NHS
Northampton General Hospital
NHS Trust

QUALITY ACCOUNT
2018/2019

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Providing the **Best Possible Care**

QUALITY ACCOUNT 2018/2019

1 PART ONE INTRODUCTION

The purpose of this quality account is to illustrate to our patients, their families and carers, staff, members of local communities and our health and social care partners, the quality of services we provide.

The report is published each year. We measure the quality of services we provide by looking at patient safety, the effectiveness of the care and treatment we provide and, importantly, the feedback we receive from our patients.

Part One of this report opens with a statement on quality from our Chief Executive, Dr Sonia Swart, Medical Director Mr. Matt Metcalfe and Director of Nursing and Midwifery Ms Sheran Oke.

In Part Two, we have provided details of our priorities for quality improvement that we intend to deliver during 2019/21 and details of a number of Statements of Assurance regarding specific aspects of service provision. The Trust is required to provide these statements to meet the requirements of NHS Improvement.

Part Three describes how we performed against the quality priorities set for 2018/19, together with performance against key national priorities in line with NHS Improvement Risk Assessment Framework.

The closing section outlines feedback from our key stakeholders.

Thank you for taking the time to read our quality account. If you would like to comment on any aspect of this document, we would welcome your feedback.
You can contact us at: pals@ngh.nhs.uk

STATEMENT OF QUALITY

1

Dr Sonia Swart
Chief Executive

Matt Metcalfe
Medical Director

Sheran Oke
Director of Nursing, Midwifery and Patient Services

Dear All

Welcome to the Quality Account of Northampton General Hospital NHS trust for 2018/19. We present updates on our progress against our quality priorities for the year in review alongside our priorities for the year ahead, which will be reflected in the Quality Improvement Strategy for 2019-2021. Beyond these, we are delighted to share some of our key achievements during the year, the highlights of which we touch upon here. These illustrate our commitment to providing the best possible care for patients which remains our overall aim. Our efforts and improvements are framed against our key values.

Patient safety above all else

There have been two major developments for our stroke service. Firstly it has been expanded to receive and care for all acute strokes in the county rather than just the hyperacute cases. Secondly the trust has led some of the first mechanical thrombectomy treatments in the country for stroke working in partnership with Oxford University Hospitals. Through all this the service has retained its SSNAP A rating.

Safe and effective emergency flows are important for all our patients and during the year the 60 bedded Nye Bevan emergency assessment building was completed to transform the way we deliver care for our urgent patients. Recognising the national shortfall in acute physicians the medical model has been delivered through the use of consultants of many medical specialities with

accreditation and experience of acute care and on a roster which facilitates early consultant review and continuity of care.

We continue to actively work on reducing patient harms and have seen reductions in our falls with harm, incidence of hospital acquired pressure ulcers and infection control metric including the rate of Clostridium Difficile.

We have also actively engaged in the maternity modernisation agenda aiming to ensure that the continuity of care model is in place by 2021

We aspire to excellence

The trust is the first UK hospital to achieve accreditation as a Pathway to Excellence® hospital by the American Nurses Credentialing Centre and also continues to progress the Nursing and Midwifery ward and department assessment and accreditation process with increasing numbers of wards receiving the much valued 'Best Possible Care' ward status. The promotion of this work at national and international level has resulted in 12 national and international awards and a number of poster presentations at this level. These programmes are designed to drive improvements in core quality standards and to motivate the clinical workforce to be proud of these achievements.

The trust continues progress on the pathway towards university teaching hospital status with the medical college at the University of Leicester. Posts have been advertised for senior lecturers with honorary NHS contracts at NGH. A candidate for the associate non-executive director role from the university, with excellent research and educational credentials, has been nominated to sit on the trust board and the appointment is in process.

For the third consecutive year NGH has been recognised as the most successful NHS Trust at the world's largest patient safety conference, the International Forum on Quality & Safety in Healthcare.

In 2019 NGH colleagues presented sixteen posters at the conference on behalf of the hospital – the largest number of QI projects presented of any NHS Trust in England.

Likewise collaboration with the university of Northampton continues at pace, with a Master's Degree in quality improvement acknowledged as a flagship collaboration project. This programme is offered to health and social care professionals who wish to develop a greater understanding and expertise in quality improvement and patient safety. The dissertation for this Master's degree is an extended improvement project. Graduates of this MSc will be the leaders of tomorrow, equipped with the skillset and knowledge to lead and deliver the complex change the NHS will be required to deliver.

We reflect, we learn, we improve

The trust has developed a comprehensive care plan to support our clinical teams in recognising and responding to deteriorating patients in timely and holistic manner. This has been piloted and is being rolled out trust wide.

Closer working between the quality improvement and governance teams is allowing us to deploy our improvement resource where it is most needed responsively. In addition to the example of the deteriorating patient work described above there has been excellent work together on the "clot busting" campaign promoting awareness among staff and patients of the importance of thromboprophylaxis and patient empowerment.

Inter-speciality referrals for inpatients are now made electronically, which allows for more timely review and audit of referrals and outcomes.

We have further developed our partnership with the University of Northampton to enable us to grow our nursing and midwifery workforce and were a pilot site for the new Nursing Associate role with 14 Nurse Associates deployed within the organisation. This is part of a programme to address shortfalls in our healthcare workforce which includes imaginative ways of recruitment to challenging areas and the utilisation of apprenticeships.

We respect and support each other

Sustainable excellence in care is underpinned by a resilient workforce, and this is a key priority for the trust. For example, over the year we have seen an 8.5% increase in consultant numbers. Alongside recruitment drives, we have strengthened staff development opportunities with development masterclasses delivered for multiple staff groups by the quality improvement and organisational development teams.

For our clinical leadership teams, we have built on the previous in house leadership programmes with a new partnership with Momentum workshops to support leadership of effective change and working across boundaries.

We continue to develop our staff recognition schemes including further development of the DAISY scheme to celebrate the compassionate care our nurses and midwives give with nominations coming from patients and families and have used the same methodology to reward other staff groups for exceptional care through our Everyday Heroes awards.

We remain a key partner in the Cavell Nurses' Trust membership programme which provides support for UK nurses, midwives and healthcare assistance when suffering a range of distressing circumstances.

There has been continued work on health and wellbeing for staff bringing support for mental health issues and a sign up to the 'Time to Change' pledge to signal this. Our campaign on respect and support continues to develop and will require further work in the coming year.

Despite our commitment to Best Possible Care and the values that drive this we know there is more to do on many fronts. The challenging environment provided by increasing emergency pressures has stretched our staff and resources and unfortunately we were not able to provide emergency care as quickly as we would like and we continue to focus on this during 18/19. There has also been an impact on waiting times in other areas and again were are determined to improve this and improve the experience of cancer patients some of whom who wait too long to commence their treatment. We also know that we have more work to do to improve the experience of our patients and our staff.

Looking forward to 2019/20 and after wide consultation with staff and stakeholders we have developed Quality Priorities that we hope will address some of our key issues. Some of these will be extended from previous work and some will be new. These include:

Patient Safety above all else

- Improve Freedom to Speak up engagement
- Improve the safety focus of huddles
- Reduce further falls, C difficile ,pressure ulcers
- Improved care of the deteriorating patient
- Better outcomes in Maternity

We Aspire to Excellence

- Improvement in 7 day services
- Improved cancer patient experience
- More effective care for patients with Urological and Orthopaedic conditions through GIRFT

We reflect we learn we improve

- Increase reporting of incidents in order to support a learning organisation
- Comprehensive programme of mortality reduction through reviewing deaths

We respect and Support each other

- Increased focus on staff health and wellbeing
- Better communication for staff and patients

We hope this quality account provides a clear picture of the importance of quality and patient safety at Northampton General Hospital and that you find it informative.

To the best of our knowledge we confirm that the information provided in our Quality Account is accurate.


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NHS
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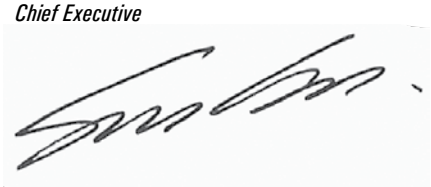
Proud
TeamNGH

STATEMENT OF DIRECTORS RESPONSIBILITIES

1

Alan Burns
Chairman

Dr Sonia Swart
Chief Executive



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 they have complied with the above requirements in preparing the Quality Report.

By order of the board

1 OUR PLAN AND ACTIONS FOR 2018/19

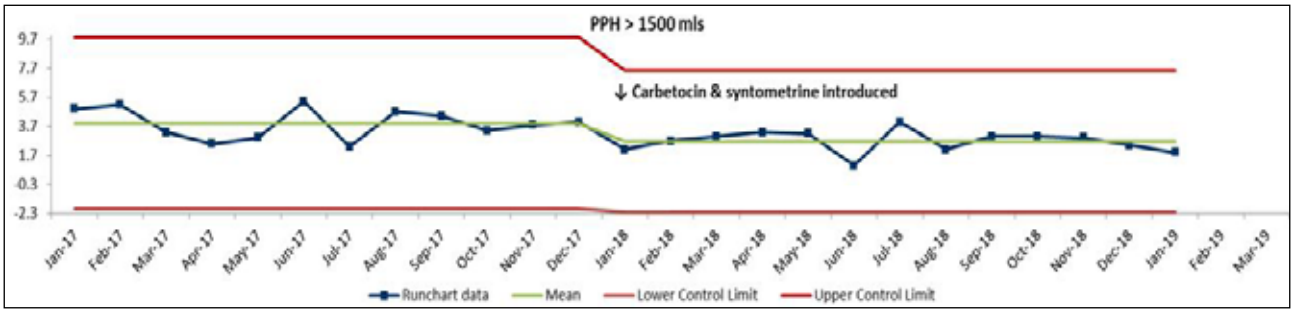
GOOD NEWS STORIES FROM THIS YEAR

National Maternal and Neonatal Health Safety Collaborative (MatNeo)

The collaborative was announced by the Department of Health and supports the aims of the NHS England's Better births maternity review and the maternity transformation programme

The Maternal and Neonatal Health Safety Collaborative is a three-year quality improvement programme, supported by NHS Improvement. Northampton General Hospital participated in Wave 2 of the programme which commenced in May 2018. Improvements made to the service included:

- Introduction of Maternity Safety Huddles
- Introduction of 10 @ 10
- Learning from Excellence
- Collaborative working between anaesthetists, obstetricians, midwives and theatre staff to agree and revised postnatal pathway, supported by a successful business case
- A reduction in the percentage of women having a postpartum haemorrhage of > 1500mls from a mean of 3.9% to 2.7%



Staff Engagement - Kitchen Table events

Receiving MatNeo Certificate from Phil Duncan – Programme Director of NHS Improvement

CNST Maternity Incentive Scheme

The CNST Maternity Incentive Scheme was launched by NHS Resolution in 2018 to incentivise Trust Boards to fund safety initiatives in support of the Government's ambition. 10 maternity safety actions were agreed by the National Maternity Champions and Trusts that were able to demonstrate the required progress against all of the following 10 actions were awarded a Maternity Incentive Scheme payment.

- Use of national Perinatal Mortality Review Tool to review all perinatal deaths
- Submission of the Maternity Services Data Set
- Transitional care facilities and implementation of the Avoiding Term Admission programme
- Effective system of medical workforce planning
- Effective system of midwifery workforce planning
- 100% Compliance with all 4 elements of the Saving Babies' Lives care bundle
- Use of patient feedback mechanisms and actions taken in response
- 90% of each staff group attendance at multi-professional maternity emergencies training in the last year
- Trust safety champions (obstetrician and midwife) meet bi-monthly with Board level champions to escalate identified issues
- 100% of qualifying incidents reported under NHS Resolution's Early Notification scheme

Northampton General Hospital was the only maternity service in the East Midlands who were successful in demonstrating compliance against all 10 maternity safety actions.

Better Births

Better Births, the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives.

Following a number of stage engagement sessions and in conjunction with the Local Maternity Services Board (LMS), the following continuity models will be implemented in 2019/20

- Horizon Team – caseloading team to care for women who have had a previous stillbirth, neonatal death or recurrent miscarriage
- Phoenix Team – hybrid continuity team caring for women who are socially vulnerable

Maternity Quality Priorities for 2019/20

Building on the work streams started in 2018/19

Avoiding Term Admissions into Neonatal Units (ATAIN)

NHS Improvement have identified that over 20% of admissions of full term babies to neonatal units could be avoided. By providing services and staffing models that keep mother and baby together we can reduce the harm caused by separation.

The maternity and neonatal services at NGH hold a monthly Avoiding Term Admissions into the Neonatal Unit (ATAIN) review meetings. Whilst some transitional care services are provided on the postnatal ward, the reviews demonstrate that many babies who are suitable for transitional care are having to be separated from their mothers and either admitted to the neonatal unit or attend the neonatal unit for the administration of IV antibiotics.

An action plan is in place and a dedicated Neonatal Transitional Care Unit will be developed in early 2019/20.

Aim: To reduce the separation of mothers and babies when babies require transitional care (need to identify baseline and improvement)

Maternity Triage

As part of the Trusts learning from incidents and claims (Darnley v. Croydon Health Services NHS Trust the maternity services have reviewed the provision of maternity triage and an action plan has been developed to introduce a more formalised approach to maternity triage. This will be based on the Birmingham Symptom-specific Obstetric Triage System (BSOTS).

Each Baby Counts

The Each Baby Counts report demonstrates the complex nature of maternity care and likens it to the aviation industry. The report highlights the need to focus much more on human factions and situational awareness, which is something the aviation industry has done very well for some time.

We currently have 72 members of staff who have undertaken human factors training facilitated by Global Air Training for Health and a further two training courses are planned for 2019/20.

During 2019/20, human factors and situational awareness processes will be implemented on the labour ward and will be incorporated into all obstetric skills drills training.

Saving Babies Lives Care Bundle:

Version two of the Saving Babies' Lives Care Bundle was released in March 2019 and has been produced to build on the achievements version one. The second version brings together five elements of care aimed at improving the safety of women and babies.

- Reducing Smoking in pregnancy
- Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
- Raising awareness of reduced fetal movement
- Effective fetal monitoring in labour
- Reducing preterm birth

Quality Improvement projects will be developed around all five elements of the care bundle.

Quality Improvement training

To support all staff with their ideas for improvement, the QI team in NGH deliver and support numerous academic and professional programmes. Participants on each of these programmes are supported with the delivery of a QI project within their work area. These programmes are:

- **Registrar Leadership & Management Programme** – In 2018/19, we delivered the largest programme to date. This is a 12 week advanced leadership programme for Specialty Registrars in the East Midlands region, which aims to improve leadership capability and capacity for our Consultants of Tomorrow. There were 30 participants in the most recent programme, double that of previous years.
- **Aspiring to Excellence SSC** – A 2 week student-selected component (SSC) offered to 5th year medical students from Leicester Medical School. This programme teaches the fundamentals of patient safety & quality improvement, enabling them to deliver a small improvement project in their area of interest.
- **Junior Doctors' Safety Board (JDSB)** – This programme coincides with the intake of junior doctors each August. Juniors are offered support to lead their own improvement project.
- **Trust Grade Development Programme** – Commencing in 2019, this new programme has been tailor-made for Trust Grade doctors in the East Midlands, following the success of the Registrar Leadership & Management Programme. The programme offers specialist sessions on Returning to Training/CESR programme, Navigating the NHS, Building Personal Resilience and Managing Change in the NHS. All participant are supported with to deliver a QI project.

- **Esther White and James Stonhouse programmes** – Delivered by Organisational Development, these programmes have a bespoke QI component delivered by the QI team.
- **Shared Decision Making** – As part of the Pathway to Excellence® programme, Shared Decision Making Councils are supported to deliver QI projects in their work area. Each council receives QI training from the team.
- **Stroke Journey** – A longstanding programme delivered by the Community Stroke Team. In 2019, NGH QI team were invited to support the delivery of this programme, supporting participants to deliver QI projects as part of the programme. There were 15 participants in 2019, with 6 projects in total.
- **Creating Excellence SSC** – Commencing in 2019, NGH have been invited to lead a new student-selected component with Leicester Medical School. This SSC will be offered to all 3rd year medical students and runs over a 4 week period.
- **Medical Student Patient Safety & Quality Improvement teaching** – Commencing in 2019, NGH have been invited to co-deliver a bespoke patient safety and quality improvement curriculum for 1st year students, alongside University Hospitals Leicester and the Medical School. This programme will be delivered to ca 300 students.
- **RCN Leadership Programme for Nurses and Midwives -**
  A longstanding programmed facilitated by Practice & Professional Development, the NGH QI team have been invited to support the quality, service improvement and redesign projects delivered as part of this programme.
- **Band 5 Nursing Programme** – The NGH QI team deliver bespoke training to Band 5 nurses on this programme. The session covers the fundamentals of patient safety.
- Foundation Year 2 Patient Safety teaching – As part of the FY2 curriculum, the QI team in NGH facilitate the delivery of bespoke patient safety teaching.

We encourage staff of all disciplines to join the programmes on offer; however we recognise that some staff may not be able to fulfil the time commitments required to complete these programmes. Therefore, in autumn 2018 the QI team commenced with a new monthly teaching slot for QI, opened to staff of all disciplines. Between October 2018 and March 2019 we have trained 335 staff in Quality Improvement Fundamentals (QI methodology, QI project management and Measuring for Improvement).

Conference success

For the third consecutive year NGH have been recognised as the **most successful** NHS Trust at the world's largest patient safety conference, the International Forum on Quality & Safety in Healthcare. In 2019 NGH colleagues presented sixteen posters at the conference on behalf of the hospital – the largest number of QI projects presented of any NHS Trust in England. The next largest number of posters presented was 12 – presented by the Royal Free Hospital.

The 16 posters presented at the International Forum on Quality & Safety in Healthcare 2019 (Glasgow, UK)

These sixteen posters reflect a small proportion of the large amount of ongoing improvement work supported by the NGH QI team. In March 2019 there were 81 ongoing QI projects recorded in the QI project repository. All 81 projects are aligned to corporate objectives and aim to improve the quality of care we deliver.
In Summer 2018 NGH were also recognised as the most successful organisation at the Patient Safety Congress. Fourteen QI project posters were presented at this conference – the largest number of any organisation in

attendance.
With our continued success on the national and international platform, NGH has become renowned as a centre for excellence for quality improvement.

Several large NHS organisations, including teaching hospitals, have sought advice from our expert QI team on how to embed local quality improvement work within their organisations.

The Registrar Leadership and Management Programme at Northampton General Hospital— Increasing Leadership Capability for the Consultants of Tomorrow

QI@ngh.nhs.uk


Jane Bradley


Sid Beech


Liz Smillie

Background

In recent years there has been an increasing emphasis on developing leadership and management skills for clinicians in the NHS. Effective clinical leadership ensures a high quality health care system that provides safe, reliable and effective care. There has been a wealth of guidance, frameworks and reports published by government organisations, charities and think tanks including:

- *Developing People—Improving Care* (2016); A national framework guiding action on the development of NHS staff co-developed by many healthcare organisations in England.
- *Leadership Development for Doctors in Postgraduate Medical Training* (2016); A report published by Health Education England that offers principles and recommendations for development of clinicians.

These two reports highlight the variability in leadership development opportunities across different regions in England, with strong recommendations to greatly improve the training offer for all staff.

Northampton General Hospital (NGH) is a district general hospital in the East Midlands of England with around 100 specialty registrars working in the organisation at any one time. The Quality Improvement (QI) team in the hospital run several academic programmes to support the personal and professional development of the multidisciplinary workforce. These programmes have various components; some with an emphasis on leadership and management, as well as improving the quality and safety of care delivered at NGH.

What are we trying to accomplish?

What change can we make that will result in improvement?

Since 2012, the QI team in NGH has delivered an annual advanced leadership and management programme for Specialty Registrars working in the hospital. The aim of the programme is to provide a broader understanding of "how the NHS works", the wider issues facing primary and secondary care, as well as to introduce practical leadership and management skills and knowledge needed as a senior clinician in the NHS. Since its inception, this programme has been offered to NGH Specialty Registrars at no cost.

The programme initially ran over a 6 week period with 6 separate modules: *Presentation Skills, Safety Science, Leadership in Medicine, Clinical Outcomes/Governance, Progressing from Registrar to Consultant and How Finance helps the Change Management Process.* Since its inception participants have been supported to lead on a QI project.

In 2017/18, Health Education East Midlands funded a pilot of the Leadership and Management Programme, offering it to Specialty Registrars across the East Midlands region. This pilot was positively evaluated by participants and the next stage will see this pilot rolled out across the East Midlands in 2019/20.

Feedback from participants and faculty has been collected each year in order to refine the content and structure of the programme. In 2018/19 the programme had 12 modules delivered during 12 weeks. The modules are delivered in a two or three hour slot by senior healthcare professionals. The 2018/19 faculty include the Chief Executive, Medical Director, Director of Finance, Simulation team and Organisational Development team. Participants were also required to complete a pre-requisite course on Quality Improvement in order to join the programme, which is led by the Quality Improvement team. The full module list is shown in Table 1.

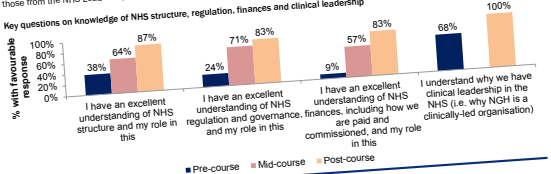
Module Name	Brief Description
Delivering Improvement in NGH Sid Beech (Head of Academic Programmes), Liz Smillie (Data Analyst)	Pre-requisite module on quality improvement methodology (Model for Improvement/PDSA), QI project process and how to measure for improvement
Patient Safety, Governance and Regulation Mr Matthew Metcalfe (Medical Director)	Introduction to the various forms of regulation in the NHS in England, the clinical and corporate governance structure in the hospital and the justification for this. Simulated investigation into several real serious incidents, to explain the process and actions that arise from them.
Dragon's Den Sid Beech (Head of Academic Programmes), Liz Smillie (Data Analyst), Dr Rebecca Cole (QI fellow), Sarah Croak (Associate Director Patient Safety/QI)	Participants present their project ideas to the wider group for advice and feedback.
Demystifying NHS Finance Phil Bradley (Director of Finance)	A brief introduction to the complex financial processes, governance and organisations in the NHS with pointers for managing a service within budget.
Improvement under pressure—confessions of a medical CEO Dr Sonia Swart (Chief Executive)	A personal perspective of how NGH has achieved 'Good' quality care, the future plans for the hospital and the importance of medical leadership.
Simulation—what it feels like to be a consultant! Vicky Garrod (Operational Simulation and Response Lead), Dr Fiona Poyner (Emergency Dept Consultant), Dr Andrew Jeffrey (Respiratory Consultant)	3 separate scenarios on breaking bad news of a medical error, rapid tranquillisation and dealing with a challenging junior doctor.
Clinical Leadership—a Divisional Director's perspective Dr Mithas Mirmeshari (Orthopaedic Director, Clinical Support Services)	An introduction to the skills and attributes needed to be a highly successful clinical leader. This session focused on emotional intelligence.
Change without migraines Fiona Pittam (Head of Organisational Development)	Managing and leading change in the NHS can be complex, especially when facing resistance. This module provides a model to consider and prepare for resistance and overcome this using a well-established toolkit.
Building personal resilience Lorraine Ruddiforth (Organisational Development Practitioner)	Recognise what depletes your energy and what restores your sense of wellbeing and personal resilience.
Mind the gap! Dr Dario Seigal (GP principal, Moulton Park Surgery)	A general physician's perspective on how to improve co-ordination and collaborative working between primary and secondary care.
Why Clinical Leadership? Dr Richard Bohmer (Senior Visiting Fellow, Nuffield Trust)	Advice on how to prepare for senior clinical roles, avoiding physician burnout, your role in the future of the NHS.
Simulation—team communication, documentation and clinical notes review Vicky Garrod (Operational Simulation and Response Lead), Dr Fiona Poyner (Emergency Dept Consultant), Dr Tom Gilbert (Emergency Dept Consultant)	Participants are placed in to groups and asked to complete a concise case note review of a recent clinical incident. This is followed by a presentation of an action plan for each clinical incident with feedback from senior clinicians.
Project presentation Jane Bradley (Deputy Director Patient Safety/QI), Sid Beech (Head of academic programmes), Liz Smillie (Data Analyst), Dr Rebecca Cole (QI fellow), Sarah Croak (Associate Director Patient Safety/QI)	Participants present the progress of their QI project to their peers and the programme faculty. These presentations are video recorded for use in portfolios and to share locally.

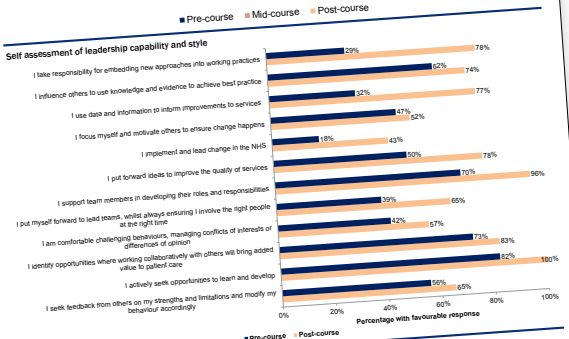
Table 1: The 2018/19 programme for the NGH Registrar Leadership and Management Programme

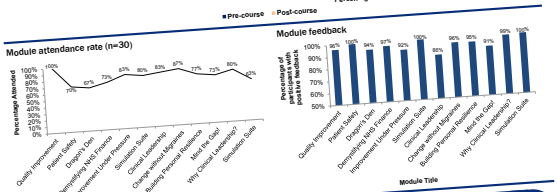
New sessions on this years programme include Change without Migraines, Building personal resilience and Why Clinical Leadership?. Participants on the programme are supported to continue with the delivery of their QI project for the remainder of the academic year, with the expectation that their work will be presented on a regional, national or international platform.

How will we know that a change is an improvement?

The programme has been evaluated using anonymised participant self-evaluation that was collected before, during and after completion of the programme. We have developed a bespoke evaluation tool for this programme, using our own questions as well as those from the NHS Leadership Academy's Self Assessment Tool in order to reflect the content of the programme.







