated, and the ways in which it is shared with the organisation and used to inform change.

Over the past 12 months we have revolutionised the ways in which we actively collect patient feedback each month, taking on a three-pronged approach:

- The Friends & Family Test (FFT)
- The Real Time Survey
- The Right Time Survey

The Friends & Family Test

The FFT has been running successfully within the hospital for a number of years, however over the past year we have further developed the ways in which we collect responses to ensure we are providing patients with every opportunity possible to give their feedback. These include:

- Online survey with over 50 languages available. Online survey link displayed throughout organisation in the two most popular languages in Northampton after English
- Children and young people's online survey- included within text message to parents as an additional opportunity for the child or young person to give their feedback. Includes 3 different survey options depending on the age of the child.
- iPad set up within the Radiology department.

We have now introduced a suite of postcards bespoke to NGH and the different services which collect FFT responses. The postcards also include demographic questions which enable us to identify recommendation rates in line with protected characteristics and demographic groups.

Our overall aim is to ensure that the information reaches the right people at the right time to be able to make improvements based on areas of dissatisfaction.

CQC National Inpatient Survey Improvements

The CQC National Inpatient Survey is a mandatory survey undertaken each year by all hospitals with inpatient wards. The survey produces a series of reports detailing the hospitals performance and comparing results against the national average. The sample is typically drawn from July with results issued to the organisations the following May/June. Results from the National Survey are an overview of performance and do not detail individual results for each of the wards. This makes it difficult to target improvement work, and further work needs to be undertaken to understand the results at ward level so that we can make any improvements identified from the survey.

For this reason we have introduced two new surveys, using questions from the inpatient survey where the trust doesn't perform well, along with additional questions covering issues identified by our patients as being of most importance to them.

- The Real Time Survey: Introduced within the Organisation in October 2016, collecting 1:1 feedback from patients currently within inpatient wards and producing reports within 24 hours.
- The Right Time Survey: Started in November 2016 collecting feedback from patients following discharge from Adult Inpatient services and the Emergency Departments.

Further details on both of these surveys are provided below:

Real Time Survey

The survey adopts a 'here and now' approach to ensure that, where possible, positive improvements/changes take place whilst the patient is still in hospital. Six wards piloted the approach, which will be rolled out further in the next few months. The surveys are undertaken by both clinical and non-clinical managers and the feedback provided to the ward manager, matron and other members of the directorate senior team on the same day. Some of the improvements made to date as a direct result of patient feedback are detailed below:

- Lamps installed in all of the side rooms within Talbot Butler Ward as patients said they found that it was difficult to read due to the lighting level
- Creaton ward had a number of comments from patients relating to sleeping on the ward. The issue has been discussed at two team meetings to raise awareness and use of the sleep well packs for patients has increased.
- Remote controls for some of the televisions on Talbot Butler were missing and how now been replaced. .

Right Time Survey

Each month 600 questionnaires seeking feedback are sent out to patients who have attended as an adult inpatient and 600 questionnaires are sent to patients who have attended A&E. The Right Time Survey uses questions taken from the National Inpatient Survey as well as the National A&E survey. This enables us to directly compare the results with national results to see where we are making process. Importantly, survey results are also available at department/ward level.

The Right Time Survey also includes questions relating to our discharge process as we are aware that this is one of our patients' biggest area of dissatisfaction.

Side Effects Medication Poster

Within the National Inpatient Survey results patients are routinely stating that they do not receive explanations about their medication side effects before they leave hospital. For this reason a poster has been designed with an eye catching picture to prompt patients about their medication side effects.

The posters have been distributed throughout the wards and can be seen in our discharge suite. Posters have also been displayed within the Boots pharmacy to prompt patients to ask for advice if they are unsure.

The 4 Cs – Comments, concerns, complaints, compliments

It is our aim to do everything possible to make sure that our patients receive the right treatment at the right time, to a high standard. We want to know what patients and relatives think of our services and how we can make their experiences count. We will listen to what patients and relatives have to say and then take action. If there is something that we can do straight away then we will aim to do it through front line staff and/or PALS. We aim to use the feedback that we receive to improve the quality of care and service provided to patients.

In the first instance anyone who raises any of the 4 C's should be advised to speak with a member of staff (i.e. nurse / midwife / manager) in that area as they are most often the person in the best position to help and take immediate action. Where appropriate and in agreement with the person concerned the member of staff should complete a 4 C's form which are located on all wards and

departments, noting the problem identified and the action taken. Completed forms should be sent to the Complaints Department and the relevant manager.

If the person feels that the issue has not been resolved by the member of staff contact should be made with the Head Nurse/Matron and a request made for them to speak with the patient/relative. Many problems can be quite easily resolved by talking things through with the right person at the right time. Misunderstandings can easily happen and are often very easy to put right.

Can anyone else help?
If the patient/relative does not wish to discuss their feelings with a member of staff then they should be advised to contact PALS who focus on the following:

- Provide on the spot advice and support to patients, their families and carers
- Provide information on NHS services
- Listen to concerns, suggestions and queries
- Help sort out problems on behalf of the patient or their representative

PALS will aim to respond to all concerns and complaints within 3 working days, or within a timescale agreed with the individual. If the person remains unhappy with the information and response received and they wish to make a complaint then they should be advised to contact the Complaints Department either in writing or by telephone.

Patients/relatives should be reassured that raising a complaint or concerns about their care will not affect their treatment or care. All complaints are treated seriously and in confidence.

Through a recent inpatient survey it was identified that members of the public were unclear how to raise concerns or make a complaint. In view of this the 4C's posters and leaflets have been reviewed and revised. The new information is more identifiable and visible and contains details advising members of the public how to raise concerns and complaints. A relaunch of the 4C's process will take place during 2017.

Listening to our patients
Listening Event
In August 2016 we held a Patient listening event. The main theme was 'Always Events', and therefore it was titled 'What patients always want'. This is something which many organisations have rolled out successfully in the past and we believe that, given the areas in which we need to improve on for our Inpatient Survey, having events like this will help us improve further

Quality Conversation - Patient Engagement
In January 2017 a patient engagement event was held entitled 'Quality Conversation- 'A Winter Warmer'. An invitation was sent out to over 1700 members of the hospital inviting them to attend the evening.

Presentations were followed by the opportunity to talk with the presenters and a number of other members of the senior team, and visit stands which were created especially for the event, which was also attended by BBC Radio Northampton. Patients, carers and families were all given the opportunity to write down any improvements which the Trust should focus on and also any areas in which the Trust does particularly well.

Improving our complaints process

Since the early part of 2016 the IQE team has been working in partnership with the Complaints team to look at ways in which our internal processes may be improved. This would support the Trust response rate which was RAG rated as amber for a number of months. A member of the IQE team was assigned to work with the Complaints team and as part of the work the following action has been undertaken:

- A random selection of 35 complaint files (from this financial year) have been independently reviewed, with 94% requiring extensions (when the initial timescale has been exceeded but the additional time is agreed with the complainant)
- Each file required on average 2 chases from the Complaints team to directorate staff as they exceeded the internal (and sometimes external) timescale
- The IQE advisor met with a number of directorate senior staff who are involved in the complaints process for their areas
- A solutions workshop was held on the 2nd November 2016, with representatives attending from some directorates and the Complaints team
- An update is being included (by the IQE team) in the Bi-Annual Quality Improvement & Efficiency Report

What we're proud of

The Best Possible Care Accreditation and Assessment Framework at Northampton General Hospital

Measuring the quality of nursing care delivered is not easy. We have developed a framework based on the Trusts 'Best Possible Care' approach to the delivery of care to our patients.
This process provides the Trust with assurance that the quality and safety of nursing care is being reviewed using the Best Possible Care framework and that action plans are in place where any fundamental standards are not being met.

The framework is designed around fifteen standards and aligns with the CQC essential standards. Each standard is subdivided into elements of Environment, Care and Leadership and also incorporates national performance indicators as well as local indicators developed from lessons learned arising from complaints, concerns, adverse and quality improvement work

The assessment process is undertaken by the Nursing and Quality Matrons who act as quasi external assessors. Each ward is assessed against the fifteen standards with each standard being Red Amber Green rated individually and when combined, an overall ward RAG rating produced. The re-assessment of the wards is dependent on the overall improvement and subsequent RAG as detailed in the table below.

Red	6 red standards
Amber	3-5 red standards
Green	2 red standards and 8 or more green standards Standard 15 must be green
Best Possible Care Ward	3 consecutive green assessments

At the end of the process the assessment result and feedback is provided to the ward sister/charge nurse and support is offered to the ward to implement their ward improvement plan by their matron and organisational development. The ward sister/charge nurse shares the result of the accreditation visit together with the improvement plan with their team.

The results and action plans from the assessment contribute to individual service reviews, and the data collated as a whole will provide the Board with comprehensive information regarding care delivery within the organisation.

When a ward's overall rating is 'Red' on two consecutive occasions and there is little or no evidence of improvement, the Matron, the divisional Associate Director of Nursing and the Director of Nursing, Midwifery and patient Experience will consider the actions that are required.

The Best Possible Care Assessment and Accreditation works at various levels:

- Patients -receive the 'best possible care'
- Ward teams – develops ownership and promotes healthy competition between wards
- Division – Can assess nursing care in their areas
- Trust Board – demonstrates the quality of nursing care across the Trust

Improving the Care of Patients with Dementia

Finger Food

Finger food is an addition/alternative to the present hospital menu and can be of particular benefit to our patients living with dementia as it has been shown to improve independence and self-esteem. Finger food was introduced as a meal option as a pilot in July 2016, followed by a hospital-wide roll-out. The food can be eaten standing up or on the move, it can renew an interest in eating and provide more choice. Positive feedback has been received from families of patients who have used the option of finger food. Other areas have also benefited such as our children's wards, maternity and post-op recovery.

