



Northampton General Hospital
NHS Trust

Quality Account 2017/18



Providing
the **Best**
Possible
Care

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Introduction

What is a Quality Account?

A Quality Account is a report about the quality of services we provide. The report is published each year and made available to the public. We believe our quality account is important because it provides us with a way of letting people know about the improvements we have made to our services as well as their overall quality. We measure the quality of services by looking at patient safety, the effectiveness of the care and treatment we provide and, importantly, the feedback we receive from our patients.

The Department of Health requires organisations like Northampton General Hospital to submit their quality account to the Secretary of State by uploading it to the NHS Choices website by 30th June each year.

Northampton General Hospital NHS Trust (NGH) – about us

NGH is an 800-bedded hospital providing general acute services for a population of 380,000 and hyperacute stroke, vascular and renal services to people living throughout the whole of Northamptonshire, a population of 692,000. There are approximately 713 general and acute beds with 60 maternity beds, and 18 critical care beds. We employ 4,800 staff, which includes 496 doctors, 1,074 nursing staff and 2,587 other healthcare professionals and non-clinical staff.

Our principal activity is the provision of free healthcare to eligible patients. We are a hospital that provides the full range of outpatients, diagnostics, inpatient and day case elective and emergency care and also a growing range of specialist treatments that distinguishes our services from many district general hospitals. We also provide a small amount of healthcare to private patients.

We are an accredited cancer centre, providing cancer services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire. In addition to the main hospital site, which is located close to Northampton town centre, we provide outpatient and day surgery services at Danetre Hospital in Daventry and have dedicated beds at the Cliftonville Care Home, Spencer Care Home and Angela Grace Care Home for patients who no longer require acute inpatient care. We are responsible for the medical care of patients transferred to those care homes, whilst all nursing care and management is the responsibility of the home.

We are constantly seeking to expand our portfolio of acute specialties and to provide services in the most clinically effective way. Examples are developments in vascular surgery and laparoscopic colorectal surgery, which place us at the forefront of regional provision for these treatments.

We also train a wide range of clinical staff, including doctors, nurses, therapists, scientists and other professionals. Our training and development department offers a wide range of clinical and non-clinical training courses within our own excellent training facilities which were recently upgraded.

Division: Medicine & Urgent Care

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

Division: Surgery

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

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

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

Division: Clinical Support Services

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

Part One

A statement on quality from our Chief Executive, Medical Director and Director of Nursing



Welcome to our 2017/18 Quality Account. The cornerstone of Northampton General Hospital NHS Trust's philosophy is to provide the best possible care for all our patients, underpinned and strengthened by our values:

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

This report summarises some of our main achievements and challenges over the last year.

The highlight of our year in review was the result of our inspections by the Care Quality Commission that saw an improvement in our official rating, from requires improvement to good. Inspector's spoke of an inclusive and supportive staff culture, confidence in leadership at all levels and a clear focus on patient safety. The inspection report painted a picture that everyone working here recognised, the essence of which is a positive team spirit delivering care of a high standard in a clinically-led structure where staff are proud of what they do.

The report echoes the hundreds of emails and letters we receive every month from patients and their loved ones, people who take the time to tell us how much it means to them when we get it right, when we prioritise their experience and safety above everything else. The report confirms that this was a whole team effort and that our direction of travel is the right one. It gives us renewed confidence that if we sustain our current improvements and continue our current approach, we will be able to move from Good to Outstanding.

The timing of our improved inspection rating, in late autumn, proved motivational as we focused on our preparations for what we predicted correctly would be our most challenging winter period yet. Every winter, as we worry that we are at the limit of our ability to provide safe care, we manage to do just that little bit more to improve things but this winter was exceptional in its pressures.

Those patients who come in are older, sicker and frailer and they stay longer. The number of patients in our beds for over seven days is just about the highest in the country and has been rising. On average this winter, this was the case with 70% of our bed capacity; a smaller bed base makes it even more difficult to admit patients who need our care. This is not safe for the patients who are staying with us too long and becoming debilitated. And it isn't safe for the patients who need to come in acutely because we have a chronic and severe problem with patient flow through the hospital.

Alongside our operational pressures, our financial position has been extremely challenging and we spent much of the year grappling with significant overspends in the main bed holding divisions. Across the organisation, we have an improved understanding that our operational performance is wedded to our financial performance: if we are able to get patients to the right bed quickly then their care will be better and safer, and we will incur less excess cost and be able to receive payment for the elective work which we can then do. We have not achieved the majority of our key performance indicators of the Referral to Treatment Time for non-emergency care within 18 weeks nor did we achieve the national access standard of 95% for patients being treated within four hours in the Accident and Emergency Department, nor the 62 day cancer standard. However most acute providers failed to meet these targets however appropriate improvement work has led to a significant improvement in cancer performance in Q4. Prioritisation of emergency performance has necessitated a planned shortfall against RTT.

Our organisation-wide response to these pressures took the form of a comprehensive programme, *Fixing the Flow*, to improve bed flow across the hospital and address exit block, the situation of patients being unable to leave the hospital despite being medically fit for discharge. Some of the barriers to optimum bed flow are external and we're working with our health and social care partners to address those issues. However, there are steps we can take that will make a significant difference to how efficiently we operate. The key outcomes we are focusing on are:

- the standardisation across the hospital of operational practices for admissions, ward rounds and discharge
- planning for discharge as soon as a patient is admitted

In delivering *Fixing the Flow*, we've asked our employees to work differently. Some examples include having additional medical consultants in A&E to increase the range of specialist expertise for patients needing emergency care. In many cases, this means our patients can be treated and be home again without the need for an admission; for other patients, it means identifying their care needs earlier even if they have needed to wait until a bed becomes available on a ward. We've fine-tuned the process of discharging a patient home once they're ready to leave, so that those beds can be made available as quickly as possible for other patients in need. We also piloted, and are now rolling out across our wards, new way of approaching the ward round so we can bring consistency in best practice across our organisation. We've seen changes in ward working arrangements, more seven-day working, lots of clinical and support staff doing extra shifts. We've also seen teams across the hospital embrace the opportunities represented by *Fixing the Flow* and been heartened by the enthusiasm for meaningful change.

Worthy of particular mention is the multiagency discharge event (MADE) held over three days in the New Year. This was supported by the national Emergency Care Improvement Programme (ECIP) and by partners across the health and social care system. We saw what we can achieve when we work collaboratively, with a significant increase in the number of patients going home. The event reaffirmed that change is needed in the way services are delivered and commissioned and this remains one of the biggest challenges in our local health economy.

Support and recognition for our employees

We continue our determination to provide the best care we can and support our staff in the best way possible. One of the most important ways of doing this is to continue our resolve to nurture an open and honest culture with respect and support for all. In the course of the

year, we launched two initiatives to say thank you to our employees and to celebrate when they do great work, when their actions made a difference in the lives of others or helped us to be a better organisation.

We're proud to be one of the first hospitals in the UK to introduce the DAISY Award, an international recognition programme that honours and celebrates the skillful, compassionate care nurses and midwives provide every day. The award gives patients or their families an opportunity to nominate a member of the nursing and midwifery workforce and share their story of how a nurse or midwife made a difference.

The focus on patient safety remains a priority for all our staff and this culture is embedded throughout the Trust. We continued to make significant progress in reducing the numbers of hospital-acquired pressure ulcers and consistently improved the delivery of harm free care as measured by the "Safety Thermometer".

During the year, we focussed our work in infection prevention and control on reducing the number of patients contracting C Difficile, MSSA, MRSA Gram Negative Bacteraemia, and Surgical Site Infections.

We welcomed the sustained improvement in the Summary Hospital-Level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) which are among the lowest in our peer group and reflect our aim to place patient safety above all else. Building on our work in this area, we are further improving engagement with bereaved families and carers and extending reviews to all patients who have died to ensure we are capturing learning wherever possible.

