Northampton General Hospital
NHS Trust

2012/13

Quality Account

'Northampton General Hospital NHS Trust (NGH) is committed to providing the very best care for all of our patients'.

Part 1

Part 2

Part 3

Part One

Statement on Quality from the Chief Executive

Quality accounts are annual reports to the public from providers of NHS healthcare, about the quality of services they deliver. The primary purpose of the quality account is to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services offered. It allows us, as leaders, clinicians, shadow governors and staff to demonstrate our commitment to continuous, evidence-based quality improvement and to explain our progress to the public.

I am therefore delighted and proud to share with you the fourth annual quality account for Northampton General Hospital NHS Trust. Our vision states that *'Northampton General Hospital NHS Trust (NGH) is committed to providing the very best care for all of our patients'. This requires the Trust to be recognised as a hospital that delivers safe, clinically effective acute services focused entirely on the needs of the patient, their relatives and carers.*

Our quality strategy, which was reviewed last year, covers all aspects of the quality agenda and focuses on patient safety, effectiveness of care and patient experience, enabling us to involve and engage with our patients, clinicians and staff to ensure that quality is at the heart of all that we do.

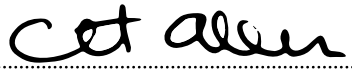
We have made significant progress in some areas but there is more to do. We have a major investment programme within emergency care and will continue to improve care for our emergency patients. We are exceptionally proud of our patient safety academy, which is providing a strong lead for staff towards the provision of safer focused patient care across the Trust. The quality account for 2012/13 describes how NGH has continued to develop over the last year and includes reviews of the previous years, performance in quality. It also describes other quality improvements made during the year. To the best of my knowledge the information contained within this quality account is accurate.

We have decided, in agreement with shadow governors, to continue with the same priorities in 2013/14 as for 2012/13. This is because the strategies developed to support those priorities are three-year strategies, which we feel are still vital to the population we serve. Within these priorities, we have set ourselves a number of additional targets; which are presented in part 2 of this document.

We have continued to face many challenges over the last year and have seen an increased demand in all our services. Our staff have worked extremely hard to meet these pressures. The demands for emergency care have provided a particular challenge for the whole healthcare system. We will continue to work with our healthcare partners to improve the emergency care pathway and to ensure that the future services for Northamptonshire can be redesigned with quality as the founding principle.

I very much hope that you enjoy reading the account of the Trust's quality achievements during the year and those that we look forward to accomplishing over the next 12 months.

Christine Allen
Chief Executive
Northampton General Hospital NHS Trust

Signature 

Part One

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 2012 to March 2013
    - 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 (2012)
    - National A&E Survey (2012)
    - NHS Staff Survey (2012)
    - The CQC quality risk profiles
    - National cancer patient experience survey (2012)

- 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

03/06/2013 ..... Date ..... Chairman

03/06/2013 ..... Date ..... Chief Executive

Part 2
Priorities for Improvement and Assurance 2013/14

Our Quality Strategy

Purpose

The ultimate purpose of this quality strategy is to provide the very best care for all of our patients. 'Equity and Excellence: Liberating the NHS' (DH, 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 amongst 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, as a result of: increased public expectation, lifestyle changes, an ageing population, developments in technology and the current and projected economic context (which brings significant financial challenges). This strategy sets out how we will respond to these challenges, keeping quality at the heart of everything we do, whilst providing excellent care to our patients in line with the vision for the NHS.

NGH's Vision

Our vision is to *"provide the very best care for all of our patients. This requires Northampton General Hospital (NGH) to be recognised as a hospital that delivers safe, clinically effective acute services focused entirely on the needs of the patient, their relatives and carers. These services may be delivered from our acute or community hospital sites or by our staff in the community"*.

In order to achieve this vision, the Trust has set out five aims, all of which reflect our vision for quality:

- Be a provider of quality care for all our patients
- Enhance our range of hyper acute services for the wider community
- Provide appropriate care for our patients in the most effective way
- Foster a culture where staff can give their best and thrive
- Ensure we invest wisely to make improvements in care.

Our Quality Goals

The Trust has identified three quality goals which link to the strategic objectives. The quality goals have been chosen to improve each of the three key components of quality.
They are to:

- Reduce all avoidable harm and save every life we can
- Improve the Friends and Family Net Promoter Score by 10% each year
- Ensure patients will receive high quality evidenced based care.

Part Two

Northampton General Hospital NHS Trust defines quality as embracing three key components:

Patient Safety - there will be no avoidable harm to patients from the healthcare they receive, this means ensuring that 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 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.

Part Two

Looking forward
Our Quality Priorities 2013/14

Part 2 is the section in our quality accounts that looks forward and identifies our quality priorities for 2013/14. It also includes our statements of assurance from the Trust Board.

We will demonstrate our commitment to quality by continuing the four main priorities identified last year:

- Redesigning the Emergency Care Pathway
- Caring for Vulnerable Adults
- Patient Safety Programme
- Patient Experience.
-

There has been significant work undertaken on last year's quality priorities and some positive improvements were achieved. The Trust however, feels that after consultation with the shadow governors, these priorities should be continued through 2013/14. This will enable the developments which have been made to be further strengthened and facilitate significant quality improvements to the patient experience and outcomes.

Where appropriate, we have aligned priorities with our Quality and Innovation (CQUIN) targets, a range of local and national quality priorities chosen by our Commissioners and by the DH.

Fig. 1 Quality Priorities 2013/14

Part Two

Quality Priority 1
Redesigning the Emergency Care Pathway 2013/14

Background

NGH continues to experience year-on-year increases in Accident and Emergency (A&E) attendances with an associated increase in admissions. The current and projected increase in attendances and admissions has required the opening of additional substantive bed capacity, consequently requiring additional nursing, medical and allied health professional staff. An additional 1076 emergency admissions were admitted to the hospital when compared with the last financial year.

In order to improve this situation, the Trust will continue to work with the wider health economy; to improve accessibility, to address the issues relating to the numbers of patients who attend A&E and require admission; and to find suitable places of care for those patients who have received treatment but no longer need to be in an acute hospital.

Meanwhile, there is still a significant amount of work to be done within the Trust to improve emergency care. NGH staff are working exceedingly hard to ensure the highest quality of care even though bed occupancy is high and additional escalation beds are sometimes required for increasing numbers of emergency patients.

As part of NGH's focus on quality, this priority involves redesigning emergency care pathways to ensure that the systems and processes are in place to support staff to deliver quality care first time every time, with an additional focus on continual improvement in the care that is given to patients attending the hospital, either via A&E or following admission. This work is supported by five clinically-led working groups, which ensure that each step of the emergency care pathway is focused on improvement.

Aim

To redesign the emergency care pathway so that we always provide best quality care, using best practice standards.

Part Two

Targets for 2013/14

Improvement targets for 2013/14 are shown in the table below:

Aim	Targets for achievement by end of March 2014
Improved patient care in the A&E and throughout the patient journey.	• 95% of patients waiting less than 4 hours in A&E.
Improved patient flow to reduce delay and improve clinical outcomes.	• Aim for all patients who attend A&E to wait less than 15 minutes for their initial assessment • 95% of radiology and pathology results to be available within 1 hour • 50% of discharges to happen before 1pm each day • Embed the management of planned discharge dates from wards linking to the visual hospital system.
Improving patient safety and patient experience.	• Aim for 100% of patients to have an Estimated Discharge Date recorded and communicated to them • Continue to work to improve both patient safety and patient experience, placing NGH in the top 10% of all Trusts nationally • Develop and embed internal professional standards that set out the way hospital teams work together and define the times within which various interventions take place.
Reduction in bed occupancy to improve patient experience and reduce harm.	• Aim to reduce bed occupancy on all adult acute wards to <90% • Reduce the number of patients who have been in hospital for more than 10 days to <210 • Establish further ambulatory care pathways where some conditions can be safely treated in hospital without the need for an overnight stay.

Fig. 2 Quality Priority 1 Targets 2013/14

Areas of improvement that were introduced in 2012/13:

- Additional resources were agreed to support the A&E teams including 2 additional consultants and 10 additional nurses
- Emergency physicians available 13 hours per day Monday-Friday, 2 physician ward rounds at the weekend, in addition to existing on-call arrangements
- Nurse facilitated discharge (NFD) has been implemented, resulting in a higher quality discharge process whilst reducing delays in patients being discharged
- Establishing ambulatory care pathways – a patient-focused service where some conditions can be safely treated without the need for an overnight stay
- New interim continuing health care (CHC) placement process in place (reduction of assessment time from 14 days to 3 days).

Despite these improvements, there has been great difficulty in providing the desired quality of care we have committed to. A targeted improvement plan to ensure that standards can be raised further to the level to which we aspire has now been developed.

Part Two

Areas of improvement planned for 2013/14

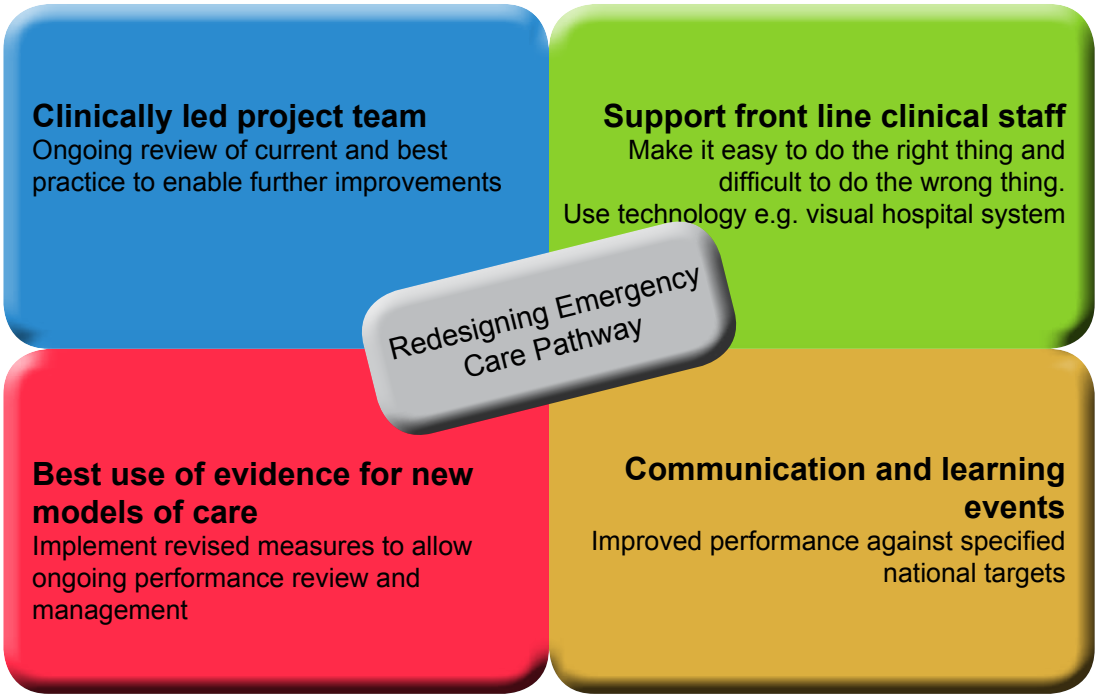


Fig. 3 Quality Priority 1 Areas for Improvement 2013/14

How progress will be monitored and measured

The emergency care pathway redesign group reports to the urgent care project board, which is chaired by the Trust chief executive. The urgent care project board will oversee the implementation of changes to the emergency care pathway and have reviewed recommendations from a range of studies undertaken by external organisations. An urgent care dashboard has been developed to provide monthly metrics to support assessment of the impact of changes implemented.

Part Two

Quality Priority 2
Caring for Vulnerable Adults 2013/14

Background

NGH is involved in the care of many people who might be frail, elderly or vulnerable to harm and abuse.

This is why we are continuing our focus and improvements in the care of patients with learning disabilities and dementia.

We will continue with our investment programme and developing our specialist team to increase awareness, support and improvement across the Trust. The team has good links with the health community and partner agencies and this enables a consistent approach to safeguarding across all agencies and provides a timely and appropriate response to safeguarding vulnerable adults.

Aim

To continue to improve the care given to people with dementia and/or learning disabilities.

Targets for 2013/14

Improvement targets for 2013/14 are shown in the table below:

Aim	Targets for achievement by end of March 2014
Deliver dementia training delivered as per the dementia training strategy.	• To review and continue to deliver dementia training for staff who have contact with patients with dementia (to become essential for key staff).

Learning disability awareness and communication training.	• Development of an 'easy read' patient feedback form for patients with a learning disability to ensure that their views of care and treatment are heard
	• Enhance the learning disability awareness training, focusing on the identification and management of patients. It will draw on the experiences of patients, carers and staff who have been involved in the learning disability pathway including sharing their stories and experiences of being in hospital
	• Development and implementation of an 'easy read' version of the Trust's equality outcomes that will be accessible to the public
	• Development of easily understood information leaflets regarding treatment options
	  • Ultrasound leaflets
	  • Endoscopy leaflets
	• Schedule of planned audits
	  • Implementation of Mental Capacity Act (MCA)
	  • Embedding use of tools developed including the hospital passport
	  • Identifying whether use of the tools made a difference to the care for patients with a learning disability, carers and health care staff through audits
	• Reports on these will be produced, learning shared and action plans developed.

Part Two

Aim	Targets for achievement by end of March 2014
Management of people with dementia.	• Develop and introduce a care pathway for patients with dementia at NGH.
Improved quality of care and experience for those with dementia.	• Further develop and embed the 'butterfly' project (this is a scheme to identify patients with dementia on the wards) to include the identification of patients with cognitive impairment, delirium or possible dementia who do not have a dementia diagnosis on admission • Improve the environment for patients with dementia • Develop the dementia champion role on the wards • Undertake a gap analysis against best practice guidelines launched by the Dementia Action Alliance in partnership with the Institute for Innovation and Improvement (March 2013) • Establish a dementia care action committee (DCA) responsible for overseeing the development and implementation of the action plan, resulting from the gap analysis.
Develop patient and carer information in an appropriate format for patients with dementia and learning disabilities.	• Encourage an integrated approach to the development of 'easy read' information for patients with dementia and learning disabilities.
Deliver the dementia CQUIN target.	• Part 1 of the dementia CQUIN 2013/14 will be incorporated into the new adult non-elective admission proforma and captured on the electronic discharge notification • Establish an audit to identify whether carers of patients with dementia feel supported as per part 3 of the CQUIN • Development of a business case for a dementia lead nurse/therapist. N.B. Part 2 of the CQUIN is to deliver training (see above).

Fig. 4 Quality Priority 2 Targets 2013/14

Areas of improvement that were introduced in 2012/13:

- 'Butterfly' care audited every 6 months reports published and action plan developed and implemented
- Staff and public awareness increased through different forums and events
- 50% of dementia care training delivered as planned in the training strategy
- Central resource developed, available via the dementia section on the Trust intranet site
- Initial work on developing care pathway commenced
- Some progress with improving the physical environment; Creaton ward
- Dignity champions updated monthly regarding dementia care at NGH, with changes being taken forward within their area of work
- Leaflets and information sourced from the Alzheimer's Society distributed to all ward areas.

Part Two

Areas of improvement planned for 2013/14:

Fig. 5 Quality Priority 2 Areas for Improvement 2013/14

How progress will be monitored, measured and reported

The safeguarding of vulnerable adults (SOVA) steering group will monitor progress through the receipt of monthly reports on progress which will inform quarterly reports to the Clinical Quality and Effectiveness Group (CQEG), the Healthcare Governance Committee (HGC) and the Trust Board. External reporting will take place through the CQUIN monitoring process. Quarterly feedback will be presented to One Health Group (county wide learning disability forum).

Part Two

Quality Priority 3
Patient Safety Programme 2013/14

Background

The Trust has introduced a high level aim that can be understood by staff and patients. This is articulated as follows: *'At NGH we aim to reduce all avoidable harm to patients and save every life we can. We aim to save 300 extra lives over the next three years.'*

The Trust has invested in a programme of development to support a team of leaders for safety who have formed a Patient Safety Academy. Under the leadership and direction of the Medical Director and the Director of Nursing, Midwifery and Patient Services, supported by the patient safety programme lead through the clinicians who support the leaders of safety, they will roll out projects and education to all staff groups. They are responsible for delivering a high profile portfolio of key projects that link to the operational delivery of services to improve quality.

During January 2013, project workshops were held for each of the work streams. The five work streams of the Patient Safety Academy are:

- Failure to plan
- Failure to rescue
- Failures of care
  - Oxygen management, Fluid balance, Patient weighing project, Nutrition and dietetics team (24 hour snack boxes) – Tissue viability nurse (TVN), Elderly - Pressure ulcers and falls
- Learning from SIs
- Learning from error and human factors safety science

Interested champions were invited to meet with the clinical leads to discuss their active involvement in safety initiatives and project work. As a result of this, the following supplementary projects are currently ongoing into 2013/14 with the safety champions locally:-

- Allebone ward is currently auditing the use of the safety action plan (SAP) forms on the ward
- The Endoscopy service is reviewing the use of the 'green card' system for referrals
- Knightley ward is trialling regular ward 'huddles' (team meetings) to allow feedback on governance data and learning from this
- The dementia nurse is being supported in work relating to the Dementia CQUIN by therapy services
- Use of the red sepsis boxes is being audited across the Trust, as is implementation of the sepsis bundle in A&E
- Staff communication and human factors are being discussed with the porters
- Increased safety training based on clinical simulation scenarios encompassing relevant mandatory training and learning from serious incidents; A pictorial fluid balance chart, to assist with fluid intake, is being trialled on Knightley ward
- The documentation of omitted medicines is being reviewed and audits completed to see why and when this occurs on the ward, to enhance compliance
- A review of the use of dementia 'butterflies' has been implemented
- A pre-assessment booklet has been reviewed, led by an Foundation Year One (FY1) Doctor
- The quality of ward rounds is being reviewed and a new format is being piloted
- An audit of consultant review of patients within 12 – 14 hours is being completed
- Equipment-related incidents have been discussed with Facilities which has led to the purchasing of beds and bed rails
- The General Practitioner (GP) 'buddy' system has been reinstated for contacts in NGH
- An audit of ward Electronic Discharge Notification (EDN) has been completed. The paediatric department have achieved zero unauthorised EDN's on the children's wards and are being consulted as to how they achieved this so that the rest of the Trust can learn from this.

Part Two

Aim

To reduce all avoidable harm and save every life we can. Our high level aim is to save 300 lives over the next 3 years and to reduce avoidable harm by 50% over the same period.

