Northampton General Hospital NHS
NHS Trust

Quality Account 2014/15

Providing the Best Possible Care

Contents

PART ONE

NGH and Quality Statements

What is a Quality Account?

A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public.

Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.

The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided.

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

Information about Northampton General Hospital NHS Trust

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

The Trust is also an accredited cancer centre and provides cancer services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire.

In addition to the main hospital site, which is located close to Northampton town centre, the Trust also provides outpatient and day surgery services at Danetre Hospital in Daventry.

We provide a full range of outpatients, diagnostics, inpatient and day case elective and emergency care as well as a growing range of specialist treatments that distinguishes our services from many district general hospitals.

Division: Medicine & Urgent Care

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

Division: Surgery

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

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

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

Division: Clinical Support Services

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

Statement on Quality from the Chief Executive

During 2014/15 Northampton General Hospital has continued to focus on delivering high quality care to patients. Our hospital is treating more patients than ever before and we are determined to continually improve both the care we give to patients and the efficiency of the services we provide

The hospital has been dominated in recent years by the pressures resulting from the year on year increases in patients requiring emergency admission to hospital and this has impacted on the experience of patients and staff across all our services. We have put a significant amount of effort into improving our emergency care pathways but there is more work underway because we know that unless we can make improvements in this core area, we will not be able to improve other parts of our services. I am proud of the improvements that have been made in our A and E department and urgent care pathway and particularly of the focus of staff on safety – safety rounds in A and E and twice daily safety huddles across the hospital have made a palpable difference

No matter how busy our hospital becomes we continue to ensure that patient safety is our first priority. This is one of the core values underpinning our overall aim of delivering the 'Best Possible Care' for patients. Our other core values also drive all our efforts for improvement and underpin our belief that each and every member of staff needs to be part of the effort to both deliver care and improve care. We know that it is important for everyone to understand these values and what it means for them to aspire to excellence, to reflect, learn and improve and to respect and support each other and our patients.

When the CQC visited our hospital in January 2014 a team of around 35 inspectors found room for improvement. In broad terms they agreed with our own overall assessment of the areas where improvements could be made and it is important to emphasise that overall our services were regarded as safe and our staff were judged as caring in all areas. We know that our very caring staff will help us make the improvements we need and help us realise our ambition of becoming an outstanding hospital.

Our response to the CQC report was to strengthen the emphasis on the improvements we were making in the areas of quality governance, leadership and urgent care as well as ensure a renewed focus on articulating our plans for a sustainable future. These were all part of progressing towards our aim of having a well governed, clinically led, patient focussed organisation focussed on quality.

During the year we have made significant changes to our various committees and governance structures which will improve assurance against standards but the most important change we have made has been to introduce a new way of managing the hospital with clinicians now accountable for all standards. The changes we have made are being supported by the introduction of a bespoke leadership and management development programme for our new leaders - managers, doctors, nurses and other health professionals will be learning together with the support of our senior team during the next year.

With the launch of our Clinical Strategy, we have now set out a clear direction of travel for our hospital. This sets out our ambition to develop the right range of sustainable services appropriate for our local population. We know that to do this we need to increase partnership working with other hospitals

including Kettering General Hospital and the University Hospitals of Leicester and with community services and general practitioners. Embedding our implementation plans for this work will be a key task for the coming year. Our clinical strategy is supported by a number of underpinning strategies all of which should assist us in aligning all our staff in a relentless focus on quality improvement centred on patient outcomes. Recruiting, retaining and developing an excellent workforce to be able to give of their best remains one of our most important priorities and a number of these strategies are in place to support this and will receive increased attention from our senior teams over 2015/16.

We have continued to imbed our previous work to reduce avoidable harm and save more lives and we did achieve good standards against the majority of quality, safety and performance standards. Although performance against the 4 hour target in A and E has not been good, we have made other improvements in the quality of care we give in urgent care and we know that when we are able to get people home in a timely way then this standard improves. We will continue to work with our partners in Health and Social Care to improve this situation so that our hospital beds can be available for patients as soon as they are needed.

We also made progress against many of last year's quality priorities and where there is more work to be done we have continued these into next year or we have agreed to continue the work with a different emphasis.

There are a couple of areas where we have struggled to improve matters for some time – in addition to getting people home effectively and safety, we also sometimes struggle to ensure that patients, carers and families receive everything they need at the end of life. We have made progress in this area and there are many examples of outstanding care but there have been times when we could have improved the care given. We are committed to taking this forward next year as we recognise that good end of life care is one of the essential elements of good care overall.

Listening to staff and patients is becoming more and more important as the pressure on hospitals rises and our Board members visit wards and departments as often as they can. Next year we have committed to an improved way of learning from our patients and a full programme of investing in our staff. We know that patients will get better treatment if we can succeed in our aim of ensuring that our entire staff feel valued and supported to give of their best. We are aiming to work together to create a more open culture to support our workforce and our new clinically led divisional management structure. Ensuring that our whole workforce understand and commit to quality improvement in its broadest sense will be at the centre of this programme which will also be supported by the emphasis in the Sign up to Safety campaign.

Despite the pressures in the NHS and particularly in acute hospitals such as ours, there is no doubt that day after day many patients receive excellent care and many of our staff go 'above and beyond' what is required in order to do their best for patients. I must end by thanking all of them. I know that striving to achieve our overall aim of 'Best Possible Care' is what unites us all and of that we should proud.

Dr Sonia Swart
Chief Executive

Statement of Directors' Responsibilities

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 2014 to March 2015
    - 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)
    - NHS Staff Survey (2014)
    - The CQC intelligence monitoring
- The performance information reported in the quality account is reliable and accurate
- There are systematic internal controls over the collection and reporting of the measures of performance included in the quality account, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the quality account is robust and reliable, conforms to specified data quality standards, prescribed definitions and is subject to appropriate scrutiny and review
- The quality account has been prepared in accordance with Department of Health guidance.

The directors confirm that to the best of their knowledge and belief they have complied with the above requirements in preparing the quality account.

By order of the Board

25 June 2015
Paul Farenden
Chairman

25 June 2015
Dr Sonia Swart
Chief Executive

PART TWO

2015/16 - Quality Priorities

Quality at the Heart of NGH

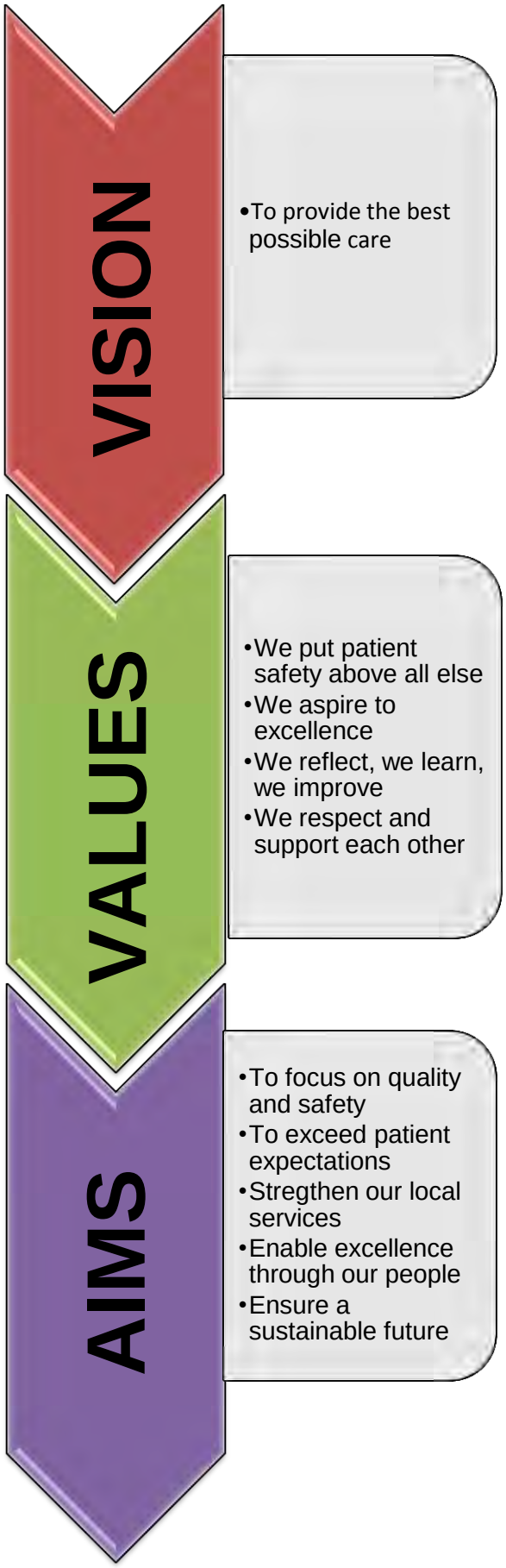
Quality has always been an integral component of our work at NGH. Our Quality Strategy sets the ambition and aim for our existing and planned work for us to provide the best possible care for all of our patients. Quality within the Trust focuses on three core areas:

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

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

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

As seen in the diagram to the right our vision, values and aims underpin all the work we do at NGH to 'provide the best possible care' for all our patients.



2015/16 – Planned Quality Priorities

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

We will deliver these priorities through our clinically led divisional structure as part of our overarching programme of Changing Care at NGH supported by our Patient Safety Academy.

It is crucial that the progress with each of these priorities is closely monitored to ensure the best possible care for our patients. Each of these Quality Priorities will be overseen by the Medical and Nursing Directors and reported to the Quality Governance Committee on a quarterly basis.

Quality Priority One	•Supporting Patients in Getting Home
Rationale	•Our patients and staff have told us about how delays in discharge from hospital impact upon them •By reviewing and improving ward based processes, including admission and discharge we can improve the patient experience by reducing the number of days spent in hospital, and save bed days thus increasing capacity and saving money
Objective	•Greater coordination of teams and services such as pharmacy and hospital transport to ensure timely discharge •Improved discharge planning resulting in a reduction of average length of stay •Increased number of patients discharged on their planned date of discharge
Success	•Increased throughput of patients, allowing the trust to treat the same or greater number of patients without increasing resources •A robust individualised patient discharge plan that interfaces with appropriate services to reduce delay and likelihood of readmission •Greater use of the discharge suite •Earlier discharge with reduced waiting form medication and transport
Metrics	•Reduce the average length of stay (LoS) for elective patients by 10% in 12 months •Reduce the length of stay for non elective patients by 5% in 18 months •Reduce the number of patients with a length of stay of more than 30 days •Embed standardised daily board rounds. •Improvement of engagement and communication with patients, their families and primary carers from 2015/16. To be measured via complaints, and completeness and timeliness of EDNs. •Increase number of patients discharged on their planned date of discharge by 10%
Monitoring	•Length of Stay Steering Group •Clinical Pathway Management

Quality Priority Two	•Listen to our Patients
Rationale	•Where things go wrong it is important we take the necessary steps to avoid reoccurence and in the instance of a complaint take steps to ensure it is investigated thoroughly with a timely response provided to the complainant and that any learning is shared
Objective	•Complaints are quickly and robustly investigated •Appropriate actions are recorded and followed through •Lessons learnt are shared across the organisation and embedded
Success	•Timely investigations •Action plans are entered onto HealthAssure •Reports and learning are shared as appropriate such as through the Patient Safety Learning Forum and within divisions •Participate in the national link network
Metrics	•3 working days to acknowledge the complaint (national) •5% reopened (local) •Response rate – below 85% red, 85-89% amber, 90%+ green (local aim) •Complaints information is monitored through quarterly reporting schedule (i.e. Patient Experience Forum) •Development plans/learning details are entered on to HealthAssure where they are monitored through to completion and embedded (provision of evidence)
Monitoring	•Patient Carer Experience and Engagement Steering Group

Quality Priority Three

- Invest in our Staff

Rationale

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

Objective

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

Success

- Particiaption of staff in leadership programmes
- Improved staff survey results
- Improved staff Family & Friends Test (FFT) results
- Completion of in the box session
- No. of Street Talk events undertaken
- No. of organisational development advocates (DoODS) signed up to network
- Improved data in relation to: appraisal completion, appraisal quality, staff turnover, sickness absence, attendance on mandatory and role specific training

Metrics

- Enrolment of 50 participants on Francis Crick Programme
- Enrolment of 15 participants on Consultant Development Programme
- Enrolment of 24 participants over 2 cohorts on Ward Sister Leadership Programme
- Enrolment of 36 participants over 3 cohorts on First Steps in Team Leadership
- Improvement in overall Staff engagement score from Staff Survey in comparison to 2014
- Improvement in Staff recommending NGH as a place for treatment and as a place to work across all areas
- 150 staff completed in the box workshop
- Reduction in rollover negative feedback trends from qualitative data captured on Staff Friends and Family test.
- 1500 staff completed Rainbow risk
- 8 street talk events
- 100 NGH organisational development advocates (DoODS) in network
- Achievement of corporate appraisal compliance target of 85%
- Improvement towards corporate target of 8% for turnover
- Improvement towards corporate target of 3.8% sickness absence
- Achievement of corporate mandatory training compliance target of 85%
- Achievement of corporate role specific training compliance target of 85%
- 200 people involved in six hat thinking tool in local areas.
- Enrolment of 100 participants in Making Quality Count Development Programme
- 25 improvement projects undertaken using D5 methodology

Monitoring

- Workforce Committee
- ESR
- Trust Dashboard

Quality Priority Four	•Sign up to Safety
Rationale	•Our pledges were composed using awareness of our performance against qualitative and safety KPI`s and feedback received from our staff and patients. We have focussed on areas where we know we can make improvements and have included areas for change where work may have already begun. Being part of Sign up to Safety will provide additional focus and drive for achievements of our goals and a platform to share with the wider NHS our Safety improvement work.
Objective	•Commit to NHS England's patient safety improvement quest to reduce avoidable harm by 50 per cent in three years. •Develop and implement a safety imporvement plan to meet the five Sign Up to Safety Pledges: Putting safety first; Continually learn; Being honest; Collaborating; and Being supportive
Success	•Patients admitted to hospital will be in a place of safety, patients and their families will receive the best possible care. Should their condition deteriorate prompt and effective treatment will be provided by staff with the right competencies, education and training .
Metrics	•Reducing harm from failure to rescue •Leadership for safety & safety culture. Promoting and leading a culture of reflective learning and improvement. •Reducing avoidable harm from failures from care •Reducing harm from essential planning of patient care ensuring that standards of record keeping and planning are accurate, timely and effectively communicated.
Monitoring	• Patient Safety, Clinical Quality and Governance Progress Report •Sign up to Safety website

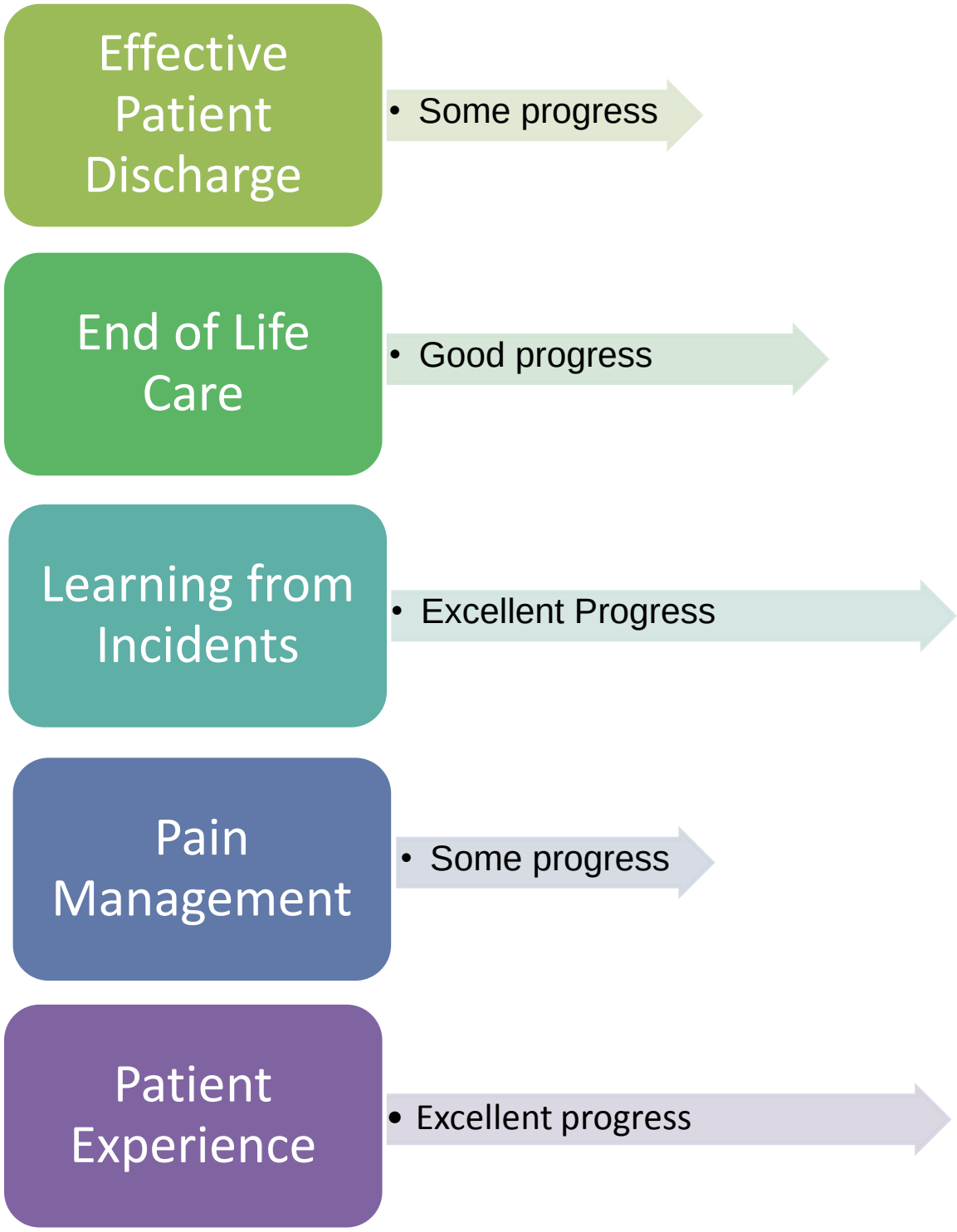
Quality Priority Five	•Improve End of Life Care
Rationale	•Wards find difficulty in identifying patients at the immediate end of their life. •If this were improved, patients would be placed on the end of life register and receive better care as a result
Objective	•All wards to identify patients who are imminently dying and to notify through the safety huddle so the patient is placed on the end of life register •Improved uptake of end of life care
Success	•The number of patients identified for inclusion on the end of life register increase quarter on quarter
Metrics	•75% of patients whose death was expected (as per EDN) were known to the End of Life team and placed included on the trust End of Life Care register •75% of patients whose death was expected (as per EDN) had an individualised plan of care using the trust Dying Person Care Plan as a format.
Monitoring	• End of Life Care Strategy Group • Patient Experience Group

PART THREE

2014/15 – Quality Priorities

Snapshot of Quality Priorities

The diagram below summaries the quality priorities identified in 2014/15 and the progress achieved.



2014/15 – Review of Quality Priorities

Quality Priority One – Effective Patient Discharge

Why we chose this priority

This was chosen as a priority last year as we had received feedback from our patients that there were areas of discharge processes that were not working well. Patient discharge is dependent on many factors to make it work well so many teams were involved in looking at how we could make improvements.

What we intended to do

We decided that the overall aim of the priority would be to improve our information and implement robust planning and monitoring processes to achieve a reduction in complaints related to discharge and improve patient satisfaction. To achieve this we set ourselves the following targets

- Overall 25% increase from the baseline in the number of patients who have planned early discharge from the wards
- Utilise our shared tracking list to promote ownership of discharges by our community partners and demonstrate a reduction in delayed transfers of care against the agreed baseline (25%).
- Improve patient experience by timely delivery of TTOs (to take out) to enable patients to be discharged with their medication and enable staff to educate patients in regards to their TTO Medications before discharge

How we performed

In improving our early discharges we had several streams of work running, this included

- Our surgical division implemented a more consistent approach in reviewing patients for discharge who were all reviewed earlier in the day
- We opened a new, larger discharge suite for patients; this was accompanied by the launch of a new operating procedure to help staff support our patients more effectively in getting home.
- We implemented a Trust-wide initiative of “discharge before 10”; this gave clinical teams the aim of seeing and discharges patients from the wards before 10 am in the morning.
- Discharge training at the grand round has taken place. This was aimed at Junior doctors and the importance of writing early discharge letters. We also run an out of hours weekend discharge team consisting of a FY1 and a Senior Nurse. The training was also aimed at this team regarding safe patient discharges and induction of expectations for the team.