Discussion & Summary

The NGH Registrar Leadership & Management programme has just completed its seventh year, with 30 Specialty Registrars completing the programme. The 2018/19 programme is the largest delivered to date, with 12 modules in total. Feedback on these modules has been very positive (favourable feedback for each module ranges from 86 % to 100 % positive). Each year we reflect on the content and delivery of each module, using faculty and participant feedback to amend, add or remove content. The three new modules added to this years programme have received very positive feedback (Change without Migraines 96 %, Building Personal Resilience 95 % and Why Clinical Leadership 100 %), and will remain on next year's programme.

We have seen significant improvements in participants' self-evaluation of their leadership and management knowledge, capability and skills. The four questions relating to an excellent understanding of NHS structure, regulation, finances and clinical leadership each saw a considerable improvement (Structure 38 % to 87 %, Regulation 24 % to 83 %, Finance 9 % to 83 % and Clinical Leadership 68 % to 100 %.) There has also been an improvement in every aspect of the self evaluation tool for leadership capability and style. Notably, we have seen large positive shifts in the following:

- *I take responsibility for embedding new approaches into working practices* (29 % to 78 %)
- *I use data and information to inform improvements to services* (32 % to 77 %)
- *I support team members in developing their roles and responsibilities* (70% to 96 %)
- *I am comfortable challenging behaviours, managing conflicts of interest and differences of opinion* (42 % to 57 %)

We will continue with the delivery of this programme each autumn/winter to support the continued development of Specialty Registrars' leadership and management capability and skillset, in order to ensure we equip our workforce to lead services and organisations in a modern NHS.

Reflecting on the positive impact of this programme, the Quality Improvement team in NGH will deliver a new programme in Summer 2019; The Trust Grade Development Programme. This bespoke programme will be available to all NGH Trust and Staff Grade Doctors.

Message for others

Investment in staff development is imperative in the modern NHS. Effective clinical leadership leads to safer, more reliable and effective care and with most NHS providers adopting a clinically-led organisational structure, it is ever more important that trainees are actively encouraged to enrol in programmes to support their leadership and professional development.

Utilising the knowledge and skills of senior clinicians and leaders within an organisation, we have been able to deliver a successful programme for 7 years. This approach can be readily replicated in other organisations with appropriate senior support.

Acknowledgements

The authors would like to thank the faculty of this programme over the last 7 years, without whom this programme would not exist. Each faculty member has supported the programme in their own time, to the considerable benefit of the registrars, the hospital and the NHS. Faculty are listed in alphabetical order: *Dr Amanda Blissett, Dr Richard Bohmer, Phil Bradley, Janine Brennan, Dr Rebecca Cole, Sarah Cross, Dr Mike Cusack, Dr Matthew Davies, Andrew Foster, Vicky Garrod, Dr Mirzaei Mirnaghsh, Deborah Needham, Dr Tom Osborn, Dr Philip Pearson, Mr Rob Hicks, Dr Andrew Jeffrey, Dr Yesim Karagahar, Simon Lazarus, Mr Matthew Metcalfe, Dr Mirzaei Mirnaghsh, Deborah Needham, Dr Tom Osborn, Dr Philip Pearson, Dr Warren Pickering, Fiona Pittam, Dr Fiona Poyner, Lorraine Ridgewell, Dr Dash Seiger, Dr Sonia Swart, Dr Fiona Thompson, Celia Warlow and Dr Jonny Wilkinson.*

NGH quality improvement

Northampton General Hospital NHS trust

MSc Quality Improvement & Patient Safety

Commencing in October 2019, NGH will deliver a new MSc Quality Improvement & Patient Safety, in collaboration with the University of Northampton.

This programme is offered to health and social care professionals who wish to develop a greater understanding and expertise in quality improvement and patient safety. The dissertation for this Master's degree is an extended improvement project.

The programme is offered on a part time basis over a 3 year period. Our mantra is that a strong understanding of QI and its application in healthcare is a fundamental requirement for any current or future leader in the modern NHS. Graduates of this MSc will be the leaders of tomorrow, equipped with the skillset and knowledge to lead and deliver the complex change the NHS will be required to deliver.

The programme will be offered to 20 students per year. Since commencing advertisement of the programme in January 2019 we have received 15 strong applications for the programme and look forward to a full cohort of 20 for October 2019.

Consultant Engagement

For the purposes of the quality account, good clinical engagement is defined as a relationship between the consultant body and the trust senior leadership based upon trust, open channels of communication with shared ownership of services and transparency of decision-making.

The fundamental aims of good clinical engagement are sustainable optimisation of the quality and efficiency of patient care. Inherent in the sustainability is a clinical workforce with a manageable and enjoyable workload.

The imperative to transform the way NGH works in the face of increasing pressures on the NHS acute sector, including emergency pressures and austere financial climate, requires strong consultant engagement.

Whilst at trust level the consultant staffing levels are comparable with regional trusts there are some significant shortfalls in some specialities. Also the number of non-consultant grade doctors is lower regionally than the national average and can negatively impact on a DGH compared to regional teaching hospitals.

Relentless winter pressures for bed holding consultants in particular have resulted in frequent urgent requests for additional clinical activity over and above job plans which when sustained over many months and combined with workforce gaps result in significant fatigue.

Workforce gaps inherently necessitate a constant balance of risk approach to clinical priorities. For example, any increase in consultant resource moved to support emergency patient pathways (a key priority for the trust and the NHS nationally) creates or exacerbates capacity gaps in the delivery of planned elective activity.

During 2017/18 there has been a clear willingness of the consultant body to respond to patient safety challenges as evidenced by the extraordinary efforts made by many through the winter of 2017/18.

This willingness of the consultant medical workforce to continue to be agile and adaptive will continue to be developed and harnessed as a priority for Trust Board executives, who will work with the energy and commitment of the consultant body in such a way that NGH patients and staff benefit from their clinical expertise in driving improvements in quality and efficiency.

Consultant Development Programme

Having received feedback from consultant colleagues who recently joined NGH and completed the consultant foundation programme including feedback from colleagues who have attended the Consultant suppers, during 2018/ 19 the Medical Director has refreshed the Consultant induction programme and updated the content to address the core requisites of a broader consultant leadership programme reflecting the dynamic changes in the NHS and NGH, making the content of the masterclasses relevant for all consultant staff regardless of their leadership position or experience.

The rolling programme will be delivered via internal and external subject matter experts as a bespoke 12 month modular masterclass course.

The aim of the programme is to provide jobbing consultants with a sense of the wider issues facing the NHS and NGH and introduce them to the management and leadership issues they will require to perform effectively as a Consultant, including a session within the Simulation Suite specifically addressing how to manage behaviours.

Professional training has traditionally, and not unreasonably, focused on the specific clinical skills and knowledge of medicine, rather than knowledge of how to work on the system in which it is practised. Therefore I am hopeful that the masterclass content will help equip Consultant colleagues to respond to such challenges and provide a broader understanding of the rapidly changing landscape in which we work.

Shared Decision Making:

Shared Decision Making (SDM), or shared governance, is a management process that empowers frontline staff and all members of the healthcare workforce to have a voice
The principles are: **Responsibility** – Staff are given the responsibility to manage Nursing & Midwifery decisions and to contribute to the Trust's vision and objectives at local level **Authority** – Staff are given the authority to act and this is recognised and supported throughout the trust **Accountability** – Staff are accountable for their decisions in terms of delivering patient care, developing the profession and initiating change **Equity** – Staff have an equal voice and no role is more important than another.

At NGH we use a councillor model, a few representatives from each area form a council they have dedicated time each month to hold meetings. Discuss department and trust wide issues that affect patients and the environment and they are empowered to make changes to improve patient care, safety and the environment. SDM started in 2017 with 6 pilot councils and has grown across the Trust, it is multi-disciplinary and without hierarchy to date NGH has 23 active councils working to improve care and or work life, with the support from the Charity some of the bigger projects have come to fruition. Projects have included giving children the variety they wanted

for drinks, offering de-caffeinated drinks to our maternity ladies, creating a quiet 'breaking bad news' room from a store cupboard, creating a dementia room on our fractured neck of femur ward, red zimmer frames for our high risk of falls patients and progressing a garden area for paediatrics and one in maternity.

Assessment & Accreditation:

The BPC Ward Assessment framework is aligns with; The Trust's vision and values, The 6 C's Practice values and The Chief Inspector of Hospitals Key Lines of Enquiry. Ward assessed against the 15 standards that describe essential elements of safe, high quality nursing care. Each standard is subdivided into elements of Environment, Care and Leadership.

Results and report are discussed with Wards Sister/ Charge Nurse by the Quality Assurance Matron who undertook the assessment. A ward Improvement Plan and support (Matrons, Organisational Development team, Practice Development Nurses, Specialist Nurses, and Buddies) is put in place. Reassessment timing is according to results/ grading, 3 Consecutive 'Green' assessments gains a recommendation for 'Best Possible Care Ward which is decided at panel following a presentation and portfolio submission by the ward. Currently NGH has 4 'best possible care' wards, 3 triple green wards, 6 green wards & 3 green outpatient areas.

DAISY Award for Nurses and Midwives:

The DAISY Award was introduced to honour and recognise the work nurses and midwives do for patients and families every day. The DAISY (Diseases Attacking the Immune System) Foundation was established in 1999 in the USA in memory of J. Patrick Barnes who died aged 33yrs from complications of Idiopathic Thrombocytopenic Purpura. The DAISY award provides on-going recognition of the clinical skill and especially the compassion nurses/midwives provide to patients and families all year long.

Since we launched DAISY at NGH in 2017 we have had 18 honourees and over 200 nominations, we launched our first annual Team award last year and awarded 3 student awards. In 19/20 we plan to introduce the DAISY leader award who will be nominated by either the patients/ families or staff.

FIT (Falls,Infection,Tissue Viabilty Council) Improvements:

NGH had its first Pressure Ulcer collaborative in 2016/17 which showcased multi-disciplinary working to achieve reductions in the amount of harm through pressure ulcers that was occurring. The success of this collaborative and changes in practice through raising awareness has been dramatic.

In 2016/17 Category 2 = 160 & Category 3 = 30, In 2017/18 Category 2 = 120 & Category 3 = 18, In 2018/19 Category 2 = 96 & Category 3 = 10

Reaching within trajectory targets set for Clostridium Difficile, set by NHS England:

In 2015/2016 rates = 31 In 2016/2017 rates = 22 In 2017/2018 rates = 20 In 2018/2019 rates = 14

Our falls rates within NGH have consistently been below national average per 100 bed days for both the number of falls and those that sustain harm. As

part of the FIT SDM council our falls lead shares and adapts ideas for improvement, collaborative forums have been run and we have been involved in the 90 day improvement collaborative.

Pathway to Excellence®

Pathway to Excellence® is an international accreditation system that acknowledges hospitals that put their nursing workforce at the forefront. This system understands that in order to deliver excellence in patient care you must first have a workforce that is enabled to deliver that. The American Nurses Credentialing Centre (ANCC) is the body who govern the process and have 6 standards that embody their values. We have become the first hospital in the UK to receive the Pathway® designated status. We have been internationally recognised as somewhere that supports and develops nurses and the teams around them to provide excellent care. To attain Pathway® designation evidence is submitted against the 6 standards – Shared Decision Making, Leadership, Safety, Quality, Wellbeing and Professional Development following acceptance of that evidence all registered staff are sent a survey to confirm the standards are in place. 81% of our registered nurses responded and 26/28 questions were responded to as strongly agree or agree – confirming that NGH is an organisation that recognises its staff and provides a positive practice environment.

"Pathway to Excellence® has enabled me to put into words a lot about what I believe makes Northampton General Hospital the best choice for staff and service users.

Hand in hand with the Visions and Values of NGH, the Standards set out within Pathway to Excellence® are things which I see carried out on a daily basis. Staff DO feel recognised, hard work IS rewarded, we ARE encouraged to grow and develop professionally and personally. We, as Nursing and Midwifery staff, Do have a voice and we can, and do, work together to drive and to ensure that the Best Possible Care is achieved".

RN Main Theatres

External Recognition:

Through our success with Pathway®, Shared Decision Making, Assessment & Accreditation and being a pilot for Nurse Associates the teams have presented national and internationally (Moya Flaherty, Michelle Coe, Holly Slyne, Tara Pauley, Carol Bradley & Natalie Green) published in journals (Gill Ashworth, Sarah Coiffait, Tara Pauley, Natalie Green, Emma-Mae Green, Holly Slyne) and we have 2 staff on scholarships, Emily Lambert for the Bronze Reseach programme and Sarah Coiffait is undertaking the Florence Nightingale Travel award.


CRITICAL CARE AND

2 PART TWO PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

OUR 2019/20 PRIORITIES

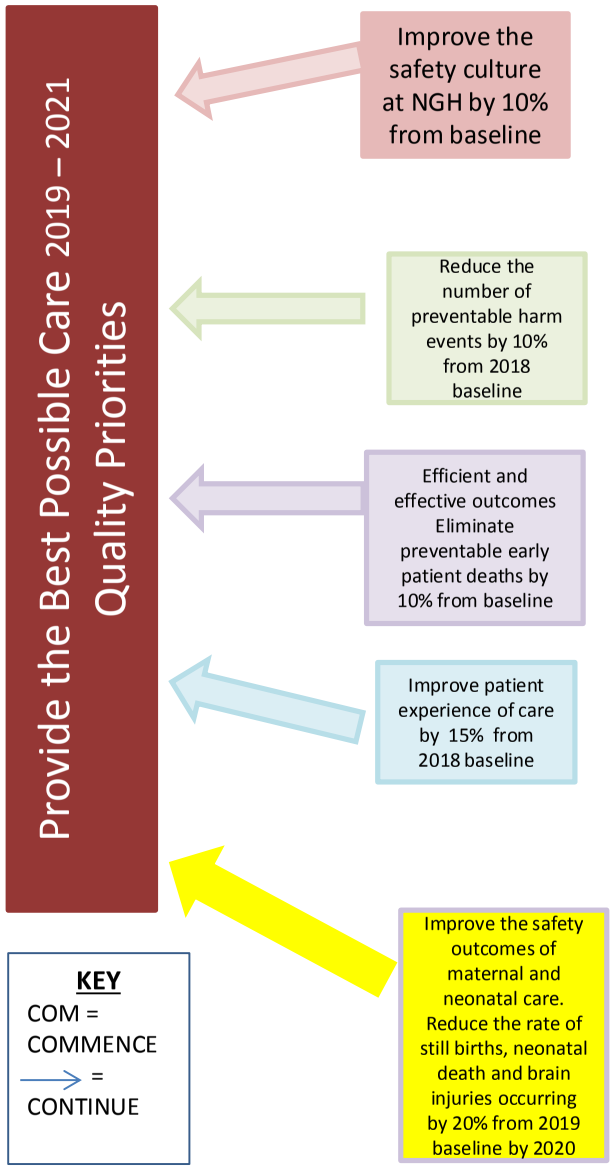
2

PRIORITIES FOR IMPROVEMENT

The traditional domains of quality include safe, effective, patient centered care and our quality priorities use these domains as a basis but take this further by focusing on continual improvement and aims to ensure that all our staff strive for excellence in all that they do and believe and support the organisational focus on delivering the "Best Possible Care".

Our quality priorities are focused on improving the safety, efficiency and effectiveness of the care we provide, as well as improving our patient experience. The Quality Priorities for 2019/21 will be year one of a three year phased programme were we deliver an accelerated and focused 12 months project which can be revised and expanded on an annual basis.
The four key work streams for our quality priorities are:

- Improving the safety culture at NGH
- Reduce the number of preventable harm events by 10% from 2018 baseline
- Efficient and effective outcome that will eliminate preventable early patient deaths
- Improve patient experience of care by 15% from 2018 baseline



Enables & Measures	2019 YR 1	2020 YR 2	2021 YR 3
# incidents reported - +/- categories	COM	→	→
# medical vacancies	→	COM	→
# nursing vacancies	→	COM	→
Staff speaking up, disclosure – "speak up champion"	COM	→	→
Staff health and well being	COM	→	→
Safety huddles (content meaningful), code red status reporting & VPac data	COM	→	→
Staff survey elements of safety culture	COM	→	→
Board to Ward visits – relaunch	COM	→	→
Hospital at night	→	COM	→
7 day hospital services (4 core standards)	COM	→	→
VTE risk assessment compliance NICE compliance	COM	→	→
Reduction in c-diff	COM	→	→
Reduction in pressure ulcers	COM	→	→
Reduction in falls +/- with harm	COM	→	→
SOC scores	→	COM	→
HSMR data (As expected or below range)	COM	→	→
SMR – Congestive Cardiac Failure	→	COM	→
Deteriorating patient care plan use/activity	COM	→	→
Specialist palliative care team referrals (nurse and doctor)	COM	→	→
MECC – smoking cessation	→	COM	→
MECC – alcohol dependence interventions?	→	COM	→
Cancer experience Improve from baseline 2018	COM	→	→
Patient communication Improve from baseline 2018	COM	→	→
Out patient appointment cancellations / changes	→	COM	→
Patients with a dementia diagnosis will receive an appropriate diet as outlined within Johns Campaign	COM	→	→
Dementia Training – 85% of patients facing staff will receive Tier 1 dementia training	COM	→	→
Cancelled operations	→	→	COM
Staff and Patient FFT	COM	→	→
GIRFT – completion of Action Plans for Urology & Orthopeadics	COM	→	→
Reducing Smoking in pregnancy	→	COM	→
Risk assessment, prevention and surveillance of pregnancies at risk of foetal growth restriction (FGR)	→	COM	→
Raising awareness of reduced foetal movement	→	COM	→
Effective foetal monitoring in labour	→	COM	
Reducing preterm birth	→	COM	→

STATEMENTS OF ASSURANCE FROM THE BOARD

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A REVIEW OF OUR SERVICES

During 2018-19, Northampton General Hospital NHS Trust provided and/ or sub-contracted NHS services with 13 relevant Health service providers.

During 2018-19, Northampton General Hospital NHS Trust held two key contracts with NHS commissioners to provide services.

- The Trust's lead commissioner is NHS Nene Clinical Commissioning Group who also commissions on behalf of NHS Corby CCG, NHS Milton Keynes CCG, NHS Bedfordshire CCG, NHS Leicester City CCG, NHS East Leicester and Rutland CCG and NHS West Leicester CCG. This contract constitutes a range of acute hospital services including elective, non-elective, day case and outpatients.
- The Trust holds a contract with NHS England for Prescribed Specialised Services.

The Trust also provides a variety of services to other NHS organisations, public sector organisations and private sector companies. Key contracts are held with:

- Alliance Medical Limited
- Avery Healthcare
- Kettering General Hospital Foundation Trust
- Northamptonshire NHS Foundation Trust
- Backlogs Ltd
- Blatchford Group and
- Boots UK Ltd

The Northampton General Hospital NHS Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services represents 92% per cent of the total income generated by the Northampton General Hospital NHS Trust for 2018/19.

NATIONAL CLINICAL AUDITS

Participation in National Clinical Audits and National Confidential Enquiries Northampton General Hospital (NGH) is committed to providing Best Possible Care in all its services and fully supports the use of clinical audit as part of our broad effort to consistently maintain and improve what we do.

During the 2018/19, 54 national clinical audits and 7 national confidential enquiries covered NHS services that Northampton General Hospital provides.

During that period Northampton General Hospital participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Northampton General Hospital was eligible to participate in during 2018/19 are as follows:

MEDICINE DIVISION		
Name of Audit	Participated Y/N	Percentage Participation
Major Trauma (TARN)	Y	Continuous data collection
Feverish Children (RCEM)	Y	100%
Vital signs in Adults (RCEM)	Y	100%
VTE risk in lower limb immobilisation (RCEM)	Y	100%
COPD Pulmonary rehabilitation	Y	Snapshot Dec18-March19
COPD secondary care	Y	Continuous data collection
National Asthma audit (NACAP)	Y	Continuous data collection Starts Nov18
Adult Community Acquired Pneumonia	Y	Snapshot Dec18-March19
Non-Invasive Ventilation (BTS)	Y	Snapshot Feb-March19
National Lung Cancer Audit	Y	Continuous data collection
National Heart Failure Audit	Y	Continuous data collection
Acute Myocardial Infarction and other ACS (MINAP)	Y	Continuous data collection
Cardiac Rhythm Management	Y	Continuous data collection
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Y	Continuous data collection
National Audit of Cardiac Rehabilitation	Y	Continuous data collection
IBD Registry	Y	Continuous data collection
Stroke National Audit Programme (SSNAP)	Y	Continuous data collection
FFFAP Inpatient Falls	Y	Continuous data collection
UK Parkinson's Audit	Y	100%
Diabetes Core Audit	Y	Continuous data collection
Diabetes Inpatient - HARMS	Y	Retrospectively entered
Diabetes Foot care	Y	Continuous data collection
National Audit of Dementia	Y	100%
Rheumatoid and Early Inflammatory Arthritis	Y	Continuous data collection

SURGICAL DIVISION		
Name of Audit	Participated Y/N	Percentage Participation
Adult Critical Care (Case Mix Programme)	Y	Continuous data collection
National Emergency Laparotomy Audit (NELA)	Y	Continuous data collection
Hip, knee and ankle replacements (National Joint Registry)	Y	Continuous data collection
Elective Surgery (National PROMS Programme)	Y	Continuous data collection
National Vascular Registry	Y	Continuous data collection
Bowel Cancer (National Bowel Cancer Audit Programme)	Y	Continuous data collection
Prostate Cancer Audit	Y	Continuous data collection
Oesophago-gastric Cancer (National O-G Cancer Audit)	Y	Continuous data collection
National Audit of Breast Cancer in Older Patients	Y	Continuous data collection
Falls and Fragility Fracture Programme - National Hip Fracture Database	Y	Continuous data collection
National Ophthalmology	Y	Continuous data collection
Nephrectomy Audit	Y	Continuous data collection
Percutaneous Nephrolithotomy	Y	Continuous data collection

WCOHCS DIVISION		
Name of Audit	Participated Y/N	Percentage Participation
Female Stress Urinary Incontinence Audit	Y	Continuous data collection
Perinatal Mortality (MBRRACE)	Y	Continuous data collection
National Maternity and Perinatal Audit	Y	Continuous data collection
National Pregnancy in Diabetes	Y	Continuous data collection
National Neonatal Audit Programme	Y	Continuous data collection
Paediatric Diabetes (NPDA)	Y	Continuous data collection
IBD Paediatric Audit of Biologic Therapies	Y	Continuous data collection
UK Cystic Fibrosis Registry	Y	Continuous data collection
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Y	Snapshot ending April ‘19

CSS DIVISION AND TRUSTWIDE		
Name of Audit	Participated Y/N	Percentage Participation
National Comparative Audit of the Management of Major Haemorrhage	Y	100%
Audit of The Management of Maternal Anaemia	Y	Snapshot, Data collection current (March '19)
National Cardiac Arrest (ICNARC)	Y	Continuous Data collection.
Fracture Liason Service Database	N	No service at NGH
Learning Disability Mortality review	Y	Continuous Data collection.
Seven day hospital services survey	Y	100%

National Confidential Enquiries - NCEPOD		
Name of Audit	Participated Y/N	Percentage Participation
Pulmonary Embolism	Y	100%
Long term ventilation	Y	100%
Perioperative Diabetes	Y	100%
Bowel Obstruction	Y	100%
Young People's Mental Health	Y	100%
Cancer in Children, Teens & Young Adults	Y	100%
Acute Heart Failure	Y	100%

The Provider is a member of the following:	Screening Programmes
East Midland Children's Cancer Network	Breast Screening Programme
Haemoglobinopathy Clinical Network	Downs Syndrome Screening Programme
East Midlands Children's and Young People Cancer Network	New Born Hearing Screening Programme
GOSH led Congenital Heart Disease Network	Bowel Cancer Screening Programme
Thalassaemia and Sickle Cell Antenatal Screening Work	Cervical Cancer Screening Programme
Central Newborn Network for Neonatology (East Midlands Newborn Network)	Chlamydia Screening Programme
The East Midlands Critical Care Network	Retinal Screening Programme
East Midlands Cardiac & Stroke Network	Cervical Cytology Screening Programme
East Midlands Cancer Network	Thalassaemia & Sickle Cell Screening Programme
Leicestershire Northamptonshire Rutland Cancer Network as part of the EM Cancer Network	Infectious Diseases in Pregnancy Screening Programme
Leicester Renal Network	Blood Grouping and Antibody Testing in Pregnancy
TARN (trauma audit research network)	Foetal Anomaly Screening
East Midlands Major Trauma Network	New Born Blood Spot Screening
Midlands Critical Care and Trauma Network	New Born and Infant Physical Examination
Central England Trauma Network (part of Midlands Critical Care and Trauma Network)	Diabetic Retinopathy
	Abdominal Aorta Aneurysm Screening

ACTIONS TO IMPROVE HEALTHCARE AS A RESULT

All completed audits provide valuable information on our compliance with the area being looked at. The new Clinical Audit Strategy outlines the inclusion of more public and patient involvement in the process and also aims to make the reports available to the public.

Each year we hold an Audit Presentation Day where audit work has led to the improvement of patient care. The applications are shortlisted by clinicians and judged by previous winners, Board Chair and Senior Clinical Staff. The top prize went to a Student Nurse (see below)

Diabetic patients stand to benefit from nursing student's 'foot assessment' work

Patients with diabetes in Northampton will benefit from enhanced patient care in hospital, thanks to the work of a University of Northampton student.

The audit was an internal review of foot assessments for diabetic patients admitted to Northampton General Hospital.

As a direct consequence of the findings, funding has now been allocated to create a post within NGH to increase the number of assessments completed.