Targets for 2013/14

The Trust is continually striving to improve the safety and effectiveness of patient care. Some of the improvements that are expected in 2013/14 are set out below:

Aim	Targets for achievement by end of March 2014
Embed the safety strategy for improvement and the safety programme which has a focus on sustaining and developing education and learning.	• Monitoring of progress against project objectives via project plans • Leadership for safety rounds will be reviewed and refined • Non-executive directors will focus on key themes and a structured format • A monthly programme of activity will be encompassed within board meetings • Feedback will be provided to clinical areas and via quarterly reporting • Number of champions nominated and trained in safety to be increased.
A reduction in harm from failure to plan care so that all patients and staff have an improved understanding of the plan of care in place and appropriate actions are taken.	• Improvements in metrics data • Reduction in crude inpatient death rates.
A reduction in harm resulting from failure to rescue so that every acutely ill or deteriorating patient is recognised immediately and all appropriate actions are taken.	• 50% improvement in measures relating to failure to rescue.
Learning from serious incidents (SI) and learning from error and human factors safety science.	• To improve communication between clinical staff regarding learning from serious incidents and complaints.
A reduction in harm resulting from failure to deliver care so that every patient receives improved essential care.	• Safety 'culture' questionnaire. A continuation of the previous safety 'climate' questionnaire which aimed to baseline and monitor safety locally • Champions are asked to complete this questionnaire at each meeting with the patient safety academy (approximately bi-monthly) • Data is being analysed to assess the impact of safety initiatives • A review of purchasing pressure relieving mattresses to provide patients with improved care.

Fig. 6 Quality Priority 3 Targets 2013/14

Part Two

Areas of improvement that were introduced in 2012/13:

- A variety of safety projects were supported with the following progress being made
- Patient safety champions increased in number to >70 enhancing and delivering safety science in their areas of work
    - Progress is reported and illustrated through a safety dashboard
- Increased portfolio of projects illustrating 50% improvement in reducing avoidable harm measures relating to
    - Planning of care
    - Failure to rescue
    - Basic delivery of care.

Areas of improvement planned for 2013/14

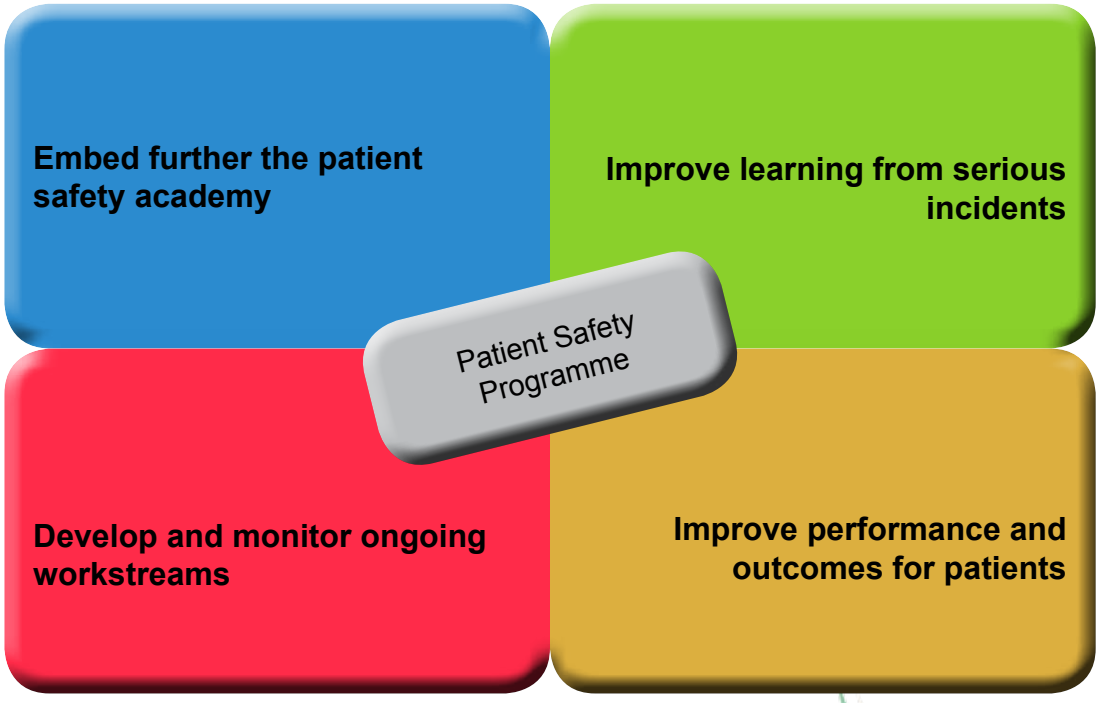


Fig. 7 Quality Priority 3 Areas of Improvement 2013/14

How progress will be monitored, measured and reported

- Improvements in quality will be demonstrated via patient safety, Clinical Quality and Governance Progress report
- Areas of concern will be challenged and scrutinised by CQEG & HGC
- Bi-monthly presentation and challenge at patient safety board
- Increase in patient safety champions within clinical areas.

Part Two

Quality Priority 4
Patient Experience 2013/14

Background

The Trust is committed to improving the patient's experience across the organisation. This year the focus will be on implementing a number of patient experience initiatives as part of NGH's patient experience strategy. Fundamental to that starting point is having a tool that will enable us to monitor and measure our progress.

NGH plans to roll-out on a Trust-wide basis a single question for monitoring real-time patient experience which is known as the 'Friends and Family' test (FFT), which asks simply; "How likely is it that you would recommend this service to a friend or family member?" This question will be standard across the country and patients will be asked to respond to one of six standard responses on the day that they are being discharged.

Aim

The Trust will achieve a 20% response rate with the FFT and A&E, and 10% increase in score.

Targets for 2013/14

The Trust is continually striving to improve the safety and effectiveness of patient care. Some of the improvements that are expected in 2013/14 are set out below:

Areas of improvement that were introduced in 2012/13

Aim	Targets for achievement by end of March 2014
A patient experience strategy and implementation plan are approved by board to include the formation of a patient experience board.	• Implementation of year two of the patient experience strategy • Successful implementation of the patient experience plan • Appointment of a full time patient experience lead • Development of the planned patient experience champion and Care Group Patient Experience Lead roles within the clinical areas - currently being redefined • 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).
The Trust is committed to providing the very best care for all our patients. This commitment requires us to do everything in our power to ensure that the experiences of patients, families and carers are positive, supportive and conducive to their health and well-being at every stage of their care pathway	• Improvement in the FFT response rates from 10% to 20% (including A&E) • 10% improvement of the FFT score • Close working with PALS to ensure early detection of themes in relation to issues or concerns • Work with operational colleagues to clarify areas of improvement against the National Inpatient Survey 2012

Fig. 8 Quality Priority 4 Targets 2013/14

- The patient experience board has taken the lead on the identification of good practice across the Trust and the dissemination of learning
- The development of a rolling programme of interventions
- Improvement of both the FFT response rates (to 15% of footfall), excluding A&E and net promoter scores
- Established a programme of patient experience initiatives to ascertain the experience of those people who are unable to complete the FFT, such as people with dementia.

Areas of Improvement planned for 2013/14

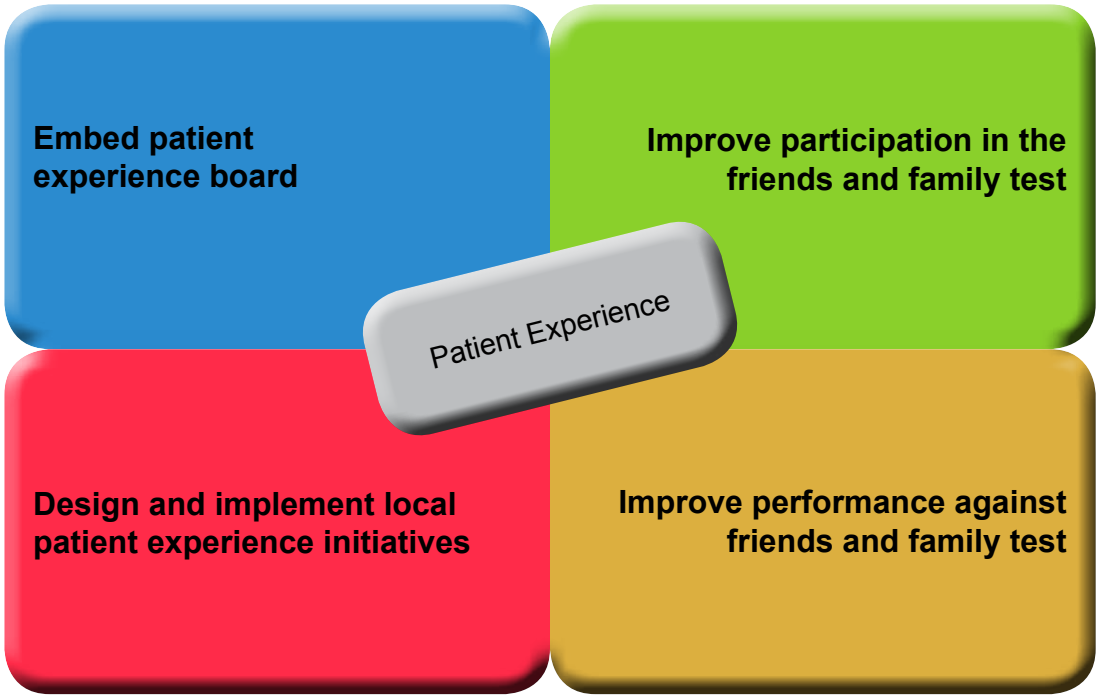


Fig. 9 Quality Priority 3 Areas of Improvement 2013/14

How progress will be monitored and measured

The results from the national FFT responses will be triangulated with other patient experience work e.g. observational studies, local patient experience audits, national patient surveys, complaint data etc. Results will be monitored by the patient experience board.

Assurance reports will be received by the Trust Board regularly.

Part Two

NGH Response to the Francis Enquiry

The long-awaited Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry Final Report) was published in February 2013. The inquiry made 290 recommendations on all aspects of NHS operation and regulation. The Government published its initial response to the Francis Inquiry on 26 March 2013.

In response, following its publication, the Trust held listening events with staff to identify what can be learnt here at NGH from the events at Mid Staffordshire Hospital. More than 500 people, including governors, were involved in the listening events and key themes were identified. These findings were combined with a gap analysis of the 290 recommendations.

The gap analysis showed that there are several positives in how the Trust is already meeting the recommendations, driving improvements and working to balance the tension between cost and quality which was identified in the report. There are also areas where the Trust already has programmes of work underway to improve performance against recommendations which must continue, in order to deliver the required improvements. Many of these are already quality priorities such as the patient safety programme, the emergency care redesign, the patient experience strategy, but also include a review of governance arrangements and improving links with the NHS Constitution through job descriptions, etc.

Some gaps were identified where further work is required to ensure that patients receive the care to which they are entitled. These included a need to:

- Review the Trust's Vision, Values and Objectives
- Develop an organisational development strategy to include leadership and communication
- Improve performance against internal and national standards (many of which are outlined elsewhere in this report)
- Develop the Nursing & Midwifery Strategy
- Focus on discharge information
- Review our approach to the duty of candour (also known as "whistleblowing" and "being open").

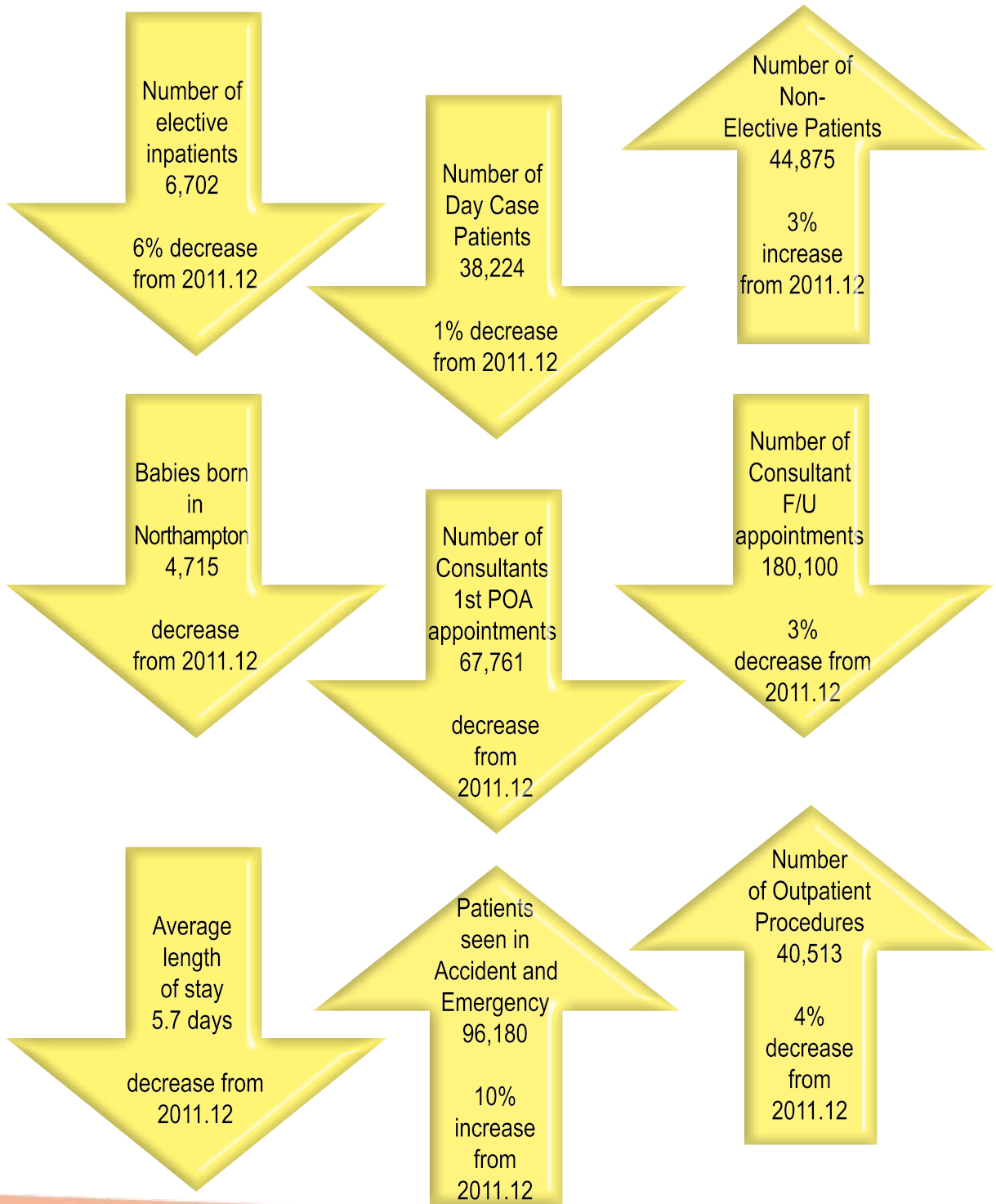
There are many recommendations which cannot yet be addressed since they will be reliant on national decision-making. A number of these are being addressed through the Care Bill (2013), but further developments are expected for a long time to come.

The Trust is committed to providing the very best care for all our patients. They will be cared for and treated with competence and kindness, and their dignity and individuality will be respected at all times

Part Three

Part 3 is the section in our quality accounts that looks back over the last year and reviews our quality performance and includes statements from external stakeholders. It also highlights other achievements that have been made to improve quality across the Trust.

A Snapshot of our activity performance



as at 16.4.2013 data also taken from annual report 2012/13

Part Three

Quality Priority 1
Redesigning the Emergency Care Pathway 2012/13

What our aim was:

To redesign emergency care so that we always provide best quality care using best practice standards.

Background

Northampton General Hospital Trust (NGH) is continuing to experience increasing emergency pressures. In order to improve as a Trust we will continue to work with the wider health economy to address issues relating to the number of patients who attend A&E and require admission. The redesigning of the emergency care pathway is supporting our aim.

As part of our focus on quality, this priority involves redesigning emergency care pathways to ensure that the systems and processes are in place to support staff to deliver quality care first time every time, with an additional focus on continual improvement in the care that is given to patients attending the hospital, either via A&E or following admission.

Meanwhile, there is still a significant amount of work to be done within the Trust to improve emergency care. NGH staff are working exceedingly hard to ensure the highest quality of care even though, bed occupancy is higher, and additional beds are needed for the increasing number of emergency patients being admitted.

What did we aim to achieve?

Fig. 10 Quality Priority 1 What did we aim to achieve? 2012/13

Part Three

Quality Improvements made throughout the year:

Aim	Target 2012/13	March 2013 Year end outcome (result)
Improved patient access to consultant advice, improved clarification of consultant accountability and improved planning of care.	• All patients have improved access to consultant advice 7 days per week • All patients and staff are aware of each individual treatment plan, the responsible consultant and the planned discharge date.	• Additional resources have been agreed to support the A&E teams including 2 additional consultants and 10 additional nurses • Emergency physician 13 hours per day Monday-Friday, 2 physician ward rounds at the weekend in addition to the on-call arrangements • Further work is needed to ensure all patients are aware of their planned discharge date • Nurse facilitated discharge has been implemented resulting in a higher quality discharge process and reducing delays in patient's being discharged.
Improved patient experience and care in A&E and throughout the patient journey.	• All emergency patients are treated according to the nationally set urgent care standards which measure for example, time spent in A&E and time to initial assessment.	• The A&E 4 hour waiting time target has not been achieved consistently. We achieved 91.46% against the transit time target of 95%. Our emergency care service experienced unprecedented demand and saw increased A&E attendance (+11% on 2011/12) and emergency admissions (+3% on 2011/12). The Trust is continuing to work with external health partners to improve this situation. However, all patients are admitted to a bed within 12 hours of a decision to admit.
Improved patient flow to reduce delays and improve clinical outcomes.	• All emergency patients who need admission are able to access an appropriate bed within 3 hours and all patients who require a longer stay in hospital are able to be transferred to their specialty ward within 24 hours.	• This target has not been achieved due to a significant increase in admissions despite additional beds being opened. However, the Trust is endeavouring to ensure all patients are admitted to the appropriate bed within 3 hours (or speciality ward within 24 hours) whenever possible and, during the last year, 100% of all patients were admitted to a bed within 12 hours of a decision to admit • Establishing of ambulatory care pathways - a patient focused service where some conditions can be treated safely without the need of an overnight stay in hospital.
Reduction in bed occupancy to improve patient experience and reduce harm.	• Reduce bed occupancy on all wards to 90-95%.	• The target of 90-95% occupancy has been achieved for paediatric beds, and was achieved for adult inpatient beds for the first half of the year. However, this was not sustained for quarters 3 and 4. This was due to the increase in admissions coupled with the severity of the presenting illness of patients.

Fig. 11 Quality Priority 1 Outcome 2012/13

Part Three

What's next? Moving forward from April 2013 - March 2014

Our targets will be:

- 95% of patients waiting less than 4 hours in A&E
- Aim for all patients who attend A&E to wait less than 15 minutes for their initial assessment
- 95% of radiology and pathology results to be available within 1 hour
- 50% of discharges to happen before 1pm each day
- Embed the management of planned discharge dates from wards linking to the visual hospital system
- Aim for 100% of patients to have an Estimated Discharge Date recorded and communicated to them
- Continue to work to improve both patient safety and patient experience, placing NGH in the top 10% of all Trusts nationally
- Develop and embed internal professional standards that set out the way hospital teams work together and define the times within which various interventions take place
- Aim to reduce bed occupancy on all adult acute wards to <90%
- Reduce the number of patients who have been in hospital for more than 10 days to <210
- Establish further ambulatory care pathways where some conditions can be safely treated in hospital without the need for an overnight stay.