- Imaging waits discussed at all huddles with plans to expedite discharge. The huddle is held twice daily for the trust and one member of every ward is expected to attend. patient safety, staffing levels, any diagnostic delays or problems are discussed. Imagining or scans can be discussed and speeded up to facilitate discharges.
- Ticket Home initiative commenced in October 2014. It provides patients with the information they need regarding when they are going home and managing their expectations of what the process of discharge is, and what needs to happen before they go. It also gives the patient a goal to achieve and a vision of the end of their stay in hospital being constantly in sight.
- Discharge traffic lights were introduced throughout the whole of the trust as a quick way to identify discharges. Red means patient not medically fit. Yellow means any patient waiting for diagnostics, medical plans or anything to expedite a discharge. Green means good to go do the TTO (to take out).
- The "Discharge Passport" was launched in November 2014 and was developed and agreed by representatives of both acute hospitals, the community hospitals, specialist care centres, social care, care providers and community rehabilitation teams. The rationale behind it is to reduce duplication of assessments for the patient and to produce one assessment that can be used, and trusted, by all involved in planning a patient's discharge from hospital.
- There was an aim to reduce the number of discharges in Q4 2014/15 before midday by 25% from the baseline data in Q1 2014/15. Whilst this was not achieved much work has been put into having an effective discharge system and this will be continuing into 2015/16.

Therefore, whilst we made many improvements and some progress with this priority we feel that there is still some work to do and the work to achieve this will continue within the 2015/16 Quality Priority for "Supporting Patients in Getting Home"

<u>Snapshot of Achievements</u>

AIM

- Promote planned early discharge on all wards.

Target

- Overall 25% increase from the baseline in the number of patients who have planned early discharge from the wards.

Achievement

- Discharge training has taken place at grand round
- Imaging waits discussed at all huddles with plans to expedite discharge.
- Ticket Home initiative commenced in October 2014
- A consistent approach has been implemented across the surgical division ensuring all potential discharges are reviewed early in the day.
- Discharge traffic light system across medicine, in order to improve discharge.
- Development of discharge lounge standard operating procedure in preparation for new Discharge suite
- Discharge passport launched in October
- Discharges before 10am have also been revitalised "Our Patients in Getting Home"

AIM

- Ensure accurate recording of delayed discharges.

Target

- Utilise the shared tracking list to promote ownership of discharges by our community partners and demonstrate a reduction in delayed transfers of care against the agreed baseline (25%).

Achievement

- Shared tracking being utlised

AIM

- Improve patient experience by timely delivery of TTOs (to take out) to enable patients to be discharged with their medication and enable staff to educate patients in regards to their TTO medications before discharge.

Target

- Pilots undertaken in the following areas prior to implementation:
  - TTO streaming in dispensary - Collingtree Pharmacist/prescriber early ward round (protected time)
  - Pre-pack medication introduced to Dryden and Eleanor
  - Pre-pack policy developed to make better use of existing pre-packs during working hours and speed up discharge
  - Streamline Sunday working hours to align with patients' needs Review data to determine if actions have supported a reduction in the number of patients who are discharged home without their medication and increased patient experience/ satisfaction with our services.

Achievement

- TTO streaming in dispensary achieved an improvement on the average time to dispense a TTO:
  - 2013/14 average time per = 106min
  - 2014/15 ave time= 61min
  - 42 % improvement on performance.
- Time taken for a pharmacist to begin the process of clinically screening a TTO after it has been prescribed by a doctor:
  - 2013/14 average time= 70min
  - 2014/15 average time= 64mins
  - 8% improvement on performance
- Average number of pre-packs issued to wards and departments:
  - 2013/14= 3,377 per month
  - 2014/15= 2,950 per month
  - 13% reduction in the use of pre-packs at discharge
- Average number of TTOs dispensed on all of the Sundays each month has increased
  - 2013/14 average = 29
  - 2014/15 average = 32.
  - Sunday working hours remain at 1pm-3pm
- 79% of all TTOs are ready at least 30mins before planned discharge time
- 44% of all TTOs are sent to pharmacy with less than 90mins notice of discharge time this is a 2% increase on 2013/14

Quality Priority Two – End of Life Care

Why we chose this priority

An average of 50% of all deaths in Northamptonshire occurred in one of the two acute hospitals between 2010 – 2012. The Trust is committed to delivering high quality End of Life Care and this priority was selected to improve the experience of patients approaching End of Life and their carers.

What we intended to do

In 2013 we agreed to participate in a national project, Transforming End of Life Care in the Acute Hospital – The Route to Success. This programme highlighted best practice in care and provided practical support to enable us to work towards improvements.

One key enabler to improving End of Life Care is the AMBER Care Bundle (AMBER = Assessment, Management, Best practice, Engagement, Recovery). This national recognised tool aims to improve the quality of care for people whose recovery is uncertain. It encourages clinical teams to work with the patient and family and discuss options of care, wishes and preferences if they are thought to be in the last eight weeks of life.

A heat map of all wards highlighted areas where the AMBER Care Bundle would be suitably implemented and an elderly medical ward was identified. The suitability was supported by a baseline audit of current practice on that ward. A clinical lead was identified and after a period training on the ward, AMBER Care was implemented. A comparative audit is in the process of completion to assess whether AMBER Care is effective in improving patient experience.

Five Band 6 and 7 nurses took part in a Quality End of Life Care for All (QELCA) programme facilitated by Cynthia Spencer Hospice. The programme consists of clinical experience in a hospice setting for 2 days and 3 days of theory. At the end of the programme, the ward sisters were asked to set SMART objectives that are aimed at improving End of Life Care on their ward

How we performed

AMBER Care was fully implemented on one ward and due to its success it was implemented on a further two wards before April 2015. An interim report on the comparative audit will be available in May and a full report in July when data is collected for patients discharged and who died within 100 days.

Within 2015/2016, AMBER Care will be implemented on a further 4 medical wards.

All the 5 participants completed the QELCA programme. Based on evaluations from the participants, the programme has been adapted and is now facilitated by the Specialist Palliative Care Team. Two courses for Band 7 nurses will run in 2015/2016.

Snapshot of Achievements

AIM

- Implementation of AMBER Care Bundle on an identified ward with a named consultant lead.

Target

- Project launched based on the AMBER Care Bundle outcomes for patients who died on the indetified ward and those who died within 100 days of discharge from the identified ward. Action plan developed to roll our AMBER across the Trust.

Achievement

- Baseline audit completed for Knightly ward to assess current practice
- Action plan completed to launch AMBER on Knightley ward Jan 2014
- AMBER launched on Holcot Ward in November 2014 and Eleanor ward in Feb 2015.
- Comparison audit for Knightly post AMBER implementation to be completed April/May 2015.
- Action plan to launch AMBER on 4 medical wards in 2015/2016

AIM

- Develop leadership in End of Life Care across the Trust through the Quality End of Life Care training programme.

Target

- Present course content and design to be reviewed following the feedback. NGH to liaise with Cynthia Spencer Hospice and identify a training course for 2014/15 using existing NMET finds. Five participants identified and training undertaken.

Achievement

- A QELCA started in March 2014 and continued through to Sept 2014. Five Band 6 and 7's completed the programme.
- Evaluation of QELCA completed.
- New programme developed based on the principles of QELCA and will start in April 2015

Quality Priority Three – Learning from Incidents

Why we chose this priority

When things go wrong it is important we find out why they happened so we can take the necessary steps to avoid the same thing happening again. To do this we needed to ensure our staff knew and were encouraged to report all incidents or mistakes which may have a negative impact on safety or quality of care.

We recognised that our processes for supporting this needed improvement and therefore we chose to make this a priority to improve our safety culture

What we intended to do

In reviewing our processes the particular areas of weakness identified were:

- Lack of organisational capability in undertaking root cause analysis to investigate what went wrong when an incident occurred.
- Improvements were required in monitoring implementation of action plans following an incident
- Communication and sharing of the outcomes and lessons learned from incidents needed to be improved

We therefore planned to:

- Implement a Trust wide training programme for various staff groups so that they could investigate and review an incident to understand how it happened.
- Ensure that our Serious Incident Group were able to oversee action plan progress through utilisation of our Health Assure system to track and evidence plans
- Implement mechanisms by which staff and external stakeholders could be informed of incidents and wider learning.

How we performed

We were extremely pleased with the progress made against this priority with the Trust seeing a 37.2% decrease in the number of serious harm incidents.

The training in root cause analysis training was planned in the early part of 2014 / 15 with implementation in October 2014 and monthly workshops have been ongoing since that point.

The Trust now use the HealthAssure tool for monitoring incident action plans and assurance that actions has also been improved with audit findings recorded and other evidence gathered and linked to HealthAssure.

We introduced a well-received quarterly staff newsletter called “Quality Street” which contains lots of information for staff on what constitutes an incident or near miss, and how to report them. In addition it tells staff important messages about incidents that have occurred, what has been done to avoid recurrence and how it may have wider organisational implications for learning.

The work to support robust reporting and learning from incidents will continue through 2015/16 with continued training for root cause analysis. The reporting and monitoring of incident action plans is now embedded in our governance structures with reports from the Serious Incident Group tracking up to the Quality Governance Committee of our Trust Board

Snapshot of Achievements

AIM

- Ensure that patient safety incidents, where harm has occurred are robustly investigated, root causes are identified and appropriate actions are put in place to reduce the likelihood of reoccurrence.

Target

- Develop and implement training for staff on root cause analysis. Agreement and roll out of action plan assurance pathway All action plans from incidents where harm has occurred will be uploaded to HealthAssure. Deliver root causes analysis training. Monitoring of action plan progress on HealthAssure and overseen by the Serious Incident Group. Evidence of completion presented to the Serious Incident Group. The Trust aims to be able to demonstrate that similar root causes are not being identified when harm occurs.

Achievement

- Root Cause Analysis training was implemented in October 2014 with monthly workshops continuing throughout 2015/16.
- Following completion of the investigation report the recommendations and action plans are monitored Directorates/Divisions. Assurance that actions have been completed and practice changed is gained from evidence collection, audit findings and further monitoring of reported incidents. Evidence is linked to HealthAssure and overseen by the Serious Incident Group.
- Monthly reports on action plan compliance are submitted to the Serious Incident Group; Quality Governance Committee and Trust Board. A month on month improvement in compliance has been demonstrated throughout the year.

AIM

- Ensure that lessons learnt from incidents where harm has occurred are shared across the organisation and the wider health economy as appropriate.

Target

- The Trust aims to demonstrate that by sharing lessons learnt there will be a reduction in the number of similar incidents occurring within the Trust. By the end of March 2015 there will be an increase in the number of positive responses in relation to lessons learnt from incidents where harm has occurred in the QuEST audits

Achievement

- During 2014/15 the Trust achieved a 2.3% increase in the number of patient safety incidents reported with a 37.2% decrease in the number of serious harm incidents.
- The Trust introduced a quarterly staff newsletter in April 2014 called 'Quality Street'. The newsletter contains information on incidents, trends and lessons learnt following investigation.
- All staff interviewed during the January 2015 QuEST were able to give examples of lessons learnt and changes implemented following serious incidents.

Quality Priority Four – Pain Management

Why we chose this priority

The Trust had noted receipt of complaints related to poor pain control for patients within our hospital. We therefore chose this as a priority to improve the overall management of acute pain control for patients, reduce incidents, and improve patient and carer experience with reduced complaints.

What we intended to do

On reviewing our position in respect of complaints and incidents relating to pain management, this showed we received 12 complaints relating to pain management in 2013/14 and aspired to reduce this number.

In order to make improvements we identified several stands of work that would contribute to a better service for patients.

- It was identified that the pain team did not always get information on incidents and complaints related to pain
- A pain management indicator is part of our Early Warning chart and Vital Pac system but was not always completed, therefore we decided to implement training and add pain management to the monthly patient safety dashboard.
- Staff did not always have access to support materials and assessment tools and therefore a programme of work was implemented to review these and raise awareness and training.
- Review the resources within the pain management team

- Review the resources available to patients for pain management

How we performed

In 2014/15 we received 10 complaints relating to pain management showing a reduction of two on the previous year.

We still wish to improve on this and there has been further improvements made and these include:

- The nursing lead for the acute pain service now receives feedback on incidents and complaints and co-ordinates the feedback on these to the pain team quarterly
- Audits are taking place as to completion of pain management assessments
- Pain assessment tools and documentation has been reviewed and updated with a particular focus on A&E, medicine and maternity services.
- There has been greater utilisation of a link nurse to support training and the awareness of resources. There is a “Pain” section on our intranet and new tools and documents to support staff are now available electronically.
- Staff now have accessible supervision if needed

Whilst pain management is not described in our quality priorities for 2015/16 it remains an issue of great importance for the Trust and work will continue to develop improved pain management services during 2015/16 as described above. In addition, it will continue to monitor our performance through Divisional scorecards reported to the Quality Governance subcommittee of the Trust Board within our Patient safety, Clinical Quality and Governance reports quarterly.

Snapshot of Achievements

AIM

- Gain an understanding of the factors affecting acute pain management in NGH and reduce the number of incidents. To monitor improvements and compliance with KPIs.

Target

- Benchmark position in respect of complaints and incidents relating to pain management including complaints/FFT/ Datix. All relevant complaints and incidents to be forwarded to the pain team. Ensure pain remains on the NEWS chart and is completed by all staff (training) in all departments. Pain management added to the monthly patient safety dashboard. Incidents reduced each quarter by an agreed percentage.

Achievement

- Pain Nursing Team complete datix. Acute Pain Team Nursing Lead co-ordinates datix’s and feeds backs to quarterly team meetings.
- All relevant complaints and incidents are forwarded to the pain team.
- Pain remains on the NEWS chart and vital pack. Issues relating to pain assessment have been highlighted. Audits completed regarding this and to be discussed at patient safety board meetings.

AIM

- To ensure that relevant materials are achievable to support staff.

Target

- Review and revise pain assessment tools trust-wide, focussing on A&E, medicine and maternity, including patient-controlled oral analgesia (PCOA) in maternity. Revised documentation to be consulted upon, approved and disseminated.

Achievement

- Pain included within A&E's electronic patient record system Symphony
- Guideline produced
- More emphasis on vital pack

AIM

- To raise awareness of available material. Increase use of link nurse network to raise awareness and ensure that all areas access available training.

Target

- Website use to be promoted for acute pain support documents. Education leaflets to be developed for staff and patients Group clinical supervision to be developed, training level set and delivered Improvement in training levels to be evaluated.

Achievement

- Established documents and assessment info available on pain website.
- Awaiting final ratification of doctor and nurse handbook.
- Staffs have had individual supervision, accessible if needed.

AIM

- Increase resources available to the acute pain management team.

Target

- Increase physical staff resources within the team by developing and submitting revised business case and recruiting relevant staff following approval. Prioritise service delivery within available resources.

Achievement

- Business case submitted for approval
- Priority is given to face to face review of patients / safety related issues

AIM

- To improve pain management resources available for patients To be able to provide/offer more comprehensive psychological assessment and treatment.

Target

- Offer a more comprehensive psychological assessment and treatment to prevent recurring admissions with pain control issues, including patients with substance misuse issues. Identify alternative treatment and support options where appropriate. Consider the possibilities of referral to clinical psychology and substance misuse specialists where this is identified as being in the patients best interests

Achievement

- Requested input from psychologist submitted in business case.
- SSN V Duff is currently seeking clarification from mental Health liaison team regarding provision / support for patients in this client group.

Quality Priority Five – Patient Experience

Why we chose this priority

The Trust is committed to the involvement of patients and the public and it was chosen to reflect one of corporate objectives around Exceeding Our Patients Expectations. At NGH we

try hard to listen to, understand and respond to patient and public opinion and expectations and to ensure their views continue to inform ongoing improvement work.

What we intended to do

The overall aim of this priority was to co-ordinate, monitor, feedback, and engage with our patients on their experiences, and work collaboratively to improve in areas where patients are voicing dissatisfaction.

Again to achieve this several programmes of work were undertaken, this included work to integrate our current patient and public involvement activity with our patient experience. To achieve this we intended to review our strategy documents to reflect partnerships and develop a patient engagement network with clear roles and responsibilities. We also planned to enhance our Patient Experience Board to reflect the input of carers and the patient engagement network.

We also wanted to enhance ownership of the patient experience agenda at ward, Directorate & Divisional and Board level and a series of activities were planned to improve awareness and enhance ownership.

Finally there was a national CQUIN related to this priority in working alongside partners such as Health watch and Age UK to support our patient experience strategy through development of structured feedback from task and finish groups, audit engagement and project leads,

How we performed

The Trust was pleased with the progress and improvements made for this Quality Priority.

In particular we achieved the following:

- A new patient Experience and Engagement Strategy was developed.
- A Patient & Carer Experience & Engagement Group (PCEEG) has been formed reporting to the Trusts Quality Governance subcommittee.
- The work plan and reporting lines into the PCEEG includes:
    - End of Life Care
    - Dementia Action
    - Equality and Human Rights (patients)
    - Disability Partnership
- A Patient & Public Engagement Network has been created, which currently has 29 members but continues to grow.
- In terms of improved ownership;
    - At ward level the ward sisters are now responsible for coordinating patient feedback and a monthly breakdown of performance with the Friends and Family test is displayed on the ward. Complaints are shared at team meetings as are compliments.
    - At Directorate & Divisional the Patient engagement network was explored as a mechanism to support the business planning process to ensure our patients and public are involved in service developments and improvements.
    - At Board level each Trust Board meeting starts with a patient story. All corporate projects aim to include a Patient Engagement Network member.

- We met all CQUIN targets for 2014/15 and we achieved this by, *inter alia,* communicating with staff, procuring Healthcare Communications to undertake FFT on our behalf in some areas, displaying posters in waiting rooms and advising patients.

Snapshot of Achievements

• Integrate current patient and public involvement with patient experience.

• Review Patient and Public Involvement activity and strategy
• Develop patient engagement network (PEN)
• Clarify roles and responsibilities for members of PEN

.

•

•A new patient experience and engagement strategy was developed
• The patient & public engagement network (PPEN) was formed.
• Roles and responsibilities of PPEN members taking part in trust based activities are made clear from the offset.
• For 2015/2016 systems for managing engagement within the hospital are being explored to ensure the organisation is able to recruit, capture and maintain members of PPEN to the highest levels and ensure engagement is targeted and available to all those that wish to be involved from within the community.

AIM

• Ensure the patient experience strategy reflects partnerships with patient and public involvement.

Target

• Review and revise patient experience strategy and develop patient experience and engagement strategy. Ratify new strategy through Patient Experience Board.

Achievement

• The patient & carer experience and engagement group (PCEEG) includes representation from Healthwatch Northamptonshire, carers' representatives as well as a number of focus groups:

- End of life
- Dementia action committee
- Black and Ethnic Minority forum
- Dignity forum
- Disability partnership forum

Engagement is a fundamental aspect of the new strategy and is heavily represented alongside patient experience and a key component.

AIM

- Improve the patient experience at ward level.

Target

- Ward sisters to be responsible for co-ordinating patient feedback and sharing with their staff. This will include:
  - Patient story/complaints/compliment at the beginning of each ward meeting
  - Share FFT, complaints and compliments with their ward team through ward meetings, huddles and 1:1
  - Review FFT scores and comments, and co-ordinate improvement plans to address areas of dissatisfaction
  - Feedback to Patient Experience Lead work undertaken and outcomes.