We continue to encourage our staff to report incidents so that we are able to improve the care given to our patients as a result of learning from incident reports and investigations. We have made real progress in the timeliness for completing investigations and improvement actions and learning from things that went well and addressing areas where we need to improve.

Our improvements in patient experience have been recognised again nationally with 3 projects shortlisted for the prestigious Patient Experience Network Awards. Our patients are telling us the care we are providing is improving with 92.6% recommending our services to their family and friends. FFT results for the Emergency Department have been above the national average.

We also launched our Winter Heroes award to acknowledge the many ways our employees and volunteers responded to our winter pressures. This initiative was prompted initially by stories of individual acts of selflessness and heroism during heavy snow in December; nominations continued to pour in for months with nominees featuring in our Winter Heroes wall of fame on Hospital Street.

The primary theme of our health and wellbeing strategy during the year was mental health awareness. We held events throughout the year helping staff to recognise the signs and symptoms of stress, anxiety and depression and looking at ways we can do more to tackle stigma and discrimination. These included mental health awareness workshops and talking therapy sessions delivered by the charity MIND and a mental health awareness drop-in event Mind Your Head that coinciding with World Mental Health Day.

We also introduced critical incident stress debriefing to support employees who have experience a profound or distressing event in the course of their work. A critical incident could be the sudden death of a patient, a serious injury, or a physical or psychological threat to the safety or wellbeing of a member of staff regardless of the type of incident. We have a core group of staff who are trained to provide debriefing, allows those involved with the incident to process the event and reflect on its impact.

During the year, we were at the spearhead of the Cavell Nurses' Trust new membership programme. Cavell Nurses' Trust is a charity providing support for UK nurses, midwives and healthcare assistants, both working and retired, when they're suffering personal or financial hardship – often because of illness, disability, domestic abuse and the effects of older age.

Our volunteers

We continue to be indebted to each and every one of our volunteers for their support and commitment. The year saw many developments for our volunteer services team, including the growth of the Bedside Book Club and an increased presence in clinical areas.

Following the disbanding of the Friends of NGH charity in August 2017, we were delighted to retain the expertise and knowledge of over 40 of experienced volunteers who chose to join our in-house service. Demand for the buggy service continues to grow with the number of journeys increasing by 25 per cent over the last year. Fundraising is ongoing to allow the buggy service to be self-sufficient.

Relationships have gone from strength to strength with Pets as Therapy charity, with two new dogs introduced into five wards. The dogs visit weekly and offer an alternative therapy to those who are in hospital and missing their own pets.

And this year, the service began developing a programme to support with people with mild learning disabilities and introduce them into voluntary positions such as gardening, guiding and working alongside the Bedside Book Club.

Our buildings, facilities and IT infrastructure

Our most significant development this year has been the construction of our new emergency assessment unit. This will be used to assess acutely unwell patients arriving from the emergency department or referred by their GP. Our staff were asked to name the new building and its wards. The overall structure will be called The Nye Bevan Building in honour of the architect of the NHS who 70 years ago established the British system of a health service funded from general taxation and free at the point of use. The two wards in the building will be named:

- The Esther White Ward, in honour of Northampton General Hospital's first matron, who began working at the hospital in 1743.
- The Walter Tull Ward in honour of the footballer who signed for Northampton Town Football Club from Spurs in 1911. He made 111 first team appearances before serving Britain's war effort in the first world war, becoming the first British Army officer of black heritage.

The building will be staffed by a dedicated team of consultants, nurses, assistant practitioners and healthcare support workers with specialist support from other services across the hospital. It offers exciting opportunities to explore new ways of working, both internally and with our community health partners and GPs.

We also reopened of our chemotherapy suite following huge public response to a fundraising appeal. The refurbishment has increased capacity by four additional treatment bays which will reduce waiting times for patients. With the careful use of design, lighting and colour, the treatment area is a more welcoming and calm environment offering more privacy to patients as well as being a more practical working space for staff. The fundraising campaign was led by the hospital's charity, Northamptonshire Healthcare Charitable Trust and saw £500k donated by individuals and local groups and businesses specifically for the refurbishment.

Another project that benefited from the support of our local community was the creation of a therapeutic sensory garden near our centre for elderly medicine. The garden has particular benefits for our patients with dementia and was created thanks to a donation from local business Michael Jones Jewellers.

Despite the high levels of activity, we were able to make significant progress in planning, re-developing and improving our clinical areas including:

- The creation of a new urgent care centre, Springfield, opposite our emergency department
- The completion of a second MRI suite
- The relocation of our children's outpatients area
- The refurbishment programme of our paediatric wards to include new sleeping spaces for parents

Another major improvement was the complete transfer of the site electrical infrastructure onto back-up generator electrical supplies. This has had a significant impact on the resilience of the power supplies across the site thus improving the day to day running of the hospital during mains failure creating a safer patient environment.

During the year, we recruited a chief information officer, a key element in our drive to become an information enabled, clinically led organisation and to drive paperless NHS agenda. Understanding that information helps deliver great care, we have created a new structure for our technology and information department to support our clinical colleagues: the technology team; the clinical support team; the data team; and the informatics team. Innovation, improvement and awards

Quality improvement is core to the delivery of safe compassionate services at NGH. During the year, our employees continued to embrace opportunities to improve the services they deliver and the experience of our patients.

For the past year, our wards have been supported with a new way of working that introduces a collaborative approach to making improvements at a local level. A number of shared decision-making councils are up and running leading to improvements in patient care, working procedures and the local environment. In a shared decision-making council process, the impetus for change comes from the team and is delivered by the team.

During the year, we became the first district general hospital in the UK to fit the world's smallest pacemaker. The leadless pacemaker can be implanted directly into the patient's heart via a vein in the leg, halving the risk of major complications associated with conventional pacemakers. Conventional pacemakers are placed in the patient's chest with leads running to the heart.

Our cardiac department also introduced a new treatment for patients with severely blocked arteries that cannot be treated with routine surgery, a complex surgical procedure, called rotablation, which uses high-speed drills to blast away hardened calcium.

We introduced a virtual fracture clinic aimed at getting patients seen by the right person at the right time in the right place. For some patients this means a telephone consultation with an orthopaedic nurse rather than a visit to hospital. The overall effect is the release of more on-site appointments for patients who need to be seen in person and a reduction in waiting times. The success of this approach is now being looked at across the hospital to identify suitable services where it might be emulated.

These examples are a microcosm of the improvement and innovation continually taking place in teams, departments and services right across the hospital.

In a year in which we cared for more people than ever before, we had so much to celebrate and the nominations flooded in from members of the public, patients and staff for our 2017 Best Possible Care Awards. We hold these awards to recognise our employees and volunteers who make an exceptional contribution to patient care – and they took place last year thanks to funding from the Northamptonshire Health

Partnerships

NGH is committed to improving quality for patients through developing regional partnerships and in particular with universities. By way of example we have signed a memorandum of understanding with the University of Leicester on a pathway to university teaching hospital status with their medical school. The first tangible steps along that path are being taken recruiting some joint academic clinical posts in oncology.

As another example, the QI team have worked with the university of Northampton and are developing an MSc in Quality Improvement and Patient Safety, with the intention of the first cohort of students commencing in 2019.

Charitable Fund

In the midst of all the discussion around pressures on NHS services, our Best Possible Care Awards are an opportunity to take stock of and celebrate the competence and commitment, the professionalism and pride, the exuberance and enthusiasm that we see every day in every ward and every department.

