Northampton General Hospital NHS
NHS Trust

2011/12

Quality Account

"Our aim is to ensure that the trust moves towards the goal of delivering the safest, most clinically effective patient focused services that we can."

Part 1

Part 2

Part 3

Part One

Statement on quality from the Chief Executive

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

I am therefore delighted and proud to share with you the third annual Quality Account for Northampton General Hospital NHS Trust. Our vision is that 'Northampton General Hospital NHS Trust is committed to providing the very best care for all of our patients'. This requires the Trust to be recognised as a hospital that delivers safe, clinically effective acute services focussed entirely on the needs of the patient, their relatives and carers. To support this, our recently reviewed Quality Strategy covers all aspects of the quality agenda and focuses on Patient Safety, Effectiveness of Care and Patient Experience enabling us to involve and engage with our patients, clinicians and staff to ensure that quality is at the heart of all that we do.

The Quality Account for 2011/12 describes how NGH has continued to develop over the last year and includes reviews of our quality performance towards the delivery of our quality priorities; and describes other quality improvements that have been made during the year. We have spent some time in the earlier part of this year, developing our quality priorities for 2012/13, involving patients, staff, members of the public and shadow governors to ensure that we focus on those areas that are most important to the population we serve. These priorities are presented in part 2 of this document.

We have faced many challenges over the last year and our staff work extremely hard to provide the level of care that should be expected of any healthcare provider whilst continuously progressing the quality agenda. We will continue to seize opportunities to develop highly reliable, high quality, timely and appropriate care across all of our services to ensure that our strategic intent for quality is realised.

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

Dr Gerry McSorley
Chief Executive
Northampton General Hospital NHS Trust

Signature

Part One

Statement of directors' responsibilities in respect of the quality account

The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Account for each financial year. The Department of Health 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;
- 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, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

27th June 2012 Chairman

27th June 2012 Chief Executive

Part Two

Looking forward
– Our Priorities for Quality Improvement during 2012/13

Part 2 is the section in our Quality Accounts that looks forward and identifies our quality priorities for 2012/13. It also includes our statements of assurance from the Board.

How the Quality Priorities for 2012/13 were identified

Our quality priorities for 2012/13 have been developed through wide involvement and consultation. A 'long list' of 7 priorities was derived from different sources - the Trust's performance over the last year; national or regional priorities; and/or from horizon scanning. The 'long list' was approved for consultation by the Trust Board in February 2012. The consultation included meetings with shadow governors and staff, publication on the internet and intranet inviting comments from the public, staff, requesting feedback from public partnership forums and other external stakeholders such as the Primary Care Trust.

After taking into account all of the views and evidence and reflecting on our progress against national and local priorities, the Board agreed our priorities for the year 2012/13 at its March 2012 meeting. These quality priorities are summarised as:

Fig. 1 2012/13 Quality Priorities

Part Two

Quality Priority 1
2012/13: Redesigning the Emergency Pathway

NGH has been subject to increasing emergency pressures in recent years. In order to improve this situation the Trust will need to continue to work with wider health economy to address the issues relating to the numbers of patients who attend Accident and Emergency (A&E) and require admission; and to the difficulty staff encounter in finding suitable places of care for those patients who have received treatment but no longer need to be in an acute hospital.

Meanwhile there is a significant amount of work to be done within the Trust to improve emergency care. NGH staff are working harder than ever before, bed occupancy is higher, and despite best efforts escalation areas are needed for emergency patients.

As part of NGH's focus on quality, this priority involves redesigning emergency pathways to ensure that the systems and processes are in place to support staff to deliver quality care first time every time. This will require dedicated project support, clinical leadership and investment in key services in order to ensure that a sustainable quality focused plan can be supported by the Trust.

Aim

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

Targets for 2012/13

The targets for improvement for 2012/13 are shown in the table below:

	Targets for achievement by end of March 2013
Improved patient access to consultant advice, improved clarification of consultant accountability and improved planning of care.	All patients have improved access to consultant advice 7 days per week. All patients and staff are aware of each individual treatment plan, the responsible consultant and the planned discharge date.
Improved patient experience and care in the emergency department and throughout the patient journey.	All emergency patients are treated according to the nationally set urgent care standards which measure for example, time spent in A&E and time to initial assessment.
Improved patient flow to reduce delay and improve clinical outcomes.	All emergency patients who need admission are able to access an appropriate bed within 3 hours and all patients who require a longer stay in hospital are able to be transferred to their specialty ward within 24 hours.
Reduction in bed occupancy to improve patient experience and reduce harm.	Reduce bed occupancy on all wards to 90-95%.

Fig. 2 Quality Priority 1 Targets 2012/13

Part Two

Measures/Areas of improvement that have been introduced in 2011/12

Consultant presence in the emergency department and in acute specialties has been increased. This has resulted in:

- An increase in the numbers of hours our consultant physicians are present in the hospital over weekends and in the evenings
- An increase in the numbers of Consultant-led rapid assessments that take place and the majority of our patients are seen by a consultant within 12 hours of admission

We have also:

- Increased the numbers of nurses that support our emergency department
- Improved the physical environment in the emergency department and have committed to an investment in additional staff over the next 3 years

Despite these improvements there has been great difficulty in providing the quality of care that we would like and we have now committed to a targeted improvement plan to ensure that standards can be raised yet further to the level to which we aspire.

Measures/Areas of improvement planned for 2012/13

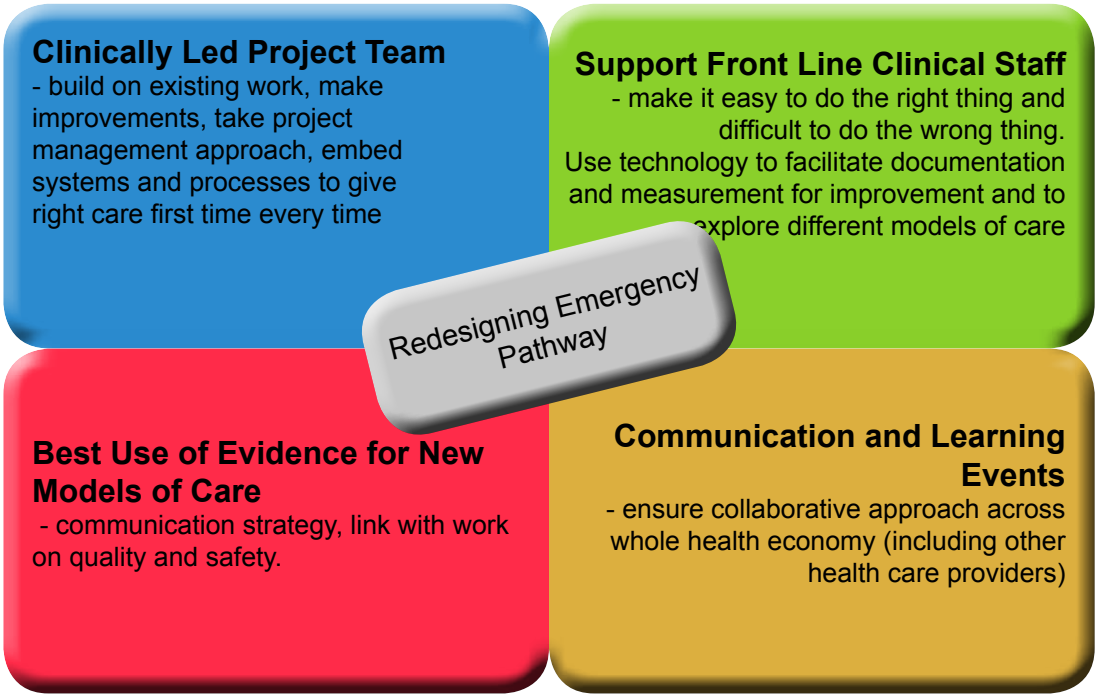


Fig. 3 Quality Priority 1 Measures/Areas for Improvement 2012/13

How progress will be monitored and measured

The Transformation Programme Management Office will oversee how the project is progressing and provide reports to all Trust Groups and Boards including the Trust Board and the hospital's Strategic Management Board (SMB).

Part Two

Quality Priority 2
2012/13: Caring for Vulnerable Adults

As part of the Trust's on-going focus on supporting Vulnerable Adults, this priority focuses on making improvements in the care of patients with Learning Disabilities or Dementia.

It builds on the achievements over the last year to include increasing the training and development of staff to support the care for this group of patients. For patients with Learning Disabilities this will focus on communication skills and for patients with Dementia an assessment of the patient during the initial admission to hospital.

Aim

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

Targets for 2012/13

The key targets set to enable delivery of this priority during 2012/13 are as follows:

	Targets for achievement by end of March 2013
Dementia training delivered as per the Dementia Training Strategy	Training provided for all staff who engage with and/or care for patients with dementia
Learning disability awareness and communication training	To be included in induction, preceptorship and bespoke training as appropriate
Management of people with dementia	Develop new care pathway so that people with dementia have their need appropriately met.
Improve quality of care and experience for those with dementia	Audit of the 'butterfly scheme' Increase use of pictorial signage LD Nurse to join the Dementia Care Action Committee
Develop patient and carer information in an appropriate format for patients with dementia or learning disabilities	Development of accessible information for different treatment options Identify reasonable adjustments on medical and surgical care pathways
Deliver the dementia CQUIN target	Improve awareness and diagnosis of dementia, using risk assessment

Fig. 4 Quality Priority 2 Targets 2012/13

Part Two

Measures/Areas of improvement that have been introduced in 2011/12

Measures that have been introduced in 2011/12 include:

- Establishment of the Trust multi-disciplinary Dementia Care Action Committee who achieved the following:
  - Adoption of a butterfly logo as a means of identification of patients with dementia or memory problems
  - Utilise a 'butterfly magnet' on the ward white boards in order that all staff are made aware that the patient may require additional support
  - Raised awareness about the needs of patients with dementia by developing Patient Profile, advise sheets, awareness poster and relative and carer information; all using the butterfly logo
  - Introduced pictorial communication folders that were purchased to aid communication
  - Purchased activity boxes containing a variety of photographs and activities to help engagement with patients and encouraged staff, volunteers and visitors to use them
  - 'Memory Boxes' were provided which relatives are encouraged to fill with items significant to the patient
  - At the end of September 2011, the 'Butterfly Care' was launched in the Trust and all wards were provided with the above information and resources
- In order to ensure we have an informed and effective workforce regarding dementia care, an education strategy was developed. Since September 2011, 34 ward cascade trainers have been trained with responsibility for the training of all ward staff
- A hospital passport* has been developed and implemented containing a core assessment tool for patients with learning disabilities
- NGH have funded a full time Learning Disability Liaison Nurse who offers support and advice
- The A&E Pathway for people with learning disabilities has been launched
- Easy read leaflets for various radiology investigations have been developed and implemented
- A pain assessment tool for individuals with communication /cognitive impairment has also been developed

**Hospital passport is an assessment initiative to identify the individual needs of those with learning disabilities in order that they can be cared for in the most appropriate way.*

Part Two

Measures/Areas of improvement planned for 2012/13 are as follows:

Fig. 5 Quality Priority 2 – Measures/Areas for Improvement 2012/13

How progress will be monitored, measured and reported:

The Safeguarding of Vulnerable Adults (SOVA) steering group will monitor progress through the receipt of monthly reports on progress which will inform quarterly reports to the Clinical Quality and Effectiveness Group, the Healthcare Governance Committee and the Board.

Part Two

Quality Priority 3
2012/13: Patient Safety Programme

The Trust has supported a variety of safety initiatives in recent years. In order to ensure this achieves the maximum effect a programme of training and investment is needed to ensure that every member of staff understands their role in patient safety and works towards it every day. As part of this Quality Priority, the Trust proposes to invest in a programme of development to support a team of Leaders for Safety who will form a 'Safety Academy' under the leadership and direction of the Medical Director and the Director of Nursing supported by the Safety Lead. The clinicians who form this academy will roll out projects and education to all staff groups and be responsible for delivering a high profile portfolio of key projects that link the operational delivery of services with the need to improve quality. Investment in quality in this way will improve clinical outcomes and reduce overall cost to the system and will ensure that staff can be confident that they are delivering the safest care that they can.

Aim

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

Targets for 2012/13

The Trust is continually striving to improve the safety and effectiveness of patient care. Some of the improvements that are expected in 2012/13 are set out below:

	Targets for achievement by end of March 2013
A Safety Strategy for Improvement and a Safety Programme Outline are approved by the Board to include the formation of a Safety Academy and Patient Safety Board (chaired by the Medical Director), which has a focus on sustaining and developing education and learning.	Safety Academy formed and in place with regular reporting.
A reduction in harm from failure to plan care so that all patients and staff have an improved understanding of the plan of care in place and appropriate actions are taken.	50 % improvement in measures relating to planning of care.
A reduction in harm resulting from failure to rescue so that every acutely ill or deteriorating patient is recognised immediately and all appropriate actions are taken.	50 % improvement in measures relating to failure to rescue.
A reduction in harm resulting from failure to deliver care so that every patient receives improved essential care.	50% improvement in the measures that relate to basic delivery of care.