Twiddle Muffs

A twiddle muff also known as a twiddle mitt/distraction mitt or muff is a unique multi-coloured knitted sleeve with buttons, bobbles, ribbons and other additions in and outside. This is for patients to put their hands into, to keep busy, distracted and to offer comfort. It may prevent patients picking or pulling at cannulas and dressings for example. T

Twiddle muffs are a single use item largely provided within the admission areas and remain with the patient throughout their hospital journey and can then be taken home when the patient is discharged.

The twiddle muffs were launched in September at the Silver Link Conference. All wards and some departments are provided with twiddle muffs. Regular supplies of twiddle muffs are obtained from local knitting groups WI, staff members and volunteers.

Pressure Ulcer Collaborative

A pressure ulcer collaborative using a 'Breakthrough Series Model' began in October 2015 with representation from relevant clinical professional groups and most wards. A series of learning sessions were held through the year, culminating in a pressure ulcer prevention summit in the spring of 2017. A change package is being rolled out across the Trust that reflects the improvements that have been developed at ward level.

Health and Wellbeing

In recognition that the wellbeing of our staff is crucial in helping them to deliver the best possible care for patients we launched our Health and Wellbeing Strategy in April 2016. As part of this we developed an Annual Programme of Activities which took place throughout 2016/17 and 27% of our staff (1355) have now participated in a Health and Wellbeing initiative.

This work allowed us to achieve the 2016/17 Health and Wellbeing CQUINs. Our NHS staff survey results from 2016/17 indicate that our organisational focus on Health and Wellbeing has shown a statistically significant improvement.

Sustainability

In 2016 NGH was recognised by the NHS for Excellence in Sustainability Reporting. The Trust was awarded the Golden Apple Award for Healthcare Environmental Best Practice by the Green Organisation and we maintained our Investors in the Environment Green Accreditation, with the status of Best Green Champion (Large Organisations) being awarded for the second successive year.

We were also highly commended in the Healthcare Supply Association Awards Sustainability section.

The Catering team maintained Bronze Food for Life Accreditation from the Soil Association for patient meals and extended it to the food served to staff and visitors in the restaurant.

Patient Experience Network National Awards (PENNA)

We were delighted to be successful in the categories of 'Staff Experience' and 'the hospital doing the most to improve the experience of those with a disability' at the PENNA awards in March 2017.

In the Staff Experience category we had described our process for the Compliments Collation and the way in which we have focused on collecting and sharing compliments with staff. The second award was for the Maternity Chit-Chat group which was set up to support ladies with learning disabilities who are expecting, or have had, babies.

Volunteer Service

Our volunteer service aims to utilise volunteers to enhance and support staff to provide the best possible care to our patients. To date the volunteer service has recruited 160 volunteers which represents an increase of 75% since April 2016. In excess of 230 of our volunteers have undertaken mandatory training which is in line with the Lampard recommendations and the NHS standards. Additional bespoke training packages have been created for voluntary roles to ensure that our volunteers are fully trained.

We now have a volunteer presence on 23 wards which is ever increasing with the continuous recruitment of additional volunteers.

Following a successful campaign for the donation of books across Northampton, the new initiative of the 'Bedside Book Club' was introduced. This service visits the wards twice weekly and allows patients to borrow books for the duration of their stay. The service has been well received and as well as the book offers additional companionship to our patients.

The volunteer service continues to work with some of Northampton's largest organisations. This has allowed the profile of the service to increase further, attracting more people to volunteer at NGH.

Priorities for Improvement in 2017/18

Our Quality Improvement Strategy aligns 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 from serious incidents. It also takes into account the recommendations of the Francis Report and Berwick Review. The focus of the strategy is to ensure that patients and service users of NGH receive safe, effective services with a positive experience. We will aim demonstrate a year on year improvement against baseline, within all measurable benchmarks.

Our vision is to provide the best possible care to all of our patients. Our Quality Improvement Strategy (2016 – 2019) will help us to achieve further improvements in the quality of our clinical service over three years. We have aligned our quality priorities for the Year 2 of the Quality Improvement Strategy with the Sign Up to Safety Campaign that aims to make the NHS the safest health care system in the world.

The aim of each of the following six quality priorities is underpinned by a number of work streams that will enable us to deliver and measure successful outcomes:

Priority 1: Reducing Harm from Failures to Rescue

Rationale for the selection of this priority:

At NGH everyone endeavours to provide care which is of the very highest standard. Despite the extraordinary work of healthcare professionals, patients can be unintentionally harmed. One area where we recognise that this can occur is through failures to recognise or rescue patients who deteriorate while they are in hospital.

This priority will continue to focus us on how we can avoid patient deterioration and improve early interventions.

The projects that we will undertake are:

Project 1 – To improve the quality and timeliness of patient observations

Project 2 – To identify and manage the deteriorating patient

Project 3 – To eliminate delays in the investigation and management of patients with sepsis

What we will measure:

- The timeliness of observations
- Identification of the deteriorating patient
- Eliminating delays in investigations
- Use of the sepsis care bundle

Priority 2: Reduce Avoidable Harm from Failures in Care

Rationale for the selection of this priority:

This aligns with our first priority and will ensure that we provide our patients with care that is as safe as possible. To do so we will work on strengthening our learning systems and build capability in our staff to recognise and prevent harm in addition to undertaking specific work to address high priority areas.

The projects that we will undertake are:

Project 1 - Eliminate all pressure ulcers

Project 2 - Reduce harm from patient falls

Project 3 - Eliminate hospital acquired VTE

What we will measure:

- Pressure ulcers
- Falls with harm
- Hospital acquired Venous Thromboembolism
- Reduce omitted medicines

Priority 3: To Deliver Patient and Family Centred Care

Rationale for the selection of this priority:

Patient centred care is central to our core aim to provide the best possible care for patients, yet traditionally neither patients nor the public have had the power to shape the services they use and pay for, or define their value. As a result, many patients find services difficult to navigate, disempowering, burdensome, and seemingly designed to frustrate

Through working and listening to patients and families we can take into account the individual needs and preferences of our patients and carers which will drive our improvement focus and service design.

The projects that we will undertake are:

Project 1 – Communication deep dive to identify key issue areas within the patient journey

Project 2 – Initiate a set of Feedback Events with patients

Project 3 – Create a repository of patient stories

What we will measure:

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

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

Rationale for the selection of this priority:

In order to have the greatest impact, staff must be able to speak up about problems, errors, conflicts and misunderstandings in an environment where it is the shared goal to identify and discuss problems with curiosity and respect. The results of our safety culture questionnaire which we will benchmark with other regional hospitals and through regular board to ward discussion with staff will help us to achieve the excellence that we aspire to. We will use unwanted or unexpected outcomes and inefficiencies of practice as the basis for a learning and improvement process.

Our work to date has incorporated a key emphasis on learning from serious incidents and complaints as well as from case note review and previous analysis of lessons from the healthcare system. We have very much supported the concept of listening to staff and empowering them to understand their own role in leading and supporting change and speaking up when they see that improvements could be made.

The projects that we will undertake are:

Project 1 - Leadership training & development for staff

Project 2 - Board to ward leadership walk rounds

Project 3 – To improve organisational safety culture

Project 4 – Learning From Error for clinical teams

What we will measure:

- New appraisal process whereby each member of staff demonstrates they have delivered or contributed to a local QI project
- Staff survey results answering the question *"Am I supported to make changes"*
- Numbers of staff trained in QI
- Number of QI projects in place
- Number of QI projects submitted for external recognition and awards
- Staff survey results
- Safety culture questionnaire
- Qualitative feedback from Board to ward walk rounds
- Leadership and Development Programmes
- QI teaching and training
- Staff and patient satisfaction survey results

Priority 5: To Deliver Reliable and Effective care

We recognise that there are aspects of healthcare that do not perform as well as they should. To achieve best practice and outcomes for patients we will use care bundles to deliver high levels of reliable, efficient and effective care.

A care bundle is a structured way of improving the processes for care and with it, patient outcomes. At the same time as improving the consistency of care, bundles also improve efficiency ensuring that we make the best possible use of the resources available to us.

The projects that we will undertake are:

Project 1 – To develop/update care bundles where clinical appropriate

Project 2 – To introduce and increase consistent of use of relevant care bundle

What we will measure:

- Intentional rounding
- SSkin
- Stroke care
- Sepsis 6
- Heart Failure
- Ventilated acquired pneumonia

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. The delivery of our projects will be supported by promoting staff training on quality improvement knowledge and the skills to bring about change in practice to embed continuous improvement.

How progress will be measured and reported:

The metrics for our quality improvement priorities are agreed by the Trust Quality Governance Committee which is a sub-committee of the Board. Progress against these priorities will be reported to the Trust Quality Governance Committee through the Quality Improvement Scorecard in consultation with the clinical leads and Divisional Management teams.


Northampton General Hospital NHS
Lorand Pusok
Charge Nurse

Statements of assurance from the Board

Review of services

During 2016/17 NGH provided and/or sub-contracted 72 NHS services. The income generated by the NHS services reviewed in 2016/17 represents 100% of the total income generated from the provision of NHS services by NGH for the reporting period 2015/16.

Participation in National Clinical Audits and National Confidential Enquiries

This continues to be a high priority for the Trust. During 2016/17 Northampton General Hospital aimed to participate in all relevant projects included in the Quality Account list published by the HealthCare Quality Improvement Partnership (HQIP) on behalf of NHS England.

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).