Dr Sonia Swart, Chief Executive of Northampton General Hospital, added: "At Northampton General Hospital we believe we all have two jobs: to deliver care and to improve care. Our hospital has been recognised on an international platform for the quality improvement initiatives our employees have delivered.
Other achievements through national and local audit include:

- Two-year mortality following colorectal major resection has fallen over the last 2 years to 11.1% compared with the national average of 18.9%.
- Our Stroke National Audit consistently receives a "level A" score and the clinical lead did an interview to the media praising our stroke service
- There have been no mortality outliers at unit or consultant level for surgical audits included in the Consultant Outcomes Programme
- End of Life Care (NICE and National Audit) – a huge amount of work has been done by the department to improve the quality of their service and deliver care fully compliant with NICE Guidance and participation with the NACEL National Audit
- Good compliance with most aspects of diagnosing and managing bronchiolitis in children and reduced unnecessary investigations and treatments but could improve further

A recent review (Jan 2019) of the clinical audit service is helping to plan increased awareness and related skills in auditing.

RESEARCH

Participation in clinical research

Northampton General Hospital NHS Trust is a research-active hospital which is striving to support the vision of providing the "Best Possible Care" and to meet its statutory duty for 'promoting research, innovation and the use of research evidence' (Health and Social Care Act, 2012). We are proud of our research history which is well established and embedded in the Trust with a history that stretches back to the 1980s.

Research is an integral part of our mission to constantly improve and be able to offer better care for patients. We see research as fundamental to everything we do which is embedded in the delivery of care.

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. We have demonstrated our engagement with the National Institute for Health Research (NIHR) by participating in a wide range of clinical trials. This 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 our commitment to testing and offering the latest medical treatments and techniques to our patients.

The number of patients receiving NHS services provided by Northampton General Hospital in 2018/19 that were recruited during that period to participate in research approved by a Research Ethics Committee was 1320 into 56 trials registered on the National Institute of Health Research portfolio. This demonstrates a significant achievement this year as the number of patients recruited to trials has increased by 79% compared to the same time last year.

The R&D department actively promotes both non-externally funded and commercial research which will ultimately improve patient care and enhance our national profile as a high-performing district general hospital. As evidenced by the Department of Health Strategy 'Best Research for Best Health', research is part of the core business of the NHS. The quality of care depends on research-based evidence, and anyone using the NHS can expect to be offered opportunities to take part in studies relevant to their needs.

We are constantly seeking to expand our portfolio of acute specialties and to provide services in the most clinically effective way. Our vision is to work with our partners at the leading edge of healthcare, realising the research potential in all areas of our hospital for the benefit of our patients and staff.

Our aspiration is that every clinical area will be engaged in high quality research and every patient and member of staff should have the opportunity to be part of a research study.

ACCREDITATION SCHEMES

The following services have undertaken the following accreditation schemes during 2018/19. Participation in these schemes demonstrates that staff members are actively engaged in quality improvement and take pride in the quality of care they deliver.

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SCHEME	SERVICE	ACCREDITATION STATUS
Medicines and Healthcare products Regulatory Agency (MHRA)	Aseptic Services Unit	Manufacturer's Specials Licence
MHRA	Pharmacy Stores & Distribution	Wholesaler Dealer's Licence
ANCC Pathway to Excellence Award	Nursing (Trust wide)	Designated 2018
Baby friendly initiative	Obstetrics	Full
ISO9001:2015 for Chemotherapy, Radiotherapy & Radiotherapy Physics	Oncology & Haematology	Full
JACIE for HPC Transplant	Oncology & Haematology	Autologus and allogeneic Transplantation in Adult Patients, Collection of HPC, Apheresis, Cell Processing – Minimally Manipulated
HTA for HPC Transplant	Oncology & Haematology	procurement, processing, testing, storage and distribution of human tissues and cells for human application under the Human Tissue (Quality and Safety for Human Application)
GMP for Radiotherapy	Oncology & Haematology	Full
CQC for Radiotherapy	Oncology & Haematology	Full
ManA for Radiotherapy	Oncology & Haematology	Full
IR[ME]R	Oncology & Haematology	Full
Clinical Pathology Accreditation	Pathology	Blood Sciences, Immunology, Microbiology

COMMISSIONING FOR QUALITY AND INNOVATION INCOME

A proportion of the Trust's income in 2018/19 was conditional, based on achieving quality improvement and innovation goals. These goals were agreed between the Trust and the person or body who entered into a contract, agreement or arrangement for the provision of relevant health services, through the Commissioning for Quality and Innovation Income (CQUIN) payment framework.

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.

CQUIN Goal	Description	Q4
Improving Staff Health and Wellbeing	a Improvement of health and wellbeing of NHS staff	**Not achieved**
	b Healthy food for NHS staff, visitors and patients	**Achieved**
	c Flu vaccinations for front line clinical staff	**Achieved**
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	a Timely identification of sepsis in emergency departments and acute inpatient settings	**Achieved**
	b Timely treatment for sepsis in emergency departments and acute inpatient settings)	**Partial Achievement**
	c Antibiotic review	**Not achieved**
	d Reduction in antibiotic consumption per 1,000 admissions	**Anticipated partial achievement – Q4 data is not yet available**
Improving services for people with Mental health needs who present to A&E		**Partial achievement** **Data quality standards – not achieved** **plan to mainstream work – achieved** **20% reduction of cohort 1 – achieved** **20% reduction of cohort 2 – not achieved** **National data submission including confirming that this has been discussed at the A&E delivery board – not achieved**
Offering advice and Guidance (A&G)		**Achieved**
	A Tobacco screening	**Achieved**
	B Tobacco brief advice	**Achieved**
	C Tobacco referral and medication offer	**Achieved**
	D Alcohol Screening	**Achieved**
	E Alcohol brief advice or referral	**Achieved**

Local Quality Requirements

The quality requirements are set out in Schedule 4 of the 2017-19 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 CCG commissioners.

We provide assurance to our commissioners quarterly on local quality requirements by submitting evidence and demonstrating where we meet the requirements.

Quality Requirement	Threshold 17-19
End of Life Care	To help deliver person-centred End of Life Care through integration within and between providers of healthcare along the pathway.
Patient Safety	1) National Information
	2) Incidents
	3) Policy
	4) Discharge Information
	5) Outpatient Letters
	6) Mortality & Morbidity
	7) Cancer Patients with a long waiting time
Learning	1) The provider will demonstrate a learning culture from ward to board.
	2) Review action taken towards implementation of NICE technical appraisal guidance, within three months of publication. Review action taken towards implementation of all other NICE guidance and Quality Standards that are judged to be appropriate to the Trust as a provider of acute care
	3) Evidence of learning from concerns about patient care raised by GPs and/or trust
Quality care for Patients with a Learning Disability	Implementation of actions from the Learning Disability 'Better Healthcare Plan'
Patient Experience	1)Evidence that patient experience is of equal importance as clinical quality and patient safety
	2) Evidence of learning from complaints and PALs enquiries
	3) Evidence of learning from National and regional surveys
Nutrition and Hydration	1) 95% of patients have completed MUST score within 24 hours
WHO surgical checklist	All patients undergoing a surgical procedure to have all stages of the WHO checklist completed

National Early Warning Score (NEWS)	Report on the percentage of patients that have NEWS under-taken within required time period and percentage of patients whose NEWS triggers need for review who are
Safeguarding Children	Implementation of Early Help Assessment (EHA), Section 11 Au- dit /Audits and Agreed Assurance Framework, Learning Supervision
Safeguarding Adults	Safeguarding Alerts Dashboard, Quality Monitoring Visits, SAAF, Safeguarding Alerts Dashboard, Quality Monitoring Visits, Learning, Supervision, Appropriate use of Mental Capacity Act (2005), Assessments and Deprivation of Liberty Safeguards, Training
Workforce	a) Assurance provided that 85% of all staff (including Drs & AHP) have received appraisals, mandatory and essential to role training b) Provider is compliant with the expectations in relation to nursing and midwifery and care staffing and capability as laid out in 'How to ensure the right People with the right skills are in the right place at the right time'.
VTE	As per Service Condition 22 the following will be required and monitored: 1. All patients receive VTE prevention in line with the NICE Quality standards. 2. Root cause analysis will be undertaken on all cases of hospital associated thrombosis.
Pressure Tissue Damage	2016/17 data to be used to set baseline of numbers of hospital acquired grade 2/3/4. Trust to agree ongoing improvement for the year in April 2017 (to be repeated for 2017/18) To continue to participate in countywide work to prevent pressure tissue damage.
Service Specifications	Assurance that all service specifications included in the 2017/19 contract are being implemented.
Quality Assurance regarding any trust sub- contracted services (list of services to be provided by the trust)	Assurance that all services sub-contracted by the trust have been fully quality monitored with any areas of concern investigated

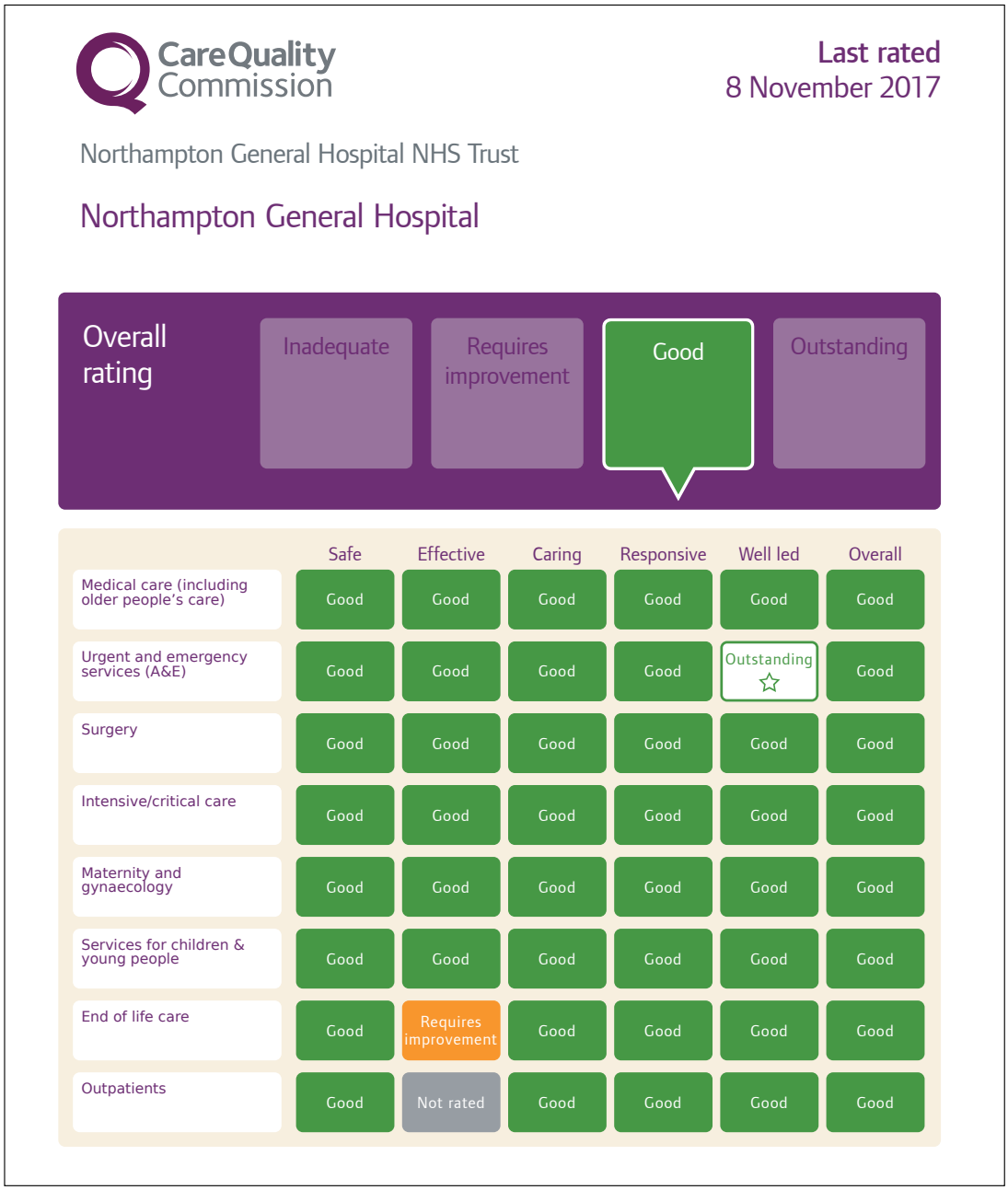
CARE QUALITY COMMISSION

NGH is registered with the CQC under the Health and Social Care Act 2008 and currently has no conditions attached to registration under section 48 of the Health and Social Care Act 2008.

The CQC has not taken any enforcement action against the Trust during 2018/19. The Trust has not participated in any special reviews or been investigated by the CQC during the reporting period.

The Care Quality Commission (CQC) did not inspect NGH during 2018/19, therefore the ratings for the Trust remain as per the report published in November 2017. Each of the eight core services was rated as good, along with an overall good rating for each of the five domains (safe, effective, caring, responsive and well-led) and for the Trust overall. The full report can be found on the CQC website https://www.cqc.org.uk/provider/RNS.

The Trust anticipates a CQC visit during 2019/20, both a use of resources (led by NHS Improvement (NHSI) and a quality inspection (led by CQC). Following these visits, the Trust will be issued updated ratings. The Trust is cited on any compliance concerns through the Assurance, Risk and Compliance Group and Quality Governance Committee.



SECONDARY USES SERVICE

NHS Number and General Medical Practice Code Validity

The Trust submitted records between April 2017 and January 2018 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 - Apr 17 to Dec 17	Valid NHS Number	Valid GMPC
Inpatients	99.70%	100%
Outpatients	99.90%	99.90%
A&E	98.40%	99.80%

Period - Apr 18 to Dec 19	Valid NHS Number	Valid GMPC
Inpatients	99.75%	100%
Outpatients	99.90%	99.98%
A&E	98.64%	95.84%

Period - Apr 18 to Dec 19	Valid NHS Number	Valid GMPC
Inpatients	99.75%	100%
Outpatients	99.90%	99.98%
A&E	98.64%	95.84%

INFORMATION GOVERNANCE TOOLKIT

DATA SECURITY AND PROTECTION TOOLKIT ATTAINMENT LEVELS

The Data Security and Protection (DSP) Toolkit is an online tool that enables organisations to measure their performance against data security and information governance requirements which reflect legal rules and Department of Health policy.

The Data Security and Protection Toolkit is the successor framework to the IG Toolkit.

All organisations that have access to NHS patient information must provide assurances that they are practising good information governance and use the DSP Toolkit to evidence this by the publication of annual assessments.

The toolkit enables The Trust to measure their compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

Where partial or non-compliance is revealed, organisations must take appropriate measures, (e.g. assign responsibility, put in place policies, procedures, processes and guidance for staff), with the aim of making cultural changes and raising information governance standards through year on year improvements.

By assessing itself against the standard, and implementing actions to address shortcomings identified though use of the toolkit, organisations will be able to reduce the risk of a data breach.

Data Security and Protection Standards for health and care sets out the National Data Guardian's (NDG) data security standards. Providing evidence and judging

whether the Trust meets the assertions, will demonstrate that the Trust is meeting the NDG standards. The NDG data security standards are;

1 Personal Confidential Data
2 Staff Responsibilities
3 Training
4 Managing Data Access
5 Process Reviews
6 Responding to Incidents
7 Continuity Planning
8 Unsupported Systems
9 IT Protection
10 Accountable Suppliers

Progress

Progress dashboard and reports

100 of 100 mandatory evidence items provided

33 0f 40 assertions confirmed

Your assessment status (if you were to publish now)

Standards Met

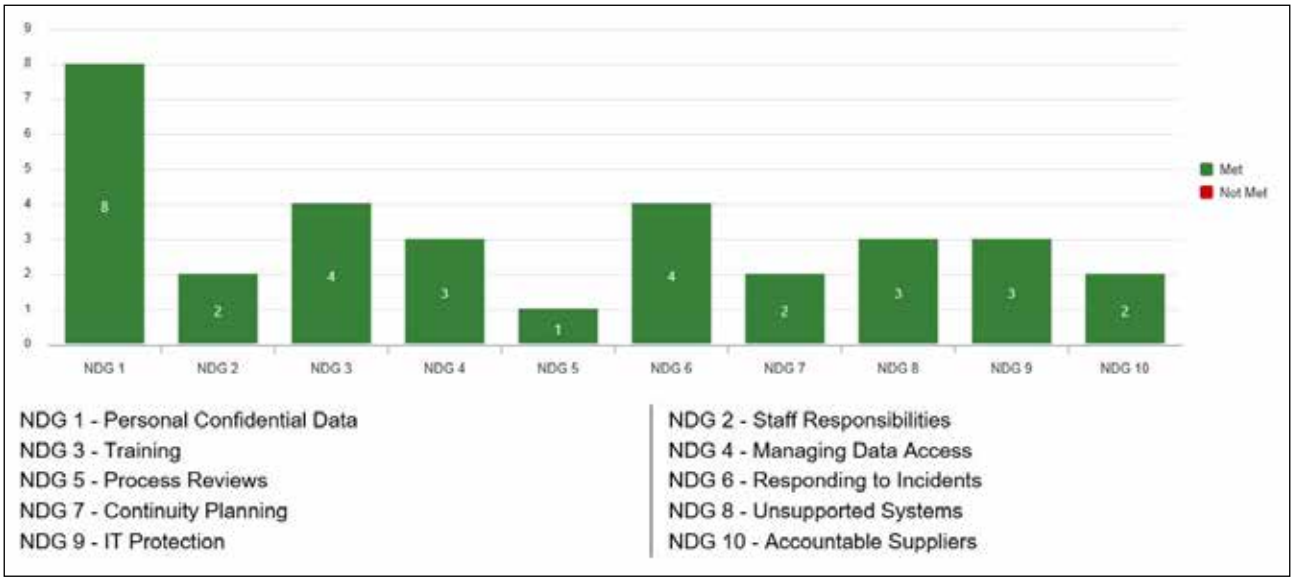
DSP Toolkit Dashboard

There are 40 areas of focus called 'Assertions' each of these has questions requiring evidence that are either mandatory or optional. 32 of these are Mandatory for the 31st March deadline.

There are currently 100 mandatory evidence requirements across the DSP toolkit. On the 31st March 2019 the Trust completed all 100 of the Mandatory requirements and confirmed all 32 Mandatory Assertions (plus one non-mandatory).

The Trust's internal auditors (TIAA) have provided us with recommendations from the previous IG Toolkit assertion with a detailed action plan.

We took TIAA recommendations and produced an Action Plan which has taken into account the new General Data Protection Regulations (GDPR) as well as the 2018 submission. The DPO who is also the Head of Data Quality, Security and Protection, is making consistent developments and long term improvements to ensure all the recommendations are actioned. We recognise that the culture of the organisation needs to align with the need for good Information Governance and have plans for education, reporting, tools to ensure compliance and controlled phishing campaigns which redirect to educational materials as ways to embed this cultural change.



Data Quality

NGH have a dedicated team that focus on data quality to ensure that data meets high standards across the 7 domains of data

1. Timeliness – determined by how the data is to be used/collected
2. Consistent – Reliable and the same across all organisations and applications
3. Currency – update to date and valid
4. Definition – each data element should have clear meaning and acceptable values (via a data dictionary)
5. Granularity – attributes values should be defined at the correct level of detail.
6. Precision – data values or data output should be precise enough to support the process
7. Relevant – data to be meaningful to the performance of the process
8. The team work under the authority of the Head of Data Quality Security and Protection who ensures we address GDPR rules.

We manage data to a strategic goal of building a single version of the Truth which is of quality to enable the Trust to be information led.

We have published a Data Quality Policy to ensure all staff are aware of their responsibilities towards Data Quality.

To ensure that we maintain data quality, we monitor our data quality metrics and have a planned pipeline of work to build automation and reduce the risks associated with human error.
To ensure that data is of the highest standard, NGH are taking the following actions;

- Data Validation, including data items and pathway coding
- Monitoring metrics from known areas of interest, such as misdirected mail, missing PAS ID, missing codes where they would be expected, late entered data, NHS number duplicates and mergers required, rebooking, etc
- Compliance with Data standards
- Compliance with data protection laws
- Data Quality Training
- Data Quality Audit
- Data Quality Policy
- Reference File Management
- CDS/SUS generation and submission
- Data Quality Kitemark (based around three core activities being performed and assessed by the auditors)
- Data Quality Alerting (Automated alerts which are generated to identify user error and system issues at source)
- Close collaboration with the Knowledge Improvement Team (to ensure frontline staff are trained appropriately)

During 2018/19, the Chief Information Officer was appointed to the role of Senior Information Risk Owner and the

Medical Director continued as our Caldicott Guardian. The Trust reported nine Information Governance incidents to the Information Commissioner's Office in 2018/19.

CLINICAL CODING ERROR RATE

Clinical Coding Audit

Clinical coding audit is fundamental to the quality assurance process by rigorously reviewing how coding standards are being applied and how consistently. It allows retrospective amendments of incomplete or inaccurate data but more crucially, provides a learning and feedback tool whereby individuals can embed outcomes within their own practice. It can also be used to identify inconsistencies across a department that do not necessarily amount to an error but improve the quality of information produced. Furthermore, clinical coding audit findings often identify recommendations that benefit the Trust as a whole e.g. improved clinical record keeping or data quality errors.

The minimum requirement as specified under Data Security & Protection (DSP) requirements is a 200 patient episode audit per financial year. At NGH, there is a rolling quarterly audit program undertaken whereby approximately 300 episodes are formally audited each quarter in accordance with the latest national audit methodology

by an approved national clinical coding auditor (internal).
However, there are varying mechanisms of audit and a variety is important to provide a comprehensive approach that suits the needs of the department and the Trust. As such, the reality is that a far larger number of episodes are audited in an informal manner.

Each quarter is audited once it is complete so at the time of writing there are two completed quarters for 2018-19 and the results below meet the mandatory requirements outlined in the DSP guidance.

Throughout 2018/19 extensive work has been undertaken around data accuracy with a team of external and internal validators engaged to prepare all data for migration into the new Patient Administration System (PAS). Post go-live with the new PAS the same team was again brought in to ensure accuracy in the use of the new system; based on the findings, a suite of validation reports have been set up to alert for poor data entry, including automated email alerts to individuals when incorrect data is input. A quality kitemark dashboard is currently being developed to provide further assurance to the trust on data accuracy.

A central Pathway Performance Management team is currently being established, which when fully recruited to will enable validation, escalation and spot check audits of elective pathways. Additionally, the trust has now developed an elective patient pathway tool which identifies anomalies in data, alerting for validation as well as alerting for escalation of the patient's journey.

Q1 2018-19	% Accuracy Including All Error Sources	% Accuracy Excluding Non-Coder Error
Primary Diagnosis	92.43%	92.83%
Secondary Diagnoses	91.84%	92.31%
Primary Procedure	96.03%	96.03%
Secondary Procedures	93.97%	93.97%

Q1 2018-19	% Accuracy Including All Error Sources	% Accuracy Excluding Non-Coder Error
Primary Diagnosis	93.03%	93.03%
Secondary Diagnoses	91.08%	91.08%
Primary Procedure	94.20%	94.20%
Secondary Procedures	91.15%	91.15%

LEARNING FROM DEATHS

Number of deaths during the reporting period

The number of deaths at NGH is monitored monthly however the number of deaths each month cannot be used to judge the quality of care provided because it does not take into account important information about the patients, the hospital and local services. The screening and review process at NGH along with monitoring of Dr Foster data gives more meaning to the number of deaths by adding context such as the age of the patient, how ill the patient was on admission, if the patient was known to have any other illnesses before admission and the impact of social care provision in the community.

During April 2018 – March 2019 **1483** of Northampton General Hospital patients died.

Q1	410
Q2	312
Q3	341
Q4	420
Total	**1483**

Screening deaths

In December 2017 The Trust introduced a process for screening of adult deaths to select cases for review and identification of learning. During April 2018 – March 2019 the notes of 1152 (78%) deaths were screened.

Q1	254 (62%)
Q2	201 (65%)
Q3	316 (93%)
Q4	381 (91%)
Total	**1483 (78%)**

Reviewing deaths

278 mortality case record reviews were completed using the Structured Judgement Review Tool (SJR) which is a validated methodology for standardising case note review supported by the Royal College of Physicians. A Trust wide review of 100 consecutive deaths in May 2018 was carried out hence the number of reviews completed for Q1 is higher than other quarters.

Q1	128
Q2	53
Q3	42
Q4	55
Total	**278**

Investigating deaths

5 deaths representing 1.8% of deaths reviewed and 0.3% of deaths overall were judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using the Avoidability of Death Judgement Score:

Score 1 Definitely avoidable
Score 2 Strong evidence of avoidability
Score 3 Probably avoidable (more than 50:50)
Score 4 Possibly avoidable but not very likely (less than 50:50)
Score 5 Slight evidence of avoidability
Score 6 Definitely not avoidable

These cases are discussed at a Trustwide Mortality Review Group bimonthly and a consensus decision reached. If Avoidability of Death Score is Grade 1,2 or 3, the death is judged more likely than not to have been due to problems in the care provided to the patient. These cases are referred to Review of Harm Group (RoHG) for consideration for investigation.

Of the 5 cases referred to RoHG, 2 were subject to a Comprehensive Investigation.

The remaining 3 cases were discussed at Review of Harm Group but not felt to require investigation.
Neonatal Deaths and Stillbirths

Q1	1
Q2	2
Q3	1
Q4	1
Total	**5**

- During April 2018 – March 2019 there were 6 neonatal deaths after 22 weeks of pregnancy and 20 stillbirths delivered from 24 weeks of pregnancy
- All qualifying deaths have been reviewed using the Perinatal Mortality Review Tool
- 2 deaths were investigated as serious incidents
- 0 deaths reviewed using the Perinatal Mortality Review Tool scored a Grade D (deaths judged more likely than not to be due to a problem in care
- Patients with a learning disability or severe mental illness
- During April 2018 – March 2019 there were 5 deaths of patients with a learning disability
- During April 2018 – March 2019 there were 6 deaths of patients with a severe mental illness (defined at NGH as a patient admitted to NGH from a mental health trust or a patient detained under the mental health act)
- The care of all 11 patients has been reviewed using the Structured Judgement Review tool
- All patients with a learning disability have been referred to the national mortality review process for learning from deaths of patients with a learning disability (LeDeR)

Reviews and investigations completed in 2018/19 relating to deaths in 2017/18

82 case record reviews were completed after 01.04.18 which related to deaths which took place in 2017/18.