Part Three

Quality Priority 2
Caring for Vulnerable Adults 2012/13

What our aim was

To improve the care given to people with dementia and/or learning disabilities.

Background

As part of the Trust's ongoing focus on supporting vulnerable adults, this priority focuses on making improvements in the care of patients with learning disabilities or dementia. It builds on the achievements over the last year for this group of patients. For patients with learning disabilities, this will focus on communication skills and for patients with dementia an assessment of the patient during the initial admission to hospital.

What did we aim to achieve?

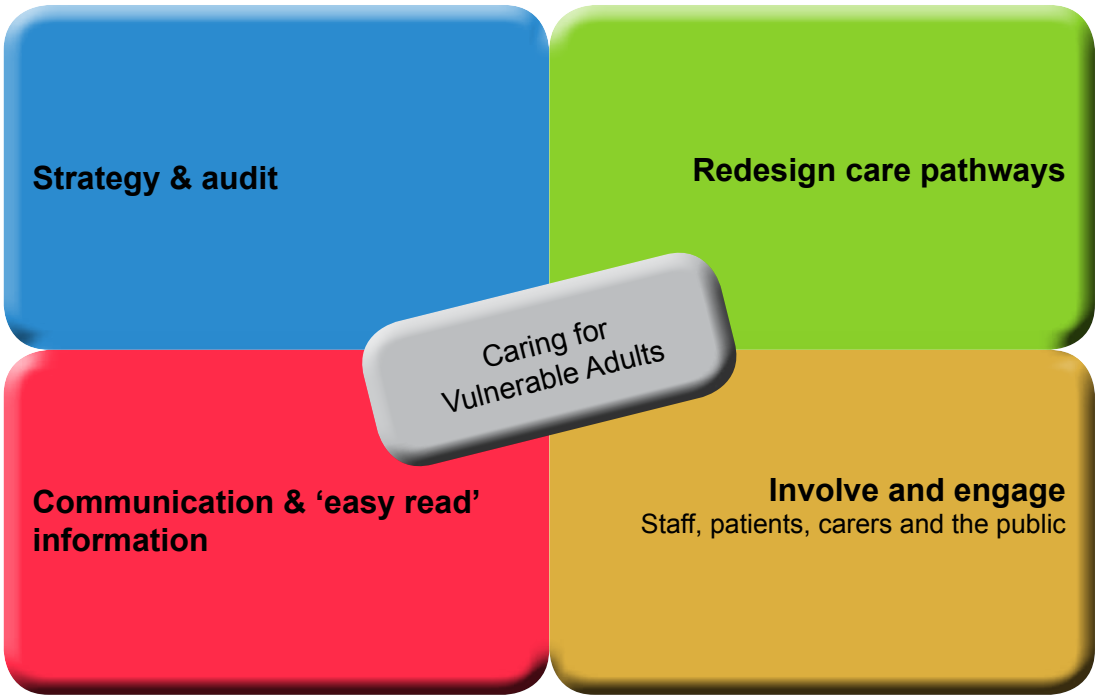


Fig. 12 Quality Priority 2 What did we aim to achieve? 2012/13

Quality Improvements made throughout the year:

Aim	Target 2012/13	March 2013 Year end outcome (result)
Dementia training delivered as per the dementia training strategy.	• Training provided for all staff who engage with and/or care for patients with dementia.	• The Trust trained 50% of ward nurses in dementia care, achieving the agreed target. However, there has been limited amounts of training delivered to other staff groups, despite opportunities being made available.

Aim	Target 2012/13	March 2013 Year end outcome (result)
Learning disability awareness and communication training.	• To be included in induction, preceptorship and bespoke training as appropriate.	• Learning disability awareness training is part of HCA induction (160 trained) and the newly qualified nurses preceptorship programme including international nurses (109 trained) • Bespoke training sessions have taken place for wards and departments as requested • In September, 60 healthcare staff from across the Trust attended a workshop faciliated by Mencap and co-presented by people with a learning disability • 48 volunteers have been trained in learning disability awareness, supporting communication and their role as “Keep Safe” advocates. NGH is now a “Keep Safe” place for people with a learning disability.
Management of people with dementia.	• Develop a new care pathway so that people with dementia have their needs appropriately met.	• The care pathway has been commenced but limited progress made. Strategic Health Authority (SHA) funding has been identified to take this forward in April/May 2013.
Improve quality of care and experience for those with dementia.	• Audit of the ‘butterfly’ scheme. • Increased use of pictorial signage. • Lead nurse to join the dementia care action committee.	• ‘Butterfly’ audit completed in May and September 2012 and report presented to safeguarding assurance group (SOVA) steering group. This requires further embedding within the service • Funding obtained from the SHA for 12 days of a temporary post to take this forward. Signage improved, further improvements being developed • Lead dementia liaison nurse member of dementia care action committee (DCAC).
Develop patient and carer information in an appropriate format for patients with dementia and learning disabilities.	• Development of ‘easy read’ information for different treatment options. • Identify reasonable adjustments on medical and surgical care pathways.	• To continue to develop patient & carer information in appropriate formats for patients with dementia and learning disability • Volunteers have received training in dementia awareness and can support patient’s and carers who require help • Some patient & carer information was developed in ‘easy read’, including for ophthalmology.
Deliver the dementia CQUIN target.	• Improve awareness and diagnosis of dementia, using risk assessment.	• The dementia risk assessment tool is now included in the non-elective admission proforma • Patients and carers were involved in development of documentation • A method of recording and capturing electronically all patients who are suffering from dementia was developed and implemented however, we did not manage to capture the data required to achieve the CQUIN

Fig. 13 Quality Priority 2 Outcome 2012/13

Part Three

What's next? Moving forward from April 2013 - March 2014

Our targets will be:

- To review and continue to deliver dementia training for staff who have contact with patients with dementia (to become essential for key staff)
- Development of an 'easy read' patient feedback form for patients with a learning disability to ensure that their views of care and treatment are heard
- Enhance the learning disability awareness training, focusing on the identification and management of patients. It will draw on the experiences of patients, carers and staff who have been involved in the learning disability pathway including sharing their stories and experiences of being in hospital
- Development and implementation of an 'easy read' version of the Trust's equality outcomes that will be accessible to the public
- Development of easily understood information leaflets regarding treatment options
    - Ultrasound leaflets
    - Endoscopy leaflets
- Schedule of planned audits
    - Implementation of Mental Capacity Act (MCA)
    - Embedding use of tools developed including the hospital passport
    - Identifying whether use of the tools made a difference to the care for patients with a learning disability, carers and health care staff through audits
- Reports on the audit results will be produced, learning shared and action plans developed
- Develop and introduce a care pathway for patients with dementia at NGH
- Further develop and embed the 'butterfly' project (this is a scheme to identify patients with dementia on the wards) to include the identification of patients with cognitive impairment, delirium or possible dementia who do not have a dementia diagnosis on admission
- Improve the environment for patients with dementia
- Develop the dementia champion role on the wards
- Undertake a gap analysis against best practice guidelines launched by the Dementia Action Alliance in partnership with the Institute for Innovation and Improvement (March 2013)
- Establish a dementia care action committee (DCA) responsible for overseeing the development and implementation of an action plan, resulting from the gap analysis
- Encourage an integrated approach to the development of 'easy read' information for patients with dementia and learning disabilities
- Part 1 of the dementia CQUIN 2013/14 will be incorporated into the new adult non-elective admission proforma and captured on the electronic discharge notification
- Establish an audit to identify whether carers of patients with dementia feel supported as per part 3 of the CQUIN
- Development of a business case for a dementia lead nurse/therapist. N.B. Part 2 of the CQUIN is to deliver training (see above).

Part Three

Quality Priority 3
Patient Safety Programme 2012/13

What our aim was

To reduce all avoidable harm and save every life we can. Our high level aim is to save 300 lives over the next 3 years and to reduce avoidable harm by 50% over this period.

Background

As part of the quality priority, the Trust has invested in a programme of development to support a team of leaders for safety who have formed a patient safety academy under the leadership and direction of the Medical Director and the Director of Nursing, Midwifery and Patient Experience supported by the patient safety programme lead.

The clinicians who form this academy undertook the education of patient safety and commenced new projects taking responsibility for delivering a high profile portfolio of key projects that link the operational delivery of services, with the need to improve quality. Investment in quality in this way will improve clinical outcomes and reduce overall cost to the system and will ensure that staff can be confident that they are delivering the safest care that they can.

During the last 5 years there has been a marked increase in the focus on quality and safety at all levels within the Trust. There has been an increase in understanding from, and engagement of, clinicians and managers as well as increasing support from the executive team and Trust Board for all improvement work related to quality and safety. This has been underpinned by improvements in the clinical governance framework and strong linkages between assurance functions and the need to improve and focus on learning lessons and improving safety.

What did we aim to achieve?

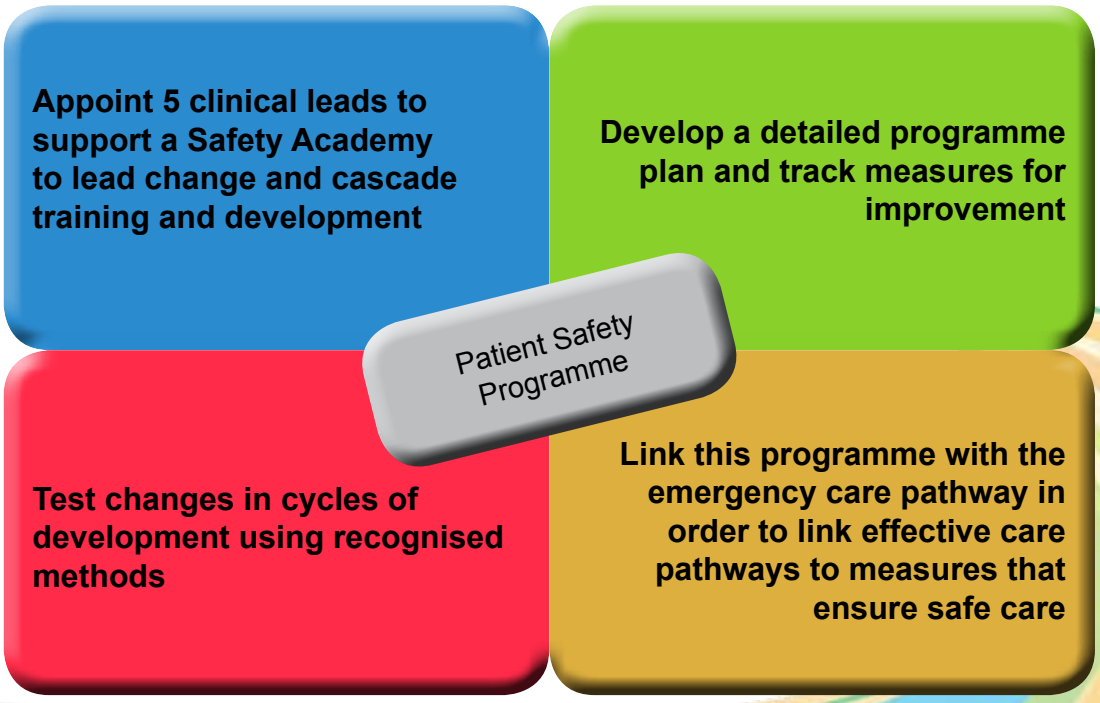


Fig. 14 Quality Priority 3 What did we aim to achieve? 2012/13

Part Three

Quality Improvements made throughout the year:

Aim	Target 2012/13	March 2013 Year end outcome (result)
A safety strategy and a safety programme outline are approved by the Trust Board to include the formation of a patient safety academy and patient safety board (chaired by the Medical Director), which has a focus on sustaining and developing education and learning.	• Patient safety academy formed and in place with regular reporting.	• The NGH safety strategy has been approved by the Trust Board and is available to all staff via the intranet. A hard copy of the safety strategy is available in safety resource files which are shared and managed by the clinically based patient safety champions • The NGH patient safety academy held 4 study days in 2012/13 with good representation from all staff groups • The patient safety board continues to meet bi-monthly and includes presentations from junior medical staff on their improvement project work.
A reduction in harm from failure to plan care so that all patients and staff have an improved understanding of the plan of care in place and appropriate actions are taken.	• Agree portfolio of projects; • Obtain baseline data; • Test cycles for improvement.	• Metrics have now been agreed and baseline data is currently being collated. To be reported on in 2013/14 • Improvements have been seen this year in GP communication/handover information/ward rounds and night team working.
A reduction in harm resulting from failure to rescue so that every acutely ill or deteriorating patient is recognised immediately and all appropriate actions are taken.	• Agree portfolio of projects; • Obtain baseline data; • Test cycles for improvement.	• Metrics have been agreed and baseline data is currently being collated. To be reported on in 2013/14.
A reduction in harm resulting from failure to deliver care so that every patient receives improved essential care.	• Agree portfolio of projects; • Obtain baseline data; • Test cycles for improvement.	• This work stream considers nursing care and improving patient experience on the wards and is focusing on skills, education and practice required for standardisation of care and elimination of avoidable harm. This work stream is supported by the senior nursing team • There has been an extensive nurse staffing review of all general wards • NGH has developed a nurse and midwifery staffing strategy which has been approved by Trust Board • Safety thermometer (the national tool for harm events) has demonstrated that since the beginning of April 2012 the Trust improved from 81% harm free care to 92% harm free care, an improvement of 11%.

Fig. 15 Quality Priority 3 Outcome 2012/13

Part Three

What's next? Moving forward from April 2013 - March 2014

- Monitoring of progress against project objectives via project plans
- Leadership for safety rounds will be reviewed and refined
- Non-executive directors will focus on key themes and a structured format
- A monthly programme of activity will be encompassed within board meetings
- Feedback will be provided to clinical areas and via quarterly reporting
- Number of champions nominated and trained in safety to be increased
- Improvements in metrics data
- Reduction in crude inpatient death rates
- 50 % improvement in measures relating to failure to rescue
- To improve communication between clinical staff regarding learning from serious incidents and complaints
- Safety 'culture' questionnaire. A continuation of the previous safety 'climate' questionnaire, which aimed to baseline and monitor safety locally
- Champions are asked to complete this questionnaire at each meeting with the patient safety academy (approximately bi-monthly)
- Data is being analysed to assess the impact of safety initiatives
- A review of purchasing pressure relieving mattresses to provide patients with improved care.

Part Three

Quality Priority 4
Patient Experience 2012/13

What our aim was

The Trust will achieve a 10 point improvement on the Friends and Family Test, by the end of March 2013, using July 2012 as the benchmark.
NB: FFT has changed its measure from point to percentage.

Background

The Trust was successful in approving the Patient Experience Strategy, but has not achieved a number of the quality priorities that were set, in part due to the inconsistency of staffing to drive the initiatives forward. Maintaining the same priorities for 2013/14 provides an opportunity for the Trust to focus attention on these important issues.

The Trust did not achieve a 10 point improvement in the FFT score, but did achieve more than a 10% response rate which exceeded the 2012/13 target.

What did we aim to achieve?

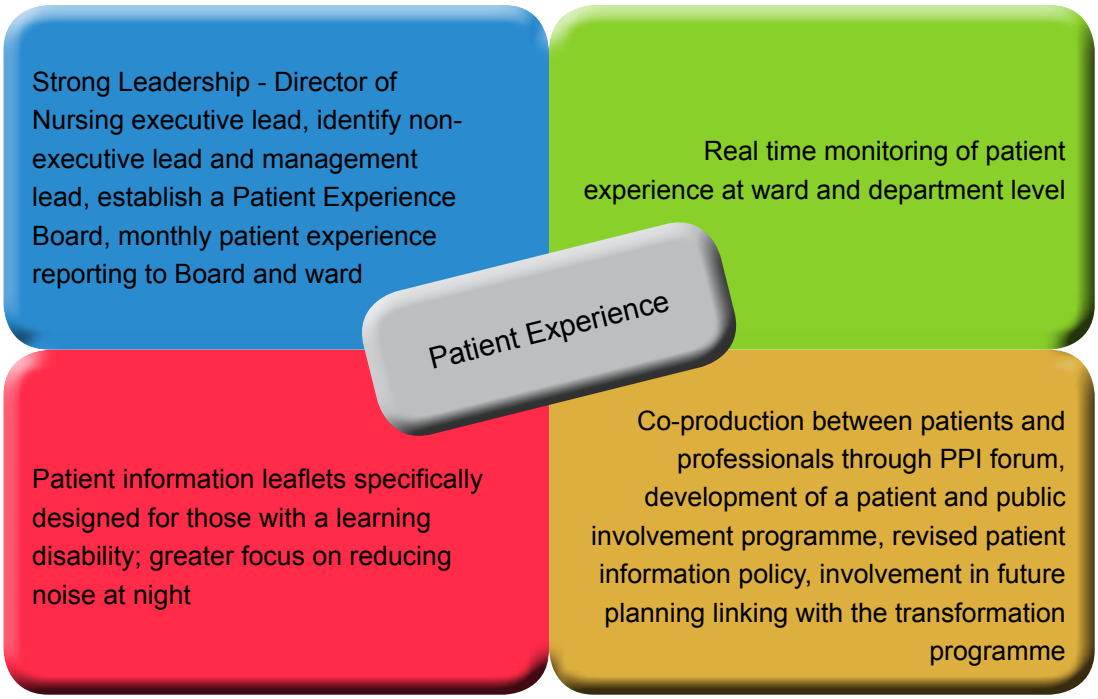


Fig. 16 Quality Priority 4 What did we aim to achieve? 2012/13

Part Three

Quality Improvements made throughout the year:

Aim	Target 2012/13	March 2013 Year end outcome (result)
A patient experience strategy and implementation plan are approved by the Trust Board to include the formation of a patient experience board	• Patient experience board formed and in place with regular reporting • Routinely involve patients and shadow governors proactively in service design and development.	• The patient experience strategy was approved by the Trust Board in June 2012 • The patient experience improvement plan was approved by the September board • Ensuring that patient experience is integrated within service design and development has been a casualty of the staff changes in that there has been no central driver. However, it is important to note that this work is going on and especially within ward areas a number of departments are currently working up proposals to utilise their patient voice • Patient experience board established.
The Trust is committed to providing the very best care for all our patients. This commitment requires us to do everything in our power to ensure that the experiences of patients, families and carers are positive, supportive and conducive to their health and wellbeing at every stage of their care pathway	• Patient experience will be at the heart of our planning and performance management, with related objectives in every business plan • There will be a 10 point improvement in the Friends and Family Test score • Real time monitoring of patient experience at ward and department level will be achieved • Achieve a step change in our National Survey of Adult Inpatients results over the next three years.	• The FFT was implemented across the Trust during 2012/13 pilot • We were unable to achieve a 10 point improvement in the resulting scores by March 2013 • Work is underway to raise awareness of the national roll out to relaunch the FFT and ensure staff are aware of the aims and objectives • The 2012 national inpatient survey results were about the same as the previous year, with two areas being worse than last year. These related to noise at night • A group of volunteers is auditing noise at night. Actions are reported elsewhere in this report e.g. lights on telephones instead of bells, oiling of squeaky doors etc. It is necessary however, to sometimes move patients to other wards overnight, due to bed pressures which makes it difficult to maintain minimum noise levels.