As well as our own awards, we were delighted that a number of our employees were recognised on the national stage for their exceptional achievements:

- We were shortlisted in three categories of the Patient Experience Network's National Awards (PENNA) which aim to highlight outstanding patient experience across the health and social care sector in the UK.
- The Keep Connected initiative is a real-time survey of patients while they are in hospital. The results equip the wards to make immediate improvements wherever possible. It was shortlisted in two categories, and received the runner-up accolade in the Measuring, Reporting & Acting category

- Meanwhile, the midwifery service's Meet the Matrons project was shortlisted for their work with expectant mothers and fathers when preparing for the arrival of their baby and providing opportunities to parents to reflect on their experience of pregnancy and birth.
- Our campaign that led to the creation of a mobile library for our patients won the Community Initiative Campaign of the Year category at the UK Public Sector Communications Awards. The awards celebrate excellence in communications in the NHS, local and national government, emergency services and not-for-profit bodies from across the UK. The library is run by our volunteers and was created thanks to book donations from the public of Northampton when earlier this year, we asked people living and working in Northampton to donate their favourite book.
- A collaborative working project to develop individualised plans for patients with learning disabilities and complex needs who need to undergo surgery in hospital was shortlisted in the Learning Disabilities Nursing category of the Nursing Times Awards. The initiative sees our lead learning disability nurse work with patients, their carers, their GP or other community health professionals, and members of our surgical team to identify challenges and areas of concern. A bespoke care plan is then produced.
- A second shortlisted entry in the Nursing Times awards, in the Theatres category, was our scheme to deliver in-house speciality training for registered nurses working in a surgical environment. The specialist training focuses on best evidence-based clinical practice and incorporates simulation training to develop clinical, leadership and team-working skills.
- Ophthalmology registrar Dr Sohaib Rufai was awarded a national research prize, the Vernon Prize Trophy, for his clinical research into the diagnosis and management of underdevelopment of the retina in young children

We hope that you find this report informative and that it demonstrates to you just how hard we are working to really focus on delivering the best possible care to our patients and the best possible working environment for our employees.

Finally, we extend our unreserved thanks on behalf of the whole trust board to the 5,000 staff and volunteers who make up Team NGH. We are immensely proud to lead an organisation with so many dedicated colleagues strive to do their very best for their patients and colleagues.

Dr Sonia Swart
Chief Executive

Mr Matthew Metcalfe
Medical Director

Mrs Carolyn Fox
Director of Nursing, Midwifery and Patient Services

Statement of Directors' Responsibilities

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality Account, directors have taken steps to assure themselves that:

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

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

By order of the Board



Paul Farenden
Chairman



Dr Sonia Swart
Chief Executive

Part Two

Priorities for Improvement 2017/18

Patient safety is the cornerstone of our philosophy at Northampton General Hospital - it is at the heart of everything we do. Our Quality Improvement Strategy sets out our ambition and aim to provide the best possible care to all our patients. Our quality priorities are focused on improving the safety, efficiency and effectiveness of the care we provide, as well as improving our patients' experience.

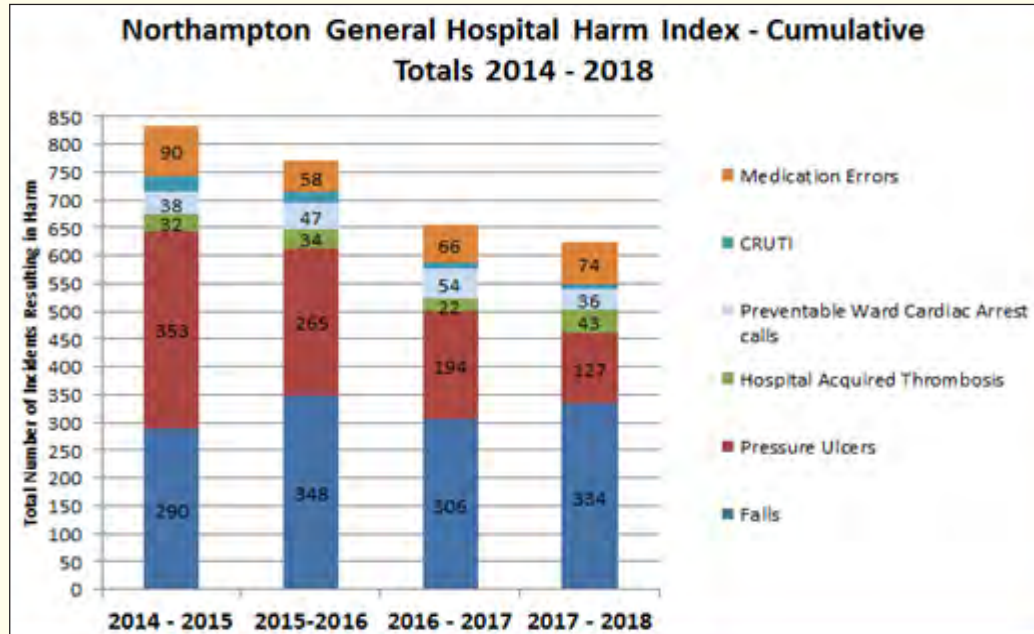
The information presented within this report summarises the progress made on the priorities we set ourselves in the first year of our Quality Improvement Strategy.

- Aim 1 – To engage and enthuse staff promoting a culture of continuous learning to deliver Quality Improvement & safety
- Aim 2 – To deliver patient centred care
- Aim 3 – To reduce avoidable harm
- Aim 4 – To achieve high levels of reliable, effective and efficient care within the hospital
- Aim 5 – To deliver more effective and efficient care in partnership with other hospitals and community providers to support population health – focussing on value for the patient and value for money.

We said we would: Provide care that is safe by reducing harm through monitoring of a harm index

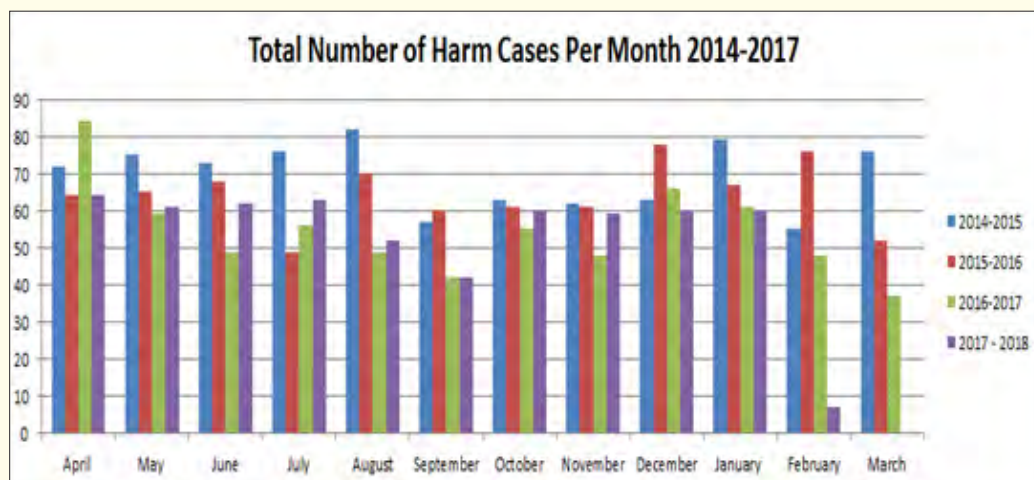
What we achieved:	
What:	In 2015 NGH developed a 'Harm Index' which is a cumulative score of six common harm measures: <ol style="list-style-type: none"> 1. Pressure Ulcers – Grade 2, 3 & 4 following validation 2. Hospital Acquired Thrombosis (HAT's) – HAT's following review of root cause analysis 3. Falls – In patient falls that result in harm (low, moderate & severe) following review by falls specialist 4. Catheter Related Urinary Tract Infections (CRUTI) – point prevalence audit of new CRUTI's, all age groups inputted to the Safety Thermometer 5. Preventable Cardiac Arrest calls – ward based cardiac arrest calls coded as preventable following full clinician review 6. Medication Errors – medication errors that result in any level of harm
How Much:	The total of these harm measures will give us an 'overall' harm index (stack). Our aim is to reduce 'harm' year on year. The stack consists of a physical number of each measure as not all the measures are currently collected by per 1,000 bed days.
When by:	There are individual projects within each of the harm measures many of which are sign up to safety projects. The Harm Index is another assurance tool for the Trust to judge if the list of six measures chosen is improving.