Fig. 6 Quality Priority 3 Targets 2012/13

Part Two

Measures/Areas of improvement that have been introduced in 2011/12:

In 2011/12 a variety of safety projects have been supported and the following progress has been made:

- There is more information for patients and staff visible in ward areas and there is more information available to the Trust Board
- We have involved all levels of staff in surveys to look at attitudes to safety. We have supported projects to improve care in high risk areas such as the treatment of pneumonia, fractured neck of femur and serious sepsis and seen a reduction in death rates in these areas
- We have succeeded in reducing serious infections such as MRSA and C Difficile and have also reduced the infections that occur after operations
- We have improved the approach to the prevention of blood clots. We have worked with our most junior doctors as well as our senior consultant staff to reduce the death rate from serious sepsis using targeted education and novel approaches
- Our Patient Safety Board brings together a variety of disciplines to present their improvement work and this is evolving into a meaningful and well supported forum

Measures/Areas of improvement planned for 2012/13

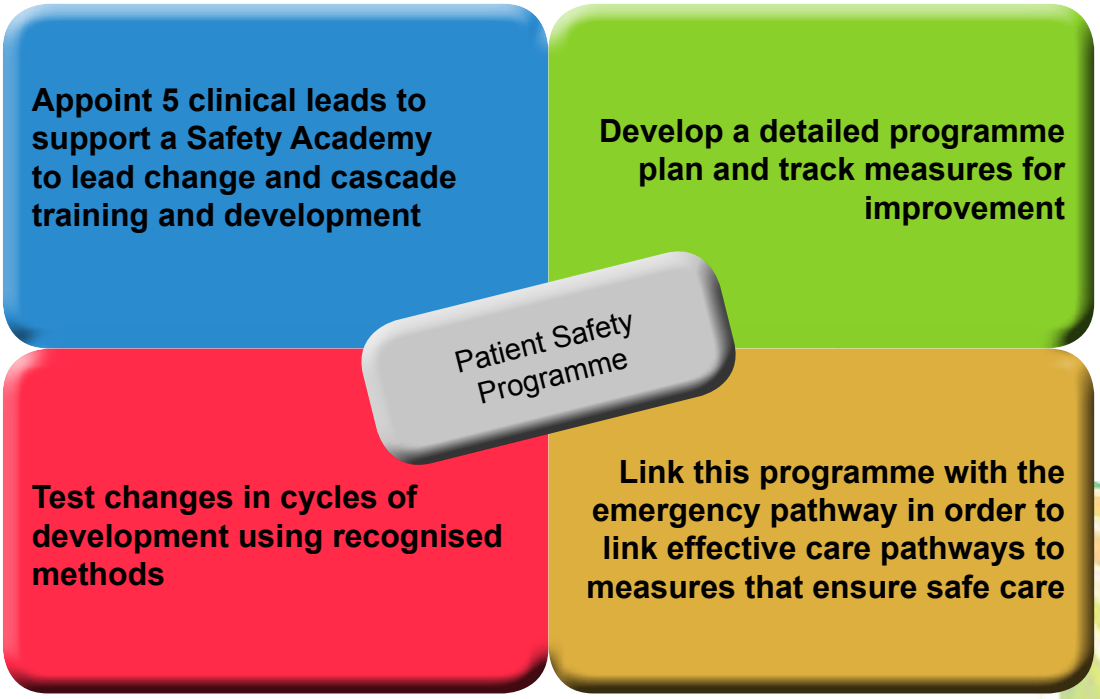


Fig. 7 Quality Priority 3 Measures/Areas of Improvement 2012/13

Part Two

How progress will be monitored, measured and reported:

The Patient Safety Improvement programme will report quarterly to all committees including the Trust Board, the Clinical Quality and Effectiveness Group and the Healthcare Governance Committee, via the Patient Safety Board (chaired by the Medical Director) which will meet monthly.

The detailed progress of the work will be monitored through the Transformation Programme Management Office to ensure that improvements in quality and safety are linked to all transformation projects throughout the Trust.

Quality Priority 4
2012/13: Patient Experience

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

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

Aim

The Trust will achieve a 10 point improvement on the Friends and Family Test, using April 2012 as the benchmark, by the end of March 2013.

Targets for 2012/13

During the month of April 2012 the Trust will be collating the first reportable data on the Friends and Family test. The first month will be used as a baseline and the trust will set a target to improve April's score by at least 10 points during the 2012/13 period.

	Targets for achievement by end of March 2013
A Patient Experience Strategy for Improvement and a patient experience programme outline are approved by Board to include the formation of a Patient Experience Board	Patient Experience Board formed and in place with regular reporting. Routinely involve patients and shadow governors proactively in service design and development
The Trust is 'committed to providing the very best care for all our patients'. This commitment requires us to do everything in our power to ensure that the experiences of patients, families and carers are positive, supportive and conducive to their health and wellbeing at every stage of their care pathway	Patient experience will be at the heart of our planning and performance management, with related objectives in every business plan. There will be a 10 point improvement in the Friends and Family Test score Real time monitoring of patient experience at ward and department level Achieve a step change in our National Survey of Adult In-patients results over the next three years

Fig. 8 Quality Priority 3 Targets 2012/13

Measures that have been introduced in 2011/12

Commissioning for Quality and Innovation (CQUIN – Patient Experience)

Through 2011/12 data for this CQUIN was collected using the Patient Experience Tracker devices. This indicator is calculated from 5 survey questions each describing a different element of the patients' experience. The target for each question and the Trust's performance is detailed in the graph on the next page:

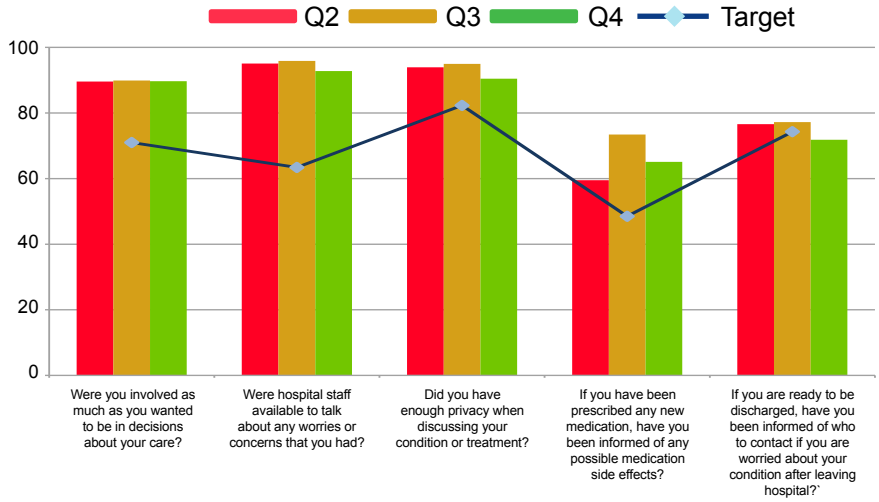


Fig. 9 – CQUIN Performance 2011/12 – Patient Experience

The Trust has performed well against all of the indicators during the year, however has fallen slightly below target during this quarter on advising patients who to contact if they are worried about their condition after leaving hospital. This will be taken forward as a part of the quality priority for 2012/13.

National Inpatient Survey 2010

The Trust has been collecting patient experience data in 10 areas identified as 'underperforming' in the National Inpatient Survey 2010, since October 2011. These areas included noise at night, sharing sleeping areas with the opposite sex and getting enough help with eating meals. Various quality initiatives were introduced to improve these results. The Trust has improved in all areas and, is either on or above the target. The latest performance figures can be seen in the chart below:

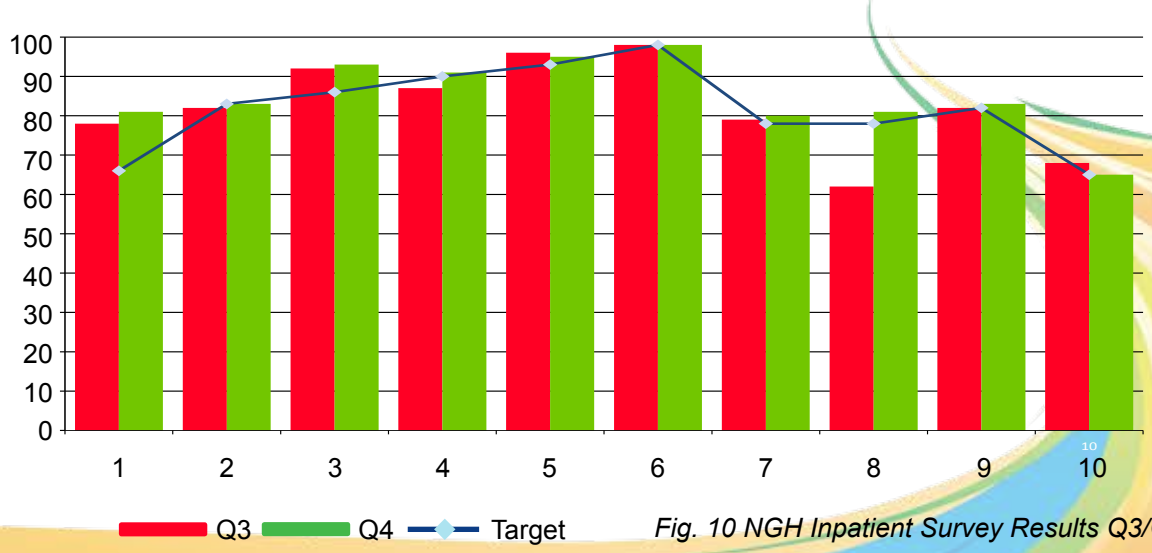


Fig. 10 NGH Inpatient Survey Results Q3/Q4

The labels 1-10 on the x axis are the questions as detailed in the table below:

Q1	*After you used the call button, how long did it usually take before you got help?*
Q2	*As far as you know, did doctors wash or clean their hands between touching patients?*
Q3	*Did nurses talk in front of you as if you weren't there?*
Q4	*Did the doctors talk in front of you as if you weren't there?*
Q5	*Did you ever share a sleeping area with patients of the opposite sex?*
Q6	*Did you feel threatened during your stay in hospital by other patients or visitors?*
Q7	*Did you get enough help from staff to eat your meals?*
Q8	*In your opinion, were there enough nurses on duty to care for you in hospital?*
Q9	*Were you ever bothered by noise at night from hospital staff?*
Q10	*Were you ever bothered by noise at night from other patients?*

Measures/Areas of improvement planned for 2012/13 are as follows

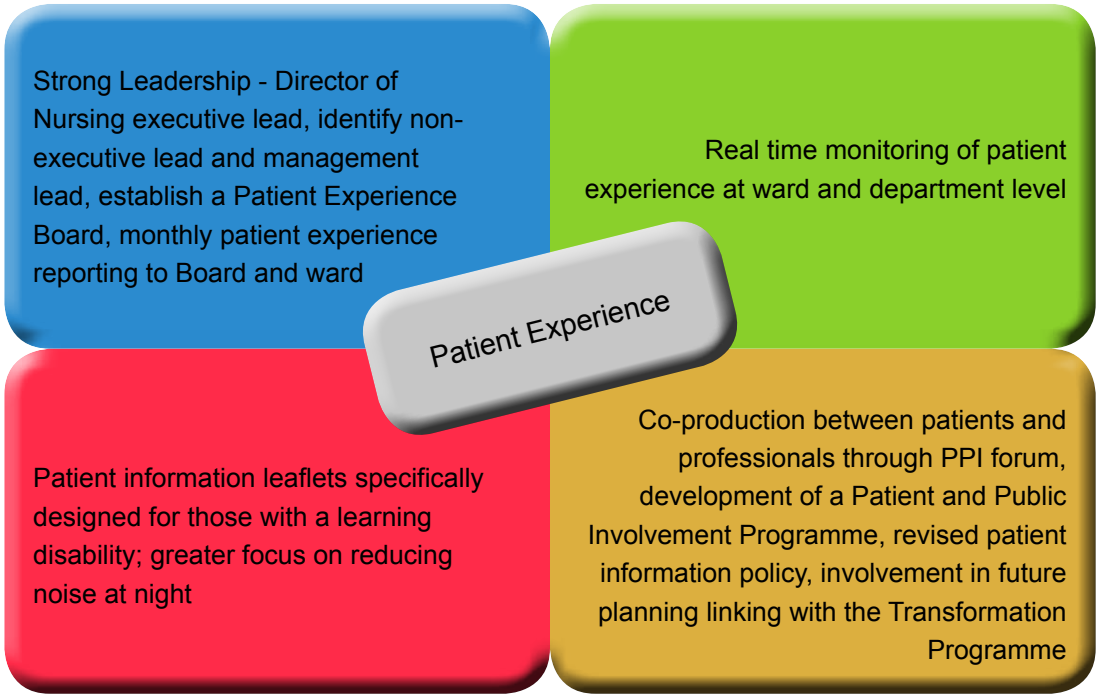


Fig. 11 Quality Priority 4 Measures/Areas of Improvement 2012/13

How progress will be monitored and measured

The Patient Experience Board, chaired by the Director of Nursing, Midwifery and Patient Services, will monitor progress against the Patient Experience Strategy.
Assurance reports will be received by the Board through the Patient Safety, Clinical Effectiveness and Patient Experience Reports on a quarterly basis. The Board will receive quality reports from the Medical Director and the Director of Nursing, Midwifery and Patient Services on a monthly basis, which will include reporting on the Friends and Family Test score.

Part Two

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

Review of Services

During 2011/12 Northampton General Hospital NHS Trust provided and/or sub-contracted 52 NHS services. The Trust has reviewed all the data available to them on the quality of care in all of these services during the year, through external review reports, national clinical audit reports, local clinical audit, scorecards and performance reports. The income generated by the NHS services reviewed in 2011/12 represents 100% of the total income generated from the provision of NHS services by Northampton General Hospital for the reporting period (2011/12).

Never Events

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

During the 2011/12 period the Trust investigated 2 'never events' as part of the serious incident investigation process. Following these events, a number of actions have been implemented to reduce the risk of recurrence and both events have helped to inform the Patient Safety Strategy.