Of the 82 deaths reviewed, 4 were judged to be more likely than not to have been due to problems in care provided to the patient. Following referral to RoHG, 2 cases were subject to Serious Incident Investigation and 2 to Comprehensive Investigation.

A revised estimate of the number of deaths during 2017/18 is therefore 8 representing 2.6% of deaths reviewed (8/ 308) and 0.5% of deaths overall (8/1636).

Appendix 1

Learning, Actions and Impact of Mortality Case Note Review in 2018/19

Mortality case note review is completed using the SJR tool at both directorate/ specialty level and at Trust wide level in response to Dr Foster alerts or other concerns. The table below gives examples of actions taken following mortality case note review.

Area targeted by review	Data source	Work stream/s	Example of actions taken or proposed
Acute and unspecified renal failure (AKI)	Dr Foster data and Trust wide mortality case note review 10	Deteriorating Patient Board	• Focus on fluid balance and medication review
Sepsis	Dr Foster data and Trust wide mortality case note review 10	Sepsis/ Deteriorating Patient Board CQC response December 2018	• Appointment of a Sepsis Nurse • Monitor compliance with Sepsis CQUIN standards • Review of clinical documentation and the effect this has on the clinical coding
Validation of screening process	30 deaths chosen randomly from December 2018 and March 2019	Led by Mortality Review Group	• Improvements made to screening tool • Developed a "what good care looks like" document for sharing with screeners and reviewers
Respiratory failure, insufficiency and arrest	Dr Foster data and directorate mortality case note review	Led by Respiratory Team	• Increased availability for specialist advice for patients on Non-invasive ventilation • Review of guidelines related to respiratory failure • Review of nurse to patient ratios in dedicated areas providing non-invasive ventilation • Submit a business case for blood gas machines in admission wards and on Becket Ward.
Excision of colon and/or rectum (procedural alert)	Dr Foster data and directorate mortality case note review	Led by Colorectal team	• Ensure all Serious Incident Investigation reports are discussed at directorate Morbidity and Mortality meetings
High HSMR May 2018	Dr Foster data (including deep dive data) and Trust wide mortality case note Review 12 (100 consecutive deaths in May 2018)	Frailty	• Shared work stream to look specifically at frailty - in development discussed with Nene CCG

	and directorate mortality case note review	Secondary Malignancy – delivery of palliative care Secondary Malignancy	• Agreement with clinical coding to ensure parameters for coding palliative care are agreed and consistently applied • Audits are planned to look at specific groups of patients who
		– delivery of palliative care	may be receiving palliative care ○ Patients with obstructive jaundice secondary to malignancy ○ Patients with a malignant pleural effusion
		Clinical care/ documentation/ coding interface	• Using iBox to highlight the working diagnosis for each patient daily to support accurate documentation that reflects the course of the admission and therefore the clinical coding
Other perinatal conditions (stillbirth)	Dr Foster data and directorate mortality case note review using the Perinatal Mortality Review Tool	Led by Obstetric and neonatal teams	• Continue to review all qualifying cases using the Perinatal Mortality Review Tool
Congestive Heart Failure	Dr Foster data	Led by Heart Failure Team	• Initial review of clinical documentation and coding • Review of data in conjunction with data from the Heart Failure National Audit and National Confidential Enquiry looking at the management of patients with acute heart failure • Review of bedside Clinical Guideline for use at NGH
Acute and unspecified renal failure (AKI)	Dr Foster data and Trust wide mortality case note review 10	Deteriorating Patient Board	• Focus on fluid balance and medication review
Process Improvements	Screening and review data	Led by Mortality Review Group	• Recruitment of 3 new Mortality Screeners to increase capacity. • The Medical Examiner Working Group has been set up to support delivery of a full Medical Examiner Service which includes recruitment and training of Medical Examiners, improved communication with bereaved families and carers and engagement with junior doctors and the coroner's office. • Processes for improving compliance with completion of mortality case note review have been improved. • Increase in the number of directorate/ specialty M&Ms • Process for external sharing of SJRs agreed • Agreement secured from Clinical IT Senate to build a local IT solution for completion of SJRs

DUTY OF CANDOUR

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.

2

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.

The Trust has worked with the Clinical Commissioning Group (CCG) and other healthcare providers within the region to produce a patient/relative Duty of Candour information leaflet. The providers were unable to reach an agreement on a leaflet that met all of their and our requirements therefore it was agreed that Northampton General Hospital would develop their own. This has been drafted and will be shared with the Review of Harm Group for feedback.

The Trust will implement the use of the leaflet in 2019/20.

Duty of candour training continues to be included in all the incident reporting/ investigating and root cause analysis training given to multi-disciplinary staff across the Trust.

Staff continue to utilise the Duty of Candour sticker which acts as a crib sheet to ensure staff correctly convey the appropriate information to any patients harmed during an incident.

Patients and/or their relevant person are encouraged to participate in any investigations that the Trust's 'Review of Harm Group' deems require a comprehensive Root Cause Analysis investigation. The patient/relevant person(s) are then offered the opportunity to meet with members of the investigation team to review the findings of the investigation and ask any questions they may have.

The Trust continues to demonstrate compliance with Duty of Candour to the CCG.

MANAGEMENT OF COMPLAINTS

Compliments, Comments, Complaints, Concerns (4Cs) and suggestions from patients, carers and the public are encouraged and welcomed. Should patients, carers or members of the public be dissatisfied with the care provided by this Trust they have a right to be heard and for their concerns to be dealt with promptly, efficiently and courteously. The Trust welcomes all forms of feedback and information which is used to improve the service that is provided to the local community.

The 4Cs process is about patient choice and the Trust's wish to ensure that where possible any of the 4Cs raised are responded to swiftly and locally by staff. If the individual is dissatisfied with the outcome then they must be offered one of the following options:

- Speak to a senior member of staff (i.e. Matron, Manager)
- Contact PALS for on the spot support, advice and information

- Make a complaint through the NHS Complaints Regulations

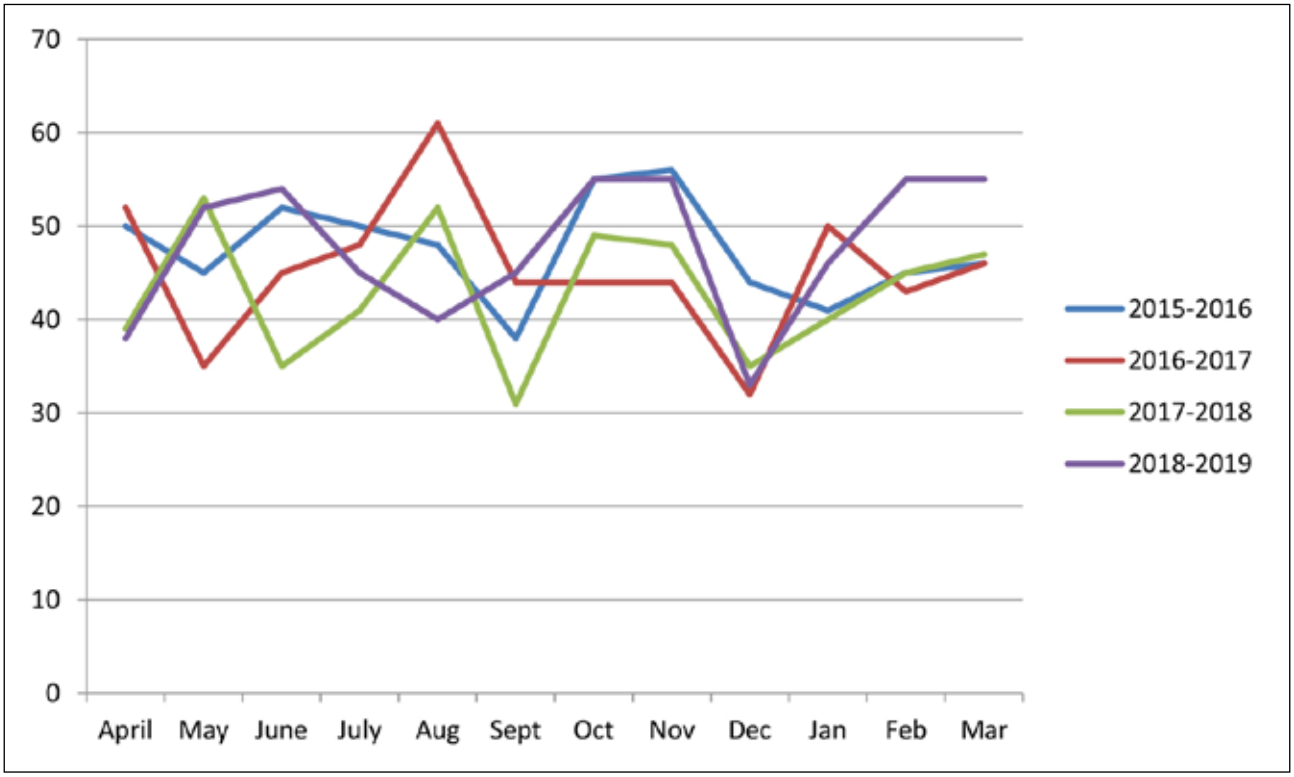
The aim is always to achieve local resolution where possible and the above should be used as an escalation process where appropriate and with the agreement of the individual. The Trust recognises that the information derived from complaints and concerns provides an important source of data to help make improvements in hospital services. Complaints and concerns can act as an early warning of failings in systems and processes which need to be addressed.

The Trust received a total of 573 written complaints that were investigated through the NHS Complaints Procedure from 1st April 2018 to 31st March 2019, which compares with 515 complaints received the previous financial year.

Total no of complaints for the year (Increase of 10%)	573
(Versus 2017/2018)	(515)
Average response rate	*97%
Total no of complaints that exceeded the renegotiated timescale	*12
Complaints that were still open at the time that the information was prepared (3rd April 2019)	*55
Total patient contacts/episodes	701,469
Percentage of complaints versus number of patient contacts/episodes	0.08%

**These figures were the current status at the time that the report was prepared 3rd April 2019. The final figures will not be complete until the end of May 2019 due to the timescales involved.*

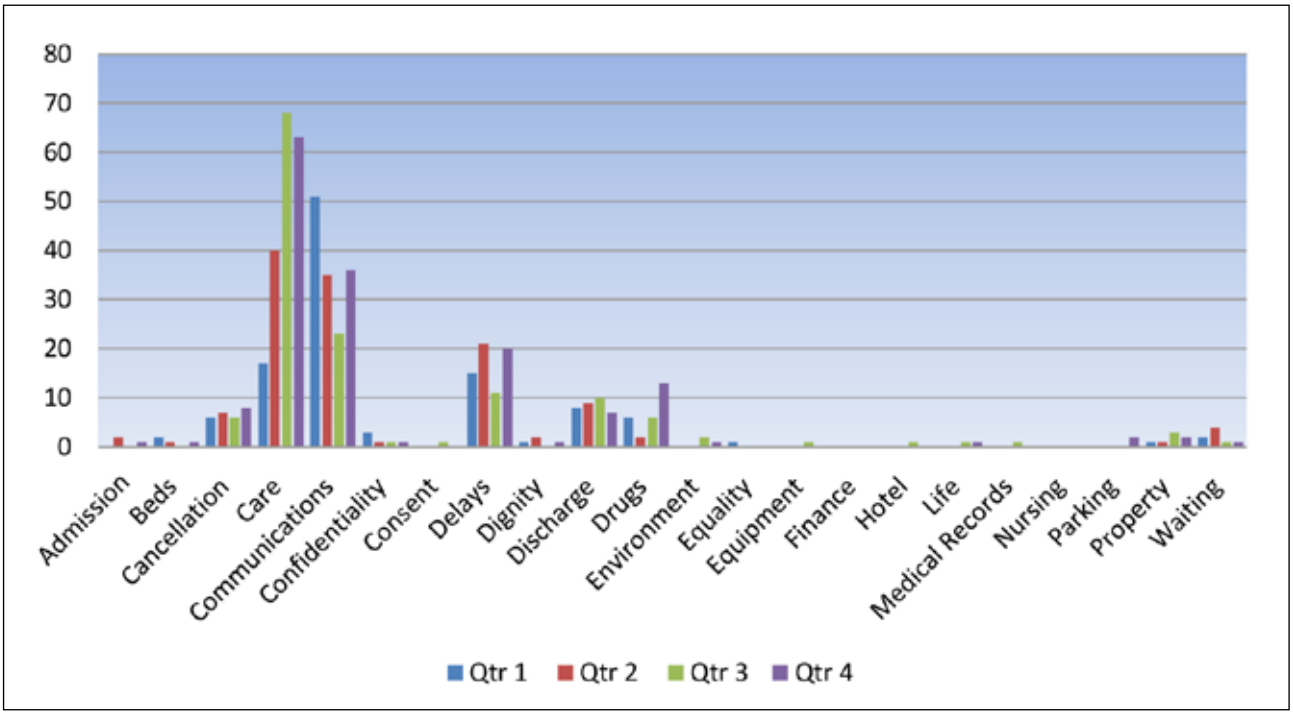
Number of complaints



Trend Analysis

The following chart provides the themes emerging from complaints:

Complaints (Primary) Subject Comparison 2018 - 2019



What we achieved in 2018/19 to improve complaints management

- Improved compliance with our performance targets in responding to formal complaints
- Aligned the Complaints Officers with the clinical divisions and compliance co-ordinators
- Attendance at Directorate and Divisional Governance meetings
- Developed a Complaints Review Panel process to be implemented in the next financial year
- Delivered bespoke training sessions to staff
- More local resolution meetings are being offered
- Recording all local resolution meetings where there is agreement
- Distribution of the new learning report to highlight learning and evidence of improvements from complaints
- Introduced electronic file processes to increase efficiency
- Working with Young Healthwatch to develop processes for younger people who access the organisation and wish to raise a complaint

FREEDOM TO SPEAK UP

Staff at Northampton General Hospital are able to speak up through their line managers or if unable to do so are able to make direct contact with the Trusts Freedom to Speak Up Guardian by telephone, personal approach or email. The Freedom to Speak Up Guardian will support staff to raise concerns and will maintain their anonymity if requested. Staff can also report concerns anonymously via the DATIX reporting system.

Feedback is provided directly to staff raising concerns as to progress with their case but also the outcome when any investigation is completed. Feedback is provided face to face. If the concern is raised anonymously, other methodologies can be utilised e.g. patient safety messages to update all Trust staff of a revised process or to reiterate appropriate processes.

The Trust Guardian will ensure any reports of detriment are dealt with robustly with staff supported accordingly.

The Freedom to Speak Up Guardian is happy to hear any concerns over quality of care, patient safety or bullying and harassment and will signpost staff appropriately to the Respect and Support helpline as required or any other HR process.

The Respect and Support Information Hotline is accessible for all staff in the Trust as part of the ongoing work that is available through the Respect and Support Campaign. The purpose of the hotline is to signpost a member of staff to the different interventions available in the Trust. These interventions have been developed through the campaign to provide support when the member of staff has concerns about an individual's behaviour or has relationship difficulties with others they work with. The hotline is a way of giving the member of staff an opportunity to talk through their issues with a trained individual and it is intended to provide the member of staff with options other than a formal process.

SEVEN DAY SERVICES

NHS England has committed to providing a 7 day service (7DS) across the NHS by 2020. The expectation is that all in-patients admitted through Non Elective routes, have access to consistent and equal clinical services on each of the 7 days of the week, at the time of admission and throughout the stay in an acute hospital bed.

The rationale for this intention is to improve safety, quality and efficiency of care, so that senior decision makers are available to provide the same level of assessment, diagnosis, treatment and intervention every day of the week. Then senior staff will be more available to provide information to patients, relatives and supervise junior staff.

To enable providers to track their progress in achieving the four priority 7DS clinical standards, a national self-assessment survey through internal audit process was developed. This is an online tool that allows providers to input data taken from patient case notes to measure achievement of standards 2 and 8, alongside an assessment of the availability of key diagnostics **(5)** and interventions **(6)**.

The four priority standards are:

- All patients admitted as an emergency to be reviewed by an appropriate Consultant within 14 hours of admission **(CS2)**
- Seven day access to Consultant directed and reported diagnostics **(CS5)**
- 24 hr access to Consultant directed intervention e.g. endoscopy, emergency surgery **(CS6)**
- Following initial assessment all patients to be reviewed daily by a Consultant or designated senior with those meeting level 2 and 3 ICU criteria to be seen twice daily. **(CS8)**

There have been changes to this over 2018-19, specifically the project has moved from a national survey based assessment to a Board Assurance Framework tool.

Acute services providers are asked to include a statement regarding progress in implementing the priority clinical standards for seven day hospital services. This progress should be assessed as guided by the Seven Day Hospital Services Board Assurance Framework.

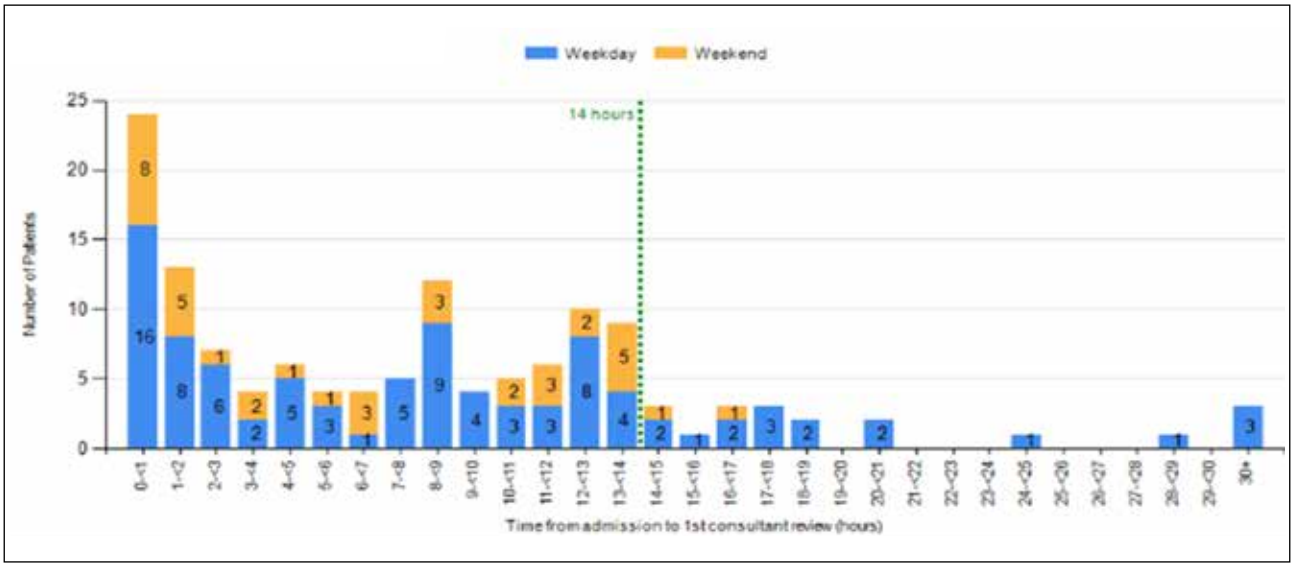
The Data for spring 2018 was as follows.

Results:
7DS Clinical Standard 2

	Day of admission									
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Weekday	Weekend	Total
Number of patients reviewed by a consultant within 14 hours	23	26	18	20	28	24	26	115	50	165
Number of patients reviewed by a consultant outside of 14 hours	2	4	5	3	3	2		17	2	19
Total	25	30	23	23	31	26	26	132	52	184
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	92%	87%	`78%	87%	90%	92%	100%	87%	96%	90%

Reasons why patients were not reviewed within 14 hours:	Number of patients
Consultant review not documented	10 patients
The patient was reviewed by a consultant but after 14 hours from admission had elapsed.	9 patients
Patient excluded from need for 1st consultant review to be by consultant as all exclusion criteria met	12

CS2 Hours between admission and 1st consultant review



7DS Clinical Standard 5
Provision of consultant directed diagnostic tests

Responses to the question:
'Ae the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs. In the appropriate timescales?

Services	Weekday Spring 2018	Weekend Spring 2019
CT	Yes	Yes
Echocardiograph	Yes	Yes
Microbiology	Yes	Yes
MRI	Yes	No
Ultrasound	Yes	Yes
Upper GI Endoscopy	Yes	Yes

It was established that high standard MRI diagnostic was available to our patients over the weekend but not as prescribed standard.

7DS Clinical Standard 6

Comparison between provision of consultant directed interventions between surveys

Services	Weekday Spring 2018	Weekend Spring 2019
Critical Care	Yes - on site	Yes - on site
Primary Percutaneous Coronary intervention	Yes - on site	Yes - on site
Cardiac Pacing	Yes - on site	Yes - on site
Thrombolysis	Yes - on site	Yes - on site
Emergency General surgery	Yes - on site	Yes - on site
Interventional Radiology	Mix of on and off site (all by formal arrangement)	Mix of on and off site (all by formal arrangement)
Renal Replacement	Yes - on site	Yes - on site
Urgent Radiotherapy	Yes - on site	Yes - on site

7DS Clinical Standard 8

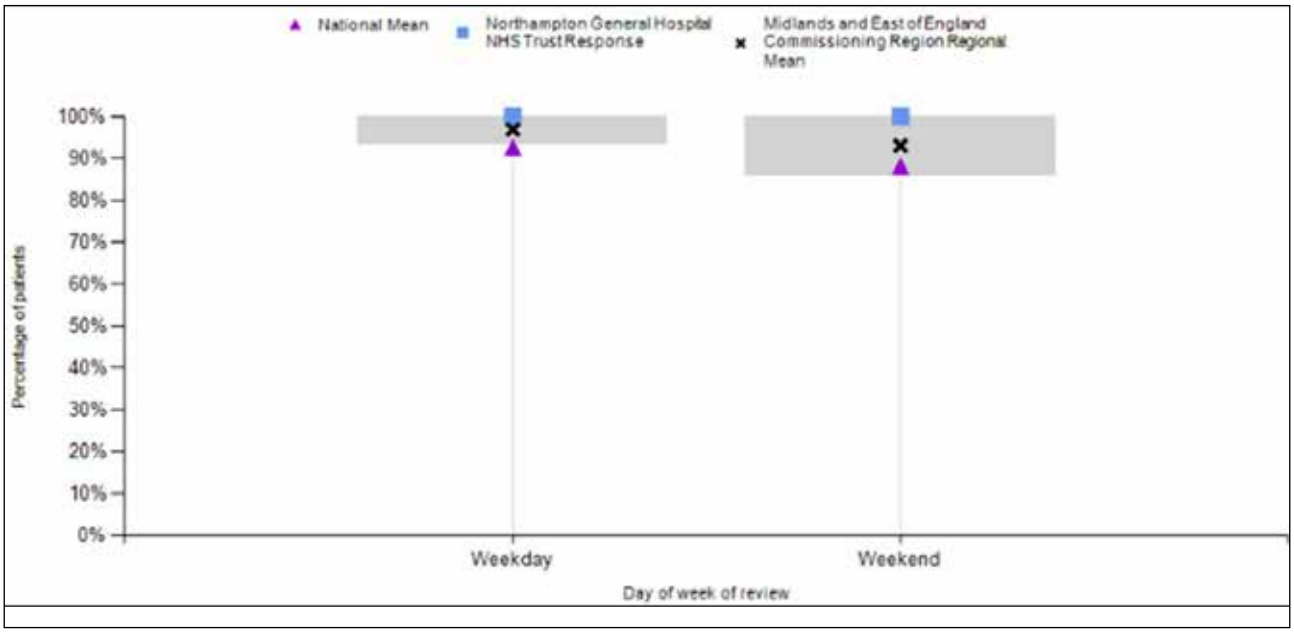
Patients who required twice daily consultant reviews and were reviewed twice by a consultant

	Day of review									
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Weekday	Weekend	Total
Twice daily reviews required & received	5	2	1			3	5	8	8	16
Twice daily reviews required & not received										
Excluded from the analysis										
Total number of daily reviews	5	2	1			3	5	8	8	16
Percentage - Receiving required once daily reviews	100%	100%	100%			100%	100%	100%	100%	100%

Patients who required once daily consultant reviews and were reviewed twice by a consultant

	Day of review									
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Weekday	Weekend	Total
Once daily reviews required & received	92	84	95	86	82	62	59	439	121	560
Once daily reviews required & not received	1	5	3	2	5	27	31	16	58	74
Excluded from the analysis	2		1	3	1	2	2	7	4	11
Total number of daily reviews	95	89	99	91	88	91	92	462	183	645
Percentage - Receiving required once daily reviews	99%	94%	97%	98%	94%	70%	66%	96%	68%	88%

National and regional benchmarking: Proportion of Twice daily consultant directed reviews



The Board Assurance Framework was presented to The Quality Governance Committee (22nd February 2019) as required by NHS Improvement. It was accepted as the way future assurance would be provided but, as directed by NHSI, it contained no new data.

This work is on our 2019-20 Clinical Audit Forward Programme. Specifically patients admitted through non-elective paths over the first two weeks of April (2019) will be audited against CS2 & CS8 by 'Real-time' data collection on the wards and obtaining notes after discharge if necessary. In addition a retrospective notes audit of patients admitted to specialist services (stroke and vascular) will be carried out.

Further information will be collected to audit compliance with against CS5 & CS6 in the same period. To supplement this, a review of mortality, complaints, incidents and patient feedback related to 7 day service provision will be carried out. This information will be presented through the Board Assurance Framework to the NGH Quality Governance Committee in time for the completed framework and the subsequent documented board assurance. This will be reviewed for lessons and improvements and amended as required for our second Bi-annual 7DS review and submission.

Submissions are due end of June and November 2019.