Fig. 17 Quality Priority 4 Outcome 2012/13

Part Three

What's next? Moving forward from April 2013 - March 2014

- Implementation of year two of the patient experience strategy
- Successful implementation of the patient experience implementation plan
- Appointment of a full time patient experience lead
- Development of the planned patient experience champion and Care Group Patient Experience Lead roles within the clinical areas - currently being redefined
- 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)
- Improvement in the FFT response rates from 10% to 20% (including A&E)
- 10% improvement of the FFT net promoter score
- Close working with PALS to ensure early detection of themes in relation to issues or concerns
- Work with operational colleagues to clarify areas of improvement against the National Inpatient Survey 2012.

Part Three

Showcasing improvements in Northampton General Hospital

Over the last 12 months many other services have seen significant improvements. Some of these are outlined below.

Doctors in Training
"Aspiring to Excellence" Programme

With a few exceptions medical students have little, if any, training in management, leadership and service improvement. Yet from the moment they graduate, doctors require a range of such competencies, which may become more important as they progress to become consultants and general practitioners. Early exposure to management and leadership provides the foundation for an NHS in which doctors appreciate their responsibilities to others within the multi-professional team, the organisation and the local health community as well as to their patients and themselves.
It is increasingly evident that although Junior Doctors are absolutely committed to improving their own knowledge and training, they are not necessarily aligned to the overall aims of the organisation for which they work. It was on this premise that the first "Aspiring to Excellence" programme was developed and led by the Medical Director which facilitates corporate exposure and opportunity to experience change management, with current operational challenges and initiatives.

The project aim for this course is to help Junior Doctors understand their role in affecting change impacting on patient safety.

The annual course has incrementally increased delegate capacity, yet continues to be oversubscribed. The following operational safety initiatives have been the central focus for the course from 2010 when the course was first commenced.

- 2010 - WHO Checklist
- 2011 - Surviving SEPSIS
- 2012 - The Deteriorating Patient

The Medical Students that often have been part of the "Aspiring to Excellence" Programme return to NGH as Junior Doctors. Their appetite and enthusiasm for further education and change management opportunities has led to the Junior Doctor safety board increasing in size and momentum on an annual basis.

Part Three

Junior Doctors' Safety Board

The Junior Doctors' safety board consists of Foundation Year 1 doctors, volunteering to take the lead on a safety project which includes a Trust wide audit relating to key safety priorities. The chosen projects have the full support of the Medical Director, and a named medical consultant to guide, and provide direction and support, through the change management process. Junior Doctors are a pivotal target group to improve safety and have proved to be the "eyes and ears" for the organisation, identifying where patient safety could be compromised and how processes could be made safer. Through engaging and empowering the Junior Doctors, the concept of patient safety and leadership resonates with them throughout their medical career.

Delivering Excellence

Acknowledging course feedback from "Aspiring to Excellence" and the Junior Doctors' safety board, and accepting that focusing on leadership development has a positive impact on the ability of leaders in any organisation, in 2012 the first in-house Registrar development course was introduced.

Under the direction of the Medical Director, a six week modular course was provided and made available to all ST3 – ST9 doctors in training who were working at NGH. The course focus was to further develop leadership skills, safety awareness and behaviour. The course was delivered on a similar premise to "Aspiring to Excellence" but at a more strategic level, with a more challenging safety audit project.

The three broad strategies that underpinned delivering excellence were:

- Challenging culture and behaviour – building and leading a culture of personal accountability for safety and operational discipline
- To provide staff with the knowledge and tools - to continue to improve communication and maintain well defined standards, and tools that facilitate integration of safety into all elements of the pathway and everyday behaviours
- To create safer work environments – reduce and eliminate any waste legacy and replace with standardised best practice and evidenced based pathways.

This course is planned to be repeated in September 2013.

Delegates from the above developmental initiatives, which focus on patient safety and frontline engagement, have had the opportunity to showcase their work across the region and nationally in relation to patient safety improvements.

Part Three

Infection Prevention

NGH healthcare assistant, Chris Head, has been presented with a national award: Hand Hygiene Champion of 2012, by the Infection Prevention Society. He was awarded the honour for his proactive and enthusiastic teaching of effective hand hygiene. Chris has taught staff the importance of effective hand hygiene in reducing the risk of infection on the Emergency Assessment Unit, Allebone and Benham wards, helping to ensure that the patients' journies through the hospital are as safe as possible. Not only has Chris been invaluable in this role at work, but he also asked for specialist training so that he could teach hand hygiene to the members of his St John Ambulance group, including children from the age of seven through to adults.

Infection prevention and control has long been a key commitment at NGH and its staff, with imaginative approaches taken to make sure that it is always at the forefront of everybody's mind, such as the NHS Northamptonshire 'Gangnam-style' YouTube video (http://youtu.be/TGddyTW5eMc|), which went viral, to promote Global Handwashing Day in which Chris and other staff took a leading role.

Focus on Cancer

Overview

As a recognised Cancer Centre, NGH provides specialist care to a wider population of 880,000 people living in Northamptonshire, North Buckinghamshire and South Leicestershire.

NGH has continued to strive to improve cancer care over the last year with positive achievements in funding for an acute oncology service, a new, and improved cancer information and support centre and new treatments. The Trust has funded an endoscopic ultrasound machine that will enable cancer patient's access to diagnostics on site. The Trust continues to engage with tertiary units to develop cancer pathways and provide specialist surgery for urology, head & neck and gynaecological cancer patients here at NGH.

Improvements in Cancer Care

NGH has been working to improve its services for cancer patients. This includes offering some of the latest treatments and techniques as well as improving the environment and facilities for patients and families.

Part Three

The 2012 national cancer patient experience survey showed NGH improved across 64% of standards in comparison to 2010 (with a further 6/53 remaining the same). However, NGH is still behind the overall national NHS rating for care (86% rated as excellent or very good, compared with national figure of 88%) and so further work is being done to improve cancer services for patients. This includes new ultrasound equipment to diagnose cancers (which were only available in a few centres in the NHS) and new treatment methods and surgical techniques to improve outcomes (including laparoscopic surgery).

Improved Cancer Information and Support Centre

NGH has funded the development of a new, improved cancer information and support centre on the ground floor of the oncology department to offer a better service to those affected by cancer. The centre has a much larger display area for written information and also provides all patients/carers access to a computer if they wish to look at cancer information and print it, so that they have their own Information Prescription, with staff on hand to assist.

The centre has a private room for discussing financial/benefit advice and help with completing benefit forms and in addition, weekly appointments are offered by the Department of Work and Pensions and the Citizens Advice Bureau.

As part of our work to improve the lives of those living with and surviving cancer, we will continue to work hard on providing survivorship courses, by providing the HOPE course and linking in with the national "Look Good, Feel Better" organisation who are looking for a suitable environment to run their courses in Northampton. The centre also advertises local support groups/carers groups and patients access to a free complementary therapy service. Patients are offered free refreshments during their visit to the centre.

The centre will be advertised to ensure that the general public are aware of the resource available in the Trust, whether they contact the centre by visit, telephone or email.

New Haematology Unit

Our state of the art haematology unit was officially opened in October 2012 by the president of Macmillan Cancer Support, The Countess of Halifax.

The unit, which treats people with blood cancers such as leukaemia, lymphoma and myeloma, cost £2.2 million to develop and was funded by the hospital and a charity appeal by Macmillan Cancer Support, with help from the Northampton Chronicle & Echo. We would like to thank everyone for their support, including all those local businesses and individuals who made donations, and everyone who organised or took part in the hundreds of sponsored events to help achieve the £1.55m fund total.

More than 650 people are diagnosed with and treated for blood cancers at NGH every year and the new haematology unit was badly needed. It is bigger than its predecessor and purpose-built to offer patients a more relaxing, comfortable and welcoming environment. There is also extra space to improve working conditions for staff and reduce waiting times for patients.

There is now a bigger waiting room, a new beverage bar, new office and nurses' stations, more consulting and examination rooms and a separate treatment area with a bed for those who feel unwell.

New Radiotherapy Treatment for Lung Cancer

In March 2013 staff carried out the first treatment in the county to target early-stage lung cancer with a technique called stereotactic radiotherapy. Using one of the high-tech linear accelerators in the hospital's specialist cancer centre, the technique (also referred to as Stereotactic Ablative Body Radiotherapy (SABR)) provides more precise radiotherapy treatment in larger doses over a shorter period of time.

The first patient to be treated with SABR for lung cancer at NGH was delighted to have been offered the new treatment, saying "I don't mind being the first patient treated here with it. I feel fine about it. I've had very little pain, and very few side effects. I'd definitely recommend the treatment to other people in the same circumstances. I'd recommend it to anyone, even my own children. It's a really good thing."

Conventional radiotherapy involves treatment every weekday for up to seven weeks, whereas stereotactic radiotherapy requires only five sessions. This treatment requires a tiny gold marker to be inserted by a needle into the tumour under local anaesthetic (a much less risky procedure than surgery) which is then used to accurately guide radiation delivery. It potentially enables patients with poor lung function or heart problems who might not be able to undergo conventional surgery to be treated.

Consultant clinical oncologist Professor Hany Eldeeb said: "SABR is painless, and patients can continue their daily activities without difficulty. It uses multiple tightly conformed radiation beams converging at the lung tumour, allowing very high doses to be given to the tumour itself, while very little surrounding tissue receives radiation. The high dose leads to cure rates comparable to surgery, and because of the low volume lung exposure there are fewer side-effects and a lower risk of complications. The gold mark enables us to track the tumour continuously, so the treatment even takes account of the patient's breathing movements."

The standard now is to treat patients in a very specialised centre. NGH is one of only three hospitals in the East Midlands to pilot SABR, and is the first in the country to carry it out on a normal linear accelerator with this particular high tech imaging equipment. Another patient is already being prepared for the treatment, and it will be extended to more people in the Northamptonshire area over the coming months.

Prof. Eldeeb concluded: "In lung cancer we rarely talk about cure, but now we can use radiotherapy as a real option to surgery, and implement it early enough to make a difference to patients' lives."

Brachytherapy for Prostate Cancer

NGH is one of only five hospitals nationally to offer both high and low dose rate brachytherapy for prostate cancer. Brachytherapy is a form of internal radiotherapy involving the use of state-of-the-art computer planning software to implant radioactive iodine seeds into the prostate which gradually release their radiation over a period of several weeks or months to treat the prostate cancer directly,

with less damage caused to surrounding normal tissues. It has been available to NGH prostate cancer patients for almost ten years, with NGH being one of the first centres in the UK to offer a one stage procedure, which combines the planning stage with treatment in order to eliminate the inconvenience to patients of a second appointment.

In October 2011 the hospital introduced a new form of the therapy, high dose rate (HDR) brachytherapy which uses a high dose radioactive source inserted into the prostate for a short period of time and then removed. This delivers a high dose of radiation to the prostate gland, but healthy tissue nearby only gets a small dose so is less likely to be damaged. The techniques can be used to treat patients with more advanced tumours that might not be suitable for the seed treatment. This has reduced treatment time, recovery time, and the potential for side effects.

A year on from its introduction, one of the first patients to be given this treatment at NGH has stated that he is pleased with the decision to go ahead with treatment, which reduced the need for radiotherapy visits from 37 to 15. He also praised staff as being “fantastic” and has taken on the role of talking to other patients who are planning to have the same procedure to allay concerns.

NGH is also now one of only three hospitals offering ultrasound guided real-time planning for prostate HDR, reducing treatment time to two hours instead of a whole day and so further improving patient’s ability to live more normally during their treatment.

A Reflection of Our Ongoing Success

Community Stroke Team

The launching of a specialist multi-disciplinary team that provides care and support for stroke patients in their own home, tailored to the needs of each individual, aiming to provide seamless care following discharge from hospital. The team works together with patients to improve their mobility and everyday tasks. They also provide psychosocial support and have developed a self-help mood group to help patients overcome issues following a stroke.

The team has earned praise from a review by the East Midlands cardiovascular network who were impressed with the “high level of commitment to the service and an enthusiasm for delivering individually targeted rehabilitation”. Patient and carer representatives particularly liked that notes are held by the patient at home so that they, their families and carers have information about their progress and treatment.

Specialist Short Stay Elderly Ward

This proactive specialist short stay elderly ward (SSE) is enabling earlier rehabilitation of acutely ill elderly patients and a reduced length of stay. It continues to provide an environment for frail elderly patients needing hospital based care who also benefit from comprehensive geriatric assessment alongside the treatment of their medical illness.

A multi-displinary approach to care has been adopted, with the team working with the outreach team and other specialties to support enhanced recovery and to plan coordinated discharge.

Part Three

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

Review of Services

During 2012/13 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 2012/13 represents 100% of the total income generated from the provision of NHS services by NGH for the reporting period 2012/13.

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 trustwide 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 Healthcare Governance Committee (HGC), which is a Trust Board subcommittee and also meets monthly. It 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 trustwide 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 2012/13 reporting period, the Trust investigated one 'never event' which related to wrong site vascular surgery. Following this event, a number of actions have been implemented to reduce the risk of recurrence and included: a full review of our practice and processes relating to completion of the World Health Organisation (WHO) surgical check list in theatres and provision of additional training.

A 'surgical never event' meeting has been held to take forward recommendations from this review and embed leaning from this incident. The findings have helped to inform the patient safety strategy.`

Part Three

Participation in Clinical Audits

During 2012/2013, NGH participated in 100% of all national clinical audits and national confidential enquiries which it was eligible to participate in. This culminated in participation in 42 national clinical audits and 3 national confidential enquiries covering NHS services that Northampton General Hospital (NGH) provides, which are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

National Clinical Audits and National Confidential Enquiries	Percentage Participation
Perinatal mortality (MBRRACH)	100%
Neonatal intensive and special care (NNAP)	See table below
Paediatric pneumonia (British Thoracic Society)	Data collection in progress
Paediatric asthma (British Thoracic Society)	100%
Fever in children (College of Emergency Medicine)	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	100%
Adult community acquired pneumonia (British Thoracic Society)	Data collection in progress
Non invasive ventilation (NIV) – Adults (British Thoracic Society)	Data collection in progress
Emergency use of oxygen (British Thoracic Society)	100%
Cardiac arrest (National Cardiac Arrest Audit)	100%
Child health (CHR-UK)	100%
Adult critical care (Case Mix Programme)	100%
Potential donor audit (NHS Blood & Transplant)	100%
Diabetes (National Adult Diabetes Audit)	100% (Snapshot audit only)
Renal colic (College of Emergency Medicine)	100%
Pain database	87.6%
Parkinson's disease (National Parkinson's Audit)	100%
Ulcerative colitis round 4 (UK IBD Audit)	Data collection in progress
Adult asthma (British Thoracic Society)	100%
Bronchiectasis (British Thoracic Society)	100%
Hip, knee and ankle replacements (National Joint Registry)	100%
Elective surgery (National PROMs Programme)	96%
National audit of dementia	100%
Coronary angioplasty (NICOR adult cardiac interventions audit)	Ongoing data collection
Peripheral vascular surgery (VSGBI vascular surgery database)	100%
Carotid interventions (Carotid Intervention Audit)	100%
Fractured neck of femur (College of Emergency Medicine)	100%
Acute myocardial infarction and other ACS (MINAP)	100%

National Clinical Audits and National Confidential Enquiries	Percentage Participation
Heart failure (Heart Failure Audit)	78%
Stroke National Audit Programme (Sentinel & SINAP)	Data collection in progress
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	Ongoing data collection
Renal replacement therapy (Renal Registry)	Ongoing data collection
Lung cancer (National Lung Cancer Audit)	93%
Bowel cancer (National Bowel Cancer Audit Programme)	86%
Head & neck cancer (DAHNO)	93.5%
Oesophago-gastric cancer (National O-G Cancer Audit)	Ongoing data collection
Hip fracture (National Hip Fracture Database)	91%
Severe trauma (Trauma Audit & Research Network)	100%
Audit of Blood Sampling and Labelling (National Comparative Audit of Blood Transfusion)	100%
Asthma deaths (NRAD)	100%
National Confidential Enquiry into Patient Outcome & Death (NCEPOD) - Cardiac Arrest Procedures	100%
National Confidential Enquiry into Patient Outcome & Death (NCEPOD) – Bariatric Surgery	100%
National Confidential Enquiry into Patient Outcome & Death (NCEPOD) – Alcohol Related Liver Disease	100%
National Confidential Enquiry into Patient Outcome & Death (NCEPOD) – Subarachnoid Haemorrhage Study	100%

Fig. 18 National Clinical Audit 2012/13

The reports of 30 national clinical audits were reviewed by the Trust in 2012/13 and NGH intends to take the following actions to improve the quality of healthcare provided following recommendations from those reports:

National Clinical Audits	Actions
1. Intensive and Special Care (NNAP)	• The report published in July 2012 for the year 2011 did not include data from Northampton as we were one of the last four units in the country to begin to submit data from Badger.net • Badger is now up and running and when the final report comes out at the end of March 2013 we will review the report and produce a summary and action plans.
2. National Paediatric Diabetes (RCPH)	• Develop a purpose built database to capture an increased dataset in 2012/13 • Ensure sufficient specialist staff are recruited to meet Best Practice Tariff standards • Increase the number of available paediatric diabetes clinics. This will require extra clinic capacity and clinic time for consultants to be included in job plans • Continue to monitor HbA1c regularly. Target mean and percentage HbA1c <7.5%

National Clinical Audits	Actions
3. National Audit of Seizure Management in Hospitals (NASH)	• Since the publication of this report a 'First seizure initial assessment protocol' and 'Known epilepsy assessment protocol' has been developed' • First seizure attendances are now referred directly on ICE • Every patient should have driving advice recorded
4. Paediatric Asthma Audit	• Importance of written discharge plans is now included in asthma guidelines.
5. Paediatric Pneumonia Audit	• To encourage all medical staff to use antibiotic protocol
6. Heavy Menstrual Bleeding Audit	• Awaiting distribution and return of follow-up questionnaires at 1 year and final report to be published.
7. Sepsis and Septic Shock (College of Emergency Medicine	• Many actions have already taken place and local audit has demonstrated improvement in compliance with sepsis 6 care bundle • 2 sepsis link nurses have been appointed to support the work and monitor the pathway and outcomes from sepsis • A Fast Intervention Team (FIT) is now in place in A&E for rapid assessment of patients arriving in A&E • In house training for all staff • Introduction of sepsis boxes • Continuous monitoring of process and outcomes by Sepsis Link nurses.
8. Pain in Children (College of Emergency Medicine)	• To address poor recording of pain scores.
9. Adult Critical Care (ICNARC)	• Review and discuss published outcome data quarterly • Emergency surgery, organ donation and escalation of sick patients on wards identified as areas for more detailed focus. These will be monitored through national and local clinical audits • Areas for concern such as pneumonia and sepsis have been given high priority locally (sepsis bundle, pneumonia care pathway). Monitored through HSMR Data which is showing an encouraging improvement • Introduction of New Early Warning Score to support early identification of sick patients on wards • New dialysis machines and high flow delivery systems improving availability of advanced therapies • New patient beds to allow regular patient weighing • Review of Mortality following elective surgical admission • Continued review of "unexpected early & late deaths" • Continue to improve pathway for patient flow through HDU and on to the wards • Continue to encourage full documentation of all episodes of clinical contact and communication with patients and/or family.