Achievement

- The ward sisters receive their FFT data from the patient experience lead monthly, this includes:
  - A poster to be displayed within the department for both staff and patients
  - A monthly breakdown of each wards individual performance
  - A graph showing month on month tracked trends from the satisfaction scores received.
- This information is shared by all ward sisters within their huddles alongside patient stories and any complaints that they have received.
- The information gained through the FFT is consistently reviewed for themes and trends and was part of the catalyst for the Sleep Well Campaign targeted at helping patients to rest and sleep whilst in hospital.
- Where reduction in satisfaction levels has been observed, or an area receives consistently poor results, the ward sister and matron are invited to attend the patient & carer experience and engagement group to report on any issues identified and progress made to address them
- An example of progress can be seen from a particular ward highlighted as an area of concern in February due to their depreciating FFT results. The sister and matron were contacted and discussions took place around their feedback data including the comments and common themes. Following these discussions and action taken, the ward saw their satisfaction levels rise from 73% of patients recommending the ward in January to 95% in February. This ward will continue to be reviewed to ensure the achievement is sustained

AIM

•Improve the patient experience at directorate level.

Target

•Engage PEN within service improvement/directorate work. Develop the role of 'critical friend' with PEN to contribute to Trust Service Improvements.

Achievement

• Meetings have been held with the Trusts Business Development Team to explore how members of PPEN can be involved in directly supporting the business case cycle. This will be reviewed alongside the cycle for 2015/2016.

AIM

• Improve the patient experience at a trust-wide level.

Target

• Trust Board and senior forums to begin with patient story. Corporate projects /workstreams to include PEN representative. Patient experience projects to be fully supported by PEN. Feedback and outcomes from patient experience activities co-ordinated and shared through patient experience lead.

Achievement

• Each Trust Board meeting begins with a patient story.

•All projects which have been initiated via patient experience have had representation from members of PPEN. For example, a group of PPEN members were involved in the Sleep Well Campaign conducting audits on the wards and attending meetings as members of the steering group. The wider PPEN was also involved in the production of supporting leaflets and posters to ensure they were user friendly.

•The hotel service focus group conduct monthly food tasting audits and visit the wards to assess the overall experience for patients during mealtimes.

•These are just two examples of the invaluable work members of our public have been able support throughout 2014/2015

•All work related to engagement is fed through the patient & carer experience and engagement group and shared in reports to the Quality Committee.

AIM

- Achieve National CQUIN.

Target

- Work with Healthwatch Northamptonshire, Age UK and other external agents to support the patient experience strategy. Develop structured feedback from Task & Finish groups, audit engagement and project leads.

Achievement

- Healthwatch Northamptonshire are represented on the patient & carer experience and engagement group and present any findings related to. They're also involved in key discussions regarding experience and engagement as part of the group.

The carers' organisation are also represented at these meeting.

Under its new structure, a number of focus groups now directly feed into the group:
- End of life
- Dementia action committee
- Black and ethnic minority
- Dignity forum
- Disability partnership forum (including deaf connect and Northamptonshire Association for the Blind (NAB).

AIM

- Continue to roll out the Friends and Family Test to outpatients and day case areas.

Target

- Identify an external technology solution for capturing FFT data throughout the organisation. Roll out FFT in outpatients in line with CQUIN requirements.

Achievement

- Healthcare Communications were procured in September 2014 following a review of a number of different providers of electronic solutions for the Friends & Family Test. Given the growing size of the FFT and the requirement to roll out to Outpatients by October 2014 to meet the CQUIN it was determined that a method which did not require data collection/entry, or the purchasing/maintenance of expensive IT equipment was the best method for the organisation.
- For this reason, Healthcare Communications were chosen as the most proficient and competitive with SMS text messaging and Interactive Voice Messaging. In addition to this, they provide an exemplary dashboard system and online monitoring.
- With the support of Healthcare Communications the organisation was able to meet the CQUIN deadline of the 1st of October and roll out to all outpatient and day case areas.
- For Q3, this saw the organisation collect 16,285 responses to the FFT from Outpatient services and 2532 for Day Case services across NGH and Danetre, providing a wealth of data related to how our patients are experiencing our services

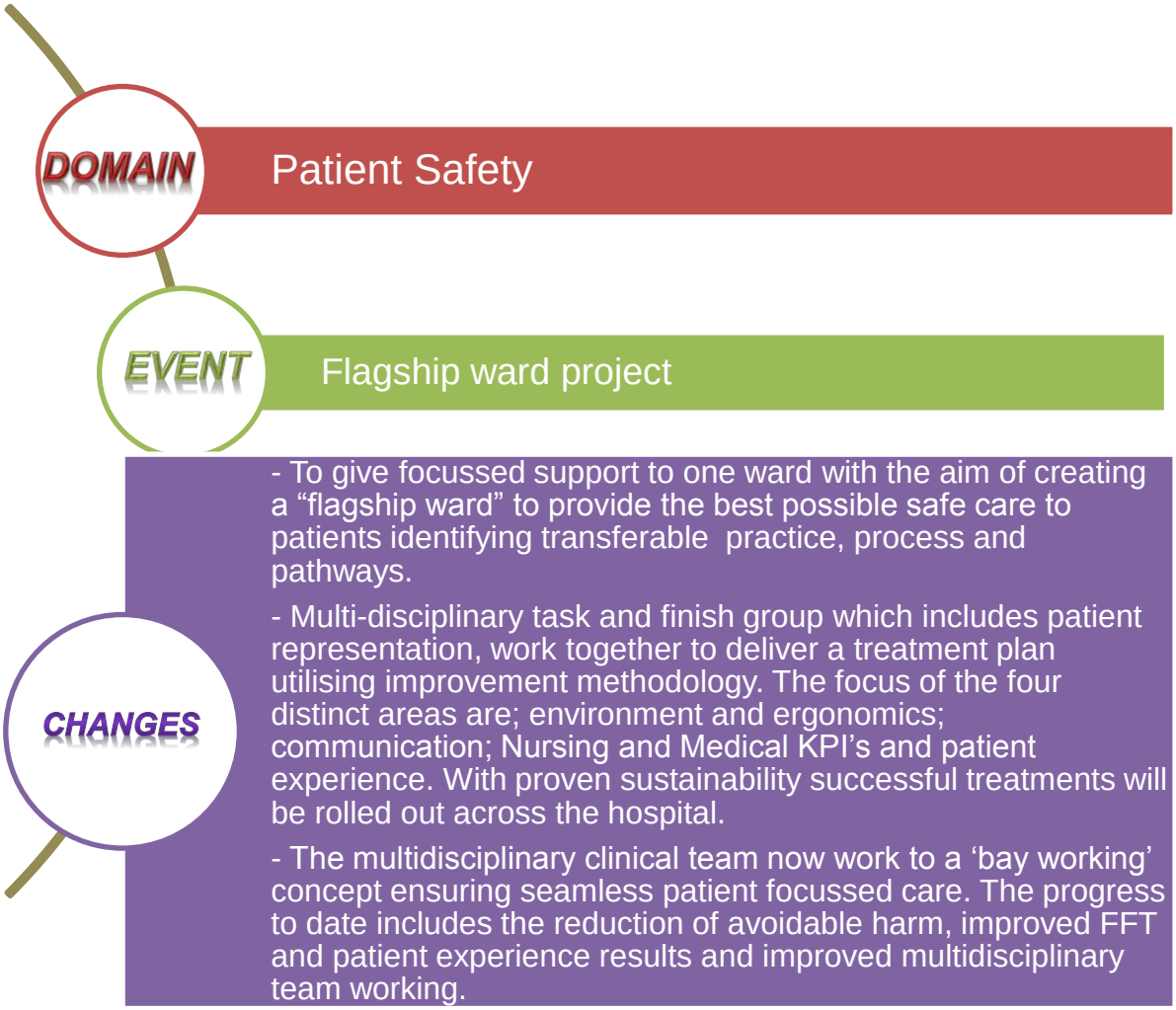
PART FOUR

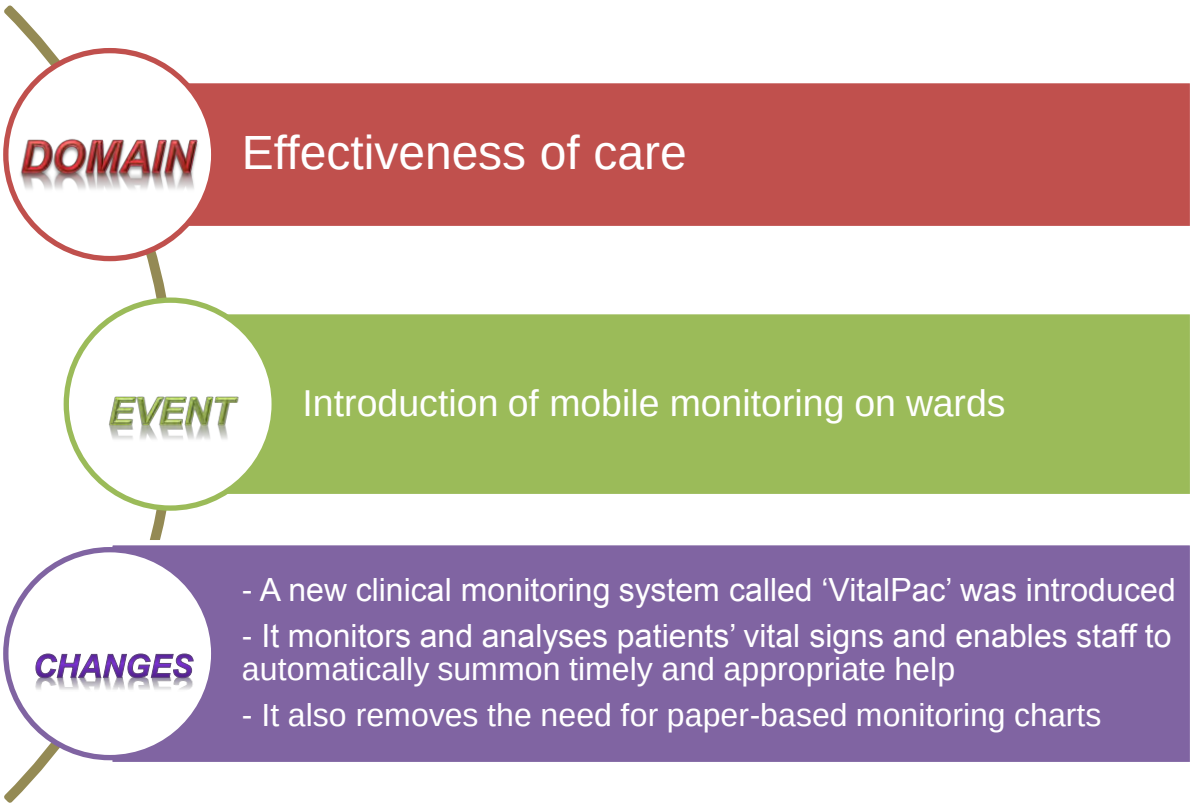
Our Improvements and Your Thoughts

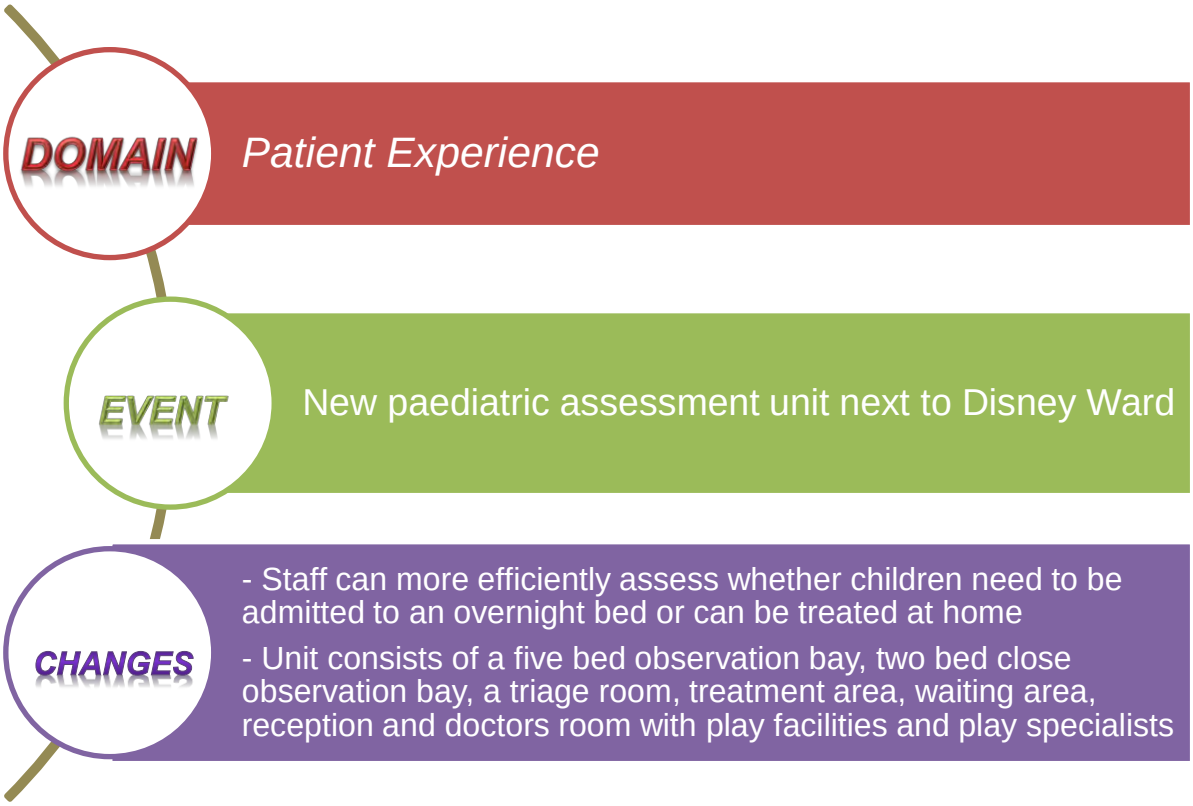
2014/15 - Improvements at NGH

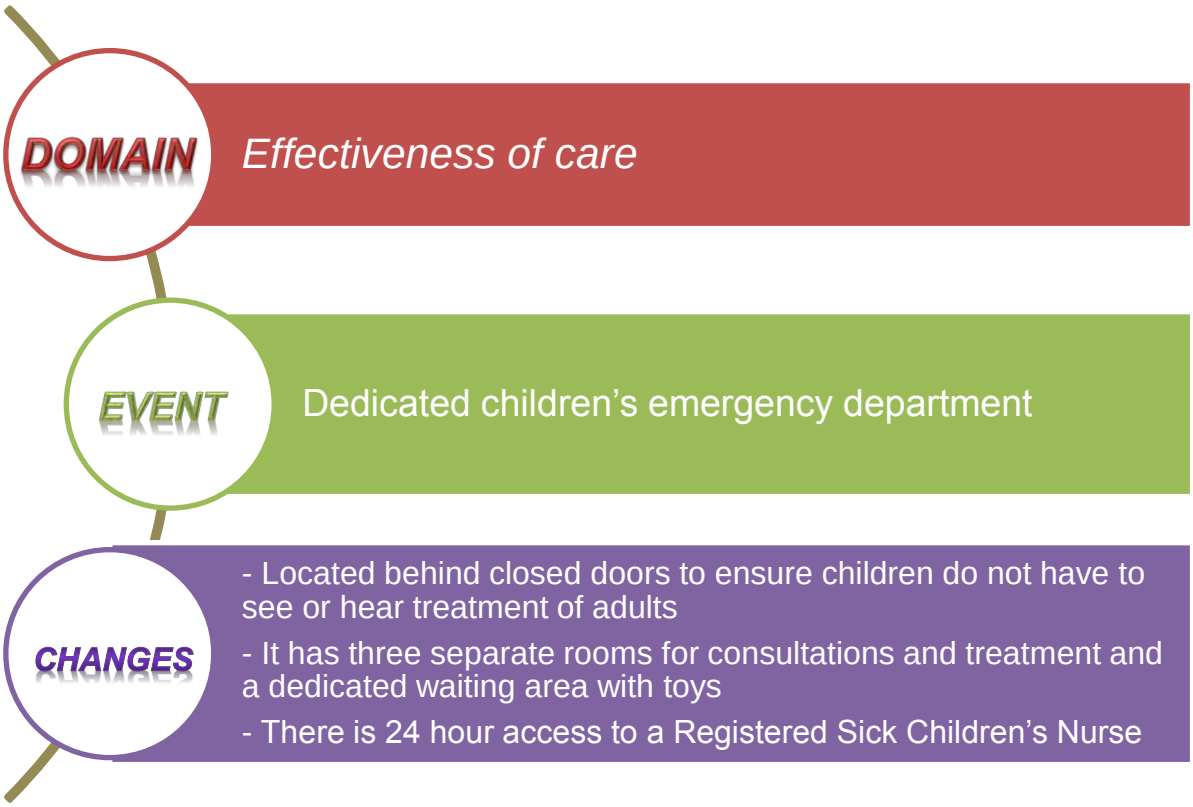
During 2014/15 the hospital has strengthened the resolve to deliver best possible care by supporting a number of improvement programmes. It would not be possible to detail all the improvements made but some are listed below.

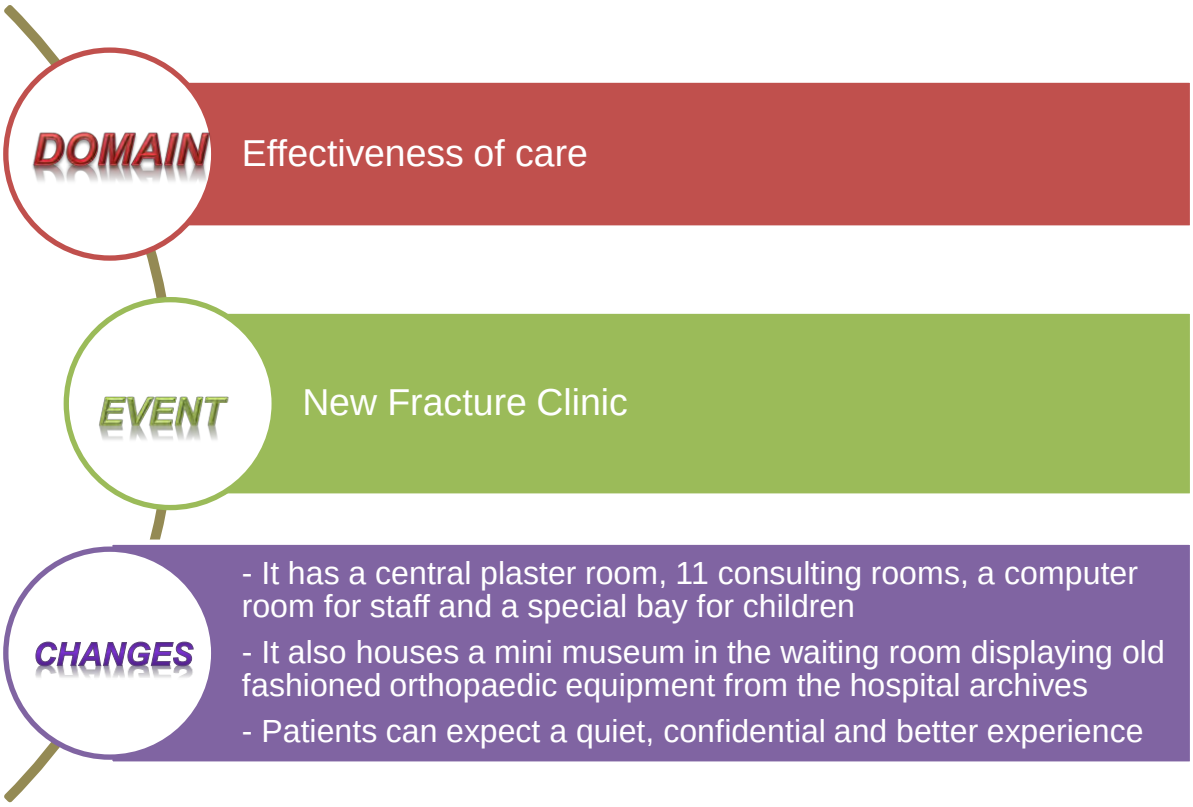
In addition to some of the specific improvements, the senior team has worked with staff to develop an aligned programme of work to ensure that quality improvement and efficiency of services receive the emphasis required and that all energy and resources are centred on these. The underpinning governance structures to monitor quality have been improved, the organisation has committed to a clinically led divisional structure underpinned by a supportive culture and a formal development programme , quality improvement projects have been supported by a dedicated team working alongside staff in the ‘ Making Quality Count’ programme and an organisational development team is in place to support services . The underpinning focus on workforce development overseen by a subcommittee of the Trust Board is an essential part of improving our services for the future and will be an area that will receive increasing emphasis in the years to come.