STATEMENTS OF ASSURANCE FOR SELECTED CORE INDICATORS

Performance Against National Quality Indicators

The National Quality Board requires reporting against a small, core set of quality indicators for the reporting period, aligned with the NHS Outcomes Framework. 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 17 – Sep18	104	2	100	127	69
Oct 16 – Sep 17	97	2	100	125	73
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 104 for the period October 2017 to September 2018 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 17 – Sep18	40.8%	31.1%	64.0%	10.7%
Oct 16 – Sep 17	41.1%	36.61%	59.8%	11.5%
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 2018/19	Quality Account 2017/18	2017/18 Average	2017/18 High	2017/18 Low
• Groin hernia surgery (EQ-5DTM Index)	No longer collected	0.091 (final Apr17 to Sep17)	0.089 (final Apr17 to Sep17)	0.137 (final Apr17 to Sep17)	0.029 (final Apr17 to Sep17)
• Varicose vein surgery (EQ-5DTM Index)	No longer collected	* (final Apr17 to Sep17)	0.096 (final Apr17 to Sep17)	0.134 (final Apr17 to Sep17)	0.035 (final Apr17 to Sep17)
• Hip replacement surgery - primary (EQ-5DTM Index)	* (provisional Apr18 to Sep18)	0.482 (final Apr17 to Mar18)	0.468 (final Apr17 to Mar18)	0.566 (final Apr17 to Mar18)	0.376 (final Apr17 to Mar18)
• Hip replacement surgery– revision • (EQ-5DTM Index)	* (provisional Apr18 to Sep18)	* (final Apr17 to Mar18)	0.289 (final Apr17 to Mar18)	0.322 (final Apr17 to Mar18)	0.142 (final Apr17 to Mar18)
• Knee replacement surgery - primary (EQ-5DTM Index)	0.401 (provisional Apr18 to Sep18)	0.343 (final Apr17 to Mar18)	0.338 (final Apr17 to Mar18)	0.417 (final Apr17 to Mar18)	0.234 (final Apr17 to Mar18)
• Knee replacement surgery - revision (EQ-5DTM Index)	* (provisional Apr18 to Sep18)	* (final Apr17 to Mar18)	0.292 (final Apr17 to Mar18)	0.328 (final Apr17 to Mar18)	0.196 (final Apr17 to Mar18)

- No scores available for fewer than 30 records.

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				
2018/19	N/A	N/A	N/A	N/A
2017/18	N/A	N/A	N/A	N/A
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				
2018/19	N/A	N/A	N/A	N/A
2017/18	N/A	N/A	N/A	N/A
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.

NHS Digital has confirmed that this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.

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
2017/18 (Hospital stay: 01/07/2017 to 31/07/2018; Survey collected 01/08/2017 to 31/01/2018)	65.1%	68.6%	85%	60.5%
2016/17 (Hospital stay: 01/07/2016 to 31/07/2016; Survey collected 01/08/2016 to 31/01/2017)	61.1%	68.1%	85.2%	60.0%
2016/17 2015/16 (Hospital stay: 01/07/2015 to 31/07/2015; Survey collected 01/08/2015 to 31/01/2016)	65.5%	69.6%	86.2%	58.9%
2014/15 (Hospital stay: 01/06/2014 to 31/08/2014; Survey collected 01/09/2014 to 31/01/2015)	66.5%	68.9%	86.1%	59.1%
2013/14 (Hospital stay: 01/06/2013 to 31/08/2013; Survey collected 01/09/2013 to 31/01/2014)	68.6%	68.7%	84.2%	54.4%

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
2018	68.6%	71.3% (Acute Trusts)	87.3% (Acute Trusts)	39.8% (Acute Trusts)
2017	69%	70% (Acute Trusts)	86% (Acute Trusts)	47% (Acute Trusts)
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				
2018/19	92.7%	N/A	N/A	N/A
2017/18	93%	96%	100%	75%
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)				
2018/19	86.3%	N/A	N/A	N/A
2017/18	88%	88%	100%	66%
2016/17	86.7%	87%	100%	45%
March 2016	85.4%	84%	99%	49%
March 2015	85%	87%	99%	58%

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 percentages, and the quality of its services by encouraging a culture of reporting throughout the Trust.

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
Q3 18/19	95.45%	95.65%	100%	54.86%
Q2 18/19	94.95%	95.49%	100%	68.67%
Q1 18/19	90.98%	95.63%	100%	75.84%
Q4 17/18	96.61%	95.23%	100%	67.04%
Q3 17/18	95.92%	95.36%	100%	76.08%
Q2 17/18	94.84%	95.25%	100%	71.88%
Q1 17/18	95.56%	95.20%	100%	51.38%
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
2018/19	5.4	N/A	N/A	N/A
2017/18	7.5	14	91	0
2016/17	8.7	12.9	82.7	0
2015/16	12.7	14.9	67.2	0
2014/15	11.8	14.6	62.6	0
2013/14	10.2	14.0	37.1	0

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 percentages, and the quality of its services by sending stool samples in a timely manner, prompt isolation of patient's with diarrhea and improving antimicrobial stewardship.

- Patient Safety incidents as per the NRLS data

Period	NGH	National Average	National High	National Low
The number of patient safety incidents reported to the NRLS within the trust - (Acute Non-Specialist)				
Oct 17 – Mar 18	3,800	5,175	19,897	1,311
Apr 17 – Sep 17	3,085	4,975	15,228	1,133
Oct 16 – Mar 17	4,335	6,707	14,506	1,301
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 to the NRLS within the trust - (Acute Non- Specialist)				
Oct 17 – Mar 18	28.76	42.5	124	24.9
Apr 17 – Sept 17	23.47	42.8	111.69	23.47
Oct 16 – Mar 17	33.3	64.3	69.0	23.1
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 reported to NRLS, that resulted in severe harm or death - (Acute Non- Specialist)				
Oct 17 – Mar 18	33	18.8	78	0
Apr 17 – Sept 17	19	18.3	92	0
Oct 16 – Mar 17	13	34.7	92	1
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 severe harm or death - (Acute Non- Specialist)				
Oct 17 – Mar 18	0.87%	0.37%	1.56%	0.00%
Apr 17 – Sept 17	0.62%	0.37%	1.55%	0.00%
Oct 16 – Mar 17	0.10%	0.36%	0.53%	0.01%
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%

NGH has taken action to increase the number of patient safety incidents reported and continues to encourage a positive reporting culture.

3 PART THREE PROGRESS AGAINST OUR PRIORITIES FOR 18/19 SET IN 17/18 QUALITY ACCOUNTS

This section shows our local improvement planning and progress made against our priorities set in the 2017/18 Quality Report, since its publication. These indicators are not covered by a national definition unless indicated otherwise.

Project Name: (1) Improving the Quality & Timeliness of Patient Observations

What are we trying to accomplish?

Setting Aims:

Aim – Improve overdue observation rate to achieve the Trust target of no greater than 7%.			
Goal Statement	**Measure**	**2014-2015 Outturn**	**Target Performance**
Improve the quality & timeliness of patient observations	Overdue observations data via VitalPac across all adult general wards	Recorded as an average of 9.14%	Improve overdue observation rate by 3% to achieve the Trust target of no greater than 7%

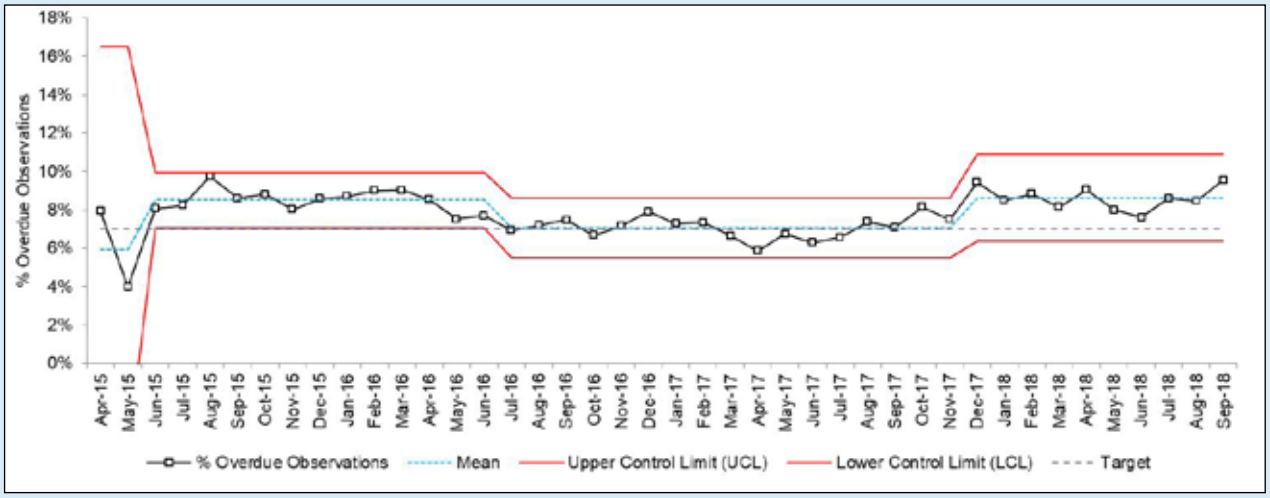
How will we know that a change is an improvement?
Establishing Measures:
VitalPac data for each ward is extracted monthly and circulated to wards. Targeted support is then offered to wards that are consistently are above the trust 7% target.

What changes can we make aimed at improvement?
PDSA

- Circulate late observation data to all adult wards monthly
- All wards non-compliant are expected to have an action plan in place.

Quality Improvement Project Update:

2018 data for late observations



Historically, late observation data was captured as part of a point prevalence audit and aligned to the 'bay working' project (this has since been superseded). as the data added little value.

Late observation data is now collected via VitalPac performance and reported and circulated to all senior nurses, matrons and ward sisters From Q2, the distribution has been distributed directly from IT colleagues. Historically NGH has placed a threshold of acceptance at 7%. Any ward that is consistently above that level is required to have an action plan in place through the senior nursing team.

During Q3 there has been some IT transitional difficulties extracting data from VitalPac and thus no data available for analysis on a monthly basis. This information is visible in VitalPac performance and reporting on a daily basis.

Project Name: (2) Improving the Early Identification & Management of the Deteriorating Patient

What are we trying to accomplish?

Setting Aims:

Aim – To improve early identification & management of the deteriorating patient			
Goal Statement	**Measure**	**2014-2015 Outturn**	**Target Performance**
Improve early identification & management of the deteriorating patient	1. Data evidencing critical risk patients 2. Reduction in preventable Cardiac arrest calls	38 coded preventable cardiac arrest calls following full review	Reduce preventable cardiac arrest calls by 15% by 2018/19 resulting in <32 preventable calls per year.

It has been reported that up to a third of hospital cardiac arrests could be preventable. Some of these could be prevented with better recognition of deteriorating patients and the correct escalation and management of these patients.

How will we know that a change is an improvement?

Establishing Measures:
- We will monitor critical risk >7 EWS patients
- We will monitor the % of these patients with a management plan in place
- We will monitor the number of cardiac arrest calls

What changes can we make aimed at improvement?

PDSA
- Monthly point prevalence EWS audit
- Resuscitation Committee standard agenda item
- Presentation of all preventable cardiac arrest call cases to CQEG monthly
- Learning to be shared across Trust
- Thematic data collected and analysed

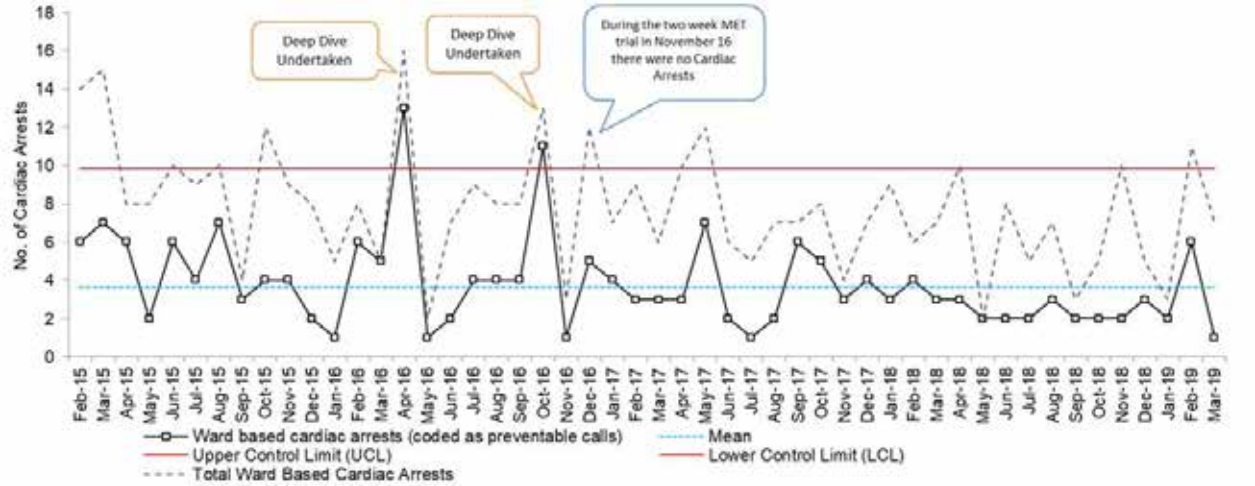
A monthly point prevalence audit reviewing critical risk >7 EWS patients each month and whether they have an appropriate plan in place. If no patients at time of audit are scoring within the critical risk category any patients scoring in the high risk >5 category will be reviewed instead. The required plan would include, Code Red, review to the appropriate level doctor, sufficient documentation to support the plan, TEP and DNACPR.

All ward based cardiac arrests will be fully reviewed by all clinicians on the Resuscitation Committee and the Resuscitation Officer responsible for the case and deemed as preventable or unpreventable. A brief review report of the case is then sent to the appropriate directorate for discussion at mortality and morbidity meetings.

UPDATE, from Q3 2018/19
A review of the data collected, the resource required, the impact and the value it offers took place and it appears the EWS audit data for patients scoring (>7 or >5, code red patients , TEP in place) proved to be of little value. A more strategic approach is suggested, which aligns to the deteriorating patient work stream and will allow the collection of more comprehensive and meaningful data, which will be of greater value. The deteriorating patient work stream leads have developed a care plan to assist in the safe and effective management of high risk patients in the Trust, which will be rolled out between February and August 2019. This will enable the identification of critical and high risk patients, whilst establishing the interventions, escalation and management plan for these patients. It is hoped that a standard of care (SOC) score will be calculated from each high/critical risk / deteriorating episode.

Preventable cardiac arrest calls

There have been 18 preventable cardiac arrest calls to date. The target of reducing preventable cardiac arrest calls by 15% is likely to be met. The main reason of missed opportunities to prevent cardiac arrest calls is a lack of anticipatory decision making relating to do not attempt cardio pulmonary resuscitation (DNACPR) orders. The deteriorating patient work stream oversees a work stream that has a focus on improving care in this area.



Project Name: (3) Eliminating delays in investigations and management for patients who are septic

What are we trying to accomplish?

Setting Aims:

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, resulting in organ dysfunction and death.

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

At NGH we aim to 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 from diagnosis for patients with red flag sepsis, for both ED and inpatients in line with national 2017/18 CQUIN targets.

How will we know that a change is an improvement?

Establishing Measures:
In 2017/18, we have continued to audit random samples of patients presenting to both the Emergency Department and inpatient wards. We are measuring performance against two sets of criteria (samples are audited monthly):

- Total number of patients presenting to emergency departments and other units that directly admit emergencies, and acute inpatients services who met the criteria of the local protocol on Early Warning Scores (from Q4: NEWS 2 greater than or equal to 5) and were screened for sepsis. Evidence is gathered from ED FIT forms' screening tool and inpatient screening data from Vitalpac, ePMA with reference to specific monthly reports from Blood Cultures and Coding.

- Total number of patients found to have sepsis in emergency departments and acute inpatient services in sample 2a who received IV antibiotics within 1 hour of the diagnosis of sepsis.
  Evidence is gathered from Vitalpac and ePMA with some reference to patient notes.

What changes can we make aimed at improvement?

PLAN:
The sepsis challenge continues into 2018/19:
Before national attention focused on the condition, patients dying of sepsis secondary to infection were often coded to the infection only, masking the prevalence and deadly potential of sepsis. During 18/19, acute and emergency units are expected to be transitioning to use the National Early Warning Score (NEWS 2) to screen patients. By Q4 of 2018/19, payment will only be made if over 90% of screened cases have been screened using NEWS 2. **NEWS 2 was established within all departments from December 2018. With the exception of Maternity departments and paediatrics departments, Both continue to utilise specific screening tools for their areas.**

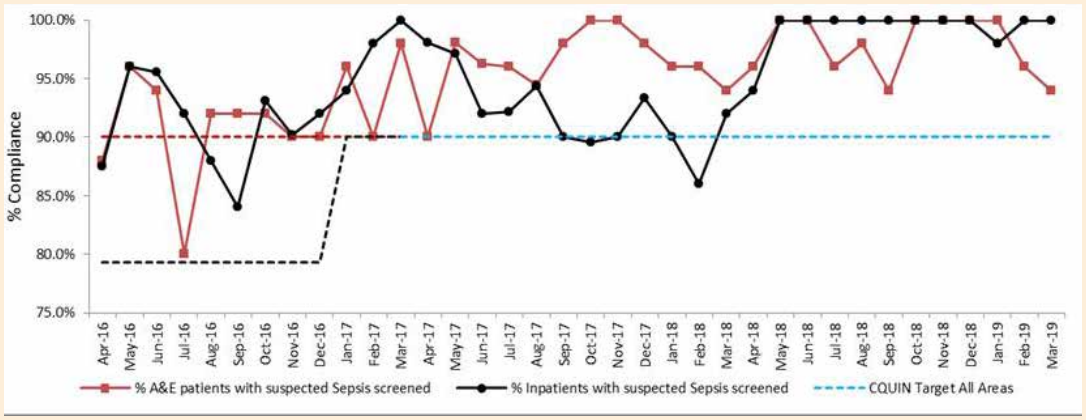
EARLY RECOGNITION:
Consistent, early recognition of sepsis presents a particular challenge and more needs to be done to educate clinical staff on early stage sepsis presentation. BLS and SIM training include a brief overview on sepsis/sepsis scenarios and Vitalpac functionality supports sepsis recognition but staff on adult inpatient ward, need to be vigilant and understand the implications of the body's dysregulated response to infection.

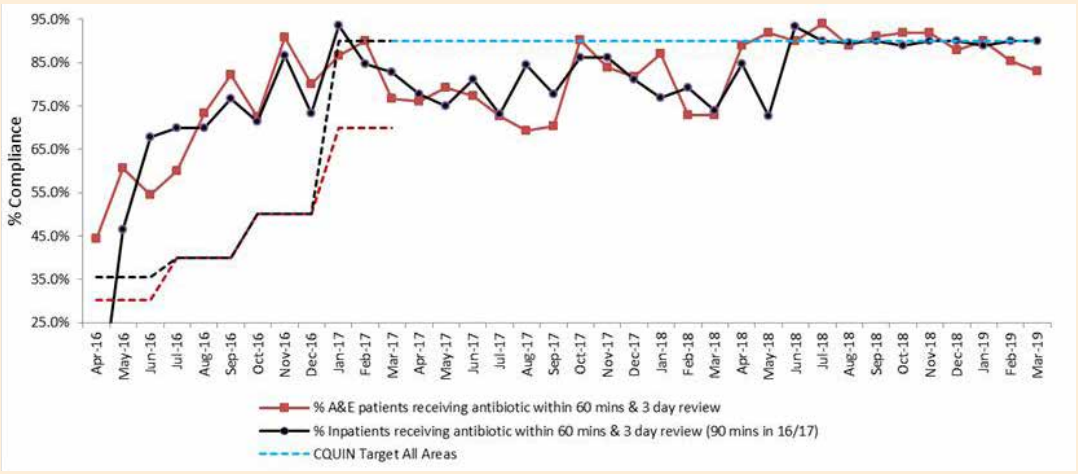
EARLY TREATMENT:
Consistent treatment with broad spectrum antibiotics < 60 minutes of diagnosis is equally challenging. 60 minutes is an aggressive target to initially assess / screen and consider, take blood cultures, prescribe/request and give ABX stat dose. Particular challenges include patients deteriorating OOH and contacting doctors when they are off ward. Where possible education of both Nurses and Doctors has highlighted, communication as a key to reducing the delay in Antibiotic treatment once prescribed.

CQUIN 2018-19:
Screening & treatment targets will continue to sit at 90% for ED and inpatients. Vitalpac auto-screening alerts facilitate, NEWS 2 high screening compliance ; however, staff need to be educated to respond to the screening questions properly and to have a low level of suspicion if patients start to deteriorate. The 60 minute ABX target will be highlighted by the system but again, human factors such as inability to contact doctors within the hour will limit treatment compliance.

CQUIN SUPPORT:
The newly appointed Sepsis Nurse will proactively review deteriorating patients, visit wards to assess & discuss, challenge and educate staff both on the ward and in specific training sessions to build on best practice as well as audit, promote, report and so on.

2018/19 CQUIN audit results – target = 90%





Quarter 4 - CQUIN targets:

DO:
See actions in project update, below.

STUDY:
Early recognition of sepsis presents a particular challenge, especially when patients present a-typically for example, with no fever or pallor. As part of her role the Sepsis Nurse, will educate and constructively challenge nursing staff and clinicians. The Sepsis nurse has embarked on a Quality improvement project to enhance nurse's knowledge and confidence within the trust on early recognition and treatment of sepsis. Initiating sepsis champions within the Trust providing sepsis workshops, shop floor teaching and also teaching new starters to the Trust.

Consistent early treatment with broad spectrum antibiotics administered < 60 minutes of diagnosis is equally challenging. 60 minutes is an aggressive target to initially assess / screen, consider and make a diagnosis then prescribe and draw up, take blood cultures then give a stat dose. Issues include clinician/nurse communication especially OOH and off ward, plus potential delays escalation as patients begin to deteriorate. Some clinicians are wary of prescribing broad spectrum antibiotics because of antibiotic resistance.

The sepsis nurse is now working to identifying then review deteriorating patients, visiting wards to assess, and advise on treatment, then discuss, challenge, action plan any issues of concern. Educate staff on a case by case basis to build on best practice and has as also promoted, those who had initiated best practice and administered Antibiotics within 60 minutes.

ACT:
The Vitalpac auto-screening and treatment function implemented on Vitalpac now facilitates high compliance with screening inpatients, using NEWS2 when EWS rises or there are signs of confusion. Treatment using Sepsis Six is flagged up when sepsis is identified by nurses responding to a set of simple questions. This should lead to clearer escalation/ treatment decisions made earlier when patients start to deteriorate.
The Sepsis Nurse role provides senior, proactive oversight, aiming to drive rapid and consistent quality improvement across the Trust.

Quality Improvement Project Update - ACTION:

FRONTLINE AWARENESS:
- Consultant sepsis lead - next FY1 teaching sessions scheduled.
- September – Sepsis Awareness Week event(s) for World Sepsis day by Sepsis Nurse
- Teaching sessions have been shaped, organised and adapted to reflect action from learning by Sepsis Nurse since July2018
- BLS sepsis overview has been included in sessions since Dec 17
- SIM Suite continuing to use sepsis scenarios including POC sessions
- Sepsis boxes now hold two stocks of Meropenem for sepsis use.

RESOURCING:
- Full time Sepsis Nurse in post from June 2018

SEPSIS GUIDELINES:
- Guidelines published on Trust intranet in May. Sepsis Nurse has dissimulated to each sepsis champions. A possible poster competition to be held to engage staff with regard to the Sepsis guidelines.
- Patient information leaflet to be dissimulated in the Emergency department. Sepsis wellbeing service to be set up in conjunction with the Psychology team at the University of Northampton.

AUTO SCREENING - VITALPAC:

- Vitalpac Nurse 3.5 upgrade with auto-screening for sepsis went live on May 2018. It is expected that there will be ongoing user-related queries and issues as the upgrade was implemented quickly with minimal change management/pre-training (it is a simple to use but additional task set on Vitalpac). Rapid implementation was due to previous IT delays and the need to have a robust screening tool in place for inpatients as adoption of manual tools had been inconsistent over the previous two years.

Management & Governance:

- Clinical Lead / PM / Sepsis Nurse or Lead Antimicrobial Pharmacist update CQUIN Progress Group, Antimicrobial Stewardship Group and Infection Prevention Steering Group & CQEG.
- Performance presented in planned Directorate QI Scorecards (work in progress)

Project Name: (4) Leadership Training & Development for staff

What are we trying to accomplish?

Setting Aims

We aim to develop a safety improvement culture as part of the roll out of the NGH Leadership model, producing leaders who are; Trusted, Motivate staff & Committed to excellence. We are trying to change behaviours to deal with issues and incidents and make improvements rather than ignore them.

It has been a busy year for the Organisational Development Team, particularly in terms of embedding our values 'We Respect and Support Each Other' across the Trust. An overview of the activities are summarised below:

1. Respect and Support Training

As part of the Respect and Support Campaign a range of training has been developed, which are available for staff. These are outlined below:

1.1 Leading with Respect

Leading for Respect is training for Team Leaders, Operational Managers and senior leaders in clinical and non-clinical roles. The training is in two parts: Forum Theatre and Classroom based training. The aim of this session is to ensure managers understand their responsibilities in addressing workplace bullying, harassment and inappropriate behaviours. It also aims to develop self- awareness around behaviours and enable managers to act as role models. The programme includes an overview of the interventions available to support all staff if they witness or experience bullying and inappropriate behaviour.

Since the launch in September 2018, 170 staff has attended this training.

1.2 Challenging Bullying and Inappropriate behaviour

Challenging Bullying and Inappropriate behaviour training is for staff that do not have line management/supervisory responsibility. Like Leading with Respect, this training includes Forum Theatre and classroom based training. The programme aims to raise awareness of bullying and inappropriate behaviours, what the behaviours look like in practice, the distinction between good management/leadership and bullying, and how to challenge these behaviours if staff experience or witness it. The programme also includes an overview of the interventions available to support all staff if they witness or experience bullying and inappropriate behaviour.

Since the launch of this programme in September 2018, 145 staff have attended the programme.