Participation in Clinical Audits

During 2011/2012, 47 National Clinical Audits and 4 National Confidential Enquiries covered NHS services that Northampton General Hospital provides. We participated in 95.7% National Clinical Audits and 100% National Confidential Enquires for which we were eligible to participate in. Details of these and the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

	Percentage Participation
Perinatal Mortality (CEMACH)	100%
Neonatal intensive and special care (NNAP)	100%
Paediatric pneumonia (British Thoracic Society)	Data collection in progress
Paediatric asthma (British Thoracic Society)	100%
Pain Management (College of Emergency Medicine)	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	100%
Adult community acquired pneumonia (British Thoracic Society)	100%
Non invasive ventilation (NIV) – Adults (British Thoracic Society)	Data collection in progress
Cardiac arrest (National Cardiac Arrest Audit)	100%
Severe sepsis & septic shock (College of Emergency Medicine)	100%
Adult critical care (Case Mix Programme)	100%
Potential donor audit (NHS Blood & Transplant)	100%
Seizure management (National Audit of Seizure Management)	100%
Diabetes (National Adult Diabetes Audit)	100% (Snapshot audit only)
Heavy menstrual bleeding (RCOG National Audit of HMB)	35%
Chronic pain (National Pain Audit)	Completed
Parkinson's disease (National Parkinson's Audit)	100%
Ulcerative Colitis & Crohn's disease (National IBD Audit)	100%

Adult asthma (British Thoracic Society)	75%
Bronchiectasis (British thoracic Society)	100%
Hip, knee and ankle replacements (National Joint Registry)	100%
Elective surgery (National PROMs Programme)	70%
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Ongoing data Collection
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	100%
Carotid interventions (Carotid Intervention Audit)	100%
Acute Myocardial Infarction and other ACS (MINAP)	100%
Heart failure (Heart Failure Audit)	100%
Acute stroke (SINAP)	100%
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	Ongoing data collection
Renal Replacement Therapy (Renal Registry)	Ongoing data collection
Lung cancer (National Lung Cancer Audit)	100%
Bowel cancer (National Bowel Cancer Audit Programme)	100%
Head & neck cancer (DAHNO)	100%
Oesophago-gastric cancer (National O-G Cancer Audit)	Ongoing data Collection
Hip fracture (National Hip Fracture Database)	91%
Severe trauma (Trauma Audit & Research Network)	100%
Bedside transfusion (National Comparative Audit of Blood Transfusion)	100%
Medical use of blood (National Comparative Audit of Blood Transfusion)	62 cases (denominator not defined)
Risk factors (National Health Promotion in Hospitals Audit)	100%
Care of dying in hospital (NCDAH)	100%
National Confidential Enquiry into Patient Outcome & Death (NCEPOD) – Peri-operative care	100%
National Confidential Enquiry into Patient Outcome & Death (NCEPOD) – Cardiac Arrest	100%
National Confidential Enquiry into Patient Outcome & Death (NCEPOD) – Paediatric Surgery	100%
National Confidential Enquiry into Patient Outcome & Death (NCEPOD) – Bariatric Surgery	100%

Fig. 12 National Clinical Audit/Confidential Enquiry Participation

The reports of 15 National Clinical Audits were reviewed in 2011/2012 and Northampton General Hospital NHS Trust intends to take the following actions to improve the quality of healthcare provided:

National Clinical Audit	Actions
1. Neonatal Intensive and Special Care (NNAP)	• Improvement in the recording and documentation of initial temperature • Improvement in timely communication with parents, and documentation of communication • Collect follow-up data and input to BADGER (the database) to inform commissioners of neonatal outcomes
2. National Paediatric Diabetes (RCPH)	• Appointment of new lead for Paediatrics diabetes • Introduction of a register to improve data submissions
3. Re-audit of Bedside Blood Transfusion Practice	• Ensure staff correctly identify patients prior to transfusion • Ensure all staff caring for patients receiving a transfusion comply with Trust policy and record transfusion theory and competency assessment training • Ensure all staff caring for patients receiving a transfusion comply with Trust policy and record transfusion observations
4. Adult Critical Care (INARC)	• Review of the management and care of patients with sepsis and pneumonia • Development of care bundles for sepsis & pneumonia

5. Potential Donor Audit (NHS Blood & Transplant)	• Improvement in referral rate to the specialist nurse for organ donation • Establish a withdrawal/do not escalate policy for critical care medicine • Improve collaborative working to increase the consent rate • Development of Trust potential donor policy • Development of a programme for basic training and updates in organ donation
6. National Diabetes Audit	• Introduction of a register to improve data quality and submission • Training programme for staff using diabetes register
7. Elective Surgery (National PROMs Programme)	• Local action plan in place to improve participation rates
8. National Vascular Database and Carotid Interventions	• Consultant led vascular preoperative assessment • Implementation of vascular risk MDT • Vascular nurse involvement in preoperative assessment • Introduction of algorithm/pathway for preoperative investigation of higher risk patient • Introduction of two surgeon operating schedule for complex cases • Consultant vascular anaesthetist for all elective major vascular cases • Increased use of cell salvage to reduce blood transfusion • Local review of mortality outcomes
9. Heart Failure (Heart Failure Audit)	• Heart failure team to review all patients during hospital stay, particularly those not under the care of a cardiologist • Heart failure team to produce periodic newsletters • Heart failure team to provide clinical training for non-specialists involved in management of heart failure patients
10. Acute Stroke (SINAP)	• Recruitment of 3 stroke physicians countywide • On-going monitoring with SINAP and education of staff • Telemedicine link in place at UHL and local staff training in progress • Establish Community Stroke Rehabilitation Team
11. Lung Cancer	• Improve data entry & quality of data on national Somerset cancer register • Development of a proforma for recoding data from multi-disciplinary team (MDT) meetings • Re-design of MDT pathway resulting in better patient experience, more efficient use of the time of the MDT • Development of a one stop lung cancer clinic from February 2012
12. Bowel Cancer	• Improve data entry & quality of data on national Somerset cancer register • Training programme for staff across Trust where data fields are incomplete on Somerset cancer register • Monitor & review of major post operative cases
13. Head and Neck Cancer	• Improve data entry & quality of data on national Somerset cancer register • Improvement in the number of patients discussed at multidisciplinary team meetings • Identification of weekly radiology slots to improve access to MRI scans • Improvement in the allocation of ITU beds
14. Hip Fracture (National Hip Fracture Database)	• Reduction in the average length of stay • Actions in place to improvement rate of falls and bone health assessments undertaken by junior doctors • Training of junior doctors • Implementation of a new falls assessment form • Availability of clinical biochemist for support regarding appropriate bone health medication assessment and subsequent prescription • Employment of nurse practitioner • Recruitment to post of orthogeriatrician
15. Severe Trauma (Trauma Audit & Research Network)	• Review of themed quarterly reports and production of recommendations and actions

Fig. 13 National Clinical Audit Actions 2102/13

Part Two

The reports of 2 Confidential Enquiries were reviewed in 2011/2012 and Northampton General Hospital NHS Trust intends to take the following actions to improve the quality of healthcare provided:

National Confidential Enquiry	Actions
1. National Confidential Enquiry into Patient Outcome & Death (NCEPOD) – Knowing the Risk	• Pathway for the Identification of high risk emergency patients • Development of validated tools for the assessment of mortality risk • Identification of high risk patient pre-operatively • Improvement in handover day/night surgical teams
2. National Confidential Enquiry into Patient Outcome & Death (NCEPOD) – An Age Old Problem	• Recruitment to post of orthogeriatrician • Local audit of compliance with use of nutritional screening tool • Pathway for the identification of at-risk patients for elective surgery • Re-launch of mental capacity act training with compliance monitoring • Annual consent audit • Continuous monitoring with compliance of completeness of fluid balance charts on matron's dashboard • Combined pre-operative assessment by surgeon & anaesthetist for patients with an acute abdomen

Fig. 14 National Confidential Enquiry Actions 2012/13

The reports of 27 local clinical audits were reviewed in 2011/2012 and Northampton General Hospital intends to take the following actions to improve the quality of healthcare provided:

Local Clinical Audit	Actions
1. Fractured Neck of Femur Action Plan	• Recruitment of Ortho-Geriatrician • Reassess medical cover on Fracture Neck of Femur (FNoF) ward • Ensure nursing care is optimised • Reduce surgical site infections • Complete review of patient record following death from a FNoF • Action plan on monthly governance meeting agenda • Ensure care pathway is fit for purpose
2. Complaints Survey	• Complaints team will resume preparation of Trust responses • Final approval, learning, and evidence will remain responsibility of Directorate • Continue to acknowledge mistakes where identified, offer apologies, and explanations • Continue to provide complainant with name and telephone number of their designated complaints contact
3. Patient Identification	• Continued education of staff regarding the policy on the use of electronic wristbands • Report presented to the wards where some patients did not have a wristband • Results reported at operational meeting
4. Patient Information Leaflet Audit	• Develop independent checklist for clinical procedures and general information • Designate patient information lead in each Directorate • Lead will report to governance meetings as a standing agenda item, to ensure that current leaflets are in date, fit for purpose, and professional • Lead will undertake future audits for their Directorates
5. Fluid Balance Chart Audit	• Ensure 12 hour totals are completed on every shift and are handed over • Ensure chart has space to initial each entry • Improve training package

Part Two

Local Clinical Audit	Actions
6. Protected Meal Times Audit	• Liaise with Patient Safety Board to review Dr's rounds • Introduce preparation rounds prior to mealtimes to ensure patient's bedside tables are clear before meals are delivered • Ensure all patients receive hand washing wipes before they eat • Ensure all patients can reach their food • Reminder on screen saver system of the importance of protected meal times
7. Nutritional Care Audits	• Introduction of small magnets with eating/drinking symbols for display on whiteboards • Purchase proposal for large magnets for behind beds • 'At Risk' score to be written on main whiteboard • 'Out of hours' and 'meal times matter' posters to be displayed on all wards • Ensure yellow jugs available on all wards for patients with impaired vision • All wards to have a link nurse resource folder • Reiterate to link nurses the importance of labelling time & date on enteral and parenteral nutrition giving sets • Posters to illustrate appropriate tube for feeding to comply with NPSA alert
8. IVC Filters Outcomes	• The results were within standards. No patient had a PE. 1 patient had a further DVT. No change in practice
9. Audit of Reporting Radiographers	• Overall 100% sensitivity and 95% specificity. Will hold regular reporting radiographer "interesting cases/discrepancy" meetings
10. VQ Audit	• The Nuclear Medicine department has increased availability of VQ scanning from 3/7 to 5/7 . • The department has changed from performing Kr 81 ventilation and Tc perfusion or Tc perfusion alone in appropriate patients. • The department is now using a DTPA ventilation agent and performing SPECT VQ examinations on nearly all patients
11. HER2 (Human Epidermal Growth Factor Receptor 2) Testing – An Audit of NICE Compliance	• Patients remain with MDT until HER2 Result confirmed • Improve the delays in the process between UHL and Northampton. • Create database for individual tumours (not patients) • Improve retrospective data entry on NBSS (the database) • Presented at EM Cancer Network meeting, May 2011
12. Audit of Nutrition Nurses NG Tube Insertion	• Implement Radiology audit looking at mal-positioned tubes following insertion by ward staff and discussion with stroke unit clinicians regarding use of nasal bridles for patients who persistently displace.
13. Audit of the World Health Organisation (WHO) Checklist	• Increase in check-list usage between the cycles • No SUI reported during the period. Improvement noted in non measureable outcomes such as team spirit, patient participation
14. Audit of coding in Interventional Radiologists (IR)	• Disseminate information • Interventional Radiologists to be more vigilant with regards to CRIS (the radiology booking system) entries when reporting • Extend audit to IPM (inpatient management system) entries completed by the coding department
15. Audit of Shoulder Radiographs	• The results reflect well on the quality and standards of practice in the department for this specific examination. • A program of education amongst Radiographers and A & E staff may be beneficial • Re-audit after an appropriate time period
16. Cardiac CT Audit	• Three quarters of patients referred for Computerised Topography Angiography (CTA) were successfully reassured without having further invasive angiography i.e. the diagnostic accuracy and the belief in the system has been enhanced • A fall inappropriate referrals for further testing. • Radiation doses have significantly reduced over the last 10 months and continue to fall • This audit has successfully showed that it is possible to introduce a new service, nurture it, audit it, implement the recommendations and re-audit, leading to enhanced patient care

Part Two

Local Clinical Audit	Actions
17. Radiation Dose Audit - room 5	• Additional beam filtration was added to some acquisition modes in June 2011 • Substantial reduction in mean dose area product (DAP) since the extra filtration was added
18. Patient Satisfaction Audit – Danetre Hospital Radiology	• Increasing the hours of operation to include Mondays on a permanent basis • Re-audit in 6 months will then assess whether this recommendation has altered patient experience and decreased waiting times on Tuesdays
19. Fine Needle Aspiration Cytology Audit	• Develop and maintain the necessary level of expertise within the Trust, the number of clinicians performing fine needle aspirations should be confined to small numbers • Pertinent, legible clinical and imaging data should be included with every request • Wherever practicable, adequate material should always be obtained. In the case of thyroid aspirates, a minimum of five groups of follicular cells should be present in order to formulate a diagnosis
20. Sepsis Audit	• Improve compliance with delivery of Sepsis Six throughout Trust • Ensure that the Early Warning Score is correctly completed on admission for all patients • Ensure antibiotics given promptly for sepsis • Resource for delivery bundle available on all wards • Improve documenting of bundle delivery • Simpler access to all hospital guidelines • Reduce contamination of blood cultures • Raise awareness of correct procedures of blood cultures • Ensure Trust wide implementation of Sepsis Screening Tool • Improvement in documentation of fluid balance charts • Improvement in the identification of patients with probable Urosepsis
21. Audit of Healthcare Records	• Review of Corporate standards for completion of healthcare records • Trained nurses to print name and NMC number against all entries in healthcare records • Addressograph labels to be used on all documentation • Record keeping training programme to include results of audit against standards as well as filing order and condition of health record
22. Accuracy of Medication on Discharge Audit	• Report to Medicines Management Committee • Feedback results to pharmacists at a clinical pharmacy meeting. • Feedback to junior doctors. • Discussions regarding refining of the electronic discharge software • Information on medicines from GPs may be more easily available if the GP software -System 1 is made more widely available to Accident and Emergency
23. VTE Risk Assessment	• Introduction of VTE magnet for display on whiteboards confirming risk assessment within 24 hours. • Training programme for all members of MDT • Monthly junior doctor audits confirming, risk assessment, correct thrombo-prophylaxis. • Confirm patient risk status and corrective actions if required. • Provide wards & Directorate teams with compliance data and any change in practice or corrective measures required.
24. Pneumonia Audit	• Improve compliance with delivery of Pneumonia Care bundle • Facilitate correct clinical coding • Resource for delivery bundle available on all wards • Simpler access to all hospital guidelines • Ensure Trust wide implementation of pneumonia algorithm • Improvement in documentation of fluid balance charts • Raise awareness • Develop educational simulation scenarios for MDT

Local Clinical Audit	Actions
25. 'Code Red' Audit	• Introduce educational programme for all clinical areas utilising NEWS cascade • Supply and deliver code red magnets to clinical areas • Provide arm bands for team leaders • Collect telephone data for all code red patients • Develop staff instruction for code red • Code red protocol is developed and encompassed within the Resuscitation policy once ratified
26. Ward Round Standardisation and Practice Audit	• Introduce ward round stickers to support standardisation of documentation • Trial sticker and process as PDSA within urology for weekend plan of care • Introduce within emergency areas within medicine as PDSA • Facilitate correct clinical coding • Create feedback form for colleagues • Re audit practice share findings whit PDSB and clinical teams
27. Inpatient Falls	• Improve documentation for in patient falls • Introduce assessment sheet for medical staff with actions for all members of MDT documented • Raise profile and education of inpatient falls amongst junior doctors • Agree a falls management proforma for adult in patient notes • Clarify pathway/criteria for CT Head post fall

Fig. 15 Local Clinical Audit Actions 2012/13

Participation in Clinical Research

The number of patients receiving NHS services provided by Northampton General Hospital NHS Trust from April 2011 to March 2012 that were recruited during that period to participate in research approved by a research ethics committee was 2163.