Outcome: The following table demonstrates the cumulative view of the data relating to the 6 harm measures comparing the year 2014/2015 with 2015/2016, 2016/2017 and the present year 2017/2018. HAT data for Q3 2017/2018 is not included.



Comparing the same point from this year to last (2016 – 2017) there are currently 31 less incidents resulting in harm. Decreases can be seen in the above table in pressure ulcers and preventable cardiac arrest calls. Whilst there are more falls resulting in harm than the previous year these are mostly included within the low harm category. The Trust’s moderate, severe and catastrophic falls/1000 days remained under the national threshold throughout the year.

The following table gives a month by month view:



Board to Ward leadership Walk rounds

What we achieved:

Why:

Patient experience concern:

Executive safety rounds have been in progress from January 2009 and have shown to have a positive effect on the safety climate and are a promising tool to improve the broader construct of safety culture. Speaking with patients, carers and staff during the safety rounds provides a timely opportunity to capture real time feedback capturing good practice and areas for improvement.

Efficiency concern:

Staff members - Implementing board to ward visits can initially sound simplistic but significant planning, preparation and commitment of time is required to ensure resultant issues and concerns are recorded, actioned and tracked and a relationship of openness and trust is developed between Board members and operational staff.

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

Another opportunity for Board members to speak with staff and patients is "Beat the Bug" ward visits, where Board members visit their allocated wards monthly.

During the visits Board members observe the environment and obtain the view from staff and patients regarding infection prevention, environmental and estates issues and broadly what works well and what can be improved. The direction and focus for the visit is provided via the Infection Control and prevention team.

Workforce Concern:

Where regular board to ward visits have occurred, the operational staff and directorate management boards have acknowledged the benefit of senior leaders regularly spending time with operational staff to talk about safety issues that concern them, following up with an appropriate focus to address those areas of concern.

Financial Concern:

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

What are we trying to accomplish?:

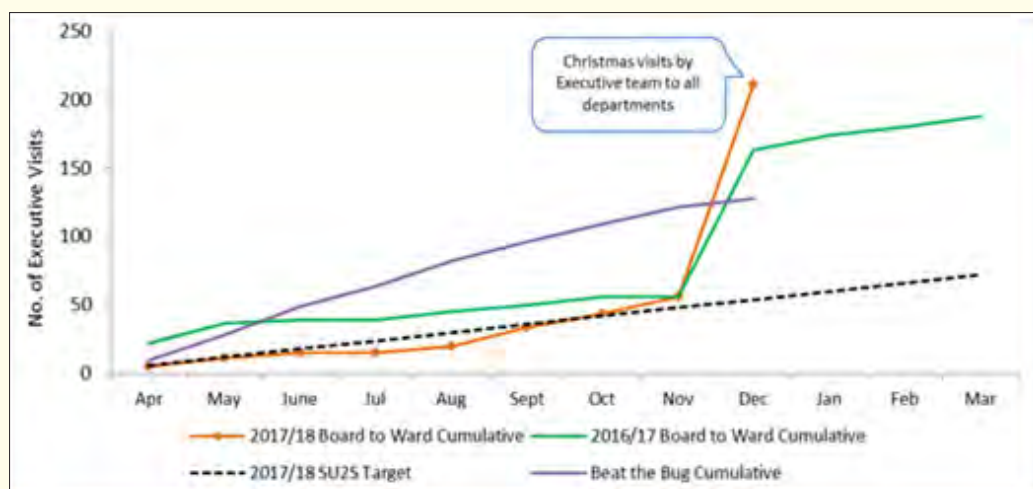
1. Setting Aims

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

2. Establishing Measures

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

- We will monitor the number of areas visited per month – presented monthly to QGC encompassed within the QI scorecard
- We will provide timely Divisional feedback if applicable, report all visits, themes and lessons learnt quarterly both internally and externally for patients and staff.
- We will demonstrate progress via improved staff surveys and safety climate results



During 2017/18 - 237 executive safety rounds have taken place, this is above the internal stretch target of 72 visits a year, 154 “Beat the Bug” executive safety visits have also taken place from April to March 2017/18 inclusive.

3. Themes identified

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

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

January 2018 – Fixing the Flow

Refreshing various streams of work required to place NGH's urgent care improvement programme in a better place an overarching refresh named "fixing the flow" was the focus for January's Executive Safety round with 11 clinical areas visited.

Executive colleagues asked Operational staff for their experience and advice on how we could further improve safe and timely patient assessment and discharge to ensure better care outcomes for patients. The feedback was stratified into three main themes:

- Assessment
- Discharge
- Site Management

The feedback was shared with the executive and work stream leads and influenced on going improvement work.

February & March 2018 – Winter Hero

During the height of winter pressures Executive colleagues visited 15 clinical and non-clinical areas asking staff:

What are you most proud of?

Who would you nominate as your "winter hero" (individual/team) and why?

What can we do differently to improve pathways/services for staff and patients?

This also provided an extra opportunity to thank staff for their hard work and commitment to deliver the best possible care for patients during a challenging winter.

The names of staff nominated were shared with the communications team to be included as part of the CEO recognition awards, suggestions to improve patient pathways and patient flow were shared with the Fixing the flow work stream leads and influenced on going improvement work.

We said we would: Provide care that is safe by reducing harm through learning from errors within clinical teams

What we achieved:

What: The Chief Medical Officers report (CMO 2008) explained in detail how simulation in all its forms would be a vital part of building a safer healthcare system. Literature reviews frequently inform practice describing how well simulation training has worked in high risk organisations because it allow staff to practice difficult scenario's an learn technical and non-technical skills in relation to safety and team work, providing the safest environments for their workers and public. Whilst delivering simulation speciality training programmes since the Simulation Suite in NGH has opened it has become apparent there were common themes especially involving human factor skills.

A programme has been developed working closely with the wards to create a bespoke session for each area that addressed human and system errors relating to their individual issues addressed through datix incident reports and any serious incidents. The objectives of each session include communication, decision making, situational awareness, task focus, escalation and challenging behaviours

How Much: We will measure the amount of ward staff attending an annual learning from errors (LFE) session within the Simulation Suite. We aim for 50% of all ward teams to attend LFE by 2018.

2014-2015 Outturn – 5% of ward staff have attended an LFE session

When by: LFE was designed and implemented in April 2015. Attendance is collated quarterly and ward managers are informed of attendance levels.

Outcome: A pragmatic decision has been made to stop running programmed LFE sessions within the Simulation Suite due in the main to lack of attendance. The Simulation and Resuscitation Service teams have worked collaboratively to achieve Point of Care (PoC) simulations instead. There are three arms to this piece of work:

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

POC simulation has been well received by all staff on the wards, each scenario has allowed for safe effective teamwork and team debriefs on clinical management and human factors



Focus groups completed within Urgent Care with feedback informing us that staff are really enjoying the opportunity to practice emergency's scenarios.

Discussions included:

- Nurses feel more confident to manage sick patients after the practice with POC
- Seniors want to have more practice at leading the POC to give them confidence in leading the teams when doctors are busy with other acutely unwell patients and are delayed
- The practical sessions are realistic
- Faculty support in debriefs is non-judgemental and supportive
- 98% of the nursing staff agree this prepares them for dealing with real life emergency's
- staff prefer live actors where possible as it feels even more realistic than manikins
- Timings can be difficult with the management of the ward and flow of patients with PM sessions suggested as being better with regards to involving medical staff

We said we would: Ensuring operational processes support essential planning, delivery and record keeping through timely consultant review

What we achieved:

What: A series of clinical standards for seven-day services in hospitals were developed in 2013 through the Seven Day Services Forum. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. Ten standards were agreed and are being rolled out across the NHS in England in acute hospitals. With the support of the AoMRC, four of these were identified as priority clinical standards on the basis of their potential to positively affect patient outcomes.