National Clinical Audits	Actions
10. Potential Donor Audit (NHS Blood & Transplant)	• Develop a Trust organ donation policy to support an improvement in current rates, engagement of senior clinicians, increase in neurological death testing rates. (Baseline assessment & action plan for NICE guideline on organ donation) • Develop a tool for use in A&E to identify and refer potential donors. The aim is to increase identification and referral rates from A&E and the actual numbers of donations initiated from A&E • Optimise consent rates through increased involvement of specialist nurses for organ donations • Consider long term development of ITU consultant on-call rota.
11. Childhood Epilepsy 12	• Increase number of epilepsy clinics to 2 per week • Improve documentation of review by specialist doctors and nurses • Regular monitoring of overall patient pathway through locally developed epilepsy database • Feedback to RCPCH regarding improvement to data collection tool, with regards to use of Electrocardiogram (ECG) as a diagnostic tool • Continue to perform local quality of service audits for all our patients.
12. Parkinson's Disease	• To continue monitoring the side effects of treatment • Continue to provide access to all patients to Parkinson's Disease Services • Develop introductory information leaflet on Parkinson's UK and the role of nurse specialists • Ensure all new patients are given introductory information leaflet • Specialist nurses to document in each letter, advice given on potential side effects of Dopamine agonists.

13. National Vascular Database and Peripheral vascular surgery (VSGBI Vascular Surgery Database)	• Outcome data is monitored and discussed quarterly for Vascular procedures
	• Relative risk by procedure
	  • Length of stay
	  • 30 day deaths
	  • In hospital deaths
	  • Rolling mortality figures
	• Should NGH have a CQC/ Dr Foster mortality outlier alert, patients would be followed up in more detail, but there have been no outlier alerts in the last year
	• To ensure 100% data submission NVD records are checked against theatre ledgers on a monthly basis.

National Clinical Audits	Actions

14. Carotid Interventions	• Carotid outcomes are also monitored and discussed quarterly
	  • Volume of workload
	  • Length of stay
	  • Referral to surgery times (improving, 82% symptom to surgery <14 days)
	  • Complications
	• Should NGH have a CQC/ Dr Foster mortality outlier alert, patients would be followed up in more detail, but there have been no outlier alerts in the last year
	• To ensure 100% data submission NVD records are checked against theatre ledgers on a monthly basis.

15. Heart failure (Heart Failure Audit)	• Referrals to heart failure team can now be made via ICE systems. Need to improve referral rates from general wards to ensure all seen by specialist team • Ensure all discharges are followed up within 2 weeks from March 2013 using enhanced GP services where appropriate • Electronic discharge notification to be completed by junior medical staff and overall improvements in discharge planning • Work with coding department to ensure all patients with Heart Failure are identified
16. Sentinel Stroke National Audit Programme Acute Organisational Report	• Re-submission of a business case for purchase of new multi- parameter patient monitors for stroke ward • Work with new site management team to ensure stroke patients are placed in a stroke bed. Stroke nurse presence overnight to support this action • Extended on call hours for nurses and consultants to improve thrombolysis rates • Develop a model that covers all aspects of care for patients to present to Clinical Commissioning Group to support care for psychology services • Improvement in availability and dissemination of patient information resources • Repeat of patient satisfaction survey for all patients discharged from both acute and community services.
17. Lung Cancer	• Ensure details for all relevant patients are identified from multidisciplinary team (MDT) minutes for inclusion in the audit • Use Somerset proforma and live data collection at MDT team meetings • Data analyst and cancer audit officer identified as key personnel to ensure quality of data capture prior to submission • Ensure that all data fields and clinical information is understood by auditors to improve data capture • MDT chair assists co-ordinator by ensuring that stage, performance status and other key fields are discussed and recorded for each patient • Record data in real time at multidisciplinary team meeting where possible, foster links with physiology departments to obtain data on relevant patients: quality assure data prior to submission.

National Clinical Audits	Actions
17. Lung Cancer (cont)	• Ensure that histological confirmation rate is in line with national standards • Review of specialist nurse service and allocation of additional nursing support alongside lung cancer clinics • Ensure that surgical resections are submitted to the audit and that thoracic surgeon attends the MDT meeting • Review of specific patients following surgical resection; active cancer treatments and chemotherapy to ensure oncological support for lung cancer patients • Ensure that CT bronchoscopy and PET data is captured and submitted to the audit.
18. Bowel Cancer	• Continue improving capture of data especially for cases of rectal cancer • Continue to assess patients for Laparoscopic surgery and offer this where appropriate. Aim is to continue to increase the proportion of cases done laparoscopically • National recommendations from the audit have been discussed and disseminated • Continuous local audit to monitor process and outcomes of all patients undergoing major elective colorectal surgery.
19. Head and Neck Cancer	• Improve the quality of data capture to the audit using a variety of resources such as; MDT meetings, cancer staging information, and histology reports • Improve pre-treatment review by the clinical nurse specialist • Ensure that the 'breaking of bad news' meeting is captured on the Somerset database and details of the presence of the CNS are recorded • Discuss with IT how allied health professions employed by other Trusts are able to access the Somerset database to capture information to improve pre-treatment reviews by dieticians and speech and language therapists • Improve data quality regarding dental assessment on Somerset database by clinicians • Improve access to the Somerset database for consultants and foundation year doctors.
20. Severe Trauma (Trauma Audit & Research Network)	• Review of themed quarterly reports and production of recommendations and actions • TARN committee meetings now take place on a monthly basis to review cases referred to Coventry • Improve documentation of thoracic imaging and ensure all body parts imaged are documented clearly on the trauma notes • Improve documentation relating to spinal protection for head injury patients • A CEPOD theatre has been made available 24/7 to facilitate abdominal injury emergency cases.

National Clinical Audits	Actions
21. Emergency Oxygen Audit	• To ensure completion of the oxygen therapy section of the prescription chart
22. Non Invasive Ventilation Audit (NIV)	• To continue using the new 'do not attempt cardiopulmonary resuscitation' form and to ensure completion of the treatment escalation plan • To adapt the A&E algorithm for the commencement of NIV for use across the organisation.
23. Community Acquired Pneumonia Audit	• To continue to raise awareness of the pneumonia care bundle • To review the records of deceased patients at directorate mortality meetings to ensure pneumonia is accurately coded.
24. Bronchiectasis Audit	• Review the pathway of patients referred for chest CT • Review referrals to respiratory physiotherapy.
25. Adult Asthma Audit	• Reconfiguration of RESTART Team to support consistent and standardised practice regarding discharge planning • Review the A&E algorithm with a view to implementation across the organisation.
26. UK Inflammatory Bowel Disease Audit – 3rd round	• Development and embed into practice Trust guidelines for the management of patients with ulcerative colitis • Care of patients to be supported by a specialist IBD nurse.
27. National Pain Audit	• Re-submission of business cases for clinical psychology & physiotherapy Service • Improve data capture of ICD-10 codes on 'Nessie' database • Education programme for GP's and Junior Doctors being developed in A&E • Develop a pain management group programme of activity.
28. Upper GI Cancer (AUGIS)	• Identify palliative care upper GI cancer patients who are being admitted or readmitted as emergencies. Perform a case note review to look for reason for admission, potential for avoiding the admission and to make suggestions as to other health care settings where care might have been provided.
29. BCIS	• NGH plan to keep more complex PCI within the unit rather than transferring patients to other centres • To expand PCI usage in more elderly frail population where its considered use may benefit patients • Employ data entry and validation admin support • Ensure that all relevant data is entered onto database by individual consultants with this support.

National Clinical Audits	Actions
MINAP	• To focus on the importance of collecting data for nSTEMI through ongoing external MINAP audit • To focus on rapidity of transfer for angiography following nSTEMI • To undertake an audit of time to angiography, including impact of weekends and comorbidities that delayed procedure • Appointment of admin support in PCi to assist with audit • More care needs to be delivered at NGH • NGH plan to deliver as much care as possible on site rather than transferring patients to other centres.

Fig. 19 National Clinical Audit Actions2012/13

The reports of 20 local clinical audits were reviewed by the provider in 2012/2013 and Northampton General Hospital (NGH) intends to take the following actions to improve the quality of healthcare provided:

Local Clinical Audits	Actions
1. Patient Identification	• Reports to wards where some patients did not have any wristband identification • Results reported to the operational meeting • Continued education of staff regarding the policy on the use of electronic wristbands • Annual re audit in February 2013.
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.
3. Protected Meal Times Audit	• Establish a way forward regarding discontinuing doctors' rounds at meal times • Bedside tables are cleaned and cleared prior to meals being served • All patients to receive hand washing wipes • Ensure all patients can reach their food • Monthly observational audits to assure compliance • Annual trust wide re audit.

Local Clinical Audits	Actions
4. Nutritional care audits	• Revised whiteboard guidance & magnet ordering process to be sent to all wards • Out of hours & mealtimes matter posters laminated and re sent to wards for display • Adequate availability of yellow jugs for vision impaired patients to be ensured by Housekeepers • Revision of enteral tube feeding care plans • Reinforce importance of Trust training programmes • Update Medical Illustration screensaver photos • Revise current parenteral nutrition care plan alongside Central venous catheter care plan • Nasogastric tube insertion training to continue reinforcing appropriate use of documentation • Screensaver to remind staff of importance of pH testing and documentation.
5. Fall Safe Audit	• Disseminate results to ward sisters • Supply disposable slippers to ward sisters • Identify obstacles to obtaining walking aids • Re run educational screensavers • Bed rails risk assessment and care plan • Highlight increased falls risk with use of sedation • Complete all sections of the care plan • Stickers to indicate medication review has occurred • Lying & standing blood pressure (BP) on all patients once per week • Urinalysis on all elderly patients on admission • Launch cognitive screening tool • Re audit 2013/14.
6. Whiteboards Audit	• Re format whiteboards design following task & finish consultation • Re issue guidance to staff of how to complete the Whiteboard appropriately • Re audit in 2013 to demonstrate compliance with corporate guidelines.
7. Metastatic Spinal Cord Compression (MSCC)	• To audit involvement of MSCC coordinator in future audits • Better education of medical and nursing staff particularly GPs and those in A&E • The current patient pathway is under review by East Midlands Cancer Network (EMCN) MSCC group • Provision of 24 hour MRI service • Possibility that when the acute oncology team are in post, the management of suspected MSCC patients will be part of their role • Re audit one year.
8. Denosumab Audit	• Perform knowledge assessment of nurses and doctors on the fracture neck of femur ward • Identify gaps in knowledge • Delivery of training to those identified as requiring it • Repeat knowledge assessment following training to assess improvement • Review in August 2013 by falls prevention group.

Local Clinical Audits	Actions
9. Audit of Healthcare Records	• Trained nurses to print name and NMC number against all entries in healthcare records • Addressograph labels to be used on all documentation • Directorates to attend healthcare Records Group and present action plans for local improvement • Review of nursing documentation being undertaken • Patient Safety documentation lead identified
10. NICE TA 226 Rituximab for the first-line maintenance treatment of follicular non-Hodgkin's lymphoma	• Consultants must ensure and document clearly that patients receive written information regarding both their initial and maintenance Rituximab treatment • Nursing staff should ensure that a consent form is completed prior to administration of maintenance treatment.
11. Accuracy of Medication on Discharge audit	• Report to medicines management committee • Feedback results to pharmacists at a clinical pharmacy meeting • Feedback to Junior Doctors • Discussions regarding refining of the electronic discharge software • Information on medicines from GPs may be more easily available if the GP software System 1 is made more widely available to Accident and Emergency
12. VTE Risk Assessment	• Introduction of VTE magnet for display on whiteboards confirming risk assessment within 24 hours • Training programme for all members of MDT • Monthly junior doctor audits confirming, risk assessment, correct thromboprophylaxis • Confirm patient risk status and corrective actions if required • Provide wards & directorate teams with compliance data and any change in practice or corrective measures required.
13. Pneumonia Audit	• Improve compliance with delivery of Pneumonia Care bundle • Facilitate correct clinical coding • Resource for delivery bundle available on all wards • Simpler access to all hospital guidelines • Ensure Trust-wide implementation of pneumonia algorithm • Improvement in documentation of fluid balance charts • Raise awareness • Develop educational simulation scenarios for MDT • Progress, monitor via patient safety assembly.

Local Clinical Audits	Actions
14. 'Code Red' Audit	• Introduce educational programme for all clinical areas utilising NEWS cascade • Supply and deliver code red magnets to clinical areas • Provide arm bands for team leaders • Collect telephone data for all code red patients • Develop staff instruction for code red • Code red protocol is developed and encompassed within the resuscitation policy once ratified • Provide real time feedback for Early Warning Scores, escalation compliance via failure to rescue workstream within patient safety academy.
15. Ward Round Standardisation and Practice Audit	• Introduce ward round stickers to support standardisation of documentation • 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 share findings with PDSB and clinical teams • Progress, develop and sustain via failure to plan workstream within patient safety academy.
16. Failure to Care	• Project which will encompass many aspects of care which are set as basic standards in our regulatory frameworks. In some of these areas we already have significant emphasis. In some areas significant improvement has already taken place and in others there is a need to extend and accelerate progress. This project encompasses many key areas where harm is known to occur such as healthcare associated infection, medication errors, hospital acquired thrombosis, falls, pressures sores, catheter associated urinary tract infection, care of vulnerable patients including those with dementia, fluid management, nutrition support and never events.
17. Failure to Plan	• This project will focus on standards of record keeping and general documentation as well as standards of documentation of plans in the medical and nursing notes and will be using improvement methodology to test cycles of change. The focus will be on the systems and processes which improve the documentation of plans and diagnoses and the way key findings and actions are handed over between clinical teams including to primary care • There is abundant evidence that clear health records keeping and the requirement to document findings and diagnoses and treatment plans improves the quality of care. It also improves the flow of information that is collected on the hospital systems and which is required for clinical coding.

Local Clinical Audits	Actions
18. Failure to Rescue	• The project will focus on ensuring that there is compliance with recording of observations, and with all policies that relate to the actions taken subsequently, indicating that the patient is very ill or deteriorating. This project will also encompass the use of care bundles to provide facilitation of correct treatments, but also to ensure that the most seriously ill patients are treated appropriately. New approaches to the recognition and prioritisation of the most seriously ill patients will be piloted, and new approaches to learning from situations where there have been failures to recognise or act on deterioration, will be adopted.
19. Learning from Serious Incidents	• An effective safety culture needs to include a clear, agreed and comprehensive system for accelerating and sharing learning. In the case of patient safety this needs to cover learning from all areas that impact upon patient safety including incidents (especially serious incidents and never events), complaints, litigation, issues identified from audits, mortality and morbidity meeting conclusions and hospital standardised mortality monitoring. It is essential that the lessons of successful intervention are shared as well as the lessons resulting from error and failure. This project will consolidate and agree current mechanisms and take forward improvement initiatives to ensure both organisational and individual learning is in place with a focus on personal reflection and education.
20. Human Factors	• This project will have a major role in assimilating the themes from all the projects to lead cascade training on patient safety necessary for the success of this programme. It is envisaged that this will include developing the programme that trains up to 70 individuals in safety science as well as ensuring that there are links between safety champions throughout the organisation. Another key role will be planning and helping to deliver scenario based training that will combine elements of mandatory training with specific training in safety methodology and theory. The key focus of this project will be to consider specifically the human factors that impact on understanding, training and failures of care.

Fig. 20 Local Clinical Audit Actions 2012/13

Part Three

Participation in Clinical Research

The number of patients receiving NHS services provided by NGH from April 2012 to March 2013, that were recruited during that period to participate in research approved by a research ethics committee was around 2,000. A total of 11,143 were recruited to studies on the National Institute of Health Research portfolio.

Participation in clinical research demonstrates our 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 treatment possibilities and active participation in research leads to successful patient outcomes. NGH was involved in 232 clinical research studies within in the clinical directorates during April 2012 to March 2013.

Clinical staff across the Trust participated in research approved by a research ethics committee at NGH during April 2012 to March 2013. In the last year there continued to be several studies in cancer, rheumatology and diabetes. Recently studies in Intensive Therapy Unit (ITU), A&E and renal care 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 thirty clinical trials, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. Our involvement with clinical research also demonstrates the Trust's dedication to testing and offering the latest medical treatments and techniques to our patients.

Part Three

Goals agreed with commissioners

Use of the CQUIN Framework

A proportion of NGH income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between the Trust and its commissioners for quality and innovation payment framework.

In 2012/13, the two commissioners (general and specialist respectively) were Northamptonshire Teaching PCT (NTPCT) and the East Midlands Specialist Commissioning Group (EMSCG). Following the national changes to the NHS structure, our commissioners are now Nene Clinical Commissioning Group and Specialised Commissioning (Leicestershire and Lincolnshire Area Team) - NHS England.

The table below summarises our targets and the outcomes for 2012/13.

