Northampton General Hospital NHS
NHS Trust

Quality Account 2013/14

Northampton General Hospital NHS
NHS Trust

Our Vision

Northampton General Hospital NHS Trust (NGH) is committed to providing the best possible care for all our patients

Providing the **Best Possible Care**

Photo courtesy of Chronicle & Echo

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Part One

Statement on quality from the chief executive

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A Quality Account (QA) is a report produced annually by providers of healthcare in the NHS. It reflects the quality of the services they deliver when compared to national and local targets across a range of scoring systems. The process of producing a QA brings together a wide range of information that enables a broad assessment of quality standards and allows us to demonstrate our commitment to continuous quality improvement in order to provide optimum care.

This year has seen many changes in leadership at NGH and a significant change in the way we are monitored by the Care Quality Commission (CQC). Whilst we continue to focus on safety, effectiveness, and patient experience there have been challenges in respect of a 10% increase in emergency admissions and a consequent sustained pressure on inpatient beds.

A recent inspection by the CQC found our staff to be caring, that the hospital was clean and that infection prevention and control were good. The safety and effectiveness of services has been maintained, despite the overriding urgent care pressures. The report highlighted issues we knew we faced and were already working to address. Where there are problems we have recognised them and we know we have the capability to turn this round – we believe this is fundamentally a good hospital that is doing well to cope with the pressures that we have faced.

We are a hospital that can improve. We are receptive to feedback from regulatory inspections, our patients, staff and the public and are willing to learn so we can continue to improve the safety and quality of the services we provide. Our staff are supportive of one another and of our patients. They welcome opportunities to share their knowledge and expertise at the same time as being open to new ideas and learning.

This year we have seen huge improvements in the response rate to the Friends and Family test which means we have a better understanding of what you think of our services- and therefore we can work with you towards the continuous quality improvement we are trying to achieve.

Throughout the year we have continued to learn from our patients' experience, respond to their needs and ensure we follow best practice. Patient safety and the provision of high quality care remain at the forefront of all we do.

This document celebrates our successes during the past year, and I very much hope you enjoy reading the account of NGH quality achievements and welcome the exciting plans we have for further improvement in the coming year.

Dr Sonia Swart
Chief Executive

Statement of directors' responsibilities in respect of the quality account.

The directors are required under the Health Act (2009), National Health Service (Quality Accounts) Regulations (2010) and National Health Service (Quality Account) Amendment Regulation (2011 and 2012) to prepare a quality account for each financial year. The Department of Health (DH) has issued guidance on the form and content of the annual quality account (which incorporate the above legal requirements). In preparing the quality account, 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 that is consistent with
    - Internal and external sources of information including trust board minutes and papers for the period April 2013 to March 2014
    - Papers relating to quality reported to the trust board over the same period
    - The trust complaint reports published under regulation 18 of the Local Authority, Social Services and NHS Complaints Regulations (2009)
    - National Inpatient Survey (2013)
    - National A&E Survey (2013)
    - NHS Staff Survey (2013)
    - The CQC quality risk profiles and intelligence monitoring
- The performance information reported in the quality account is reliable and accurate
- There are systematic 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, 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 that to the best of their knowledge and belief they have complied with the above requirements in preparing the quality account.

By order of the Board

_____	29 May 2014	Paul Farenden	Chairman
_____	29 May 2014	Dr Sonia Swart	Chief Executive

Northampton General Hospital NHS
NHS Trust

Part Two

Priorities for improvement and assurance for coming year

Providing the **Best Possible Care**

Our Quality Strategy 2012-2015

The purpose of our quality strategy is to ensure we provide the best possible care for all of our patients.

'Equity and Excellence: Liberating the NHS' (DoH, 2010) sets out a vision for the NHS focused on improving quality and achieving world-class outcomes by ensuring that care providers:

- Are genuinely centred on patients and carers
- Achieve quality outcomes that are among the best in the world
- Refuse to tolerate unsafe and substandard care
- Reduce mortality and morbidity

There are significant challenges in delivering reliable, responsive healthcare influenced by increased public expectation, lifestyle changes, an ageing population, developments in technology and the current and projected economic context (which continues to bring significant financial challenges).

Our strategy sets out how we will respond to these challenges, keep quality at the heart of everything we do, and provide excellent are to our patients in line with the NHS vision.

Our Vision, Values and Aims

Our vision is to provide the best possible care for all our patients. we want to be recognised as a hospital that delivers safe, clinically effective acute services that are focused entirely on the needs of our patients, their relatives and carers. These services may be delivered from our acute or community hospital sites or by our staff in the community.

Our values

Our values are the behaviours against which we will be judged as we deliver our vision. They are:

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

We define quality as embracing three key components:

- Patient safety
- Effectiveness of care
- Patient experience

Our aims

In order to achieve our vision, the Trust has set out five strategic aims, all of which reflect our vision to provide the best possible care.

- Focus on quality and safety
- Exceed patient expectations
- Strengthen our local services
- Enable excellence through our people
- Ensure a sustainable future

2

This means our patients can expect to:

- Receive the right treatment, at the right time, in the right place in line with national guidelines
- Be kept safe from avoidable harm
- Be treated as individuals and have their needs addressed
- Be treated with compassion, respect and dignity
- Be kept fully informed and share in decision-making about their care
- Have any concerns addressed as early as possible
- Be cared for in a clean and safe environment

We define quality as embracing three key components:

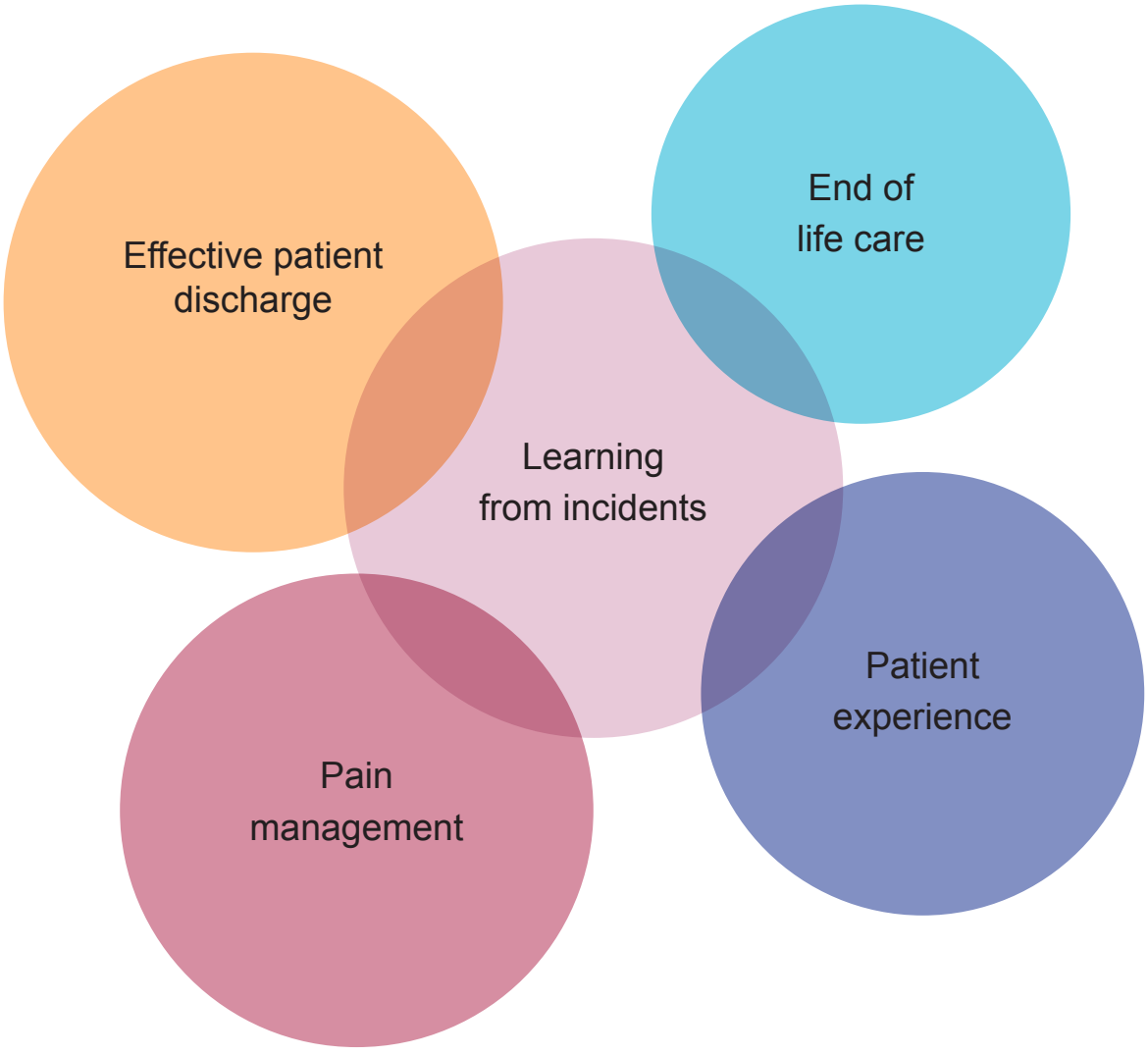
- Patient safety – there will be no avoidable harm to patients from the healthcare they receive. This means ensuring the environment is clean and safe at all times and that harmful events never happen.
- Effectiveness of care – the most appropriate treatments, interventions, support and services will be provided at the right time and in the right place to those patients who will benefit. Our patients will have healthcare outcomes which achieve those described in the NHS Outcomes Framework and NICE quality standards.
- Patient experience – patients will experience compassionate, caring and communicative staff who work in partnership with patients, relatives and carers to achieve the best possible health outcomes

A number of potential priorities were agreed by the trust board, following which they were subject to wide consultation and prioritisation with staff, patients, the public, public, our shadow governors, members and external stakeholders.

- Following review of the feedback received, the five work streams below were selected to demonstrate our commitment to quality in the coming year:
- Effective patient discharge – improving the process
- End of life care – using alternative care planning methods
- Learning from incidents – making better use of the information we collect to improve patient care and safety

- Pain management – focussing on the acute phase of care
- Patient experience – increase patient involvement in reviewing and planning services

Targets identified with the quality priorities have been compiled into a quality priority scorecard which we will use to measure incremental levels of progress through the year. This is reported quarterly to our integrated healthcare governance committee and included in the patient safety book reviewed by the trust board to enable ongoing corporate monitoring of progress in addition to providing local managerial oversight.



Effective Patient Discharge

Background

From feedback we receive from patients tells us there is room to improve on our processes for discharging patients from hospital. The factors influencing this are many and varied and we will be working hard during the coming year to ensure we fully understand the issues.

AIM :

We will improve our information and implement robust planning and monitoring processes to achieve a reduction in complaints related to discharge and improve patient satisfaction

2

AIM	Targets for achievement by end of March 2015
Promote planned early discharge on all wards	Overall 25% increase from the baseline in the number of patients who have planned early discharge from the wards
Ensure accurate recording of delayed discharges	Utilise the shared tracking list to promote ownership of discharges by our community partners and demonstrate a reduction in delayed transfers of care against the agreed baseline **(25%)**
Improve patient experience by timely delivery of TTOs to enable patients to be discharged with their medication and enable staff to educate patients in regards to their TTO medications before discharge.	Pilots undertaken in the following areas prior to implementation: - TTO (to take out) streaming in dispensary - Collingtree Pharmacist/prescriber early ward round (protected time) - Pre-pack medication introduced to Dryden and Eleanor - Pre-pack policy developed to make better use of existing pre-packs during working hours and speed up discharge - Streamline Sunday working hours to align with patients' needs Review data to determine if actions have supported a reduction in the number of patients who are discharged home without their medication and increased patient experience/ satisfaction with our services

End of Life Care

Background

Half of the deaths that occurred in Northamptonshire during 2012 were in one of the two general hospitals, so NGH is one of the main providers of end of life care in the county.

In 2013 we agreed to participate in a national project, Transforming End of Life Care in the Acute Hospital - The Route to Success. This programme highlights best practice in care supported by the National End of Life Care Programme, which is now part of NHS Quality Improvement. The practical support it provides enables us to work towards providing the best possible service to patients approaching the end of their life.

The AMBER Care Bundle – Assessment, Management, Best practice, Engagement with patient and relatives, for patients whose Recovery is uncertain. It was developed at Guys and St Thomas' hospital to improve the quality for care of people whose potential for recovery is uncertain, for whom active medical care may still be appropriate but have a probable life expectancy of up to two months.

Evidence collected suggests that AMBER:

- improves decision making
- provides a positive impact on multi-professional team communication and working
- increases nurses' confidence about when to approach medical colleagues to discuss treatment plans
- ensures patients are treated with dignity and respect
- provides clarity around preferences and plans about how these can be met
- significantly lowers emergency readmission rates.

AIM :

To improve end of life care and care of the dying

AIM	Targets for achievement by end of March 2015
Implementation of AMBER Care Bundle on an identified ward with a named consultant to lead	Project launched based on the AMBER Care Bundle outcomes for patients who died on the identified ward and those who died within 100 days of discharge from the identified ward Action plan developed to roll out AMBER across the Trust
Develop leadership in End of Life Care across the Trust through the Quality End of Life Care (QELCA) training programme	Present course content and design to be reviewed following participant feedback NGH to liaise with Cynthia Spencer Hospice and identify a training course for 2014/2015 using existing NMET funds Five participants identified and training undertaken

Learning from Incidents

A good reporting culture indicates an open and healthy environment where staff are willing to learn from their mistakes.

Background

When things go wrong we need to find out why they happened so we can take the necessary steps to avoid a recurrence and make Northampton General Hospital NHS Trust an even safer environment for patients and staff. We can only do that if we know about the things that might cause problems. That's why our staff are constantly encouraged to report all incidents or mistakes which may have a negative impact on safety or quality of care.

2

Evidence shows us that teams, departments, and organisations reporting more safety incidents are much more willing to learn from their mistakes and this promotes an open and healthy culture.

Whilst the incident reporting rate within NGH is slightly above the national average when compared to other medium sized acute trusts, there is room for improvement and we aim to be in the top 25% of reporters by the end of March 2015.

Through achieving this, our aim is to maximise the opportunities to learn from experience, which is a core part of any risk management strategy. The initiatives planned in the coming year will ensure that robust processes for both organisational and individual learning is in place, which if effective will result in an increase in the number of incidents being reported but a decrease in the number of incidents which result in harm to patients and staff.

AIM:

Improve learning from patient safety incidents and ensure that lessons learnt are used to improve patient safety and quality of care

AIM	Targets for achievement by end of March 2015
Ensure that patient safety incidents, where harm has occurred are robustly investigated, root causes are identified and appropriate actions are put in place to reduce the likelihood of reoccurrence.	Develop and implement training for staff on root cause analysis Agreement and roll out of action plan assurance pathway. All action plans from incidents where harm has occurred will be uploaded to HealthAssure Deliver root cause analysis (RCA) training Monitoring of action plan progress on HealthAssure and overseen by the serious incident group Evaluation of RCA training that has taken place by quality checking incident investigations, identification of root causes and action plans developed and implemented. Evidence of completion presented to the Serious Incident Group The trust aims to be able to demonstrate that similar root causes are not being identified when harm occurs

AIM	Targets for achievement by end of March 2015
Ensure that lessons learnt from incidents where harm has occurred are shared across the organisation and the wider health economy as appropriate.	We aim to demonstrate that by sharing lessons learnt there will be a reduction in the number of similar incidents occurring within the trust. By the end of March 2015 there will be an increase in the number of positive responses in relation to lessons learnt from incidents where harm has occurred in the QuEST audits

Pain Management

AIM:

To improve the overall management of acute pain control across the trust and reduce incidents, poor patient and family feedback and complaints

AIM	Targets for achievement by end of March 2015
Gain an understanding of the factors affecting acute pain management in NGH and reduce number of incidents. To monitor improvements and compliance with key performance indicators (kpi) as listed	Benchmark position in respect of complaints and incidents relating to pain management including complaints/FFT/ Datix All relevant complaints and incidents to be forwarded to the pain team Ensure pain remains on the NEWS (National Early Warning Score) chart and is completed by all staff (training) in all departments. Pain management added to the monthly patient safety dashboard Incidents reduced each quarter by an agreed percentage
Ensure relevant materials are available to support staff	Review and revise pain assessment tools trust-wide, focussing on A&E, medicine and maternity, including patient-controlled oral analgesia (PCOA) in maternity. Revised documentation to be consulted upon, approved and disseminated.
To raise awareness of available material Increase use of link nurse network to raise awareness and ensure that all areas access available training	Website use to be promoted for acute pain support documents Education leaflets to be developed for staff and patients Group clinical supervision to be developed, training level set and delivered Improvement in training levels to be evaluated

AIM	Targets for achievement by end of March 2015
Increase resources available to the acute pain management team	Increase physical staff resources within the team by developing and submitting revised business case and recruiting relevant staff following approval. Prioritise service delivery within available resources
To improve pain management resources available for patients To be able to provide/ offer more comprehensive psychological assessment and treatment	Offer a more comprehensive psychological assessment and treatment to prevent recurring admissions with pain control issues, including patients with substance misuse issues Identify alternative treatment and support options where appropriate Consider the possibilities of referral to clinical psychology and substance misuse specialists where this is identified as being in the patient's best interest

2

Patient experience

Background

The involvement of patients and the public is core to healthcare reform and achieving a patient-led NGH. As a healthcare organisation we will listen to, understand and respond to patients and public opinion, perceptions and expectations to ensure their views continue to inform ongoing improvement work. Involving patients and the public in planning and development of health services became a statutory duty to NHS Trusts in January 2013, (S242 of the NHS Act 2006.) We have appointed a patient experience lead who will co-ordinate and lead our patient experience agenda.

AIM:

To co-ordinate, monitor, feedback and engage with our patients on their experiences, and work collaboratively to improve in areas where patients are voicing dissatisfaction

AIM	Targets for achievement by end of March 2015
Integrate current patient and public involvement with patient experience	Review Patient & Public Involvement activity and strategy Develop patient engagement network (PEN) Clarify roles and responsibilities for members of PEN
Ensure the patient experience strategy reflects partnerships with patient and public involvement	Review and revise patient experience strategy and develop patient experience and engagement strategy. Ratify new strategy through patient experience board
Improve the patient experience at ward level	Ward sisters to be responsible for co-ordinating patient feedback and sharing with their staff. This will include: Patient story/complaints/compliment at the beginning of each ward meeting Share FFT, complaints and compliments with their ward team through ward meetings, huddles and 1:1 Review FFT scores and comments, and co-ordinate improvement plans to address areas of dissatisfaction Feedback to patient experience lead work undertaken and outcomes
Improve the patient experience at directorate level	Engage PEN within service improvement/directorate work Develop the role of 'critical friend' with PEN to contribute to trust service improvements
Improve the patient experience at a trust-wide level	Trust board and senior forums to begin with patient story Corporate projects/workstreams to include PEN representative Patient experience projects to be fully supported by PEN Feedback and outcomes from patient experience activities co-ordinated and shared through patient experience lead.

AIM	Targets for achievement by end of March 2015
Achieve national CQUIN (Commissioning for quality and innovation)	Work with HealthWatch, Age UK and other external agents to support the patient experience strategy Develop structured feedback from task and finish groups, audit engagement and project leads
Continue to roll out the Friends and Family Test (FFT) to outpatients and day case areas	Identify an external technology solution for capturing FFT data throughout the organisation Roll out FFT in outpatients in line with CQUIN requirements

How progress will be monitored, measured and reported

The patient experience strategy and improvement plan will be monitored through the receipt of monthly reports on progress to the patient experience board and integrated healthcare governance committee.