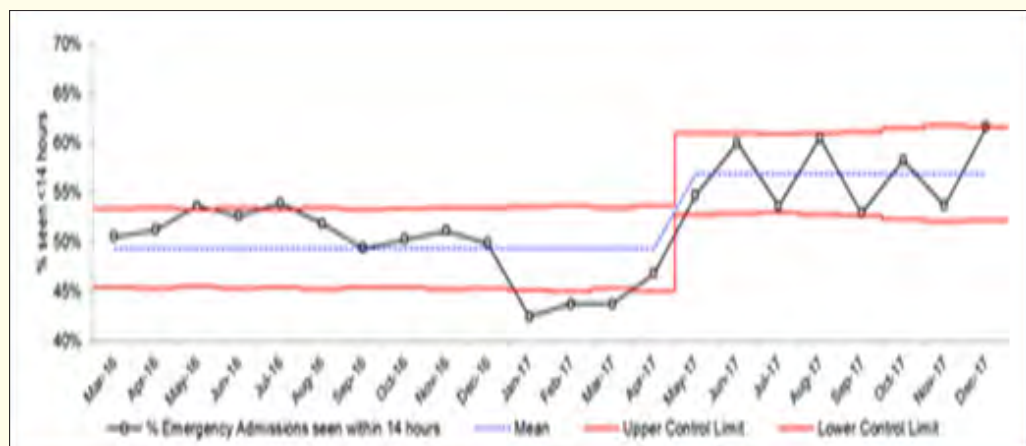
Standard 2 – Time to first consultant review

Time to first consultant review: This should be measured from the time of admission to hospital rather than the time of arrival at hospital. This reflects the original source document for this standard (Royal College of Physicians acute care toolkit number 4, referenced in the AoMRC 2012 paper, 'Seven day consultant present care'), and aligns better with the usual daily pattern of emergency patient admissions and associated consultant staffing rosters. For this standard, the definition of 'consultant' remains a doctor who has completed all their specialist training and been placed on the General Medical Council's specialist register.

How Much: Previously the metric reported the % compliance for patients receiving a consultant review within 8 hours during the day and 14 hours during the night for all patients admitted to Creaton and Benham assessment areas, this has been calculated from time of registration. The revised report focuses on the % of patients reviewed within 14 hours from time of the decision to admit.

When by: Implemented in April 2015 the target performance was set at 100% of emergency admissions will be seen by a consultant within 14 hours from the time of arrival to hospital.

Outcome: During December compliance improved to 61.6% from 54% during November.



Planned improvement work is being led by the Medical Director and is encompassed within the Assessment work stream of Fixing the Flow non-elective Improvement programme. The effect of the recent ward moves during November creating an assessment floor will continue to be monitored.

We said we would: Provide care that is safe by reducing harm through omitted medicines

What we achieved:

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

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

When by: Due to capacity the improvement project was initially focused on those wards where the average % of patients with omitted doses (not documented) was much higher than average. The improvement tool was based on local feedback to nurses at the time of audit, and a feedback of the Trust results to Matrons for discussion at directorate level. With the introduction of EPMA on a couple of the wards there was noted to be a further reduction in omitted doses (not documented).

The smart aim being to reduce omitted does of medicines by 10% in year 1 and thereafter by 20% year on year by March 2018.

Outcome: Omitted Doses (Not Documented)

It is now possible for the ePMA system to report on omitted doses. However the report remains difficult to interpret for omitted doses due to some medications not being documented but a report is available for medication doses unavailable.

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

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

For one day in March, 60 patients missed a dose because the medication was documented as unavailable. Of these 5 patients (8%) missed Critical Medicines; which should not be omitted or delayed (Apixaban, Fludrocortisone, Gliclazide, Warfarin, and Linagliptin). All are available in the Emergency Duty Cupboard which is accessible out of hours. There is also a procedure for escalating ordering of Critical Medications during Pharmacy Hours.

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

We said we would: Provide care that is safe by reducing harm through failure to rescue through identification of the deteriorating patient

What we achieved:

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

How Much: SMART aim – to reduce preventable cardiac arrest calls by 15% by March 2018. This would result in <32 preventable calls per year. The programme of work included measuring:

- monitoring critical risk >7 EWS patients
- monitoring the % of these patients with a management plan in place
- monitoring the number of cardiac arrest calls

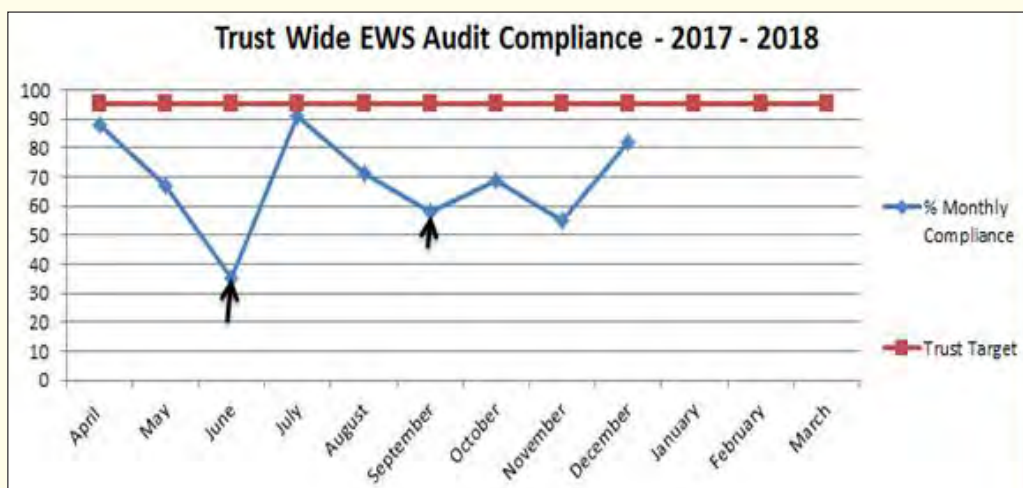
When by: A monthly point prevalence audit reviewing critical risk >7 EWS patients each month and whether they have an appropriate plan in place. If no patients at time of audit are scoring within the critical risk category any patients scoring in the high risk >5 category will be reviewed instead. The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

- Resuscitation Committee standard agenda item
- Presentation of all preventable cardiac arrest call cases to CQEG monthly
- Learning to be shared pan trust
- Thematic data collected and analysed

All ward based cardiac arrests will be fully reviewed by all clinicians on the Resuscitation Committee and the Resuscitation Officer responsible for the case. A coding will then be awarded as either preventable or unpreventable. A brief review report of the case is then sent to the appropriate personnel for shared learning.

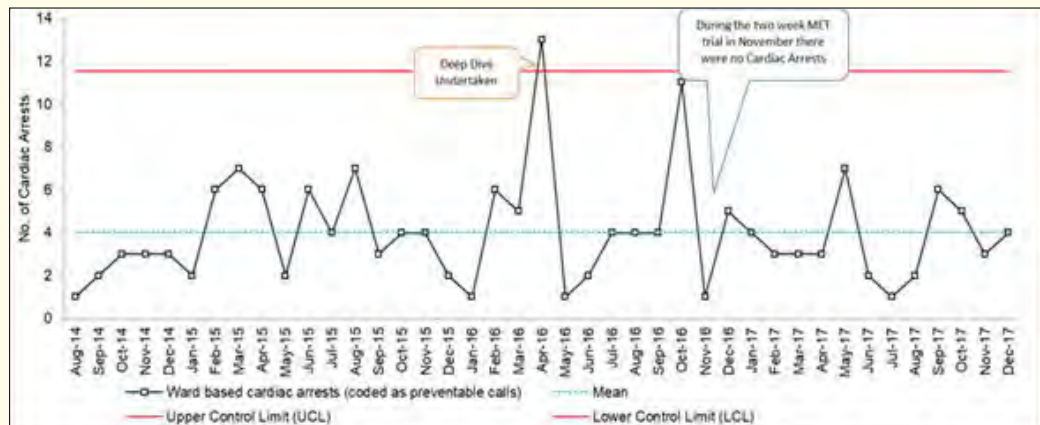
Outcome: Monthly EWS Audits:

The focus of the monthly audit and compliance awarded is based upon identifying patients scoring within the critical level >7 EWS and of those how many have received an appropriate level of escalation. During the audit time if no patients on a ward are scoring >7 then any patients scoring within the high risk category (>5) are reviewed instead.