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. NGH was involved in conducting 219 clinical research studies in the clinical directorates of the trust during April 2011 to March 2012.

217 clinical staff participated in research approved by a research ethics committee at NGH during April 2011 to March 2012. These staff participated in research covering all clinical directorates. In the last three years, we have demonstrated our engagement with the National Institute for Health Research (NIHR) by participating in over fifty six clinical trials, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. Our engagement with clinical research also demonstrates NGH's commitment to testing and offering the latest medical treatments and techniques.

Goals Agreed with Commissioners

Use of the CQUIN Framework

A proportion of Northampton General Hospital's income in 2011/2012 was conditional on achieving quality improvement and innovation goals agreed between Northampton General Hospital and any period or body they entered into contract, agreement or arrangement with for the provision of NHS

services, through the commission for Quality and Innovation payment framework. The following tables show the anticipated levels of achievement for each of these indicators:

	Target / Trajectory	2011/12
1. **Cancer - Improve appropriate assessment and Improve mortality rates**		
Percentage of Oncology patients deaths within 30 days of receiving chemotherapy		
Percentage of Haematology patients deaths within 30 days of receiving chemotherapy		
Performace Status Recorded	*Q.4 maintain current performance*	
Audit Size	*30 patients*	
Increase the number of patients receiving treatment via homecare	*Q.4 maintain current performance*	
Compliance with national cancer standards and best practice	*Q.3 Repeat of 3 key question survey and aspects of national survey where trust scored<70%*	
2. Neonatal - Initial Parent Consultation with Senior medical Staff at admission to a neonatal units		
Participation rate		
Percentage temperature taken within an hour of admission		
Screening for cranial abnormality	*95%*	
Screening rate for retinopathy of prematurity	*Q.4 maintain current performance*	
3. Hepatitis C		
To increase compliance with Hepatitis C	*Q.4 maintain current performance*	
To improve outcomes associated with Hepatitis C treatment		
Reduce avoidable death, disability and chronic ill health from venous-thromboembolism (VTE)	*90%*	
Improve responsiveness to personal needs of patients	*5/5 Scores > 2010-11*	
Normalising birth	*Q4 <12%*	
4. Lifestyle		
Is the smoking status recorded	*Q4 > 65%*	
Number of smokers given brief advice	*Q4 > 65%*	
5. End of Life		
PPOC documentation rate > 90% @ Q4	*Q4 90% PPOC & 80% referral*	
Referred to appropriate service		
6. Ensuring effective communication between Primary and Secondary Care	Q4 75% discharged according to agreed protocol HF	
	Q4 75% discharged according to agreed protocol COPD	
7. Prescribing and Meds Management. Accuracy of medication on discharge	Q4 70% of discharge letters without errror	
a) Interface prescribing Statins 2		
Patients with a clear indication of ACS diagnosis	*Q4>86%*	
Duration of treatment stated	*Q4>24%*	
Step down treatment stated	*Q4>24%*	
b) Interface prescribing Inhaled Corticosteroids	*Q4 evidence that we are prescribing against agreed protocol*	
c) Interface prescribing Pregabalin and Gabapentin	*Q4 evidence that we are prescribing against agreed protocol*	
d) Interface prescribing Exenatide and Liraglutide (and other GLP-1 mimetics)	*Q4 evidence that we are prescribing against agreed protocol*	

Fig. 16 CQUIN scheme - achievement 2011/12

Further details of the agreed goals for 2011/12 and for the following 12 month period are available electronically at:

http://www.institute.nhs.uk/commissioning/pct_portal/2011%1012_cquin_schemes_in_east_midlands_.html

Part Two

What Others Say About Northampton General Hospital NHS Trust

CQC

Northampton General Hospital NHS Trust is required to register with the Care Quality Commission (CQC) and is currently registered with no conditions.

The CQC has not taken any enforcement action against Northampton General Hospital during the 2011/12 period.

The CQC visited the Trust in the summer of 2011 to review compliance with the following essential standards of quality and safety:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 16 - Assessing and monitoring the quality of service provision

The overall CQC judgement following this review was that 'NGH was meeting all the essential standards of quality and safety but, to maintain this, they have suggested that some improvements are made.' Following this the Trust implemented a full action plan to address the recommendations made.

In February 2012, the CQC visited Hazelwood Ward, Isebrook Hospital which is a 34 bedded rehabilitation ward for elderly patients provided by Northampton General Hospital NHS Trust. Compliance to the following essential standards for quality and safety was reviewed:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who services from abuse
Outcome 10 - Safety and suitability of premises
Outcome 13 - Staffing
Outcome 16 - Assessing and monitoring the quality of service provision

The overall CQC judgement following this review was that 'NGH was meeting all the essential standards of quality and safety but, to maintain this, they have suggested that some improvements are made.' Following this the Trust implemented a full action plan to address the recommendations made.

The CQC also carried out an unannounced visit in March 2012 to test compliance with Outcome 4J – termination of pregnancy, as part of a national review. A full report is awaited, although the Trust has put an action plan in place to address the issues raised at the time of the visit.

Data Quality

Validation of Trust information is completed within individual directorates with these processes centrally supported by the Information & Data Quality Department. It is the responsibility of the Head of Information

and Data Quality to ensure the robustness and accuracy of information and to investigate inconsistencies prior to publication in either internal or external forums.

Data Quality is subject to internal and external challenge and is monitored through various internal forums including the weekly performance meeting, the mortality group, and the HSMR coding review group. External challenge is via the commissioner data challenge process. Inconsistencies in data quality are fed back directly to individuals and any agreed actions monitored through the weekly performance meeting. Reports in respect of data quality are submitted to the Trust board and to sub-committees of the board.

The Audit Committee commissions an annual programme of internal audit to ensure the robustness of information provided to the Board and the Healthcare Governance Committee which uses Performance Management and PAS Data Quality. However, the Audit Committee recognises that this needs to be extended to include other types of data reported to give the committee wider assurance.

The Audit Committee commissions an external auditor to undertake a review of the Quality Accounts to ensure accuracy of information. The Trust's external auditors are required to test two specified performance indicators included in the 2011/12 Quality Account and have tested the systems for C. Difficile and 62 day cancer wait, however 3 were tested including MRSA. The auditors were able to give 'good' assurance in both of these areas as at April 2012.

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

NHS Number and General Medical Practice Code Validity

The Trust submitted records between April 2011 and January 2012 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records that included valid numbers were as follows:

	Valid NHS Number	Valid GMPC
Admitted Patient Care	99.6%	100%
Outpatient Care	99.8%	100%
Accident & Emergency Care	96.9%	100%

Fig. 17 NHS Number and General Medical Code Validity 2011/12

Information Governance Toolkit attainment levels

Northampton General Hospital NHS Trust Information Governance Assessment Report overall score for April 2011-12 was 79%. This is an increase in relation to 2010-11 but is graded as 'not satisfactory' due to 3 of the 45 requirements not meeting the expected level of attainment.

The Trust's Information Governance Programme Board will monitor the Information Governance Action Plan on a monthly basis and oversee the submission in 2013 in order to strive towards greater percentage compliance and an overall 'satisfactory' grade.

Part Two

Clinical Coding Error Rate

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

In October 2011 a national assurance audit was completed at the Trust. The initial draft report details the findings from the audit and outlines recommendations to be taken forward. In summary the key findings were:

Area audited	Percentage of spells with clinical coding errors affecting price	Percentage of spells with additional data items errors affecting price	Percentage of spells with an error affecting price
Locally determined specialty - General Surgery	6.4	2.1	8.5
Random selection from SUS	8.6	0.0	8.6
Overall	**7.5**	**1.1**	**8.6**

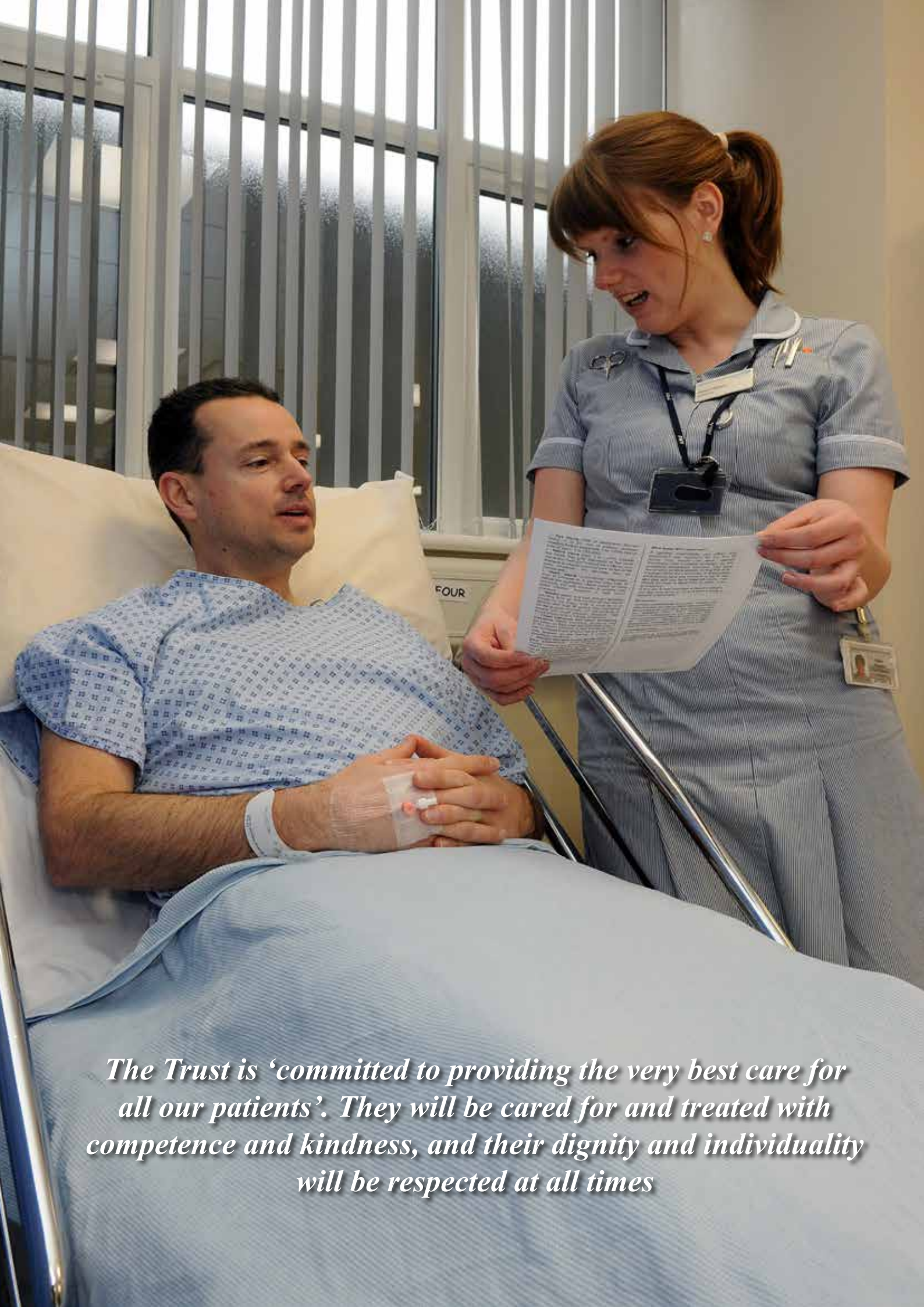
Fig. 18 Clinical Coding Error Rate 2011/12

The performance of the Trust, measured using just the clinical coding HRG error rate, is better than the national average of 9.1% (using the 2009/10 full year results). This year the Trust's average HRG error rate is 7.0%. See table 2

Table 2

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

Fig. 19 Clinical Coding HRG Error Rate 2011/12



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

Part Three

Review of Quality Performance

Part 3 is the section in our Quality Accounts that looks back over the last year and reviews progress with our quality priorities for 2011/12. It also includes some of the other achievements that have been made to improve quality across the Trust.