The following table gives details of all Quality Account audits and confidential enquiries to which Northampton General Hospital submitted data in 2016/17. 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 pneumonia (British Thoracic Society)	Y	Audit in progress
Diabetes (RCPH National Paediatric Diabetes Audit)	Y	Data collection ongoing
Adult Asthma	Y	100%
Chronic Obstructive Pulmonary Disease	N	no data entered
Chronic Obstructive Pulmonary Rehabilitation (British Thoracic Society)	Y	Audit in progress
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 3 – 100%
		Year 4 – 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 3 data collection ongoing
		Inpatient Audit – 100%

IBD Registry	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
Asthma (paediatric and adult) CEM	Y	100%
Severe Sepsis and septic shock 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 - National Hip Fracture Database	Y	Data collection ongoing
National Audit of Dementia	Y	100%
Severe Trauma	Y	100%
National Ophthalmology	N	No data entered
Renal Registry	Y	Data collection ongoing
Endocrine and Thyroid National Audit	Y	Data collection ongoing
Nephrectomy Audit	Y	Data collection ongoing
Percutaneous Nephrolithotomy	Y	Data collection ongoing

National Confidential Enquiries (NCEPOD)	Y	Young People's Mental Health – 100%
		Non-invasive Ventilation – 100%
		Chronic Neurodisability – Data collection ongoing
		Cancer in Children, Teens and Young Adults – Data collection ongoing
Re-audit of Patient Blood Management in Scheduled Surgery	Y	100%

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 or can be viewed on line. There were over 40 reports published relating to national clinical audit and NCEPOD between 1 April 2016 and 31 March 2017, the majority of which were relevant to acute hospitals. The clinical audit and effectiveness department monitors the publication of these 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. The results of many audits demonstrate good results compared with national figures and in these instances, no changes may be required.

Described below are some examples of some of the changes and learning we have identified following the publication of National Clinical Audit reports during 2016/17.

- Clinical Effectiveness
    - The Sentinel Stroke National Audit Programme measures the Key Indicators of the quality of a Stroke Service and NGH continues to perform very well. Over the course of 2016/17 rapid access to CT scanning although already good in Q1 has improved further and has been rated as “A” (the highest level possible) for the last 3 quarters.
    - The Cardiac Arrhythmia Audit shows that the use of pacemakers for Sick Sinus Syndrome at NGH has increased and is now in line with national figures. In addition more pacemakers are being inserted for primary prevention to manage problems before they arise.
    - The National Emergency Laparotomy Audit recommendations have been followed up locally by a review of pre-operative management of patients requiring emergency abdominal surgery to find the best way of ensuring that all patients receive the appropriate opinions, investigations and treatments without delaying surgery. Surgery for some patients brings a higher risk than others so this is assessed pre-operatively to identify those patients who will need a higher level of care such as Critical Care post operatively.
    - The Adult Cardiac Interventions Audit data (NICOR) continues to show that patients treated at NGH for a heart attack get the best recommended treatment available.
    - The Neonatal and Obstetric Teams continue to have joint meetings to share learning from the review of Perinatal Mortality (MBRRACE) data.
- Patient Safety
    - Using the results of the College of Emergency Medicine snapshot audits the Accident & Emergency Department is improving safety for patients receiving sedation by improving training for staff and developing “Sedation Champions” to help to spread the message. The audit has also helped highlight concerns about the use of the sedation across other areas and a Trust Sedation Committee is being established to address this.

- Safe discharge for children from the Emergency Department is also a priority and as a result of the Paediatric Vital Signs audit it is being enhanced by senior review before discharge where applicable.
- Unplanned admission to Critical Care in the 7 days after emergency abdominal surgery and unplanned return to return to theatre have been highlighted for review by the NGH team involved in The National Emergency Laparotomy Audit in order to learn and improve patient safety.

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- Patient Experience

  - Following publication of the National Neonatal Audit Programme the Neonatal Team continues to support breastfeeding by making DVD's and other resources available on the wards.
  - The End of Life Team has used the Care of the Dying Audit to launch a teaching programme to help staff feel more confident in supporting patients and their relatives/ carers. The care plan has been improved to make it easier to focus on and document the patient's wishes and the team have also started to routinely gather feedback from relatives/ carers after the death to help them improve the service they provide.
  - The National Hip Fracture data (part of the Falls and Fragility Fracture Audit Programme) recommended that more patients should be mobilised the day after surgery. This has been addressed locally by reviewing the way local anaesthetics are used at the end of the operation to see if a new approach will allow patients to mobilise earlier but still provide effective pain relief.

- Service Improvement

  - The Pulmonary Rehabilitation report (part of the COPD National Audit) showed that locally more patients should be referred for pulmonary rehabilitation and that some patients started the course but didn't finish it. In response the team have made changes to their referral processes to support the referral of the patients who will benefit the most.
  - Following the publication of the Care of the Dying Audit, the Specialist Palliative Care Team have expanded their service to be available seven days a week.
  - The Sentinel Stroke National Audit Programme Key Indicators are reviewed quarterly by the team to identify areas for improvement. For example, it is not always possible to admit a stroke patient to the Stroke Unit within 4 hours. Whilst recognising that pressure for beds remains very high efforts are being made to alleviate the concern. This includes actions to "ring fence" beds on the Stroke Unit, enhance the process for repatriating patients to their local hospital when appropriate and highlighting the knock on effect of delay in discharge caused by a lack of appropriate social care provision.

- Communication

  - The Accident & Emergency Department have reviewed the information that is shared with patients on discharge. Advice leaflets for those patients who required sedation during their stay and those with a plaster cast on their lower limb have been developed and are given to patients on discharge from the Emergency Department.

- Having identified a lack of awareness of the role of Advance Care Plans the End of Life Care Team plan to highlight this during their Trust “Dying Matters” week.
- National Neonatal Audit Project data continues to show how well the team at NGH respond to the needs of parents by communicating with them as soon as possible after a baby is admitted to the neonatal unit.
- For services that are shared between different healthcare providers, national audits can help providers come together to discuss the findings and improve care. For example the Cardiology Teams from NGH meet regularly with their colleagues from KGH to discuss Adult Cardiac Interventions Audit data (NICOR). The recommendations of a recently published Confidential Enquiry “Treat as One” which looks at the care of patients in general hospitals who also have a mental health diagnosis are being reviewed by a team made up of individuals from NGH, NHFT and the CCG.

- Data quality and Documentation
  - In order for audit reports to be useful the data entered must be as complete and accurate as possible and this partly relies on documentation in the notes being sufficiently detailed. One of the key actions for many of the clinical leads of the national audits is to continually review the quality of the data submitted and improve documentation to capture the relevant information if required.
  - An example of this during 2016/17 was the findings of the Paediatric Vital Signs Audit in the Emergency Department which showed that the current Paediatric Assessment Form didn’t capture the data required for the audit and therefore the results did not reflect the actual standard of care provided. The form has been redesigned and re-audited to provide assurance of the care provided.
  - The National Audit of Oesophago-Gastric Cancer raised concerns at a national level that Trusts were not submitting data for a particular subset of patients. NGH reviewed this locally and was able to confirm that data for all patients has been submitted.

- Resources and staff recruitment
  - The National Audit of Inpatient Diabetes runs annually and in response to the latest report a business case for an additional diabetes nurse specialist and consultant has been developed.
  - The Pulmonary Rehabilitation team require further resources in order to be able to provide routine exercise assessment which is crucial for vigorous exercise prescription.
  - The Stroke Team have used learning from the national audit and a recent CQUIN to develop a service for delivering mood support to inpatients. A joint business case is being prepared with NHFT, KGH and Nene CCG to ensure the service will continue.

- National audit mortality and consultant level data

    - In 2016/17 there were 8 audits which published mortality data for NGH. This data could be specific to a service or to an individual consultant and is intended to signpost whether the service or the individual is performing "better than expected", "as expected" or "worse than expected". If a particular service or consultant is noted to be an "outlier" (data suggests they might be performing worse than expected) then this is investigated further.
    - The following audits published service level mortality data in 2016/17. Performance in all was at the "as expected" level.
        - National Emergency Laparotomy Audit (NELA)
        - National Hip Fracture Database (Part of the Falls and Fragility Fractures audit)
        - National Vascular Registry (NVR)
        - National Joint Registry (NJR)
        - British Association of Urological Surgeons (BAUS)
        - Intensive Care National Audit and Research Centre (ICNARC)
        - National Bowel Cancer Audit Project (NBOCAP)
    - Data from the UK Perinatal Mortality Report (MBRRACE) was reviewed in further detail as published standardised and adjusted mortality rates suggested that NGH rates has previously been '10% higher than the average' when compared to similar sized units. It was noted that the sample size or number of patients was very small. All of these patients and the care they received has been reviewed in detail by the neonatal team to ensure that all possible learning has been identified and changes to practice made where necessary.
    - The following audits published individual consultant level data in 2016/17. Performance in each case was "as expected".
        - National Vascular Registry (NVR)
        - National Joint Registry (NJR)
        - British Association of Urological Surgeons (BAUS) - Nephrectomy
        - National Bowel Cancer Audit Project (NBOCAP)

Local Clinical Audit

In 2016-17 we undertook 163 local clinical audits including 39 specifically against NICE guidance. Some examples are outlined below together with the resulting actions aimed at improving clinical quality, patient experience and patient safety.

All of the registered clinical audits were eligible for entry to the annual Trust Audit Presentation Day. The highlights from the Audit Day are described below.

Effective documentation or Continuation of care whilst in Emergency Department

There is an expectation that all A&E patients will have the following ongoing documented whilst they are in the Majors or Resuscitation areas:

- All patients with EWS >3 will have their vital signs documented after care intervention
- All pain scores should be repeated after initial assessment and pain management intervention (if pain score >1)
- All patients with a raised Anderson score will have pressure area care documented.
- Documentation of hygiene and elimination support should be clear in all patient notes
- Documentation of nutrition and hydration care intervention should also be clear in all patient notes.