Northampton General Hospital NHS
NHS Trust

Part Three

Review of 2013/14 performance

Review of 2013-14 performance

Snapshot of performance activity to 31st March 2014

Activity Comparison	2012-13	2013-14	Diff	% Diff
Emergency inpatients	32,379	35,907	3,528	11%
Elective inpatients	7,087	7,329	242	3%
Elective daycases	38,616	38,052	-564	-1%
New outpatient attendances - consultant led	75,387	77,973	2,586	3%
Follow-up outpatient attendances - consultant led	140,633	152,425	11,792	8%
New outpatient attendances - nurse led	36,578	39,775	3,197	9%
Follow-up outpatient attendances - nurse led	78,247	81,535	3,288	4%
Total number of outpatient DNAs	21,942	26,513	4,571	21%
Patients seen in Accident & Emergency	98,075	107,786	9,711	10%
Number of babies born	4,655	4,573	-82	-2%
Average length of stay (in days)	4.65	4.60	-0.05	-0.01%

During 2013-14 the trust achieved the following key standards:

- Trust-wide referral to treatment (RTT) standards for admitted and non-admitted patients across all specialties
- All two week wait cancer standards
- 31 day cancer standards for first treatment and all subsequent treatments
- 62 day standard from screening
- 6 week diagnostic waits
- C Diff trajectory

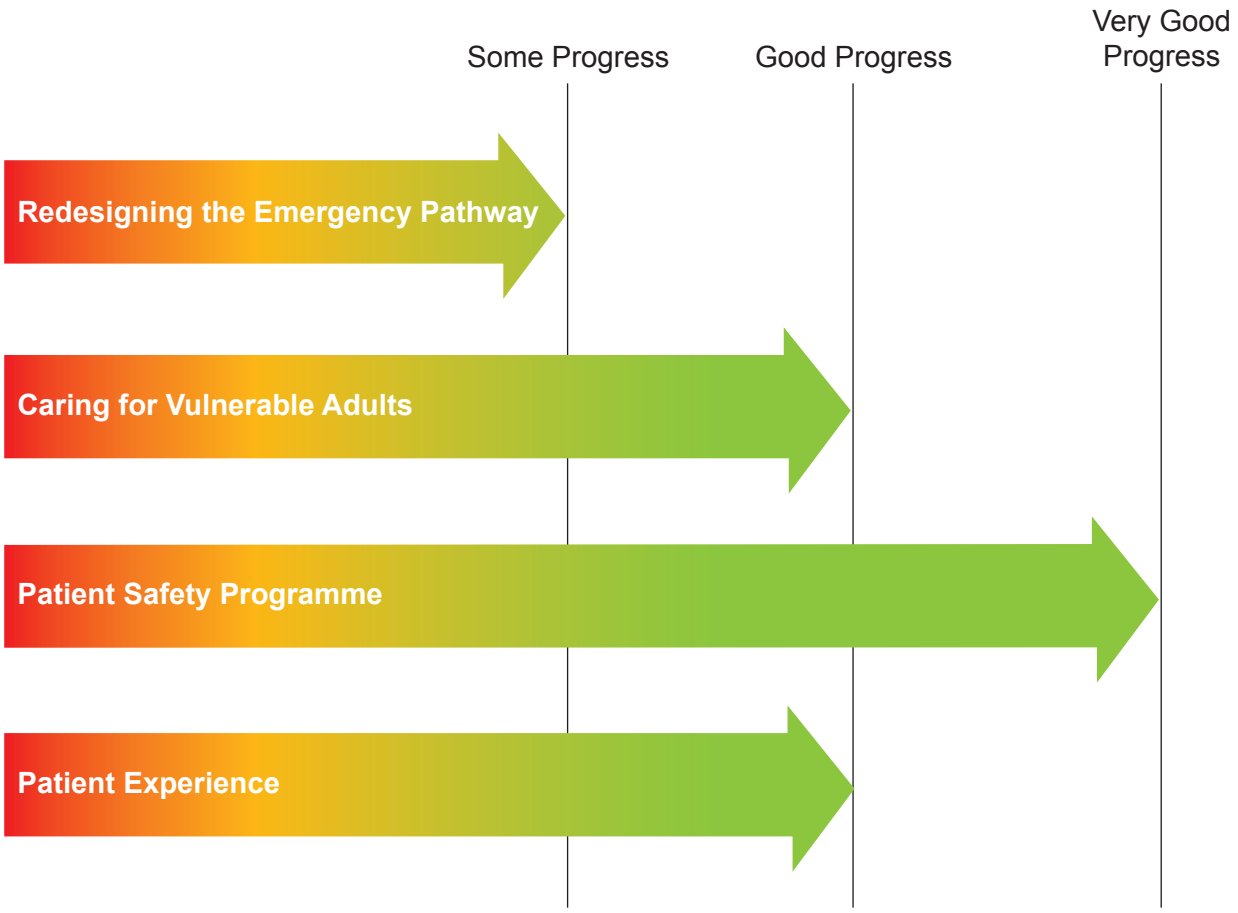
The following standards were not achieved:

- The quarterly and year end 62 day cancer standard from urgent GP referral
- The quarterly and year-end 4 hour A&E target

The 62 day standard from urgent GP referral to start of treatment remains a challenge to the trust. We will focus on developing robust plans to achieve this standard quarterly, working closely with University Hospitals Leicester NHS Trust.

Review of 2013-14 performance

The diagram below summarises the priority workstreams for quality innovation in 2013-14 and the progress achieved.



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Quality Priority One - Emergency Care Pathway

Our aim

- **Improve patient care in A & E and throughout the patient journey**

Demonstrated by

- 95% of patient waiting less than 4 hours in A&E
- Assessment and treatment implemented promptly
- Introduction of ambulatory care pathways and admission avoidance schemes

We have achieved

- Ambulatory Care Centre opened in September 2013 - now seeing more than 100 patients/month
- Commenced 2 hour safety rounds
- Introducing a system to indicate seriously unwell patients (red flags)
- Implemented a rapid assessment model (FIT)

3

Our aim

- **Improve patient flow to reduce delay and improve clinical outomes**

Demonstrated by

- All patients being assessed, treated and discharged onward from A&E in a timely manner
- All patients having an initial assessment within 15 minutes of their arrival
- Radiology and pathology tests results being avialable within one hour
- 50% of hospital discharges happening before 1.00pm each day
- Planned discharge dates linked from wards to the visual hospital system

We have achieved

- An improvement due to better emergency department (ED) processes and rapid assessment. However, this was offset by increased numbers of patients seen in the department.
- Some improvement on the entire patient discharge process
- Dispensing of medicines to take home are prioritised by the pharmacy department
- Electronic management system launched. At any one time approximately 90% of patients have an estimated date of discharge
- Development of improved handover documentation between wards

Our aim

- **Improve patient safety and experience**

Demonstrated by

- Improved discharge planning
- Reviewing performance and promoting multi-disciplinary working to reduce the number of patient interventions
- Patients having an estimated discharge date (EDD) recorded and shared with them
- Safety and experience - a reduction in infection and mortality rates

We have achieved

- Developed improved handover documentation between wards
- Changes to staff on-take rotas to ensure continuity of care
- Approximately 90% of patients have an expected discharge date recorded within the system at any given time
- A full range of measurements are recorded as part of the urgent care programme
- Reduction in infection and mortality rates

Our aim

- **Reduce bed occupancy to improve patient experience and reduce harm**

Demonstrated by

- Reduce bed occupany on all wards to below 90%
- Reduce the number of patients who had been in hospital for more than 10 days to less than 210

We have achieved

- Progress has not been as expected due to ongoing increased numbers of A&E attendances which have resulted in delays in patient flow
- High levels of bed occupancy has resulted in failure to meet A&E targets and a specific workstream is in place to break the cycle
- Availability of community beds is a critical factor and this matter is being addressed by the urgent care working group who meet weekly with all health partners attending

Quality Priority Two - Caring for Vulnerable Adults

Hospitals are very confusing places for patients with dementia and they may feel lost and frightened. The importance of a dementia friendly environment is recognised by the Trust and we have started to make some changes to our wards

Our aim

- **Deliver dementia training in line with our dementia training strategy**

Demonstrated by

- Training provided at an appropriate level for all staff who engage with and/ or care for patients with dementia

We have achieved

- Dementia education strategy developed and training delivered throughout the year
- More than 50% of all registered nurses and healthcare assistants working in the identified inpatient areas have received training in demntia care
- Improved the quality of care and experience for patients with a learning disability

3

Our aim

- **Improve the quality of care and experience for patients with a learning disability**

Demonstrated by

- Accessible feedback process developed to enable patients with a learning disability to provide feedback on their experience in a meaningful way
- Audit of the use of tools avialable to support the care of patients with learning disabilities, including the hospital passport
- Review of the learning disability awareness and communication training and evaluation of how attendance on the training influences practice in supporting patients with a learning disability

We have achieved

- Pilot of an accessible patient feedback tool that enables patients with a learning disability to give feedback on their experience of care in hospital. To be implemented across the trust following evaluation.
- Monthly audits undertaken to monitor compliance in relation to implementation of the Mental Capacity Act (MCA) in clinical areas. Current compliance is 80%.
- Learning disability awareness and communication training and evaluation completed

Our aim

- **Improve the quality of care and experience for patients with a learning disability**

Demonstrated by

- Accessible feedback process developed to enable patients with a learning disability to provide feedback on their experience in a meaningful way
- Audit of the use of tools avialable to support the care of patients with learning disabilities, including the hospital passport
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- Monthly audits undertaken to monitor compliance in relation to implementation of the Mental Capacity Act (MCA) in clinical areas. Current compliance is 80%.
- Learning disability awareness and communication training and evaluation completed

Our aim

- **Improve the way we manage the care of people with dementia**

Demonstrated by

- Develop and implement a pathway of care for patients with dementia

We have achieved

- New dementia focus group established, led by a trust governor, which consists of service users and staff working closely together. They have undertaken a dementia audit and carer interviews. The feedback will help us plan what changes we need to make.
- A dementia pathway has been developed to help staff understand the principles of dementia care and guides them regarding the care of their aptients.
- To help patients become familiar with the hospital environment we have introduced colour coding to identify different bays. Dementia-friendly clocks have been purchased for all wards, mounted on ward orientation boards. Work is underway to introduce pictorial signage for toilets and bathrooms.

3

Our aim

- **Improve the quality of care and experience for those with dementia**

Demonstrated by

- Dementia action committee agreed the trust action plan 2013-14
- Dementia care action committee has overseen implementation of the plan

We have achieved

- The trust has adopted a butterfly symbol to identify patients with dementia on the wards, which alerts staff that those patients may require extra support. We have continued to develop and embed work around ‘butterfly care’ and introduced an additional outline butterly symbol to be used where patients do not have a dianosis of dementia on admittion, but have evidence of cognitive impairment.
- Each ward and department has identified a dementia champion who has received bespoke training and is kept up-to-date with developments in dementia care. This individual is the single point of contact for staff and acts as a role model, resource and support to promote best practice in dementia care.

Our aim

- **Develop patient and carer information in an appropriate format for patients with dementia and learning disabilities**

Demonstrated by

- Demonstrated by
- Developing an integrated approach to the development of accessible information for different treatment options.

We have achieved

- Easy-read leaflets developed for ultrasound scans, including those for pregnant women
- Easy-read quality outcomes developed.

3

Our aim

- **Deliver the dementia CQUIN target**

Demonstrated by

- Improving awareness and diagnosis of dementia by raising the profile

We have achieved

- Improved our partnership working with carers when patients are admitted to hospital. We have developed an information leaflet that is available for carers of patients with dementia and signposts them to services they can access. We have undertaken a monthly audit of carers of patients with dementia to understand whether they feel supported and the results generally are very positive.
- We delivered the dementia CQuIN

Quality Priority Three - Patient Safety Programme

Our aim

- **Embed the safety strategy for improvement and the safety programme, which has a focus on sustaining and developing educationa and learning**

Demonstrated by

- Monitoring safety academy progress
- Monitoring progress against project objectives via monthly project plans
- Leadership for safety rounds for executive and non-executive board members
- Standardised safety boards introduced at all ward entrances displaying public and staff information on quality and safety, any areas of concern escalated and the monthly quality assurance audit
- Academy safety-based presentations for multi-disciplinary teams
- Increased simulation training for all staff disciplines

We have achieved

- Ongoing monitoring of progress against project objectives
- Currently 34 projects are encompassed within the safety academy's portfolio, with 138 measurements monitored and reported monthly to the board for further scrutiny and challenge
- Leadership safety rounds now part of the monthly board agenda. Executive and non-executive directors visit wards and talk to patients and staff, with a focus on a specific theme. Progress and outcomes from board to ward meeting are fed directly back to the clinical teams and reported via the quarterly patient safety clinical quality and governance report.
- Safety boards are on display at the entrance to all wards and audts are taking place
- The target of 8 presentations to multi-disciplinary teams has been achieved.
- The target of training 1,000 staff has been achieved.
- As part of the safety strategy, the target to recruit 70 patient safety champions was exceeded and as at March 2014 there were 240 multi-disciplinary safety champions in place at NGH.

3

Our aim

- **Reduce harm from failure to plan care so that all patients and staff have an improved understanding of the plan of care in place and approriate action can be taken.**

Demonstrated by

- All directorates submit data as part of the healthcare records audit
- An electronic handover system developed and embedded
- Time to conslutant review within 12 hours of emergency admission to be audited against the national target of 14 hours

We have achieved

- Improvement in data and an overall improvement in the reduction of inpatient death and avoidable harm
- Mortality and safety information provided by Dr Foster intelligence monitoring and measured via hospital standardised mortality ratio (HSMR). There is a detailed monitoring process in place to track HSMR and investigate individual diagnosis or areas for concern. HSMR for the first half of 2013-14 fell to 86 (516 deaths against 590 expected).
- Corporate roll-out of electronic handover system has taken place
- The consultant review target is consistently achieved

Our aim

- **Reduce harm from failure to rescue so that every acutely ill or deteriorating patient is recognised immediately adn all appropriate actions taken**

Demonstrated by

- A 50% improvement in measures relating to failure to rescue
- Early Warning Score (EWS) trust-wide monthly compliance
- Improved compliance with the sepsis care bundle and an audit in A&E of first hour time to antibiotics

We have achieved

- A focused escalation campaign has produced significant progress with regards to early identification in escalation of the deteriorating patient. The 50% target has been exceeded and 60% compliance has been achieved.

Our aim

- **To learn from serious incidents (SI) and error and human factors safety science**

Demonstrated by

- Improved communication between clinical staff regarding learning from serious incidents and complaints
- A monthly compliance audit with the WHO (World Health Organisation) safer surgery checklist
- Serious incident lessons learned and best practice presented at the patient safety learning forum
- A serious incident template established for local learning and sharing best practice

We have achieved

- A revised process for investigating serious incidents and learning from error was introduced during 2013-14 which has resulted in greater ownership and sharing of lessons learned. Action plans associated with serious incidents have a robust reporting, implementation and assurance process in place. Assurance is monitored via the care group governance team, which is overseen by the medical director.

Our aim

- **A reduction in harm resulting from failure to deliver care so that every patient receives improved essential care**

Demonstrated by

- Safety culture questionnaire developed which gives a baseline for local safety performance
- Monthly safety related questionnaire facilitated by the safety champions
- Point prevalence safety questionnaire undertaken to audit and measure performance, results analysed and shared trust-wide
- Bi-annual safety culture questionnaire

We have achieved

- Safety culture and climate questionnaires continue to be monitored by the aptient safety academy
- Safety champions gain the view of their colleagues or audit practice in clinical areas
- Safety champions invited to attend the patient safety board where learning is discussed and shared

Quality Priority Four – The Patient Experience

Our aim

- **To produce a patient experience strategy for improvement and a patient experience programme outline to be approved by the board, including setting up a patient experience board**

Demonstrated by

- Patient experience board formed, with quarterly reporting in place
- Patients and shadow governors routinely involved in service design and development
- Second year of the patient experience strategy implemented and progress monitored monthly by the patient experience board
- Implementation of the patient experience plan
- Appointment of a full-time patient experience lad
- Developing patient experience champion and care group patient experience lead roles within clinical areas
- A serious of trust-wide projects to explore how the patient experience could be enhanced
- Bi-annual safety culture questionnaire
- Develop a serious incident emplate for local learning and sharing best practice

We have achieved

- Year 2 of patient experience strategy implemented and key objectives achieved. The strategy is now being reviewed to reflect the next steps in the patient experience journey
- Comprehensive analysis of all patient experience-related projects undertaken and a number of workstreams identified. These will shape the implementation plan for 2014-15.
- Substantive, ful-time patient experience lead joined the trust in September 2013
- Five patient experience champions identified to date from a range of services
- Dignity champion identified within each ward, supported by the patient experience lead
- Information regarding the patient experience collected via the Friends and Family Test, ward inspections, surveys in relation to maternity services and mealtime experience, as well as national surveys. In addition the trust has commissioned additional surveys within neonatal and outpatient surveys which will take place in 2014-15.
- Series of improvement projects to be developed and taken forward during 2014-15

Our aim

- **To ensure the experiences of our patients, their families and carers are positive, supportive and conducive to their health and wellbeing at every stage of our patients' care pathways in line with our aim to provide the best possible care**

Demonstrated by

- Ensuring the patient experience is at the heart of planning and performance management, with related objectives in every business plan
- Real time monitoring of the patient experience at ward and department level
- Achieving a step change in our national survey of adult inpatient resuls over the next 3 years
- Establishing a baseline Friends and Family test response rate and achieving improvement from 10% to 20%
- Working with our Patient Advice and Liaison Service (PALS) to identify early detection of themes in relation to issues or concerns
- Identify themes and plan service changes accordingly

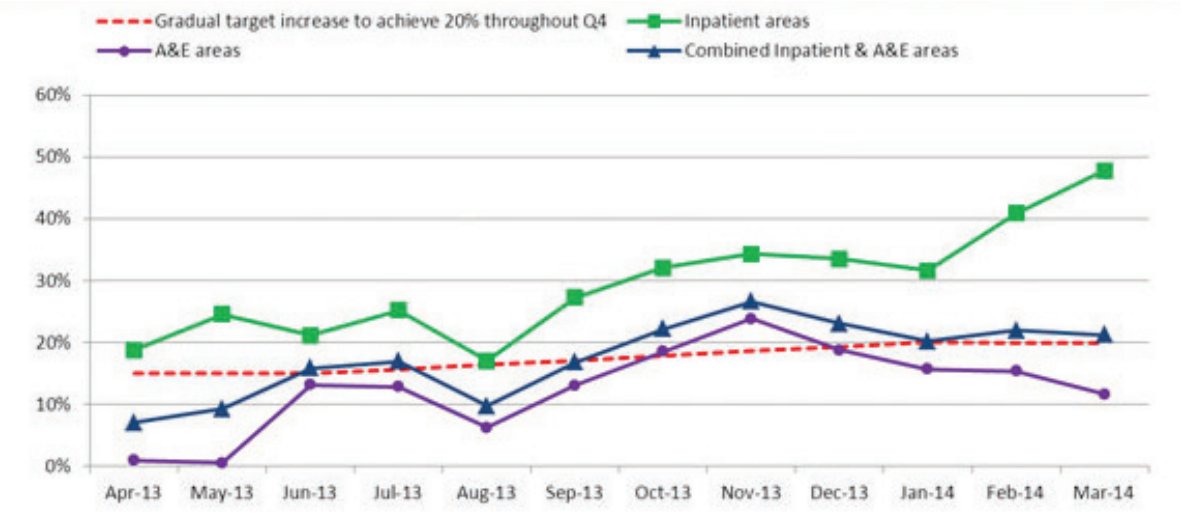
We have achieved

- 2013-14 has seen demonstrable changes in the Friends and Family Test collections, particularly through progress of response rates within inpatients and A&E. This is discussed in more detail below.