DOMAIN
Patient Safety
EVENT
Flagship ward project
CHANGES
- To give focussed support to one ward with the aim of creating a “flagship ward” to provide the best possible safe care to patients identifying transferable practice, process and pathways.
- Multi-disciplinary task and finish group which includes patient representation, work together to deliver a treatment plan utilising improvement methodology. The focus of the four distinct areas are; environment and ergonomics; communication; Nursing and Medical KPI’s and patient experience. With proven sustainability successful treatments will be rolled out across the hospital.
- The multidisciplinary clinical team now work to a ‘bay working’ concept ensuring seamless patient focussed care. The progress to date includes the reduction of avoidable harm, improved FFT and patient experience results and improved multidisciplinary team working.

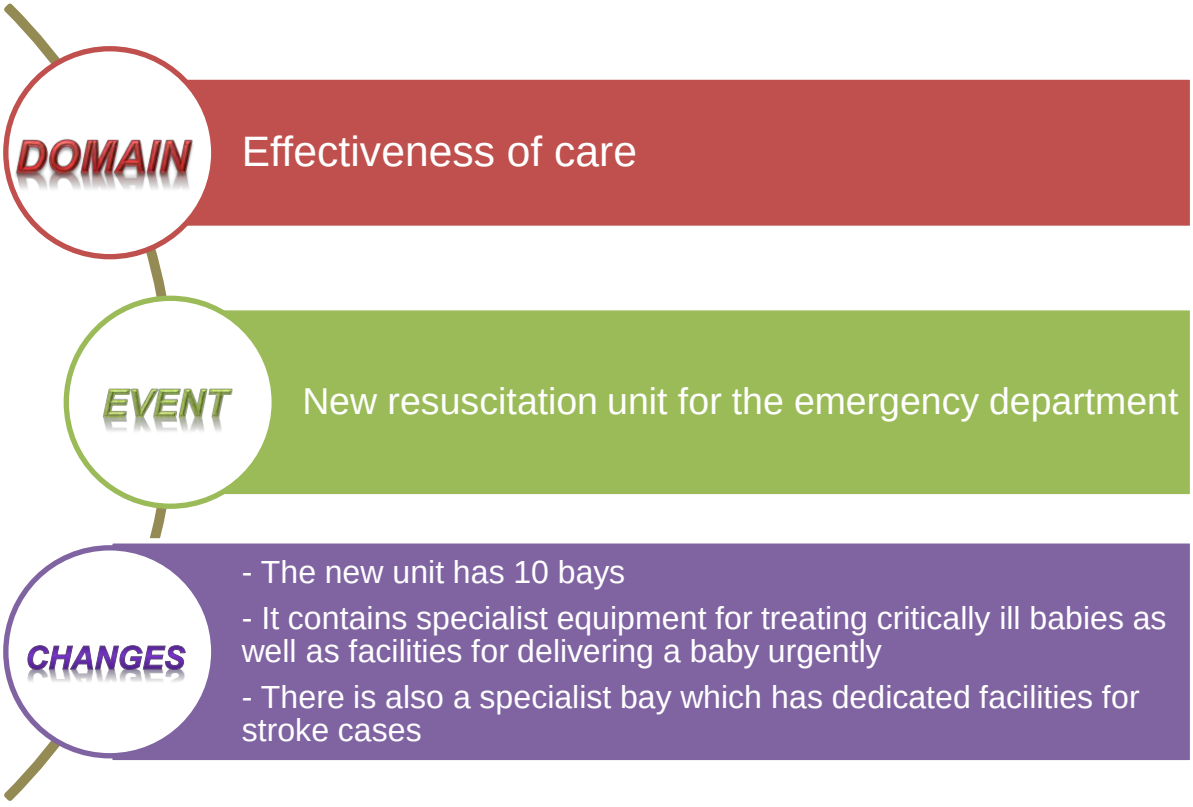

DOMAIN
Effectiveness of care
EVENT
Introduction of mobile monitoring on wards
CHANGES
- A new clinical monitoring system called ‘VitalPac’ was introduced
- It monitors and analyses patients’ vital signs and enables staff to automatically summon timely and appropriate help
- It also removes the need for paper-based monitoring charts

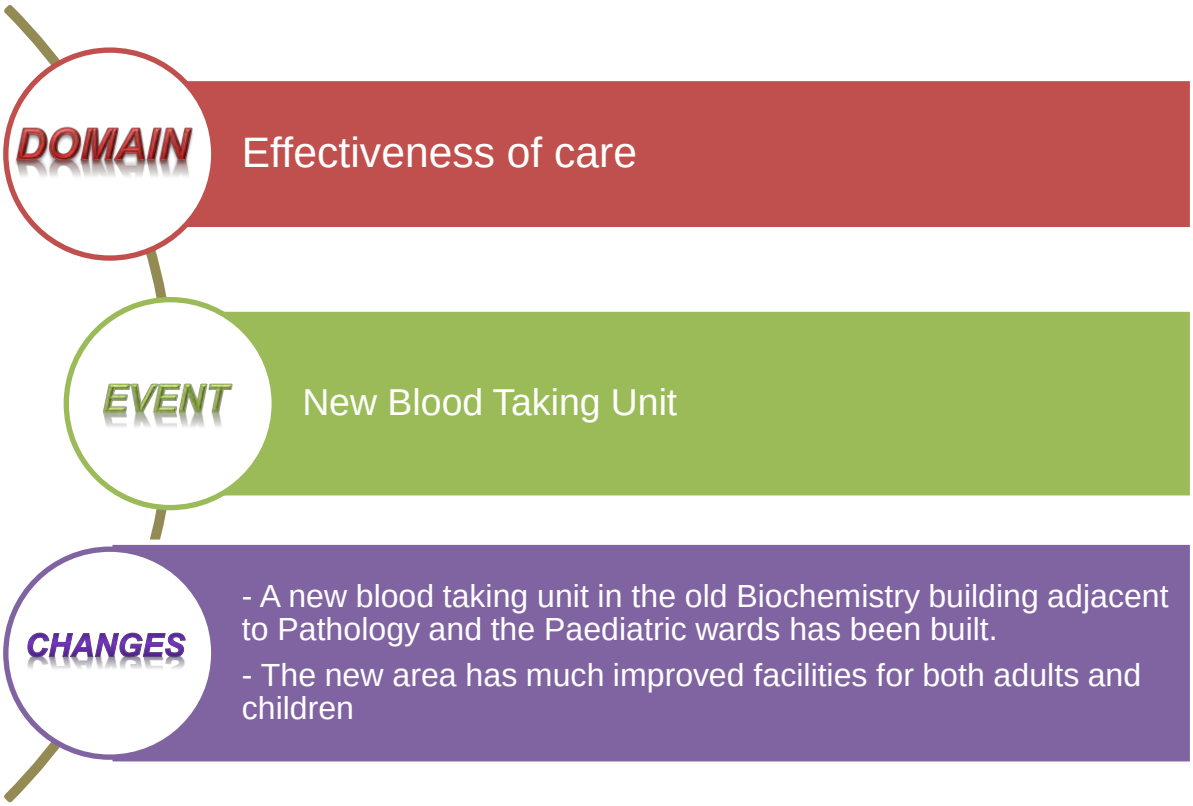

DOMAIN
Patient Experience
EVENT
New paediatric assessment unit next to Disney Ward
CHANGES
- Staff can more efficiently assess whether children need to be admitted to an overnight bed or can be treated at home
- Unit consists of a five bed observation bay, two bed close observation bay, a triage room, treatment area, waiting area, reception and doctors room with play facilities and play specialists

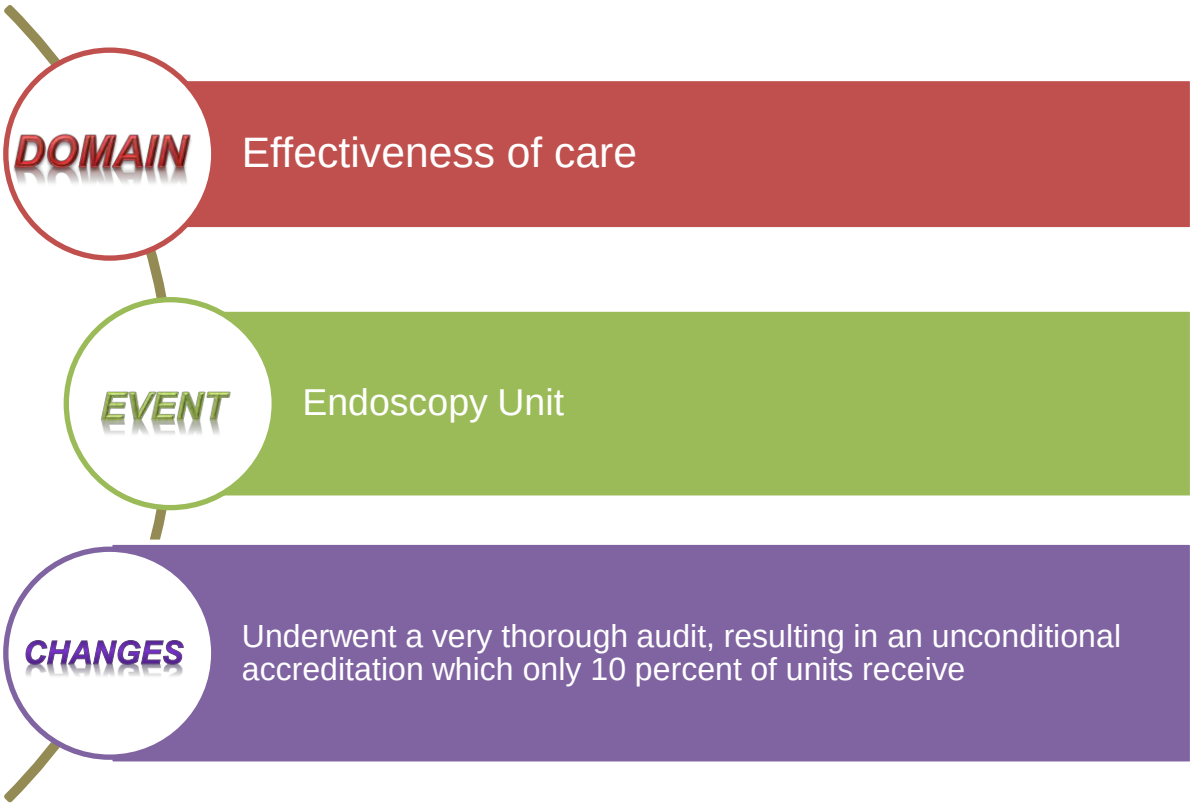

DOMAIN
Effectiveness of care
EVENT
Dedicated children's emergency department
CHANGES
- Located behind closed doors to ensure children do not have to see or hear treatment of adults
- It has three separate rooms for consultations and treatment and a dedicated waiting area with toys
- There is 24 hour access to a Registered Sick Children's Nurse

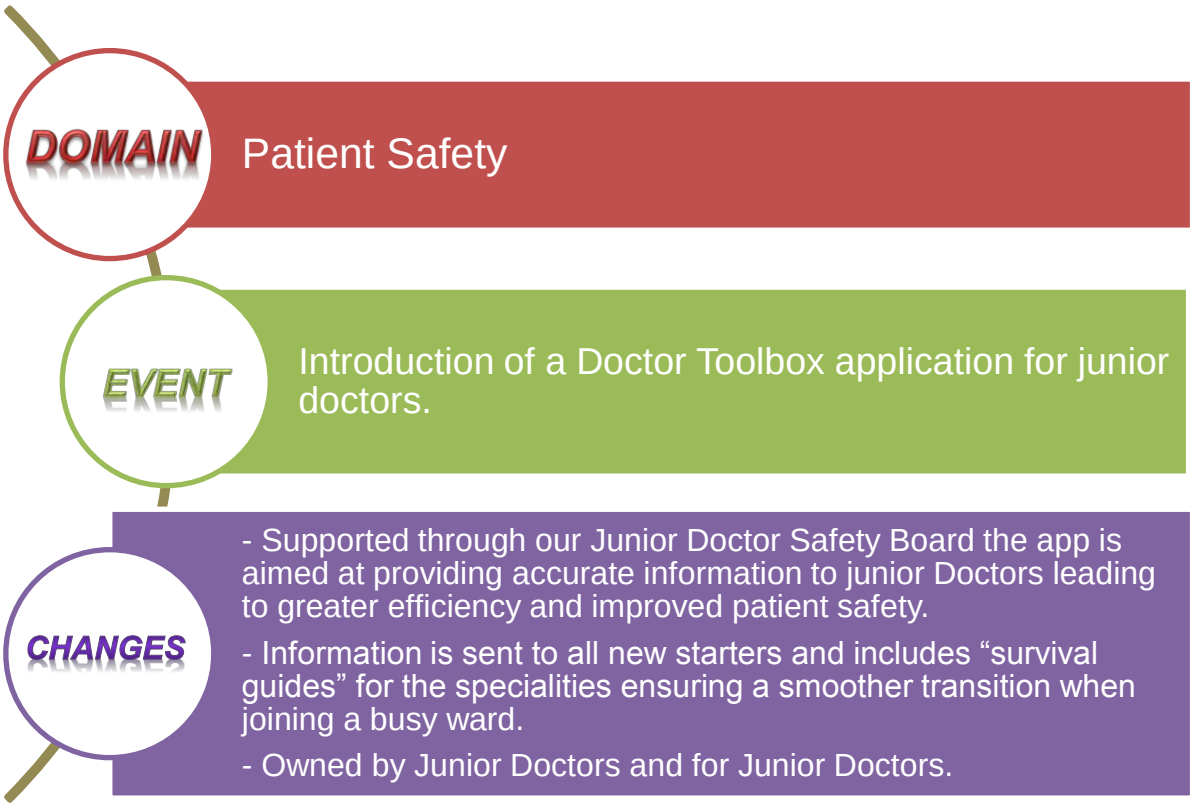

DOMAIN
Effectiveness of care
EVENT
New Fracture Clinic
CHANGES
- It has a central plaster room, 11 consulting rooms, a computer room for staff and a special bay for children
- It also houses a mini museum in the waiting room displaying old fashioned orthopaedic equipment from the hospital archives
- Patients can expect a quiet, confidential and better experience


DOMAIN
Patient Experience
EVENT
New Discharge Suite
CHANGES
- Patients who no longer need to be in hospital have a comfortable place to wait while paperwork or prescriptions are processed and while they wait for transport home
- Has facilities for up to 20 patients in chairs and four side rooms for patients in beds

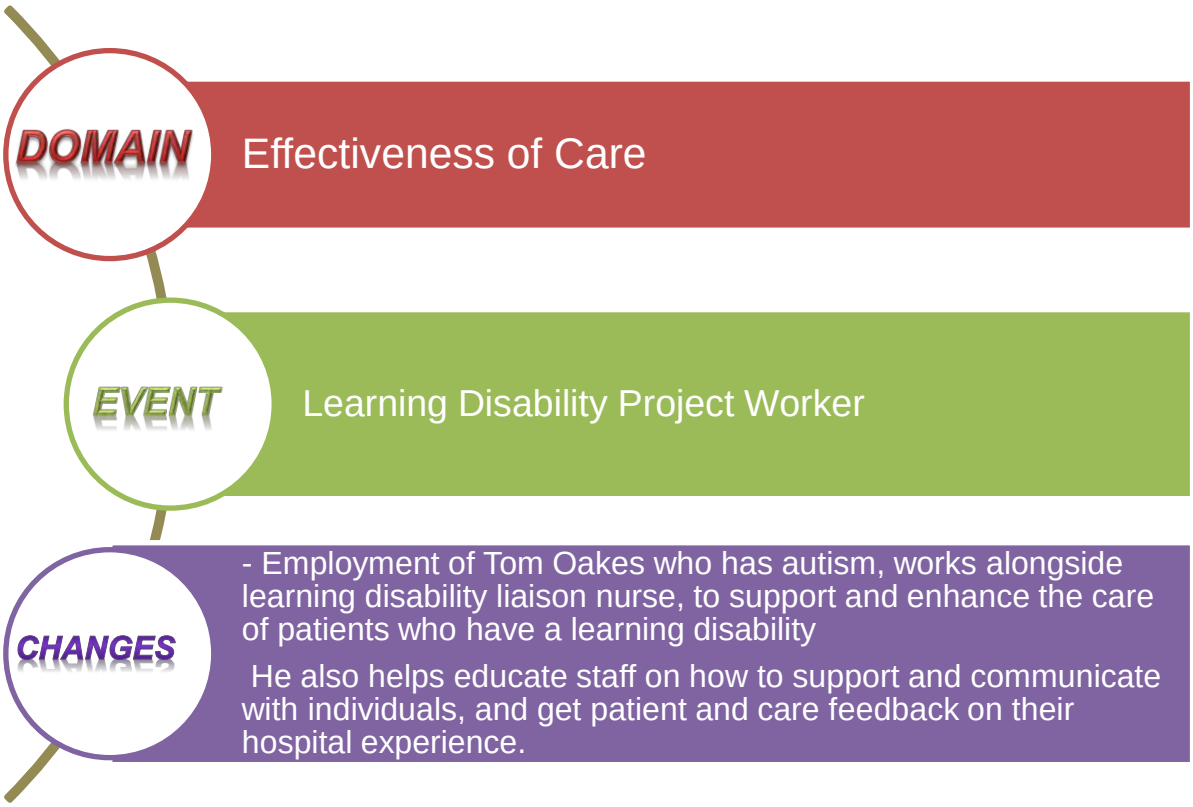

DOMAIN
Effectiveness of care
EVENT
New resuscitation unit for the emergency department
CHANGES
- The new unit has 10 bays
- It contains specialist equipment for treating critically ill babies as well as facilities for delivering a baby urgently
- There is also a specialist bay which has dedicated facilities for stroke cases


DOMAIN
Effectiveness of care
EVENT
New Blood Taking Unit
CHANGES
- A new blood taking unit in the old Biochemistry building adjacent to Pathology and the Paediatric wards has been built.
- The new area has much improved facilities for both adults and children


DOMAIN
Effectiveness of care
EVENT
Endoscopy Unit
CHANGES
Underwent a very thorough audit, resulting in an unconditional accreditation which only 10 percent of units receive


DOMAIN
Patient Safety
EVENT
Introduction of a Doctor Toolbox application for junior doctors.
CHANGES
- Supported through our Junior Doctor Safety Board the app is aimed at providing accurate information to junior Doctors leading to greater efficiency and improved patient safety.
- Information is sent to all new starters and includes “survival guides” for the specialities ensuring a smoother transition when joining a busy ward.
- Owned by Junior Doctors and for Junior Doctors.