Recommendations following the audit that were implemented – Use of a care plan continuation, introduction of a chart for efficient documentation of care interventions and as a prompt for e-documentation and repeating NEWS and pain scores.

Management of pain in patients with fractured neck of femur (NOF) in the Emergency Department

Due to increased assessment and monitoring of pain and increased use of Fascia Iliaca Block (FIB) technique more patients with moderate or severe pain are receiving analgesia within the first 60 minutes of arrival. On re-audit it was found that 37% of patients received a FIB and 46% of patients with severe pain received a FIB and these figures continue to improve.

Post-operative Blood Tests in Patients Undergoing Routine Urological Surgery

Post-operative blood tests in patients undergoing the majority of urological procedures have been found to be unnecessary. The changes implemented as a result have reduced the incidence of postoperative blood testing by 75%.

There were associated cost savings of at least £383,310 since the audit took place.

Use of CT Pulmonary Angiograms (CTPA) for patients with suspected Pulmonary Embolism

Many of the patients who have a CTPA scan to investigate for pulmonary embolism are found not to have this diagnosis. In some cases, 'rule-out' testing with a D-Dimer blood test were not performed at all before proceeding to the CTPA or Ventilation/Perfusion scans.

The audit found that the Wells deep vein thrombosis probability scoring system was rarely used for patients with a presumed pulmonary embolism. Most of the patients, who had a CTPA scan had presented with shortness of breath or chest pain due to Asthma or Chronic Obstructive Pulmonary Disease.

It was found that therapeutic Enoxaparin had not been started in some patients with a presumed pulmonary embolism.

Following the audit a pulmonary embolism treatment protocol has been designed which includes the use of the Wells Score and other clinical indicators to be assessed before referring for CTPA scan.

Consent in total hip and total knee replacement

The Trust undertook a joint clinical audit conducted University Hospitals Leicester NHS Trust to look at consent in lower limb joint surgery.

Recommendations from the audit included the use of the British Association of Anaesthetists approved consent forms or pre-printed stickers agreed by the orthopaedic surgeons. We are conducting a patient survey on the consent process and the use of different consent forms including electronic versions.

There has also been a trial of the use of patient workbooks to assess how well patients understand the patient information sheets for total hip replacement and total knee replacement to be conducted in patient joint school classes run in Physiotherapy.

Participation in clinical research

The number of patients receiving NHS services provided by Northampton General Hospital NHS Trust from April 2016 to March 2017 that were recruited during that period to participate in research approved by a research ethics committee was around 1200. To date 832 have recruited to 67 studies on the National Institute of Health Research portfolio within this financial year. This has shown an increase year on year of research activity resulting.

Participation in clinical research demonstrates the Trust'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 a wide range of clinical trials. This which is consistent with 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.

Use of Commissioning for Quality and Innovation (CQUINs) payment framework

NHS Nene Commissioning Group is our main commissioner. 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 2016/17 NGH agreed five local CQUINs and three themed national CQUINs equating to seven strands. NGH also holds a contract with commissioners known as Specialised Commissioners who are NHS England – Midlands and East. This contract is for specialised treatments that are commissioned on a regional or national basis. In 2016/176 NGH agreed three specialist CQUINs.

The CQUINs agreed with our commissioners contain milestones which must be met in order for the Trust to claim achievement. Each CQUIN is outlined below together with the RAG status of achievement.

KEY

No milestone
Milestones partially met
Milestones met
Results awaited

TYPE	CQUIN INDICATOR NAME	Q1	Q2	Q3	Q4
LOCAL	1. End of Life Care Pathways				
	2. Dementia Discharge Summaries				
	3. Dementia Johns Campaign				
	4. Acute Kidney Injury				
	5. Delayed Transfer of Care				
NATIONAL	1a. Introduction of Health and Wellbeing Initiatives				
	1b. Healthy food for NHS staff, visitors and patients				
	1c. Improving the Uptake of Flu Vaccinations for Front Line Clinical Staff				
	2a. Timely identification and treatment of Sepsis in emergency departments				
	2b. Timely identification and treatment of Sepsis in acute inpatient settings				
	4a. Reduction in antibiotic consumption per 1,000 admission				
	4b. Empiric review of antibiotic prescriptions				
SPECIALIST	WCa. Two year follow up assessment for very preterm babies				
	WCb. Pre-term Babies Hypothermia Prevention				
	IM3. Multi-system Auto-immune Rheumatic Diseases MDT Clinics, Data Collection and Policy Compliance				

The CQUINs for 2017/18 have been agreed with our Commissioners and the Trust has two local CQUINs, six themed national CQUINs equating to 11 strands of work and three specialist CQUINs.

National CQUINs
1a. Improvement of staff health and wellbeing
1b. Healthy food for NHS staff, visitors and patients
1c. Improving the uptake of flu vaccinations for frontline clinical staff within Providers.
2a. Timely identification of patients with sepsis in emergency departments and acute inpatient settings
2b. Timely treatment of sepsis in emergency departments and acute inpatient settings
2c. Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.
2d. Reduction in antibiotic consumption per 1,000 admissions
4. Improving services for people with mental health needs who present to A&E.
6. Offering advice and Guidance (A&G)
7. NHS e-Referrals CQUIN
8. Supporting Proactive and Safe Discharge – Acute Providers
9. Preventing ill health by risky behaviours – alcohol and tobacco
Specialised CQUINs
IM3. Multi-system auto-immune rheumatic diseases MDT clinics, data collection and policy compliance
GE3. Hospital Pharmacy Transformation and Medicines Optimisation
Public Health CQUIN
1. Clinical Engagement

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
World Health Organisation Surgical Checklist
National Early Warning Score
Safeguarding Children
Safeguarding Adults
Workforce
Venous Thromboembolism
Pressure Tissue Damage
Service Specifications
Quality Assurance regarding any trust sub-contracted services (list of services to be provided by the trust)

Care Quality Commission (CQC)

The trust is registered with the Care Quality Commission under the Health and Social Care Act 2008. The CQC is the independent health and adult social care regulator. Their role 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.

A focused, short-notice announced CQC inspection of the trust took place on 30 January, 7-9 and 17 February 2017. The inspection team focused on the four core services medicine, surgery, urgent care and end of life care. The first three were rated requires improvement and the later inadequate at the inspection in 2014. There was also a review of the well-led domain at trust level. The report was published on 23 May 2017 showing the four core services inspected were all rated as good.

The inspection team acknowledged the significant action taken and improvements the trust had made since the January 2014 inspection, particularly in relation to the focus on patient safety supported by the open and inclusive staff culture. Currently the overall rating for the trust remains as requires improvement.

The CQC have advised they will return prior to August 2017 to inspect the remaining four core services (Critical care, Outpatients & diagnostic imaging, Maternity and gynaecology and Services for children and young people). After this inspection the ratings for all the core services will be aggregated and revised ratings given for the trust as a whole.

Ten areas of outstanding practice were specifically recognised in the report.

The trust was given one requirement notice. This was in relation to evidence of completion of mental capacity assessments in the patient's health record, particularly when decisions are made about performing cardiopulmonary resuscitation.

A trust-wide action plan was developed by the executive team in response to this and other initial feedback given at the end of the inspection. This included work relating to

- Ensuring review of patient risk assessments for venous thromboembolism (VTE).
- The safer surgery checklist in plastic surgery to be reviewed to be compliant with the World Health Organisation (WHO) Five steps to safer surgery principles.

- Controlled drugs (from syringe drivers) were not being denatured (made inactive) before disposal in sharps bins.
- Confidential patient information displayed on whiteboards on wards was visible to patients and visitors.
- Medical records were not stored securely on all wards.
- Drug rounds for inpatients at the Heart Centre did not all take place at an appropriate time.
- Mental Capacity Act assessments were not consistently recorded to support do not attempt cardiopulmonary resuscitation decisions.
- Board sub committees following terms of reference, with regards frequency of review of the board assurance framework and risk registers.
- The review process for risks on the corporate risk register.
- Some trust policies found to be out of date for review.

The majority of these actions have been completed, any remaining have been transferred to the trust-wide improvement plan developed following the publication of the report.
The full report can be found here https://www.cqc.org.uk/location/RNS01/reports

CareQuality Commission

Last rated
23 May 2017

Northampton General Hospital NHS Trust

Northampton General Hospital

	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Urgent and emergency services (A&E)	Good	Good	Good	Good	Outstanding ☆	Good
Surgery	Good	Good	Good	Good	Good	Good
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	Good	Requires improvement	Good	Good	Good	Good
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement

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 successful introduction of the Duty of Candour sticker was welcomed by the clinical staff and is widely used. The Governance Team has received positive feedback since the implementation, that the advice to staff is clear on what they need to deliver to be compliant with the statutory requirement.

The concept of a crib sticker for the staff has been shared at a Countywide Patient Safety Forum and has been utilised by another provider within the region.

Patients and/or their relevant person are encouraged to participate in the investigation and are offered being open meetings.

The Trust continues to demonstrate compliance with Duty of Candour to the Clinical Commissioning Group (CCG).