Quality Priority 1
2011/12: Right Care, Right Place, Right Time

Aim:

To ensure that all inpatients receive the right care, in the right place, at the right time. This will improve the patient's experience of their hospital stay and increase the quality and safety of care provided

Quality Improvements made throughout the year:

Target	Year end outcome (result)
Reduce average length of stay at speciality/Directorate level to 3.88 days	Target not reached at end of year. Although reducing average length of stay (ALOS) has been a focus for the Trust, enabling a reduction in the first 2 quarters of the year, this was not sustained in quarters 3 and 4. This was due to the increase in admissions coupled with the severity of illness that patients were presenting with. This was particular to emergency patients within medicine and Trauma and Orthopaedics. ALOS in March 2012 was 6.6 days (see Fig. 21)
Reduction in delayed discharges and bed days lost - 50% less than our 2010-11 achievements	The target reduction of 50% was not reached due to the increase in delayed transfers of care in November, reflective of the increase in emergency admissions as described above. The Trust is continuing to work with external health and social care partners through the Northamptonshire integrated care partnership to improve this situation (see Fig. 22)
Reduce numbers of internal ward transfers	The Trust is currently slightly above the target, however the trend is downwards. Numbers of internal ward transfers reduced in Q1 & Q2, but increased over the winter period (see Fig. 23)
Reduce the number of patients who are not cared for in the appropriate ward for their speciality	The target reduction of 50% has been achieved for this priority and is currently sustained. Both care groups worked on capacity modelling throughout summer and in November 2011 realigned the bed base to ensure each speciality had enough beds for their anticipated demand this included a flexible ward to be used for either medicine and / or surgery. The decrease of patients being cared for in an outlying ward (see Fig. 24)

Fig. 20 Quality Priority 1 (2011/12) Progress

Part Three

Average length of stay

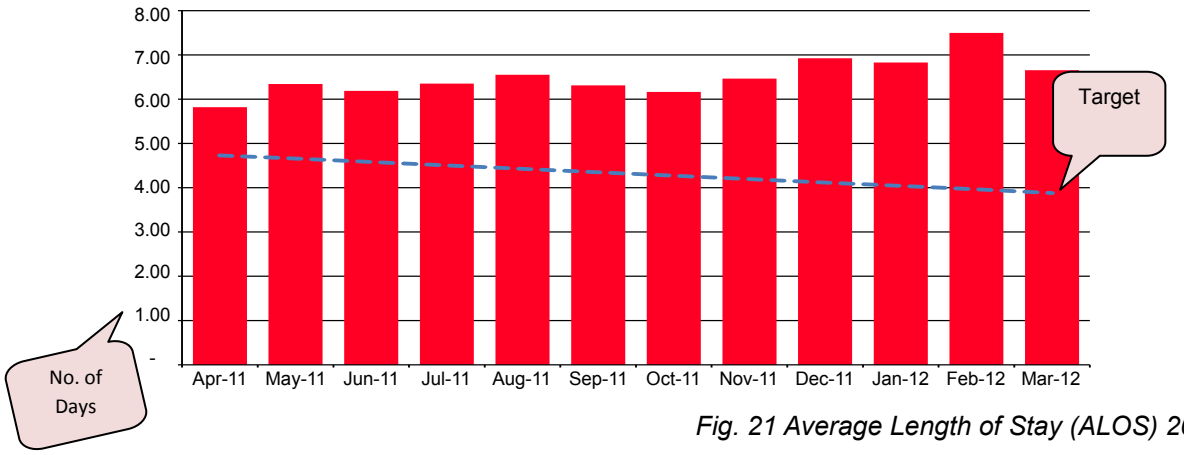


Fig. 21 Average Length of Stay (ALOS) 2011/12

Bed days lost

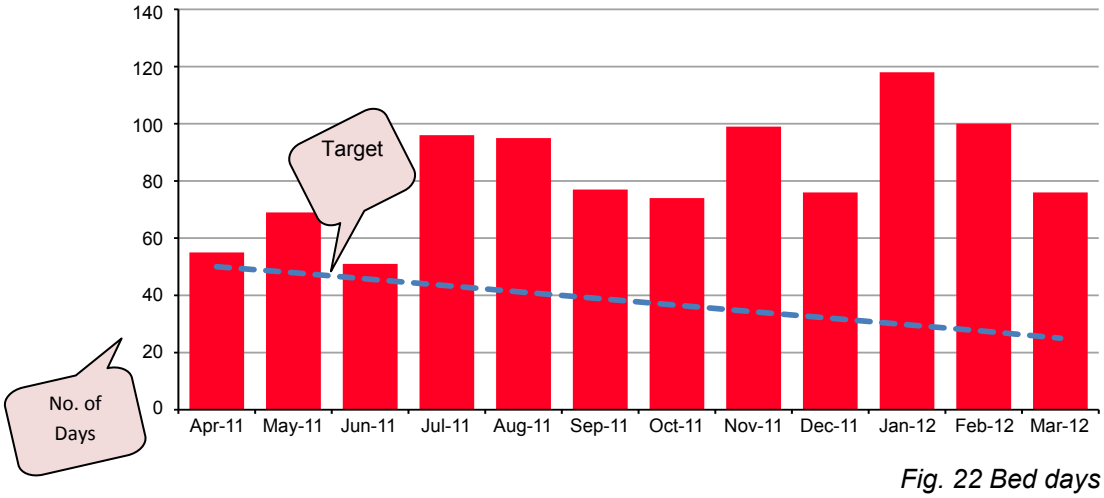


Fig. 22 Bed days lost 2011/12[1]

Number of internal ward transfers

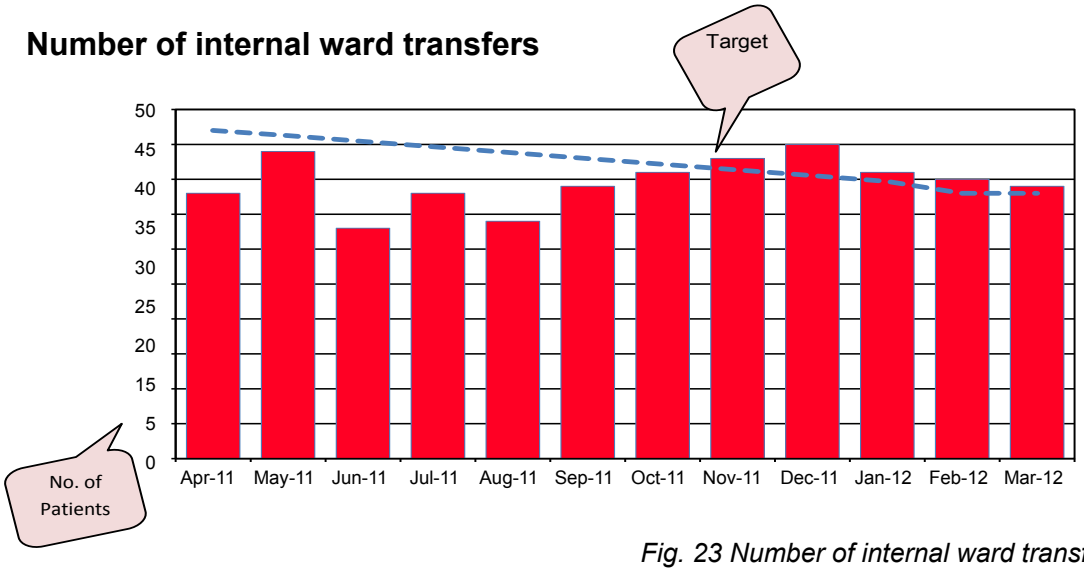


Fig. 23 Number of internal ward transfers 2011/12[2]

1. Bed days lost – these are the number of days between when a patient was assessed as being ready for discharge and the day they were actually discharged.
2. Internal ward transfers – sometimes it is necessary to move patients to a different ward, these are known as 'Internal ward transfers'.

Part Three

Numbers of patients cared for in an outlying ward

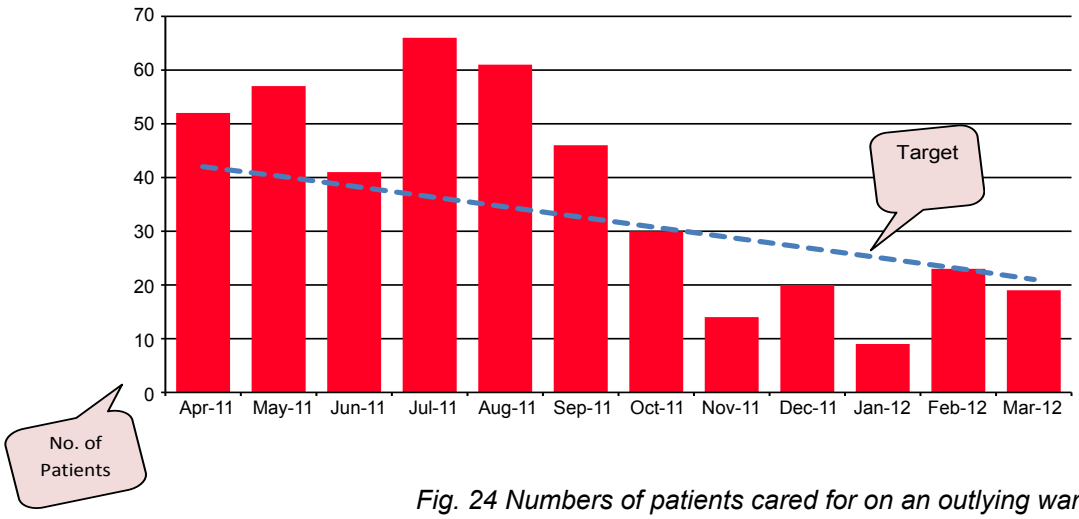


Fig. 24 Numbers of patients cared for on an outlying ward 2011/12[3]

3. Patients being cared for on an outlying ward – these are patients that are being cared for on a ward outside of the prime specialty (e.g. hip replacement patient being care for on a general surgical ward instead of a trauma and orthopaedic ward).

Key Improvements to practice

Reconfiguration of beds to respond to changing needs within the local community	Successful reduction in av erage length of stay in cellulitis and nephrology by streamlining the care pathway and reducing waste in the process	Process review for patients requiring CHC, changes to the process and pathway implemented
Introduction of Short Stay Elderly (SSE) ward to reduce the length of time patients wait for rehabilitation. ALOS for this cohort of patients reduced by 40%	Early implementation of transit lounge and expanded discharge facilitator role to include weekend working	Introduction of more specialist wards to ensure patients are treated by nurses and doctors with specialist qualifications to ensure care is person centred and appropriate

Fig. 25 Quality Priority 1 2011/12 – Key Improvements to Practice

What's next?

Over the next 12 months the focus on reducing length of stay will continue and this will be linked into the urgent care programme. Areas of work will include

- Introduction of the visual ward
- Review and changes (as required) of community beds
- Refocus on predictive planning to ensure patients are treated in the right place at the right time
- Introduction of the physician's assistant to support consultants and junior doctors

Part Three

Quality Priority 2
2011/12: Improving the Experience of People Who Are Vulnerable

Aim

In order to improve the experience of people who are vulnerable, the following aims have been set:

- 20% reduction in the number of serious pressure ulcers (grade 3 and 4) developed in hospital
- 20% reduction in falls causing serious harm and death in hospital
- Improve patient experience in hospital through the annual in-patient survey so that NGH is comparable to the top 25% performing Trusts in England
- Protected mealtimes implemented in each ward area so that patients are able to eat meals without unnecessary interruptions
- Hourly Care Rounds implemented to ensure that patients' care needs are being met
- New dementia training programme implemented on all wards

Quality Improvements made throughout the year

Target	Year end outcome (result)
20% reduction in the number of serious pressure ulcers (grade 3 and 4) developed in hospital (number=13)	66% decrease from 2009/10 levels 18% increase from 2010/11 levels (19 pressure ulcers by end February 2012)
20% reduction in falls causing serious harm and death in hospital (N=9)	18% increase from 2010/11 levels (13 falls by end Q3)
Improve patient experience in hospital through the annual in-patient survey so that NGH is comparable to the top 25% performing Trusts in England	Local monitoring conducted at NGH indicates that the targets have either been met or exceeded. The National Inpatient Survey indicated that the Trust has further work to do on noise at night. The National Outpatient Survey has also indicated some areas for improvement
Protected mealtimes implemented in each ward area so that patients are able to eat meals without unnecessary interruptions	All wards operate protected mealtimes
Hourly Care Rounds implemented to ensure that patients' care needs are being met	All wards have implemented hourly care rounds
New dementia training programme implemented on all wards	Dementia training is implemented on all wards

Fig. 26 Quality Priority 1 (2011/12) Progress

Part Three

Key Improvements to Practice

Staff have worked hard to improve the experience of vulnerable people who use our services. Key improvements that have been made in year include:

Pressure Ulcers - new training programme, electronic profiling beds, prevention care bundle, new anaysis tool, new wound formulary	Falls - falls prevention care bundle, new traning programme, falls champion on each ward, pilot of chair alarms, new post falls protocol	Patient Experience - new care bundles to reduce noise at night, improve communication with patients on admission, improve communication with patients with a learning disability
Protected mealtimes - re-introduced in May 11, new training package, updated process, policy review, trust-wide audit shows improvement in 7 out of 9 areas, coloured magnets for nutrition and hydration introduced, more volunteers recruited to help with feeding	Dementia training - introduced for all health care assistants	Hourly care rounds - revised approach for those patients who are at risk of falling

Fig. 27 Quality Priority 2 2011/12 – Key Improvements to Practice

What's next?

Next year the focus will continue on reducing avoidable pressure ulcers and reducing falls in hospital and this continues to be one of our Quality Priorities for the coming year. The Trust is working as part of the Midlands and East Strategic Health Authority to achieve our ambition to eliminate all pressure ulcers by December 2012. The Trust will review current documentation and assessments and will introduce a new approach to learning from pressure ulcers that have developed in hospital. A review of how pressure relieving mattresses are supplied to the wards to ensure that the process is as straight forward as possible will be undertaken.

Part Three

Quality Priority 3
2011/12: Improving patient safety through junior doctor engagement

Aim

The Trust's aim was to improve patient safety awareness and safety behaviour of Junior Doctors, by introducing the set of measures listed below.

Junior Doctors are a transient workforce, often spending a limited time in each hospital placement. A planned programme of engagement was therefore needed to improve patient safety at NGH.

Quality Improvements made throughout the year

	Targets for March 2012	Year end outcome result (March 2012)
Bi-monthly Junior Doctor Safety Board Meetings	6 meetings	6 meetings plus project specific meetings
Junior Doctor Representation on the Patient Safety Board	6 meetings attended	All bi-monthly meetings held have included junior doctor representation. Junior doctors have also presented their safety projects findings at this forum
Junior Doctor Presentations on the Grand Round	8 presentations	12 presentations
Improve the patient safety climate throughout the organization	Baseline to be determined by bi-annual audit findings	Bi-annual safety climate questionnaire has been circulated to all members of staff at NGH. The analysis of both questionnaires has been completed and will direct the focus for the pending questionnaire and is expected to show a positive change following safety interventions
Participation by Junior Doctors in patient safety audits, for example VTE, medication errors	15 audits	All adult inpatients have a minimum of one monthly safety audit completed resulting in more than 180 junior doctor audits being completed
Specific patient safety training/ awareness initiatives for junior doctors will be introduced	12 initiatives	A monthly junior doctor teaching programme is in place with extra educational sessions available to all FY1`s on a weekly basis within the Simulation Centre
Include Patient Stories as part of the Junior Doctor Safety Board to embed the importance of being patient safety conscious	4 patients stories	A patient story is presented via the Medical Director at each meeting with junior doctors

Fig. 28 Quality Priority 3 (2011/12) Progress

Part Three

Key Improvements to Practice:

Junior Dr Safety Board - increased membership	Junior Dr Safety Projects - increased in number, consultant medical staff support	Recognition at national and international forums for junior doctor engagement and safety work showcasing safety initiatives at NGH
Junior Dr Safety Board - increased membership Increased number of monthly safety audits completed	Bespoke communication strategy which includes mobile text alerts and e-portal on Trust patient safety web page	Clinical audit aligned with Trust safety priorities

Fig. 29 Quality Priority 3 2011/12 – Key Improvements to Practice

What's next?