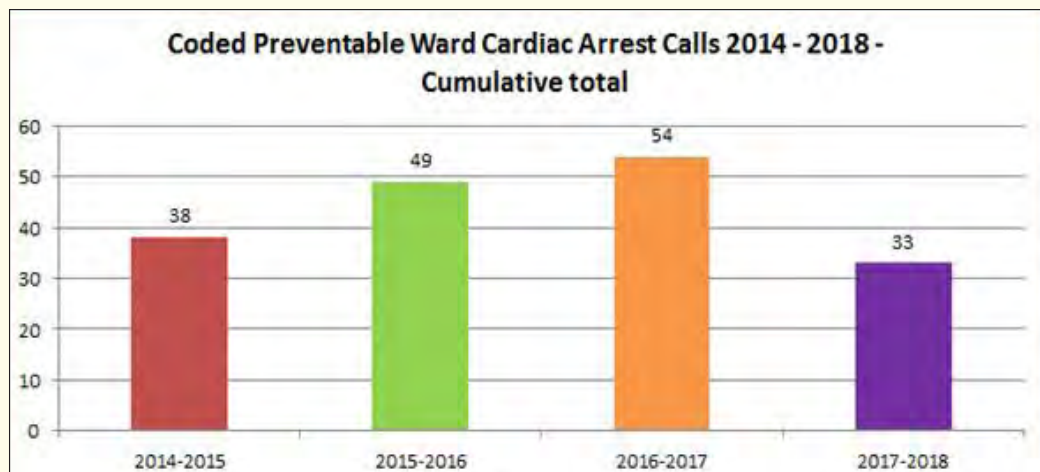
Preventable Cardiac Arrest Calls:

The Resuscitation Committee review all data pertinent to the deteriorating patient at every meeting and as each ward based cardiac arrest occurs are asked to electronically review each case and code whether a call has been deemed preventable or not. This ensures the coding awarded to each review is robust.



There have been no unusual spikes in data within Q3. Feedback continues to be given to the clinical teams involved with each case and the relevant division is required to discuss at the appropriate M&M meeting. Coded preventable cardiac arrest calls are presented monthly to CQEG where there is divisional representation.

NGH collate a harm stack which preventable cardiac arrest calls are one aspect of data collected within the stack. The stack for preventable cardiac arrests over the past three years is



The stack demonstrated an average of 3 per month in 2014-2015, 4 per month in 2015-2016, 4.5 preventable calls in 2016-2017 and currently 3.5 during 2017 - 2018. There is also a stack for each adult ward which allows each area to compare year on year.

There are two new additional projects that have commenced within Q1 & Q2 to help address preventable cardiac arrest calls and:

1. Buddy ward project

Aim – to reduce preventable cardiac arrest calls on the assessment wards by 15% by March 2018

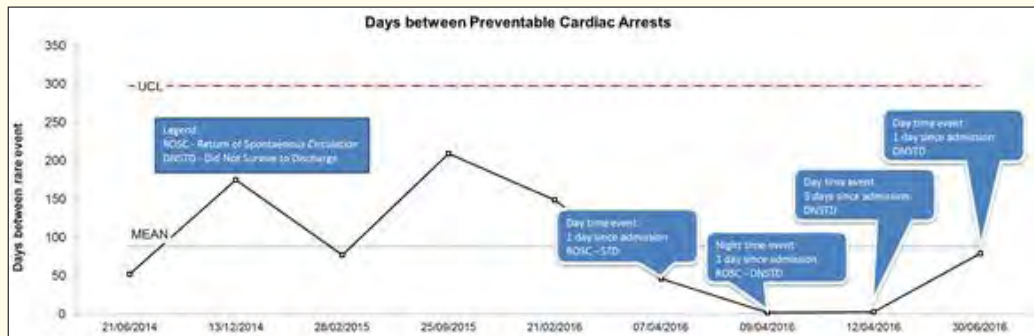
Outcome Measure – Cardiac arrest calls coded as preventable

Process measure 1 – number of training events and Point of Care simulations for the assessment wards

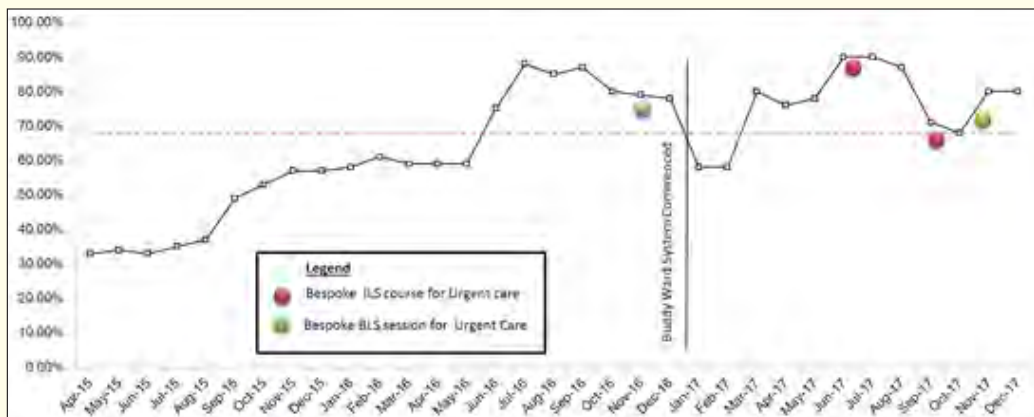
Process measure 2 – DNACPR / TEP audit compliance

Balancing measures – Peri-arrest calls / staff self-reported confidence skills / staff satisfaction in training / staff views on team communication, leadership, teamwork etc.

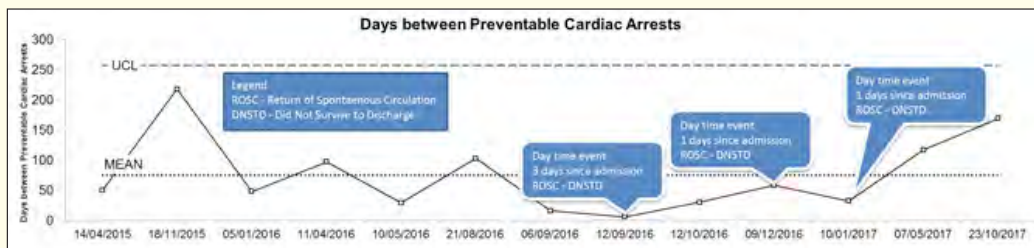
Creaton ward:



% of staff trained:



Benham ward:



% of staff trained



Current agreed plans:

- Decrease the amount of POC simulations being run in the urgent care areas and increase the complexity and feedback of those POC Sims.
- A level 1 pathway has been on trial within the two assessment wards and the data is now being analysed. The roll out of such a pathway is supported and there is an identified Clinical lead.
- The data set for April 2018 onwards has been further refined to consist of three main sections, EWS compliance, DNACPR compliance and cardiac arrests (compliance being no preventable cardiac arrest calls). The Trust wide compliance will be reported via the Quality Improvement scorecard & by wards via the Directorate performance scorecards

We said we would: To ensure operational processes support essential planning, delivery and record keeping by effective safe patient transfer

What we achieved:

What we achieved:

What: Audit's completed on night handovers and patient transfers identified poor documentation and poor transfers/handover of care. The aim of this project was to ensure that patients requiring an internal transfer will have a documented transfer plan in place and appropriate staff escort. Patient transfers out of hours will be risk assessed. Deteriorating patients or patients with a EWS >7 will be discussed at night team handover.