DOMAIN
Patient Safety
EVENT
Shortlisted for the finals of the Patient Safety and Care Awards 2014
CHANGES
- This was for producing a training course designed to help doctors of tomorrow become more safety aware
- The programme known as “Aspiring to Excellence” guides final year medical students through a stimulating, interactive, consultant-led programme, focusing on many of the patient safety issues faced at the hospital

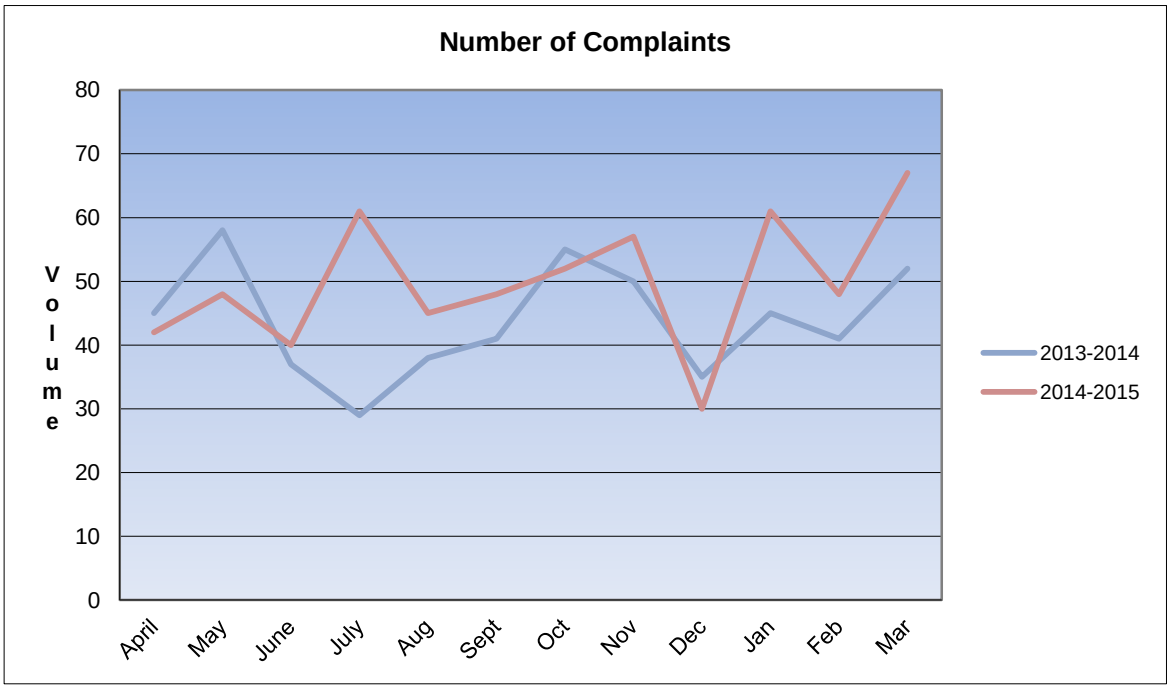

DOMAIN
Effectiveness of Care
EVENT
Learning Disability Project Worker
CHANGES
- Employment of Tom Oakes who has autism, works alongside learning disability liaison nurse, to support and enhance the care of patients who have a learning disability
He also helps educate staff on how to support and communicate with individuals, and get patient and care feedback on their hospital experience.

Complaints

The Trust received a total of 599 written complaints that were investigated through the NHS Complaints Procedure from 1 April 2014 to 31 March 2015, which compares with 526 complaints received the previous financial year.

Total no of complaints for the year (Versus 2013/2014)	**599 (526)**
Average response rate (including 307 renegotiated timescales)	*78%
Total no of complaints that exceeded the renegotiated timescale	*103
Complaints that were still open at the time that the information was prepared (14th April 2015)	*67
Total patient contacts/episodes (Versus 2013/2014)	607,659 (571,868)
Percentage of complaints versus number of patient contacts/episodes (Versus 2013/2014)	0.10% (0.11%)

**These figures were the current status at the time that the report was prepared 14th April 2015. The final figures will not be complete until the end of May 2015 due to the timescales involved.*



	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2013-2014	45	58	37	29	38	41	55	50	35	45	41	52	526
2014-2015	42	48	40	61	45	48	52	57	30	61	48	67	599

Trend Analysis

The following table provides the top 5 themes emerging from complaints.

	2014-2015	% of Total Complaints Received
Clinical Care	64	11%
Delays/Cancellations	26	4%
Communication	20	3%
Attitude	16	2.6%
Discharge	12	2%

Ombudsman

Total number of complaints that progressed to the PHSO in 2014 / 2015	Cases currently under review	Cases not upheld or closed without investigation	Cases partially or fully upheld	Financial remedies for PHSO cases (total costs paid)
6	8 (3 from previous years)	1	2 partially upheld (from previous years)	0

Ombudsman cases which are fully or partly upheld are shared through the Trust's Patient Safety Learning Forum whereby the Trust Head of Complaints presents any learning, recommendations and redress to members of staff from across the organisation. A copy of the document presented is then circulated for onward communication to other Trust staff.

Learning

For every complaint, where learning is identified, a development table is included within the Trust letter of response which details the area for development, action required, lead, timescale for completion and action taken to date. This information is entered on to the Trust assurance tool (HealthAssure) and assigned to the relevant lead, as well as the divisional Governance Manager and Head of Complaints who is the sponsor for each learning point identified.

An internal assurance timescale is set and evidence must be provided by the relevant area to show that they have done what they said that they would do, to learn from the complaint. The evidence can be in many different forms but is saved to a complaint specific folder on the governance drive. The evidence is approved by senior staff within the 'sign off' process and the learning must be disseminated through divisional meetings and huddles. Learning is also shared through governance and patient experience reporting processes.

Clwyd/Hart report

The Francis Report prompted the Prime Minister and the Secretary of State for Health to commission a review into NHS hospitals complaint handling arrangements. The review was

co-chaired by the Right Honourable Ann Clwyd, MP for the Cynon Valley and Professor Tricia Hart, Chief Executive of South Tees Hospitals NHS Foundation Trust. Through the review the aim was to consider the way in which concerns and complaints are handled across NHS hospitals in England. The focus was on acute hospitals, although evidence was also taken from other care providers. Subsequently the Clwyd /Hart report 'A review of the NHS hospitals Complaints System – Putting Patients Back in the Picture' - was published.

Following the release of the report the Trust's Head of Complaints prepared a detailed gap analysis early in 2014 incorporating the recommendations made within the report. The Trust had previously received an 'excellent' rating from the most recent full audit of complaints handling incorporating CQC outcome 17 and the NHS Statutory Complaints Regulations.
However, on the back of the Clwyd/Hart report the Trust identified that some improvements could be made to the way in which complaints are handled within the Trust, at directorate, divisional and corporate levels. A development plan was subsequently prepared which is ongoing at present.

In December 2014 the Parliamentary & Health Service Ombudsman published a report 'My expectations for raising concerns and complaints'. This report was has been combined with the Trust's Clwyd/Hart development plan, devised by the Trust, as it all relates to improving complaints handling within the NHS.

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. The Trust works in accordance with the Parliamentary & Health Service Ombudsman's 'Principles for Remedy'.

What our Patients Say - Compliments

The midwives in NGH are amazing. All of our 6 babies were born there and I could not fault them with each delivery. I had a few high risk pregnancies and the care we received each time was wonderful. Well done!
x

Northampton Hospital staff are all brill. I've been to so many different areas in the last couple of weeks and all the staff I met were amazing.

I have just come through a period of contact with a number of NGH departments and wanted to write to you to say how impressed I was with the service I received from all of them.

I would love to say a huge thank you to all the staff on Rowan ward. They were friendly and helpful; they are treating every patient very professionally. They were totally helpful all of the time. That's what I call nursing and caring people

To everyone on Gosset, thank you for your kindness and support over the last (many) weeks. You have been like my family and will hold a special place in my heart

I would just like to say a huge thank you to the three staff who were in the room at the children's outpatients department today. When I brought my two-year old Harry in for a blood test he was seen on time, and he didn't even flinch. The play worker lady was fantastic, reading him a story as the nurses took blood.

I had a brilliant experience having my baby by CS at NGH. Brilliant aftercare and support

I was admitted to Althorp ward for a hip replacement, all went well and I am now well on the way to a full recovery. I feel I must bring to your attention the wonderful care and attention given to me by the staff of NGH. Everyone from my consultant and his team, the wonderful staff on Althorp ward, the x-ray people, the physio's and the porters were all totally professional and efficient as you would expect, but so much more. You are all wonderful people and I cannot thank you enough for all you have done for me, above and beyond does not come into it

What our Patients Say - Complaints

Patient raised concerns regarding her experiences within the Accident & Emergency Department mainly in relation to the care provided by the doctor, discharge prior to the release of blood test results and the content of discharge documentation.

- Issues addressed directly with junior doctors to ensure that they:
  - Ensure that the required level of care is provided to patients taking in to consideration all of the symptoms identified
  - Transfer patients to the short stay area pending the outcome of test results.
  - Discharge system is being updated to reflect improved clinical information for discharge notifications

Relative raised concerns about various aspects of care that his elderly mother received, predominantly with regard to aspects of her discharge/transfer: Communication, time of night, clothing not suitable and left in a wheelchair for some considerable time before she was transferred to another area. Nursing and medical staff were unaware of the patient's transfer which was initiated by the night team. The patient's zimmer frame was left on her previous ward leaving her without any means of mobility. Follow up tests could not be completed in a timely manner as no-one knew where the patient was. The patients TTO's were late being delivered and her discharge ended up being delayed as the discharging doctor did not know where she was.

- It has been acknowledged that the patients discharge planning should have been appropriately discussed with her family, and staff caring for the patient, to ensure that the necessary arrangements were in place. The concerns regarding the lateness and appropriateness of the transfer and the attire that the patient was wearing have been addressed with all of the staff involved in the process to ensure that action is taken accordingly to prevent this from happening again. Staff have also been reminded that when a patient is moved outstanding reviews/tests must be communicated to the relevant staff to ensure that the patient has these completed prior to discharge.

Patient raised concerns about various aspects of the care and treatment that she received during her admission. The majority of the concerns relate to personal hygiene support, protective cover for her plaster, call bell location, pain relief, ward moves, meals and the omission of staff to follow postoperative instructions.

- Through the learning from this complaint it was identified that some staff were agency/bank and that they must receive ward based inductions when they commence their shift which had not been completed on this occasion. All staff have been reminded to ensure that call bells are within easy reach of the patient, in line with hourly care rounds and that hygiene needs must be supported fully at all times.

A relative raised a complaint regarding the care and treatment that the patient had received during their admission to NGH. A number of concerns were raised but the main issue related to the patients medication (pain relief) upon discharge. The patient was for palliative care only and was discharged with standard pain relief whereas he had been intermittently receiving stronger pain relief during his admission. A conversation had also taken place with the patients GP asking for a review when possible upon the return to the community. The relative stated that upon returning to his residential home the patient was found to be in extreme pain and did not have access to the required strong pain relief that was required. A subsequent emergency call out took place and the GP attended. However, by this time the patient had been in pain and distress for some considerable length of time.

- Through the course of the Trust's investigation it was identified that the consultant had requested that stronger pain relief should be prescribed upon discharge to support the patient upon his return to his residential home. However, this was not acted upon by the junior doctor when medications to take home were prescribed. The junior doctor has since left the Trust but with the relatives permission will be provided with a copy of the complaint and response to ensure that they are made aware of the issues raised. Action is also being taken by the relevant directorate to ensure that the appropriate pain is prescribed when a patient is discharged to ensure their needs are met through junior doctors education.

What our Staff Say

The 2014 annual National NHS Staff Survey took place during September to December 2014. A total of 850 surveys were sent directly to a random sample of staff. A total of 394 members of staff returned the survey, constituting a 46.63% response rate, an improvement from the 2013 response rate of 42.4%. Of the 29 key findings this year there has been improvement in 17, six deteriorated, four have stayed the same and two could not be compared.

The Trust was above average for Acute Trusts in:

- % appraised in last 12 months
- % reporting errors, near misses or incidents witness in the last month
- Staff motivation at work

The Trust has statistically improved since 2013 in:

- % appraised in last 12 months
- % receiving health and safety training in last 12 months

Key areas for improvements are:

- Work related stress and work pressure
- Effective team working
- Appraisal
- Support from immediate managers
- Witnessing potentially harmful errors, near misses or incidents
- Fairness and effectiveness of incident reporting procedures
- Raising concerns about unsafe clinical practice
- Physical violence & harassment and bullying
- Staff involvement and feedback
- Job satisfaction
- Recommendation as a place to work/receive treatment
- Equal opportunities
- Discrimination

Staffs most positive perceptions

Staff feel

- They are trusted to do their job
- Their role makes a difference to patients/service users
- They always know what their work responsibilities are
- The trust encourages them to report errors, near misses and incidents
- They know who the senior managers are
- They are satisfied with the quality of care they give to patients/service users
- They are able to do their job to a standard they are personally pleased with
- They are satisfied with the support they get from their work colleagues
- They are satisfied with the amount of responsibility they are given
- Their training, learning and development has helped them stay up-to-date with professional requirements
- Team members have to communicate closely with each other to achieve the team's objectives
- They have clear. Planned goals and objectives for their job

Following the 2013 results, it was agreed that NGH would change the approach to responding to the outcomes of the staff survey. To improve results, it was recognised that rather than a disconnected list of actions, it would approach the root causes. This means working towards a fundamental shift in culture, where everyone is focused on quality, continuous improvement and meaningful staff engagement to sustainably improve staff satisfaction at work.

We recognise that the survey highlights some areas of concern and we have already taken steps to address many of those issues in our recently launched staff engagement strategy. This lays the foundations as we start working with individuals and teams. This year's results show that we are on target to achieve that goal as there have been some areas of improvement on last year's results and we will continue to build on those.

Surveys

The National Inpatient Survey – CQC Results

In total when comparing against previous results the Trust performed statistically better in 1 question, and statistically worse in 5. When comparing nationally, the Trust performed within the 'worse' category for 4 questions:

- Q15 Were you ever bothered by noise at night from other patients?
- Q16 Were you ever bothered by noise at night from staff?
- Q46 Were you told how you could expect to feel after you had your operation or procedure?
- Q51 Were you given enough notice about when you would be discharged?

It should be noted that the sample for this was taken in August 2014 and the Sleep Well Campaign began in October. This is therefore in no way a reflection of the campaign itself.

An action plan has been amended to represent the new report and is currently being updated by numerous leads within the organisation.

The National Outpatient Survey – 2014

This survey was not mandatory and was offered to the organisation by Patient Perspective at a cost. As there had not been an Outpatient Survey for some time the decision was made to commission this survey to help inform the work being undertaken within Outpatient departments.

From reviewing the scores obtained, the following areas were identified as areas of dissatisfaction within the survey.

- Waiting Times
- Appointment Booking and Information
- Involvement in care
- Information

There were a number of questions which saw the Trust receive the highest score ever obtained by the Trust for this survey:

- Q2 From when you were first told you needed an appointment, how long did you have to wait?
- Q7 Before your appointment, did you know what would happen to you during the appointment?
- Q10 In your opinion, how clean was the Outpatients Department?
- Q13 Did a member of staff explain why you needed these tests in a way you could understand?
- Q46 Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?
- Q50 Overall, did you feel you were treated with respect and dignity when in the OP Department?

The results have been fed to the Divisional Manager and will form part of the Outpatient Theme which is Trust wide.

The National Children & Young Peoples Survey – 2014

The results for this mandatory survey were published by patient perspective in April. As this is the first ever survey of this kind there is no comparative data to previous years and the CQC survey will not be available to compare national position until June.

Care Quality Commission

The Trust is registered with the Care Quality Commission under the Health and Social Care Act 2008.

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

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

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

As reported in the Quality Account 2013/14 NGH was the subject of an in-depth inspection by the CQC in January 2014 with a formal report published in March 2014. The Trust was rated overall as 'Requires Improvement' but the CQC rated "are the services at the trust caring" as 'Good'. The report highlighted areas where improvements at NGH must and could be made. Action plans were drawn up to address high level actions and compliance actions.

The high level action plan was completed by June 2014 and the compliance action plan completed by March 2015.

Some of the changes and improvements made following the CQC inspections and as a result the NGH action plans are:

- A risk assessment is completed for patient moves
- A patient leaflet was develop advising patients they may be moved
- Medications are no longer sent to a patients home by taxi
- Record rates of mandatory training, appraisals and role specific training have all increased
- Introduction of a dedicated paediatric emergency area with the emergency department with a selection of toys in the play area
- Do not attempt cardio pulmonary resuscitation paperwork was withdrawn, redesigned and implemented
- Raised awareness of record keeping standards and the importance of tracking records
- Robust governance arrangements to ensure we identify and mitigate risks to patients and learn from experience
- Plan for medical equipment to be serviced by a qualified safety engineer
- Implement the new 'Personalised care of the dying person and their family' care plan
- A robust urgent care programme

The Trust received a follow up inspection in September 2014 with the primary purpose to determine whether we had addressed the issues raised on these areas.

The CQC acknowledged the huge amount of work done since their visit in January 2014 and identified some areas to continue to improve on and these are:

- The trust should continue to embed effective training and staff appraisals systems in place to ensure trust targets are met
- The trust should continue to monitor the capacity and demand of the ED to ensure all patients are assessed within the 4 hour target time.
- The trust should continue to review all areas of patient risk and ensure all areas of risk highlighted on the corporate risk register are reviewed within the prescribed timescales.
- The trust should continue to monitor all out of hours patient moves and embed the risk assessment process to achieve its target for 100% completion of these risk assessments.

The CQC made a number of favourable comments in relation to the improvements that they saw. Issuing their formal report in April 2015 they noted the improved leadership and governance within the Trust and also noted improvement in several areas including:

- Urgent and Emergency services
    - Reconfiguring the physical environment to ensure that urgent and emergency services were secure
    - Children's emergency department
    - Records were being completed in accordance with trust policies
    - Appropriate safeguarding controls were in place and staff had appropriate training
    - Patient spoke highly about the caring attitude of staff and were kept informed of the treatment options and that their wishes were respected
    - Patient's privacy and dignity were respected

- Medical Care
    - Staff were aware of the trust's incident reporting procedures
    - Performance information, including patient safety risks, was on display in ward areas
    - Appropriate records were being maintained
    - There were procedures in place for the safe handling of medicines
    - Staff followed the trusts' procedures for effective infection control measures
    - Staff appraisals' compliance had significantly improved
    - Pain relief, nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain
    - Patients told us that the staff were caring, kind and respected their wishes
    - People we spoke to during the inspection were complimentary, and full of praise for the staff looking after them.
    - The hospital had taken significant action to monitor the number of patients moved out of hours.

Through our own processes, feedback and internal inspections we have a good understanding of where improvements can be made and the CQC report agreed with our own assessment of where further work is needed to be done.

PART FIVE

Audits, Research and Commissioner Goals

Participation in Clinical Audit and Confidential Enquiries

National Clinical Audit and Confidential Enquiries

Participation in National Clinical Audits and National Confidential Enquiries is a high priority and during 2014/15, Northampton General Hospital aimed to participate in all relevant projects included in the Quality Account list.

The Quality Account list includes a variety of different topics and ways of collecting data. Some of the projects collect data for a short period of time (snapshot audits) and others collect data continually on the management of certain conditions. Some of the larger projects have developed to include several different work streams for example questions about the structure of the service provided (organisational questionnaires), questions about the process of individual patient care (case note reviews) and questions about the patient experience (patient questionnaires). NGH has achieved a very high level of participation again this year with the only exception being the Core Audit of the National Diabetes Audit (Data has not been entered to this audit in the past due to lack of appropriate software. This is being addressed to try and find a local solution).

The following table gives details of all Quality Account audits and confidential enquiries to which Northampton General Hospital submitted data in 2014/15.