1.3 Courageous Conversations

This workshop is a follow on workshop to Leading with Respect for managers to enable them to handle difficult conversations calmly and successfully by providing feedback in a way that shapes rather than shames the person on the receiving end. The workshop helps individuals to understand the psychology behind conflict, know why and when they should have a courageous conversation and provide tools to address behaviour they are finding inappropriate.
This was piloted on 14 individuals and is being redesigned for launch in March. There are 11 on the waitlist to attend.

1.4 Resilience Training

Resilience training is a programme that has been developed to look at personal emotional resilience. It helps individuals to recognise what depletes and what restores personal resilience, and provides a range of strategies and tools to build resilience and promote health and well-being.

Since the launch of this programme in August 2018, 169 staff has attended the programme.

1.5 Respect and Support Information Hotline

The Respect and Support Information Hotline is about to launch February 2019. The helpline uses a triage approach to signpost staff to interventions if they experience or witnesses bullying, harassment or inappropriate behaviour. These interventions have been developed through the Respect and Support campaign to provide support when members of staff have concerns about an individual's behaviour or have relationship difficulties with others they work with. The hotline is a way of giving the member of staff an opportunity to talk through their issues with a trained individual and it is intended to provide the member of staff with options other than a formal process.
1.6 Round Table Conversations
Round Table Conversations is an offering currently being developed and will be available by April 2019. It involves facilitated conversations to help resolve issues of conflict between two people and reach resolutions in an informal way without the need for the formal Grievance process and potential negative impact for all. The principle of holding a round table is based upon mediation theory. The process involves two facilitators meeting with the separate parties in conflict before bringing the two parties together to facilitate understanding of different perspectives and movement towards resolution. What is shared between all parties remains confidential, allowing for greater honesty and disclosure.

2. Leadership and Management Programme.

2.1 Esther White

This leadership programme consisting of six modules is for those who are new to leadership/ management or are existing leaders/managers that would like to upskill (typically Band 7). It is developmental, experiential and practical, based on the latest leadership theory and evidence. In this programme, individuals will increase their knowledge of the core skills for managing a team, learn how to use coaching conversation skills to manage and lead and understand how to manage and successfully implement change, . Quality Improvement methodologies and training is also provided on this programme.
Since the launch in April 2018, 28 delegates have completed this programme and 31 are currently engaged in the programme.

2.2 James Stonhouse

This leadership programme consisting of six modules is for those who are in a supervisory role (typically Band 4-6) who would like to develop themselves and learn helpful material to lead and manage their teams effectively. It is developmental, experiential and practical, based on the latest leadership theory and evidence. In this programme individuals develop core management skills, coaching skills, and self and other-awareness and they acquire tools to help them lead and get the best out of their team, Quality Improvement methodologies and training is also provided on this programme.
Since the launch in April 2018, 27 delegates have completed this programme and 55 are currently engaged in/enrolled onto the programme.

3. Staff Engagement

3.1 Staff Friends and Family

The Staff Friends and Family test is a quarterly survey to gather feedback from staff on two questions. The 'Care' question asks how likely staff are to recommend the NHS services they work in to friends and family who need similar treatment or care. The 'Work' question asks how likely staff would be to recommend the NHS service they work in to friends and family as a place to work. In Q1 2018, 402 individuals responded, in Q2 489 individuals responded, in Q3, 2133 individuals responded to the National Survey and in Q4 2019 ongoing to 15th March 2019, there have been 118 replies to date.

3.2 Rainbow Risk

Rainbow Risk is a team intervention that provides insight into four personality types and different associated work styles. By exploring common and different traits, and the value each type bring to the organisation, individuals understand how to communicate more effectively with others including with staff and patients. In Q1 2018, 90 individuals participated, in Q2 2018, 37 individuals participated, and in Q3 2018, 15 individuals participated. There has been a decrease in delivery of this intervention with focus on the Respect and Support Campaign, however we are in the process of redesigning this to incorporate the Respect and Support values to relaunch and take teams across the Trust through this from March.

3.3. Boxes training

Out of the box training is a follow on team intervention for those who have completed Rainbow Risk. It explores how aspects of our work and life experiences can influence the way we think and feel about life, and lead us to become restricted in our view to be less objectively and rationally. In the session, individuals recognise attitudes they may develop and behaviours that can be displayed when 'in the box' which are not necessarily positive or beneficial.

In Q1 2018, 30 individuals have participated, in Q2 2018, 26 individuals have participated, in Q3 2018 41 individuals have participated and in Q4 2019, 11 individuals have participated to date.

Quality Account - IQET Update

2018 has been a very successful year for the IQE team. We successfully delivered our targets to the end of Quarter 4 in terms of participation and projects for the making quality count programme. We also delivered a new programme called SAFER 100 days across all 12 medical inpatient wards as part of the fixing the flow programme.

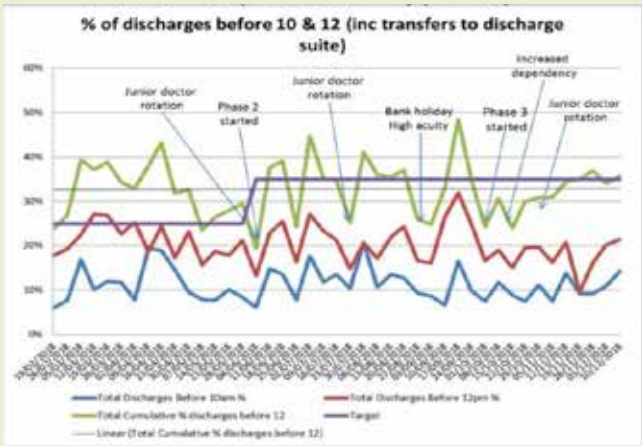
The safer in 100 days programme involved coaching our front line multi-disciplinary teams (MDT) in delivering a new method of patient planning through high quality board rounds, containing the following principles:-

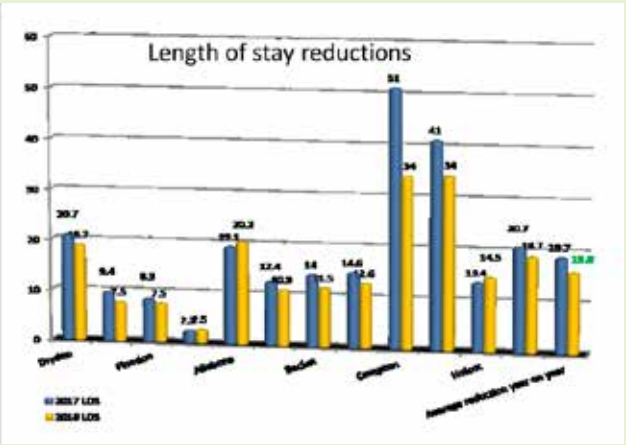
- Introducing a daily rhythm and set agenda to standardise the system.
- Implementing 'Fit 2 Sit' and 'End PJ Paralysis' , reducing the loss of muscle strength and deconditioning
- Twice daily board rounds Using "Red to Green" - ensuring each patient has a plan for the day and there is ownership of the actions with an afternoon update to ensure progress of the plan or delays/constraints have been escalated
- The main objective was to refocus the MDT on the patient's most valuable currency which is time.

Key elements of the system are to ensure we are working to the Safer daily rhythm, reinforce roles and responsibilities so everyone knows how they contribute to our patient care, log tasks and ownership and measure outcomes. This was trialed initially on four medical wards and is now being rolled out across the remaining medical division and urgent care with our on-going ambition for iBox and Safer to be Trust wide.

Our objective was to improve flow through the hospital much earlier in the day. Our headline metrics were:

- Patient flow before 12noon increase from 17% to 35%.
- Our peak of discharging patients moved from 6pm in 2017 to 3-4pm.
- LOS reduced from 18.7 days to 15.8 days.
- Stranded patients dropped by >25%





Throughout the programme we delivered a communication plan to keep the rest of the Trust aware of what's going on and our successes. We also created a "grab pack" with infographics and user guides for ongoing roll out to new team members to support sustainment.

IT supported us to build a scalable technology solution to sustain the Safer system via electronic white boards. This tool will help us to maintain the standards in the system.

The Quality Advisors continue to support other areas of the Trust with ongoing service improvement projects ranging from virtual clinics in Dermatology to support RTT Performance, Eye Casualty Triage, Domestic Services to improve isolation clean logistics and delivery, Outpatient Administration and Processes in Maxillo Facial and Urology and Paedaitric Cystic Fibrosis.

Project Name: (5) Board to Ward leadership Walk rounds

What are we trying to accomplish?

Setting Aims
Leaders need to interact with staff frequently, visiting their work place and asking for frank input. When all executives commit to regular visits (walkrounds), it can create a shared insight into the organisations safety issues.

How will we know that a change is an improvement?

Establishing Measures
A revised format was introduced in July 2012 to include all Executives and Non-Executive Board Members to visit clinical areas as part of monthly Trust Board Business.

- We will monitor the number of areas visited per month

- We will provide Divisional feedback identifying areas of good practice and improvement.
- We will demonstrate progress via improved staff surveys and safety climate results

What changes can we make that will result in improvement?

PDSA
The content of the board to ward guidance will continue to evolve, as regular reviews will be conducted to improve and update the process as initiatives and learning opportunities are developed and become available

What are we trying to accomplish?

1. Setting Aims

Leaders need to interact with staff frequently, visiting their work place and asking for frank input. When all executives commit to regular visits (walkrounds), it can create a shared insight into the organisations safety issues.

2. Establishing Measures
A revised format was introduced in July 2012 to include all Executives and Non-Executive Board Members to visit clinical areas as part of monthly Trust Board Business.

- We will monitor the number of areas visited per month – presented monthly to QGC encompassed within the QI scorecard
- We will provide timely Divisional feedback if applicable, report all visits, themes and lessons learnt quarterly both internally and externally for patients and staff.
- We will demonstrate progress via improved staff surveys and safety climate results
- During 2018/19 – 197 executive safety rounds have taken place, this is above the internal stretch target of 72 visits a year, this is in addition to the "Beat the Bug" executive safety visits.

3. Themes identified
As this initiative becomes more embedded into practice, the discussion of areas of concern and the options for resolution becomes more dynamic. The purpose of the safety round is firstly to send a message of commitment and it also fuels a culture for change pertaining to patient safety.

The increase in issues raised is due to the increase in wards visited by the Executive Board members and the process of Board to Ward becoming embedded and accepted by clinical staff.

Project Name (6): To deliver training in QI methodology

What are we trying to accomplish?

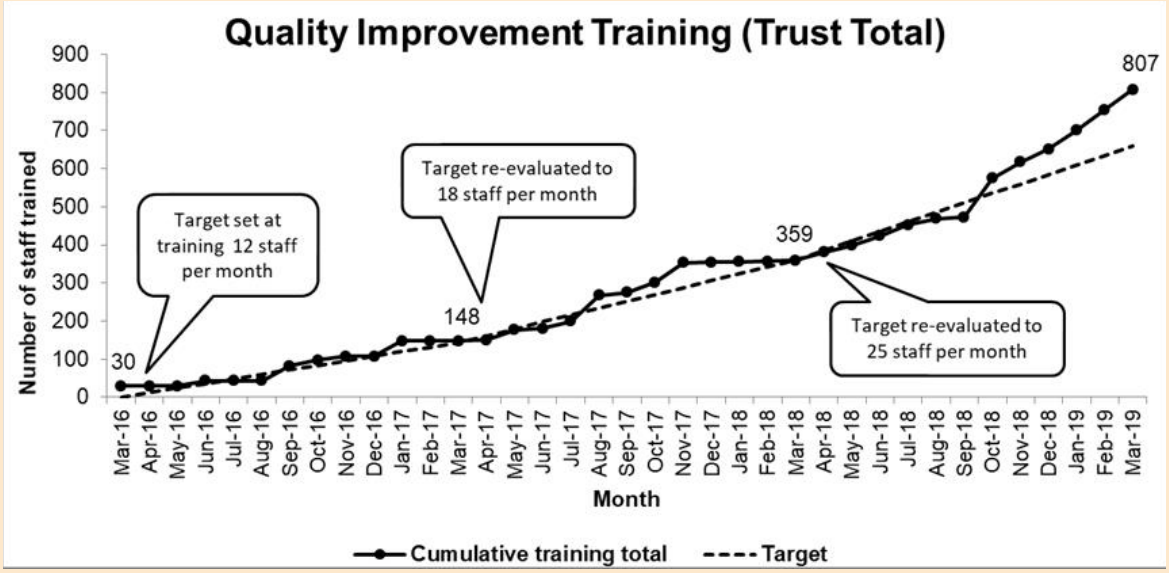
Setting Aims:
Initial aim set in March 2016:
By December 2018, train 400 staff in Quality Improvement methodology in Northampton General Hospital.

New smart aim set in March 2018:
By December 2018, train a minimum of 600 staff in Quality Improvement methodology (defined as the Model for Improvement using a standardised NGH QI project process) in Northampton General Hospital

How will we know that a change is an improvement?
Establishing Measures:

1. QI training
We will measure the number of staff we have trained in Quality Improvement methodology (IHI Model for Improvement and NGH QI project process) on a monthly basis. This data is stored in a database of all current NGH staff, enabling us to track progress by division and directorate.

The graph below shows the current training progress in a cumulative format.

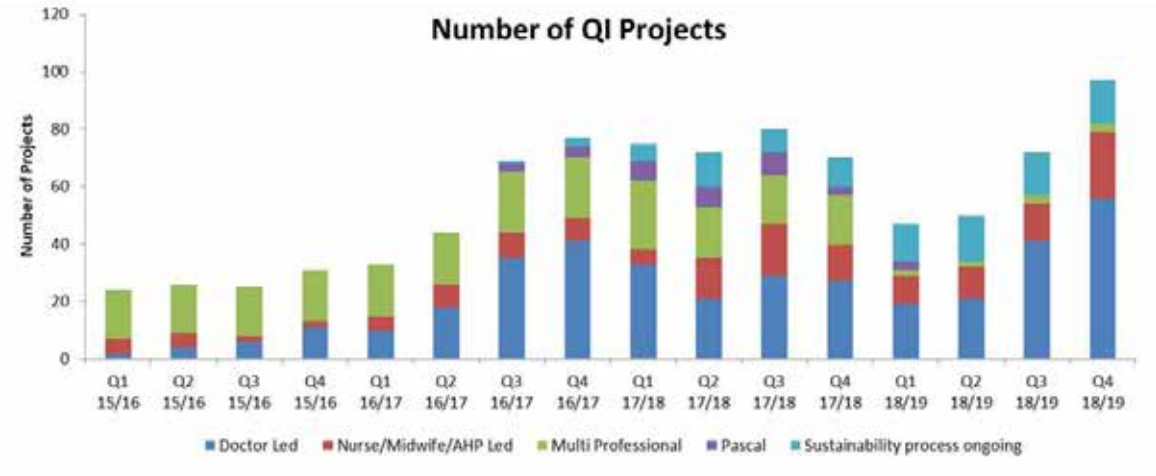


We have achieved our aim – training a total of 660 staff between March 2016 and December 2018.

3

2. QI projects

We are also measuring the number of ongoing QI projects supported by the QI Hub. This is detailed in the graph below, also reported in the Quality Improvement Scorecard.



What changes can we make aimed at improvement?

The Quality Improvement team deliver various academic programmes to support the personal and professional development of our staff. Such programmes include:

- Junior Doctors' Safety Board
- Registrar Leadership & Management programme
- Trust Grade Development Programme
- Aspiring to Excellence Patient Safety programme
- Creating Excellence programme

We also deliver QI half-day sessions on programmes led by other teams including:

- Esther White and James Stonhouse programmes, led by Organisational Development
- Shared Decision Making Councils, led by Patient & Nursing Services
- The Stroke Journey, led by the Community Stroke team

The QI team also deliver monthly teaching sessions (previously quarterly until September 2018), which has seen 180 staff trained in 4 months.

We hope to train an additional 150 – 200 staff between January 2019 and March 2019.

Commencing in October 2019, NGH will also be delivering a new MSc Quality Improvement & Patient Safety in collaboration with the University of Northampton. This MSc will have 20 students per annum, with a large proportion expected to come from NGH each year.

Project Name (7): Safety Culture Assessment (Pascal Metrics)

What are we trying to accomplish?

Setting Aims: Safety Culture Measurement Programme (PASCAL Metrics)

Safety culture is broadly defined as the norms and values and basic assumptions of the entire organisation.
Safety climate is more specific and refers to the employees perceptions of particular aspects of the organisations culture.

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.

Safety culture and leadership were identified as mandatory areas for improvement from the Francis and Berwick report.

How will we know that a change is an improvement?

Establishing Measures:
Safety culture evaluation was completed using a 43-point questionnaire, developed by Pascal Metrics. The survey was completed by the two 'front door' services in the acute hospitals: Emergency Department and Maternity Department.

The safety culture survey has been broken down into 9 domains:
- Overall perceptions of patient safety
- Safety climate
- Job satisfaction
- Teamwork
- Working conditions
- Non-punitive response to error
- Perceptions of local management
- Perceptions of senior management
- Exhaustion / Resilience

What changes can we make aimed at improvement?
A baseline evaluation of the safety culture in both departments was completed in Summer 2016.

The NGH Emergency Department results for 2016 are shown below.

NGH ED had the highest scoring domains overall out of the 8 acute hospitals in the region.

The survey was repeated in Summer 2018, using the same key questions. The results are shown below.

We have seen an improvement in 4 domains (teamwork, safety climate, perceptions of local management and working conditions). Six of the nine domains remain on or above the industry median.

The Maternity Department results for 2016 are shown below.

The results for summer 2018 are shown below.

2018 is the final evaluation commissioned by the Patient Safety Collaborative. The findings have been collated for each department and shared with the departments for further analysis and investigation.

Project Name: (8) Point of Care (PoC, previously LFE) for Clinical teams

What are we trying to accomplish?

Setting Aims:

NHS Quality and Safety documents and reports state that cases of failure to recognise the deteriorating patient, and not calling for the correct help have become common themes during investigations, with the breakdown in team work and poor decision making as one of the main reasons, (Yu, Flott, Chainani, Fontana, & Darzi, 2016) (Dept of Health, 2015). Many cases of failure to recognise the deteriorating patient have been linked to difficulties in asking for advice and relaying information across professional and hierarchical boundaries.

During incident investigations staff raises issues such as the lack of awareness of time passing when dealing with problems, also systems and targets are challenging. They report that staffing levels are often insufficient, leadership is sometimes ineffective, and that there is still a blame culture in some areas. These all result in making working conditions difficult especially when dealing with deteriorating patients and communicating concerns to senior healthcare practitioners, (Dept of Health, 2015)(Yu et al., 2016)

During a Consultant core simulation faculty meeting chaired by the operational simulation and response lead within our Trust, the team discussed the national concerns and how we as a Trust could deliver educational programmes to support our staff. The core team discussed also how it had become apparent whilst delivering simulation speciality training programmes, there was a lack of understanding, especially around human factors skills. These Human Factor issues included a lack of situational awareness, communication, decision making, task focus and poor or inappropriate escalation to the correct member of staff. During debriefing of these sessions, the operational simulation and response lead found that the majority of staff were not aware of how human factors can either enhance or reduce performance in healthcare. (Reason J 1999).

Human factors science is concerned with interactions between humans using non-technical skills e.g. communication, situational awareness, assertiveness and task focus. In healthcare, staff having an understanding of how human factors science can improve efficiency, safety and effectiveness is fundamental to communication, leadership and patient safety (Flin, O'Connor, & Crichton, 2008)(Dept of Health, 2015)

The operational simulation and response lead discussed these findings with the risk management team to see if these themes were common in the Trust and how they could work collaboratively to develop a programme for teaching around human and system errors. To develop the learning from error (LFE) programme making it a fundamental part of the Trust educational journey, the operational simulation and response lead simulation worked closely with the Quality Improvement team, matrons, ward sisters and Director of Medical Education.

A programme was then designed for all wards and departments to have bespoke training using relevant scenarios based on real incidents from their ward/department as well as general incidents. Using Datix data from potential errors and common themes, the aim and objectives were based on communication, decision making, situational awareness, task focus, escalation and challenging behaviours. The operational simulation and response lead presented to the Trust executive team for approval before commenting with the educational programme.

Several literature reviews discuss how well simulation training has worked in high risk organisations, because it allows the staff to practice difficult situations and learn about technical and non-technical skills in relation to safety and teamwork, providing the safest environments for their workers, public and passengers. Simulation has been used in the forces and industry particularly in aviation since the 1st world war, focusing on human and system errors. However, it has only been in recent years embraced by the NHS, partly because of a focus on Patient Safety, Quality Improvement and litigation. Both the complexity of the NHS and patient safety innovative improvements have made it difficult for students and staff to gain opportunities in clinical placements and to explore how they would deal with real life emergencies and advanced clinical procedures. Often healthcare professionals have to recall classroom based learning to deal with emergencies or rare events for the 1st time on a patient. The Chief Medical Officers (CMO) Report explains in detail how simulation in all its forms will be a vital part of building a safer healthcare system. (CMO 2008)

How will we know that a change is an improvement?

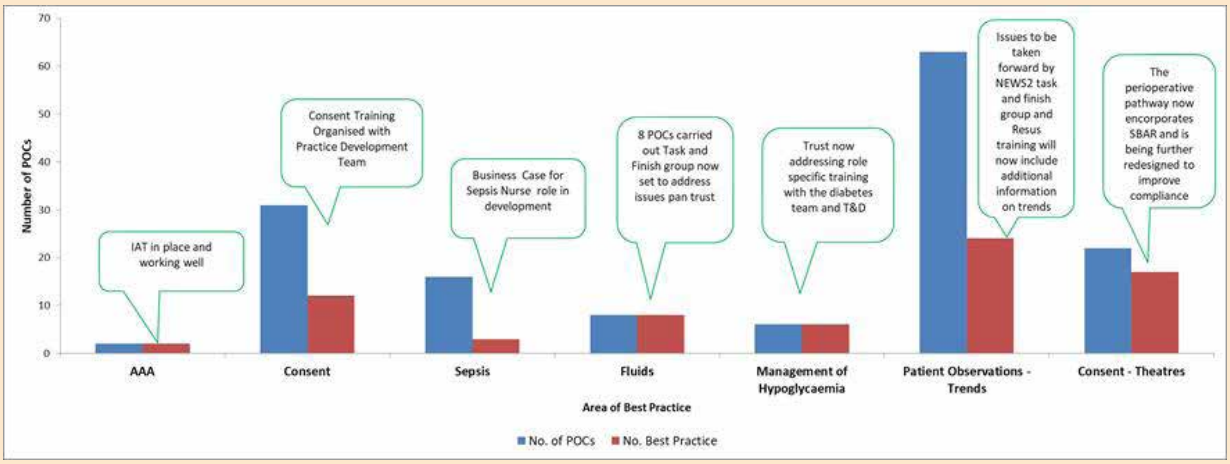
Establishing Measures
The aim was to have at least 50% of ward teams attending Learning from Error (LFE) sessions annually, by 2018. Over the year the programme achieved over 50% of nursing and allied health professional training but had minimal uptake from the medical teams. PDSA revealed the need to change the process. A pragmatic decision was made to stop running programmed LFE sessions within the Simulation Suite due in the main to lack of attendance, but this would be offered to teams if needed in the future. Learning from error training has now been built into all simulation training programmes both locally and regionally.

The Simulation and Resuscitation Service team have worked collaboratively to achieve Point of Care (PoC) simulations.
There are three arms to this piece of work:

Quality Improvement Project Update:
Phase 1

- **Annual plan** – the aim is that all wards will receive PoC during the year which addresses bespoke issues highlighted through datix reports.
- **Urgent care** – the urgent care project which is supporting staff on the two assessment wards to address reducing preventable cardiac arrests and increasing awareness of escalation of the deteriorating patient issues.
- **Reactive PoC's** – The Review of Harm group meets weekly and any major thematic concerns from the weeks agenda are formulated into PoC simulations, the report from which is accepted within the following weeks' agenda and escalated appropriately. These simulations are aimed at determining if staff are equipped to respond to a given clinical situation following National / local best practice.

Reactive PoC's



System improvements form the RoHG PoC simulation programme are as follows:

- Consent training for all ward staff which included, a new design of a perioperative care pathway to enable staff to make sure all patients are prepared correctly for surgical procedures before going to specialist clinics or theatres.
- Layout of our pain clinic to make sure all emergency equipment is accessible when needed
- Review of the diabetic treatment plans
- Escalation procedures including the use of SBAR DNACPR and MCA

2 x Identity Bracelets. One wrist, one alternate ankle, not operation site. ☐				
Details on identity band are correct	Yes ☐	No ☐		
Signed and dated Consent Form to planned operation present	Yes ☐	No ☐		
If Consent Form 4 required, a completed MCA Form is available	Yes ☐	No ☐		
Medicine Chart	Paper Chart present? ☐		On EPMA ☐	
Seen by surgeon to confirm need for surgery	Yes ☐	No ☐		
Relevant notes present	Yes ☐	No ☐	Anaes Questionnaire completed? Yes ☐	No ☐
Operation site marked	Yes ☐	N/A ☐		
IF ANY ITEMS WITHIN THIS BOX ARE NOT COMPLETED / CORRECT, THE PATIENT DOES NOT MOVE TO THEATRE				

- oUsing simulated patients the team tested the safety functions of the new Nye Bevan building before it opened to the public, including transferring of patients from the emergency department, ambulance to the new assessment building for urgent care and from urgent care building to areas of the trust, for example: CT, x-ray, wards, theatre and ITU. To make sure all the Trust systems worked effectively in line with patient safety initiatives.

Phase 2:

Priority proactive PoC simulation programme

- All wards received PoC training and this in situ training allowed for the team to work together with a deteriorated patient. All teams were prepped about the training but no told when the PoC would occur. The operational simulation and response lead, Safety leads and ward manager would decide on the day of the PoC that it was safe to proceed with the training. This occurred weekly and on a monthly basis the emergency cardiac /per arrest or trauma teams were also bleeped to attend.
- Expert core faulty observed the teams and a hot debrief after the simulation with the team. This allowed for a team discussion on clinical management and non-technical skills. This programme was very successful because of senior staff support within the Trust, and feedback from all staff who participated in PoC to say how safe and realistic the training was, the PoC programme became an integral part of education within our Trust. All teams received a written report of the PoC for their own learning, including learning from errors leaflet on human factors.