NGH will continue to build on the current achievements and progress of junior doctor engagement and the junior doctor safety board, reinforcing that junior doctors are ideally placed and have the ability to make improvements in patient care. The Trust will:

- Increase the number of junior doctor safety projects and audits
- Introduce a similar in-house initiative to develop Registrars at NGH
- Widen the access for more medical students to attend the 3 week safety module
- Support doctors in training to audit, initiate, implement and manage change to improve patient safety facilitating junior doctors to showcase their safety initiatives through presentations

Part Three

Quality Priority 4 2011/12: Improving Patient Outcomes And Speeding Up A Patient's Recovery After Surgery Through The Enhanced Recovery Programme

Aim

The Trust aim was to introduce an Enhanced Recovery Programme in 4 elective surgical specialities to enable patients to recover from surgery and leave hospital sooner. Enhanced recovery for patients undergoing surgery is a relatively new concept in the UK which is transforming planned surgery and cancer care pathways, by improving both patient outcomes and speeding up a patient's recovery.

Quality improvements made throughout the year

	Target for March 2012	Year end outcome result (march 2012)
Patients have received written and verbal explanation of the Enhanced Recovery Programme	95%	75%
Carbohydrate drinks received pre-operatively	95%	75%
Admission on the day of operation	70%	100%
NG tube removed before exit from theatre	70%	75%
Early nutrition/solid food intake post-operatively	70%	75%
Early planned mobilisation within 24hours of surgery	70%	75%
Reduced length of stay in hospital (please note that this is just for patient's in the enhanced recovery programme)	5 days	4.74 average LOS
Enhanced Recovery Programme Clinical Champions identified	4 champions	8 champions, clinical lead and nurse champion
Monthly compliance monitoring of agreed outcomes	100%	75%
Active directorate and corporate ERP committee/working group	100%	100%

Fig. 30 Quality Priority 4 (2011/12) Progress

Part Three

Key Improvements to Practice:

- Increased number of patients on the ERP pathway for colorectal surgery with a decreasing length of stay from 11.14 days to 4.66 days
- Increased number of patients on the ERP for urology with a decreasing length of stay from 9.2 days to 5.1 days
- Dedicated clinical nurse specialist leads for colorectal and urology
- Agreed outcome measures for Gynaecology, Urology and Colorectal surgery
- ERP expanded to include cystectomies, showcased at the regional cancer network meeting
- Patient information, diaries and care pathways developed for gynaecology, urology and colorectal surgery
- Dedicated anaesthetist specialising in goal directed fluid management
- Clinical leads and champions identified in all four specialties
- Findings, progress and practical examples presented internally, at public open evenings and regional events

Fig. 31 Quality Priority 4 2011/12 – Key Improvements to Practice

What's next?

NGH will continue to build on the current achievements and progress increasing the learning and good practice to more sub-specialities, this will further improve the results that were achieved at the end of the 2011/12 period.

NGH has secured funding to appoint a nurse lead dedicated to ERP as a secondment opportunity to focus on the ERP progress and support the directorate of orthopaedics to make progress with this initiative, whilst increasing ERP to more surgical sub-specialties.

Making the decision to adopt enhanced recovery will challenge current traditional practice for all members of the multi-disciplinary team across the whole local health community, from primary care through to post discharge. Integral to this will be the development of joined up working, bringing together all disciplines to work as one team across the whole enhanced recovery pathway.

Part Three

Core Quality Indicators

This section provides details of a core set of quality indicators that are likely to form a new mandatory reporting requirement in the Quality Accounts from 2012/13. Reporting against these indicators is not mandatory for the 2011/12 round of Quality Accounts, however it is good practice to report against these this year in preparation for next year.

	NGH Performance	National Average
Domain 1 – Preventing people from dying prematurely		
Summary Hospital-Level Mortality Indicator (SHMI): SHMI value and banding	1.09 (2)	1.0
Percentage of admitted patients whose treatment included palliative care	0.7%	-
Percentage of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care (context indicator)	14.9%	-
Domain 3 – Helping people to recover from episodes of ill health or following injury		
Patient reported outcome scores for: • Groin hernia surgery	60.5%	57.1%
• Varicose vein surgery	47.54%	47.2%
• Hip replacement surgery	81.2%	78.6%
• Knee replacement surgery	90.9%	76.6%
Emergency re-admission to hospital within 28 days of discharge	4.7	<5.0
Domain 4 – Ensuring that people have a positive experience of care		
Responsiveness to inpatients' personal needs	(see CQUIN patient experience graph fig. 8)	
Staff recommendation of the trust as a place to work or receive treatment (NHS staff survey)	3.38	3.5
Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm		
Percentage of admitted patients risk-assessed for Venous Thromboembolism	90.9%	84.1% (DH, June 2012)
Rate of C. difficile	50	54
Rate of patient safety incidents and percentage resulting in severe harm or death	5726 (0.66%)	1,194,138 (0.88%)

Fig. 32 Core Quality Indicators 2011/12

Explanation of Performance and Steps to Improve

Domain 1 – Preventing people from dying prematurely

Staff at the Trust have worked extremely hard to review performance and reduce the mortality rate, details of this can be found on page 57.

Part Three

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

The participation rate for the Trust is currently above the national rate for all procedures, however further improvement needs to be made in participation rates groin hernia and varicose vein surgery. The latest data published by HES is February 2012 and this will be refreshed in May 2012. Actions are in place to improve this which is monitored through the directorates and the governance department. Quarterly performance reports are provided to CQEG from the directorates and bi-annually to CQEG by the Clinical Audit Department.

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

Patient Experience

Details of performance with regard to responsiveness to inpatients' personal needs can be found on page 13. Quality Priority 4 2012/13 reiterates the Trusts commitment to patient experience and focuses on improving on this further during the coming year. Details of this quality priority can be found at page 13.

Staff Engagement

There is widespread recognition across the National Health Service of the absolute need to engage and empower all staff, particularly clinicians, around the delivery of better outcomes for patients, for staff themselves and for their Trusts. Whilst there are parts of the hospital with high morale, engagement etc.; the results of our Staff Surveys over a number of years shows that generally we are seen as not being amongst the best of employers or places to work. NGH has set out to become one of the best places to work. Our approach to this clear aspiration is how we engage our staff in how the hospital 'runs'. To support this aspiration we need a clear approach to staff engagement and our plan is to use Listening into Action, (LiA).

Listening into Action (LiA) is a systematic, compelling and practical response to these challenges. It has been developed through intensive, hands-on work with over 40,000 NHS staff and leaders from across more than 70 NHS Trusts' since 2007, with national endorsement and a keen interest from many of the Senior Leaders across the Service. The foundations for LiA are based on:

- The need for Senior Leaders to connect the right people around all our major challenges;
- Providing service teams with the opportunity to collaborate and share ideas
- Having 'permission' to get on and deliver actions which will benefit patients and staff;
- Fostering a sense of collective ownership by the teams themselves for delivery of results.

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Full details of this programme were presented to the Board at its April 2012 meeting and papers can be accesses via:

http://www.northamptongeneral.nhs.uk/AboutUs/Downloads/PUBLIC-Trust-Board-25-April-2012---2.pdf

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

As at the end of Quarter 4 2011/12 the Trust is performing above the national average in the indicators within this domain.

Part Three

Corporate Scorecard 2011/12

The Trust continually monitors its performance against various key indicators, including mandatory indicators, which are used to inform the organisation and external organisations of progress and to drive service improvement. An example of this is the 'Corporate Scorecard' which is shown below:

Corporate Scorecard 2011-12		
Patient Safety	Target / Trajectory	
HQU01: HCAI measure (MRSA)	3	
HQU02: HCAI measure (CDI)	54	
HQU08: MMSA numbers	No Target	
E Coli ESBL quarterly average	<17 Per Qtr	
MRSA screening elective patients	100%	
MRSA screening non-elective patients	95%	
Ward traceability compliance number of unfated units	0	
Incidence of pressure ulcers		
Type 3 *Type 4*	20% reduction vs. 2010-11 (Target 13)	
Rate per 1,000 Bed Days (All Grades)	1.31	
Reduce harm from falls		
Catastrophic *Major/Severe*	20% reduction vs. 2010-11 (Target 9)	
Mandatory training compliance full year impact		
Primary levels excluding B&H	80%	
Number of surgical site infections		
Fractured neck of femur number of operations infections	1.90%	
Long Bone Fracture (ORIF'S) Infections		
Large Bowel Surgery Infections		
Open Central Alert System (CAS) Alerts	0%	
Participation in National Audits on the Quality Account	90%	
NICE clinical practice guidelines and TAG compliance	80%	
Serious Untoward Incidents	No Target	
Never Events	2	
WHO Surgical Safety Checklist	100%	
Patient Experience	Target / Trajectory	
HQU04: Patient Experience Survey		
Patient Experience Headline score for safe high quality coordinated care	77.94	
Patient Experience Headline score for better information, more choice	68.69	
Patient Experience Headline score for building closer relationships	79.36	

Part Three

Patient Experience Headline score for clean, comfortable, friendly place to be	84.27	
Grand Total	86.8	
Cancelled Operations not rebooked within 28 days	0%	
Hospital Cancelled Operations	6%	
Complaints Responded to within agreed timescales	100%	
HQU05-07: Referral to Treatment waits (95th percentile measures) Admitted Patients		
95th Percentile Target	23 Weeks	
Median Target	11.1 Weeks	
Non Admitted Patients		
95th Percentile Target	18.3 Weeks	
Median Target	6.6 Weeks	
Ongoing Patients		
95th Percentile Target	28 Weeks	
Median Target	7.2 Weeks	
HQU09-13: A&E Quality Indicators (5 measures)		
Time Spent in A&E	=<4 hrs	
Time Spent in A&E (Admitted)	95th	
Time Spent in A&E (Admitted)	Longest	
Time Spent in A&E (Non-Admitted)	95th	
Time Spent in A&E (Non-Admitted)	Longest	
Unplanned Re-attendances	>1% and <5%	
Left Without Being Seen	=<5%	
Time To Initial Assessment For Patients Arriving By Ambulance Assess<20	1	
Time To Initial Assessment For Patients Arriving By Ambulance 95th percentile	<15 mins	
Time To Treatment Median	<1hr	
Time To Treatment 95th	0	
Cancer Wait Times		
2 week GP referral to 1st outpatient	93.0%	
2 week GP referral to 1st outpatient - breast symptoms	93.0%	
31 Day	96.0%	
31 day second or subsequent treatment - surgery	94.0%	
31 day second or subsequent treatment - drug	98.0%	
31 day second or subsequent treatment - radiotherapy	94.0%	
62 day referral to treatment from screening	90.0%	
62 day referral to treatment from hospital specialist	85.0%	
62 days urgent referral to treatment of all cancers	85.0%	
SRS08: Length of Stay (Acute & MH)		
Elective	4.23	
Non-Elective	6.34	

Combined	5.33	
SRS09: Daycase Rate	81.5%	
Day of Surgery Admission Rates (DOSA)	89%	
SQU11: PROMS Scores - Pre Operative participation rates		
Groin Hernia - Participation Rate	80%	
Hip Replacement - Participation Rate	80%	
Knee Replacement - Participation Rate	80%	
Varicose Vein - Participation Rate	80%	
All Procedures - Participation Rate	80%	
(Please note PROMs Scores is national data from HES and reflects April 10 to March 11)		
Clinical Outcomes	Target / Trajectory	
HSMR - cumulative position from Apr 2011		
Pneumonia	<100	
Fracture of neck of femur (hip)	<100	
Urinary tract infections	<100	
Acute cerebrovascular disease	<100	
Aspiration pneumonitis, food/vomitus	<100	
Congestive heart failure, non hypertensive	<100	
Chronic obstructive pulmonary disease and bronchiectasis	<100	
Acute myocardial infarction	<100	
Billiary tract disease	<100	
Acute and unspecified renal failure	<100	
Point of Delivery		
Combined	<100	
Non-Elective	<100	
Elective	<100	
Diagnosis Group		
Pneumonia	<100	
Chronic obstructive pulmonary disease and bronchiectasis	<100	
Urinary tract infections	<100	
Acute cerebrovascular disease	<100	
Fracture of neck of femur (hip)	<100	
Acute myocardial infarction	<100	
Congestive heart failure, non-hypertensive	<100	
SQU12: Maternity 12 weeks	>90%	
SRS10: Delayed Transfers of Care – Acute & MH	3%	
Percentage of patients admitted with FNOF operated on within 48 hours of admission	100%	
Patients admitted as emergency with GI bleed scoped within 24 hours		
25% of suspected stroke patients given CT scan within 3 hours of arrival	25%	

75% of suspected stroke patients given CT scan within 24 hours of arrival	75%	
Percentage Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	65%	
Patients who spend at least 90% of their time on a stroke unit	80%	
Breast feeding initiation	75%	
Caesarean Section Rates - Total	<25%	
Caesarean Section Rates - Elective	<10%	
Home Birth Rate	<14%	
Number of women smoking at delivery	<13%	
Achievement of Cancer waiting times in 2011/12	Target	2011-12
2 week GP referral to first outpatient	93.0%	96.1%
2 week GP referral to first outpatient - breast symptoms	93.0%	98.1%
31 Day diagnosis to first treatment	96.0%	98.8%
31 day second or subsequent treatment - surgery	94.0%	98.2%
31 day second or subsequent treatment - drug	98.0%	99.2%
31 day second or subsequent treatment - radiotherapy	94.0%	98.1%
62 day referral to treatment from screening	90.0%	96.8%
62 day referral to treatment from hospital specialist	85.0%	94.0%
62 days urgent referral to treatment of all cancers	85.0%	86.2%

Fig. 33 Corporate Scorecard 2011-12

Part Three

Statements from Local Involvement Networks, Overview and Scrutiny Committees and Primary Care Trusts

Local Involvement Network (LINk)

LINk has worked closely with Northampton General Hospital during 2011/2012 and has observed and participated in the following areas of care:

- Attending the hospital's multi-disciplinary Falls Steering Group, Dignity Forum, Estates and Facilities and Vulnerable Adults Steering Group
- Carrying out ward audits and feeding back to the hospital in order to ensure that both the positive and negative issues are addressed and if necessary rectified.
- LINk will continue to monitor any reorganisation of wards and ensure that care is taken to make this as non disruptive as possible.
- The roll out of protected meal times on all wards ensures that all patients needs can be effectively met and that any assistance required can be delivered without distraction.
- The focus on patient and public involvement (PPI) and engagement is increasing and LINK will support the PPI initiatives to ensure that they are effective.
- Discharge remains a focus and LINk will continue to work with the hospital to help identify the barriers and improve discharge procedures.
- There have been several new initiatives introduced this year as a direct result of listening to the needs and view of patients and the public including the new Community Stroke team and the new Short Stay Elderly Specialist ward.
- The introduction of the Dementia Care Action Committee earlier this year is already increasing awareness into care of patients with dementia and progressing well and although not fully achieving its targets is clearly putting improved patient outcomes at the fore and will be developed further.