2013-2014 saw changes in the Friends and Family Test collections, with one of the largest developments seen through the progress of the response rates within Inpatients and A&E. The year began with a combined response rate of just over 7%, with the highest response rate of 26.67% seen during November 2013. A reduction in response rates in A&E during March 2014 is attributed to the pressures experienced within the department.

	Q1			Q2			Q3			Q4		
	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Gradual target increase to achieve 20% throughout Q4	15.0%	15.0%	15.0%	15.7%	16.4%	17.7%	17.9%	18.6%	19.3%	20.0%	20.0%	20.0%
Inpatient areas	18.78%	24.53%	21.13%	25.17%	17.05%	27.26%	32.13%	34.30%	33.53%	31.59%	40.87%	36.05%
A&E areas	0.97%	0.57%	13.16%	12.87%	6.23%	13.08%	18.52%	23.82%	18.78%	15.70%	15.37%	11.87%
Combined Inpatient & A&E areas	7.09%	9.27%	15.88%	16.93%	9.7%	16.84%	22.17%	26.67%	23.06%	20.18%	21.99%	18.32%

Between April 2013 and March 2014 response rates there was an overall increase of 11.23% for inpatients and A&E combined. For inpatients alone, there was an increase of 17.27% and for A&E 10.97%.



We successfully increased the combined FFT response rate to over 20% within Q4, which meant we achieved the attached CQUIN:

CQUIN criteria (IP & A&E only) Period: Q4 2013-14 1st Jan to 31st Mar 2014	Total responses in each category for each ward								Target = 20%	Target yet to be agreed
Month	Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely unlikely	Don't know	Total no. of people eligible to respond (discharged)	Total responses for each area	Response rate	Score for each ward/area
Jan - 14	1045	294	28	11	23	26	7073	1427	20.18%	70
Feb - 14	1114	301	19	10	21	18	6743	1483	21.99%	73
Mar - 14	949	308	39	21	26	23	7455	1366	18.32%	64
Q4	3108	903	86	42	70	67	21271	4276	20.10%	69

• *10% improvement of the FFT net promoter score*

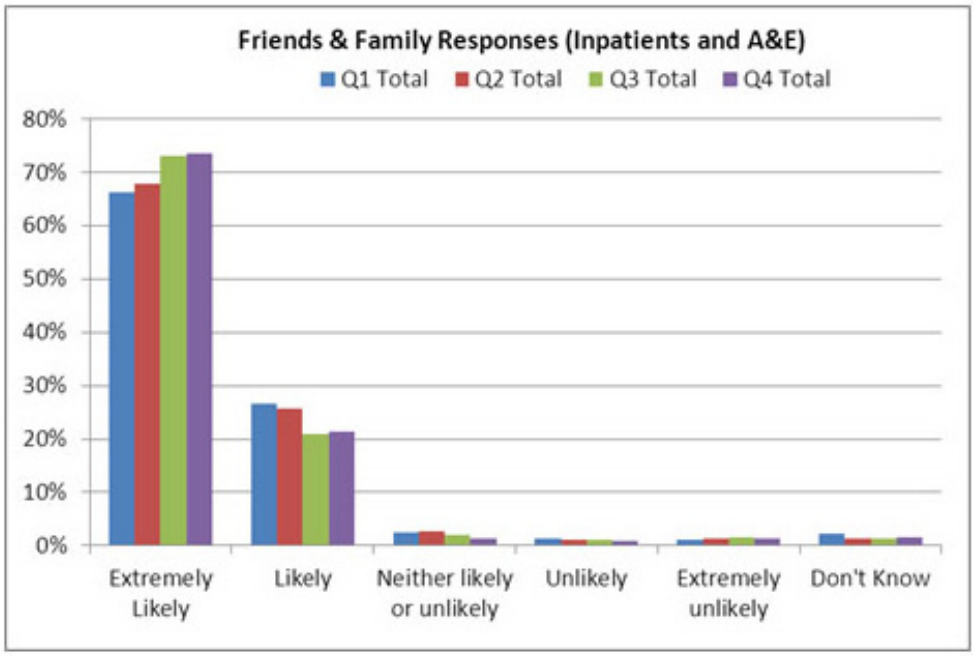
The Net Promoter Score (NPS) for both inpatients and A&E was tracked throughout the year. A&E (including eye casualty and ambulatory care) saw a steep rise in the NPS during the year, from a score of 20 in April 2013 to a score of 74 in February 2014.

The NPS for Inpatients fluctuated throughout the year. The lowest score of 63 was obtained in April 2013, and the highest score of 74 was obtained in September 2013. Overall, however, there was an increase of 9%.

Net Promoter Score Test Results	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
2013-14 Inpatient Score Results	63	68	67	69	70	74	68	64	71	67	71	69
2013-14 A & E Score Results	20	55	57	55	61	55	67	72	72	72	74	59

The combined figures for inpatients and A&E show an overall increase of 9% in the Net Promoter Score, which is just below the improvement target.

We also saw an increase in the number of 'Extremely Likely' responses, with the highest number of 1114 in February 2014 compared to 349 in April 2013.


Friends & Family Responses (Inpatients and A&E)
Q1 Total
Q2 Total
Q3 Total
Q4 Total
80%
70%
60%
50%
40%
30%
20%
10%
0%
Extremely Likely
Likely
Neither likely or unlikely
Unlikely
Extremely unlikely
Don't Know

Northampton General Hospital NHS
NHS Trust

Part Four

Showcasing Improvements in NGH

SHOWCASING IMPROVEMENTS IN NGH

Service Quality and Safety

Our QuEST for excellence

To assure ourselves that we are delivering the high quality care our patients have a right to expect, during 2013-14 we introduced a new programme of internal inspections, QuEST (Quality, Effectiveness, Safety Team) reviews.

QuEST reviews are a comprehensive rolling programme of visits by teams of reviewers (staff, shadow governors and patient representatives/members of the trust) to every ward and clinical area in the hospital to assess how well each is performing against key standards of practice.

The reviews take the form of unannounced inspections. Each month our matrons review the wards as part of a peer review process. Each quarter a full QuEST review is undertaken by a team of three/4 people, which includes a patient representative or shadow governor. Key information is made available to the team in advance of the review such as performance data, any recorded serious incidents, complaints, Care Quality Commission notifications, safeguarding referrals etc.

The results of the QuEST reviews are shared with the ward and clinical area teams; areas of good practice and any improvements identified are then shared across the organisation in order to promote wider learning.

Nurse Staffing

In March 2013 the board approved an additional investment of £1.9 m to increase the number of nursing staff at the hospital as part of the wider nursing and midwifery strategy to address both nursing numbers and skill mix. To date this has resulted in more than 120 additional nurses being recruited.

This forms the first part of a 4 year nursing & midwifery strategy to address both nursing numbers & skill mix. This commitment for the future will ensure we can provide the best possible care for our patients.

The trust is committed to taking the strategy forward, with investment where needed, to ensure we have the staffing levels we need in order to provide the best possible care for our patients.

NGH Nurse Training Scheme – A model of best practice

In March 2013 the government endorsed a recommendation made in the Francis Report that nurses should work as healthcare assistants (HCAs) for at least a year in order to complete their training. The Open University (OU) requires all students to be an HCA before starting on their nurse training scheme and, when this was highlighted as good practice, the OU in turn recommended NGH as a successful site for Health Education England (HEE) to visit and speak with staff about their experiences.

One of the students commented: 'Since the Francis report there has been a lot of talk about compassionate care, but you can't teach somebody to be compassionate. You can use role models - It's an innate ability and by working as a healthcare assistant your managers can see somebody who is showing that compassion which is so important in nursing. Working as a healthcare assistant means you understand that basic nursing care and you develop that within your team.'

Improving the ward round

One of our Patient Safety Academy workstreams has focused on making improvements to the ward round, utilising available skills with the overall aims of improving team and patient communication, expediting discharge of those who are ready and improving safety.

Some ward rounds now often consist of a consultant, junior doctor and nurse working to the ward round template. This assures a consistent approach and ensures ward rounds run efficiently, effectively and safely.

Technology plays a part in the new style round, with the use of digital dictation and a computer on a trolley. The junior doctor uses the computer to order tests; the consultant dictates the notes and these are printed off after being typed up rather than being hand-written. This frees up the doctor's time and has improved the content of the notes, which are more accurate and legible. Ordering tests at the time of the ward round means departments such as radiology can plan more efficiently.

Patient Experience

- *Implementation of year two of the patient experience strategy*

  Year two of the implementation of the strategy has been successful with many of the key objectives achieved. Patient experience within the trust has moved at such a pace within 2013 that the strategy is being reviewed in March 2014 to take into consideration the next steps in the patient experience journey.

- *Successful implementation of the patient experience plan*

  As with the strategy, the implementation plan has had many successes and is being reviewed in March 2014, in line with the revision of the patient experience strategy to ensure it represents the progress which has been made to date and the plans for the next financial year.

A comprehensive thematic analysis was undertaken in September 2013 of all patient experience related projects conducted covering an 18 month period. These projects were quality reviewed to ensure the data produced was valid. Those that were deemed as good quality were analysed

using qualitative methods to identify common themes. From this, a number of work streams have been identified. This work will largely shape the implementation plan for the next financial year.

- *Appointment of a full time patient experience lead*

  The substantive, full time patient experience lead joined the trust in September 2013.

- *Development of the planned patient experience champion and care group patient experience lead roles within the clinical areas - currently being redefined*

  Five patient experience champions have been identified to date within the trust from a range of different services including maternity, oncology and opthalmology. The trust is currently in the process of defining their roles in line with the new strategy and identifying the work which they will support moving forward. In addition to these roles, the dignity forum run by one of the patient experience champions has identified a dignity champion within every ward in the hospital. The patient experience Lead now sits within the dignity forum and will be supporting the dignity champions in undertaking patient experience related improvement projects.

- *Commencement of a series of projects across the trust which explore how patient experience could be enhanced using 'experience based design' methodologies (King's Fund).*

As mentioned previously, a great deal of work has been undertaken with the thematic analysis to understand the true picture of patient experience within the organisation. In addition to this a number of old and new metrics have been identified or reconfigured to ensure the trust is routinely collecting real time data on patient experience. A large part of this is the Friends & Family Test, but in addition to this, for example, the trust carries out quarterly and monthly ward inspections through the QuEST programme, Hospedia surveys related to maternity services and mealtime experience. On top of the locally run metrics, the trust is making good use of the national surveys, including the commissioning of additional surveys such as within neonatal and outpatients, both of which will run in 2014/2015. It was considered important to ensure the trust had a good understanding, and a comprehensive means of monitoring progress, before large improvement work was undertaken.

The trust is now at a stage to begin a series of improvement projects and the King's Fund Experience Based Co-Design (EBCD) will form a large part of that improvement work. Close links have been identified with workforce development and organisational development for how best to take this forward and the programme itself will commence in 2014/2015.

Friends and Family Test

The Friends & Family Test (FFT) asks patients at the point of discharge whether they would recommend the hospital ward, A&E department or maternity service to others if they needed similar care or treatment. This means every patient attending a ward or department at NGH is able to give their feedback on the quality of the care they received, providing the hospital with an opportunity to gain a better understanding of the views of patients, and helps to identify where changes need to be made. All the scores are tracked to see whether the areas are improving or if scores are decreasing, in which case this will be followed up. The response rates and scores are also available to the public via the NHS Choices website.

NGH has opted to include a free-text question 'What is the reason for the answer you have given? This then allows patients to leave a more detailed comment. These comments have proved very helpful and the information provided has meant we have been able to make immediate common themes across the services and link any working groups aimed at improving patient experience directly to the issues identified by our patients.

Sample comments from the Friends and Family Test:

> Fantastic doctors and nurses. We have received excellent care and would like to say a big thank you. Truly wonderful staff who do a great job.

> Excellent service from staff. A bit of a wait but that is to be expected, and the treatment received easily made up for the wait. A great service. Many thanks

> Wonderful nurses, dedicated and kind - the long hours they work shows strain on them at times. Very well cleaned ward. Food served hot and palatable, good choice - would prefer more fruit (not hard apples!) Rather noisy - a can of machine oil on wheels would help.

> Staff were excellent day and night. I was taken for physio nearly every day. Every member of staff on the ward has been helpful and kind. I could not have received better treatment if I was at the London Hilton. Thank you to everybody.

> The ward staff are all so nice and work so hard to make your stay as pleasant as possible, under the circumstances. The only difficulty is how hard it is to sleep at night with all the activity and the challenges of non-cooperative patients. Your staff all deserve medals for their patience, kindness and cheerfulness.

Public and Patient Involvement

As a result of comments such as those above we have been able to make improvements and are working closely with our patient advice and liaison service (PALS) to ensure early detection of themes in relation to issues or concerns.

Sir Bruce Keogh stated *'All trusts need to review their quality performance reporting to ensure it is measuring the right things, triangulated effectively to identify risk areas and is tested through systematic assurance programmes'*. At NGH we have created an effective way to triangulate information relating to our patients' experience across PALS, patient experience, complaints and incidents.

The National Inpatient Survey 2012 identified a number of areas where we needed to improve. Based on the survey findings, improvement and work has been undertaken throughout the year to address the issues of concern.

The results from 2013 inpatient survey demonstrate areas of significant improvement when compared with the 2012 survey.

Public and Patient Involvement Strategy

The patient and public involvement (PPI) strategy approved by the patient experience board (PEB) in July 2013 provides direction to the steering group.

A number of user groups and forums are active within the trust, including:

- **Disability Advisory Partnership Group** An audit carried out by Northamptonshire Association for the Blind (NAB) of the eye department indicated need for dedicated drop off point, clearer signage, better colour scheme and improved lighting

- **Maternity Focus Group** – Patients supported the design of the new birth centre by informing the colour scheme of the unit, birthing rooms, furniture, furnishings and amenities.

- **Infection Prevention Focus Group** – Following concerns regarding visitors' compliance with hand hygiene the group devised a questionnaire to identify the level of knowledge and awareness of infection prevention amongst patients and other hospital users. The results were fed back to the infection prevention team

- **Cancer Partnership Group** – The cancer partnership are evaluating the lung cancer patient/carer experience as a baseline for the lung project. They are working with patients who have gastro–intestinal problems on their experience of the diagnosis stage and also helping us develop a cancer survivorship event.

- **Dementia Focus Group** – Established in late 2013 the group is chaired by a shadow governor and made up of service users and carers with interest in or experience of people living with dementia. They work with members of the trust's dementia action committee to monitor and improve the experience of patients with dementia and their carers whilst at NGH. They are currently developing a project to explore the experiences of carers of patients with dementia within the hospital.

- **The NGH Black and Minority (BME) Sub-Regional Partnership Group** – Meets quarterly and, at their request, have received presentations on a variety of topics including elderly care, stroke, organ donation, sickle cell anaemia and A&E.

In addition to the groups and forums there have been two task and finish groups established to review noise at night and protected mealtimes.

The noise at night group identified a number of environmental issues within the wards and direct changes were made as a result of their observations, such as introducing soft closing bins. However, we continue to have issues in relation to noise at night and we will continue to look at ways of addressing this and make further changes during the coming year.

The future of PPI

It is evident that PPI is growing and we acknowledge the breadth of expertise and experience patients and members of the public can bring into the organisation. Plans have begun to reform PPI and ensure that it is more closely aligned to patient experience, in particular the identified work streams which are being established based on patient experience data. This will involve creating a new patient and public engagement network (PPEN) made up of patients, members of the public, shadow governors, carers, volunteers and members, all of whom will be given opportunities to be involved in a range of structured, planned activities throughout

the organisation. This will include patient experience data collection, peer review, service development and task and finish groups.

As is evident above, there are many focus groups active within the organisation and systems need to be established to ensure the hard work they undertake is shared widely throughout the trust. In addition to this we acknowledge the need to work closely with our external stakeholders, including (but not exclusively) Age Concern, HealthWatch, The National Association for the Blind, Deaf Connect, MIND and Alzheimer's UK.

For true collaboration the voice of the patient needs to be heard throughout all areas of the organisation and we believe that 2014-2015 will be the year that PPI truly becomes embedded into the structure of the organisation.

Improvements in Cancer Services

Nurse-led skin cancer clinics

Nurse-led clinics began in the dermatology department in January 2012, supported by the skin cancer multi-disciplinary team. The original clinics were set up to see people who were coming back to receive their test results and diagnosis. The clinics enable many patients to be seen at this stage. They are provided with a clear understanding of their condition, introduced to the key worker role, receive written information and a thorough holistic assessment. Since the nurse-led clinics began, the number of patients referred to this service for face-to-face contact has increased by 15%, as the service has become better known by relevant staff.

To complement the clinics there is a nurse-led follow-up service for patients with a low risk condition. Patients are seen every three months over the year after their diagnosis. The nurse specialist has completed a Master's degree level training in skin lesion recognition to prepare for this role. There is also ongoing nurse-led appointments for more intensive assessment and support for people through all stages of their illness.

Results of a survey sent to people seen over a six month period were favourable. Of 49 people surveyed, there was a 78% response rate, and 79% of respondents gave a maximum satisfaction score of 10. No-one surveyed said they would rather have seen a doctor than attend the nurse-led clinic.

Macmillan cancer support service moves to a new home.

The hugely successful Macmillan cancer information and support service at the Northamptonshire centre for oncology has recently moved to a bigger and better centre provided by the trust and is expanding the service they offer.

The service offers free, good quality, comprehensive information and support to people affected by cancer, their relatives, friends and carers. They have a huge resource library including books, leaflets, videos and audio tapes. The centre is staffed by a Macmillan information specialist and information assistant who are supported by volunteers, many of whom have personal experiences of cancer and are trained to provide appropriate emotional support.

The service has now moved to a larger area on the ground floor of the oncology department. The size of the new centre means there will now be appropriate space for Macmillan welfare benefits advisers to attend and offer a financial advice outreach service.

There are also plans to offer complementary therapies in the new centre and link in with the look good feel better workshops which teach women how to manage the visible side effects of cancer and its treatment.

Group support for cancer patients

We see a large number of patients with colorectal cancer from Northampton and the surrounding area. Our clinical nurse specialists recognise that, because of the nature of colorectal cancer, many patients need support to come to terms with their diagnosis and the long-term effects of treatment. Patients tell us that they simply want someone with whom they can share their experience.

In response to patient feedback we sent out invitations to patients who had completed treatment but were still receiving follow-up care. The first meeting was very well attended and was used to let patients explain how they felt and find out what they wanted from a support group. The group agreed that meetings should be open not only to patients who had completed treatment, but also to those still receiving treatment and those whose cancer cannot be cured. The group now meets every two months and continues to grow. Each meeting begins with an informative talk from an external speaker and the remaining time is devoted to open discussion.

Managing unscheduled Care.

Ambulatory care centre reduces hospital admissions

A new ambulatory care centre (ACC) opened during the year where some patients referred from their GP or A&E are seen, treated and sent home within a single day, thereby avoiding the need to be admitted to hospital.

We have received very positive feedback from patients who might previously have been kept in a hospital bed overnight for investigations and subsequent aftercare. The centre creates a better experience for the patient because their care needs can be met on an outpatient basis rather than them being admitted. We are trying to change the traditional thought that patients must be admitted in to a hospital bed to receive the best care. The ACC has the potential to provide high quality emergency care and a good patient experience in a cost effective way, which is becoming apparent through the results of our Friends and Family Test scores.

Number of A&E consultants doubles

The busy workload of A&E departments has been well documented by the media. Some areas are struggling to recruit consultants in emergency medicine but at NGH, while there is no doubt that our emergency department is seeing record numbers of patients, we have doubled the number of consultants employed.