Current QI project : Urgent care division

- The urgent care wards needed to be clinically prepared for the new urgent care building which was due to open in October 2018. The operational simulation and response lead worked closely with the senior management team of the new build to
- Teach staff new skills for the assessment unit through simulation.
- Weekly PoC training programme within the new building to embed safe practices and support the teams with the new ways of working.

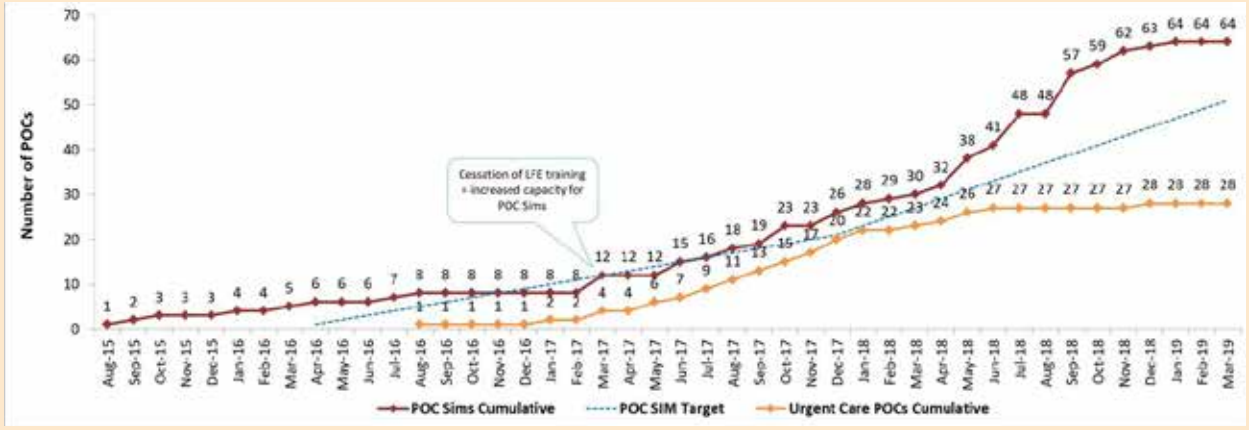
Reactive PoC simulations programme

- The RoHG PoC simulation programme now includes the deteriorating patients work stream.
- The aim of the deteriorating patient work stream is to improve patient safety across the Trust. Patients will be scored on the standard of care they receive, any lapses or omissions in care will be identified and an action learning plan established to improve care. The resuscitation and simulation team provide in terms of education, training, evaluation and sustaining good practice, through the PoC simulation training programme.

What changes can we make aimed at improvement?

- Collaborative working with the Governance, Safe Guarding and Quality Improvement Safety Leads
- The trust 2019 programme is divided into divisions enabling 3 months of PoC training for each division, capturing as many areas within the division as possible.

Annual PoC's



Examples from our staff Feedback: post PoC teaching

- Staff nurses feeling more confident managing difficult patients after the practice with POC
- Seniors want to have more practice at leading the POC to give them confident in leading the teams when doctors are busy with other acutely unwell patients and are delayed
- The practical sessions are realistic
- Faculty support in debriefs is non-judgemental and supportive
- 98% of the nursing staff agree this prepares them for dealing with real life emergency's
- They prefer the live actor where possible as it feels even more realistic
- The administration staff can see who helpful they are in an emergency
- Timings can be difficult with the management of the ward and flow of patients
- Understand the correct escalation process for patient who is scoring high on their EWS
- Understand the importance of the SBAR communication tool
- What the processes are if the doctor you call is too busy to attend
- Feedback is personalised and useful to our team
- It's realistic and safe
- Hands on practical and understating the knowledge behind the decision making process
- Its makes you nervous but found the learning helpful
- PM session were suggested to involve medical staff more
- The importance of effective communication

Best practice observed:

good recognition of the deteriorating patient
calling for help in less than 30 seconds
Prompt response and treatment for all medical emergency's with all teams
Good open and honest debriefs allowing for constructive safe learning
Good responses from the on call teams and participation
Good leadership from senior staff to junior staff
Minimal disruption to clinical teams working day

Improvements for 2019

Extensive work for all staff on escalation of the deteriorated patient and communication and use of SBAR for handovers
Through PoC simulation the team will focus all educational training on explicit communication using SBAR, decision making, situational awareness and teamwork when dealing with simulated clinical emergencies, followed by hot debriefs.

Project Name: (9) Eliminate Hospital Acquired Pressure Ulcers

What are we trying to accomplish?

Setting Aims:

Hospital acquired pressure damage continues to remain the biggest harm to our patients and the Trust continues to be an outlier for prevalence and incidence. Pressure ulcer prevention care at NGH is, for the most part, good with risk and skin assessments being completed almost comprehensively and the correct interventions are made for the majority of patients.

The Tissue Viability Team (TVT), with support from the Director of Nursing, Midwifery and Patient Services, and Senior Nursing Team, are committed to supporting the heightened level of activity across the Trust to sustain change and will continue to reduce the level of pressure harm that our patients experience whilst in our care.

How will we know that a change is an improvement?

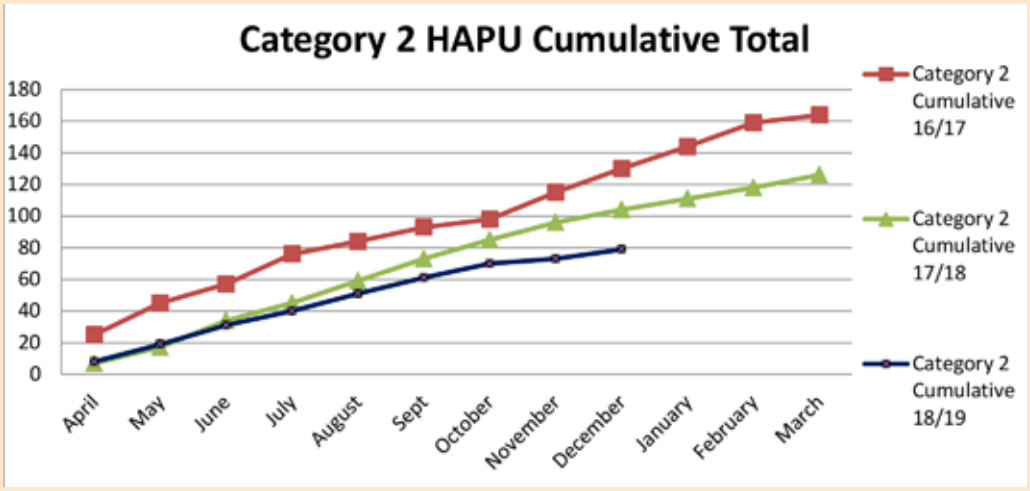
Establishing Measures:
We will measure the number of pressure ulcers of grade 2, 3 and 4. With a target to reduce grade 2 by 10% each year, grade 3 by 10% each year one and maintain grade 4 at 0%. We aim to reduce pressure ulcers by 50% overall by March 2019.

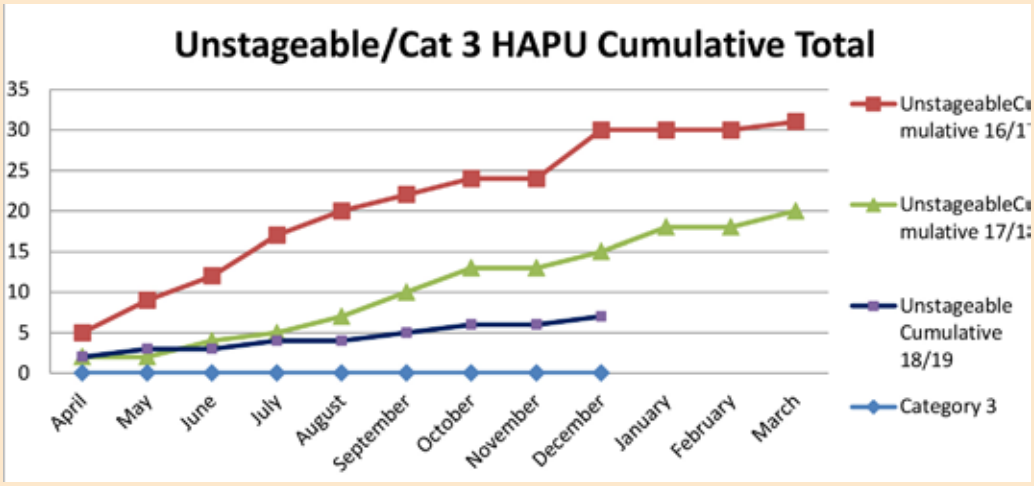
What changes can we make aimed at improvement?

PDSA:

- Collaborative working with Fall Prevention Team and IPC Team, which includes working together to reduce harms on the wards by carrying out post harm reviews together, redesigning new ward safety boards on wards.
- QI Projects to reduce harms and improve safety.

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18
Category 2	8	11	11	9	11	10	9	3	6
Unstageable	2	1	0	1	0	0	1	1	0
Grade 4	0	0	0	0	0	0	0	0	0
Total HAPU (NGH) excluding sDTI's	10	12	8	9	11	12	16	3	6





Countywide TV Forum

The aim of this forum is to enhance collaborative working across all trusts in Northants and improve communication. It will be used as a platform where new ideas and strategies can be shared as well as providing an opportunity to share patient stories and best practice.

October saw the launch of the **1st** Tissue Viability Conference with our partners from **NHFT, KGH, NGH and Three Shires Hospitals**. The day was really well attended by over 70 staff, with excellent presentations from our nurses and from Convatec, Biomonde and Smith & Nephew.

There were Q&A sessions and shared learning amongst all who attended.

SSKIN Audit

The priority for this audit is to establish the effectiveness of pressure ulcer prevention by measuring compliance with the SSKIN bundle on all general inpatient adult wards, excluding Critical Care. The "Skin ambassadors" were asked to undertake this audit and all of them found it a learning experience and were going to take it back and use it on their own wards.

From the audit results the Tissue Viability Team are working closely with the wards to improve on the issues identified, by providing more training on the ASSKING documentation, risk assessments and categorising of pressure ulcers.

An audit was undertaken on 20th August 2018, on the SSKIN documentation using a new revised audit tool to incorporate the new documentation that was implemented in April 2018, the results of this are below, another SSKIN audit was completed in December, results of which are still being reviewed.

Introduction of Training

- Training Dates for Pressure Ulcer Prevention and SKIN ambassadors have been arranged throughout 2019 as these sessions were well attended in 2018 and the team received excellent feedback.
- The Tissue Viability Team is also supporting the therapy teams with bespoke training.
- Trialling the use of Cameras on Assessment Wards for out of hours early photography of suspected damage.

Challenges to the Tissue Viability Team

- Implementing the New Guidelines from NHSi
- Gain Trust approval for Pressure Ulcer training to be Role Specific for frontline inpatient teams.

Other Actions

- Continue to work closely with ward areas that have a higher number of harms
- Communication across the hospital via screensavers and bi monthly newsletter.
- Manual Handling to visit wards to do spot checks of practice

Project Name: (10) To Reduce harm from (In-patient) Falls

What are we trying to accomplish?

Setting Aims:

Falls are the most commonly reported incident in all hospitals in the UK and can cause significant harm. At NGH we are implementing a 4 year programme to reduce harm from falls aiming for a 15% reduction by March 2019.

How will we know that a change is an improvement?

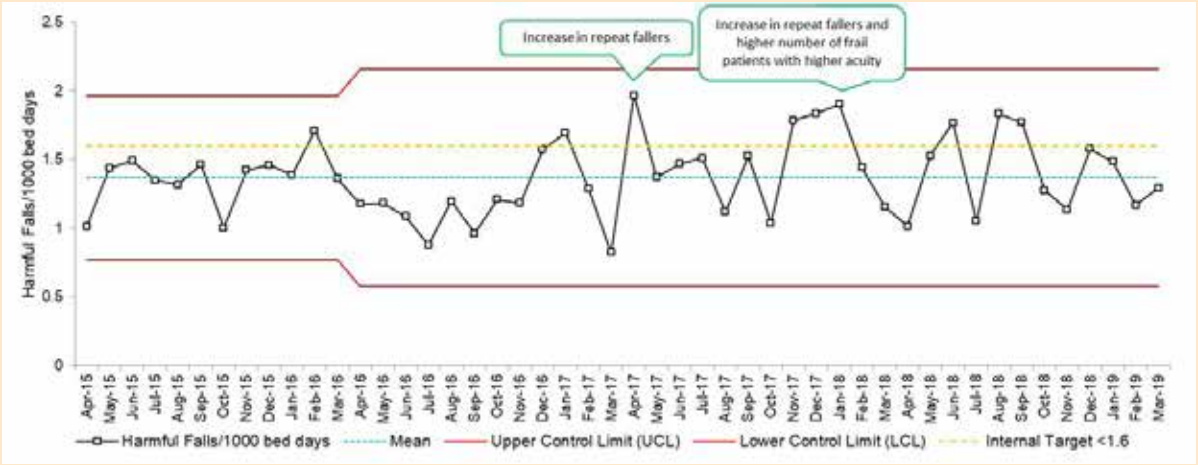
Establishing Measures:
We will monitor the number of harmful falls per 1000 bed days with a view to reducing them by 15%. Falls assessments will be completed within 12 hours of admission in 95% or more patients. Falls care plan will be completed within 12 hours of admission in 90% or more patients. 85% or more of staff to be trained.

What changes can we make aimed at improvement?

PDSA:

- Review current process for post falls review and make appropriate changes
- Develop a delirium policy to manage patients with confusion
- Introduce a process to review medication that may lead to increased falls

Quality Improvement Project Update:



The graph above demonstrates the harmful falls categorised as low, moderate, severe and catastrophic recorded at NGH between April 2015 and December 2018. The graph above demonstrates that the Trust remained below the internally set target of 1.6 harmful falls/1000 bed days during quarter 3.

Sign up to Safety 1 - Falls assessment will be completed within 12 hrs of admission in 95% or more patients.
In Quarter 3 2018/19 the mean average for completing Falls Risk Assessments was 98% - target achieved

Sign up to safety 2 - Falls care plan will be completed within 12 hours of admission in 90% or more patients
In quarter 3 2018/19 the mean average for completing falls care plans was 94% - target achieved

Sign up to safety 3 - Review current process for post falls review and make appropriate changes.
New post falls packs have been made available on all wards and the head injury flow chart updated.

Sign up to safety 4 - Develop a delirium policy to manage patients with confusion
Delirium Guidelines have been approved and are available on the Trust intranet.

Sign up to Safety 5 - Introduce a process to review medication that may lead to increased falls for patients admitted with a fall, **Sign up to safety 6** - Introduce a process to review medication that may lead to increased falls for patients at risk of a fall.
Work remains ongoing for auditing the number of medication reviews that are being completed.

Project Name: (11) Eliminate Hospital Acquired VTE

WHY:
Venous thromboembolism (VTE) has an estimated incidence of 1-2 per 1,000 of the population. Up to 60% of VTE cases occur during or within 90 days after hospitalisation, making VTE a leading preventable cause of death in hospital. However, research suggests that at least two thirds of cases of hospital-associated thrombosis are preventable through VTE risk assessment and using appropriate preventative strategies (for example, early mobilisation following surgery, anti embolic stockings and anticoagulants in those most at risk).

What are we trying to accomplish?
Improve the percentage of VTE risk assessments undertaken at the time of admission.
Improve the timeliness of providing thromboprophylaxis to those patients deemed at risk of VTE.

Ensure that stockings provided as mechanical thromboprophylaxis are used appropriately
Reduce the number of Hospital Associated Thromboses (HATs) and increase learning from Root Cause Analysis (RCA).

Project Name: (12) To Reduce Omitted Medicines

What are we trying to accomplish?

Setting Aims
Omitted medication is the most regularly reported medication incident nationally, reported to the National Reporting & Learning System (NRLS). One of the highest reasons for omitted doses is doses which have not been documented.
The improvement project aims to reduce omitted doses (not documented) across the Trust.
The implementation of EPMA is anticipated to reduce omitted doses (not documented) further as the EPMA system at NGH highlights to nursing staff, doses that have not been documented as have being administered.

How will we know that a change is an improvement?

Establishing Measures
Following previous improvement work a baseline measure of all wards was undertaken in September 2014 which gave an average of 9% of patients, monitored 24 hours previously that had an omitted dose (not documented). The intention is to measure the percentage of omitted doses of medicines (not documented) with an aim to reduce by 10% in year 1 and 20% each year thereafter.

What changes can we make aimed at improvement?

PDSA:
The improvement tool is based on local feedback to nurses at the time of audit, and a feedback of the Trust results to Matrons for discussion at directorate level.

Planned changes undertaken:

- Implementation of EPMA across the Trust [Excl Paediatrics and Outpatient clinics].
- Project to improve availability of medication for patients using Green Bag Scheme with East Midlands Ambulance Service and highlighting to patients the importance of bring medication into

Quality Improvement Project Update:

The wards in the medical directorate had the greatest reduction in omitted doses 'not documented' which directly correlates with the introduction of electronic prescribing to these areas over this period of time.

Following improvements in 'omitted doses 'not documented'we have recently concentrated on 'omitted doses due to medication unavailable'.

Current work streams to improve this have been:

- Nurse ordering via EPMA button
- Priority ordering for Critical medication via EPMA
- Streamlining of ward stock lists
- Omnicells on wards for automatic ordering
- Campaign to improve patients own medication bought into hospital working with EMAS, and CCG and local radio
- Increase in digital lockers at bedside for patients own medication
- Technicians visits to wards to transfer medication not transferred with patient
- Dispensary liaison with urgent care wards for newly dispensed medication

The Medication Safety team implemented some work in August 2018 with the Communication team, Nene Commissioning and the East Midlands Ambulance Service to improve the availability of medications across the trust during 2018/19. This work hoped to increase the number of patients coming into hospital with their own medications to reduce the risk of patients missing doses due to unavailability at ward level.

In support of this a baseline audit for the month of April was conducted. This utilised data from the EPMA system which is now used across the trust (apart from Paediatrics).

During Q1 2018 – 2019 in addition to the above improvement work there is also a project within Urgent care to reduce omitted does due to medications not being prescribed.

We have been able to improve our reporting on omitted doses so that the report can be used as originally intended as an improvement and assurance tool which will be circulated on a monthly basis to ward sisters ,matrons and governance. The EPMA system has an option for documenting omitted doses marked as 'Other –Add note' . We have asked the provider of the EPMA system to remove this as an option but until this is done there is no assurance for the trust that this note is completed so the improvement will be to reduce the use of this reason ' Other –Add note' which can be easily used as a 'not documented' option.

Starting again using the EPMA report from January 2019:

Reason	Number of Omitted doses	%
Drug unavailable	140	11.4
Other (not documented)	316	25.8
Total omitted doses	1224	

Now that we have a more robust reporting system we can revert to our previous tool improvement tool based on local feedback to nurses at the time of audit, and a feedback of the Trust results to Matrons for discussion at directorate level.

Project Name (13): Effective Night Team Handover

What are we trying to accomplish?

Setting Aims:
Audit's completed on night handovers and patient transfers identified poor documentation and poor transfers/handover of care. The aim of this project is to ensure that patients requiring an internal transfer will have a documented transfer plan in place and appropriate staff escort. Patient transfers out of hours will be risk assessed.

How will we know that a change is an improvement?

Establishing Measures:
We will measure the number of attendances at night team handover, the aim being that all on call specialties will be represented and the number of patients transferred with a completed risk assessment in place . The aim is to get both of these measures to 100%.

What changes can we make aimed at improvement?

PDSA:
- Night team handover to be relaunched
- Roll out of patient transfer checklist.

Quality Improvement Project Update:

Ward moves risk assessed: inpatient move risk assessment completion rate kept above 97% in October and November 2018 and dipped to just under 97% in December.
OOH risk assessments: OOH risk assessment completion rate maintained around 97% until December, when it dipped to just over 91%.
The risk assessments are embedded practice, which includes monthly auditing to ensure standards are maintained.

Night time Handover :
This is now embedded. Data collection (hard copies) were started but were found to not add any value to the process. The register of attendance is now embedded and electronic works well.

Transfer Checklist :
The transfer checklist is being rolled out. ADNs asked to offer forward a programme of audit after one month of roll out. This is still to be completed

Project Name: (14) Pain Management

What are we trying to accomplish?

Setting Aims:
The message that we are getting from comments on Friends & Family tests and as secondary comments on complaints is that some patients feel that their pain has not been well managed. Our aim is to increase the number of ward based nurses competent to complete a pain score and timely reassessment.

How will we know that a change is an improvement?

Establishing Measures:
We will measure:
1. Is pain evaluated and documented each shift
2. Are patients satisfied with their overall pain management during their admission

What changes can we make aimed at improvement?

PDSA:
- Ongoing pain score training for acute wards
- Acute Pain Team auditing accuracy of pain scores on patients that they review.

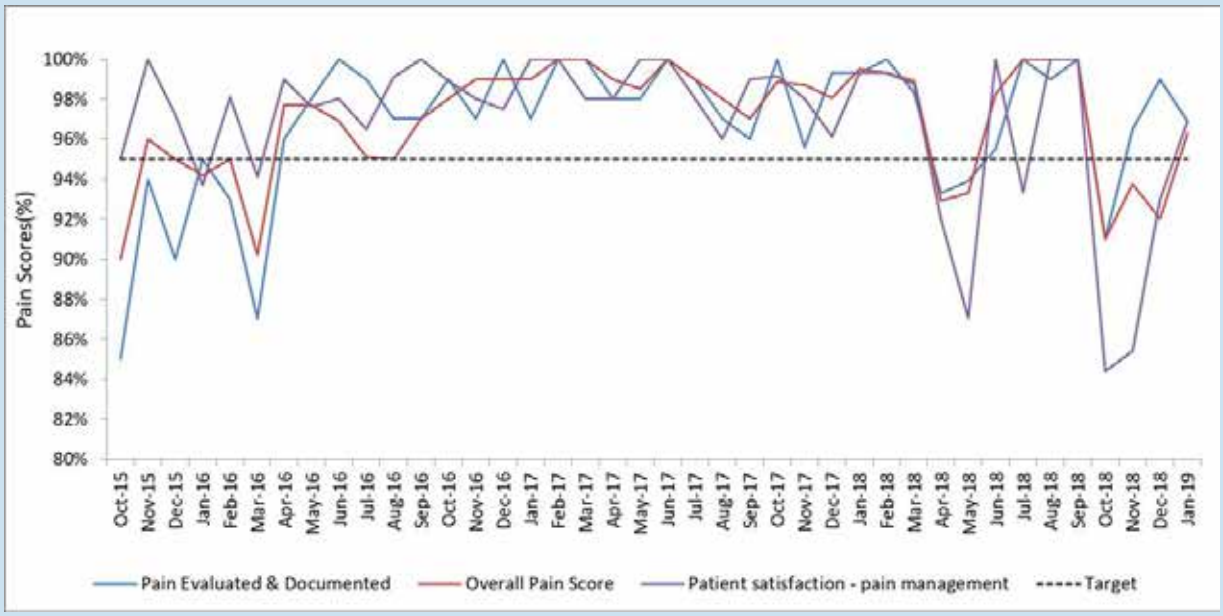
Quality Improvement Project Update:

1. Plan Training Schedule
Acute Pain Team members continue to deliver training requests and provide drop in sessions for departments if requested. Link Nurse meetings take place regularly. There continue to be monthly pain study days. No staffing issues which will affect the training schedule since full establishment achieved.

2. Monitor Pain Management QCI Data
Data continues to be collected on a monthly basis for all inpatient areas. The number of wards has increased in Q3 and there were inaccuracies in the QCI data recorded as a result. This has been corrected for this report. There is a sustained and significant improvement demonstrated through QCI's

3. Acute Pain Team to Audit accuracy of pain scores on patients they review
This audit is ongoing and reported monthly. Correlation between Ice referral scores and Pain Team demonstrate sustained improvement. HCA scores training continues. Acute Pain Team are now correlating the data so that there can be an increase in any specific learning gaps, and any common themes addressed

The project needs to be reviewed with Patient Experience lead to establish the number of complaints received regarding pain management as this project was a PDSA cycle



Project Name: (15) Time to Consultant Review

What are we trying to accomplish?

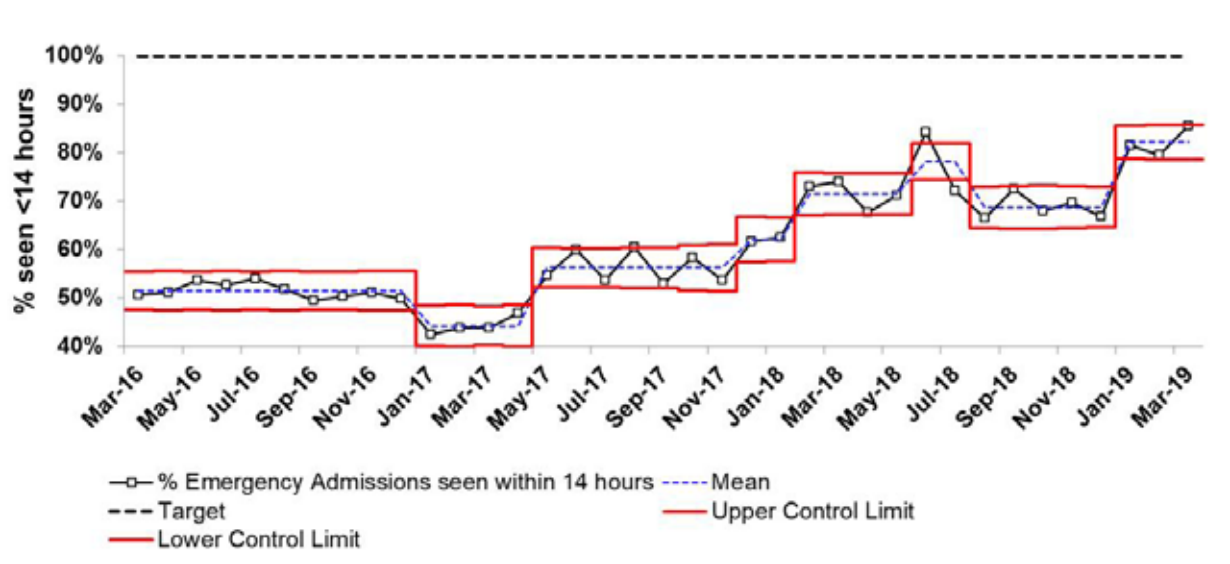
Setting Aims:
All patients should have Clinical review by a senior decision maker within 14 hours of admission irrespective of the day of the week. The new medical model implemented in Nye Bevan is expected to provide continuous presence of consultants for 13 hours (with 2 consultants) in the day for 7 days a week. The model also caters to consultant presence during peak hours of the day to avoid backlogs into the night. Hence it is expected to comply with set standards in Medicine. Also through review of other non elective services, including surgical specialties, oncology and haematology, this will further improve access to Consultants. This is already evident in the improvements in this area in the audit performed in Spring 2018.