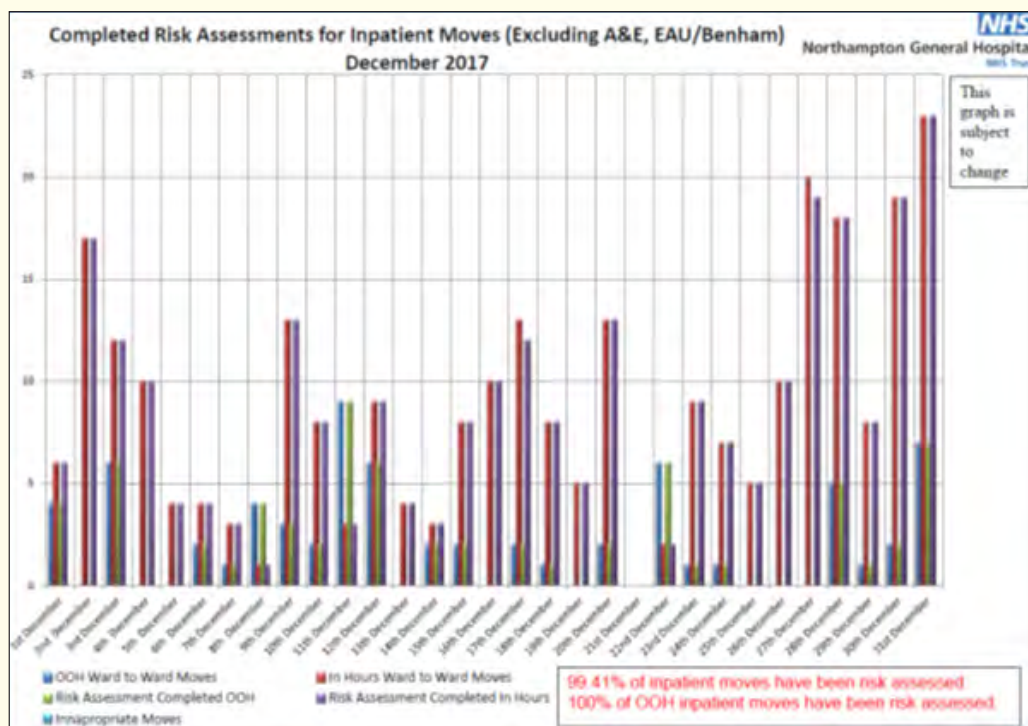
How Much: We will measure the number of attendances at night team handover, the aim being that all on call specialties will be represented. We will track the number of transfers with EWS >7 with a plan in place and the number of wards using patient transfer checklists. The aim is to get both of these measures to 100%.

When by: Night team handover to be relaunched. Monthly point prevalence audit for patients with critical EWS to confirm management plan in place.

Outcome: **Night time Handover:**
This has had slippage due to winter pressures and unrealistic expectations of the designed data collection tool. Data collection (hard copies) were started but were found to not add any value to the process. Further work needs to be performed if the group feels this is required. The register of attendance is now embedded and works well.

Transfer Checklist:

The transfer checklist is being rolled out. ADNs asked to offer forward a programme of audit after one month of roll out.



A new transfer checklist has been rolled out. AND's have been asked to offer a programme of audit after one month of roll out.

We said we would: Provide care that is safe by reducing harm through ensuring operational processes support essential planning, delivery & record keeping for safer surgery

What we achieved:

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

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

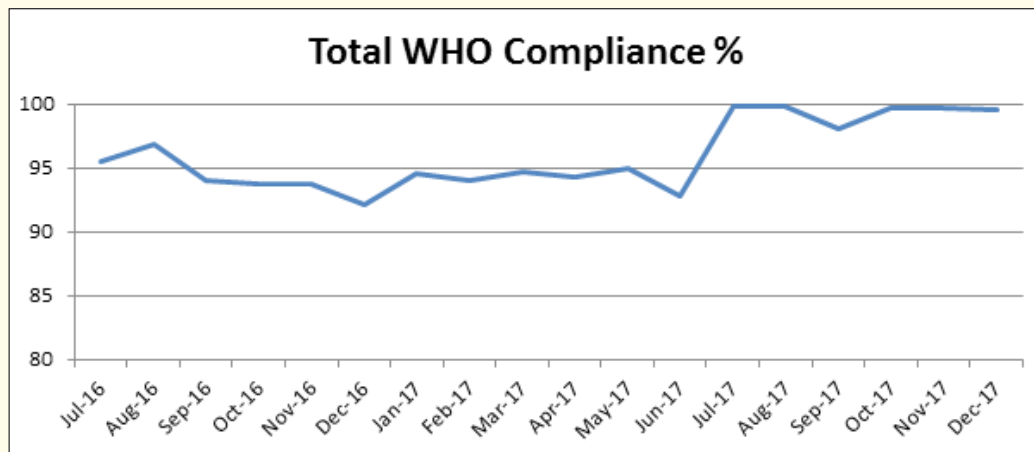
2014-2015 Outturn – 80% of hard copies of the WHO safer surgery checklist were available in the patient notes – with a target performance that patients will have all stages of the WHO safer checklist completed resulting in 100% compliance

When by: Monthly progress will be monitored via:

- Use of a white board to record information shared at the Brief in place in some areas.
- Human factors team training in DSU is planned for October 2017

Outcome:

- Human Factors team training programmed for all teams. Within Q3 training held in Ophthalmology and Day Surgery Theatres
- A draft report is currently being reviewed regarding the forward plan for theatre safety action plans
- The WHO safer surgery training leaflet has been distributed to all members of the multi-disciplinary team
- A Policy on a page version of the 5 steps to safer surgery theatre standard is being created for inclusion in the standard and for sharing with staff
- Installation of some of the brief whiteboards has occurred. Obstetrics still awaiting theirs.
- Renewed focus on enrichment of the de-brief process to optimise learning and opportunities i.e. Late starts



Staff Feedback on Patient Safety and Quality

What we achieved:

Why:

Patient experience concern:

In recent years there has been an increase in focus in the UK and internationally on approaches to improve safety and this has led to greater recognition of the importance of the culture of organisation and teams.

NHS England launched the Patient Safety Collaborative in October 2014 following the publication of the Francis and Berwick Reports. Safety culture and leadership were identified as mandatory areas

Workforce concern:

On 13th June 2016 the patient's safety culture work in eight acute trusts in the East Midlands commenced with online safety attitudes/climate surveys for the workforce in emergency departments and maternity units in all acute trusts.

To prepare our workforces in A&E and maternity and to capitalise on the effectiveness of this programme some preliminary preparation was required.

All members of staff on the nominal role that form part of your multidisciplinary teams (A&E and Maternity) were requested to provide their preferred email address where the first survey was received. The surveys were organised and analysed by Pascal Metrics. A US based company who have delivered a number of similar projects in the NHS. The results were received late September 2016

Financial Concern:

A positive safety culture has tangible links with reduction in error, positive patient experience and improved patient and staff experience.

What are we trying to accomplish?

Setting Aims: Safety Culture Measurement Programme (PASCAL Metrics)

Safety culture is broadly defined as the norms and values and basic assumptions of the entire organisation.

Safety climate is more specific and refers to the employees perceptions of particular aspects of the organisations culture.

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Three workstreams have been identified for both A&E and Maternity, shown below.

Work streams	
A&E	Maternity
<p>Three primary work streams from this survey have been identified as:</p> <ul style="list-style-type: none"> • Improving the monitoring and care of patients in the clinical observation area (EDCOA) • Introduction of rapid assessment for paediatric minors (Rapid Assessment) • Improving the work culture within A&E (Work Culture) 	<p>Three primary work streams from the survey have been identified as:</p> <ul style="list-style-type: none"> • Reducing the postpartum haemorrhage rate (> 1500mL) from 4.3% to 2.15% • Improving communication within Maternity • Improving the perception of the senior managers in Maternity, reducing perception of blame culture and providing more support to staff to address the issue of burnout

How will we know that a change is an improvement?