Between November 2013 and February 2014 we welcomed four new consultants to our emergency department, bringing the total number to eight.

Cliftonville ward helps us make best use of bed capacity

Some NGH patients who have completed their hospital treatment and are awaiting community care packages or residential placements are transferred to Cliftonville ward – which is part of Cliftonville Care Centre on the hospital site.

All patients remain under the care of NGH until they are ready to go home, with a dedicated consultant who performs two weekly rounds. The centre offers a varied leisure and recreation

programme to our patients, a cinema and landscaped gardens. It also has a visiting hairdresser, barber and chiropodist, whose services are available to patients who are cared for in an excellent facility designed to help them prepare for discharge.

Intermediate care intravenous service and diabetic foot team

People with diabetes are prone to frequent and often severe foot infections requiring admission to hospital. Diabetic foot infections take up more bed days in the UK than all the other complications of diabetes combined. The intermediate care team and diabetic foot team work with our staff to either discharge patients home earlier on intravenous (IV) antibiotics or avoid a hospital admission.

The home IV service has become an increasingly important facility for our patients. Where possible it offers patients choices about where they receive their treatment. Over the last few years we have seen younger patients present with diabetic foot infections which we know will require many weeks of treatment. As patients often feel well they don't want to stay in hospital and we are delighted to be able to offer such a service.

Improvements in Specialist Services

End of life care

In March 2013 we signed up to the national transforming end of life care programme, route to success. Our end of life care facilitator and Macmillan specialist palliative care clinical nurse specialist completed a train the trainer course to deliver QELCA (quality end of life care for all) training. We also worked with the University of Northampton to write and publish the end of life care workbook which provides nurses with a competency framework.

We developed a training programme in end of life and palliative care for nurses and healthcare assistants using theory and simulation learning. In October 2013 we completed a national care of the dying audit and await a report from the Royal College of Physicians. We will then develop a local action plan for quality improvement. In preparation for this work we undertook a baseline audit in March 2014 using a national Amber care bundle proforma. Our end of life care strategy is currently out for consultation. The final document will take account of the feedback received.

Maternity antenatal pathway redesign

We have redesigned our maternity antenatal pathway to improve safety. This includes longer opening hours for the maternity day unit and a maternity observation ward for higher risk women.

Barratt Birth Centre gives choice of birth options

With the opening of the new Barratt Birth Centre in December 2013, we now provide a complete range of choices to women who are due to give birth. Our midwives and maternity care assistants work with women and their families where appropriate to plan the labour and birth that women want.

Women at low risk of complications during pregnancy are given the choice of having their baby in their home or in the new birth centre, which bridges the gap between a home birth and an obstetric labour ward, providing pools, double beds, en-suite bathrooms and kitchenettes in an altogether more homely and calming environment, but with the benefit of having expert medical support close by should the need arise. While a majority of women experience a normal

pregnancy and birth, our labour ward provides care for women and babies who need additional monitoring and care throughout labour and birth.

One of the first mums to use the centre commented:

> 'I couldn't have wished, planned or asked for a more perfect birth. I had complete faith in the NGH team and, although the birth was monitored closely from start to finish, it all felt so natural that it could have been just me and my husband in the room. I was allowed to make the decisions, and nothing was hurried or interfered with It didn't stop after our little bundle arrived either! I was lucky as I was the only lady in labour at the time, but the midwives cared for all of us intently after the birth, not leaving my side until I was completely recovered. After giving birth at 19:53, I was home by 23:30 that night – not because anyone was in a hurry for us to leave, but because everything was so calm and well that it felt right.'

Additional special care baby unit cots

The SCBU has been open to 20 cots since the end of September 2013 following additional staff coming into post. This has had a positive impact on the maternity service as well as for the community and the network in which we operate.

By increasing the capacity here at Northampton we have not only reduced the risk of family separation but are also able to accommodate babies from the network which reduces further distances for other families to travel.

Gosset parents' room

After a year of planning and fundraising, the Gosset ward parents' room has been officially opened. A mother who has used the room in the past was invited to cut the ribbon to formally open it in a ceremony attended by some of the fundraisers and medical staff. The room, which is the first step for parents when preparing to take their baby home, was refurbished from donations of over £15,000 and has been described as a 'home from home'.

Child health care

The consultant schedule has been rearranged to enable more senior medical staff input to be provided much earlier in the child's or young person's care pathway. We now have one consultant who takes responsibility for the inpatient activity, focussing on the ongoing care of the child or young person, and another consultant dedicated to the emergency care pathway, seeing children newly referred to us by their GP, A&E etc. This change led to investigations being undertaken earlier, thereby facilitating safe earlier discharge or a decision to admit for ongoing investigations or care being made much earlier.

Hysteroscopic sterilisation

In 2013 a sterilisation procedure using the Essure device was introduced into the gynae endoscopy unit, providing women with a choice between the traditional operative procedure and a minimally invasive one. Sterilisation using the Essure device requires no anaesthesia or abdominal surgery. This reduces risk to patients as the procedure can be carried out in an outpatient setting.

Photodynamic therapy (PDT) in dermatology

We are grateful to a national charity that donated a most up-to-date PDT treatment lamp to our dermatology department in September 2013. Photodynamic therapy is a treatment that uses a photosensitizer, and a special light source to produce a form of oxygen that kills cancer cells. A drug (photosensitizer) is applied as a cream, and the patient returns 3 hours later to have the light treatment.

A review by NICE noted efficacy in precancerous skin conditions and non-melanoma skin cancers including basal cell carcinoma, Bowen's disease, and actinic keratosis following treatment.

PDT is a nurse-led service provided under the supervision of a consultant and as part of the work we do we collect information to enable future audit and potential research. Since November 2013, the department has treated over 40 patients. Most patients have tolerated the treatment well and with high patient satisfaction and good cosmetic outcomes.

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New dedicated parkinson's disease (PD) service at NGH

Our aim is to provide the best possible care for PD patients in line with the national guidance, which includes holistic care with multiple disciplines being involved. The PD service has rapidly grown since its inception in April 2012 from about 50-60 patients seen in a general elderly medicine clinic to about 200 patients, 150 of whom are now regularly seen by the consultant. This is in addition to patients who are seen in the general neurology clinics.

After specialist medical assessments patients are referred onto other services like nurse clinics, physiotherapy, occupational therapy, SALT (speech and language therapy) assessments, memory clinics, Parkinson's UK and, if required, to the tertiary centres. The service is in line with NICE guidelines and the national Parkinson's disease audit outcome requirements, which NGH takes part in.

An inpatient service for PD is being developed and currently about 3-4 patients are being reviewed a week. However, this number is projected to increase over time. We expect the service to expand to about to about 300-350 patients in the next 3 years. This will mean we will need to provide more outpatient and nurse led clinics. Efforts are underway to develop a PD multi-disciplinary team, an advanced PD service with apomorphine and to pilot a PD dementia service, as well as improving the existing inpatient service to improve patient care and experience. A county-wide Northamptonshire PD forum has been set up with a view to improving care for patients with PD and also to network, disseminate knowledge and provide training countywide with meetings being held twice a year.

Accolades

Midwives shortlisted for "Excellence in Maternity Care" Award.

Three midwives were shortlisted for an 'Excellence in Maternity Care' award from the Royal College of Midwives in January 2014. They planned and implemented a birth after caesarean (BAC) clinic to help reduce the number of women electing to have a caesarean section.

Regular clinics and workshops help women and their partners to make informed choices about their birth options. Out of women choosing to have a normal birth following a caesarean over 80% will be successful, which is higher than the national average. The risk associated with caesarean section is reduced, recovery time is quicker and there is usually a shorter hospital stay.

What Our Patients Say About Us

A summary of the results of the 2013 national inpatient survey is shown below:

Northampton General Hospital NHS Trust	%	Number
Responded	54	447
Did not respond-including opted out or ineligible	46	403
Eligible cases	100	850

The Care Quality Commission (CQC) has published the results of the 2013 survey of adult inpatients, which includes a random sample of Northampton General Hospital (NGH) inpatients treated between September 2013 and January 2014.

NGH achieved a rating of 'about the same' as all other NHS trusts in England in 58 scores, and a 'worse' rating in just two. But eight of the scores showed a statistically significant improvement on the last survey, including the overall patient experience result which increased from 7.6 to 8.1.

We are pleased to see that some important scores - including overall experience, privacy and dignity, answering of call buttons, and being involved in decisions about care and treatment - have shown a significant improvement. None of the scores showed a decline.

We would like to improve on the rating of 'about the same' as other hospitals, as we aim to provide the best possible care for our patients. We have an active patient experience strategy, and we are working very hard to ensure that the experience of all our patients now and in the future is 'better than other hospitals'.

We can see from the results of the 60 survey questions there is still a lot more we can do, particularly around patients being bothered by noise at night, and delays in being discharged from hospital. Various actions are under way to address these issues, and improvements are expected to be shown in the next annual survey.

Over recent years the hospital has continued to see a rise in the number of emergency admissions many of which are often complex cases. As these take place at all hours of the day and night, it can be difficult for us to always guarantee a quiet night's sleep on every ward, but we will continue to do all we can to help eliminate the noise situation.

Improving the safety and quality of care is the hospital's main priority. We fully understand that a patient's experience isn't just about whether their treatment was a clinical success. It also means listening to and acting on individual patient concerns, including such things as how we talk to patients, how clean the hospital is and the quality of the food. We won't rest until we get it right.

What Our Staff Say About Us

Results of the 2013-14 staff survey

NGH undertook the NHS National Staff Survey between October and December 2013. With a response rate of only 42% we recognise the increasing need to improve staff engagement and make positive changes.

The results show that we are above average in relevant training, which represents a significant improvement on the previous year. Reporting of errors and incidents is also above average, so we have a clearer picture of where mistakes are made which means they can be rectified. We have also significantly improved in our recommendation by staff as a place to work or receive treatment.

Key areas for improvement:

- Support from immediate managers
- Appraisal rates
- Health and safety training
- Work related stress, work pressure and working extra hours,
- Effective team working,
- Witnessing potentially harmful errors, near misses or incidents,
- Fairness and effectiveness of incident reporting procedures
- Feeling pressure to attend work when feeling unwell
- Physical violence and harassment and bullying

Key issues identified by staff are:

Resources (staffing)

Staff involvement and communication

Pay and feeling valued

However there were a number of positive perceptions by staff who feel:

- they are trusted to do their job
- their role makes a difference to patients and service users
- they always know what their work responsibilities are
- their organisation does not blame or punish people who are involved in errors or incidents
- the trust encourages an open culture of reporting errors and incidents
- they know who the senior managers are
- they are satisfied with the quality of care they give to patients and service users
- team members communicate closely with each other to achieve the team's objectives
- they are able to do their job to a standard they are personally pleased with
- they have clear, planned goals and objectives for their job.

What We Heard Through Complaints and Compliments

Our aim is to make local complaint handling a positive experience. Through the 4Cs (comments, concerns, complaints, compliments) members of the public are provided with a range of options to choose from.

Our front line staff provide initial support and advice, while further advice and information is available to patients, their families and carers from our Patient Advice and Liaison Service (PALS), or our complaints team. We are continually looking for ways in which we can improve our complaints handling arrangements in order to respond to our patients' dissatisfaction more effectively in terms of providing a high standard of customer service and good practice. Our aim is to:

- Offer more flexibility through providing a number of different options through the 4Cs (comments, concerns, complaints, compliments)
- Offer more local resolution meetings at an earlier stage
- Learn from complaints and concerns to improve our services

Upon receipt of a complaint our complaints team will identify the appropriate organisation who will take the lead in the investigation, which is undertaken in consultation with each complainant and a named contact is assigned to each person/family. In this way we ensure clear, effective communication takes place and good relationships are established from the outset.

We take pride in the way in which we manage our complaints as it is important to us that the process, the decision making and the way in which we communicate are as straight forward and effective as possible and meet the needs of the individuals accessing the service. We ensure that we agree the points to be investigated with the complainant at the earliest opportunity, and we often offer meetings on either a local or formal basis. Through our letter of response, which may involve a number of different clinical areas and/or other organisations, we aim to provide various remedies through the issuing of an apology, explanation or financial redress where appropriate.

All complaint responses are signed by the chief executive or deputy. This underpins our approach to complaints handling and because we wish to reassure the public that we take complaints very seriously. We always ensure that organisational learning is clearly identified in the response and that this is supported internally through evidential information to show that we have done what we said that we would do.

Gap analyses have been undertaken on the Francis and Clwyd/Hart reports and action plans developed to ensure we learn and develop moving forwards and changes are made. We want to learn from complaints and ensure they make a difference and help us further improve the services we provide.

Complaints Analysis

	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014
Total number of complaints	430	467	517	533	*526
Response within the agreed timescale	86%	96%	100%	77%	*84%
Number of requests received for an Independent Review (Parliamentary & Health Service Ombudsman)	21 (including some from previous year)	18 (including some from previous year)	23 (including some from previous year)	11 (including some from previous year)	18 (including some from previous year)

**Figures as of 24th April 2014, the date this report was compiled*

Top 5 complaint categories

Category	2009-2010	2010-2011	2011-2012	2012-2013
Clinical care	251	215	226	*263
Communication	198	179	226	*52
Attitude and behaviour	70	76	61	*63
Delays/cancellations	48	46	103	*93
Discharge	29	38	55	*47

The trust is required to categorise the outcome of all complaints. The information is included in our annual complaints report and provided to the Department of Health. We are required to collate action plans for all complaints where learning has been identified. Learning from complaints and incidents is a quality priority for the year 2014-15.

Compliments

As part of the 4Cs process members of the public are also encouraged to tell us when they believe that we have 'got it right'. This feedback is monitored through the trust's quarterly reporting schedule (along with complaints).

What Our Patients Say About Us
(Source: 4Cs compliment forms)

'I would just like to say that having been in your hospital 4 times in the last year Hawthorn ward, where I am now, is run by wonderful nurses who are professional, cheerful and a total credit to the NHS'.

'We have found Northampton General to be very efficient i.e. tests and results have been carried out quickly. There has always been a doctor to answer any questions we have had. All staff are very friendly and kind and extremely hard working. We would like to say how clean the ward and areas are. We were also quite surprised at the choice and quality of food'.

'Thank you for listening to me rant and putting up with my crying. Thank you for listening to my concerns and putting my mind at ease. You've an amazing ward and an amazing team of staff. We will never be able to thank you enough'

"The staff have been wonderful and looked after my sister in law so well. Even though they have been very busy they have taken all the time that was needed to explain to all of us the treatment and outcome, making a very distressing hard time more bearable. Thank you so much".

Care Quality Commission (CQC)

Northampton General Hospital NHS Trust (NGH) is registered with the CQC with no conditions. The CQC inspected the trust in January 2014 and reviewed services against the following questions:

- Are services safe?
- Are services caring?
- Are services responsive to people's needs?
- Are services effective?
- Are services well-led?

The CQC inspected this hospital as part of an in-depth hospital inspection programme. NGH was chosen because it represented the variation in hospital care according to the new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, Northampton General Hospital was considered to be one of a number of high-risk service providers across the country.

Before visiting, the CQC looked at a wide range of information about the trust and asked other organisations to share their views about the organisation. They carried out an announced visit in January 2014 and before visiting the trust they held a public listening event where patients and members of the public shared their views and experiences of the trust. During the inspection they held focus groups with different staff groups and individuals from all areas of the hospital.

The inspectors reviewed the personal care or treatment records of patients, observed how staff were caring for people and talked with patients, carers, family members and staff. In addition, they continued to request, receive and review information from various sources during and after the inspection.

They found that:

NGH appeared to be very clean throughout. In a national survey the trust was noted to have been performing well in relation to infection prevention and control.

The trust had a recent history of poor staffing levels on some wards but they saw that action taken had begun to address staffing issues. Staff stated that improvements in staffing levels were already having a positive impact on services.

Some of the executive post holders were either new to post or in interim positions. This had an impact on the trust's leadership as staff reported that senior leaders were rarely visible on wards. Recruitment to these key posts was already underway.

There were areas of poor performance in relation to the management and maintenance of equipment, and to the dispensing of medications to patients on discharge, were identified during the inspection. The inspection revealed that end of life care was an area where the trust required more focus and commitment to improve.

They also identified areas of good practice:

- The A&E department was commended for its contribution to a trauma audit and research network.
- The maternity unit had one of the highest home birth rates nationally.
- The hospital had excellent facilities where simulation exercises take place to investigate the cause(s) of and learn from serious incidents.

The CQC raised some concerns at the immediate feedback session on 17th January 2014, following which the trust took immediate action to rectify those issues.

The formal report was received during March 2014 and an action plan drawn up to address the key areas of concern raised by the CQC. The action plan identifies actions to work towards:

Improving the emergency care pathway and bed capacity management

4

In order to:

- improve patient experience and outcomes by ensuring patients are admitted to and treated in the right place, first time, without having to wait longer than four hours for treatment.
- minimise the number of patients' moves and ensure patients do not stay in hospital longer than necessary.
- support the trusts values of putting patient safety above all else, aspiring to excellence and we reflect, re learn, we improve

Actions:

- Review the emergency care flow issues and improve all processes from admission through to discharge
- Track patient moves
- Risk assess all patient moves
- Work to understand those areas where maximum impact will be required
- Work in partnership with the health and social care economy
- Use electronic systems to assist our processes
- Understand the blocks in the system

Improving the robustness of our governance processes

In order to:

- • ensure we identify and mitigate risks to patients, learn from experience, in line with our value of 'putting patient safety above all else'.

Actions:

- Review our quality governance arrangements
- Clarify the accountability and assurance mechanisms underpinning the Care Group structure
- Review risk management arrangements
- Obtain external support and challenge
- Develop an implementation plan for improvement

Improving leadership from board to ward

In order to:

- ensure staff are confident the organisation is well led and that the leaders are driving improvements in care
- support our values of 'we reflect, we learn, we improve' and 'we respect and support each other'

Actions:

- Accelerate a board development programme
- Recruit a substantive executive team
- Clarify our directors' key responsibilities for ourselves and our stakeholders
- Support a clinical leadership programme for senior medical staff and clinical leads
- Accelerate the implementation of the trust's organisational development strategy

Making changes to 'Do not attempt cardio pulmonary resuscitation' paperwork so it is clearer

In order to:

- ensure that paperwork is completed consistently to mitigate any risks to patients in line with our value of 'putting patient safety above all else'.

Actions:

- Withdraw the existing documentation
- Implement a redesigned document
- Support the implementation of the new documentation with a programme of training and audit to ensure understanding

Ensuring that all equipment is maintained and available in clinical areas where required

In order to:

- ensure we identify and mitigate risks to patients, learn from experience, in line with our value of 'putting patient safety above all else'.

Actions:

- Ensure all medical equipment has been serviced by a qualified safety engineer
- Implement a centralised medical equipment maintenance strategy

- Develop a planned maintenance register and forward plan

Implement a robust process to ensure that medication is dispensed to patients before they have left hospital

In order to:

- identify and mitigate risks to patients, learn from experience, in line with our value of 'putting patient safety above all else'.

Actions:

- Cease the practice of discharging patients home without their prescribed medication

Improving arrangements for children's care in the A&E department

In order to:

- improve patient experience and outcomes for children and their families when they attend A&E by ensuring the environment is appropriate to their needs.
- support the trusts values of 'we put patient safety above all else'.

Actions:

- Ensure 24 hour access to an RSCN (registered sick children's nurse) for A&E
- Designated an area within the A&E department for use solely by children
- Ensure children are appropriately prioritised in A&E

4

Increasing compliance with mandatory and essential to role training and appraisal

In order to:

- deliver improved outcomes to patients through the development of staff, enabling excellence though out people to deliver our values of 'we put patient safety above all else', 'we aspire to excellence' 'we reflect, we learn, we improve', and 'we respect and support each other'.