Hospital mortality monitoring

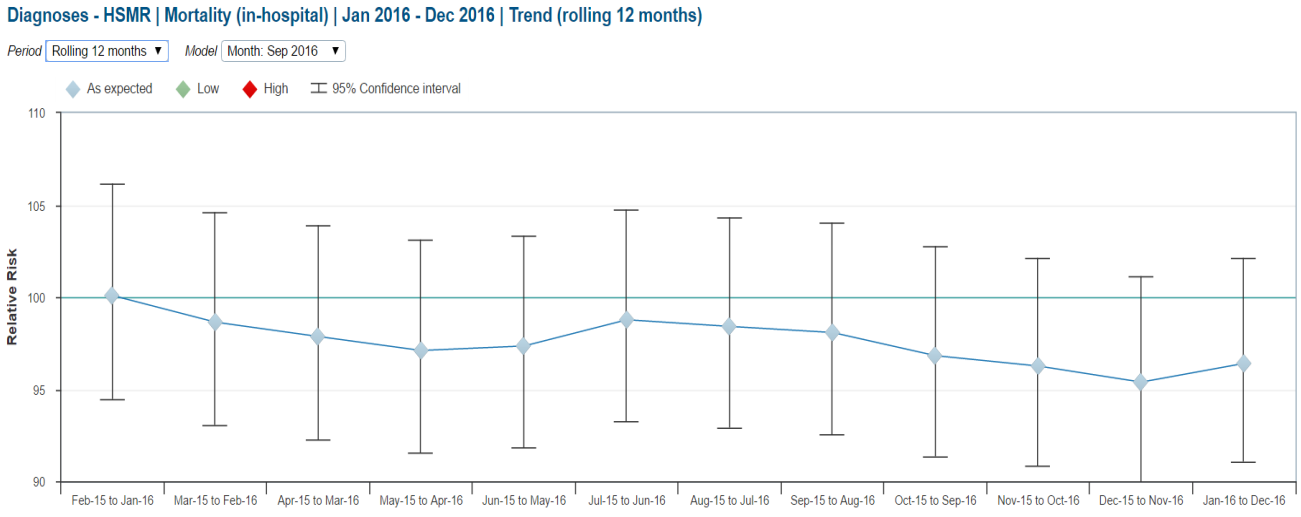
Northampton General Hospital uses three key mortality metrics which are benchmarked against all other hospitals in England and examine patient outcomes. These metrics are provided to the Trust by Dr Foster™ and the Health and Social Care Information Centre (HSCIC):

- The HSMR [Hospital Standardised Mortality Ratio] analyses mortality from the 56 most common and serious conditions which result in more than 80% of deaths which occur in hospital. The Standardised Mortality Ratio can be quoted as a percentage or ratio relative to the number of deaths that would have been expected to occur based on what is known about the patients that were admitted to hospital. A hospital that is performing ‘as expected’ would have an HSMR that is equal to 100. If the HSMR is higher than 100, then there is a higher reported mortality ratio. An HSMR that is less than 100 suggests that the mortality is low than would have been expected.

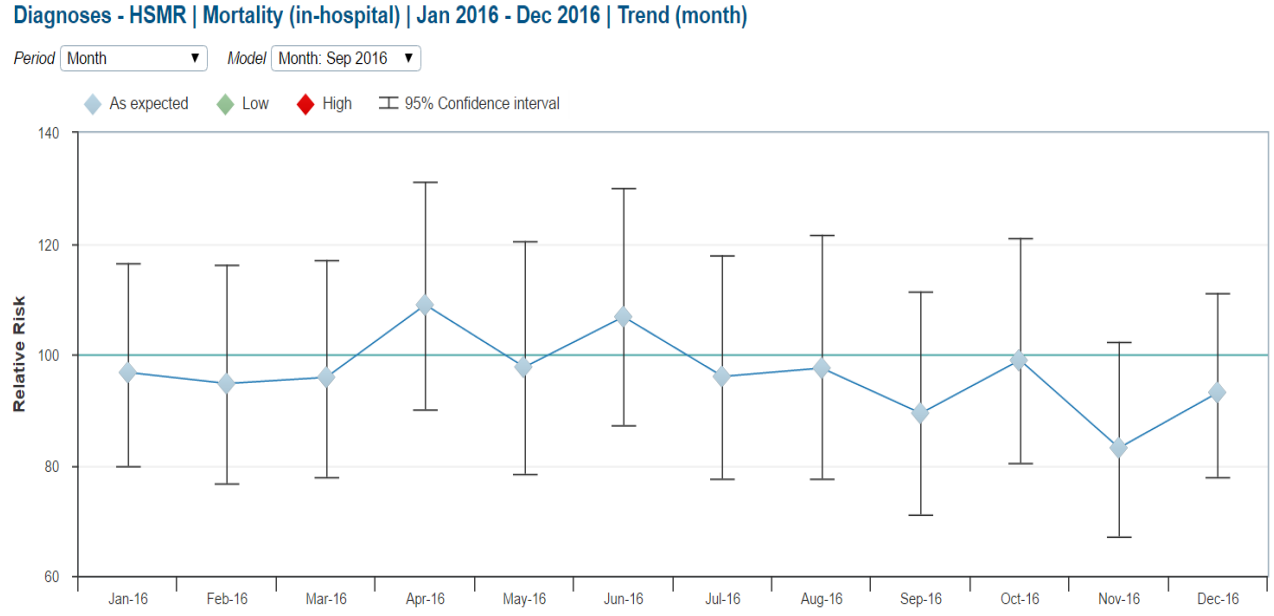
- The HSMR 100 looks at all hospital deaths. Both mortality indicators are case mix adjusted, taking into account the age of each patient and their general health before their admission to hospital.
- The Standardised Hospital Mortality Index (SHMI) provides similar information to the MSHR but also includes patients who have recently been discharged from hospital (in the previous 30 days)

This information is under continuous review to identify areas of adverse performance which require further analysis and investigation. The analysis is presented to the Mortality Review Group each month and to the Clinical Quality and Effectiveness Group by the Associated Medical Director. The Medical Director reports to the Trust Board on mortality and planned actions in relation to any areas of concern through the Quality Governance Committee.

The HSMR is reported 3 months in arrears. During the year to December 2016 the HSMR has remained within the 'as expected' range: at 96.4:

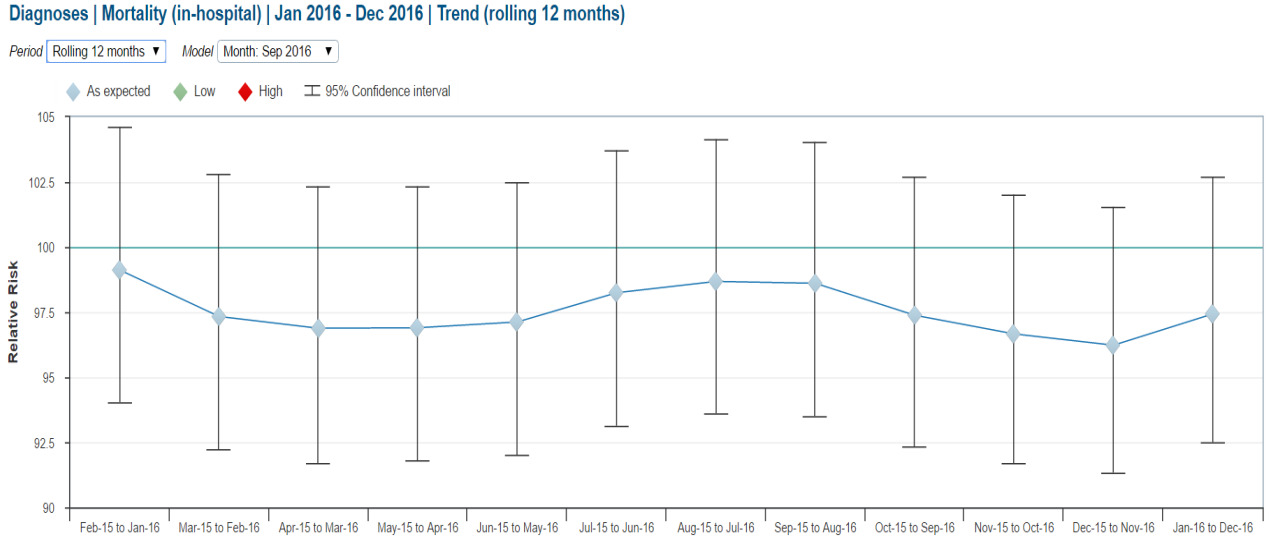


The monthly variation in the standardised mortality ratio over this 12 month period is shown below:

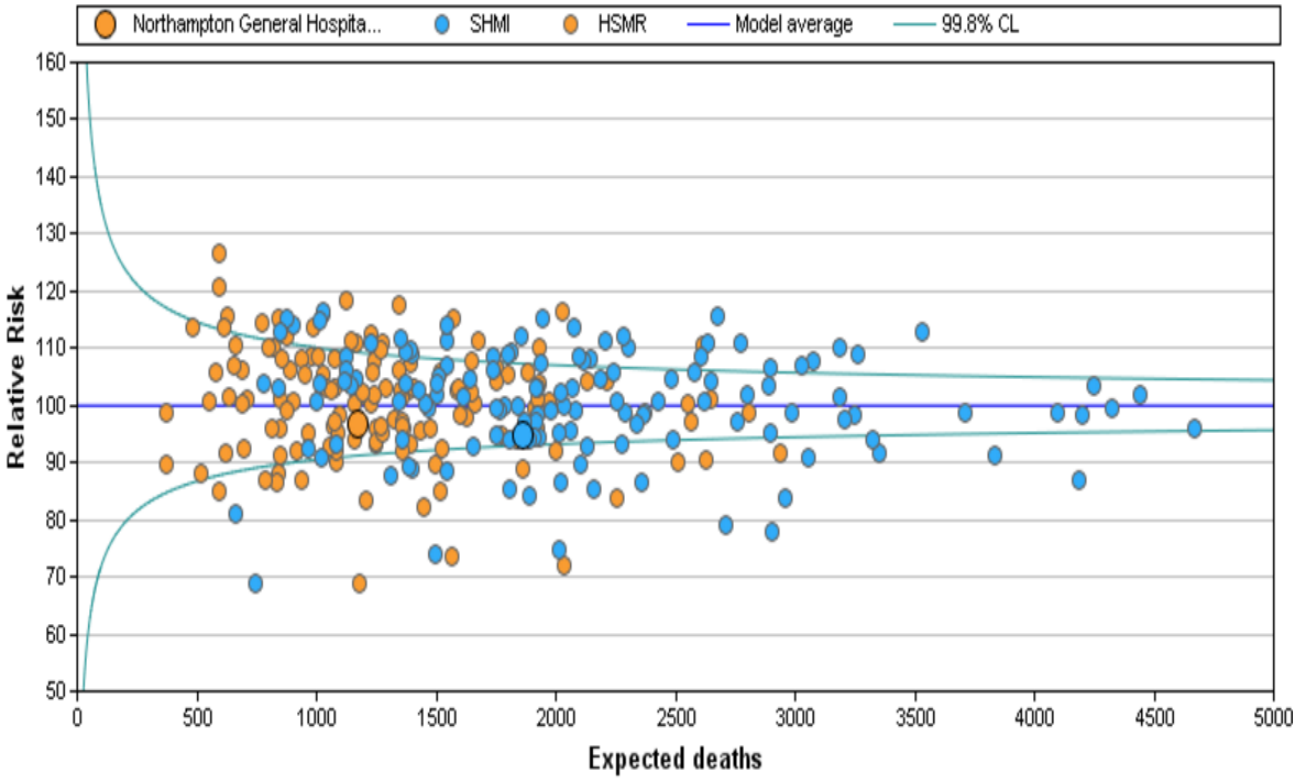


Due to the shorter monthly time frame there is more variation seen. The monthly Trust results have also remained in the as expected range.

The HSMR-100 metric which covers all diagnoses shows a similar pattern to that of the HSMR:



The Standardised Hospital Mortality Index (SHMI) has also remained in the 'as expected' range. The most recent update of the SHMI for the year from October 2015 to September 2016 was 94.7 and is shown in the graph below relative to our national peer group:



In December 2016 the CQC published a report "Learning, candour and accountability: a review of the way NHS Trusts review and investigate the deaths of patients in England". This review found that learning from deaths was not being given sufficient priority in some organisations and suggested that opportunities for improvements were being missed. It highlighted that Trusts could do more to engage families and carers and use their insights as a source of learning.

Following on from this the Secretary of state for Health delivered a parliamentary statement announcing his intentions that all NHS Trusts should collect and publish data on all deaths occurring in hospital including an estimate of the number of deaths assessed as more than likely to have been due to problems in care (i.e. “avoidable” deaths), an assessment of potential causes of any variation from the national average, and evidence of learning and the actions taken.

In March 2017 the National Quality Board published the document “National Guidance on Learning from deaths – a framework for NHS Trusts and Foundation Trusts on Identifying, investigating and Learning from deaths in care”.

In response to this the Trust has developed a policy for “Reviewing, investigating and learning from mortality”. This policy describes how we learn and share this from reviewing the care of all patients who have died, and how we will engage with bereaved families and carers.

The majority of deaths are considered to be expected and unavoidable. It is recognised from available evidence that approximately 4% of deaths in hospital have an element of avoidability. We have developed a process to enable us to identify patients whose death may have been avoidable which will allow for an in-depth review of the case.

The outcome of these reviews will be provided to the Quality Governance Committee and the Trust Board by the Medical Director.

Data Quality

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 national Hospital Episode Statistics (HES) database which are included in the latest published data outlined below and compared to the previous year’s results.

Period – April16 – Dec 16	Valid NHS Number	Valid GMPC
Inpatients	99.6%	100%
Outpatients	99.8%	99.9%
A&E	98.2%	99.5%

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

Comparison	Valid NHS Number	Valid GMPC
Inpatients	0.0%	0.0%
Outpatients	-0.1%	-0.0%
A&E	+0.1%	-0.7%

Information Governance Toolkit attainment levels

The Information Governance Toolkit version 14 was completed and submitted on 29th March 2017 with an overall score of 81% and a return of 'Satisfactory'.

For the previous version (2015/16), 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.

Version 14 emphasised the improvements made in-year by ensuring a robust Information Governance Management Framework process was followed with regular compliance reviews; however there remains 2 main areas which have seen significant improvement but have not attained the target set by the Trust at the start of the financial year. These are:

112 – Information Governance training

The toolkit target set by NHS Digital is for 95% of all staff to be trained in IG on an annual basis. This has not previously been achieved. The target was made compulsory in the version 14 release of the IG Toolkit.

Although compliance figures are higher this financial year, the Trust has been unable to achieve 95% training compliance and would have had to claim a level 1 assurance for this requirement. However as NHS Digital decommissioned their IG e-learning training tool in December 2016 (the core tool for IG training for NHS Organisations); NHS Digital have accepted that for Version 14, IG training figures can be reported over a 2 year period (April 2015 to March 2017).

Due to this directive, the Trust IG training compliance for April 2015 – February 2017 is 95.6% and therefore the Trust can claim a level 2 assurance for this requirement. This provision is only available currently for version 14 submission and may revert back to the annual compliance for version 15 which will be released in June 2017.

305 – Systems User Access

This element of the IG Toolkit requires the Trust to provide significant assurance that there is controlled access to Information Assets and systems by ensuring that system functionality is configured to support user access controls and by further ensuring that formal procedures are in place to control the allocation of access rights to local information systems and services.

These procedures are expected to cover all stages in the life-cycle of user access, from the initial registration of new users to the final de-registration of users who no longer require access to information systems and services. Robust procedures should be in place for the management of access rights which allow support staff to override system controls.

It was identified that although the Trust had formal procedures are in place to control the allocation of access rights to information systems and services, additional evidence was required to provide assurance that these procedures are operating effectively for all key business systems. The IG Team will be working with the IT team to ensure that there is a comprehensive monitoring process for key systems and inactive system accounts. Spot checks will be carried out to ensure the effectiveness of our processes.

An action plan, work schedule and a comprehensive confidentiality/information governance audit programme is being 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 and the Quality Governance Committee as required.

Clinical coding error rate

Background

An audit was internally commissioned by Northampton General NHS Trust to fulfil the Information Governance (IG) Toolkit requirement 505 and the associated objectives are clearly defined to support this purpose. The toolkit requirement states that there should be established procedures in place for regular quality inspections of the coded clinical data using the Clinical Classifications Service (CCS) Clinical Coding Audit Methodology to demonstrate compliance with the clinical classifications OPCS-4 and ICD-10 and national clinical coding standards and the organisation's commitment to continual improvement of its coded data. The clinical coding audits are undertaken by a CCS approved clinical coding auditor.

In the audit, each of the 3 bed-holding clinical Divisions have been selected for audit which included all associated inpatient sub-specialties. This represents a snapshot of all inpatient coded data.

In addition to this yearly audit, there is a cycle of audit both random (individual coders quarterly) and targeted (monthly) undertaken by management staff which covers a minimum of 100 Consultant episodes each month.

NGH was not subject to an externally commissioned clinical coding audit at any time during the reporting period.

Objectives

- To assess Trust-wide inpatient coding performance against recommended achievement levels for Information Governance Toolkit Requirement 505.
- To review the coded information for accuracy and adherence to national standards.
- To identify a baseline measure of accuracy for continuous improvement.
- To analyse the information provided to the coders at the time of the coding with the information contained in the case notes at the time of audit.
- To make recommendations where appropriate, to improve the quality of the coded clinical data.

Methodology

The individual episode data was selected at random across each of the Division's activity. The sample period was quarter 2 of 2016-17 and comprised 120 spells for each Division. A total of 5 excess notes were pulled per Division in case folders were unable to be audited.

The auditors carried out the audit strictly adhering to the Clinical Coding Audit Methodology Version 10.0 in order to satisfy the Information Governance requirement 505.

Results

The overall results for the 403 episodes (360 spells) audited reached IG level 2 requirements across all areas. In some areas, notably secondary coding, the percentages are above level 3 IG requirements.

The primary diagnosis and primary procedure scores were where the largest percentage of error was noted. Primary Diagnosis is the main condition treated or investigated during the relevant episode of healthcare, and where there is no definitive diagnosis, the main symptom, abnormal findings or problem. The primary procedure is the main surgical operations in terms of complexity and use of resources.

Of the 38 primary diagnosis errors found, 12 were incorrect at 3rd character level, 11 at 4th character level and 7 were present but incorrectly sequenced in a secondary field. Of the 18 primary procedure errors found, 6 were due to the procedures not being coded, 5 were incorrect at 4th character level and 3 were incorrect at 3rd character level.

Financially, there was a 1.18% change in the value of the episodes following audit.

OVERALL	**% Accuracy Including All Error Sources**	**% Accuracy Excluding Non-Coder Error**
Primary Diagnosis	90.57%	91.07%
Secondary Diagnoses	91.54%	92.64%
Primary Procedure	92.41%	93.25%
Secondary Procedures	93.40%	93.64%
Divisional	***% Accuracy Including All Error Sources***	***% Accuracy Excluding Non-Coder Error***
Medicine & Urgent Care		
Primary Diagnosis	90.26%	90.26%
Secondary Diagnoses	90.15%	91.54%
Primary Procedure	90.48%	92.07%
Secondary Procedures	95.28%	95.28%
Surgery		
Primary Diagnosis	90.32%	90.32%
Secondary Diagnoses	90.31%	90.62%
Primary Procedure	91.09%	91.09%
Secondary Procedures	89.67%	90.14%
Womens, Childrens & Oncology		
Primary Diagnosis	91.20%	92.80%
Secondary Diagnoses	95.91%	97.17%
Primary Procedure	95.89%	97.26%
Secondary Procedures	100.00%	100.00%

	% Accuracy	**IG Level 2 Requirements**	**IG Level 3 Requirements**
Primary Diagnosis	90.57%	%	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%

Themes of Good Practice Noted

- Standard of oncology chemotherapy coding was exceptional, both procedurally and diagnostically.
- Obstetric coding was of a high standard in the midst of some complex cases within the sample.
- Inpatient orthopaedic and general surgery was generally coded to a good standard.