Over the last year LINk has continued to work closely with the hospital including the ward audits looking at areas suggested by the director of nursing, and we receive regular updates from the PALS team. We are seeing significant improvements with the hospital and will continue to support them in addressing the areas that are still of concern.

NHS Milton Keynes and Northamptonshire PCT Cluster and Nene Clinical Commissioning Group

We have reviewed Northampton General Hospital NHS Trust (NGH) quality account for 2011-12. All of the nationally mandated elements of a quality account are covered and there is assurance that both internal and external assurance mechanisms for quality have been used.

We are satisfied as to the accuracy of the data contained within the quality account.

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We welcome the progress against the quality priorities for 2011-12 and note that NGH did not achieve its own targets for a reduction in Length of Stay, Bed Days lost, Falls or Pressure Ulcers.

We welcome the reduction in mortality identified in the quality account and recognise the significant work the Trust has already undertaken in this area and that will be continued in 2012-13. We would ask the Trust to use more clearly the Summary Hospital-level Mortality Indicator (SHMI) alongside Hospital Standardised Mortality Ratio (HSMR) when identify improvements in mortality.

The commissioners fully support the quality priorities, identified by NGH, for 2012-13 and welcome the focus on:

- Improving emergency care to provide the best quality care
- Improving patient experience and supporting people with dementia and learning disability
- Improving the care for dementia patients and vulnerable adults
- Reducing avoidable harm.

We are pleased that the Trust's quality priorities align with the SHA ambitions in relation to the elimination of avoidable pressure ulcers and implementation of the Patient Revolution.

We note the mixed picture to the achievement of CQUIN schemes with some schemes such as a reduction in Caesarean Sections and Improvements in Patient Experience being only partially achieved.

We would ask the Trust to consider including more detail on the Patient Reported Outcomes Measures (PROMS) beyond participation rates.

We will continue to work closely with NGH and support their ambitions to maintain the delivery of high quality care providers to service users and patients through incentivising quality improvements (CQUIN), quality monitoring and performance management.

The coming year will provide a continued challenge for NGH in terms of maintaining high quality care within a difficult financial climate and the changing commissioning landscape. We are confident that NGH will continue to deliver improvements in quality for all those who access their services.

Overview and Scrutiny Committee.

Northamptonshire County Council Overview and Scrutiny Committee have not provided a response to this year's Quality Accounts.

Part Three

Over The Last 12 Months Many Services Have Seen Significant Improvements. Some Of The Showcase Exmples Are Outlined Below.

New County Wide Vascular Service

A countywide vascular service and an 'abdominal aortic aneurysm' (AAA) screening check for men in the year they turn 65 are being introduced in April 2012, providing a considerably enhanced local service for patients with vascular problems.

The overall aims of the service are to provide sustainable vascular services for patients in the county with disorders of the arteries, veins and lymphatics that will deliver world class outcomes for patients, support other clinical services, deliver AAA screening and improve equity of access.

Clinical and management teams from NHS Northamptonshire, Northampton and Kettering general hospitals have been working hard to develop the new enhanced service over the last year. From April 2012 all elective arterial surgery and all vascular emergencies will be treated here at NGH, where there will be a consultant vascular surgeon available 24 hours a day, 7 days a week and consultant interventional vascular radiologist cover for Northamptonshire.

New Community Stroke Team

A new community stroke team has been established at Northampton General Hospital NHS Trust to provide a countywide rehabilitation service to support stroke patients, as well as their carers and families, to develop a rehabilitation programme that fits their needs, with the aim of helping patients to achieve their goals and regain as much independence as possible.

The multi-disciplinary team consists of occupational therapists, physiotherapists, nurses, speech and language therapists, rehabilitation practitioners and assistants – all of whom have specialist knowledge and experience of stroke and stroke related issues.

Accident and Emergency Refurbishment

Our Accident and Emergency Department is staffed by a highly skilled team, but the number of patients they treat has sometimes tested it to capacity. The A&E staff recently helped to redesign a new department and the work to update and expand the area is due for completion at the end of June 2012. This should significantly reduce the pressure the service has been under during recent months.

The area has been partly refurbished and more space created in which to treat patients, whose attendance has increased by 8% in the last year. There are now an additional five cubicles, made possible by transferring doctors and administration offices out of the main department. This is the first expansion of A&E at NGH for 15 years.

The physical changes are just one of the initiatives introduced by the hospital and NHS Northamptonshire to improve the department. An extra £750,000 has been secured to enable the funding of four new emergency consultants and ten new nursing staff. All of this should be in place in the next 6 to 12 months.

New Short Stay Elderly Specialist Ward

Previously elderly patients coming into hospital would be admitted to a medical ward for treatment, before later being transferred to a rehabilitation ward. Patients may not have had the full specialist input to facilitate a prompt return home, often leading to greater dependency and confusion, long hospital stays and larger care packages on discharge or long term care.

Now such patients are admitted to a special 'short stay elderly' ward (Brampton ward) which combines the two previously separate stages. Patients now have quick access to a geriatrician to have their medical problems addressed and see physiotherapists and occupational therapists who enable them to become fit enough to return home. Patients unable to go home immediately are transferred to a care facility outside of the hospital, freeing up costly acute care beds for other patients.

Brand New Simulation Suite

Northampton General Hospital NHS Trust has opened a brand new state-of-the-art training suite which will help prepare doctors and nurses of the future. The Simulation Suite has the ability to replicate any clinical area within the hospital or community environment, providing realistic facilities so that all grades of staff and students can receive training and practise their skills in simulated settings without compromising patient safety.

The suite boasts three life-size patient 'manikins' which can breathe, bleed, blink, react to medicine and even speak. They can simulate life-threatening conditions and can be cannulated, catheterised and intubated. The simulation can be video recorded so that team members can view and comment on performance. Following this a facilitated debriefing session allows candidates the opportunity to learn through reflection, mutual support and shared skills.

Award Winning Aspiring to Excellence Programme

A three week safety module for medical students, prompted by work with junior doctors led by the Medical Director was set up following identification of a gap within the medical school curriculum. The project aim was to help junior doctors understand their role in effecting change impacting on patient safety.

The Medical Director (MD) assisted by a senior nurse established a forum for junior doctors to encourage their direct involvement in patient safety by providing an opportunity to share their concerns with the MD, who could also give a wider perspective. This lead to the formation of a Junior Doctor Safety Board where trust wide audits relating to key safety priorities were delivered in a safe environment with senior support.

The same principles were utilised to develop a similar format for medical students, addressing key safety issues to result in a positive learning experience for the students and meaningful results for the Trust.

The Medical School supported the Trust to develop a safety teaching module, which contained a trust wide audit related to a safety topic as well as components from the curriculum.

The first cycle in 2010 was the WHO checklist which was refined in 2011 for Surviving Sepsis.

The 'Aspiring to Excellence Programme' remains high profile. The linkage with key important quality issues for the Trust has ensured Board support is maintained and this annual patient safety module is sustainable, receiving enthusiastic support from consultants and other clinical teachers and external interest.

Feedback has been uniformly positive; the safety module remains oversubscribed, the Deanery has supported further modules and the Aspiring to Excellence project won an East Midlands Safety Innovation Award in 2011.

New Medical Kit to Help Combat Septicaemia

A new medical kit designed by junior doctors at Northampton General Hospital will help in patients fight potentially deadly blood poisoning. The NGH sepsis kit pulls together all the equipment in one box that staff need to combat septicaemia as soon as the signs are spotted.
One box is allocated to all adult in patient wards within the hospital and, as well as intravenous fluid and cannulae, the box contains antibiotics for use by trained members of staff. It means that the box will save vital minutes in the race to save a patient's life compared with the time taken to search a treatment room for relevant equipment and drugs.

Dementia Care

Dementia is one of the most important issues we face as the population ages. There are estimated to be over 750,000 people in the UK with dementia and numbers are expected to double in the next thirty years. It is estimated that 40% of hospital inpatients have some degree of dementia.

The multi-disciplinary Dementia Care Action Committee was established at NGH in February 2011. The remit of the group is to ensure that the recommendations of both local and national dementia strategies are fully implemented within NGH. The Committee developed a comprehensive action plan and met monthly throughout 2011/12 to ensure that progress (see page 9 for details) was consistently made in the delivery of the plan.

A training needs analysis in mid-2011 identified the core groups of staff that required training in dementia care. The Dementia Training Strategy was developed to address the gap in knowledge and practice, it was agreed that the Corporate Practice Development Nurse would deliver a bespoke 'train the trainer' programme. The train the trainer programme has been run on seven occasions over the past few months with a total of 46 trainers who are now in the process of delivering the training package on their respective wards.

Part Three

An evaluation of the success of the 'Butterfly Care' programme will be undertaken in March 2012 which will include a review of the current documentation and information.

In the forthcoming year, the Dementia Care Action Committee plan to develop a specific care pathway for patients with dementia. The pathway will give clear guidance regarding actions to be taken at each step of the journey and will include comprehensive guidelines and procedures within one document. Plans are also in place to develop a befriending service for patients with dementia in conjunction with the Women's Royal Voluntary Service (WRVS). Two members of the Committee have also been invited to join the new Northamptonshire Action Alliance chaired by the Alzheimer's Society. This will ensure that the Committee share learning and experience with the wider Health Economy.

Results of National Surveys

Cancer Patient Survey

This national survey was undertaken with all patients with a primary diagnosis of cancer who were discharged form Northampton General Hospital NHS Trust during July and August 2011. 649 patients were sent questionnaires, with 353 responses giving a response rate of 57% once two undelivered and 23 deceased patients had been accounted for.

Where we do well

- ✓ Free prescription advise
- ✓ Giving easy-to-understand written information about the relevant operation
- ✓ Doctors definitely knowing about how to treat the specific cancer
- ✓ Someone close to the patient definitely had enough opportunity to talk to a doctor

Where we could do better

- X Providing easy-to-understand written information about the side effects of treatment before that treatment is started
- X Make contacting the Clinical Nurse Specialist easier
- X Provide better information about support and self help groups
- X Provide a more complete explanation of how the operation had gone
- X Provide all information needed to the carer to care for the patient at home
- X Treat people as if they are not a 'set of cancer symptoms'

National Out-patient Survey

The Care Quality Commission (CQC) national survey of adult outpatient services involved 163 acute and specialist NHS trusts. Responses were received from more than 72,000 patients, a response rate of 53%.

People were eligible for the survey if they were aged 16 years or older and attended an outpatients department(s) during any one month period (month chosen by the trust) in either April or May 2011. This included any outpatient clinics run with the emergency department (A&E/casualty) such as fracture clinics. Fieldwork for the survey took place between June and October 2011.

Part Three

468 patients completed the survey in response to care at Northampton General Hospital (NGH), equating to a local response rate of 55.9% (almost 3% better than the national response rate).

Where we do well

- ✓ Advising patients on how to find out the results of their tests
- ✓ Explaining the results of tests in a way which people can understand
- ✓ Patients receiving copies of letters sent between the hospital doctors and the family doctor (GP)

Where we could do better

- X Explain what will happen during the outpatient appointment
- X Advise patients on how long they will be waiting once in the outpatient department
- X Explain what will happen during the treatment
- X Advising of the associated risks and benefits
- X More time to discuss health/medical problems with the doctor
- X Doctors being more aware of the individuals medical history
- X Providing answers to patients questions in a way that they understand
- X Explain the purpose of the medicines to take home
- X Advise medication side effects to watch out for
- X Explain the reason for medication changes in a way that patients can understand

National In-patient Survey

The National Adult Inpatient survey was carried out between September 2011 and January 2012 with the co-operation of patients discharged from Northampton General Hospital NHS Trust in August 2011. 476 patients completed the survey in response to their care here, equating to a response rate of 57.6%.

Where we do well

- ✓ Patients not having to share a sleeping area with patients of the opposite sex
- ✓ Upon arrival, patients did not have to wait long before being admitted to a bed on a ward
- ✓ Not having to use the same facilities as patients of the opposite sex

Where we could do better

- X Improve hospital food
- X Seeking patients views on their quality of care whilst they are in hospital
- X Noise at night from hospital staff
- X Making staff available to listen to patients about their worries and fears
- X Better explain the purpose and side effects of new medicines
- X Better explain the danger signals on discharge

Part Three

National Staff Survey

Between October and December 2011, staff at the Trust took part in the ninth annual National NHS Staff Survey. The results will be used inform improvements in working conditions and practices at a local and national level. The Trust response rate was 48% which showed a decrease from 49% in 2010.

Where we do well:

- ✓ A higher percentage of staff have been appraised in the last 12 months
- ✓ An increased number of staff agreed personal development plans in the last 12 months

Where we could do better:

- X Staff feeling pressure to attend work when feeling unwell
- X Staff less motivated to go to work
- X A higher percentage of staff having the intention to leave their job
- X Less staff received health and safety training in the last 12 months
- X Staff feeling bullied or harassed

Public and Patient Involvement

The Public and Patient Forum focus groups set up in 2010 have continued to meet focusing on:

Pain Management;
Hotel Services;
Trauma and Orthopaedics;
Medicine;
Surgery.