Actions:

- Accelerate current programmes for improving training compliance
- Accelerate current programme for improving essential to role training compliance
- Accelerate current programmes for improving appraisal compliance
- Report on these to the board monthly

Progress against all of the actions will be monitored at trust board.

Statements of Assurance from the Board relating to the Quality of NHS services provided here at NGH.

Review of Services

During 2013-14 NGH provided and/or sub-contracted 52 NHS services. The trust has reviewed all the data available to them on the quality of care in all of these services during the year, through external review reports, national clinical audit reports, local clinical audit, scorecards and performance reports.

The income generated by the NHS services reviewed in 2013-14 represents 100% of the total income generated from the provision of NHS services by NGH for the reporting period 2013-14.

Managing Quality in NGH

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

The Clinical Quality Effectiveness Group (CQEG) meets monthly and receives reports on aspects of quality, both from individual directorates and on a trust-wide basis including quarterly directorate reports, infection control, pathology, compliance with NICE guidance, clinical effectiveness and audit, external reviews, risk management, incidents, complaints, PALS and claims management, CQC compliance, mandatory training, safeguarding, along with reports from its sub-committees, which include transfusion, consent, pharmacy, resuscitation, radiation protection, etc.

CQEG reports and escalates issues to the Integrated Healthcare Governance Committee (IHGC), which is a trust board subcommittee and meets monthly. The committee receives performance and assurance reports on the quality of care provided at NGH. Of particular note is the quarterly patient safety, clinical quality & governance progress report. This comprehensive report incorporates an overview of performance across the trust in nine key sections: Introduction and executive summary, ongoing trust-wide priorities, failure to plan, failure to rescue, failures of care, learning from error, emergency care, assurance with national standards, directorate reports and quality scorecards. HGC reports and escalates issues to the trust board.

Never Events

Never events, first introduced in 2010, are a list of events described as ‘serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers’ (National Patient Safety Authority, 2010). These can be used as an indicator of how safe an organisation is and the patient safety culture within that setting.

During the 2013-14 reporting period, there were no ‘never events’ reported in NGH.

Northampton General Hospital NHS
NHS Trust

Part Five

Participation in Clinical Audits

Providing the **Best Possible Care**

Participation in Clinical Audits

Participation in national clinical audits is a high priority at Northampton General Hospital. During 2013/14, Northampton General Hospital participated in 100% of national clinical audits and 100% national confidential enquires which were relevant to the services provided (36 national clinical audits and 3 national confidential enquiries).

The department of clinical audit, safety and effectiveness supports the clinical teams to identify and participate in the relevant audits. The audit reports are reviewed and discussed within the relevant specialty and across the trust where appropriate.

Northampton General Hospital uses the audit reports to support trust objectives and to deliver best possible care.

In 2013-14, data from selected national clinical audits in which the trust participates was used to publish individual consultant-level outcome data. This demonstrated that there were no areas for concern at Northampton General Hospital.

The national clinical audits and national confidential enquiries that Northampton General Hospital participated in, and for which data collection was completed during 2013-14, are listed below alongside the percentage participation.

National Clinical Audits and Confidential Enquiries	Percentage Participation
Perinatal mortality (MBRRACE-UK)	100%
Neonatal intensive and special care (NNAP)	100%
Paediatric bronchiectasis (British Thoracic Society)	No cases at NGH
Paediatric asthma (British Thoracic Society)	100%
Moderate or severe asthma in children (College of Emergency Medicine)	Data collection in progress
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	100%
Child health reviews (CHR-UK)	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	100%
Chronic obstructive pulmonary disease (British Thoracic Society)	Data collection in progress
Emergency use of oxygen (British Thoracic Society)	100%

National Clinical Audits and Confidential Enquiries	Percentage Participation
Cardiac arrest (National Cardiac Arrest Audit)	100%
Adult critical care (Case Mix Programme)	100%
National emergency laparotomy audit	Data collection in progress
Diabetes (National Adult Diabetes Audit)	(Snapshot audit only) 100%
	NPID 95%
	Continous Audit – NGH not currently entering data
Paracetamol overdose (College of Emergency Medicine)	Data collection in progress
Rheumatoid and early inflammatory arthritis	Data collection in progress
Ulcerative colitis round 4 (UK IBD Audit)	100%
Hip, knee and ankle replacements (National Joint Registry)	100%
Elective surgery (National PROMs Programme)	93.7% (2012/13 data)
Coronary angioplasty (NICOR Adult cardiac interventions audit)	100%
National vascular surgery, including CIA elements of NVD	100%
National audit of seizure management (NASH 2)	100%
Severe sepsis & septic shock (College of emergency Medicine)	Data collection in progress
Acute Myocardial Infarction and other ACS (MINAP)	100%
Heart failure (Heart Failure Audit)	68.9% (target 70%)
Stroke National Audit Programme (Sentinel & SINAP)*	100%
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	Ongoing data collection
Renal Replacement Therapy (Renal Registry)*	Ongoing data collection
Lung cancer (National Lung Cancer Audit)	Ongoing data collection
Bowel cancer (National Bowel Cancer Audit Programme)	85%
Head & Neck Cancer (DAHNO)	98.2%

National Clinical Audits and Confidential Enquiries	Percentage Participation
Oesophago-gastric cancer (National O-G Cancer Audit)	Ongoing data Collection
Falls & fragility fracture programme, includes National Hip Fracture Database	NHFD 99%
	Inpatient Falls pilot 100%
Severe trauma (Trauma Audit & Research Network)	53.6%
Audit of patient information and consent (National Comparative Audit of Blood Transfusion)	Data collection in progress
Audit of the use of anti -D (National Comparative Audit of Blood Transfusion	100%
National Confidential Enquiry into Patient Outcome & Death (NCEPOD) – Lower Limb Amputation	100%
National Confidential Enquiry into Patient Outcome & Death (NCEPOD) – Tracheostomy	100%
National Confidential Enquiry into Patient Outcome & Death (NCEPOD) – Gastrointestinal Bleed	Data collection in progress

Northampton General Hospital does not provide the following primary or specialist services and therefore data was not entered for the audits listed below.

Adult Cardiac Surgery (ACS)
Congenital Heart Disease (Paediatric Cardiac Surgery)
National Audit of Schizophrenia
Paediatric Intensive Care
POMH-UK (Prescribing in Mental Health Services)
Pulmonary Hypertension
Suicide & Homicide in Mental Health (NCISH)

The reports of 33 national clinical audits were reviewed by the provider in 2013-2014 and Northampton General Hospital intends to take the following actions to improve the quality of healthcare provided:

National Clinical Audits	Actions
1. Neonatal intensive and special care (NNAP)	• Continue to work with midwifery services to increase the number of babies who have their temperature measured in the first hour. • Promote the use of antenatal steroids where appropriate. • Continue to promote breastfeeding and expression of breast milk. • Continue to update parents as soon as possible after admission and record the conversation. • Establish system for recording two year neurodevelopmental outcomes.
2. National Paediatric Diabetes (RCPH)	• Embed the use of the "Twinkle" database into routine use. • Recruitment of a Paediatric Diabetes Specialist Nurse. • Increase available clinic space for MDT. • Recruitment of a new specialist consultant (business case approved). • Aim to further increase the percentage of children who meet target HbA1C levels.
3. National Audit of Seizure Management in Hospitals (NASH2)	• Report received in January 2014. • An initial self-assessment has been performed and the report will be discussed in more detail at the directorate governance meeting.
4. 4. Paediatric Asthma Audit	• Promote use of written asthma management plans for all children admitted with asthma.
5. Paediatric Pneumonia Audit	• Continue to encourage current practice.
6. Feverish Children Audit (College of Emergency Medicine)	• Development of emergency department analgesia Guidelines. • Notes audit for emergency department medical and nursing staff. • Implementation of the paediatric observation priority scoring system.
7. Fractured Neck of Femur (College of Emergency Medicine	• Notes audit for emergency department medical and nursing staff. • Design and implementation of a pro-forma for patients attending with suspected fractured neck of femur. • 2 hourly patient safety rounds.
8. Renal Colic (College of Emergency Medicine)	• Notes audits for emergency department medical staff. • Development of ambulatory care pathway for renal colic. • A pro-forma has been designed and will be implemented once the pathway has been finalised.

9. Adult Critical Care (ICNARC)	• Continue quarterly monitoring of outcomes compared to national benchmarking figures. • Review areas for concern e.g. sepsis, “trauma, perforation or rupture” and “emergency surgical admissions”. • Review of all late and early deaths following discharge from ITU. • Monthly reviews of all deaths. • Discussion of certain cases at joint speciality meetings.
10. Child Health Reviews - UK	• Design a care plan for all children with epilepsy which links to the protocol for treatment. • Consider linking the care plan to a patient held record or passport. • Implementation of a new dose of buccal midazolam. • Reinforcement of systems already in place to make sure Epilepsy consultant is aware of all relevant patients. • Continue with child death reviews. • Reinforce process for peer-review to support epilepsy consultant.
11. Cardiac Arrest (ICNARC)	• During 2013, this audit started to publish benchmarking figures for the first time. The reports are reviewed by the resuscitation team and included in the patient safety workstream.
12. Parkinson’s Disease	• Improve documentation of motor, non-motor and ADL assessment.
13. National Vascular Database	• Quarterly reports are compiled and used to monitor activity and outcomes [mortality, length of stay, Dr Foster case-mix adjusted outcomes]. • Cases are cross-checked against theatre ledgers to ensure 100% participation [104%infra-renal AAA report] and monthly coding checks of NVD data are carried out to ensure consistency with HES data. • Performance against the key service outcomes for specialised vascular services is also monitored quarterly. This includes minimum cases required for each procedure.
14. Carotid Endarterectomies	• Quarterly reports are compiled and used to monitor activity and outcome data outcomes [mortality, length of stay, Dr Foster case-mix adjusted outcomes]. • Carotid specific indicators required for monitoring compliance with NICE standards and the key service outcomes for specialised commissioning are also monitored quarterly.

	These include 1. Stroke rate within 30 days 2. Delay from symptom to surgery 3. Delay from referral to surgery ● Continue to ensure 100% participation by theatre ledger and coding checks monthly. [104% participation Round 5 carotid audit]. ● Friday morning emergency list to ensure theatre capacity for carotid surgery within 3 days of referral. ● Feedback to be sought from patients undergoing carotid surgery.
15. Elective Surgery (National PROMs Programme)	● Continue to encourage completion of initial patient questionnaire ● Continue to review the results.
16. Heart Failure (Heart Failure Audit)	● Submit a business case for more administrative support. ● Continue to monitor BNP for identification of patients. ● Appointment of a new heart failure nurse. ● Continue working as MDT and liaising with community team. ● We aim to identify patients who are for palliative care and liaise with Primecare and palliative care teams to ensure appropriate care and treatment in preferred place care.
17. Sentinel Stroke National Audit Programme (SSNAP)	● Development of mood assessment pathways and intervention with support from the CCG. ● Development of continence improvement programme. ● Continue to work closely with other local hospitals to provide high quality care. Countywide meetings are held to ensure all patients with a stroke are managed at NGH. Data from SSNAP is shared and discussed at these meetings. ● Improvement of the imaging pathway for stroke patients.
18. Lung Cancer	● Report received in January 2014. ● The report will be discussed in more detail at the directorate governance meeting.
19. Bowel Cancer	● MDT Lead and team to work with cancer services audit officer to ensure data input and submission are accurate. Sign off with MDT lead prior to uploading the data. ● Recording of detail offering laparoscopic surgery to patients.
20. Head and Neck Cancer (DAHNO)	● Continue to improve capture of key data items on Somerset database via the MDT. ● Education of SHO's re importance of clear documentation of dental assessment. ● Development of a standard proforma to help improve documentation of co-morbidities.

21. Severe trauma (Trauma Audit & Research Network)	• Review of major haemorrhage protocol and transfer pack. • Review of trauma team leadership. • Review protocol for repatriation of patients. • Review of process for return of X-rays when patients are repatriated. • Develop a system for identification of patients for discussion at trauma group meetings. • Work to ensure all data is captured on TARN. • Improving documentation of trauma reviews by all grades and specialities of doctors, including during transfers. • Established a system for reporting governance issues back to CETN. • Participated in a trauma network peer review. • Developed a system for monthly review of patients transferred to UHCW. • Developed a system for review of patients not transferred from NGH to ensure appropriate management.
22. Emergency Oxygen Audit	• Enhance use of posters explaining appropriate delivery systems for oxygen. • Develop guidance for use of non – rebreathe masks including recommended length of use. • Clarification of rules for signature of oxygen use on drug rounds. • Further education across the trust regarding the prescription and administration of oxygen. • High performance wards to share good practice. • Review anaesthetic prescribing of oxygen. • Local audit in 2014 to assure sustained improvement.
23. Non Invasive Ventilation Audit (NIV)	• The flow chart devised for A&E for the decision making about commencing NIV is to be adapted across the organisation. • With HDU's input review the guidance and produce up to date guidance on settings for NIV. • To review and agree what process will be in place for patient's discharged on oxygen therapy.
24. Hip knee and ankle replacements (National Joint Registry)	• NJR has produced leaflets for circulation to patients which outlines the work and findings of the NJR these leaflets should be available in clinic for patients to see. • Consultants to continue to enter full and accurate data to the NJR • A data quality audit representative has been appointed.
25. National Hip Fracture Database	• All deaths are reviewed. • Monthly data captured for the NHFD is discussed at directorate meetings. • Morbidity is also captured on the T&O M&M database. • Root cause analysis of all cases of post-op infection. • A locum consultant geriatrician has been appointed who will take responsibility for the BPT.

26. Bronchiectasis Audit	• Develop a bronchiectasis patient information leaflet.
27. Adult Asthma Audit	• Review guidelines according to BTS. • Inhaler technique checklist will be reviewed to determine if applicable, however a process that checking inhaler technique is documented will be implemented. • Mini audit of asthma admissions will be conducted.
28. National Audit of Dementia	• Targets for dementia training for all ward staff have been agreed. • Work has commenced on a draft care pathway for patients admitted with dementia and a consultant has been nominated as responsible for the implementation and review of the care pathway. • Dementia champions will be identified for each ward/ outpatient department. • Development of monthly audit regarding the support received by carers of people with dementia. Results will be reported to the trust board. • Improve access to written information on wards and outpatient departments. • Improve the discharge process and notification so it is more appropriate to the needs of the patients with dementia and their carers. • Full implementation of the NGH carers' policy. • Review of guidelines for assessment of patients aged 75 and over presenting as an emergency with dementia or other causes of cognitive impairment. (including use of butterfly patient profile) • All patients with a diagnosis of dementia, in whom behavioural changes are reported, will be assessed for the presence of delirium. • Information about patients with dementia will be sought from carers and next of kin. • MDT assessment and specialist assessments will be available for all patients with dementia. • Development of appropriate end of life guidance for patients with dementia. • For those patients who have cognitive impairment but do not have a diagnosis of dementia, the "outline butterfly" magnets will be used to indicate the need for further assessment of dementia. • Development of guidelines for the use of anti-psychotic drugs. • Determine service level agreement for liaison psychiatry to meet required standards for patients with dementia. • Monitor inpatient falls in this group of patients. • Monitor readmissions, delayed transfers, use of intermediate care, complaints and feedback from patient forums and focus groups.
29. Cardiac Arrythmia	• Report received in January 2014. • The report will be discussed in detail at the directorate governance meeting.

30. Upper GI Cancer (AUGIS)	• The recommendations of the report have been reviewed.
31. IBD Biological Therapies Audit	• Register as a user on biologics audit website and familiarise with biological therapies audit report and dataset. • To seek clarification from information governance and Royal College of Physicians about of the amount of patient identifiable data required in the audit. • Commence data input with effect from 01/01/14 in with a view to retrospective data entry.
32. MINAP	• The reports have been reviewed and discussed. • Continue high standard of data entry and compliance with targets.
33. Coronary Angioplasty (NICOR Adult cardiac interventions audit)	• Report received in January 2014. • The report will be discussed in detail at the directorate governance meeting.

The reports of 2 Confidential Enquiries were reviewed by the provider in 2012/2013 and Northampton General Hospital intends to take the following actions to improve the quality of healthcare provided:

Enquiry	Actions
1. National Confidential Enquiry into Patient Outcome & Death (NCEPOD) – Too Lean a Service (October 2012)	• Self- assessment checklist reviewed. • NGH does not provide a bariatric service. On occasion patients with complications of bariatric surgery are admitted as an emergency.
2. National Confidential Enquiry into Patient Outcome & Death (NCEPOD) – Measuring the units (June 2013)	• Self – assessment checklist reviewed. • Highlight issue of need for multidisciplinary alcohol care team and specialist nurse with CCG. • Development of guidelines for 1) Acute decompensated liver disease (1st presentation) 2) Acute alcoholic hepatitis 3) Chronic decompensated liver disease • Clarify Indications for ascitic tap, include in the guidelines • Use the guidelines to outline the full set of investigations that are required for a patient who presents acutely with decompensated liver disease. • Further develop “Every Contact Counts” across the trust to screen for alcohol misuse. • Review the potential use of assessment tools and withdrawal scales. • Ensure gastroenterology team are notified of all relevant patients as soon as possible after admission. • Local audit to check adherence to standards for treatment of alcohol – related liver disease. • Continue mortality review.

The reports of 25 local clinical audits, including safety academy initiatives were reviewed by the provider in 2013/2014 and Northampton General Hospital intends to take the following actions to improve the quality of healthcare provided:

Local Clinical Audits	Actions
1. Patient Identification	• Wards notified where patients did not have any wristband identification • Results reported to the operational meeting • Where some wristbands were hand written, continued education of staff regarding the policy on the use of electronic wristbands • Annual re audit in 2014
2. Fluid Balance Chart Audit	• New format for the fluid balance chart will be introduced • Plan, Do, Study, Act (PDSA) will be undertaken to trial new documentation • Review the need for education for all staff involved in fluid measurement and incorporate where possible into existing training. • Ensure that the trust's signage is used to raise awareness of fluid balance in general and individual patients' fluid restrictions specifically. • Report all fluid balance-related incidents in line with the trust protocol for incident reporting
3. Protected Meal Times Audit	• Report to nursing & midwifery board • Matrons to cascade the information back to their areas of responsibility • Include observational audit of PMT into the monthly and quarterly QUEST
4. Nutritional care audits	• Revised 'whiteboard' guidance and magnet ordering process to be sent to all wards • Feedback of 'nutritional care' audit findings, to wards and nutrition link nurses • Revise current care plan alongside central venous catheter care plan • Training re nasogastric tube insertion to continue reinforcing appropriate use of documentation • Screensaver to be produced to remind staff of pH testing and documentation
5. The Electronic Handover System	• Incorporate training on the electronic handover system into the induction for all juniors (Foundation Year 1 to Specialty Registrars). • Incorporate reviewing and updating tasks on the electronic handover system into the 'hospital at night' handover. • Consultants must support juniors to recognise patients at risk out of hours and formulate clear management plans for the on-call team.