Sources of error:

- Errors in the application of the primary diagnosis definition among a number of the coding team.
    - Driven by insufficient analysis of the full medical record where there is a conflicting main condition stated on the discharge letter.
- Errors in low complexity e.g. emergency medicine.
- Specific issues identified in coding for functional endoscopic sinus surgery (FESS) operations and the necessary code sequencing.
- Simple primary diagnosis errors noted within oral surgery.
- Histology reports not always referenced to update the coding.
- Some errors associated with non-recording of external cause codes.
- Evidence of coders not confining some diagnosis codes to the episode in which they were relevant.

Conclusions

The overall results met the required standard to reach IG level 2 across every Division which is positive. There were some particular areas identified where the coding was of a very good standard and this included the more complex activity within the sample. Errors were found within more low complexity, short stay spells.

The main priority for the department will be to highlight the importance of the primary diagnosis. This will also include reference to the discharge letter where there is a ‘main condition stated’ recorded by the clinician.

There were some specific training needs identified in relation to ENT surgery which will be addressed.

Work will be undertaken to ensure that multi-episode spells are extracted and coded at the same time within the coding office. This will assist with ensuring episodes are coded in isolation.

Actions undertaken

- Developed an intra-departmental project to place emphasis on improving primary diagnosis accuracy.
- Ensured that coders can view episode start/end times when extracting from notes on wards.
- Notes to be coded within the coding department for wards where multi-episode spells occur.
- Provided cross-departmental training on Head & Neck coding with a particular focus on FESS surgery.

Performance Against National 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.

For the following information data has been made available to the Trust by NHS Digital. Where this has not been available, other sources have been used and these sources have been stated for each indicator.

In accordance with the reporting toolkit the trust can confirm that it considers that the data contained in the tables below are as described, due to them having been verified by internal and external quality checking.

Domain 1 – Preventing people from dying prematurely and Domain 2 – Enhancing quality of life for people with long term conditions

- *Summary Hospital-Level Mortality Indicator (SHMI) – (*value and banding of the SHMI)

Period	NGH Value	NGH Banding	National Average	National High	National Low
Oct 15 – Sep 16	95	2	100	116	69
Oct 14 – Sep 15	102	2	100	117	65
Oct 13 – Sep 14	98	2	100	119	59

*SHMI banding:

- SHMI Banding = 1 indicates that the trust's mortality rate is 'higher than 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'

The Trust has an 'as expected' SHMI at 95 for the period October 2015 to September 2016 as demonstrated in the table above. Unlike HSMR, the SHMI indicator does include deaths 30 days after discharge and therefore patients, including those on palliative care end of life pathways, who are appropriately discharged from the Trust.

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* – *(*percentage of patient deaths with palliative care coded at either diagnosis or specialty level)

Period	NGH	National Average	National High	National Low
Oct 15 – Sep 16	36.62%	29.74%	56.26%	0.39%
Oct 14 – Sep 15	25.9%	26.6%	53.5%	0.19%
Oct 13 – Sep 14	26.6%	25.32	49.4%	0.0%

NGH has taken the following actions to improve this rate and quality of its services; by prioritising end of life care and placing greater importance on palliative care

Domain 3 – Helping people to recover from episodes of ill health or following injury

- *Patient Reported Outcome Measures scores (PROMs)* - (adjusted average health gain)
  - Hip replacement surgery
  - Knee replacement surgery
  - Groin hernia surgery
  - Varicose vein surgery

	NGH Performance		National Performance		
	Reporting Period 2016/17	NGH Quality Account 2015/16	Reporting Period Average	Reporting Period High	Reporting Period Low
• Groin hernia surgery (EQ-5D™ Index)	0.116 (provisional Apr16 to Dec16)	0.103 (provisional Apr15 to Dec15)	0.087 (provisional Apr16 to Dec16)	0.162 (provisional Apr16 to Dec16)	0.016 (provisional Apr16 to Dec16)
• Varicose vein surgery (EQ-5D™ Index)	N/A (provisional Apr16 to Dec16)	N/A (provisional Apr15 to Dec15)	0.093 (provisional Apr16 to Dec16)	0.0152 (provisional Apr16 to Dec16)	0.016 (provisional Apr16 to Dec16)
• Hip replacement surgery - primary (EQ-5D™ Index)	0.488 (provisional Apr16 to Dec16)	0.528 (provisional Apr15 to Dec15)	0.449 (provisional Apr16 to Dec16)	0.525 (provisional Apr16 to Dec16)	0.33 (provisional Apr16 to Dec16)
• Hip replacement surgery - revision (EQ-5D™ Index)	N/A (provisional Apr16 to Dec16)	N/A (provisional Apr15 to Dec15)	0.291 (provisional Apr16 to Dec16)	N/A (provisional Apr16 to Dec16)	N/A (provisional Apr16 to Dec16)
• Knee replacement surgery - primary (EQ-5D™ Index)	0.300 (provisional Apr16 to Dec16)	0.328 (provisional Apr15 to Dec15)	0.330 (provisional Apr16 to Dec16)	N/A (provisional Apr16 to Dec16)	N/A (provisional Apr16 to Dec16)
• Knee replacement surgery - revision (EQ-5D™ Index)	N/A (provisional Apr16 to Dec16)	N/A (provisional Apr15 to Dec15)	0.263 (provisional Apr16 to Dec16)	N/A (provisional Apr16 to Dec16)	N/A (provisional Apr16 to Dec16)

N.B. - Where N/A is stated, this information has not been made available by NHS Digital at the time of publication.

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* - percentage of patients readmitted to hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust)

Period	NGH	National Average	National High	National Low
Patients aged 0-15				
2016/17	N/A	N/A	N/A	N/A
2015/16	N/A	N/A	N/A	N/A
2014/15	N/A	N/A	N/A	N/A
2013/14	N/A	N/A	N/A	N/A
2012/13	N/A	N/A	N/A	N/A
2011/12	13.15%	10.01%	13.58%	5.10%

N.B. - Where N/A is stated, this information has not been made available by NHS Digital at the time of publication.

Period	NGH	National Average	National High	National Low
Patients aged 16 and over				
2016/17	N/A	N/A	N/A	N/A
2015/16	N/A	N/A	N/A	N/A
2014/15	N/A	N/A	N/A	N/A
2013/14	N/A	N/A	N/A	N/A
2012/13	N/A	N/A	N/A	N/A
2011/12	11.15%	11.45%	13.50%	8.96%

N.B. - Where N/A is stated, this information has not been made available by NHS Digital at the time of publication.

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 and working to improve the discharge process to ensure that early and effective planning for discharge is undertaken

Domain 4 – Ensuring that people have a positive experience of care

- *Responsiveness to the personal needs of patients*

Period	NGH	National Average	National High	National Low
2016/17	N/A	N/A	N/A	N/A
2015/16	65.5%	69.6%	86.2%	58.9%
2014/15	68.9%	68.9%	86.1%	54.4%
2013/14	68.6%	68.7%	84.2%	54.4%

N.B. - Where N/A is stated, this information has not been made available by NHS Digital at the time of publication.

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 – (*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)

Period	NGH	National Average	National High	National Low
2016	68%	69% (Acute Trusts)	85% (Acute Trusts)	49% (Acute Trusts)
2015	52%	69%	85%	46%

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* - (percentage recommended)

Period	NGH	National Average	National High	National Low
Inpatient				
2016/17	91.1%	96%	100%	80%
March 2016	85.4%	67%	93%	38%
March 2015	78%	95%	100%	78%

Period	NGH	National Average	National High	National Low
Patients discharged from Accident and Emergency (types 1 and 2)				
2016/17	86.7%	87%	100%	45%
March 2016	85.4%	84%	99%	49%
March 2015	85%	87%	99%	58%

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.

Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

- *Venous Thromboembolism – (*percentage of patients who were admitted to hospital and who were risk assessed, for venous thromboembolism)

Period	NGH	National Average	National High	National Low
Q4 16/17	95.90%	95.46%	100%	63.02%
Q3 16/17	95.87%	95.57%	100%	76.48%
Q2 16/17	95.25%	95.45%	100%	72.14%
Q1 16/17	94.10%	95.74%	100%	80.61%
Q4 15/16	95.2%	96%	100%	79.23%

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* - (rate per 100,000 bed days of cases of C.Diff infection, reported within the Trust amongst patients aged 2 or over)

Period	NGH	National Average	National High	National Low
2016/17	8.2	13.3	82.9	0
2015/16	13.2	14.9	66.0	0
2014/15	12.2	15.1	62.2	0
2013/14	11.21	13.9	37.1	0

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 and improving antimicrobial stewardship.

- *Patient Safety*

Period	NGH	National Average	National High	National Low
The number of patient safety incidents reported within the trust - (Acute Non-Specialist)				
Apr 16 – Sep 16	3,830	6,575	13,485	1,485
Oct 15 – Mar 16	3,538	4,335	11,998	1,499
Apr 15 – Sep 15	3,722	4,647	12,080	1,559

Period	NGH	National Average	National High	National Low
The rate (per 1,000 bed days) of patient safety incidents reported within the trust - (Acute Non- Specialist)				
Apr 16 – Sep 16	30.8	40.9	71.8	21.1
Oct 15 – Mar 16	28.4	39	75.9	14.8
Apr 15 – Sep 15	31.1	39.3	74.7	18.1

Period	NGH	National Average	National High	National Low
The number of such patient safety incidents that resulted in sever harm or death - (Acute Non- Specialist)				
Apr 16 – Sep 16	13	33.6	98	1
Oct 15 – Mar 16	18	34.6	94	0
Apr 15 – Sep 15	6	19.9	89	2

Period	NGH	National Average	National High	National Low
The percentage of such patient safety incidents that resulted in sever harm or death - (Acute Non- Specialist)				
Apr 16 – Sep 16	0.33%	0.51%	1.73%	0.02%
Oct 15 – Mar 16	0.51%	0.40%	2.0%	0%
Apr 15 – Sep 15	0.16%	0.43%	0.74%	0.13%

The results show that the trust is below the national average for the level of harm. NGH has taken 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.