How will we know that a change is an improvement?

Establishing Measures: Time to consultant review to be determined by biannual audit of clinical notes as recommended by national 7 day services sustainable improvement team. We currently have a plan endorsed by Quality and Governance Committee to assure Trust Board of the process of this service delivery.

What changes can we make aimed at improvement? The delivery of timeliness of review depends on how Consultant workforce are scheduled to facilitate this care and duration of the presence of consultants within the day to meet the demands placed on them.

	Autumn 2016	Spring 2017	Autumn 2017	Spring 2018
Clinical Standard 2: Time to 1st consultant review	71%	75%	72%	90%
Clinical Standard 5: Access to consultant directed diagnostics	N/A	89%	N/A	97%
Clinical Standard 6: Access to consultant directed interventions	N/A	89%	N/A	100%
Clinical Standard 8: Ongoing daily consultant directed review	Once daily 90% Twice daily 83%	90%	N/A	87%



Project Name: (16) WHO Safer Surgery Checklist

What are we trying to accomplish?

Setting Aims:
Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There are 5 Steps to Safer Surgery which are; Brief, Sign-In, Time-Out, Sign-Out and Debrief. The WHO Safer Surgery Checklist covers Sign-In, Time-Out and Sign-Out and should be used for every patient undergoing a procedure within theatres. The team meet for the Brief before the start of the operating list and discuss every patient on the list, identifying any issues. The Sign-In is a conversation between the anaesthetist and Anaesthetic Practitioner, as a minimum. The Time-Out and Sign-Out is a conversation between all members of the perioperative team. The Debrief is a conversation between all members of the team at the end of the operating list. We aim to improve staff engagement with these discussions, ensuring that all relevant issues are addressed and lessons are learnt.

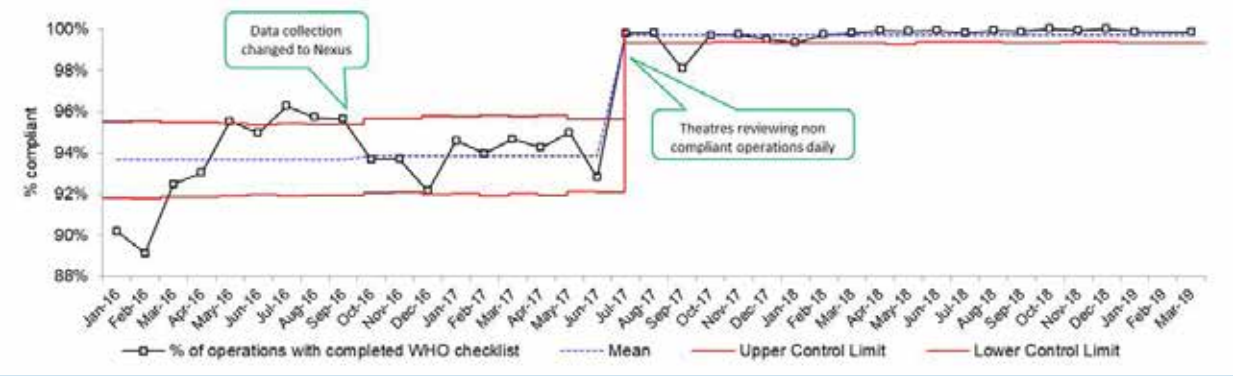
How will we know that a change is an improvement?

Establishing Measures:
We will measure the number of completed checklists versus the number of operations as a monthly spot-check, with the aim being that a checklist will be completed for 100% of operations. We will monitor the number of surgical never events with the aim being to eliminate them entirely. It is difficult to measure staff engagement in a conversation so we need to measure the impact of the increased staff engagement. This could be demonstrated through a reduction in issues arising during the list, which should be recorded on the Debrief Form.

Quality Improvement Project Update:

- Practice Educator for Theatres now in post
- MDT Human Factors training session Ophthalmology in November 2018
- A NatSSIPs / WHO Policy is in the process of being written by Amanda Bisset.
- Installation of some of the Brief whiteboards is still outstanding within Obstetrics and DSU

WHO Compliance Data for December 2019



Project Name: (17) To Reduce the Number of Stillbirths and Undiagnosed Small for Gestational Age Babies

What are we trying to accomplish?

Setting Aims:

To increase antenatal detection of small for gestational age babies by 50% by March 2019

NGH use the Perinatal Institute Customised Growth protocol (GROW). The GROW software programme calculates a baby's 'term optimal weight' adjusted for maternal characteristics such as height, weight, ethnic group and parity and produces a chart to predict the optimal fetal growth curve for each pregnancy. The customised growth charts are used for serial plotting of fundal height and estimated fetal weight measurements by ultrasound scan. The fundal height should be measured at antenatal assessments after 25 weeks but not more frequently than every 2 weeks.

The use of GROW charts have been shown to increase antenatal detection of intrauterine growth problems

To increase the number of women who are screened for smoking by 50% by March 2018.

The Preventing Avoidable Harm in Maternity Care Capital Fund is part of the commitment by the Government, and NGH had a bid approved to buy 75 carbon monoxide monitors, one for every community midwife and supplies for Antenatal Clinic and the Maternity Day Unit. The monitors will identify women that smoke and those at risk of passive smoking and they will have increased surveillance in a midwife led ultrasound clinic. Smoking in pregnancy can lead to miscarriage, stillbirth, premature birth and low birth weight. It also increases the risk of sudden infant death syndrome. A further bid was made to Charitable funds for an ultrasound scanner and we are in the process of developing a new pathway for the detection, investigation and management of small for gestational age babies.

How will we know that a change is an improvement?
Establishing Measures:
We will monitor:

1) The number of women who have a carbon monoxide measurement recorded at their booking appointment. For women with a CO reading of over 11ppm we will monitor how many of these women have extra antenatal surveillance which will include serial growth scans. We are aiming for a 50% increase in both of these measures.

2) The number of small for gestational age babies detected during the antenatal period will be monitored via the Growth Assessment Protocol (GAP). We are aiming for a 50 % increase in this measure.

What changes can we make aimed at improvement?

- Carbon Monoxide readings to be taken at antenatal booking appointments
- Develop pathway for detection, investigation and management of small for gestational age babies
- Multi-disciplinary review of all stillbirths, and ensure lessons learnt are shared
- Implementation of the National Perinatal Mortality Review Tool (NPMRT)
- Establish a rolling audit programme to monitor performance through:
  - The SGA rate (proportion of babies born with a birthweight below the 10th customised centile)
  - The rate of antenatal referral for suspected SGA and antenatal detection/diagnosis of SGA

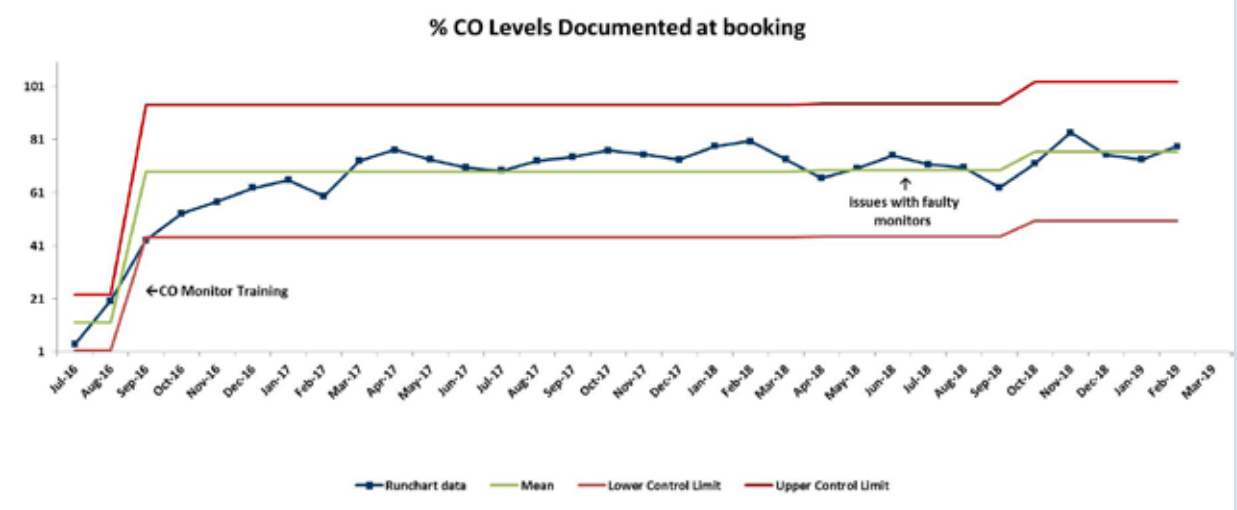
- Regular case-note audit of SGA/FGR cases that were not antenatally detected, and action plans on response to system failures
- Implementation of Stillbirth Care Bundle
- Implementation of Stillbirth Care Bundle

Quality Improvement Project Update:

1) To increase the number of women who are screened for smoking by 50% by March 2018

By March 2018 there was a 73.4% increase in the number of women who had a CO measurement taken at booking.

Women with a CO result of ≥ 4ppm are given a leaflet about the dangers to their unborn baby from smoking and will have an opt out referral to Northamptonshire Stop Smoking Service.

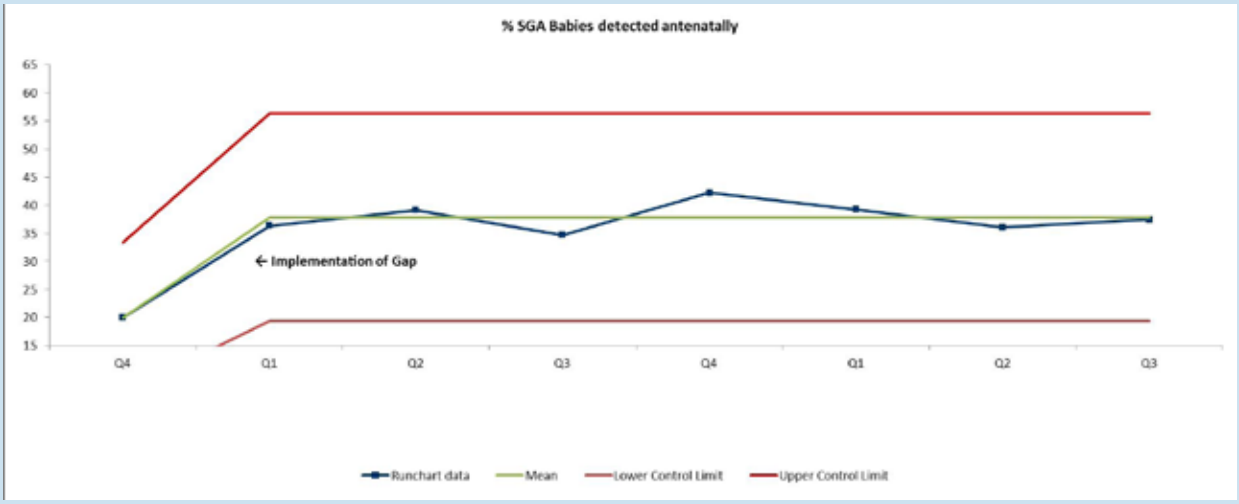


During 2018/19, CO measurements have continued to be taken at the booking appointment. There will always be some women who will decline to be screened. During the period April – September 2018 there were issues with faulty carbon monoxide monitors – these were returned to the manufacturers for replacement.

2) To increase antenatal detection of small for gestational age babies by 50% by March 2019

- Perinatal Institute's Growth Assessment Protocol (GAP) purchased and staff training undertaken as part of the annual skills drills training
- A random selection of records were audited on GAP from 2016/17 to establish a baseline of the number of babies with a birth weight below the 10th customised centile who were detected antenatally
- Review of the Management of Low Birthweight Babies guideline undertaken by Consultant Paediatrician to ensure correct neonatal observations are carried out when a baby birthweight plots below the 10th customised centile

The run chart below shows that the antenatal detection rates for SGA has increased from a baseline of 20% to a mean of 37.8% in Q3 2018/19 which demonstrates an increase of 89%



Implementation of the Saving Babies Lives Care Bundle – Version 2:

Northampton General Hospital NHS Trust have implemented all four elements of the care bundle but further improvement could be made. Version 2 of the Care Bundle is due to be released in March 2019. In order to be able to continue the quality improvement work required to implement and monitor progress, the maternity services will be recruiting a Band 7 Fetal Surveillance Midwife. This post will be the lead for quality improvement and audit for all four elements of the Saving Babies Lives Care Bundle.

STAFF AND CULTURE

Our aim is to nurture the energy and commitment of our workforce so that they can deliver the best possible care for our patients. We do this by aligning staff around our desire to continuously improve the experience, care and safety of our patients. To support this staff can access a range of Quality Improvement development opportunities to enable them to improve the care they give and the service they provide. This aim is reinforced through our 4 values, which we measure each year as part of our annual staff survey.

Since the values were introduced we have seen year on year improvement in staff being aware of the values and saying that they experience the values being lived each day. Our staff engagement score, measured through the annual staff survey, has also seen year on year improvement, being maintained at 'above average' compared to the national average in the 2018 survey.

We have also worked hard, and continue to do so, to make this a great place to work for staff. This has included supporting staff health and well-being which includes initiatives such as free health checks, providing and promoting physical exercise and social activities such as the NGH Choir. We are one of the very few NHS organisations that has signed up to the national 'Time to change' pledge, aimed at removing the stigma associated with mental health conditions and providing support to staff during difficult times.

We have implemented a programme of work to support staff maintain their emotional and mental well-being has been rolled out across the trust with many staff participating in this programme.

Recognising the national shortage of staff in some areas for example nursing, we have introduced and supported new roles such as The Nurse Associate and have a proactive recruitment strategy that has seen significant reductions in nursing vacancies and medical vacancies.

We are pleased to have established a junior doctors forum and undertaken a range of initiatives such as providing doctors with breakfast after a night shift and other such actions designed to improve the working lives of our junior doctors.

We recently changed our trust appraisal process (designed around our values) and through this we encourage our staff to reflect, learn and improve. To support this we have a comprehensive range of education and development programmes ranging from personal and professional development to leadership and management development programmes. In the 2018 staff survey we saw a significant improvement in staff saying that the quality of our appraisals process had improved, rating as 'above average' compared nationally to other trusts.

Our challenge remains that we need to do more to support our staff who work in an increasingly challenging environment and to this end we are in the process of refreshing our People strategy to take us into 2019/20 and beyond.

AUDITED INDICATORS

Our auditors, KPMG audited performance indicators:

1. This year the reporting of Clostridium difficile infection has changed nationally. Acute Trusts are measured against two new descriptors for 2019/20

- Hospital onset healthcare associated: cases that are detected in the hospital two or more days after admission (HOHA).
- Community onset healthcare associated : cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks (COHA).
- This is the first time that these new national descriptors have been used, the ceiling for these new descriptors is 40. So therefore, it is not possible to identify a reduction percentage.

2. FFT patient element score - For this year's quality account we will be aiming to achieve 94% on recommendation rate (inpatients) This rate does currently fluctuate, for May 2019 the recommendation rate was 92.7%, which will mean an improvement target of 1.3%. The aim the following year will be to achieve the national average of 95.7% (inpatients)

The information below summarises the findings of their report.

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

We are required to perform an independent assurance engagement in respect of Northampton General Hospital NHS Trust's Quality Account for the year ended 31 March 2019 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2019 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 2018 to June 2019;
- papers relating to quality reported to the Board over the period April 2018 to June 2019;
- feedback from the Commissioners dated 30 May 2019;
- feedback from Local Healthwatch;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 04 June 2018;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated January 2019;
- the latest national staff survey dated February 2019;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2019;
- the Annual Governance Statement dated 23 May 2019; and
- the Care Quality Commission's Inspection Report dated 08 November 2017.

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 2019:

- 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
Chartered Accountants
One Snowhill
Snowhill Queensway
Birmingham
B4 6GH

27 June 2019

HOW OUR QUALITY ACCOUNT WAS PREPARED

Priorities for Improvement

The traditional domains of quality include safe, effective, patient centered care and our quality priorities use these domains as a basis but take this further by focussing on continual improvement and aims to ensure that all our staff strive for excellence in all that they do and believe and support the organisational focus on delivering the "Best Possible Care".

We have listened to what our staff have told us is important to them, we have acknowledged lessons learnt from serious incidents complaints and concerns and we understand that we need to identify quality priorities that will maintain the progress achieved to date.

We will further improve the progress and outcomes to eliminate avoidable harm whilst using different approaches to increase the health and wellbeing of our patients and staff, responding to our patients and carers on what they consider to be important.

The five key work streams for our quality priorities are:

- Improving the safety culture at NGH by 10% from baseline
- Reduce the number of preventable harm events by 10%from 2018 baseline
- Efficient and effective outcome that will eliminate preventable early patient deaths by 10% from baseline
- Improve patient experience of care by 15% from 2018 baseline
- Improve the safety outcomes for maternal and neonatal care Reducing the rate of still births, neonatal death and brain injuries occurring by 20% from 2019 baseline by 2021

ANNEX 1

STATEMENTS FROM STAKEHOLDERS

Northamptonshire County Council

Ms Jane Bradley
Deputy Director of Quality Improvement & Safety
Northampton General Hospital NHS Trust
Cliftonville
Northampton
NN1 5BD

Please ask for: James Edmunds
Tel: 01604 366053
Our ref:
Your ref:
Date: 20 May 2019

Dear Ms Bradley,

Northampton General Hospital NHS Trust – Draft Quality Report 2018/19

Response from the Northamptonshire County Council Overview & Scrutiny Committee

As context for this response it should be noted that Northamptonshire County Council adopted a new model for Overview & Scrutiny (O&S) in September 2018. The new model is based on a single O&S Committee, with a remit that is strongly focused on the following areas:

- Delivery of Northamptonshire County Council's current budget and savings plans
- Development of the Council's future budget proposals
- Major risks to the Council, the local community and the county
- Engagement, alignment and support for the Council's improvement plans

The O&S Committee's remit includes the statutory function for scrutinising the planning and provision of health services in Northamptonshire. However, the prioritisation of the focus areas set out above, as well as the need to bring a newly-constituted Committee into operation, has necessarily minimised the amount of health scrutiny work that the O&S Committee has been able to do in 2018/19.

The O&S Committee formed a working group to consider and respond to local healthcare providers' draft Quality Accounts / Reports for 2018/19. The working group consisted of Councillors Mick Scrimshaw, Wendy Brackenbury, Gill Mercer and Christina Smith-Haynes.

The working group has the following comments on the draft Quality Report:

- The Quality Report uses a clear, readable layout. The content flows well. The formatting used to distinguish the different sections is helpful.

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Angel Street
Northampton NN1 1ED
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t. 01604 366053
e. jedmunds@northamptonshire.gov.uk

Northamptonshire County Council

- The depiction of the 16 posters presented at the International Forum on Quality & Safety in Healthcare 2019 is not clear and is therefore potentially counterproductive. The intended point could be made more effectively by depicting some representative examples of the posters in a larger size.
- NGH's improvement priorities for 2019/20 could be highlighted even more clearly at the start of the Quality Report.
- The working group considers that the chart in the Quality Report setting out NGH's 5 key success factors, respective enablers and measures and the timing for activity during 2019-21 gives the impression of aiming to convey more information than may have been intended. It questions whether a better format could be used.
- The working group welcomes NGH's commitment to participating in clinical research. The related section of the Quality Report is well set out and conveys a strong impression of NGH as a forward-looking organisation.
- The section of the Quality Report concerning performance against national quality indicators provides good information about how NGH's position compares with national data. On the other hand, the working group considers that there seems to be limited value in presenting data for areas such as emergency readmissions to hospital within 28 days of discharge where the vast majority of information has not yet been made available by NHS Digital.
- Information presented in the Quality Report relating to learning from deaths should be sufficiently explained and contextualised to enable the lay reader to take a reasonable view of NGH's relative performance. The working group considers that it would be helpful to provide more context when stating the number of NGH patients who died during 2018/19 to explain the significance of this number.

Yours sincerely,

Councillor Mick Scrimshaw
Chair, Overview & Scrutiny Committee

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30 May 2019

Private & Confidential
Sheran Oke
Director of Nursing, Midwifery and Patient Services
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By email only: sheran.oke@ngh.nhs.uk

Dear Sheran

Northampton General Hospital NHS Foundation Trust
Annual Quality Account – CCG Feedback May 2019

The Northampton General Hospital (NGH) annual quality account for 2018/19 has been reviewed by the Northamptonshire CCGs. It is noted this was reviewed whilst in draft format.

Part One
The Quality Account contains a statement summarising the trust's view of the quality of relevant health services it provided, the statement relating to sub-contracted services has been included in part two rather than part one. It may be helpful to consider re-sizing some of the information contained in part one as it may be difficult to read due to the small size of the print.

Part Two
Northamptonshire Clinical Commissioning Groups support the 2019/20 quality priorities as set by NGH in relation to improving patient safety, clinical effectiveness and patient experience. It would be helpful to include the actions the trust plans to take to achieve these and how they will be monitored.

The dates on the tables in relation to NHS numbers appear incorrect. Both tables including information about the payment by results clinical coding audit relate to quarter 1 and the plans to improve data quality have not been included.

It would be helpful to ensure that all of the acronyms in the mortality section are explained e.g. SJR. The section on patients with a learning disability or serious mental illness and the section on the number of deaths related to problems in care appear incomplete. The description of the actions taken relates Dr Foster alerts rather than the learning from mortality reviews.

The trust achievement for the Commissioning for Quality and Innovation (CQUIN) schemes for 2018/19 will need to be updated in the final report to reflect the year-end position. The current table does not accurately reflect where CQUINs have/have not been achieved. It would be helpful to include the impact of implementation of CQUINs on patient care.

Part Three
Achievement against the quality priorities for 2018/19 and performance against indicators and performance thresholds is included within the report, although it is not clear when targets have or have not been achieved. The trust could consider including some information about public sector equality duty and the workforce race equality standard within their update on leadership training and development.

Commissioners will continue to work closely with the Trust and support ambitions to sustain high quality standards of care for people who use services via incentivising quality improvements, quality review assessments and performance management.

Yours sincerely

Angela Dempsey
Chief Nurse and Quality Officer
Northamptonshire Clinical Commissioning Groups

cc: Michelle Metcalfe, Head of Governance, NGH

Healthwatch Northamptonshire statement on Northampton General Hospital NHS Trust (NGH) draft Quality Account 2018/19

During 2018/19 Healthwatch Northamptonshire has continued to represent the public and work with NGH through attending the Patient and Carer Experience and Engagement Group (PCEEG) and providing patient feedback. We also visited the Accident and Emergency department to talk to patients about their experiences of accessing care and thank NGH for facilitating this visit.

Healthwatch Northamptonshire believes that this Quality Account demonstrates in details the progress NGH has made against their 2018/19 Quality Priorities during the year.

We believe NGH has chosen appropriate Quality Priorities for 2019/20 and particularly support the inclusion of 'better communication', as issues with communication is one of the most common themes we hear about from members of the public and can have a big impact on patient, and family, experience.

Through attendance at the PCEEG we have continued to see the importance NGH places on improving quality and learning from patient feedback and support them as them as they work to ensure patient experience is considered by all staff.

The feedback we receive from members of the public relating to services provided by NGH is varied and much of it relates to specific examples of care. In 2018/19 Healthwatch Northamptonshire raised concerns with NGH about aspects of administration and capacity in the Ophthalmology Department and received a prompt and helpful response from the directorate manager providing reassurance and explaining the remedial actions being taken to address the issues.

We welcome the opportunity to continue to work with NGH to ensure that patient and public feedback is valued and leads to improvements across the Trust.

Kate Holt

CEO

Connected Together CIC (contract holder of Healthwatch Northamptonshire)

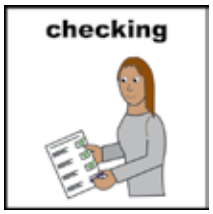
ANNEX 2

EASY READ PRIORITIES FOR 2019/20

These are things we will do to make your care better next year.

We will make sure you are safe by:

Finding better ways to make sure people do not hurt themselves.



Making sure we always check how we do things.

Understanding why people may fall over and who might fall over. Then make plans to help them.

We will always check how patients are feeling by:

Creating courses that help people get better.

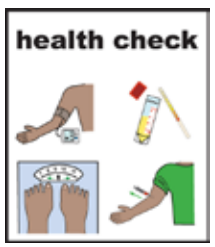
Getting more service users to help us decide who should work for us.

Finding more ways to help service users tell us what they think.

We will make sure your care is the best it can be by:

Sharing stories and information with our staff, to help us give better care.

Teaching our staff new ways to give you even better care.



Doing our best to always check your physical health.

ABBREVIATIONS

A	#	Fracture
	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

Prepared by Quality Improvement

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April 2019