6. 5 Steps to Safer Surgery	• Team leader's role to extend to overseeing 'The 5 steps to safer surgery' • Unless the 'first' step is carried out, there should be a refusal to move on to the 'second' step and so on • Full attention and engagement by all members of the team to be expected • Importance of above needs to be emphasised and reiterated to all ODPs, nurses, anaesthetists and surgeons • Continual re-auditing
7. Audit of the initiation, prescription and administration of opioid analgesia to adult palliative cancer patients in an acute hospital	• Tailor the NICE opioids in palliative care education resource pack to meet the needs of NGH. • Work with practice educators to incorporate guidance into drug administration competencies and training. • Develop formative assessments to be conducted in the ward environment by ward managers following completion of training. • Liaise with the trust's medication safety group to review the current medicines management policy and controlled drugs procedure. • Identification of errors, including omissions, to be linked with education and competences to measure ongoing areas of concern. • Task/finish group to produce a patient information leaflet and identify a process to ensure this is effectively implemented into clinical practice. • Task/finish group to produce local guidance on both prescription and administration of opioids • Task/finish group to review the current trust pain assessment and core care plan to reflect NICE (2012) guidance.
8. Re-audit of Management of Head Injury in Children	• Minor amendments to be made to ICP • Training of new doctors and nurses to be included in Induction training and discussed at paediatric audit department meeting • ICP to be loaded on NGH intranet.
9. Audit of Wet Age Related Macular Degeneration Service at NGH	• Continue to ensure compliance with college standard of seeing (and treating) all new patients within 2 weeks.
10. Audit of temporal arteritis referrals to the Rheumatology department at Northampton General Hospital and evaluation of temporal artery biopsies.	• Continue improvement in biopsy positivity following changes to referral pathway. • Re-audit in 2014/15.

11. An audit of the use of Image Guided Percutaneous Lung biopsy in the management and diagnosis of primary bronchial carcinoma	• Continue to use cytology or histopathological sampling as appropriate for final diagnosis.
12. Velcade Audit [NICE TA228]	• Review inconsistencies in data between cancer registry and pharmacy data.
13. Allergy Documentation Audit	• Teaching session for junior doctors on allergy documentation and penicillin reactions
14. Audit of the sensitivity of Double Contrast Barium Enema examinations for Colorectal Cancer	• Double reporting of DCBE to be continued as the diagnosis rate was increased. • For re-audit in 2014/15.
15. Prescription of extended VTE prophylaxis	• A prompt for eVTE prophylaxis to be added to the EDN prescribing section. • To raise awareness, include in induction for all junior doctors.
16. Accuracy of MRI for Endometrial Cancer Staging	• MRI reporting should be standardised. • MRIs should continue to reviewed in gynaecological MDTs and be subject to double reporting.
17. Audit of Documentation of FIGO Staging Data for Gynaecological Cancers 01/04/2012–31/03/2013	• Ensure that all staging is discussed, agreed and entered onto the Somerset database at the MDT. • Contact the Somerset database team to clarify how to document stage for patients with recurrent cancer and for those who do not have surgery where a surgical stage is required by FIGO. • Re audit in 12 months as required by the CLE in peer review.
18. Renal Biopsy	• Develop a biopsy referral pathway • Establish criteria for day case renal biopsies • Acquire a dissecting microscope to reduce negative biopsies
19. Code Red Audit	• All staff who have direct patient contact receive code red within all resuscitation training appointments. • All adult wards have code red magnets (including obstetrics,) • Paediatric wards to have code red magnets issued with PEWS launch early summer. • Team leader arm bands are in all emergency trolleys to be worn by the most appropriately trained person at an emergency, and this is embedded within all resuscitation training appointments.

	• Code red protocol is included within the resuscitation policy. The paediatric element is being drafted and will be forwarded for ratification by April 2014 • PDSA project regarding giving timely factual feedback regarding EWS is on track for commencing in May 2014. • There is presently no system available for collecting telephone data for code red patients. However this will hopefully be possible once VitalPac has been launched.
20. Ward round standardisation and practice audit	• Ward round stickers have been introduced within Medicine and now need roll out to other specialities • The ward round project won 1st prize at NGH hospital audit competition as well as 1st prize at the Royal Society of Medicine. • Meetings are underway within general surgery and T&O to facilitate usage of the productive ward round. There is a trial underway currently to ascertain patient satisfaction within acute surgical ward rounds • Trial sticker and process as PDSA within urology for weekend plan of care • Introduce into the emergency areas within medicine as PDSA • Facilitate correct clinical coding • Create feedback form for colleagues • Re audit practice and share findings with PDSB and clinical teams
21. Failures of Care	• Much work has been undertaken which addresses aspects of care which are set as basic standards within our regulatory frameworks. Eg: • Training staff into oxygen prescription awareness is included within all resuscitation training appointments. The Trust is now seeing an improvement in the BTS audit. • An audit conducted last year demonstrated 100% compliance with MRSA decolonisation protocols in the relevant wards. Surgical site infection results are 0% for patients who have had caesarean sections, hip replacements or knee replacements. • Incidence of omitted medicines in December was 6%, with only one ward with > 25% of patients having a medicine omitted. This is the lowest since May 2012. • E learning package for falls prevention introduced. • Internal QuEST audit has demonstrated compliance with pressure ulcer prevention documentation (aggregate of 5 measures relating to care planning documentation was 88.9%). • Re-decoration of selected wards in a way as to assist patients with dementia to find their way around the ward is underway. Funding to purchase 50 wall clocks obtained from charitable funds. Work commenced to replace signage on toilet and bathroom doors in selected wards • New food intake charts are currently being developed.

22. Failure to Plan	• Nursing documentation is now reviewed via the internal QuEST audit inspections. • The question data set for reviewing medical documentation has been streamlined in order to ensure continuity and reproducibility. There is a focus on the current episode rather than the whole documentation. • New focus on the surgical non-elective admission proforma. The audits within the medical directorate continue to have promising results. • There is much work underway on our EDN including the formation of a multidisciplinary test and finish group. • There is a refreshed focus on communication with GPs & primary care. This includes the GP issues log which has been reinstated. The work stream safety lead has attended the Central & West PLT to discuss this, EDN and pneumonia discharge information. An early evening drop-in session for GPs to have an audience with members of the safety academy is planned as a pilot. • The trust overall HSMR remains satisfactory for pneumonia. A new CURB sticker is due for launch soon along with a patient discharge information leaflet.
23. Failure to Rescue	• EWS audits have been extended to the inpatient community sites, obstetric and paediatric wards. Since October 2013 the safety academy has worked on one joint campaign, the EWS escalation campaign. The campaign has focussed on supporting and educating staff in their workplace with all aspects of the EWS system. The campaign so far has demonstrated increases in: ► Patient safety leaflets issued to patients has risen from 10 to 90% ► Safety board compliance has risen from 42 to 93% ► Staff knowledge – on campaign visits, 79% of staff have been confident on questioning, with 21% of staff requiring some input/education • VitaPac is on target for roll out from March 2014. This will enable data to be available to CCOT, doctors and for audit purposes identifying the location of patients who are deteriorating within the Trust. • All resuscitation training appointments / courses include; cardiac arrest prevention; oxygen prescription; sepsis (pneumonia bundle for all doctors); BLS. • The maternity service has recently launched a sepsis care pathway and the paediatric wards have been asked to address having a pathway for their specialty. • DNACPR & TEP forms have been re-launched in January 2014 to clarify when a TEP should be completed and by whom. • A project to reduce in patient ward cardiac arrests by at least 50% utilising a score is to commence in May 2014. A trustwide PDSA will be undertaken for a month. This will facilitate learning from situations where there have been failures to recognise or act upon deterioration and enable new approaches to be adopted.

24. Learning from Serious Incidents	• The management of incidents including SI's policy has been rewritten and is now out for consultation. Training and allocation of suitable investigators has been agreed. All closed SI action plans will be reviewed by the Safety Academy and is now a standard agenda item every two months. • A review of all serious incidents within medicine and emergency care over the past year has been developed into a newsletter called SIN (Serious Investigation News), shared with all relevant consultants. A review of all action plans from the previous 2 years is also incorporated into the SIN discussion. • Weekend and out of hours support - the additional support on 2 evenings and at weekends is now embedded within the out of hours rota, and its success has now led to other departments looking at the same model. • The patient safety learning forum now has a refreshed agenda which includes all attendees sharing one aspect of learning that has occurred as a result of a recent incident / SI / complaint. The governance leads also feedback within this group the active incidents within the care groups that they are responsible for.
25. Human Factors	• The trust currently has 260.safety champions from all areas in the trust (clinical & non-clinical). All champions receive 3 monthly updates and are asked to communicate key messages to their teams and get involved with project work as appropriate. Ward based champions names are displayed on the safety & quality boards. • There is now a plan to run educational sessions linked to recent SI's to help with embedding lessons learnt. It is envisaged that video's will be taken to assist with wider dissemination of these key messages. • All attendees within the Sim Centre receive human factors awareness training.

5

Participation in Clinical Research

The number of patients receiving NHS services provided by Northampton General Hospital NHS Trust from April 2013 to March 2014 that were recruited during that period to participate in research approved by a research ethics committee was around 2000. 1308 patients were recruited to studies on the National Institute of Health Research portfolio.

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

Clinical staff across the trust participated in research approved by a research ethics committee at NGH during April 2013 to March 2014. In the last year there has continues to be a lot of studies in newly research active areas such as dermatology and renal. Recently studies in ITU, accident and emergency have contributed many patients into the recruitment figures.

In the last three years, we have demonstrated our engagement with the National Institute for

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

Goals Agreed with Commissioners

A proportion of NGH income in 2013/14 was conditional on achieving agreed quality improvement and innovation goals as part of the commissioning contract. In 2013/14 the two lead commissioning bodies were Nene Clinical Commissioning Group and Specialised Commissioning (Leicester and Lincolnshire Area Team) NHS England.

The table below summarises our targets and outcomes for 2013/14

CQUIN 2013-14	Final
NATIONAL CQUINS	
1.VTE	
1a. 95% of all adult inpatients to have a VTE risk assessment	
1b. VTE Root Cause Analysis.	
3. Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting	
3a. Dementia case finding	
3b. initial diagnostic assessment	
3c. referral for specialist diagnosis	
3d. Lead clinician and appropriate training of staff	
3e. Supporting Carers of People with Dementia (monthly audit)	
LOCAL CQUINS	
1. Develop and implement AECP	
1a AECP for Chest Pain	
1b. AECP for Pulmonary Embolism	
1c. AECP for Supraventricular Tachycardia	
1d. AECP for Pleural Effusion	
1e. AECP for Painless Jaundice	
2. Development of HOT Clinic	
2a. HOT Clinic for Paediatrics	
2b. HOT Clinic for Surgery	
2c. HOT Clinic for Medicine	
NHS ENGLAND CQUINS	
1. Friends & Family	
1a. Phased expansion of Friends and Family Test (maternity services)	
1b. increase response rate to at least 20%	
1c. Improve performance on staff Friends & Family Test	
2. 50% reduction in all new Pressure Ulcers that are avoidable.	
3. Quality Dashboards	
4. Timely Simple Discharge	
5. Improved access to breast Milk -% of babies less than 33wks discharged on breast milk	
6. Acute Kidney Injury	

CQUIN Key	GREEN	AMBER	RED
	Full payment	Partial payment	No payment

Explanation of red area:

50% Reduction in all new pressure ulcers that are avoidable. Recent recruitment of a new tissue viability teams means that more accurate assessment and reporting across the Trust has resulted in achieving a clearer picture of the true position. A significant work stream is now in place to increase training, improving nursing documentation and implementing the SSKIN care bundle as a local CQUIN for 2014.

Goals Agreed with Commissioners for 2014/15

The tables below indicate the targets agreed for the current year.

	CQUINS
National 1 Friends and Family Test Staff	1a Implementation of staff FFT as per guidance, according to the national timetable
	1b Early implementation
Friends and family Test Patients	2 Increased or Maintained Response Rate
	3 Decreasing negative responses in patient FFT or maintaining zero negative responses
National 2 NHS Safety Thermometer	2.1 Reduction in the incidents of avoidable hospital acquired Grade 2 pressure tissue damage
	2.2 Reduction in the incidents of avoidable hospital acquired Grade 3 pressure tissue damage
	2.3 Reduction in the incidents of avoidable hospital acquired Grade 4 pressure tissue damage
National 3 Dementia	3.1 Dementia – Find, Assess, Investigate and Refer
	3.2 Dementia – Clinical Leadership
	3.3 Dementia – Supporting Carers of People with Dementia
Local 1	Standardised approach to morbidity & mortality review
Local 2	7 day working
Local 3	Effective Discharge Arrangements
Local 4	SSKIN Care Bundle Implementation
Local 5	Indwelling urethral urinary catheter, insertion and on-going care. (CRUTI)
Local 6	Care Bundles – Heart failure
Local 7	Care Bundle - COPD
Specialist Local 1	Specialised Services Quality Dashboards

Local Quality requirements NGH Quality Schedule

Quality Requirement
Making Every Contact Count
End of Life care
Enhanced Recovery
Ambulatory Care Pathways
Patient Safety
Learning
Quality care for Patients with a Learning Disability
Patient Experience
MUST Assessments
WHO surgical checklist
National Early Warning Score (NEWS)
Safeguarding
Cost Improvement Programmes
Workforce
VTE

Northampton General Hospital NHS
NHS Trust

Part Six

Audit and Quality Assurance

Audit and Quality Assurance

The audit committee commissions an annual programme of internal audit to ensure the robustness of information provided to the trust board and the integrated healthcare governance committee.

In order to be able to give wider assurance the audit committee also commissions an external auditor to undertake a review of the quality account and to specifically test two performance indicators included in the 2013/14 quality account. These were agreed as the FFT results and infection control reporting for Clostridium Difficile.

NHS Number and General Medical Practice Code (GMPC) Validity

The trust submitted records between April 2013 and December 2013 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data as below and compared to the previous years' results:

Period: Apr 12 - Dec 12	Valid NHS Number	Valid GMPC
Admitted Patient Care	99.6%	100%
Outpatient Care	99.8%	100%
Accident & Emergency Care	94.9%	100%

Period: Apr 13 - Dec 13	Valid NHS Number	Valid GMPC
Admitted Patient Care	99.6%	100%
Outpatient Care	99.8%	100%
Accident & Emergency Care	97.3%	98.7%

Comparison	Valid NHS Number	Valid GMPC
Admitted Patient Care	0.0%	0.0%
Outpatient Care	0.0%	0.0%
Accident & Emergency Care	2.4%	-1.3%

Information Governance Toolkit Attainment Levels

The information governance (IG) toolkit was completed and submitted on the 31 March 2014 with an overall score of 80% and a return of 'satisfactory'. There are 3 main areas which require ongoing improvement.

These are:

- 112 information governance mandatory training – the trust is required to achieve 95% staff compliance in IG training within a year's cycle. This has been a continuous struggle to achieve however the IG Team will be implementing new initiatives to improve the trust's compliance figures.

- 300's information security assurance - further work is required to ensure that our processes are robust in identifying and managing risks. The trust will build an up-to-date information asset register with detailed system risk assessments and information asset owners

- 604 corporate records management – the trust is required to carry out corporate records audit in at least 4 corporate areas annually. The aim of this requirement is to have all corporate areas audited within a 3 to 4 year cycle. This has not been properly implemented for previous submissions.

Action plans and a work schedule are being developed for a more proactive and robust approach to the information governance toolkit, with particular attention paid to the above areas. This is monitored through the IG leads board chaired by the head of information and data quality.

Clinical Coding Error Rate

Objective/Method

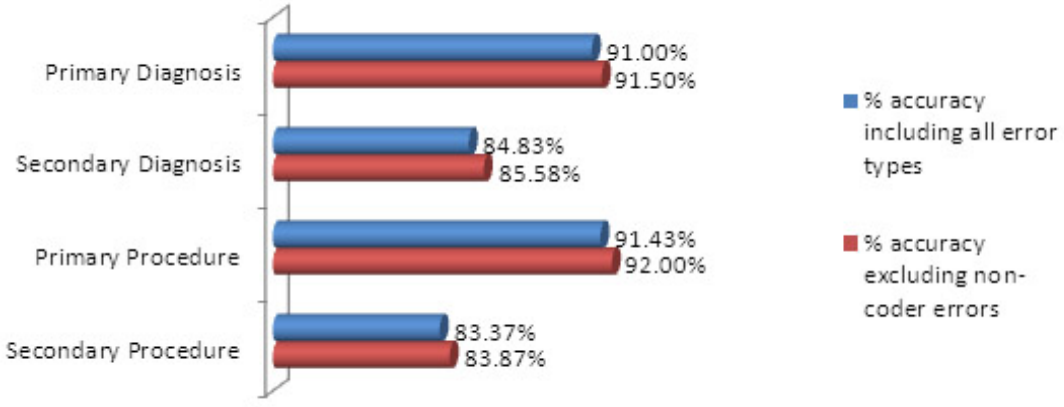
To assess Northampton General Hospital NHS Trust surgical care group coding performance against recommended achievement levels for information governance toolkit requirement 505. Exactly 200 surgical episodes were audited using the NHS classification service clinical coding audit methodology Version 6.0.

Findings

The figures in the table below outline the percentage accuracy scores for the 200 episodes. As the table demonstrates, both the diagnostic and the procedural coding were found to be sufficient to reach level 2 IG requirements.

	% Accuracy	IG Level 2 Requirements	IG Level 3 Requirements
Primary Diagnosis	91.00%	90.00%	95.00%
Secondary Diagnoses	84.83%	80.00%	90.00%
Primary Procedure	91.43%	90.00%	95.00%
Secondary Procedures	83.37%	80.00%	90.00%

The majority of error source could be attributed to the coder though there were instances of non-coder errors found. A comparison of the overall percentages with and without non-coder errors is seen in the chart below.



Core Quality Indicators

In 2009, the Department of Health established the National Quality Board (NQB) bringing the DH, the CQC, Monitor, the National Institute for Health and Clinical Excellence (NICE) and the National Patients Safety Agency (NPSA) together to look at the risk and opportunities for quality and safety across the whole health system. The NQB requires reporting against a small, core set of quality indicators for the 2013/14 reporting period, aligned with the NHS Outcomes Framework.

The performance of data for NGH is shown for 2013-14 and the previous year (2012-13), along with the national average for 2012-13 where this is available. NGH considers that this data is as described because it has been verified by internal and external quality checking.