Name of Audit	Participated Y/N	Percentage Participation
Perinatal Mortality (MBRRACE)	Y	100%
Neonatal (NNAP)	Y	100%
Fitting Children (CEM)	Y	100%
Childhood Epilepsy (RCPH National Childhood Epilepsy Audit	Y	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	Y	100%
Adult Community Acquired Pneumonia	Y	Data collection in progress
Chronic Obstructive Pulmonary Disease (British Thoracic Society)	Y	Case note review 100% Pulmonary Rehabilitation Data collection in progress
Pleural Procedures (British Thoracic Society)	Y	100%
Cardiac Arrest (National Cardiac Arrest Audit)	Y	100%
Adult Critical Care (Case Mix Programme)	Y	100%

National Emergency Laparotomy Audit	Y	Year 1 – 100% Year 2 – Data collection in progress
Diabetes (National Adult Diabetes Audit)	Y	Core Audit – No data entered Foot Care Audit - Data collection in progress Case note review – 100%
Rheumatoid and Early Inflammatory Arthritis	Y	Data collection in progress
UK IBD Audit (Biologics)	Y	100%
Hip, knee and ankle replacements (National Joint Registry)	Y	97%
Elective Surgery (National PROMS Programme)	Y	83%
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Y	100%
National Vascular Surgery, including CIA elements of the NVD	Y	100%
Older People (CEM)	y	94%
Mental Health [Care in Emergency Department] (CEM)	y	100%
Acute Myocardial Infarction and other ACS (MINAP)	Y	100%
Heart Failure Audit	Y	Data collection in progress
Stroke National Audit Programme (SSNAP)	Y	Ongoing Data Collection
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Y	Ongoing Data Collection
Renal Replacement Therapy (Renal Registry)	Y	Ongoing Data Collection
Lung Cancer (National Lung Cancer Audit)	Y	Ongoing Data Collection
Bowel Cancer (National Bowel Cancer Audit Programme)	Y	Ongoing Data Collection
Head and Neck Cancer (DAHNO)	Y	Ongoing Data Collection
Oesophago-gastric Cancer (National O-G Cancer Audit)	Y	Ongoing Data Collection
Falls and Fragility Fracture Programme (Include National Hip Fracture Database	Y	Ongoing Data Collection
Severe Trauma	Y	71%
Ulnar Neuropathy at the Elbow Testing	Y	100%
Prostate Cancer Audit	Y	Ongoing Data Collection
National Confidential Enquiries (NCEPOD)	y	Sepsis – 100% Gastrointestinal bleeding – 100% Acute Pancreatitis – Data collection in progress
National Audit of Blood Transfusion (Audit of Transfusion in Children and Adults with Sickle Cell Disease)	Y	Case note review – 100% Organisational questionnaire submitted

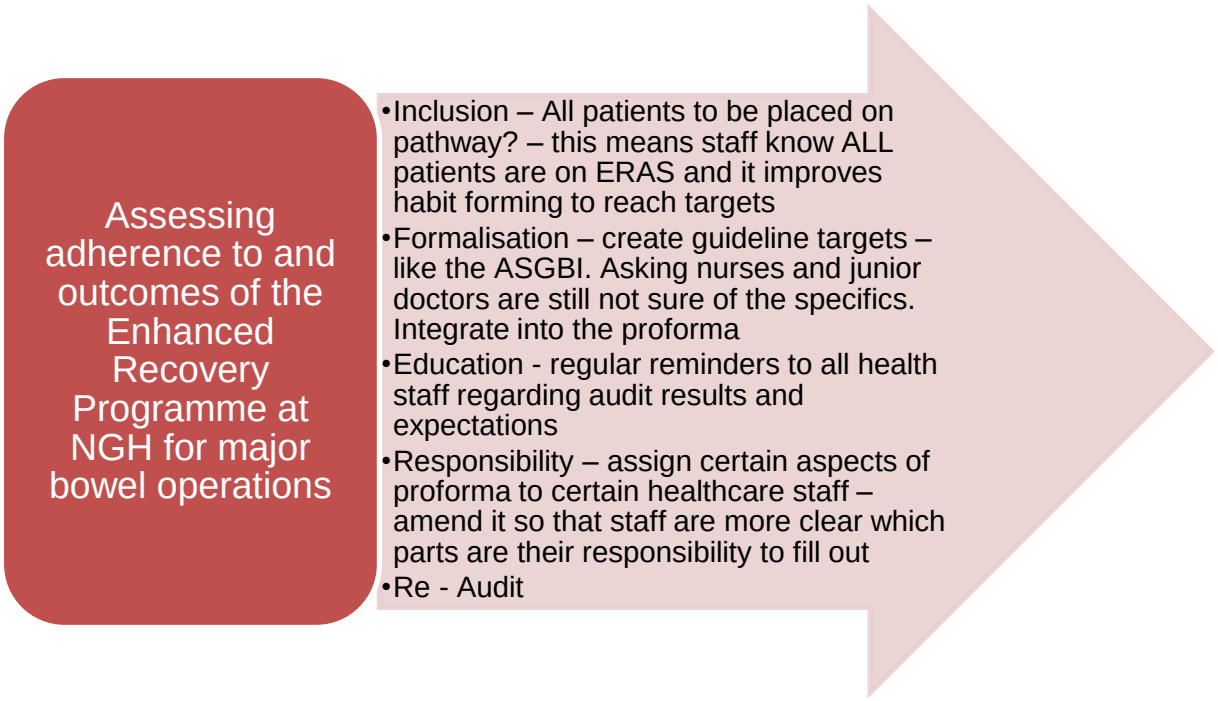
National reports (including hospital specific results where appropriate) are published at varying intervals. Most audits will report annually but some also provide quarterly updates. The audit department monitors the publication of reports and shares them with the clinical leads. The clinical leads are asked to review the report and recommendations, share the findings with their colleagues and assess the need for changes to their practice. The recommendations made are wide ranging and some examples of changes that have been made following the review of national audit recommendations are given below.

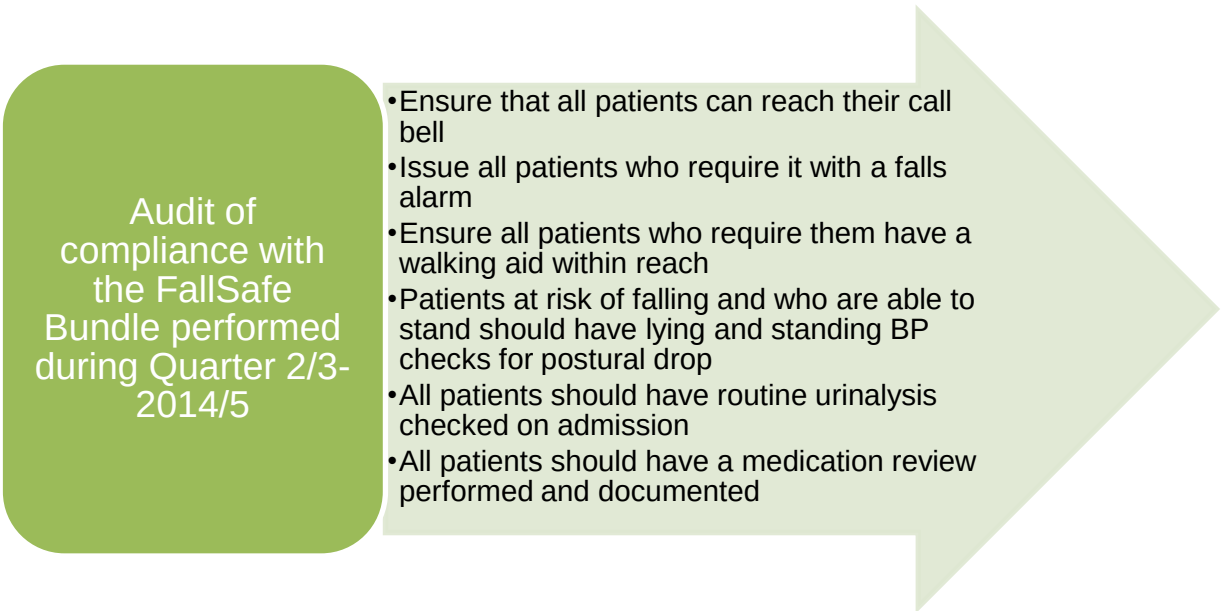
- Clinical effectiveness
    - Brachytherapy is being offered to more patients with prostate cancer.
    - Surgery following diagnosis with lung cancer is monitored to make sure that patients are offered all suitable treatments.
    - Ensure that antenatal steroids are used when appropriate.
    - Review of the patient pathway and implementation of the MHRA guidance for paracetamol overdose.
- Patient Safety
    - Allocation of a specific representative from pharmacy to work with the falls team and assess medication issues related to falls.
    - For patients undergoing emergency laparotomy, use risk scores to plan appropriate level care before, during and after the operation.
- Patient experience
    - Develop NGH drug information leaflets to help improve access to information for patients with inflammatory bowel disease.
    - Improve joint health and social care planning on discharge for patients following a stroke.
    - Ensure that a Cancer Nurse Specialist is present for all appointments to support patients receiving a diagnosis of lung cancer.
    - Provide access for patients with diabetes to pre-pregnancy counselling appointments.
- Service Improvement
    - Aim to “ring fence” beds for patients who have had a stroke so that they are admitted to a specialist stroke bed whenever possible.
    - Develop multidisciplinary team meetings to discuss the care of patients with complex inflammatory bowel disease.
- Communication
    - Use Electronic Discharge Notification document to communicate falls assessment to a general practitioners.
    - Develop an integrated pathway for blood transfusion to ensure that patients clearly understand why a transfusion is being recommended, what the risks and benefits are and if there is an alternative treatment option available.
    - Improve the use of self-management plans on discharge for all children with a diagnosis of asthma
- Data quality and documentation
    - Ensure all data entry fields are completed. This is very important to allow NGH results to be compared with those of other hospitals.
- Resources
    - Purchase of a new piece of equipment to ensure multiparametric MRI scans are more widely available to patients being treated for prostate cancer.
- Recruitment of Staff

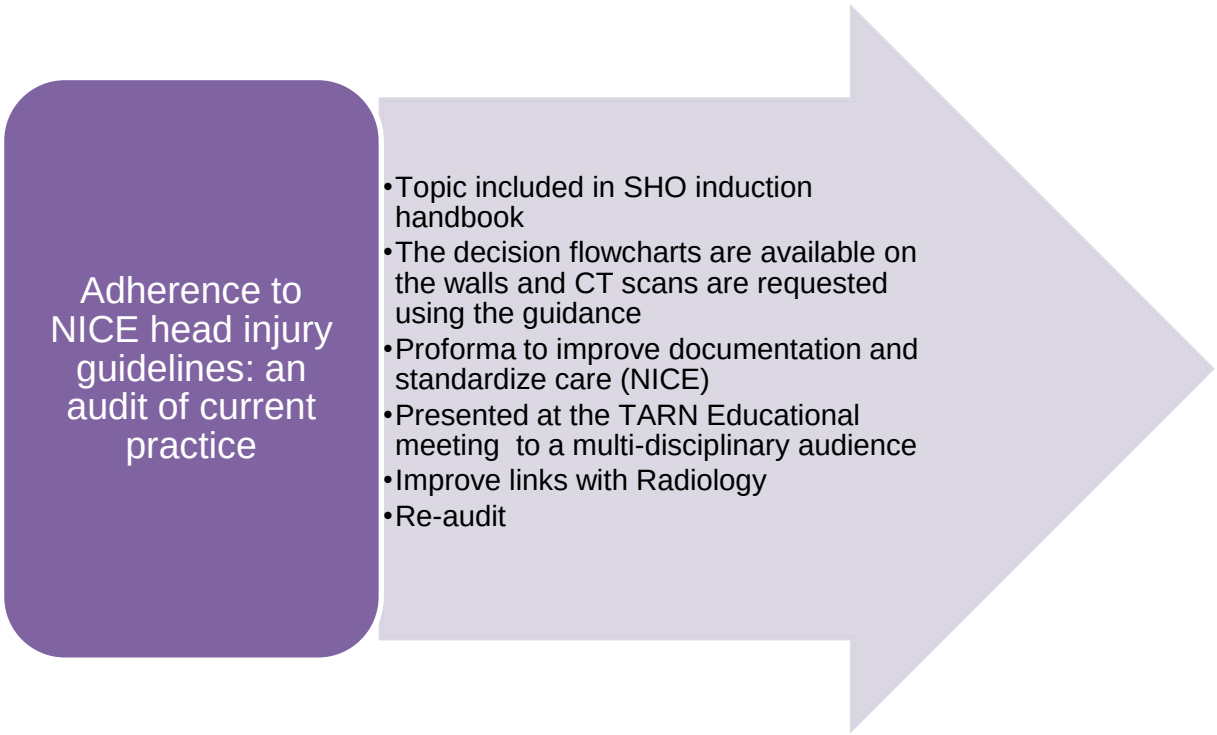
- Business cases have been developed for a part-time consultant and a specialist nurse to care for children with diabetes
- A business case has been developed for a dietician to support patients with head and neck cancers.

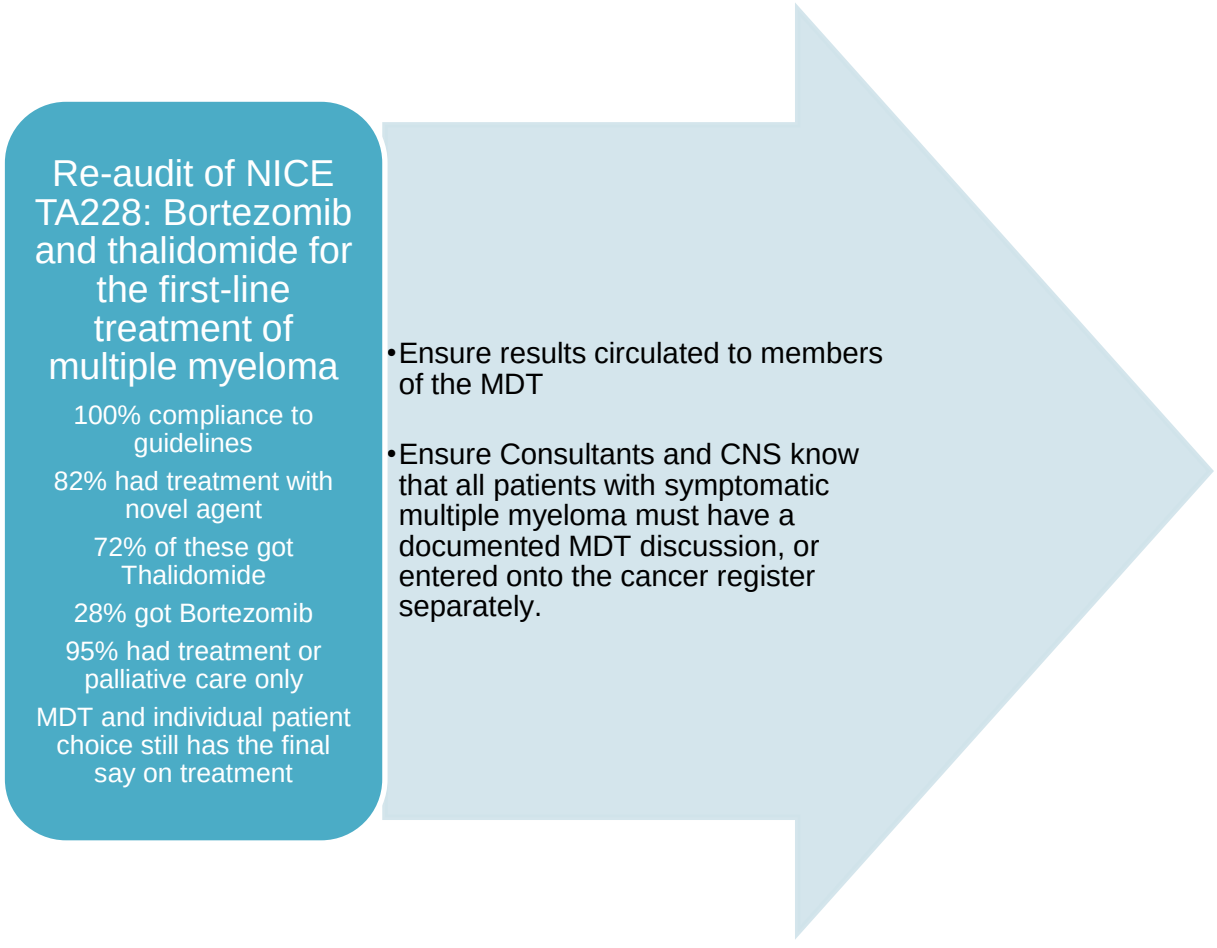
Local clinical audit

Over 150 local clinical audits were registered in 2014/15. Some examples are outlined below together with actions arising to improve clinical quality, patient experience and patient safety. All audits are multidisciplinary, patient safety focused, cancer specific, broad range of patient category, common conditions, major surgery and NICE compliance






Adherence to NICE head injury guidelines: an audit of current practice
•Topic included in SHO induction handbook
•The decision flowcharts are available on the walls and CT scans are requested using the guidance
•Proforma to improve documentation and standardize care (NICE)
•Presented at the TARN Educational meeting to a multi-disciplinary audience
•Improve links with Radiology
•Re-audit


Re-audit of NICE TA228: Bortezomib and thalidomide for the first-line treatment of multiple myeloma
100% compliance to guidelines
82% had treatment with novel agent
72% of these got Thalidomide
28% got Bortezomib
95% had treatment or palliative care only
MDT and individual patient choice still has the final say on treatment
•Ensure results circulated to members of the MDT
•Ensure Consultants and CNS know that all patients with symptomatic multiple myeloma must have a documented MDT discussion, or entered onto the cancer register separately.

Participation in Clinical Research

The number of patients receiving NHS services provided by Northampton General Hospital NHS Trust from April 2014 to March 2015 that were recruited during that period to participate in research approved by a research ethics committee was around 1500. To date 977 have recruited to studies on the National Institute of Health Research portfolio within this financial year

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

We have demonstrated our engagement with the National Institute for Health Research (NIHR) by participating in many clinical trials, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. Last year our performance put us in the top 100 performing Trust for R&D. Our engagement with clinical research also demonstrates NGH's commitment to testing and offering the latest medical treatments and techniques to our patients.

CQUINs

NHS Nene and NHS Corby Clinical Commissioning Groups are NGHs main commissioners. We receive part of our income from them through an agreed CQUIN scheme where prior to the start of the financial year negotiations take place to agree specialist projects which bring about innovative quality improvement for our patients. Our CQUIN agreements with them are both local agreements and part of a national agenda. In 2014/15 NGH agreed seven local CQUINs and three national CQUINs. NGH also have secondary commissioners known as Specialised Commissioners who are Leicester and Lincolnshire Area Team, NHS England. In 2014/15 NGH agreed three specialist CQUINs.

TYPE	CQUIN INDICATOR NAME	Status
LOCAL	Standardised approach to morbidity & mortality review	
	7 day working	
	Effective Discharge Arrangements	
	SSKIN Care Bundle Implementation	
	Indwelling urethral urinary catheter, insertion and on-going care. (CRUTI)	
	Care Bundles – Heart failure	
	Care Bundle - COPD	
NATIONAL	Friends and Family Test - Implementation of staff FFT	
	Friends and Family Test - Early implementation	
	Friends and Family Test - Increased or Maintained Response Rate	
	Friends and Family Test - Increased response rate in acute inpatient services	
	Reduction in the incidents of avoidable hospital acquired Grade 2 pressure tissue damage	
	Reduction in the incidents of avoidable hospital acquired Grade 3 pressure tissue damage	
	Reduction in the incidents of avoidable hospital acquired Grade 4 pressure tissue damage	
	Dementia – Find, Assess, Investigate and Refer	
	Dementia – Clinical Leadership	
	Dementia – Supporting Carers of People with Dementia	
SPECIALIST	Specialised Services Quality Dashboards	
	Improved access to breast milk in preterm infants	
	Standardising the Children's Cancer MDT decision making process	

CQUIN KEY

Fully Met	Partially Met	Not Met

Exception Report for those CQUINs in 2014/15 that have not been fully met.

- Reduction in the incidents of avoidable hospital acquired Grade 2 pressure tissue damage
    - There has been an increased focus on reducing the grades of pressure ulcers which has meant a rise in the number of grade 2 pressure ulcers and work is continuing to further reduce these including through the contractual local quality requirements

- Reduction in the incidents of avoidable hospital acquired Grade 3 pressure tissue damage
    - There has been an overall reduction in the number of pressure ulcers and work is continuing to further reduce these including through the contractual local quality requirements

- Improved access to breast milk in preterm infants
    - NGH did not have ultimate control over this CQUIN because it was down to parental choice to formula feed and whilst the team encouraged breastfeeding they had very little control over whether women chose to breastfeed or not.

For 2015/16, NGH have agreed with NHS Nene and NHS Corby Clinical Commissioning Groups six local CQUINs and four national CQUINs. NGH have also agreed seven specialist CQUINs with NHS England for 2015/16.