Review of Activity 2016/17

The table below shows a snapshot of the Trusts performance activity up to 31 March 2017 with a comparison to the previous year's activity.

Activity	2015/16	2016/17	Difference	% Difference
Emergency inpatients	43,456	47,701	4,245	10%
Elective inpatients	5,824	5,634	-190	-3%
Elective day cases	39,610	42,393	2,783	7%
New outpatient attendances – consultant led	83,474	105,790	22,316	27%
Follow-up outpatient attendances – consultant led	155,562	208,420	52,858	34%
New outpatient attendances – nurse led	42,127	27,758	-14,369	-34%
Follow-up outpatient attendances – nurse led	154,412	101,938	-52,474	-34%
Total number of outpatient DNAs	34,770	36,708	1,938	6%
Patients seen in A&E	114,179	116,183	2,004	2%
Number of babies born	4,726	4,867	141	3%
Average length of stay (in days)	4.36	4.52	0.16	4%

healthwatch Northamptonshire

Healthwatch Northamptonshire statement on Northampton General Hospital NHS Trust (NGH) draft Quality Account 2016/17

During 2016/17 Healthwatch Northamptonshire has continued to work with NGH through attending the Patient and Carer Experience and Engagement Group (PCEEG) and providing patient feedback. We have also held monthly 'Pop Up Shops' at the hospital to help patients, staff and other members of the public share their views and experiences.

Healthwatch Northamptonshire believes that this Quality Account demonstrates the progress NGH has made against their 2016/17 Quality Priorities, and are pleased to see an honest assessment of what still needs to be done as well as details of the many quality improvement initiatives that have taken place during the year. We support the way NGH have linked their Quality Priorities to their three year Quality Improvement Strategy as a way of embedding change within the Trust.

We believe NGH has chosen appropriate Quality Priorities for 2017/18 and are pleased that the lessons learnt from complaints and serious incidents were considered when developing them.

Through attendance at the PCEEG we have been able to observe the good work carried out by NGH during 2016/17 to improve how patient experience is both recorded, through the development of robust processes and methods for gathering patient feedback, and acted upon and are encouraged by the good representation of divisions and services at NGH on the PCEEG. We support NGH as they focus on ensuring this feedback leads to short term and long term improvements and learning and will continue to work with them to in ensuring high quality, innovative and patient-centred care.

The most common theme to the feedback we received about poor patient experiences at NGH during 2016/17 was communication. This is a theme mentioned in several areas of this Quality Account and we encourage NGH to continue to work on ensuring all frontline staff (including administration) understand the importance of communicating well with patients and their relatives, as communication and staff attitude tends to have the biggest impact on the quality of patient experience.

We congratulate NGH for the progress they have made resulting in those services that were previously rated as 'Requires Improvement' or 'Inadequate' now being rating as 'Good' following the recent CQC inspection. This reflects much hard work by both management and staff.

Northampton General Hospital
NHS Trust

Northamptonshire County Council

FAO: Simon Hawes
Corporate Governance Manager
Northampton General Hospital NHS Trust
Cliftonville
Northampton
NN1 5BD

Please ask for: Jenny Rendall
Tel: 01604 367560
Our ref:
Your ref:
Date: 25 May 2017

Dear Simon

Re: Quality Account 2016-17

The NCC Health Adult Care & Wellbeing Scrutiny Committee formed a working group of its members to consider a response to your Quality Accounts 2016-17. Membership of the working group was as follows:

- Councillor John McGhee
- Councillor Eileen Hales
- Mr Andrew Bailey (Northamptonshire Carers Voice Representative)

The working group also considered the following in relation to all quality accounts:

- It was felt it would be useful for Scrutiny to receive summary quarterly updates from providers of progress data against the key actions taken to deliver the objectives set in the Quality Account for that year. This would be consistent with the Department of Health guidance that discussions between OSCs and providers of the Quality Accounts should be conducted throughout the reporting year.
- Whilst the 'ransomeware' attack on IT systems had happened in the current year, it might be nice to be able to report its affects to reassure the public that their information remained safe.

The working group considered how far the quality account was a fair reflection of the healthcare services provided by Northampton General Hospital, based upon members' knowledge of the provider. The formal response from the Health Adult Care & Wellbeing Scrutiny Committee based on the working group's comments is as follows:

- It was felt the Quality Account included too much detail and should have focussed on the facts.
- Concerns were raised regarding staff recruitment and possible 'burn out'.
- The glossary missed many acronyms and there was a lack of page numbering.
- There were references to mental health but no information on the co-ordination of staff with NHFT.
- Further information on work with other organisations would also have been welcomed.
- Information required updating in terms of priorities and improvement.
- It was disappointing to note that the hoped for decrease in preventable cardiac arrests had not been achieved.
- There appeared to be significant issues in A&E and Maternity

- The investment in staff was welcomed but information on the grades that nursing staff would be trained to would have also been welcomed.
- It was good to see that supporting carers had improved but feedback suggested there was still work to be undertaken in communications. The Quality Account appeared to demonstrate a strong reliance on IT.
- It was noted from the staff survey results that staff did not feel entirely comfortable in their working areas. Whilst some improvements had been made it was quite worrying to note they were still in the bottom 20% and it was hoped senior management would address what appeared to be culture factors as a matter of urgency.
- Concerns were raised that those consenting to total hip and knee replacements were not always completely aware of all the factors or that they were recorded.
- The work with the university was considered to be good.
- Improvements in CDIF were welcomed.
- Positive progress on SEPSIS was welcomed.
- It was felt an important part of communication with the public could be achieved via all types of media including the television and the management decision to engage in this way was to their credit.
- The introduction of finger food and twiddle muffs were welcomed.
- It was good to note they were improving communication and nursing care.
- There appeared to be a very good way of dealing with complaints, demonstrating they were taken seriously.

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

Councillor John McGhee
Chairman of the Committee.

NHS
Northampton General Hospital
NHS Trust

NHS
Corby Clinical Commissioning Group

Private & Confidential
Carolyn Fox
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TEL: 01604 651100
DDI: 01604 651252
Ref: AJ/HS/EC
30 May 2017

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

Dear Carolyn

Re: Quality Account 2016-2017

The Northampton General Hospital (NGH) NHS Trust annual quality account for 2016-17 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.

It is positive to note the work undertaken by the trust in 2016/17 against the previous year's priorities and the plans that the trust has to continue this work. The language used to describe some of this work has been written in a clinical/corporate way so it may be difficult for all people to understand the achievements made. As the review of the account has been undertaken in draft format this does not yet include a summary of the providers' view of the quality of the NHS service and sub-contracted services provided.

The account contains six key quality priorities for 2016-17. These are supported by Nene and Corby CCGs as these reflect national and local priorities. It may be useful to include a description of how progress will be monitored and measured. It was positive to note the work undertaken by the trust on the development and implementation of the Best Possible Care Accreditation and Assessment Framework.

The trust has participated in all, except two applicable National Clinical Audits and has plans in place to ensure they can participate in these next year. It is clear that there has been a large amount of local audit undertaken and is useful to see some of the learning from this.

Whilst the draft account contains details of performance to date against CQUIN schemes for 2016/17 it is suggested 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 2016/17 CQUINs and the proposed 2017/19 CQUINs to patients.

POSITIVE ABOUT DISABLED PEOPLE

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 2017/18 is.

We note the positive work undertaken in understanding patient experience and the themes identified from surveys. The draft report does not identify themes from complaints.

It is not clear within the draft report what Quality, Innovation, Productivity and Prevention activity has been undertaken by the trust 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.

The core quality indicators have not been presented in the prescribed format and the draft does not contain all required reporting periods or the most recent data for all indicators.

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.

Although not a requirement the trust may wish to consider information against the public sector equality duty (PSED) in future quality accounts.

The trust should be congratulated on the 'Good' rating from the Care Quality Commission focused inspection report published in May.

Commissioners will continue to work closely with the trust and support their 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

Dr Matthew Davies
Medical Director
NHS Nene Clinical Commissioning Group

Dr Miten Ruparelia
Clinical Vice Chair
NHS Corby Clinical Commissioning Group

cc: Mike Cusack, Medical Director, Northamptonshire General Hospital NHS Trust
Alison Jamson, Deputy Director of Quality NHS Nene & NHS Corby CCGs
Emma Clarke, Senior Quality Improvement Manager, NHS Nene & NHS Corby CCGs

KPMG

INDEPENDENT AUDITOR'S 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 2017 ("the Quality Account") and certain performance indicators contained therein. 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 2017 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 2016 to June 2017;
- papers relating to quality reported to the Board over the period April 2016 to June 2017;
- feedback from the Commissioners 30/5/17;
- feedback from Local Healthwatch dated 25/5/17;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 ;
- the latest national patient survey dated 2016;
- the latest national staff survey dated 2016
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2017;
- the annual governance statement dated May 2017; and
- the Care Quality Commission's Inspection Report dated 23/5/17.

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 2017:

- 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
1 Waterloo Way
Leicester,LE1 6LP
30 June 2017

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	QCI	Quality Care Indicator
	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