NHS Outcomes Framework Domain	NGH Performance		National Average		
	2013/14	2012/13	2012/13 Average	2012/13 High	2012/13 Low
Domain 1 – Preventing people from dying prematurely					
The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust	113	116	100	119	63
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust	32%	N/A	21.28%	44.9%	0%
Domain 2 – Enhancing quality of life for people with long term conditions					
The value and banding of the summary hospital-level mortality indicator (SHMI) for the trust	110	116	100	119	63
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust	32%	N/A	21.28%	44.9%	0%
Domain 3 – Helping people to recover from episodes of ill health or following injury					
Patient reported outcome scores (PROMS) (participation) for:					
• Groin herina surgery	81.9%	86.3%	61.3%		
• Varicose vein surgery	48.0%	69.9%	44.0%		
• Hip replacement surgery	61.0%	97.6%	89.6%		
• Knee replacement surgery	68.5%	114.0%	89.6%		
Emergency readmission to hospital within 28 days (age 0-14)	10.9%	9.6%	4.19%	14.94%	0%
Emergency readmission to hospital within 28 days (age 15+)	6.9%	6.6%	6.16%	41.65%	0%

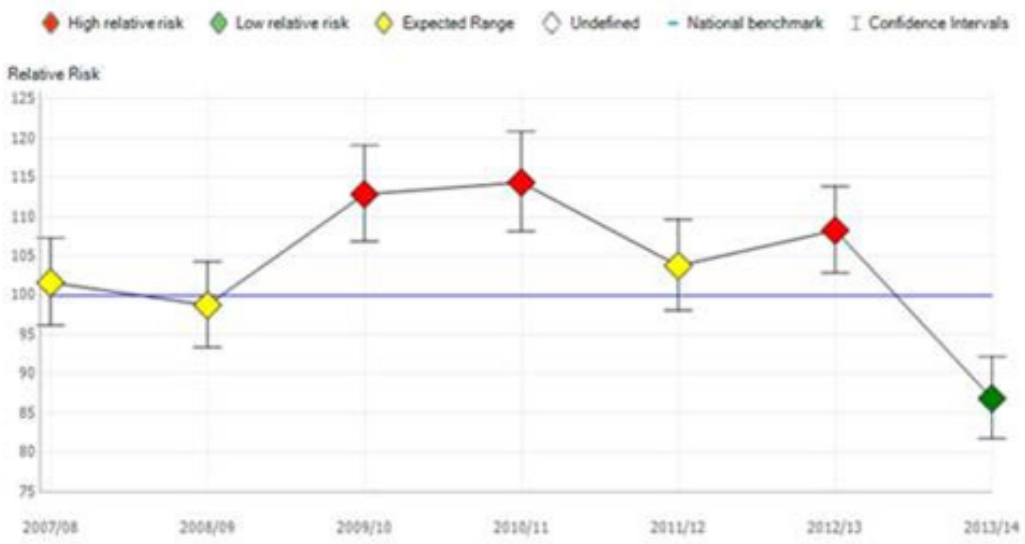
Domain 4 – Ensuring that people have a positive experience of care					
Responsiveness to inpatients' personal needs	68.6%	65.7%	68.1%	84.4%	57.4%
Staff recommendation of the trust as a place to work or receive treatment (NHS staff survey) **	56%	50%	65%	93%	38%
Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm					
Percentage of admitted patients risk-assessed for venous thromboembolism (VTE)	96.75 %	93%	96%	100%	77%
Rate of C. Difficile (number of cases)	26	30	17.3	0	30
Number of incidents reported in the financial year	3,980 (NRLS Apr 13 to Sep 13)	6,760 (NRLS)	Middle 50% of reporters (NRLS)		
Rate of patient safety incidents per 100 admissions (as defined by National Reporting Learning System (NRLS)	8.27 (NRLS Mar 13 to Sep 13)	7.60 (NRLS Oct 12 to Mar 13)	7.23 (NRLS Mar 13 to Sep 13)		
Number and percentage resulting in severe harm or death	13 0.30% (NRLS Mar 13 to Sep 13)	11 0.30% (NRLS Oct 12 to Mar 13)	0.20% (NRLS Mar 13 to Sep 13)		

Hospital Mortality Monitoring

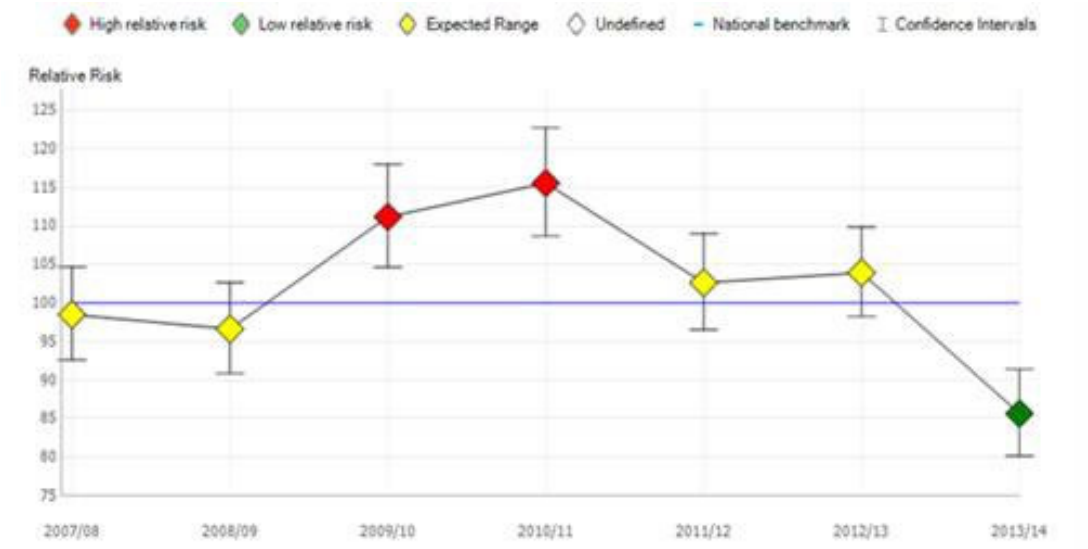
NGH uses 3 headline mortality monitoring tools which are benchmarked against all other hospitals in England and examine inpatient mortality rates. 2 indicators [HSMR and HSMR 100] are provided to the Trust by Dr Foster™ 2 months in arrears.

HSMR [hospital standardised mortality ratio] measures mortality from the 56 most common and serious conditions causing >80% hospital deaths: HSMR 100 looks at all hospital deaths. Both mortality indicators are adjusted, taking into account the age of each patient and their general health before their admission. These indicators can be analysed in detail to identify areas of care which require further analysis and investigation. The information is reviewed in detail each month by the associate medical director, and a structured report is presented to the medical director and discussed at CQEG and trust board. The findings and planned actions for any areas of concern are presented bimonthly to the mortality & coding review group.

HSMR 100

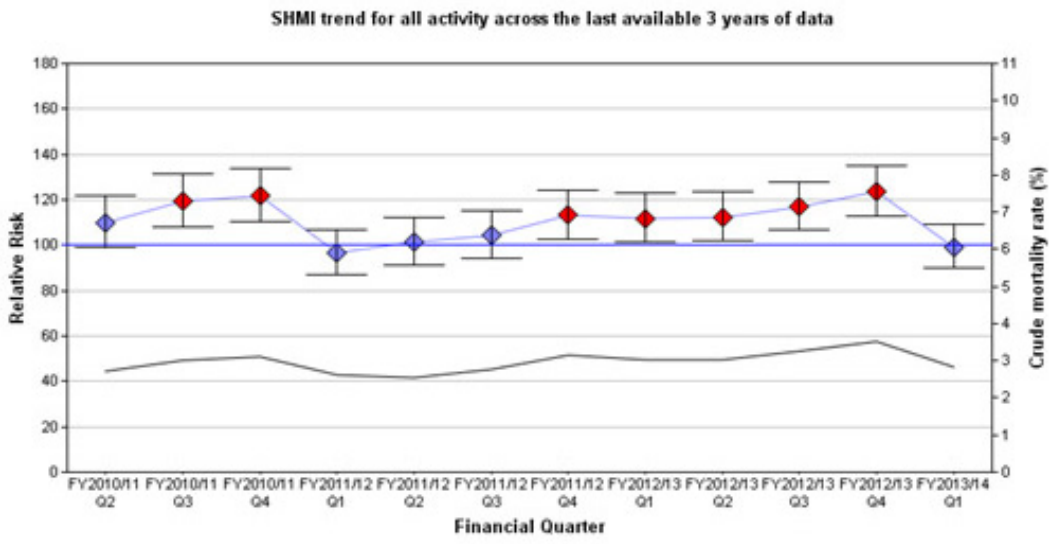


HSMR 56



Both of the above measures show improvement since 2008. Performance during 2012-13 was as expected; performance to January 2014 shows continuing improvement.

A third metric, SHMI [summary hospital-level mortality Indicator] is also used, provided by DH 9 months in arrears since 2010. It looks not only at hospital mortality, but also deaths that occur within a month of discharge, which may therefore reflect the care received outside the hospital. It also has a different casemix adjustment method, and so is not directly comparable to HSMR. Trust performance assessed by this method has been less satisfactory during 2012-13, but is now showing signs of substantial improvement and is expected to return to normal by the end of 2013-2014.



The trust is currently rolling out a programme to enable clinicians to monitor performance in their own specialty and review all deaths to ensure that standards of care are appropriate.

Improving Patient Safety by Reducing Infections

The infection prevention team is pleased to confirm that the 2013-14 target set by our commissioners for the number of hospital-attributable (post-3 days after admission) cases of C.difficile infection was met. We have reported a total of 26 cases against a target of 29. This was achieved by prudent antibiotic prescribing and applying appropriate infection control measures to all patients with symptoms of diarrhoea while carefully ensuring appropriate laboratory testing. C.difficile infection remains a significant issue for patients. The trust managed 48 cases of C.difficile infection, including 22 cases diagnosed in primary care or in the first 3 days of admission.

By focussing on the care and management of patients with central venous catheters we have successfully reduced the number of hospital acquired (post-48 hours after admission) methicillin-sensitive Staph. aureus bloodstream infections from 12 in 2011-12 and 11 in 2012-13 to just 6 in 2013-14.

We were disappointed to have to report a case of hospital-attributable MRSA bacteraemia. A case review was undertaken to ensure lessons were learnt from this incident.

Corporate scorecard report 2013/14

The trust continually monitors its performance against various indicators which are used to inform the Trust and external organisations of progress and to inform decisions about service improvement. The corporate scorecard for year end March 2014 is shown as an example below.

Corporate Scorecard 2013-14	Target 2013-14	Final	Final RAG Rating
Patient Safety			
HQU01: HCAI measure (MRSA)	0	0	
HQU02: HCAI measure (CDI)	29 per year	2	
HQU08: MSSA Numbers	No national ceiling set	0	
E Coli ESBL Quarterly Average	7 per month	1	
VTE Risk Assessment completed	95% month on month	97.2%	
High risk patients receive appropriate treatment	95% Month on month	100%	
MRSA Screening Elective Patients	100% month on month	99.6%	
MRSA Screening Non-Elective Patients	100% month on month	96.9%	
Ward Traceability Compliance Number of Unfated Units	0 month on month	15	
Incidence of pressure ulcers			
Grade 3 - New avoidable pressure ulcer		7	
Grade 3 - New unavoidable pressure ulcer		1	
Total Grade 3 - New pressure ulcer		8	
Grade 4 - New avoidable pressure ulcer		0	
Grade 4 - New unavoidable pressure ulcer		0	
Total Grade 4 - New pressure ulcer		0	
Total Grade 3 & 4 Pressure Ulcers		8	
Reduce harm from falls			
Catastrophic	0	0	
Major/Severe	0	1	
Moderate	0	0	
Mandatory Training compliance Full Year Impact			
Primary Levels Excluding B&H	80%	75.5%	
Attendance at Trust Induction	80%	88.1%	
Number of surgical site infections			
Fracture neck of femur - Number of Operations	-	3	
Number of infections	-	0	
% infection rate (monthly)	National average 1.6%	0.0%	

Corporate Scorecard 2013-14	Target 2013-14	Final	Final RAG Rating
Total hip replacements - Number of Operations	-	18	
Number of infections	-	0	
% infection rate (monthly)		0.0%	
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%	0.0%	
Total knee replacements - Number of Operations	-	21	
Number of infections	-	0	
% infection rate (monthly)	National average 1.6%	0.0%	
Full implementation of patient safety alerts e.g. NPSA, CAS, Medical Device Alerts etc			
Open Central Alert System (CAS) Alerts	0	0	
NICE clinical practice guidelines and TAG compliance	80%	81.1%	
Serious Untoward Incidents	-	12	
Never Events	0	0	
WHO Surgical Safety Checklist	100%	100%	
Healthcare Notes Audit			
Q.1 Does the front page of every sheet contain an addressograph label	100%	64%	
Q.2 Does addressograph include the NHS Number?	100%	97%	
Q.3 If there is NO addressograph label does the page contain: Patient's Full Name	100%	75%	
Q.4 If there is NO addressograph label does the page contain: Date of Birth	100%	61%	
Q.5 If there is NO addressograph label does the page contain: Hospital Number	100%	58%	
Q.6 If there is NO addressograph label does the page contain: NHS Number	100%	21%	
Q.7 Is record legibly written	100%	97%	
Q.8 Written in blue/black ink	100%	100%	
Q.9 Is record Contemporaneous i.e. Written in chronological order and within 24 hours of care event	100%	97%	
Q.10 Is date recorded for each entry	100%	86%	
Q.11 Is time recorded for each entry	100%	86%	
Q.12 Is there a signature of the person making the entry	100%	92%	
Q.13 Is surname printed in block capitals	100%	64%	
Q.14 Is the staff designation recorded	100%	62%	
Q.15 Medical Records Audit only: Is the GMC number present	100%	50%	
Q.16 Are any alterations / deletions scored through with a single line	100%	46%	
Q.17 Is there a signature recorded next to any alterations/ deletions	100%	43%	

Corporate Scorecard 2013-14	Target 2013-14	Final	Final RAG Rating
Q.18 Is there a date recorded next to any alterations/ deletions	100%	43%	
Q.19 Is there a time recorded next to any alterations/ deletions	100%	16%	
Q.20 Medical Records Audit only: Is there evidence of a clear plan of care/treatment	100%	97%	
Q.21 Medical Records Audit only: Is there evidence of communication to relatives and teams	100%	57%	
Q.22 Medical Records Audit only: Is there evidence of an entry by medical staff at least once a day	100%	96%	
Q.23 Are there any loose sheets in the Healthcare record % of surgical site infections (Quarterly HPA submission)	0%	6%	
Patient Experience			
Cancelled Operations not rebooked within 28 days	0	1	
Hospital Cancelled Operations	6.0%	10.5%	
Complaints Responded to within agreed timescales	100%	93%	
Referral to Treatment waits			
Admitted Patients	90.00%	95.18%	
Non Admitted Patients	95.00%	98.57%	
Ongoing Patients	92.00%	97.05%	
A&E Quality Indicators (5 measures)			
Time Spent in A&E (Month on Month)	95%	90.43%	
Time Spent in A&E (Cumulative)	95%	90.47%	
Total time in A&E (95th percentile)	95th	05:42	
Time to initial assessment (95th percentile) patients arriving by ambulance	<15 mins	00:59	
Time to treatment decision (median)	<60 mins	00:51	
Unplanned re-attendance rate	=<5%	6.24%	
Left without being seen	>1% and <5%	0.25%	
Ambulance handover times > 15 minutes	0	1165	
Ambulance handover times > 60 minutes	0	90	
Cancer Wait Times			
2 week GP referral to 1st outpatient	93%	90.9%	
2 week GP referral to 1st outpatient - breast symptoms	93%	86.0%	
31 Day	96%	93.2%	
31 day second or subsequent treatment - surgery	94%	100.0%	
31 day second or subsequent treatment - drug	98%	100.0%	
31 day second or subsequent treatment - radiotherapy	94%	96.2%	
62 day referral to treatment from screening	90%	94.4%	
62 day referral to treatment from hospital specialist	80% (local target)	92.9%	

Corporate Scorecard 2013-14	Target 2013-14	Final	Final RAG Rating
62 days urgent referral to treatment of all cancers	85%	79.2%	
SRS08: Length of Stay (Acute & MH)			
Elective	3.20	3.9	
Non-Elective	5.30	4.7	
SRS09: Daycase Rate	85%	83.5%	
SQU11: PROMS Scores - Pre Operative participation rates			
Groin Hernia - Participation Rate	Eng.Ave 57.6% (target 80%)	81.9%	
Hip Replacement - Participation Rate	Eng.Ave 79.2% (target 80%)	61.0%	
Knee Replacement - Participation Rate	Eng.Ave 90.5% (target 80%)	68.5%	
Varicose Vein - Participation Rate	Eng.Ave 39.9% (target 80%)	48.0%	
All Procedures - Participation Rate	Eng.Ave 72.7% (target 80%)	69.8%	
Clinical Outcomes			
HSMR - monthly position for 2013-14 (YTD)	<100	85.6	
HSMR - 12 Monthly cumulative position		84.1	
HSMR- cumulative position for 2013-14			
Pneumonia	<100	65.97	
Fracture of neck of femur (hip)	<100	74.05	
Acute Cerebrovascular disease	<100	83.32	
Congestive heart failure, nonhypertensive	<100	96.69	
Acute myocardial infarction	<100	101.54	
SHMI (based upon date of SHMI report publication)	<100	112.89	
SQU12: Maternity 12 weeks	90%	81.0%	
SRS10: Delayed Transfers of Care – Acute & MH	3.0%	9.4%	
Fractured neck of Femur			
% of patients admitted with FNOF who were operated on within 36 hrs of being fit for surgery	100%	85.7%	
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	93.0%	

Corporate Scorecard 2013-14	Target 2013-14	Final	Final RAG Rating
50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	49%	
100% of suspected stroke patients given CT scan within 24 hours of arrival	100%	100%	
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	60%	76.9%	
Patients who spend at least 90% of their time on a stroke unit	80%	63.0%	
Breast Feeding initiation	75%	81.4%	
Caesarean Section Rates - Total	<25%	29.2%	
Caesarean Section Rates - Emergency	14.98%	16.8%	
Caesarean Section Rates - Elective	12.00%	12.4%	
Home Birth Rate	>=3%	4.3%	
Number of readmissions within 28 days (Adult)	-	Not Avail	
Number of readmissions within 28 days (Children)	-	Not Avail	
CQUIN 2013-14			
NATIONAL CQUINS			
1.VTE			
1a. 95% of all adult inpatients to have a VTE risk assessment	95% month on month CQUIN payment to be received if both 1a and 1b are achieved. 60% of all root cause analyses completed	97.2%	
1b. VTE Root Cause Analysis.		On track	
3. Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting			
3a.Dementia case finding	90% 3 consecutive months	90.7%	
3b.initial diagnostic assessment	90% 3 consecutive months	95.5%	
3c. referral for specialist diagnosis	90% 3 consecutive months	95.0%	
3d.Lead clinician and appropriate training of staff	Yes	On track	
3e.Supporting Carers of People with Dementia (monthly audit)	Yes	On track	

Corporate Scorecard 2013-14	Target 2013-14	Final	Final RAG Rating
LOCAL CQUINS			
1. Develop and implement AECP			
1a AECP for Chest Pain		On track	
1b. AECP for Pulmonary Embolism		On track	
1c. AECP for Supraventricular Tachycardia		On track	
1d. AECP for Pleural Effusion		On track	
1e..AECP for Painless Jaundice		On track	
2. Development of HOT Clinic			
2a. HOT Clinic for Paediatrics		On track	
2b. HOT Clinic for Surgery		On track	
2c. HOT Clinic for Medicine		On track	
NHS ENGLAND CQUINS			
1. Friends & Family			
1a. Phased expansion of Friends and Family Test (maternity services)	Implementation by Oct 2013	39.88%	
1b. increase response rate to at least 20%	=>20% by Yr End	21.27%	
1c. Improve performance on staff Friends & Family Test		CQUIN requirement achieved	
2. 50% reduction in all new Pressure Ulcers that are avoidable.	Max 3 incidents p/m	9	
3. Quality Dashboards		On track	
4. Timely Simple Discharge	Improvement on baseline (37%)	0.0%	
5. Improved access to breast Milk -% of babies less than 33wks discharged on breast milk	Improvement on baseline	20.0%	
6. Acute Kidney Injury	Q1 Process recorded and definition in place	On track	

Statements from Nene Clinical Commissioning Group & Corby Clinical Commissioning Group; Northamptonshire County Council Health & Social Care Scrutiny Committee and Healthwatch

NHS Nene Clinical Commissioning Group and NHS Corby Clinical Commissioning Group

Northampton General Hospital (NGH) NHS Trust annual quality account for 2013-14 has been reviewed by NHS Nene Clinical Commissioning Group (Nene CCG) and NHS Corby Clinical Commissioning Group (Corby CCG). It is noted that the report was reviewed whilst in draft format.

The account contains five key Quality Priorities for 2014-15. These are supported by Nene and Corby CCGs as these do reflect both national and local priorities. However, how these will be monitored could be more clearly articulated. Some plans for 2014/15 refer to the Community Hospitals which are no longer provided by the Trust.

It is not clear from the Quality Account which Commissioning for Quality and Innovation (CQUIN) schemes for 2013/14 were national, local with the CCGs or from Specialist Commissioning. It is suggested that it would be positive to identify the impact for patients of the CQUIN schemes achieved and to have a more detailed description of the CQUIN not achieved and actions taken.