	Northampton Teaching PCT (NTPCT)	Final
National VTE	1a. 90% of all adult inpatients to have a VTE risk assessment	
	1b. High risk patients receive appropriate treatment	
National 2 Patient experience	Improve responsiveness to personal needs of patients	
National 3 Dementia	Improve awareness and diagnosis of dementia using risk assessment, in an acute hospital setting	
National 4 NHS Safety Thermometer	Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE	
Regional 1 Patient Experience	1. Establish question and baseline Net Promoter score	
	2. Board and Commissioner reporting	
	3. Weekly reporting	
	4. Performance improvement by 10 points from July 2012 position	
Local 1 High Impact	Implement oesophageal doppler monitoring (ODM) or similar fluid management technology	
Local 2 Right Care, Right Place (Unscheduled Care)	2a. Ensure that a greater number of patients are seen and discharged within 3 hours of arrival time	
	2b. Manage all appropriate emergency cases on an ambulatory basis by the appropriate number of referrals to the community elderly care service/intermediate care service from A&E	
Local 3 Medicines Management	3a. Accuracy of medicines information on discharge	
	3b. Analgesic transdermal patches	
	3c. Oral nutritional supplements (ONS) - reduce the use of ONS	
	3d. Triptorelin	

	Northampton Teaching PCT (NTPCT)	Final
Local 4 Improved communication between secondary and primary care	4a. Implementation of a policy to send first outpatients letters back to referring rather than registered GP	
	4b. NGH will scope electronic communication systems and implement within 1 year if possible to ensure the swift and secure transfer of information	
	MESCG CQUINS	
National 1 VTE	1a. 90% of all adult inpatients to have a VTE risk assessment	
	1b. High risk patients receive appropriate treatment	
National 2 Patient experience	Improve responsiveness to personal needs of patients	
National 3 Dementia	Improve awareness and diagnosis of dementia using risk assessment, in an acute hospital setting	
National 4 NHS Safety	Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with catheter, and VTE	
1	Quality Dashboards	
3	Use of Intensity Modulated Radiotherapy	
4	Cancer Chemotherapy a) Performance Status b) Performance score of 2 and above	
5	Hepatitis C. Compliance with treatment/Improved patient outcomes	
7	Reduction of catheter - related conditions	

CQUIN Key	
Green	Full Payment
Amber	Partial Payment
Red	No Payment

Fig. 21 CQUIN 2012/13

For 2011/12 further details of the agreed goals for 2011/12 and for the following 12 month period are available electronically at:
http://www.institute.nhs.uk/commissioning/pct_portal/2011%1012_cquin_schemes_in_east_midlands_.html

Explanation of amber and red areas

National 2: Patient Experience
The results of the national Inpatient Survey did not pass the threshold to achieve full payment of the CQUIN.

National 3: Dementia
The Trust did not meet the threshold for these indicators as an effective method of assessing and capturing the information was not available throughout the year.

Regional 1: Patient Experience
As reported elsewhere in the quality account, the Trust did not achieve a 10 point improvement in the Net Promoter Score and so did not achieve a full payment for this CQUIN.

Local 3: Accuracy of Medicines on discharge
A partial payment was received as the Trust did not achieve full compliance with the indicator CQUIN.

Part Three

Goals agreed with commissioners for 2013/14

The table below outlines our targets for 2013/14.

	Nene CCG CQUINS
	Indicator Number & Name
National 1 Friends & Family Test	1.1 Phased expansion of FFT
	1.2 Increase response rate to at least 20%
	1.3 Improve performance on staff FFT
National 2 NHS Safety Thermometer)	2.2 50% reduction in all new hospital acquired pressure ulcers that are avoidable
National 3 Dementia	3.1 Find, assess, investigate and refer
	3.2 Clinical leadership
	3.3 Supporting carers
National 4 VTE	4.1 95% of all adult inpatients to have a VTE risk assessment
	4.2 VTE root cause analysis
Local 1	Development and implementation of Acute Emergency Care Pathway (AECP) for chest pain
Local 2	Development and implementation of AECP for pulmonary embolism
Local 3	Development and implementation of AECP for supraventricular tachycardia
Local 4	Development and implementation of AECP for pleural effusion
Local 5	Development and implementation of AECP for painless jaundice
Local 6	Development of HOT* clinic for paediatrics
Local 7	Development of HOT clinic for surgery
Local 8	Development of HOT clinic for medicine

* Hot clinics are designed to avoid unnecessary admissions by offering rapid access clinic slots.

	NHS England	
	Indicator Number & Name	
National 1 Friends & Family Test	1.1	Phased expansion of FFT
	1.2	Increase response rate to at least 20%
	1.3	Improve performance on staff FFT
National 2 NHS Safety Thermometer)	2.2	50% reduction in all new pressure ulcers that are avoidable.
National 3 Dementia	3.1	Find, assess, investigate and refer
	3.2	Clinical leadership
	3.3	Supporting carers
National 4 VTE	4.1	95% of all adult inpatients to have a VTE risk assessment
	4.2	VTE root cause analysis
Local 1		Quality dashboards
NIC		Timely simple discharge
NIC		Improve access to breast milk in preterm infants
Renal		Acute kidney injury

Fig.22 CQUIN 2013/14

The CQUIN programme will remain a challenge, many are already quality priorities.

Care pathways are designed to improve the effectiveness of care and will support implementation of quality priority 1 (Redesigning the Emergency Care Pathway).

The Trust is continuing in its ambition of zero tolerance to avoidable hospital acquired pressure ulcers. Our CQUIN this year is a significant challenge that the Trust fully supports. The priorities are to implement all aspects of the SSKIN bundle, appoint a lead tissue viability nurse, develop and implement a training programme and implement the nursing and midwifery staffing strategy.

Part Three

What others Say About Northampton General Hospital NHS Trust (NGH)

Care Quality Commission (CQC)

Northampton General Hospital NHS Trust (NGH) is registered with Care Quality Commission (CQC) and is currently registered with no conditions. The CQC has not taken any enforcement action against NGH during 2012/13. The CQC visited the Trust in July 2012 and reviewed the following essential standards of quality and safety:

- Outcome 2 - Consent to care and treatment
- Outcome 4 - Care and welfare of people who use services
- Outcome 7 - People should be protected from abuse and staff should respect their human rights
- Outcome 9 - Management of medicines
- Outcome 13 - Staffing
- Outcome 16 - Assessing and maintain the quality of service provision.

The summary below describes why the Care Quality Commission (CQC) carried out this review, what they found on their visit and the action required.

Why the CQC carried out this review

CQC carried out this review as part of its routine schedule of planned reviews.

How the CQC carried out this review

The CQC reviewed all the information they held about the hospital and on the 18 July 2012, carried out a 5 day inspection. They observed how people were being cared for, looked at records of people who use services and spoke with staff and people who use our services.

The CQC carried out inspection visits to NGH on consecutive days. The inspection visit was unannounced. The main focus of the inspection was on emergency care, with additional visits being made to the emergency assessment unit, six wards and the eye department.

Part Three

What people told the CQC

The CQC spoke to several patients and in some cases their relatives on each of the wards and departments visited. Some of the patients spoken with had experienced lengthy delays in the A&E, waiting for a bed to be available on a ward. Despite this, they found that the majority of patients were satisfied with their care and treatment.

Patients told the CQC that their care and treatment had been discussed with them and they had been kept informed. Patients and relatives gave examples of the care of patients who were acutely unwell being prioritised. Two patients who had been in hospital earlier in the year told them that this time the care and treatment was much better and that there had been an improvement in their experience in the A&E department. One of the comments received from a relative was echoed by others spoken with; “the care has been excellent this time, staff have communicated with me every step of the way, we have not been left alone for very long”.

What the CQC found

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it
We were judged to be meeting this standard. Where people did not have the capacity to consent, we acted in accordance with legal requirements.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights
We were judged to be meeting this standard. People experienced care, treatment and support that met their needs.

Outcome 07: People should be protected from abuse and staff should respect their human rights
We were judged to be meeting this standard. People who use the service were protected from the risk of abuse, because we had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way
We were judged not to be meeting this standard fully. The inspectors found that we did not always protect people against risks associated with the unsafe use and management of medicines because appropriate arrangements for the storage and recording of medicines were not followed consistently.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs
We were judged not to be meeting this standard fully. The inspectors found that we did not always protect people against risks associated with not having sufficient numbers of suitably qualified, skilled and experienced staff to meet the individual needs of patients.

Part Three

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care
We were judged to be meeting this standard. We had an effective system to regularly assess and monitor the quality of service that people receive.

Actions to be taken
We welcome inspections and reviews to our service as these help us to make improvements. Concerns are acted upon immediately with action plans submitted to the CQC to explain the changes we have and will be making.

A number of improvements have been made in response to the concerns that have been raised with us these include:

- Regular hourly care rounds by nursing staff to check on the comfort of each patient
- Making sure call bells are in reach
- Successful recruitment of a large number of registered nursing staff and healthcare assistants, resulting in the general wards being up to full establishment by summer 2013
- The revision and storage of medicine
- Improving practice relating to missing medicines
- Improving practice relating to variable doses
- Improving practice relating to documentation of medications/omissions of medications.

In addition we have completed a review of nursing documentation and are in the process of improving individual care plans.

Other information
There have been concerns raised by the informal CQC enquiry process during the period of the report. Responses have been sent for all of these with associated action plans where required.

Data Quality

Validation of Trust information is completed within individual directorates with these processes centrally supported by the information & data quality department. It is the responsibility of the head of information and data quality to ensure the robustness and accuracy of information and to investigate inconsistencies prior to publication in either internal or external forums.

Data quality is subject to internal and external challenge and is monitored through various internal forums including the weekly performance meeting, the mortality group, and the HSMR coding review group. A data quality working group to address data quality issues with key stakeholders across the Trust including the staff responsible for data input is in the process of being established. External challenge is via the commissioner data challenge process.

Inconsistencies in data quality are fed back directly to individuals and any agreed actions monitored through the weekly performance meeting. Reports in respect of data quality are submitted to the Trust Board and to sub-committees of the board.

The audit committee commissions an annual programme of internal audit to ensure the robustness of information provided to the Board and the healthcare governance committee which uses performance management and patient admissions system (PAS) data quality. However, the audit committee recognises that this needs to be extended to include other types of data reported to give the committee wider assurance.

The audit committee commissions an external auditor to undertake a review of the quality accounts to ensure accuracy of information. The Trust's external auditors are required to test a minimum of two specified performance indicators included in the 2012/13 quality account and have tested the systems for serious incidents and 28 day readmissions. The auditors were able to give 'assurance' in all of these areas as at June 2013.

The Board views audit as critical to the review and assessment of the control environment and effective implementation of action to address identified concerns is critical. Internal and external audit recommendations are reviewed and agreed actions to address any concerns are followed up.

NHS Number and General Medical Practice Code (GMPC) Validity

The Trust submitted records between April 2012 and December 2012 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records that included valid numbers were as follows:

	Valid NHS Number	Valid GMPC
Admitted Patient Care	99.6%	100%
Outpatient Care	99.8%	100%
Accident & Emergency Care	94.9%	100%

Fig. 23 Code Validity 2012/13

Information Governance Toolkit Attainment Levels

The Information Governance (IG) Toolkit was completed and submitted at the close of the financial year. There are two areas which require ongoing improvement. These are:

- 112 Information governance mandatory training - we are required to achieve 95% compliance with training
- 300 - 324 Information Security Assurance - further work is required to ensure that our processes are robust in identifying and managing risks.

A work programme is in place to address all of the issues in the Information Governance Toolkit, with particular attention paid to the above areas. This is monitored through a local group.

Clinical Coding Error Rate

Northampton General Hospital (NGH) was subject to the payment by results clinical coding audit during the reporting period by the Audit Commission and error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) are detailed below.

Part Three

In October 2012 a PbR data assurance audit was completed on admitted patient care data in general medicine at the Trust. The report details the findings from the audit and outlines recommendations to be taken forward. In summary the key findings were:

Spells tested	% of spells changing payment	Clinical Coding						Other Data items	
		% of spells changing HRG	% clinical codes incorrect	% diagnoses incorrect		% procedures incorrect		% spells with other data items incorrect	% other data items incorrect
				Primary	Secondary	Primary	Secondary		
96	3.1	3.1	9.6	4.8	10.5	7.1	13.8	0	0

Fig. 24 Clinical Coding Error Rate 2012/13

The performance of the Trust, measured using just the clinical coding HRG error rate, is 3.1%, well below last year's average HRG error rate of 7.0%. The percentage of diagnoses coded incorrectly is also significantly improved. Although the error percentage for procedure codes is slightly higher, this is due to very small denominator in this specialty i.e. very few procedures are carried out in General Medicine.

Area audited	% Procedures coded incorrectly		% Diagnoses coded incorrectly		% of episodes changing HRG	% of spells changing HRG
	Primary	Secondary	Primary	Secondary		
Locally determined speciality - General Surgery	4.5	18.8	6.0	13.0	6.0	6.4
Random selection from SUS	8.2	5.2	11.0	13.5	8.0	8.6
Overall	6.3	12.2	8.5	13.2	7.0	7.5

Fig. 25 Clinical Coding HRG Error Rate 2012/13

What Patients Said About NGH

National Inpatient Survey 2012

The results of the national inpatient survey were published by the Care Quality Commission in April 2013.

Northampton General Hospital NHS Trust	%	Number
Responded	61.23	507
Did not respond - including opted out or ineligible	38.77	321
Eligible cases	100.00	828
Excluded - undelivered or deceased	1.00	22

Fig. 26 National Inpatient Survey 2012

Part Three

The results show the Trust response rate (61%) is higher than the overall rate for all Trusts (51%). The majority of scores are similar to most Trusts. In all but 5 cases, the scores remain consistent with the 2011 results, with no statistically significant change to the negative or positive. Where the scores are lower than the 2011 results, the issues raised have been identified within other surveys and are currently being addressed as part of existing patient experience work. It has been very encouraging to see that there are no areas identified by the survey that are not also being highlighted elsewhere and gives the Trust confidence about its current processes for capturing feedback. There are action plans in place for all of the areas where we would like our performance to improve, many of which are also quality priorities.

National A&E Survey

The findings of the national 2012 Accident and Emergency patient survey (published in December 2012) showed some encouraging results for NGH. The survey highlighted some improvements in cleanliness, privacy and advice given to patients compared to the previous survey. Since the survey took place, we have expanded and updated A&E, providing an additional five cubicles, a larger waiting area and greater privacy at reception. A new system of working has also been introduced to speed up the treatment of seriously ill patients, helping to reduce the time taken for ambulance patients to be handed over to the hospital.

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 has introduced mandatory reporting against a small, core set of quality indicators for the 2012/13 reporting period, aligned with the NHS Outcomes Framework. The performance of data for NGH is shown for 2012/13 and the previous year (2011/12), along with the national average for 2011/12 (taken from the Health and Social Information Centre data unless otherwise stated). 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
	2012/13	2011/12	2011/12
Domain 1 – Preventing people from dying prematurely			
Summary Hospital-Level Mortality Indicator (SHMI): SHMI value and banding (Health and Social Information Centre)	111 (most recent data Oct 11 - Sept 12)	104 (Oct 10 - Sept 11)	100%
Percentage of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care	13% (most recent data Oct 11 - Sept 12)	12.5% (Oct 10 - Sept 11)	18.9% (most recent data Oct 11 - Sept 12)

Part Three

NHS Outcomes Framework Domain	NGH Performance		National Average
	2012/13	2011/12	2011/12
Domain 3 – Helping people to recover from episodes of ill health or following injury			
Patient reported outcome scores for:			
• Groin hernia surgery	98%	60.5%	62.9%
• Varicose vein surgery	54.1%	47.54%	33.3%
• Hip replacement surgery	93%	81.2%	79.5%
• Knee replacement surgery	110.5%	90.9%	87.9%
Emergency readmission to hospital within 28 days of discharge (Dr Foster)	7.16%	4.7%	As expected (reported by Dr Foster, Apr - Dec 12)
• Emergency readmission to hospital within 28 days (age 0-14)	9.75%	(not reported)	Significantly higher than expected (reported by Dr Foster, Apr - Dec 12)
• Emergency readmission to hospital within 28 days (age 15+)	6.62%	(not reported)	As expected (reported by Dr Foster, Apr - Dec 12)
Domain 4 – Ensuring that people have a positive experience of care			
Responsiveness to inpatients' personal needs*			National Comparison 2012
Wait to be allocated a bed on a ward	7.4	7.9	About the same as other Trusts
Noise at night (patients)	5.1	5.0	Worse than other Trusts
Noise at night (staff)	7.3	7.2	Worse than other Trusts
Patients involved in decisions about their discharge from hospital	6.6	(not asked last year)	About the same as other Trusts
Explanations around side effects of medications following discharge	4.3	4.8	About the same as other Trusts
Staff recommendation of the Trust as a place to work or receive treatment (NHS staff survey)**	3.35	3.4	3.57 (2012 scores)

NHS Outcomes Framework Domain	NGH Performance		National Average
	2012/13	2011/12	2011/12
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)	93% (Quarter 3 12/13 figure published)	90.9%	94.2% (Quarter 3 12/13 figure published)
Rate of C. Difficile (number of cases not rate)	30	50	54
Number of incidents reported in the financial year (internal data)	7,899 (as at May 22nd 2013)	5,875	Slightly below average according to NRLS.
Rate of patient safety incidents per 100 admissions (as defined by National Reporting Learning System (NRLS)	6.6 (April - September 2012)	6.3 (October 11 - March 2012)	6.7 (April - Sept 2012) For medium acute Trusts
Number and percentage resulting in severe harm or death (internal data)	78 (1%)	55 (0.95%)	1%
Percentage of incidents resulting in severe harm or death	29 (0.37%)	31 (0.53%)	

Fig. 27 NHS Outcomes 2012/13

* The scores from the national inpatient survey are presented out of ten to emphasise that they are scores and not percentages. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the Trust is performing. The Trust's performance is benchmarked by the CQC to show if NGH is better, the same or worse than other Trusts.

** The summary score is calculated by converting staff responses to particular questions into scores. For each of these summary scores, the minimum score is always 1 and the maximum score is 5.

Domain 1 - Preventing People from Dying Prematurely
Staff at the Trust continue to work hard to review performance and reduce the mortality rate. Details of this can be found on page 67.

Domain 2 - Enhancing quality of life for people with long term conditions
This is a contextual indicator and gives an indicator of the nature of patient's conditions and whether the end of the patients life was expected and planned for.

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

The participation rate for the Trust in PROMS is currently above the national rate for all procedures. Over the last year, this has also improved for groin hernia. The latest data is from April 2011 to March 2012 (published February 2013). N.B. A percentage of over 100% means that we had more patients who had that type of surgery than had been predicted by the past data. Additional information on the results is situated on the following page. Performance is reported to specialities on an aggregate and an individual surgeon basis so that it can be monitored locally. Quarterly performance reports are provided to CQEG from the directorates and bi-annually to CQEG by the Clinical Audit Department.

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

Patient Experience

The results of the national inpatient survey 2012 for 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. The two questions rated 'worse' than most other Trusts in England both concern patients being bothered by noise at night.

Various actions have been implemented to address the issue, including telephones being turned to silent or vibrate mode, lights and call bells being switched to night mode, and staff talking more quietly to each other. We have an ongoing audit programme to review noise at night which includes lay people. This remains one of our quality priorities for 2013/14. Further details can be found in quality priority 4.

Staff Recommendation

The result for staff recommendation of the Trust as a place to work or receive treatment, taken from the NHS staff survey has shown a reduction in the 2012 results. The Trust takes this very seriously and the Director of Workforce is undertaking work to develop and implement an organisational development strategy.

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

The Trust saw a small improvement in the number of patients having a VTE risk assessment in the last financial year. A further step-improvement will be required in 2013/14 to achieve the revised CQUIN target of 95% completion of VTE risk assessment. This is monitored on an ongoing basis.

The number of cases of C-Difficile identified throughout the year was better than the trajectory set for the Trust by its commissioners (30 against a target of 36). Whilst this is very positive, infection prevention remains a key priority for the Trust as outlined on page 68.