Local CQUINs Agreed for 2015/16	
CQUIN INDICATOR NAME	**IMPROVEMENT IN QUALITY FOR PATIENTS**
Electronic Holistic Needs Assessment and Care Planning	Cancer patients should have a holistic needs assessment (HNA) at key stages during their illness experience in line with national directives. Cancer patients should be encouraged to self-manage with support from the point of diagnosis.
AMBER Care Bundle	The AMBER care bundle provides a systematic approach to manage the care of hospital patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months. AMBER stands for: • **A**ssessment • **M**anagement • **B**est practice • **E**ngagement • **R**ecovery uncertain
Cardiac Rehabilitation	They should be supervised group exercise-based cardiac rehabilitation programmes for people with chronic heart failure that include education and psychological support and which culminates in a home based exercise programme.
Heart Failure – Single Point of Access	Continuation of Heart failure care bundle being available to increased patient population. To ensure patients with heart failure are reviewed by a member of the heart failure team prior to discharge. Patients who have been discharged with a diagnosis of heart failure have direct access to the same

	heart failure team up to 4 weeks post discharge. After 4 weeks post discharge, the direct access to the same heart failure team will shift from the patient to their GP.
Psychological Support in Stroke Care	To improve psychological care to NGH stroke patients. This will involve the development and implementation of a pathway to screen for mood and cognitive impairment post stroke and training for staff.
Improving delivery of Speech and Language therapy to Stroke patients at NGH	Development and implementation of a training package to nursing and therapy assistants in the Stroke Team at NGH to improve the delivery of speech and language therapy to stroke inpatients.

National CQUINs Agreed for 2015/16	
CQUIN INDICATOR NAME	**IMPROVEMENT IN QUALITY FOR PATIENTS**
Acute Kidney Injury (AKI)	This CQUIN focuses on AKI diagnosis and treatment in hospital and the plan of care to monitor kidney function after discharge, measured through the percentage of patients with AKI treated in an acute hospital whose discharge summary includes each of four key items of information. Improving the provision of information to GPs at the time of discharge will start to develop the knowledge base of GPs on AKI and will also positively impact on readmission rates for patients with AKI.
Dementia and Delirium • Find, Assess, Investigate, Refer and Inform • Staff Training • Supporting Carers	To improve care for patients with dementia or delirium during episodes of emergency unplanned care.
Sepsis • Sepsis Screening • Sepsis Antibiotic Administration	Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually. Of these some estimates suggest 12,500 could have been prevented. Problems in achieving consistent recognition and rapid treatment of sepsis are currently thought to contribute to the number of preventable deaths from sepsis
Reducing the proportion of avoidable emergency admissions to hospital	This should ensure that patients with ambulatory care sensitive conditions and similar conditions that do not normally require admission to a hospital bed receive highly responsive urgent care services outside of hospital.

Specialised Services CQUINs Agreed for 2015/16	
CQUIN INDICATOR NAME	**IMPROVEMENT IN QUALITY FOR PATIENTS**
Eligible patients receiving a NICE DG10 compliant test with provision of monitoring data	To help patients, who cannot be categorised as low or high risk by existing clinical practice, make more informed choices about whether to undergo chemotherapy through greater insight into their likelihood to benefit

Vascular services Quality improvement programme for outcomes of major lower limb amputation.	The QIPP scheme aims to utilise established quality improvement methodology to: • Improve mortality and morbidity rates • Reduce re-interventions and re-admissions • Reduce length of hospital stay including usage of critical care • Reduce unwarranted variation in the number of amputations being undertaken.
Multi-system auto-immune rheumatic diseases network	Earlier diagnosis and intervention, enhanced recognition of severe or refractory manifestations requiring specialised centre involvement, and earlier detection/prevention of relapse will reduce avoidable mortality and morbidity, reduce costs, and improve quality of life.
To reduce delayed discharges from ICU to ward level care by improving bed management in wards	This CQUIN aims to support removal of 24 hour delays in year 1 with a view to moving to national target within year 2.
2 Year outcomes for infants <30 weeks gestation	The monitoring of 2 year outcomes is critical both to the individual patient in terms of avoidance of late detection of neuro-development and/or learning disability and in order to inform future service development and improvement.
Standardising the Children's Cancer MDT decision making process	To focus on the clinical outcome and patient feedback resulting from MDT discussions
Neonatal Critical Care – Reducing Clinical Variation and Identifying Service Improvement Requirements by ensuring data completeness in the 4 NNAP Audit Questions identified	Where data are complete for an individual child and for a whole unit for these four questions, clinical quality will be improved through identification of areas for improvement and reduced clinical variation.

Local Quality Requirements

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

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

Quality Requirement	Included for 2014/15	Included for 2015/16
Making Every Contact Count	✓	✓
End of Life care	✓	✓
Enhanced Recovery	✓	✓
Ambulatory Care Pathways	✓	×
Patient Safety	✓	✓
Learning	✓	✓
Quality Care for Patients with a Learning Disability	✓	✓
Patient Experience	✓	✓
MUST Assessments	✓	✓
WHO Surgical Checklist	✓	✓
National Early Warning Score	✓	✓
Safeguarding	✓	✓
Cost Improvement Programmes	✓	✓
Workforce	✓	✓
VTE	✓	✓
Pressure Tissue Damage	×	✓
Service Specifications	×	✓
Quality Assurance regarding any trust sub-contracted services (list of services to be provided by the trust)	×	✓
Learning from Morbidity & Mortality Review Meetings	×	✓

PART SIX

Quality Assurance, Reporting and Monitoring

NHS Number and General Medical Practice Code Validity

The trust submitted records between April 2014 and January 2015 to the Secondary Users service for inclusion in the Hospital Episode Statistics which are included in the latest published data as below and compared to the previous year's results.

Period - Apr14 to Jan15	Valid NHS Number	Valid GMPC
Inpatients	99.7%	100%
Outpatients	99.9%	100%
A&E	98.2%	99.2%

Period – Apr 13 to Dec 13	Valid NHS Number	Valid GMPC
Inpatients	99.6%	100%
Outpatients	99.8%	100%
A&E	97.3%	98.7%

Comparison	Valid NHS Number	Valid GMPC
Inpatients	+0.1%	0.0%
Outpatients	+0.1%	0.0%
A&E	+0.9%	+0.5%

Information Governance Toolkit

The Information Governance Toolkit version 12 was completed and submitted on 27 March 2015 with an overall score of 82% and a return of 'Satisfactory'

For version 11 (2013/14) submission, one of the potential issues raised was the lack of a robust Corporate Records Management programme within the Trust. The Information Governance team put a plan in place for a rolling records management audit scheme. This enabled the Trust not only to exceed the Information Governance Toolkit expectation in requirement 604 for version 12 but also to ensure we are compliant with the NHS Records Management Code of Practice and the Data Protection Act (principle 5). This is an ongoing programme, dispatched in phases to ensure all departments within the Trust are audited within a three year cycle resulting in a comprehensive corporate records inventory.

There are however, 2 main areas which require ongoing improvement. These are:

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

team will be implementing new initiatives to improve the Trust's compliance figures. The final training figure at submission was up 8.7% from the previous year (2014)

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

Action plan, a work schedule and a comprehensive information governance audit programme are being developed for a more proactive and robust approach to the Information Governance Toolkit, with particular attention paid to the above areas. This is monitored through the Information Governance Leads Board chaired by the Head of Information and Data Quality with regular reporting to the Senior Information Risk Owner and the Assurance, Risk and Compliance Group.

Clinical Coding Error Rate

Objective/Method

To assess Northampton General Hospital NHS Trust General Medicine coding performance against recommended achievement levels for Information Governance Toolkit Requirement 505. Exactly 200 episodes were audited using the NHS Classification Service Clinical Coding Audit Methodology Version 8.0.

Results

	% Accuracy	IG Level 2 Requirements	IG Level 3 Requirements
Primary Diagnosis	92.00%	90.00%	95.00%
Secondary Diagnoses	85.43%	80.00%	90.00%
Primary Procedure	92.05%	90.00%	95.00%
Secondary Procedures	89.61%	80.00%	90.00%

Conclusions

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

The diagnostic coding highlighted areas of good practice though there were some basic coding errors were found. A possible source of some of those errors could be related to the use of the text search facility on the encoder without referencing the classification books. A

number of secondary diagnostic errors associated with the omission of mandatory or relevant clinical conditions were noted.

Procedurally, the standard of coding was good within a limited audit of this area. Errors were noted around ventilation and diagnostic imaging which made up the majority of the auditable procedures anyhow.

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

Recommendations

- For the Clinical Coding Manager to highlight the rule around ventilation and intubation and ensure it is understood.
- For the Clinical Coding Manager to highlight the errors around missing echocardiograms to ensure all imaging is captured.
- To review the use of the Encoder system and the potential for error given that READ codes will be unsupported from April 2016 onwards.

Core Quality Indicators

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

The performance of data for NGH is shown for the reporting period as indicated and the data contained within the 2013/14 Quality Account, save as stated otherwise. Also included, where available, is the national average, the highest and lowest information available. All information for the reporting period has been taken from the Health and Social Care Information Centre and the links provided therein.

NHS Outcomes Framework Domain	NGH Performance		National Performance		
	Reporting Period 2014/15	*NGH Quality Account 2013/14*	*Reporting Period Ave.*	*Reporting Period High*	*Reporting Period Low*
Domain 1 – Preventing people from dying prematurely and Domain 2 – Enhancing quality of life for people with long term conditions					

NHS Outcomes Framework Domain	NGH Performance		National Performance		
	Reporting Period 2014/15	*NGH Quality Account 2013/14*	*Reporting Period Ave.*	*Reporting Period High*	*Reporting Period Low*
The data made available to the trust by the Information Centre with regard to the value and banding of the summary hospital-level mortality indicator (SHMI) for the trust for the reporting period	98 Band 2*	113 Band 1* 101* (2013/14)	100 Band 2* (Oct 13-Sep14)	119 Band 1* (Oct 13-Sep14)	59 Band 3* (Oct 13-Sep14)
*SHMI banding: • SHMI Banding = 1 indicates that the trust's mortality rate is 'higher than expected' • SHMI Banding = 2 indicates that the trust's mortality rate is 'as expected' • SHMI Banding = 3 indicates that the trust's mortality rate is 'lower than expected'					
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this rate, and so the quality of its services by undertaking regular morbidity and mortality meetings to share learning across the trust					
The data made available to the trust by the Information Centre with regard to the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period	26.6%	32%	24.77% (Jun13-Jun14)	49% (Jun13-Jun14)	0% (Jun13-Jun14)
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this percentage, and so the quality of its services by prioritising end of life care and placing great importance on quality palliative care					
Domain 3 – Helping people to recover from episodes of ill health or following injury					
The data made available to the trust by the Information Centre with regard to the trust's patient reported outcome measures scores for (during the reporting period):					
• Groin hernia surgery (average health gain)	0.075 provisional	0.086 (provisional Apr13 – Mar 14)	0.084 (provisional Apr14-Dec14)	0.155 (provisional Apr14-Dec14)	0.009 (provisional Apr14-Dec14)
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this percentage, and so the quality of its services by developing the work undertaken in theatres					
• Varicose vein surgery (average health gain)	N/A	N/A (provisional Apr13 – Mar 14)	-8.8 (provisional Apr14-Dec14)	-15.267 (provisional Apr14-Dec14)	7.572 (provisional Apr14-Dec14)
N/A = Not Applicable due to too few procedures to apply the model (less than 30 procedures per year)					
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this percentage, and so the quality of its services by developing the work undertaken in theatres					
• Hip replacement surgery (average health gain)	22.491 provisional	23.526 (provisional Apr13 – Mar 14)	21.875 (provisional Apr14-Dec14)	25.167 (provisional Apr14-Dec14)	19.184 (provisional Apr14-Dec14)

NHS Outcomes Framework Domain	NGH Performance		National Performance		
	Reporting Period 2014/15	*NGH Quality Account 2013/14*	*Reporting Period Ave.*	*Reporting Period High*	*Reporting Period Low*
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this percentage, and so the quality of its services by developing the work undertaken in theatres					
• Knee replacement surgery (average health gain)	18.535 provisional	19.204 (provisional Apr13 – Mar 14)	16.313 (provisional Apr14-Dec14)	19.834 (provisional Apr14-Dec14)	12.835 (provisional Apr14-Dec14)
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this percentage, and so the quality of its services by developing the work undertaken in theatres					
The data made available to the trust by the Information Centre (during the reporting period) with regard to:					
• The percentage of patients aged 0-14 readmitted to hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust	9.3%	10.9%	Not available	Not available	Not available
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this percentage, and so the quality of its services by improving discharge planning with an aim to reduce readmissions					
• The percentage of patients aged 15 or over readmitted to hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust	8.7%	6.9%	Not available	Not available	Not available
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this percentage, and so the quality of its services by improving discharge planning with an aim to reduce readmissions					
Domain 4 – Ensuring that people have a positive experience of care					
The data made available to the trust by the Information Centre with regard to the trust's responsiveness to the personal needs of its patients during the reporting period	68.6%	68.6%	68.7% (2013/14)	84.2% (2013/14)	54.4% (2013/14)
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this percentage, and so the quality of its services by further developing positive patient experience					

NHS Outcomes Framework Domain	NGH Performance		National Performance		
	Reporting Period 2014/15	*NGH Quality Account 2013/14*	*Reporting Period Ave.*	*Reporting Period High*	*Reporting Period Low*
The data made available to the trust by the Information Centre with regard to the percentage of staff employed by, or under contract to, the trust who would recommend the trust as a provider of care to their family or friends	52%	56%	67% (2014)	93% (2014)	38% (2014)
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this percentage, and so the quality of its services by further developing positive patient experience					
Friends and Family Test – Patient. The data made available by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre for all acute providers of adult NHS funded care, covering services for:					
• for inpatients	86%	Not reported	95% (Mar 15)	100% (Mar 15)	78% (Mar 15)
• patients discharged from Accident and Emergency (types 1 and 2)	89%	Not reported	87% (Mar 15)	99% (Mar 15)	58% (Mar 15)
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this percentage, and so the quality of its services by encouraging a culture of reporting					
Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm					
The data made available to the trust by the Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	97% (Feb15)	96.75%	96% (Feb15)	100% (Feb15)	75% (Feb15)
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this percentage, and so the quality of its services by further developing systems to ensure patients review risk assessments					
The data made available to the trust by the Information Centre with regard to the rate per 100,000 bed days of cases of C. difficile infection reported within the trust amongst patients aged 2 or over during the reporting period	11.21	11.10 (reported number of cases 26)	13.9 (Apr13-Mar14)	37.1 (Apr13-Mar14)	0.0 (Apr13-Mar14)
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this rate, and so the quality of its services by accurately sending stool samples, prompt isolation of					

NHS Outcomes Framework Domain	NGH Performance		National Performance		
	Reporting Period 2014/15	*NGH Quality Account 2013/14*	*Reporting Period Ave.*	*Reporting Period High*	*Reporting Period Low*
patient's with diarrhoea and improving antimicrobial stewardship					
The data made available to the trust by the Information Centre (during the reporting period) with regard to:					
• The number of patient safety incidents reported within the trust	10,192	9,963 (2013/14)	4,196 (Apr14-Sep14)	12,020 (Apr14-Sep14)	35 (Apr14-Sep14)
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this number, and so the quality of its services by further encouraging an open reporting culture					
• The rate (per 1,000 bed days) of patient safety incidents reported within the trust	32.44 (Apr14-Sep14)	8.27	36.0 (Apr14-Sep14)	74.96 (Apr14-Sep14)	0.24 (Apr14-Sep14)
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this rate, and so the quality of its services by further encouraging an open reporting culture					
• The number of such patient safety incidents that resulted in sever harm or death	32	51 (2013/14)	20 (Apr14-Sep14)	97 (Apr14-Sep14)	0 (Apr14-Sep14)
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this number, and so the quality of its services by further encouraging an open reporting culture					
• The percentage of such patient safety incidents that resulted in sever harm or death	0.31%	0.53%	1% (Apr14-Sep14)	1.9% (Apr14-Sep14)	0% (Apr14-Sep14)
The Northampton General Hospital NHS Trust considers that this data is as described for the following reasons. It has been verified by internal and external quality checking. The Northampton General Hospital NHS Trust has taken the following actions to improve this percentage, and so the quality of its services by further encouraging an open reporting culture					

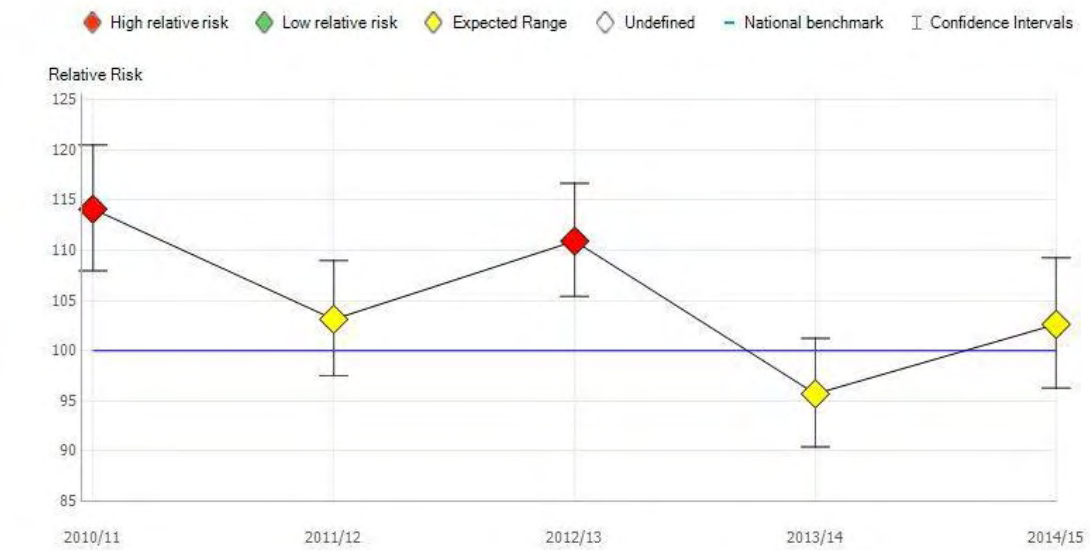
Hospital Mortality Monitoring

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

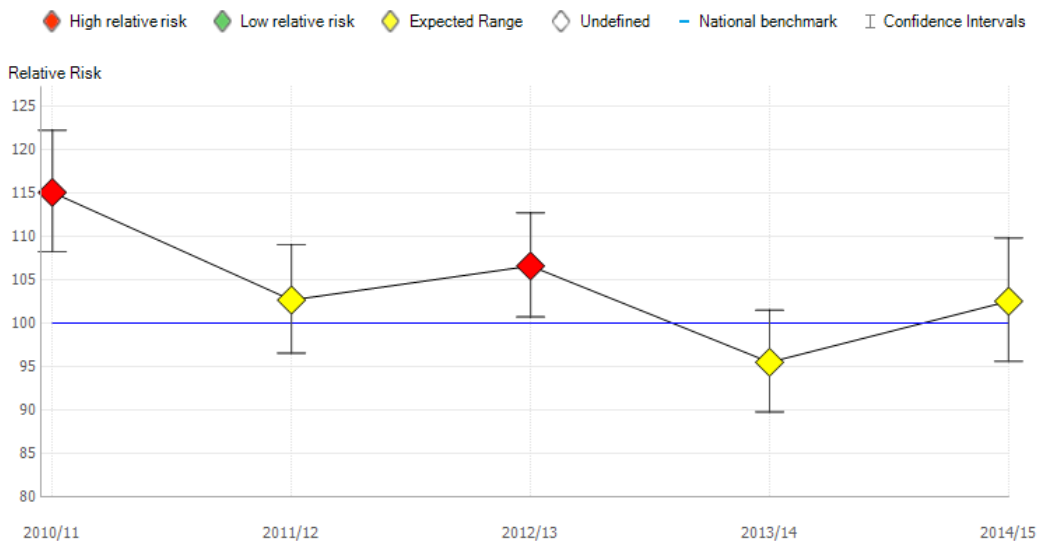
The information is reviewed in detail each month by the Associate Medical Director, and a structured report is presented to the Medical Director and discussed at CQEG and Trust Board Quality Governance Committee. The findings and planned actions for any areas of concern are presented bimonthly to the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

During 2014 the pathways for management of patients with leukaemia's, non-Hodgkin's lymphoma, biliary tract procedures and pancreatic cancer were reviewed and action plans are in progress. CQC uses HSMR 56 as part of its assessment process when inspecting Trusts.