It would be helpful to identify how CQUIN and quality schedule plans for 2014/15 will improve the quality of care for patients.

It is stated within the Quality account that external auditors have tested two performance indicators, the Friends and Family Test results and Infection Control reporting for Clostridium Difficile. It may be helpful to include their findings.

The Trust has participated in all applicable National Clinical Audits and two out of three National Confidential Enquiries.

It is noted that data reporting has improved in some areas but that there is still work to be undertaken to improve Information Governance and clinical coding. It may be helpful to detail what actions will be taken to improve clinical coding.

Categories of complaints are contained within the report but actions to improve against these are not. It is not clear how many complaints that have gone to the Parliamentary and Health Service Ombudsman have been upheld.

Within the draft Quality Account there is no mention of the Trust Development Authority review. Whilst the draft version of the Quality Account notes that there was a CQC inspection and that some immediate actions were taken and that there are further remedial actions to be taken it is not clear that there is a warning notice and the nature of this.

The quality account does not reference how any cost improvement programmes have impacted on the quality of care. It may have been helpful to include this information.

The CCGs believe that the corporate scorecard used within the draft report may be misleading as the data appears to be the year end position but is in fact the performance for March 2014.

Given the challenges faced by the increase in numbers of patients, and the concerns raised by the CQC, the Commissioners will work very closely with the Trust to understand and support ambitions to improve quality standards of care for people who use services.

Northamptonshire County Council (NCC) Health & Social Care Overview and Scrutiny Committee

The NCC Health & Social Care Scrutiny Committee formed a working group of its members to consider a response to your Quality Accounts 2013-14. Membership of the working group was as follows:

- Councillor Sally Beardsworth
- Councillor Eileen Hales
- Councillor Ron Sawbridge
- Councillor Judy Shephard (Chairman)
- Mr Andrew Bailey (Northamptonshire Carers Representative)

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

- The Working Group felt the hospital was making good progress against targets, particularly in relation to baby and child care and patient safety.
- The glossary at the end of the document was considered to be good.
- Inclusion of the Corporate Scorecard was also welcomed.
- The Working Group noted the good scores in NGH's QuEST for excellence and it was noted the scores relating to patient/family response were not only increasing in numbers but were also becoming increasingly more positive.
- It was felt the introduction gave insufficient credence to issues previously highlighted by the Care Quality Commission.

The Working Group would like to encourage medical directors of the organisation to contribute to the introduction.

- The document was considered to be difficult to read. A graph on page 53 of the Quality Account which related to the number of complaints received was given as an example of difficulty in reading the layout.
- A further example of this was provided in the section relating to the improvements in End of Life Care and Care of the Dying. It was felt members of the public would mistake the 'AMBER Care Bundle' for a traffic light system with the hospital aiming to be 'middle of the road' in terms of improvements. The Working Group felt the public would feel reassured that patients were properly cared for should the document provide an explanation for the 'AMBER Care Bundle' which clearly stated the organisation did not aim for average performance in this respect..
- The Working Group felt the document did not adequately balance positive and negative comments.
- It was not felt the text in the document was a fair reflection of the information provided in the Corporate Scorecards. An example was the handover time from ambulance crews to hospital staff where the Scorecard reported this had been greater than 60 minutes for only 90 patients.

- It was suggested further information on the numbers of patients who were self- referred or referred by their GP could be helpful, particularly as non-attendance for an appointment created a cost to the local health economy in general.
- It was also suggested information relating to the reasons for re-admissions could have been a helpful addition to the document.
- The Working Group felt that inclusion of the reasons for, and sums paid, in compensation would assist in reassuring the public that issues were being addressed.

The working group also made the following comment in relation to quality accounts in general:

- It was felt the guide for Overview & Scrutiny Committees produced by the Department of Health required updating particularly in light of the Care Act 2014.
- That there should be more uniformity across the whole sector in the production of Quality Accounts. The Quality Account produced by Kettering General Hospital was considered to be an exemplar of good practice.

Healthwatch Northamptonshire (HWN)

We welcome this opportunity to comment on the draft quality account for Northampton General Hospital NHS Trust (hereafter referred to as NGH). As the independent champion for people in Northamptonshire using health and social care, we wish to submit the following comments. Recommendations are in bold italics.

Part 2: Quality Improvement Priorities 2014-15

We agree that the agreed priorities are the correct ones to focus although we would recommend that urgent care should be an additional priority given the particular pressures on NGH and the agreed countywide focus on urgent care as the top priority for the health and social care system.

Discharge planning: We would like to see a greater emphasis on care planning referenced in this section. It is implied but should be made explicit.

End of Life Care: This was categorised as red (i.e. inadequate) by the CQC inspection report. It was clear from the CQC listening event in January that end of life care requires urgent attention and the feedback we heard indicates a strong correlation with the need to improve pain management. We recommend that, in appropriate circumstances, relatives are offered the opportunity to comment on the quality of End of Life care at NGH. HWN would be happy to collaborate with NGH on seeking relative/carer views.

Learning from Incidents: We fully support this but we would also want to see learning from complaints included in this section. There is reference further in the account to learning from complaints but we would like to see integration of the learning.

Pain management: We have heard feedback, particularly from relatives, about the need for pain management to be improved. We would be happy to collaborate with NGH in seeking the views of patients and families.

Patient experience: We welcome the reference to formalising Healthwatch and other patient/user groups such as Age UK, to support the patient experience strategy. We would welcome a detailed conversation with NGH about how we can work in partnership to support the delivery of this priority.

Part 3: Review of 2013/4 quality priorities

Emergency care pathway

As reference above, we recommend this remains a priority. HWN conducted a two-week survey of people attending A&E in April 2014. Our report will be published shortly and our initial observations found:

- Children not being prioritised in A&E (as recommended by CQC) and no separate waiting area. Parents were understandably concerned about this.
- Lot of people being referred to A&E directly by the 111 service (which is a system wide issue).
- The process for being directed to the minor injuries and minor ailments service not being clear.
- Misleading signage in some local pharmacies (their own signage) which may have driven people to A&E (system wide issue).
- Difficulties in getting GP appointments – many people have told us of regular waiting times of two weeks and some of one month (system wide issue).

Caring for vulnerable adults

We recommend that NGH explores the arrangement used by Kettering General Hospital (KGH) to support patients with learning disabilities. KGH employ a learning disability liaison officer to work with key nurses when a patient with a learning disability is admitted. We have received good feedback about this initiative from the Learning Disability Partnership Board.

Part 4: Showcasing improvement in NGH

Patient experience

Noise at night: We know from our gathering of the views of patients and the public that noise at night at NGH remains a big issue.

What do others say about Northampton General Hospital NHS Trust

We are disappointed to see no reference to the work of HWN in assessing the patient experience during 2013-14. This is of particular concern as we had set out a summary of all the patient feedback we received during 2012-13 and 2013-14 in our submission for the CQC inspection in January 2014. We launched the report in early April following publication of the CQC report and a copy was sent to NGH. Our report included the following information:

- Summarised views of 147 people we spoke to across 20 inpatient wards at NGH and nearly 80 people attending Eye Casualty;
- Analysis of a county-wide survey of the public we conducted in September 2013 (Make Your Voice Count) - 27 of the 214 respondents gave us specific comments about their experiences at NGH, 13 of these mentioned poor experiences and 14 mentioned good experiences;
- Issues and complaints we received between June 2013 and March 2014 – one third (27 out of 83) of the negative issues logged are about patient experience at NGH;
- Additional feedback we received from the public during January 2014 - nine responses, four broadly negative and five positive.

We received a mix of views about NGH – both positive and negative. The positives included quality clinical care, clear information, and compassionate staff. The areas for improvement

included Accident and Emergency, treatment and clinical care, dignity and general care on wards, discharge and after care, food, and communication and administration. The lack of reference to our findings is a serious omission and we hope the final quality account references our findings.

Goals agreed with commissioners

We are concerned to note the under achievement of the target to reduce avoidable pressure ulcers but are pleased to see that there is a work stream addressing this now in place. We would welcome further details.

Part 6: Core Quality indicators

Hospital mortality rates: The information regarding death rates should be displayed in a more straightforward way. This is an issue of significant public interest and should be explained in simple terms. Some of the graphs are difficult to understand and given that the Trust has higher rates than the national average according to the Summary of Hospital Level Mortality Indicators, there is a particular need for this to be set out really clearly.

Additional comments

We are concerned that there is no direct reference to significant incidents which occurred during the year or the outcome of investigations that were reported during the year. These include the multi-agency safeguarding investigation into care and treatment on Cedar ward (concerns included patients not receiving pain relief quickly enough, call bells not being answered in a timely fashion and the attitude and behaviour of some members of staff), and the coroner's inquest into the death of a man who waited for over 5 hours in A&E after suffering an abdominal aortic aneurism (AAA) that was not diagnosed, followed by further delays in sourcing a reinforced operating table. In the interests of balance, it is essential that the Quality Account provides a full summary of quality issues.

Presentation of the Quality Account

We welcome the glossary of terms at the end of the document. The document could be simplified in places (e.g. see above reference to mortality rates) and we would ask the Trust to provide a shorter, more accessible summary and ideally an easy read summary.

Consultation

We recommend that Total Voice, the providers of NHS complaints advocacy, Independent Mental Health Advocacy and Independent Mental Capacity Advocacy, is invited to comment on this quality account. They should be a rich source of feedback on the quality of care and their views should be sought. Additionally we would recommend that patients, relatives and staff are invited to comment on the quality accounts.

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

We are required by the Audit Commission to perform an independent assurance engagement in respect of Northampton General Hospital NHS Trust's Quality Account for the year ended 31 March 2014 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act"). 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 2014 subject to limited assurance consist of the following indicators:

- Clostridium Difficile infections
- Friends and Family Test patient element score

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

Respective responsibilities of Directors and auditors

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 2013/14 issued by the Audit Commission on 17 February 2014 ("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 iwe 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 2013 to June 2014;
- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;
- feedback from the Commissioners dated 21/05/2014:
- feedback from Local Healthwatch dated 28/05/2014:
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated July 2013;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the national patient survey report 2013;
- the 2013 national staff survey;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 08/04/2014;
- the annual governance statement dated 02/06/2014;
- Care Quality Commission quality and risk profiles/intelligent monitoring dated March 2014;

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 Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. 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 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 our appointment under the Audit Commission Act 1998 and in accordance with the Commission's 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.

Basis for qualified conclusion
In relation to the indicators tested, Clostridium Difficile infections and Friends and Family Test patient element score, we are unable to confirm that they have both been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We are unable to confirm the accuracy and completeness of the Clostridium Difficile infections indicator due to the non-compliance with guidance provided during the 2013/14 financial year.

We were unable to confirm the accuracy, and completeness of the Friends and Family Test patient element score due to a lack of audit evidence during the 2013/14 financial year.

Qualified Conclusion
Based on the results of our procedures, with the exception of the matters reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- 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.

KPMG LLP,
Statutory Auditor Chartered Accountants
St Nicholas House
Park Row
Nottingham NG1 6FQ

20 June 2014

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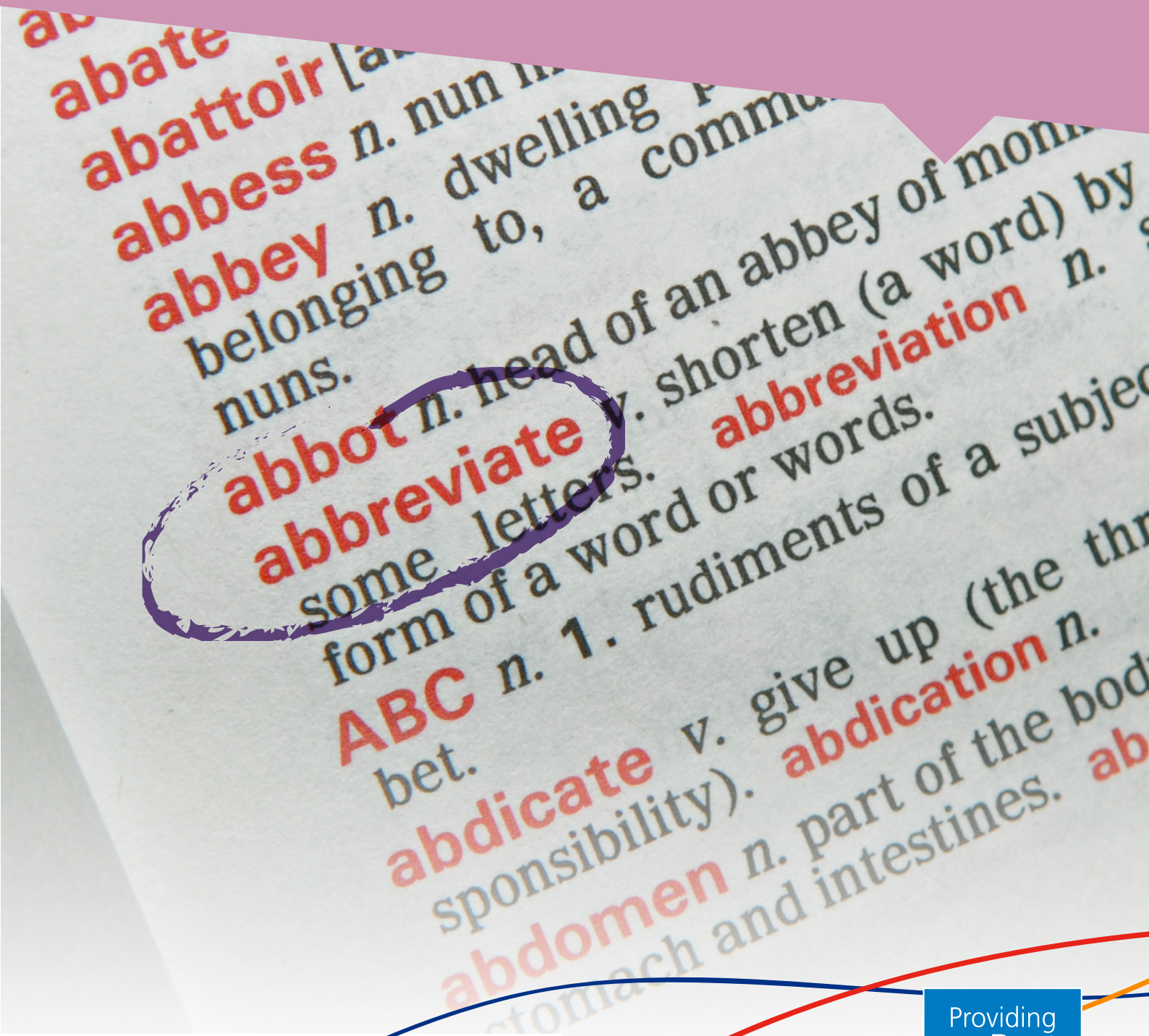
Part Seven

Abbreviations List



Providing the Best Possible Care

Abbreviations list

A

AAA- Abdominal Aortic Aneurism
A&E –Accident & Emergency
ACC- Ambulatory Care Centre
ACS – Acute Coronary Syndrome
ADL- Activities of Daily Living
AECP – Advanced and Emergency Care Pathway
AUGIS – Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland

B

BCIS – British Cardiovascular Intervention Society
BLS – Basic Life Support
BME – Black and Minority Ethnic
BNP – Brain natriuretic peptide
BP – Blood pressure
BPT – Best practice tariff
BTS – British Thoracic Society

C

CCG – Clinical Commissioning Group
CCOT – Critical Care Outreach Team
CEPOD– Confidential Enquiry into Patient Outcome and Death
CETN – Central England Trauma Network
CHD- Coronary Heart Disease
CHC – Continuing Healthcare
CHR – Child Health Review
CNS – Central Nervous System
CT – Computerised Tomography
CQC – Care Quality Commission
CQEG – Clinical Quality and Effectiveness Group
CQUIN - Commissioning for Quality and Innovation
CURB – Confusion, Urea, Respiratory, Blood pressure

D

DAHNO – Data for Head and Neck Oncologist
DCA –Dementia care action Committee
DNA –Did Not Attend
DNACPR –Do Not Attempt Resuscitation
DH/DoH – Department of Health
DTOC – Delayed Transfers of Care

E

ECG – Electrocardiograph
EDD – Estimated Date of Discharge
EDN – Electronic Discharge Notification
EMCN – East Midlands Cancer Network
EWS – Early Warning Score

F

FFT - Friends and Family Test
FIGO – International Federation of Gynaecology and Obstetrics
FIT- Fast Intervention Team

F/U appointments – Follow up

G

GP-General Practitioner
GI –Gastro Intestinal

H

HCA – Health Care Assistant
HDR - High Dose Rate
HDU - High Dependency Unit
HEE – Health Education England
HRG – Healthcare Resource Group
HOT – Healthy Options Team
HSMR – Hospital Standardised Mortality and Ratio

I

ICD -10 – International Statistical Classification of Diseases and related Health Problems.
ICE – Integrated Clinical Environment
ICNARC – Intensive Care National Audit and Research Centre
IDB – Inflammatory Bowel Disease
IHGC - Integrated Healthcare Governance Committee
ITU – Intensive Therapy Unit

M

MBRRACE-UK – Mothers and Babies Reducing Risk Through Audits and Confidential Equiries across the UK
MCA – Mental Capacity Assessment
MINAP – Myocardial Ischemia National Audit Project
MDT – Multi-Disciplinary Team
M&M – Morbidity and Mortality
MRI – Magnetic Resonance Imaging
MRSA - methicillin-resistant staphylococcus auresis

N

NAB - Northamptonshire Association for the Blind
NCC – Northamptonshire County Council
NCEPOd– National confidential Enquiry into Patient Outcome and Death
NEWS – Northampton Early Warning Score
NGHT- Northampton General Hospital NHS Trust
NHS- National Health Service
NICE – National Institute for Health and Excellence
NICOR – National Institute for Cardiovascular Outcome Research
NIHR - National Institute for Health Research
NIV- Non Invasive Ventilation
NJR –National Joint Review
NMC – Nursing Midwifery Council
NNAP – National Neonatal Audit Programme
NPSA – National Patient Safety Agency
NRLS – National Reporting and Learning System
NSTEMI – Non-ST-Segment-evaluation Myocardial Infarction
NVD – National Vascular Database

O

ODP – Operating department practitioner
O-G – Oesophago- Gastric

P

PALS – Patient Advice and Liaison Service
PAS – Patient Admissions System
PbR – Payment by Results
PCI – Percutaneous Coronary Intervention
PD – Parkinson's Disease
PDSA – Plan, Do, Study, Act
PDT - Photodynamic therapy
PEN –Patient Experience Network
PET – Position Emissions Tomography
PEWS – Paediatric Early Warning Score
POA appointments – Pre-operative Assessment
PPI – Patient and Public Involvement
PROMs – Patient Reported Outcome Measures

Q

QA –Quality Account
QELCA - Quality End of Life Care for All
QuEST – Quality Effectiveness Safety Team

R

RCPH – Royal College of Paediatrics and Child Care
RESTART – Respiratory Therapy Acute Response Team
RGN –Registered General Nurse

S

SABR – Stereotactic Ablative Radiotherapy
SALT –Speech and Language Therapy
SHO – Senior House Officer
SI –Serious Incident
SINAP – Stoke Improvement National audit Programme
SSNAP - Sentinel Stroke National Audit Programme
ST3 – ST9 Doctors specialist Training
SUS – Secondary Users Service

T

TARN – Trauma audit and Research Network
TEP – Treatment Escalation Plan
T&O – Trauma & Orthopaedic
TTO – To Take Out
TVN – Tissue Viability Nurse

U

UHCW – University Hospitals Coventry and Warwickshire NHS Trust

V

VSGBI – Vascular Society of Great Britain and Ireland
VTE – Venous Thromboembolism

W

WHO – World Health Organisation

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