The number of incidents reported within the year increased which shows an improving reporting culture. The proportion of serious incidents is at the national average. The Trust aims to reduce the risk of all incidents happening by assessing the risk of harm proactively and by learning when things have gone wrong to reduce the likelihood of the event happening again. All serious incidents have an action plan that is approved by the commissioner. Completion of these actions is also reviewed through regular SIAM (Serious Incident Action) meetings.

Part Three

The Patient Reported Outcome Measures programme is a compulsory audit that measures a patient's health status or health-related quality of life. The measures are a means of collecting information on the clinical quality of care delivered to NHS patients as perceived by the patients themselves. In April 2009 we began PROMS for groin hernias and varicose veins with hip and knee replacements commencing in October 2009.

NGH PROMS Response for QA – Data taken from HESonline PROMS-Key Facts April 2011-March 2012 (published 14th February 2013).

Groin Hernia (National average is shown in brackets for comparison)

- EQ-5D percentage improving 53.6% (49.8%)
- EQ-VAS percentage improving 32.0% (38.8%)
- This is based on 106 patients who completed both questionnaires out of 367 eligible episodes (28.9% response rate).

Hip Replacement (National average is shown in brackets for comparison)

- EQ-5D percentage improving 83.5% (87.4%)
- EQ-VAS percentage improving 64.8% (63.7%)
- Oxford hip score percentage improving 97.0% (95.8%)
- This is based on 213 patients who completed both questionnaires out of 326 eligible episodes (65.3% response rate).
-

Knee Replacement (National average is shown in brackets for comparison)

- EQ-5D percentage improving 82.2% (78.4%)
- EQ-VAS percentage improving 51.1% (53.7%)
- Oxford knee score percentage improving 94.0% (91.6%)
- This is based on 193 patients who completed both questionnaires out of 306 eligible episodes (63.1% response rate).
-

Varicose Vein (National average is shown in brackets for comparison)

- EQ-5D percentage improving 35.3% (53.2%)
- EQ-VAS percentage improving 52.9% (42.0%)
- Aberdeen varicose vein questionnaire percentage improving 83.3% (83.1%)
- This is based on 18 patients who completed both questionnaires out of 76 eligible episodes (23.7% response rate).

Part Three

Hospital Mortality Monitoring

The Hospital Standardised Mortality Rate (HSMR) is an index that compares mortality rates across the country, risk adjusted for age and pre-existing medical conditions (for example a patient may have died from pneumonia, but also had diabetes). The average HSMR is 100. An index above that would indicate a higher level of deaths in the hospital than would be expected.

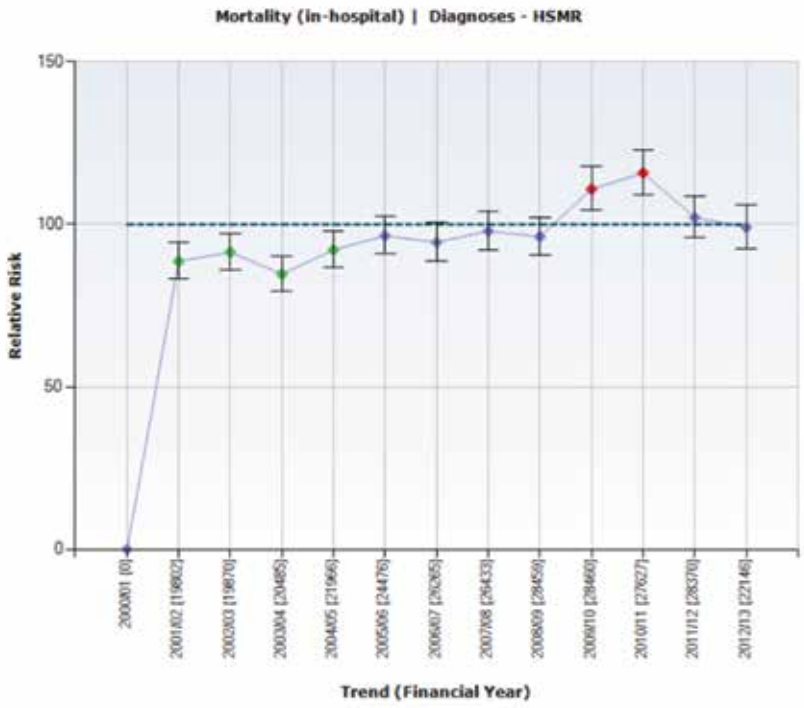
HSMR rates provided to us by Dr Foster are reviewed on a monthly basis by the Associate Medical Director and monthly reports are presented to the Medical Director, discussed at the CQEG, and reported monthly to Trust Board.

NGH also looks at another mortality indicator which is called SHMI (Standardised Hospital Mortality Indicator). This gives very similar results to HSMR for our hospital.

HSMR and SHMI for 2012/13 are both in the range of 'as expected' compared to other hospitals (as reported within the core quality indicators).

There is a continuous and careful analysis of all areas where there might be a cause for concern and these are investigated carefully to determine whether there are any quality of care issues. This requires multi-disciplinary scrutiny of each area of concern and has resulted in a number of initiatives to improve care over recent years. The Trust has, for example, focussed on the treatment of serious blood infections, pneumonia, stroke, myocardial infarction and fractured neck of femur.

The Trust is working closely with Dr Foster to ensure that there is continuous improvement in the tools we use to monitor mortality and safety outcomes.



Part Three

Improving Patient Safety by Reducing Infections – MRSA and Clostridium Difficile

The Trust maintained its focus on eliminating acquired infections throughout the 2012/13 period, including reducing both MRSA bacteraemia and Clostridium Difficile rates.

We continued to exceed our target reduction in Clostridium Difficile infection during the year, with 30 cases infections reported against a Trust target of 36. Disappointingly, two MRSA bacteraemia (blood stream infection) were reported against a Trust target of one.

Healthcare associated infection will remain a top priority for staff, patients and the public.

Part Three

Corporate Scorecard 2012/13

The Trust continually monitors its performance against various key indicators, including mandatory indicators, which are used to inform the organisation and external organisations of progress and to drive service improvement. The corporate score card is one such tool, a sample from Trust Board (March 2013 Data) is shown below.

Patient Safety	Target 2012-13	March 2013	Rating
HQU01: HCAI measure (MRSA)	1 per year	0	
HQU02: HCAI measure (CDI)	36 per year	5	
HQU08: MSSA Numbers	No national ceiling set	0	
E Coli ESBL Quarterly Average	7 per month	0	
VTE Risk Assessment completed	90% month on month	90.1%	
MRSA Screening Elective Patients	100% month on month	99.4%	
MRSA Screening Non-Elective Patients	100% month on month	97.0%	
Ward Traceability Compliance Number of Unfated Units	0 month on month	45	
Incidence of pressure ulcers			
Type 3	0	5	
Type 4	0	1	
Reduce harm from falls			
Catastrophic	0	0	
Major/Severe	0	1	
Moderate	0	1	
Mandatory Training compliance Full Year Impact			
Primary Levels Excluding B&H	80%	Not avail	
Attendance at Trust Induction	80%	Not avail	
Number of surgical site infections			
Fracture neck of femur - Number of Operations	-	45	
Infections	-	0	
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.6%	0%	
Spinal Surgery - Number of Operations	-	13	
Infections	-	0	
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.7%	0%	
Vascular Surgery - Number of Operations	-	13	
Infections		0	
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 4.0%	0%	

Part Three

Patient Safety	Target 2012-13	March 2013	Rating
Breast Surgery	-	Breast Surgery and Limb Amputations infection rates monitored up until Sept 2012	n/a
Infections			n/a
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 1.0%		
Limb Amputations	-		n/a
Infections	-		n/a
% of surgical site infections (Quarterly HPA submission)	Nat. Ave 3.8%		
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%	Not avail	
Serious Untoward Incidents	-	36	
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%	72%	
Q.2 Does addressograph include the NHS Number?	100%	92%	
Q.3 If there is NO addressograph label does the page contain: Patient's Full Name	100%	84%	
Q.4 If there is NO addressograph label does the page contain: Date of Birth	100%	64%	
Q.5 If there is NO addressograph label does the page contain: Hospital Number	100%	46%	
Q.6 If there is NO addressograph label does the page contain: NHS Number	100%	18%	
Q.7 Is record legibly written	100%	99%	
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%	100%	
Q.10 Is date recorded for each entry	100%	88%	
Q.11 Is time recorded for each entry	100%	75%	
Q.12 Is there a signature of the person making the entry	100%	94%	
Q.13 Is surname printed in block capitals	100%	58%	
Q.14 Is the staff designation recorded	100%	58%	
Q.15 Medical Records Audit only: Is the GMC number present	100%	38%	
Q.16 Are any alterations / deletions scored through with a single line	100%	40%	
Q.17 Is there a signature recorded next to any alterations/deletions	100%	28%	
Q.18 Is there a date recorded next to any alterations/deletions	100%	24%	
Q.19 Is there a time recorded next to any alterations/deletions	100%	17%	
Q.20 Medical Records Audit only: Is there evidence of a clear plan of care/treatment	100%	100%	
Q.21 Medical Records Audit only: Is there evidence of communication to relatives and teams	100%	44%	
Q.22 Medical Records Audit only: Is there evidence of an entry by medical staff at lease once a day	100%	100%	
Q.23 Are there any loose sheets in the Healthcare record	0%	13%	
Patient Experience	**Target 2012-13**	**March 2013**	**Rating**
Cancelled Operations not rebooked within 28 days	0	2	
Hospital Cancelled Operations	6.0%	Not Avail	
Number of written complaints received	-	52	
Complaints Responded to within agreed timescales	100.00%	N/Avail	

Part Three

Patient Experience	Target 2012-13	March 2013	Rating
Referral to Treatment waits			
Admitted Patients	90.00%	94.70%	
Non Admitted Patients	95.00%	97.80%	
Ongoing Patients	92.00%	Not avail	
A&E Quality Indicators (5 measures)			
Time Spent in A&E (Month on Month)	95%	82.49%	
Time Spent in A&E (Cumulative)	95%	91.51%	
Total time in A&E (95th percentile)	95th	08:08	
Time to initial assessment (95th percentile) patients arriving by ambulance	<15 mins	01:10	
Time to treatment decision (median)	<60 mins	00:52	
Unplanned re-attendance rate	=<5%	7.04%	
Left without being seen	>1% and <5%	0.22%	
Cancer Wait Times			
2 week GP referral to 1st outpatient	93%	98.3%	
2 week GP referral to 1st outpatient - breast symptoms	93%	100.0%	
31 Day	96%	99.2%	
31 day second or subsequent treatment - surgery	94%	100.0%	
31 day second or subsequent treatment - drug	98%	94.7%	
31 day second or subsequent treatment - radiotherapy	94%	95.8%	
62 day referral to treatment from screening	90%	84.2%	
62 day referral to treatment from hospital specialist	85%	100.0%	
62 days urgent referral to treatment of all cancers	85%	76.5%	
SRS08: Length of Stay (Acute & MH)			
Elective	3.20	4.2	
Non-Elective	5.30	4.7	
SRS09: Daycase Rate	85%	Not avail	
SQU11: PROMS Scores - Pre Operative participation rates			
Groin Hernia - Participation Rate	Nat.Ave 62.9% (target 80%)	98.0%	
Hip Replacement - Participation Rate	Nat.Ave 79.5% (target 80%)	93.0%	
Knee Replacement - Participation Rate	Nat.Ave 86.9% (target 80%)	110.5%	
Varicose Vein - Participation Rate	Nat.Ave 33.3% (target 80%)	54.1%	
All Procedures - Participation Rate	Nat.Ave 72.6% (target 80%)	96.0%	
Clinical Outcomes	**Target 2012-13**	**March 2013**	**Rating**
HSMR - monthly position for 2012-13	<100	Data not yet published	
HSMR - cumulative position current financial year			
HSMR- cumulative position for 2012-13			
Pneumonia	<100	Data not yet published	
Fracture of neck of femur (hip)	<100		
Acute Cerebrovascular disease	<100		

Part Three

Clinical Outcomes	Target 2012-13	March 2013	Rating
Congestive heart failure, nonhypertensive	<100	Data not yet published	
Acute myocardial infarction	<100		
SHMI (based upon date of SHMI report publication)			
SQU12: Maternity 12 weeks	90%	94.1%	
SRS10: Delayed Transfers of Care – Acute & MH	3.0%	Not avail	
Fractured neck of Femur			
Number of patients admitted with FNOF	-	46	
Patients fit for surgery within 48hrs	-	45	
Number of patients admitted with FNOF who were operated on within 48 hrs	-	43	
Percentage of patients admitted with FNOF operated on within 48 hours of admission	100%	95.6%	
Cardiac Arrests (Numbers)			
Peri Arrests (Numbers)			
Patients admitted as Emergency with GI Bleed scoped within 24 hours	100%	69.6%	
50% of suspected stroke patients given CT scan within 1 hour of arrival	50%	48%	
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%	69.2%	
Patients who spend at least 90% of their time on a stroke unit	80%	96.4%	
Breast Feeding initiation	75%	79.4%	
Caesarean Section Rates - Total	<25%	24.9%	
Caesarean Section Rates - Emergency	14.98%	9.4%	
Caesarean Section Rates - Elective	10.06%	15.5%	
Home Birth Rate	6.00%	6.6%	
CQUIN 2012-13	**Target 2012-13**	**March 2013**	**Rating**
National CQUINS			
1a. 90% of all adult inpatients to have a VTE risk assessment	90% month on month	90.1%	
1b. High risk patients receive appropriate treatment (inadequate volume of data Q2)	95% Month on month	99.4%	
2. Improve responsiveness to personal needs of patients (5 questions based on inpatient survey results)		Internal assurance results	
Were you involved as much as you wanted to be in decisions about your treatment or care?	>71.0	77.4%	
Were hospital staff available to talk about any worries or concerns that you had?	>63.4	83.3%	
Did you have enough privacy when discussing condition or treatment?	>82.3	73.3%	
If you have been prescribed any new medication, have you been informed of any possible medication side effects?	>48.5	61.1%	
If you are ready to be discharged – have you been informed who to contact if you are worried about your condition after leaving hospital?	>74.3	57.1%	
3. Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting			
a) Dementia case finding	90%	Not avail	
b) initial diagnostic assessment	90%	Not avail	
c) referral for specialist diagnosis	90%	Not avail	

Part Three

CQUIN 2012-13	Target 2012-13	March 2013	Rating
4. Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE	-	Monthly data submitted for all ward areas from Apr 12. Theatre recovery area submission from June 12.	
Submission of 3 consecutive months of survey data, covering 100% of appropriate patients per Quarter	RAG		
Regional CQUIN			
1. Establish question and baseline Net Promoter score	10%	15.15%	
2. Board and Commissioner reporting	Submission to HCG	Submission to HCG	
3. Weekly reporting	-	Weekly reports submitted from Hospedia	
4. Performance improvement by 10 points from July 2012 position	10 point improving	72	
Local CQUINS			
1. Implement Oesophageal Doppler Monitoring (ODM) or similar fluid management technology	50% adoption by Q4	Repeat audit in progress due for completion by mid March. Year end results show 84% adoption	
2a, Ensure that a greater number of patients are seen and discharged within 3 hours of arrival time at A&E (CQUIN negotiations ongoing)	65% for Q3, 75% for Q4	79%	
2b. Appropriate referrals to CECs/ Intermediate service from A&E		Revised process agreed with commissioners and data currently being validated by Nene CCG	
3a. Accuracy of medicines information on discharge	75% error free	Junior doctor audit undertaken in Medicine on monthly basis for internal assurance purposes. GP audit to be undertaken in Q4. Internal audit results for Dec12 - Jan 13 = 53% error free	
3b. Analgesic transdermal patches (CQUIN negotiations ongoing)	Undertake baseline audit	Q4 audit completed in Rheumatology and Pain clinic, analysis being undertaken.	
3c. Oral nutritional supplements (ONS) - reduce the dispensing of ONS	50% reduction between Q1 and Q4	Quarterly figure	
3d. Triptorelin	Q3 - 70% compliance, Q4 - 80% compliance	Completed & compliant as at Feb-13	
4a. Implementation of a policy to send first outpatients letters back to referring rather than registered GP.	Quarterly Updates internal		

CQUIN 2012-13	Target 2012-13	March 2013	Rating
4b. NGH will scope electronic communications systems and implement within 1 year if possible to ensure the swift and secure transfer of information.	Quarterly Updates Primary Care		
MESCG CQUINS			
1. Quality Dashboards	-		
Identify and provide contact details of the following:			
- an overall dashboards lead for the Provider		Head of Information & Data Quality	
- a dashboard lead in each clinical area for which a dashboard is required in 12/13	-	Clinical Directors	
Provide a summary setting out the plans for implementation of the dashboards within the required timescale		Dashboards submitted	
3. Use of Intensity Modulated Radiotherapy	33%	Q4 = 60%	
4a. Cancer Chemotherapy Performance Status	90%	94.9%	
4b. Cancer Chemotherapy Performance status 2 or above	100%	100%	
4c. Improve appropriate assessment and Improve mortality rates			
Number of Oncology patients deaths within 30 days of receiving chemotherapy	-	Avail May 2013	
Percentage of Oncology patients deaths within 30 days of receiving chemotherapy	-		
Number of Haematology patients deaths within 30 days of receiving chemotherapy	-		
Percentage of Haematology patients deaths within 30 days of receiving chemotherapy	-		
5. Hepatitis C. Compliance with treatment / improved patient outcomes	Audit undertaken	Quarterly audit undertaken	
7. Reduction of catheter - related CONS	7% Baseline 2011-12	0	

Fig. 29 NGH Scorecard 2012/13

Part Three

What have staff said about the Trust?

NHS Staff Survey Results 2012

The Trust takes the Staff Survey results very seriously as it provides us with an indication of what is important to our staff and the aspects of their working lives which we need to improve upon collectively.

The response rate from staff for the 2012 Staff Survey was below the acute Trust average, with 385 individuals responding. The results were disappointing, but provide us with an added impetus to increase engagement with our staff and to make positive changes.

A presentation event, prepared by Capita Health Service Partners, was delivered to both management and staff side in April 2013. A reference group was set up to review the results and determine approaches to be taken to ensure our staff are engaged in the process and have the opportunity to feedback their suggestions, which will inform the actions we need to take to make the necessary improvements.

On a positive note, the Trust continues to be above the average for staff having equality and diversity training and saying that hand washing materials are always available.

Areas identified by staff where we need to improve are:

- Effective team working
- Support from immediate managers
- Health and safety training
- Work related stress, work pressure and working extra hours
- Witnessing potential harmful errors, near misses or incidents
- Physical violence
- Harassment and bullying
- Employee engagement.

During 2013/14 there will be an emphasis on staff engagement, communication and involvement with our staff. The Trust will be developing a three to five year organisational development strategy which will encompass actions to support the improvements we recognise are key to developing a culture for our staff where they can thrive and give their best.