HSMR 100

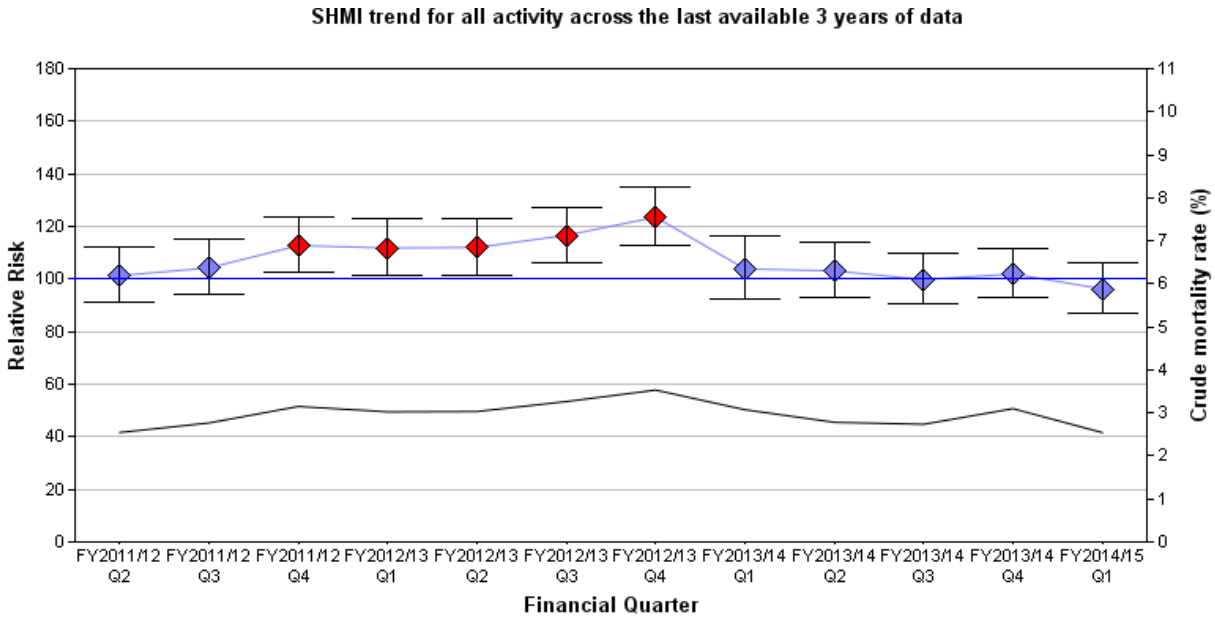


HSMR [56]



Both of the above measures (HSMR 100 and HSMR (56) show improvement since 2010. Performance during 2013/14 was as expected; performance to December 2014 remains within the expected range.

A third metric, SHMI [Summary Hospital-level Mortality Indicator] is also used, provided by DH 9 months in arrears since 2010. It looks not only at hospital mortality, but also deaths that occur within a month of discharge, which may therefore reflect the care received outside the hospital. It also has a different casemix adjustment method, and so is not directly comparable to HSMR. Trust performance assessed by this method has returned to expected levels during 2013/14 and this progress has been maintained in the first quarter of 2014/15.



In 2014/15 the Trust implemented a programme to enable clinicians to monitor performance in their own specialty and review all deaths to ensure that standards of care are appropriate.

The trust monitors its performance against various indicators which are used to inform the trust and external organisations of progress and is used to inform decisions about service improvement. The corporate scorecard for each quarter is shown below.

2014/15 - Corporate scorecard

	Indicator	Target	Q1	Q2	Q3	Q4
Caring	Complaints rate per bed days	**None**				
	Complaints responded to within agreed timescales	**90%**				
	Friends & Family Test: Inpatient score	**70**				
	Friends & Family Test: A&E score	**60**				
	Friends & Family Test: Maternity score	**70**				
	Mixed Sex Accommodation	**0**				
	Patients in last days of life with a care plan in place	**None**				
	Transfers: Patients moved with a risk assessment completed	**None**				

	Indicator	Target	Q1	Q2	Q3	Q4
Effective	Emergency re-admissions within 30 days (adult elective) ****	**None**				
	Emergency re-admissions within 30 days (adult non - elective) ****	**None**				
	Length of stay - All	**None**				
	Length of stay - Elective	**None**				
	Length of stay - Non Elective	**None**				
	Maternity: C Section Rates - Total	**<25%**				
	Maternity: C Section Rates - Emergency	**<14%**				
	Maternity: C Section Rates - Elective	**<10%**				
	Mortality: SHMI*	Within expected range				
	Mortality: HSMR**					
	Mortality: HSMR - Weekend**					
	Mortality: HSMR - Week day**					
	Mortality: Low risk conditions**					
	Mortality: Maternal Deaths	**0**				
	NICE compliance	**80%**				
	Number of patients cared for in an escalation area	**None**				
	# NoF - Fit patients operated on within 36 hours	**80%**				
	Stroke patients spending at least 90% of their time on the stroke unit	**80%**				
	Suspected stroke patients given a CT within 1 hour of arrival	**50%**				

	Indicator	Target	Q1	Q2	Q3	Q4
Safe	C-Diff	**Ave. 3 per mth**				
	Dementia: Case finding	**90%**				
	Dementia: Initial diagnostic assessment	**90%**				
	Dementia: Referral for specialist diagnosis/follow-up	**90%**				
	Falls per 1,000 occupied bed days	**5.8**				
	Harm Free Care (Safety Thermometer)	**93%**				
	Medical Notes: Availability for clinics***	**99%**				
	Medical notes: Documentation - Doctors	**95%**				
	Medical notes: Documentation - Nurses	**95%**				
	Medical notes: Documentation - Allied Health	**95%**				
	Medication incidents that cause significant harm	**0**				
	MRSA	**0**				
	Never event incidence	**0**				
	Pressure Ulcers: Total grade 3 & 4 hospital acquired (incidence)	**None**				
	Pressure Ulcers: Avoidable grade 3 & 4 (incidence) - verification of current month required prior to publishing	**3**				
	Pressure Ulcers: Avoidable grade 2 (incidence) - verification of current month required prior to publishing	**7**				
	Number of Serious Incidents Requiring Investigation (SIRI) declared during the period	**None**				
	Overdue CAS alerts	**0**				
	Overdue CAS alerts	**0**				
	UTI with Catheters (Safety Thermometer-Percentage new)	**0.4%**				
	VTE Risk Assessment	**95%**				
	Transfers: Patients transferred out of hours	**0**				
	Percentage of patients cared for outside of specialty	**<10%**				
	Percentage of discharges before 10.00 a.m.	**>25%**				
	Number of cancelled operations due to bed availability	**0**				

	Indicator	Target	Q1	Q2	Q3	Q4
Responsive	A&E: Proportion of patients spending more than 4 hours in A&E	**95%**				
	A&E: 4hr SitRep reporting	**95%**				
	A&E: 12 hour trolley waits	**0**				
	Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	**99%**				
	Discharge: Number of medically fit patients awaiting discharge (average daily)	**None**				
	Cancer: Percentage of 2 week GP referral to 1st outpatient appointment	**93%**				
	Cancer: Percentage of 2 week GP referral to 1st outpatient - breast symptoms	**93%**				
	Cancer: Percentage of patients treated within 62 days of referral from screening	**90%**				
	Cancer: Percentage of patients treated within 62 days of referral from hospital specialist	**80%**				
	Cancer: Percentage of patients treated within 62 days urgent referral to treatment of all cancers	**85%**				
	Cancer: Percentage of patients treated within 31 days	**96%**				
	Cancer: Percentage of patients for second or subsequent treatment treated within 31 days - surgery	**94%**				
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - drug	**98%**				
	Cancer: Percentage of Patients for second or subsequent treatment treated within 31 days - radiotherapy	**94%**				
	Operations: Urgent Operations cancelled for a second time	**0**				
	Operations: Number of patients not treated within 28 days of last minute cancellations - non clinical reasons	**0**				
	RTT for admitted pathways: Percentage within 18 weeks	**90%**				
	RTT for non- admitted pathways: Percentage within 18 weeks	**95%**				
	RTT waiting times incomplete pathways	**92%**				
	RTT over 52 weeks	**0**				

Well Led	Indicator	Target	Q1	Q2	Q3	Q4
	Friends & Family: NHS England Inpatient response rate	**25%**				
	Friends & Family: NHS England A&E response rate	**15%**				
	Friends & Family: NHS England Maternity response rate	**20%**				
	Friends & Family: % of staff that would recommend the trust as a place of work	**None**				
	Data quality of Trust returns to HSCIC (SUS)	**None**				
	Staff: Trust turnover rate	**8%**				
	Staff: Trust level sickness rate (annaul average)	**3.8%**				
	Staff: Trust level vacancy rate - All	**>12% R, 7-12% A, <7% G**	**Not available**			
	Staff: Trust level vacancy rate - Doctors					
	Staff: Trust level vacancy rate - Nurses					
	Staff: Trust level vacancy rate - Other					
	Staff: Temporary costs & overtime as a % of total pay bill	**None**				
	Staff: Percentage of staff with annual appraisal *(Target raised to 85% from Oct 14)*	**85%**				
	Staff: Percentage of all trust staff with mandatory training compliance *(Target raised to 85% from Oct 14)*	**85%**				
	Staff: Percentage of all trust staff with role specific training compliance *(Target raised to 85% from Oct 14)*	**85%**				

Finance	Indicator	Target	Q1	Q2	Q3	Q4
	Income v Forecast - YTD	**Fav**	**Not available**			
	Expenditure Pay v Forecast - YTD	**Fav**				
	Expenditure Non Pay v Forecast - YTD	**Fav**				
	Surplus / (Deficit) v Forecast - YTD	**Fav**				
	CIP delivery v. Plan YTD	**Fav**				

2014/15 – Review of Performance, Services and Quality

Review of Performance

The table below shows a snapshot of the Trusts performance activity up to 31 March 2015 with a comparison to the previous year's activity.

Activity	2013/14	2014/15	Difference	% Difference
Emergency inpatients	35,907	40,349	4,442	12%
Elective inpatients	7,329	6,208	-1,121	-15%
Elective day cases	38,052	38,346	294	1%
New outpatient attendances – consultant led	77,973	80,037	2,064	3%
Follow-up outpatient attendances – consultant led	152,425	149,977	-2,448	-2%
New outpatient attendances – nurse led	39,775	38,571	-1,204	-3%
Follow-up outpatient attendances – nurse led	91,535	114,953	33,418	41%
Total number of outpatient DNAs	26,513	29,913	3,400	13%
Patients seen in A&E	107,786	109,305	1,519	1%
Number of babies born	4,573	4,685	112	2%
Average length of stay (in days)	4.60	3.92	-1	-15%

Review of Services

During 2014-15 NGH provided and/or sub-contracted 52 NHS services.

The income generated by the NHS services reviewed in 2014-15 represents 100% of the total income generated from the provision of NHS services by NGH for the reporting period 2014-15.

Review of Quality

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

The Assurance Risk and Compliance Group and Clinical Quality Effectiveness Group all meet monthly and receive differing assurance reports on aspects of quality and governance,

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

PART SEVEN

External Stakeholder Statements

NHS Nene and NHS Corby Clinical Commissioning Groups

The Northampton General Hospital (NGH) NHS Trust annual quality account for 2014-15 has been reviewed by NHS Nene Clinical Commissioning Group (Nene CCG) and NHS Corby Clinical Commissioning Group (Corby CCG). It is noted that the quality account was reviewed whilst in draft format.

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

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

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

The trust has participated in all applicable National Clinical Audits and National Confidential Enquiries. The report highlights the learning from local audit and whilst research and innovation is mentioned it is not clear what clinical research patients were involved in.

Whilst the account contains details of CQUIN schemes for 2014/15 it is suggested that it would be positive to identify the impact for patients of the CQUIN schemes achieved and ensure that the final version correctly identifies all CQUINs not achieved and any actions taken by the trust.

We note the positive feedback received from patients, the trust might consider including some of the feedback from 'you said, we did' which evidences how they have responded to challenging feedback.

Whilst the quality account does discuss mortality, this is not easy to understand without some knowledge of mortality and therefore it does not highlight the significant improvements the trust has made in this area over the last year.

The draft quality account includes actions required following the CQC inspection in January 2014 and actions that have been taken.

Activity against Quality, Innovation, Productivity and Prevention is not clear within the account and there is no reference as to how any cost improvement programmes have impacted on the quality of care. It may have been helpful to include this information.

In the Core quality indicators section the data reporting period used is not consistently the most recent data available and the same time period for all indicators. Only one rather than last two reporting periods are used. Readmission data relates to patients who are aged 0-14

and 15 and over, this should relate to patients who are aged 0-15years and 16 years and over. Some of the data used does not match the data provided by the Health and Social Care Information Centre (HSCIC). Where the trust is planning on taking actions to improve these are not clearly articulated.

The CCG believe that it may be more useful to include numerical data in addition to a RAG rating on the corporate scorecard used.

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

Healthwatch Northamptonshire

Healthwatch Northamptonshire (HWN) are pleased this Quality Account demonstrates patient experience is an integral component of quality at NGH.

2015/2016 planned quality priorities

HWN commend NGH for consulting external stakeholders when selecting their quality priorities and that 'Listen to Our Patients' has been included. We agree with the importance of ensuring all complaints are robustly investigated and result in learning and would emphasise the need to respond to complainants in a timely, open and detailed way. We recommend that the objectives for this priority are widened to include strengthening systems for gathering and learning from positive and negative feedback from other patients, relatives and carers.

We agree that 'Supporting Patients in Getting Home' and 'Improve End of Life Care' are two specific priorities to include. Ensuring patients can be discharged from hospital in a timely manner with an appropriate package of support in place is a key step to reducing system pressures. HWN suggests NGH also prioritise developing their competencies in partnership working to enable them to work more effectively with others. An example of positive working in this area (not referenced here) is the introduction last autumn of the psychology liaison service provided by NHFT into A&E and most wards (particularly the elderly wards for dementia support).

We talked to a relative of two patients who received end of life care at NGH within the last year. They were more critical of the care received at NGH compared to other settings. We heard examples of clinical staff who had not been adequately trained in management of end of life care, poor treatment and pain management, and a lack of care and dignity. This account (and those of earlier experiences) demonstrates a need to train clinical staff in particular, in caring for end of life patients and communicating with their relatives, and this should be included in the quality priority objectives.

2014/15 review of quality priorities and performance

HWN would like to see specific reference to the NGH activities that take place at Danetre, Isebrook and Corby Community Hospitals. HWN, having heard from members of the public

regarding the closure of cardiac rehab services at Danetre, made representations to NGH on their behalf, and were encouraged that NGH took this seriously and re-introduced services last year, demonstrating a willingness of NGH to operate as a learning organisation.

Effective Patient Discharge: Based on the information given we agree NGH have made some progress but that discharge should remain a quality priority.

End of Life Care: Whilst some progress has been reported, more needs to be done to ensure that a larger number of staff are trained in good, person-centred end of life care.

Pain Management: We hope that the progress started here will continue and are particularly concerned about the lack of timely pain relief given during the end of life experiences we heard.

Patient Experience: HWN attends the NGH Patient and Carer Experience and Engagement Group. We see that patient experience at NGH is monitored and valued and that initiatives aiming to improve patient experience have been introduced. The membership of this group does not often match the attendance seen. NGH is addressing this and encouraging senior colleagues to attend. We are concerned about the recent disbanding of the Shadow Governors and the impact this has on patient engagement and think this was poorly communicated to the Shadow Governors. We also hope the new patient engagement network and subgroup structure allows for engaging with a wide range of patients and carers not always reached or represented.

Complaints: As well as learning from individual complaints we recommend developing plans to address some of the most common themes arising overall.

Additional HWN patient experience findings from 2014-15

In April 2014 HWN surveyed 173 people using A&E at NGH just after the minor injuries and minor illnesses service relocated there. Some patients were not clear about the changes and signage was poor. We also observed that waiting time and other information was not communicated well. NGH have acted on some of our recommendations resulting in improvements to the information provided in the waiting area and staff training. The survey was repeated in May 2015 and we will share our finding with NGH.

Additional feedback received from the public in the past year includes:

- Three people frustrated about the cancellation of outpatient appointments or surgery, two of which related to ophthalmology. One was cancelled at the very last minute and two were cancelled twice.
- Two people thought the food choices were very poor for vegans or vegetarians and one told us they saw elderly people struggling to eat without assistance.

45% of 363 respondents to our Autumn 2014 countywide survey of people's experience of health and care had used NGH in the last 12 months. 30% rated NGH as 'Excellent', 29% as 'Good', 27% as 'Satisfactory' and 14% as 'Poor'. Respondents wanted HWN to take action on NGH A&E waiting times, waiting times for appointments, better access and parking, the quality of services provided to patients and the availability of beds.

We have concerns about the planned closure of the X-ray unit run by NGH at the Weston Favell Health Centre. We have not yet been able to form an opinion on the merits of this decision as we have not received the impact assessment conducted in 2014 which informed this decision. We are not aware of proper or adequate (or indeed any) consultation or engagement with the public using the Weston Favell service by NGH or Nene Clinical Commissioning Group to ascertain impact on users of the service and local communities.

Summary

In our opinion this Quality Account gives a balanced account of quality at NGH and gives evidence that NGH is a learning organisation. Their quality priorities seem appropriate but we recommend the points above are considered. We would like to see NGH strengthen its commitment to further embedding patient engagement and hearing the patient experience, including at Board level.

Northamptonshire County Council Health and Social Care Overview and Scrutiny Committee

Northamptonshire County Council's Health, Adult Care & Wellbeing Scrutiny Committee formed a working group of its members to consider a response to your Quality Accounts 2014-15. Membership of the working group was as follows:

- Councillor Sally Beardsworth
- Councillor Eileen Hales
- Mr Andrew Bailey (Northamptonshire Carers Representative)

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

- The Working Group were disappointed that complaints were only included within statistics. They would have preferred to be able to read anonymous details of complaints with details of how these had been addressed in a way that improved the service.
- The Working Group would have also liked to see examples of compliments.
- The Working Group were disappointed there was no input from the Nursing and Medical Director.
- The Quality Account appeared to focus on work undertaken on the hospital site. The Working Group however, felt it was equally important to include information on the work undertaken with other organisations such as the Northamptonshire County Council's Social Care Department when discharging patients from hospital care.
- Following on from the above point, information would also have been appreciated on the work undertaken with others such as carers, occupational therapists and the voluntary sector to prevent re-admission to hospital.

- It was felt more information could have been included about Substance Misuse Specialists. For example, who they were and where they provided treatment. It was felt anonymous case studies would have been informative.
- There appeared to be no details on how winter pressures were managed and addressed.
- Some of the information provided was difficult to judge because it was not fully explained. For example there was uncertainty around the data in the trend analysis in the section on complaints as it appeared to only cover 23% of the total number of complaints received.
- A further example of the above point was in the section on the Information Governance Toolkit which stated in relation to training that it was '8.7% up from the previous year'. This was difficult to judge as no figures were given for the previous year.
- The Working Group felt the information about NGH at the beginning of the document was helpful.
- The Working Group felt the contents page should be numbered.

The Working Group also requested the following information:

- An explanation of the bands that were referred to in the tables relating to Core Quality Indicators.

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

- Although there appeared to be some consistencies in the quality accounts produced, the Working Group felt a standard template would be useful

KPMG

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

We are required to perform an independent assurance engagement in respect of Northampton General Hospital NHS Trust's Quality Account for the year ended 31 March 2015 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following indicators:

- Rate of clostridium difficile infections: and
- Friends and family test patient element score.

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

Respective responsibilities of the Directors and the auditor

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

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 ("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 2014 to June 2015;
- papers relating to quality reported to the Board over the period April 2014 to June 2015;
- feedback from the Commissioners dated 27 May 2015;
- feedback from Local Healthwatch dated 26 May 2015;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey 2014;
- the Head of Internal Audit's annual opinion over the trust's control environment reported to the Audit Committee on 27 May 2015; and
- the annual governance statement dated 1 June 2015.

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

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

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

Assurance work performed

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

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

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

Limitations

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

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

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

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

KPMG LLP

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29 June 2015

PART EIGHT

Abbreviations List

Abbreviations

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

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

If you would like more information please contact:

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