The groups have been instrumental in providing valuable feedback to the trust through various reviews set up to look at particular aspects of the patient environment. This has included, for example, a review of the use of the hand gel dispensers situated at ward entrances. Results from this review enabled the Infection Prevention Team to understand how well members of the public and staff have appreciated the importance of hand hygiene and where actions can be taken to further improve on this.

A groups of trust members have volunteered to take part in a series of ward audits which have been developed to examine specific aspects of patient care that were highlighted in recent patient satisfaction surveys and the CQC inspections in June/July 2011. The subject of these reviews was:

Noise at Night-time;
Protected Mealtimes;
Patient Information Boards.

Part Three

Working with Partners across the Healthcare Community

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

Some of the initiatives that are being implemented include:

- Community Elderly Care Service – this service aims to reduce emergency admissions to hospital by better supporting elderly people in community settings
- Pro Active Care – this service aims to better support people with long term conditions to live in the community and reduce the need for admission to hospital
- End of Life Care – this service aims to better support people who are dying so that they die in the place of their choice and ensures that their carers are better supported at home
- Adoption of “Right Care” protocols in primary care to reduce outpatient referrals
- Initiatives to reduce demand in accident and emergency

The Trust is also actively involved in the “Healthier Together” programme; a review of acute services across Northamptonshire, Bedfordshire and Milton Keynes that will determine the optimum configuration for hospital services across the five acute hospitals in that region.

Complaints and Compliments

The reformed NHS Complaints system is now in its third year of operation. Northampton General Hospital recognises that during this time complaints have become more complex and may involve an increasing number of different organisations (NHS and Social Care for Adults). It is our aim to ensure that the pathway, for each complaint received, is acted upon in a way that meets the needs of each individual / organisation involved.

NGH aims to make local complaint handling a positive experience for those who seek to access the service. Through local network meetings a joint way of working has been agreed for organisations within this area, which has been tried and tested on an increasing number of occasions. Upon receipt of a complaint our Complaints Team will identify the appropriate organisation who will take the lead in the investigation, which is undertaken in consultation with each complainant and a named contact is assigned to each person/family. This ensures that clear, effective communication takes place and a good relationship is established from the outset.

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. The points to be investigated are agreed with the complainant at the earliest opportunity, and meetings are offered on either an informal or formal basis. Through our letter of response, which may involve a number of different clinical areas and/or other organisations, we aim to provide various remedies through the issuing of an appropriate apology and a variety of actions which aim to redress the issues identified, where appropriate.

Part Three

All of our complaint responses are signed by our Chief Executive or deputy, in order to underpin the organisations approach to complaints handling, and our wish to reassure the public that we take complaints very seriously. We always ensure that organisational learning is clearly identified in the response and that this is supported internally through evidence being available to assure stakeholders that we have done what we said that we would do.

The 4 C's (comments, concerns, complaints and compliments) principles also form part of this process as members of the public are provided with a range of options that they may choose from. This involves initial support and advice through front line staff to on-the-spot support from our Patient Advice & Liaison Service (PALS), to our Complaints Department, both of whom sit within our Patient Experience Team. The complexities of PALS enquiries mirror those of complaints, which can prove challenging with the resources that are currently in place.

The introduction of the 4 C's has shown a significant positive impact when the number of complaints is compared to the year prior to the reformed NHS Complaints system (2008-2009). However, the number of complaints has gradually increased, which we believe may be due to the constantly growing and evolving demographics of the community that we serve.

It is important that members of the public are fully aware as to how they may raise concerns or complaints regarding all aspects of their experiences of services that are provided by NGH.
Following the recent national inpatient survey (2011) it was identified that some service users were unable to locate information in relation to how to raise their concerns. Whilst this information is available in all areas, through the use of leaflets and posters, it is acknowledged that they may not be as evident as had initially been planned. We are currently in the process of reviewing the way in which this information is presented and available across the organisation.

Complaints Analysis

	2008-2009	2009-2010	2010-2011	2011-2012
Total number of complaints	601	430	467	517
Response within the agreed timescale	83%	86%	*96%	100%
Number of requests received for an Independent Review (parliamentary & Health Service Ombudsman)	**13	21 (including some from previous year)	18 (including some from previous year)	23 (including some from previous year)

Fig. 34 Complaints Analysis 2011/12

(*At the time of reporting 59 complaints remained open and were still within timescale)
(** The Healthcare Commission was responsible for stage 2 until April 2009)

Primary Theme of Complaint Categories

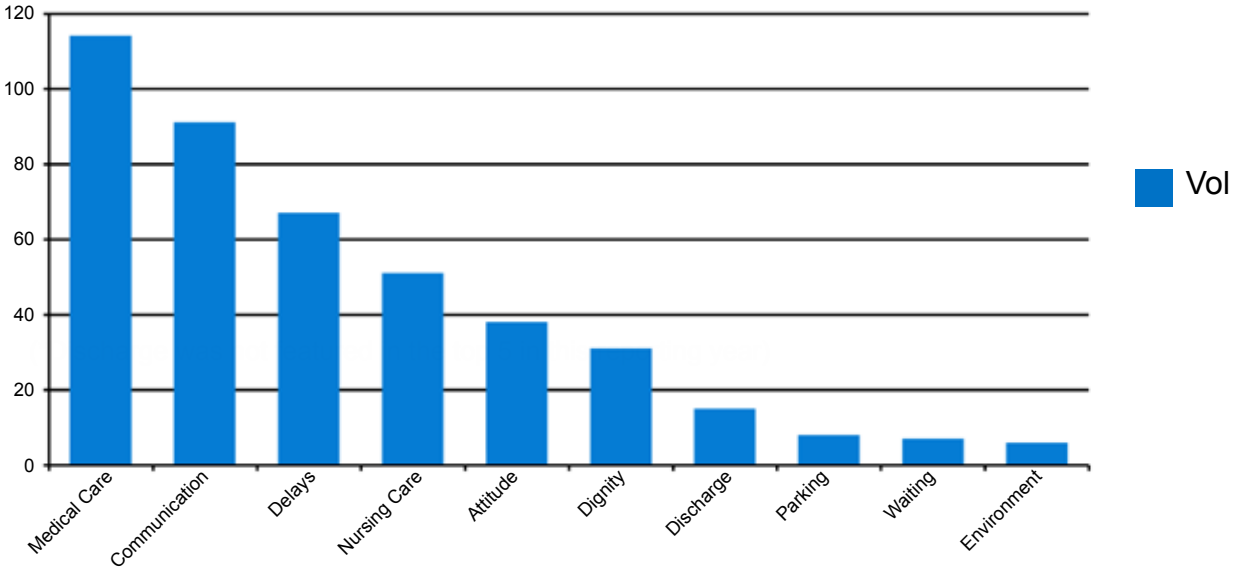

Fig. 35 Top 5 Complaint Categories 2011/12

Learning from Complaints

The Trust seeks to learn from complaints and where appropriate an action plan will be prepared to ensure that necessary changes are made. Examples of changes that have been made as a result of complaints received during 2011-2012 are:

- The wife of an oncology patient (upper GI cancer) sent a very detailed letter of complaint regarding various aspects of her husband's care including problems surrounding the significant loss of weight that he had experienced. The relative considered that this aspect of her husband's care was not properly recognised or addressed by the staff when he was attending his oncology appointments. As a result of the issues raised the directorate has now arranged for a dietician to be present during the upper GI cancer outpatient clinic. The dietician has a private clinic room where she is able to consult with patients at the time, in clinic to address any concerns as and when they arise
- A patient attended A&E by ambulance with a suspected stroke (identified by the ambulance crew). However, upon the patients arrival to A&E the stroke care pathway was not followed, as the patients symptoms were not correctly recognised, resulting in the patient not receiving the appropriate level of care and attention, in a timely manner. In view of the problems identified through the investigation the stroke care pathway has been reviewed and is now being monitored for compliance

The Trust Board continues to receive examples of patient stories (complaints and compliments) at every Board meeting.

Compliments

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

Part Three

What Our Patients are Saying about Northampton General Hospital NHS Trust:
(Source 4 'C's compliment forms)

"If it was not for the....my son…would not be where he is today. Everything was so positive and outstanding. I am at long last getting the help and support that is needed. If it was not for the… I would be none the wiser to my son's issues, so thank you so much to everyone in the …dept you do a fantastic job"
(June 2011)

"My stay has been quite pleasant due to the care and attention I've had from all staff. I couldn't have wished to be treated any better. This is my first stay in hospital (in 91 years), it's been quite an experience and not unpleasant"
(December 2011)

"….has been professional and compassionate all day and is a credit to the ward. Thanks so much…"
(December 2011)

"I have nothing but absolute praise for the nursing staff who have and are looking after… especially.. and.. who I feel very happy to leave.. in their care. They both create confidence and care, beautiful girls both of them."
(January 2012)

Part Three

Hospital Mortality Monitoring

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

HSMR rates provided to us by Dr Foster are reviewed on a monthly based by the Associate Medical Director and monthly reports are presented to the Medical Director, discussed at the Clinical Quality & Effectiveness Group, and presented monthly to Trust Board.

HSMR for 2011-12 (April 2011- January 2012) has shown significant improvement during the year. Performance was poor in the winter of 2010-11 during the cold weather and flu epidemic of December and January when both crude mortality rates and HSMR rose.

In 2010-11 the HSMR was higher than expected at 116 when it was adjusted at the end of the financial year taking data for all Trusts across the UK.

Since April 2011, the HSMR at Northampton General Hospital NHS Trust has fallen and is currently running at 94 for the period ending March 2012. When it is adjusted at the end of the year it is likely to be around 102. This is no longer significantly different from other hospitals. Amongst the 8 acute trusts in the East Midlands the crude mortality in this group also continues to be one of the lowest at 3.9% [EMSHA range 3.8-5.2%, average 4.3%.], continues to fall each year and is also amongst the lowest in the whole country for Trusts providing similar services. During the last year extensive work has taken place, led by the Medical Director and Director of Planning, to improve the way that data is collected and analysed but also to be assured that the Trust is focusing appropriately on areas where quality of care can be improved. Further work will continue to ensure the improvements are maintained and services are continually improved.

A new mortality indicator was introduced Nationally last year which is called SHMI (Standardised Hospital Mortality Indicator) This gives very similar results to HSMR for our Hospital. The last SHMI are only available for the period up until September 2011 and for this reason we have chosen to report on HSMR in this report. The SHMI for the period April to September 2011 is in line with the national average rate.

Mortality (in hospital) Diagnoses - HSMR

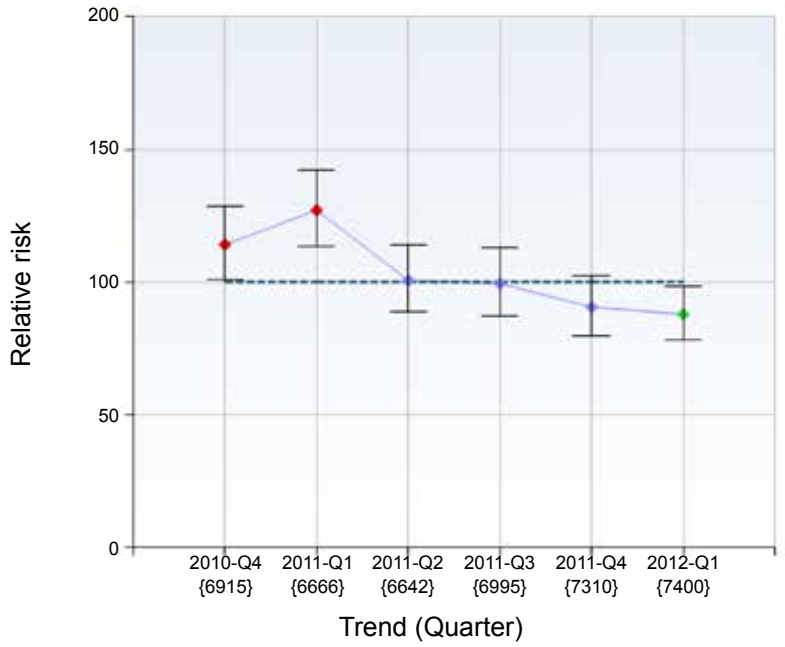

Fig. 36 HSMR Rates 2011/12

Improving Patient Safety by Reducing Infections – MRSA and Clostridium Difficile

The Trust, building on the significant achievements in this area last year, has continued its focus on reducing infections throughout the 2011/12 period.

The number of hospital acquired infections was below the centrally determined target trajectory, with just 2 MRSA bacteraemia reported during the year against a target of 3 and 52 clostridium difficile infections reported against a target of 54

NGH achieved all national hospital aquired infection targets set for 2011/12, however we continue to focus on reducing infection as a priority.

Part Three

Appendix 1

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

I am required by the Audit Commission to perform an independent assurance engagement in respect of Northampton General Hospital NHD Trust's Quality Account for the year ended 31 March 2012 ("the Quality Account") as part of my work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and the National Health Service (Quality Account) Amendment Regulations 2011 ("the Regulations"). I am required to consider whether the Quality Account includes the matters to be reported on as set out in the Regulations.

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

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

- the Quality Accounts 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.

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the Quality Account is not consistent with the requirements set out in the Regulations.

I read the Quality Account and conclude whether it is consistent with the requirements of the Regulation and to consider the implications for my report if I become aware of any inconsistencies.

This report is made solely to the Board of Directors of Northampton General Hospital Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Assurance work performed

I conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the NHS Quality Accounts Auditor Guidance 2011/12 issued by the Audit Commission on 16 April 2012. My limited assurance procedures included:

- making enquiries of management;
- comparing the content of the Quality Account to the requirements of the Regulations.

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

The scope of my assurance work did not include consideration of the accuracy of the reported indicators, the content of the quality account or the underlying data from which it is derived.

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. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that the Quality Account for the year ended 31 March 2012 is not consistent with the requirements set out in the Regulations.

John Cornett
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22 June 2012

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