In June 2012 the Trust introduced Listening into Action (LiA), a proven approach which looks at how to fundamentally shift the way we work and lead, putting staff at the centre of change. This approach supports our Trust's vision of providing the very best care for all of our patients by asking our staff and patients how best we can achieve this.

Part Three

We began in the summer of 2012 by holding conversations with staff across the Trust to understand what day to day issues get in the way of staff delivering their service. Our staff wanted the Trust to look at various corporate themes: communication, patient experience, documentation, car parking, IT, staffing and documentation. From these themes we have delivered actions that are helping our staff improve the service to our patients and visitors, including:

- Introducing a monthly core brief
- Developing proposals to increase car parking provision on site
- Appointing a patient experience lead
- Improving IT service desk support.

Eleven teams introduced LiA as a new way of working in September 2012 and held their own team conversations to find out what their day to day issues are and have achieved fantastic results. Some examples are below.

Ward/Department What staff said … Together we did …

Pathology We would like to work closer with other teams in the Trust to assist with quicker diagnosis of patients. For example A&E teamed up with cardiology to change the protocol for troponin testing on patients on admission. As a result we have saved £250K of bed days in the hospital.

Theatres Communication is poor ..
`Group huddle' held in main and Manfield Theatres every morning for all staff, providing an overview of the day ahead and any relevant news.
Monthly theatre newsletter to keep staff informed of theatre and Trust related news.

Holcot Ward (Stroke Unit) We would like improved communication between all members of our MDT (multi disciplinary team). Improved written and verbal handover.
New blue signs now in use so nursing staff can quickly identify those patients due for physiotherapy the next morning.
New yellow patient progress charts have been developed to aid improved communication between therapists and nursing staff.

In February 2013 a further ten teams began using LiA and we have four corporate themes we will be taking forward: communication, respect, accountability, responsibility, roles and `In Your Shoes'.

`In Your Shoes' was launched in March 2013 and is an exciting initiative for staff to visit other departments in the Trust to find out more about what they do, the services they provide and how they impact on patient care.

Part Three

Public and Patient Involvement

The established public and patient forum focus groups have continued to meet within the year, focusing on:

- Infection prevention
- Hotel Services
- Trauma and Orthopaedics
- Medicine
- Surgery.

The groups have been instrumental in providing valuable feedback to the Trust through various reviews set up to look at particular aspects of the patient environment. This has included, for example, a review of the use of the hand gel dispensers situated at ward entrances. Results from this review enabled the infection prevention team to understand how well members of the public and staff have appreciated the importance of hand hygiene and where actions can be taken to further improve on this. The infection prevention group continues to review the use of the gel dispensers and the result of these audits are reported via the patient and public involvement strategic steering group and then to the patient experience board. The hotel services group has carried out ward visits, and works with the management team to discuss ideas for improving services for patients.

The trauma and orthopaedic group has met to discuss the appointment of an Orthogeriatrician to provide support to elderly patients with complex medical conditions which require treatment whilst in the hospital as an orthopaedic case.

Volunteer audit teams have been monitoring the effectiveness of the protected mealtime initiative and these results are reported back to the ward, patient experience board and incorporated into the Matron's dashboard.

A team has recently carried out audits of the patient information boards situated on each ward. The results are currently being analysed and will be reported back to the Director of Nursing , Midwifery & Patient Services.

Part Three

Complaints and Compliments

Formal complaints, and informal concerns/enquiries via our Patient Advice & Liaison Service (PALS) team provide the Trust with important intelligence in terms of real time patient/service user experience of the quality of the services provided. Irrespective of the information derived from surveys, a written or verbal complaint or concern indicates that in some way the high standard of care we aim for has not been delivered to an individual. For this reason we take all complaints and concerns seriously.

It is fundamentally important that these services are recognised and valued at all levels of the organisation. Additionally, feedback and any trends identified are acknowledged and acted upon to ensure that the quality of services, care and treatment focus on the needs of those that access them.

It has been a challenging period in terms of service provision across the NHS, which has led nationally to an increase in the number of complaints being received by Trusts. This includes a rise in the number of complaints that are extremely complex, and often involve other health care providers, or social care for adults. Despite all of this NGH continues to make local complaint handling a positive experience for those who seek to access the service. Through local network meetings a joint way of working has been agreed for other providers within this area, which has been tried and tested on an increasing number of occasions.

The Trust takes pride in the way in which complaints are managed 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. We aim to provide various remedies through the issuing of an appropriate apology and a variety of actions which aim to redress the issues identified, where appropriate.

All of the Trust's complaint responses are signed by the Chief Executive or deputy, in order to underpin the organisations approach to complaints handling, and our 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 evidence being available, to assure stakeholders that we have done what we said that we would do.

It is important that members of the public are fully aware as to how they may raise concerns or complaints regarding all aspects of their experiences of services that are provided by NGH. The 4 C's (comments, concerns, complaints and compliments) principles form part of this process as members of the public are provided with a range of options that they may choose from. This involves initial support and advice through front line staff to on-the-spot support from our PALS team, to our complaints department.

Part Three

Our complaints and PALS teams recognise the value of all feedback whether it is a comment, concern, complaint or compliment (4Cs). Our posters and leaflets actively support and encourage patients to tell us about their experience, and we deliver training to staff to help give them the confidence to resolve issues locally wherever possible. In 2012 complaints and PALS received an excellent rating from the CEAC internal audit report regarding the handling arrangements for formal, and informal complaints/ concerns, a rating rarely awarded to Trusts, for which staff worked exceptionally hard to achieve.

Complaints Analysis

	2009-2010	2010-2011	2011-2012	2012-2013
Total number of complaints	430	467	517	*538
Response within the agreed timescale	86%	96%	100%	*77%
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)	*16 (including some from previous year)

*Fig. 30 Complaints Analysis 2012/13 * data taken from annual report*

Top 5 complaint categories

	2009-2010	2010-2011	2011-2012	2012-2013
Clinical care	251	215	226	*230
Communication	198	179	226	*103
Attitude & Behaviour	70	76	61	*45
Delays/Cancellations	48	46	103	*102
Discharge	29	38	55	*53

*Fig. 31 Complaints Categories 2012/13 * taken from annual report 2012/13*

Learning from Complaints

The Trust seeks to learn from complaints and where appropriate an action plan will be prepared to ensure that necessary changes are made. Examples of changes that have been made as a result of complaints received during 2012-2013 are:

Ophthalmology Department

A high number of complaints/concerns were received regarding the administration processes within the ophthalmology department. This was escalated through the Trust's reporting structures and the senior management / executive team. The service was subsequently reviewed, an action plan implemented, and a significant number of improvements have been made. This can be evidenced by the low number of issues that are now received about this area.

Part Three

Orthopaedics

A patient was referred in to the A&E Department, as an orthopaedic expected patient, by the GP, but following a review did not require an admission to the hospital, and was discharged home. The patient raised concerns as the GP did not subsequently receive any information regarding the review/tests/ investigations carried out, and the patient was also unsure of the care plan. It is normal practice, that when a patient attends the A&E department that discharge notes are normally sent to the GP within 48 hours. However, this is not necessarily the case for GP expected patients, who do not require an admission to the hospital. In view of this, it was suggested by the directorate that the on-call orthopaedic team could have access to an 'on-call dictaphone'. This would then ensure that a letter detailing all investigations and planned follow up could then be sent to the GP, with a copy to the patient, and the on-call consultant for that day, to improve communication. This has since been implemented in the orthopaedic department and is now being considered by other clinical areas.

Compliments

As part of the 4 Cs 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 Are Saying About Northampton General Hospital NHS Trust (NGH):
(Source 4 Cs compliment forms)

"We just want to commend and thank all the staff, nursing, medical, catering and cleaning, on Abington ward for the quality of professional care. It was evident from the time.. .....was admitted to the ward, to the present. Time with the staff nurse explaining.....condition and needs (for someone with severe Alzheimer's is great), was so helpful. The positive and welcoming approach has been equally evident on subsequent visits."

"The staff at the A&E unit were all very professional and polite and exceedingly good at their roles. About midnight I was transferred to EAU and they too were excellent in every way. I was then transferred to Creaton ward and I must say all the staff were exceptionally professional and knowledgeable about medications and exceedingly polite, helpful and understanding."

"All staff on Gossett ward, thank you all for your care and support over the last month. Not only do you carry out the job you are employed to do you go way beyond your roles. We could never thank you enough for the care you have given to .....and to be taking her home so content and happy is down to your enthusiasm and hard work"

Part Three

Working with partners across the healthcare community

NGH has been actively working in partnership across the healthcare community to support and implement the Quality, Innovation, Productivity and Prevention (QIPP) agenda which will improve quality and efficiency whilst reducing cost. There are a range of initiatives which have the aim of reducing workload in the acute sector, each of which is being implemented in partnership with our Commissioners.

Changes to the commissioning structure of the NHS locally were implemented during 2012/13 in readiness for formal implementation from 1st April 2013, with the implementation of Clinical Commissioning Groups (CCGs) which supersede PCTs, and NHS England, which have subsumed Specialist Commissioning Groups. During the year the Trust worked with its partners to support a smooth transition.

Clinicians and senior managers from the Trust were actively involved in the Healthier Together programme, which explored potential models of care that outlined how services might be delivered across the five acute general hospitals in the South East Midlands so that they can continue to meet the changing needs of a growing and ageing population, whilst at the same time keeping up to date with national and international best practice. This included two clinical summits.

The next phase of this programme was taken forward locally and in January 2013 the Boards of Northampton General Hospital and Kettering General Hospital agreed that they would look at ways in which the hospitals could work more closely together. Consideration was due to be given to a broad range of options, up to and including a full merger of the Trusts with any recommendations being made, subject to consultation and approval. In early June, (subsequent to Board approval of this document), however, in the light of recent advice from the Trust's regulators, NGH has agreed to focus on achieving a sustainable future delivering safe, high quality services. Collaborative work with other Trusts will focus on clinically led service change to best serve our local population. NGH will receive on-going support from the Trust Development Authority who are now responsible for supporting non-foundation Trusts. They will help us to continue our programmes of quality improvement and transformation and ensure that we progress towards financial viability.

Part Three

Statements from Nene Clinical Commissioning Group & Corby Clinical Commissioning Group; Northamptonshire County Council Health & Social Care Scrutiny Committee and Local Involvement Networks (LINks) – Healthwatch

Nene Clinical Commissioning Group & Corby Clinical Commissioning Group

Commissioners have reviewed the Northampton General Hospital NHS Trust annual Quality Account for 2012-13. It is noted that the report contains accurate data although is still waiting for some information to be inserted such as the corporate scorecard.

Nationally mandated requirements have been included and the report has included mechanisms for internal and external reporting requirements.

A review of quality indicators demonstrates achievement against these and the improvements that have been undertaken in patient care during 2012-13. The CQUIN for dementia was not achieved and two other schemes were only partially met.

Nene & Corby Clinical Commissioning Groups (N&C CCG), wholly support the 2013/14 quality priorities as set by NGH in relation to improving patient safety, clinical effectiveness and patient experience.

This year has seen changes in commissioning organisations; commissioners will continue to work closely with the Trust and support ambitions to sustain high quality standards of care for people who use services via incentivising quality improvements, quality review assessments and performance management.

Northamptonshire County Council Health & Social Care Scrutiny Committee

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

- The Working Group welcomed specific targets that were also measurable
- NGH were also congratulated on providing up to date figures
- The quality account was considered to be very clear
- There was no explanation of the 'butterfly' project despite several references to it within the document
- There was also no information on how NGH managed patients with mental health issues
- The work undertaken to address issues with delays in 'take home drugs' was welcomed and the Committee looked forward to hearing how this aim had been achieved in future accounts.

It was felt further information could have been provided with regard to how NGH worked with partners including for example, the Health & Wellbeing Board or Olympus Care Services. It was also felt more could have been included with regard to the community.

- It was felt the actions listed with regard to patient meal times should be standard practice and not planned improvements
- It was suggested patients could have earlier involvement when discussing care pathways

- It was felt more information could have been provided with regard to stroke support, particularly as NGH was a lead hospital for stroke care
- In noting the Trust had been unsuccessful in delivering the training strategy targets affecting delivery of the dementia CQUIN target, it was hoped this could be addressed in the future
- Targets relating to key improvements in practice (as detailed on page 22 of the quality account) were considered to be good
- It was suggested more information could have been included on how improved use of A&E was being promoted.

The working group also made a number of comments in relation to quality accounts in general as follows:

- Earlier involvement with scrutiny when producing quality accounts could be useful as would a brief overview at the front of the document
- Not all quality accounts referred to prevention work undertaken in line with the major national priority of reducing slips, trips and falls
- It was noted some organisations operated on more than 1 site and it was suggested Information could be included on variations in performance at each of the major sites operated.

Local Involvement Networks (LINks) – Healthwatch

LINk has worked closely with Northampton General Hospital during 2012/2013 and has observed and participated in the following areas of care.

Attending hospital meetings of multi-disciplinary staff in Dignity and Safeguarding Vulnerable Adults, also at various events and functions. LINk finds these meetings invaluable in listening to plans for improvement and what is happening generally. The great improvement in caring for people with learning Disabilities and seeing what is now available for them is to be commended. This applies also in the field of Dementia and Alzheimer's where great improvements have been achieved and plans for the future have been formed.

We have resumed our programme of ward audits and found the standard of care excellent. To be commended is in the field of rehabilitation of stroke patients and this is also appreciated by relatives and carers. We are soon to achieve our object of visiting every adult ward and found the same high standard throughout. We meet with the relevant ward sisters every six months and discus our observations and they have thanked us for our input.

LINk representatives have also been in involved in the A&E meetings, food tasting and reviewing patients regarding their thoughts on possible improvements. We are also involved in the annual PLACE inspection and contribute in meetings regarding improvements in facilities.

We have been invited to attend functions such as the Star Awards and the Nursing and Midwifery Awards when staff have an opportunity to demonstrate good ideas in enhanced nursing care and techniques. Staff are thereby encouraged to play an active part in contributing to good practice and staff moral enhanced. LINk representatives regularly also attend Board meetings. This past year has also included meetings on the Big Conversation and Patient Experience.

LINk members continue to find year by year improvements in Northampton General Hospital.

NB: Local Involvement Networks (LINks) will be replaced by Healthwatch in April 2013 to be the new consumer champion for both health and social care. This was outlined in the Health and Social Care Act 2012.

Part Three

Appendix 1

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF NORTHAMPTON GENERAL HOSPITAL 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 Trust's Quality Account for the year ended 31 March 2013 ("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 2013 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents that resulted in severe harm or death; and
- Emergency re-admissions within 28 days of discharge from hospital.

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 2012/13 issued by the Audit Commission on 25 March 2013 ("the Guidance"); and

- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2012 to April 2013;
- papers relating to the Quality Account reported to the Board over the period April 2012 to April 2013;
- feedback from the Commissioners dated 15/05/2013;
- feedback from Local Healthwatch dated 30/05/2013;
- the trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 21/05/2013;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey published April 2013;
- the latest national staff survey published February 2013;
- the Head of Internal Audit's annual opinion over the trust's control environment presented to Audit Committee on 17/04/2013;
- the annual governance statement dated 03/06/2013;
- Care Quality Commission quality and risk profiles last dated 7/05/2013; and
- the results of the Payment by Results coding review dated May 2013.

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

This report, including the conclusion, is made solely to the Board of Directors of Northampton General Hospital NHS Trust 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 NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

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

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

Limitations

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

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

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

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

John Cornett

Director

KPMG LLP

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03/06/2013

Part Three

Part Three

Abbreviations list

A

ACS – Acute Coronary Syndrome

A&E – Accident & Emergency

AECP – Advanced and Emergency Care Pathway

AUGIS – Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland

B

BCIS – British Cardiovascular Intervention Society

BP - Blood Pressure

C

CEPOD– Confidential Enquiry into Patient Outcome and Death

CHD - Coronary Heart Disease

CNS – Central Nervous System

CT – Computerised Tomography

CQC – Care Quality Commission

CQEG – Clinical, Quality and Effectiveness Group

CQUIN – Commissioning for Quality and Innovation

D

DAA – Dementia Action Alliance

DAHNO – Data for Head and Neck Oncologist

DCA – Dementia Care Action Committee

DH – Department of Health

E

ECG – Electrocardiograph

EDN – Electronic Discharge Notification

EMCN – East Midlands Cancer Network

EMSCG- East Midlands Specialist Commissioning Group

F

FFT – Friends and Family Test

FIT _ Fast Intervention Team

F/U – Follow up appointments

FYI – Foundation Year One Doctor

G

GP – General practitioner

GI - Gastrointestinal

H

HDR – High Dose Rate

HDU - High Dependency Unit

HGC – Healthcare Governance Committee

HRG – Healthcare Resource Group

HOT – Hot clinics are designed to avoid unnecessary admissions rapid access clinic slots.

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

ITU – Intensive Therapy Unit

M

MBRRACH – Perinatal mortality

MCA - Mental Capacity Act

MINAP – Myocardial Ischemia National Audit Project

MDT – Multi-Disciplinary Team

MSCC- Metastatic Spinal Cord Compression

Part Three

Abbreviations list

N

NASH - National Audit of Seizure Management in Hospitals

NCEPOD - National confidential Enquiry into Patient Outcome and Death

“NESSIE” - Database

NEWS - Northampton Early Warning Score

NFD - Nurse facilitated discharge

NICE - National Institute for Health and Excellence

NICOR - National Institute for Cardiovascular Outcome Research

NIHR - National Institute for Health Research

NIV- Non-invasive ventilation

NMC - Nursing Midwifery Council

NNAP - National Neonatal Audit Programme

NPSA - National Patient Safety Agency

nSTEMI - Non-ST-Segment-evaluation Myocardial Infarction

NTPCT - Northamptonshire Teaching PCT

NVD - National Vascular Database

O

O-G – Oesophago- Gastric

P

PALS – Patient Advice and Liaison Service

PAS – Patient Admissions System

PbR – Payment by Results

PCI – Percutaneous Coronary Intervention

PDSA - Plan, do, study, act

PET – Position Emissions Tomography

Ph - symbol relating the hydrogen ion

POA appointments – Pre-operative Assessment

PPI – Patient and Public Involvement

PROMs – Patient Reported Outcome Measures

R

RCPH – Royal College of Paediatrics and Child Care

RESTART – Respiratory Therapy Acute Response Team

S

SABR – Stereotactic Ablative Radiotherapy

SAP - Safety action plan

SHA – Strategic Health Authority

SI – Serious Incident

SINAP – Stoke Improvement National audit Programme

SOVA - Safeguarding of vulnerable adults

SSE – Specialist Short Stay Elderly

ST3 – ST9 Doctors specialist Training

SUS – Secondary Users Service

T

TARN – Trauma audit and Research Network

TVN – Tissue Viability Nurse

V

VSGBI – Vascular Society of Great Britain and Ireland

VTE – Venous Thromboembolism

W

WHO – World Health Organisation

If you would like more information please contact the Director of Nursing, Midwifery & Patient Services,
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