Establishing Measures:

The overall outcome measure for this project will be the percentage of staff who have a favourable opinion of the safety culture in their department (A&E and Maternity) based on the results from the Pascal Survey.

A&E

NGH received the highest favourable scores within the region for A&E. 60% of staff had a favourable opinion of the safety culture in the department. Our SMART aim is that by 2020, 80% of staff will have a favourable opinion of the safety culture in A&E.

In order to further evidence the anticipated improvement in the safety culture in A&E, other measures have been established, related to the three workstreams:

Workstream	Type of Measure	Measure
EDCOA	Outcome	Length of stay in the COA
		Adverse events in the COA
	Process	% of continuative care sheets completed
		% of falls risk assessments completed
		% of EDCOA sheets completed
		Number of patients in COA, by acuity
Balancing	Re-attenders to ED	
Rapid Assessment	Outcome	Time to triage
		Time to see a doctor
		Time to decision to admit
	Process	Number of staff upskilled
	Balancing	Re-attenders to ED
Rapid Assessment	Outcome	% of staff with a favourable opinion of the senior managers
		% of staff who feel emotionally drained
		% of staff with a favourable opinion of the work culture
		% approval rate for annual leave
Work culture		Sickness rate
		Attrition rate
		Vacancy rate

Maternity

56% of staff had a favourable opinion of the safety culture in Maternity. Our SMART aim is that by 2020, 75% of staff will have a favourable opinion of the safety culture in Maternity. The 2018 survey is planned for 30th April – 25th May

As for A&E, other measures have been determined in order to further evidence the anticipated improvement in the safety culture:

Workstream	Type of Measure	Measure
PPH rates	Outcome	% of patients with postpartum haemorrhage > 1500 mL
	Process	Number of births per month
		Number of c-sections per month
Balancing	Average volume lost	
Communication	Outcome	% staff who believe there is good communication in maternity
	Process	% of staff who know about the Take 5 communication tool
MaPS	Outcome	% of staff with a favourable opinion of support for midwives in psychological distress
	Process	No of staff undertaking MaPS training
	Process	% of staff with a favourable opinion of the PMA (professional midwife advocate) role
	Balancing	Sickness and attrition rates

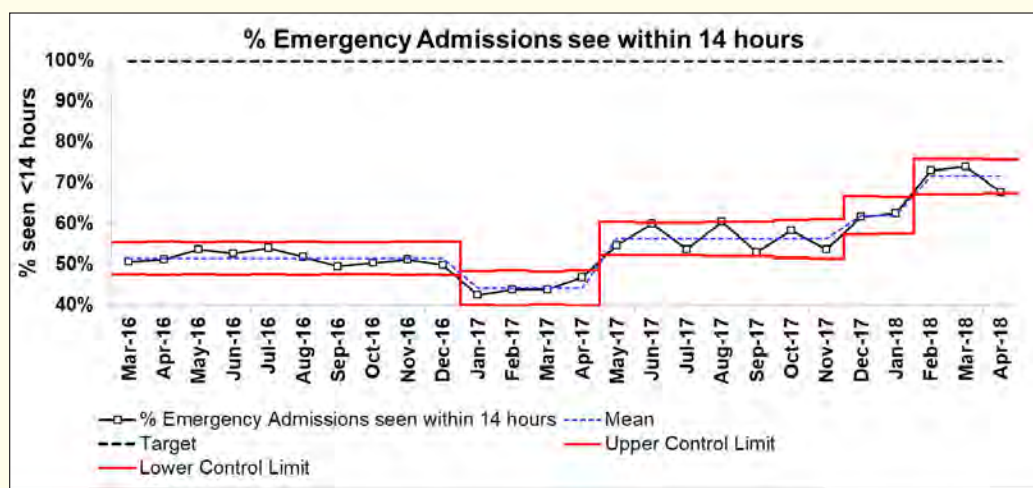
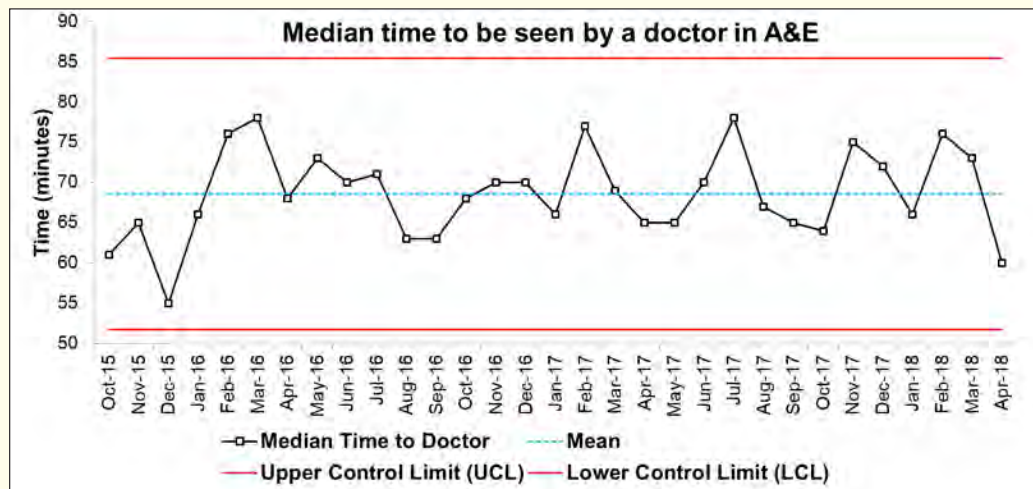
What changes can we make aimed at improvement?

**PDSA
A&E**

There are many tests of change currently in progress in A&E which will also support the opening of a purpose built assessment unit for non-elective patients (Nye Bevan). The Nye Bevan unit will provide high quality, timely, safe and efficient urgent and emergency care for patients. The aim is for our patients to be seen by senior experienced emergency doctors and nurses and then as quickly as possible be rapidly directed to the most appropriate specialty experts for their individual needs, this is also expected to have a further positive impact on the patient safety culture in A&E.

The associated metrics are in development for the above key piece of work and will be further expanded and reported during Q3 2018/19.

Progress to date for key work streams within A&E:



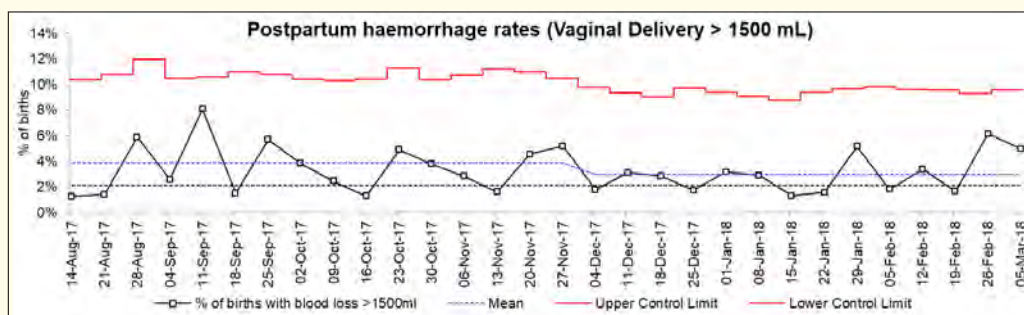
Metrics in development:

- Medical staffing recruitment and retention pipeline
- Multiprofessional urgent care training and education
- Care flow metrics to support timely consultant to consultant specialist referral

- Directory of Services for current specialist clinics and services in NGH and the community which will provide a Capacity and demand analysis for new rapid access clinics, resulting in a more timely and efficient service for non-elective patients who require specialist consultant review

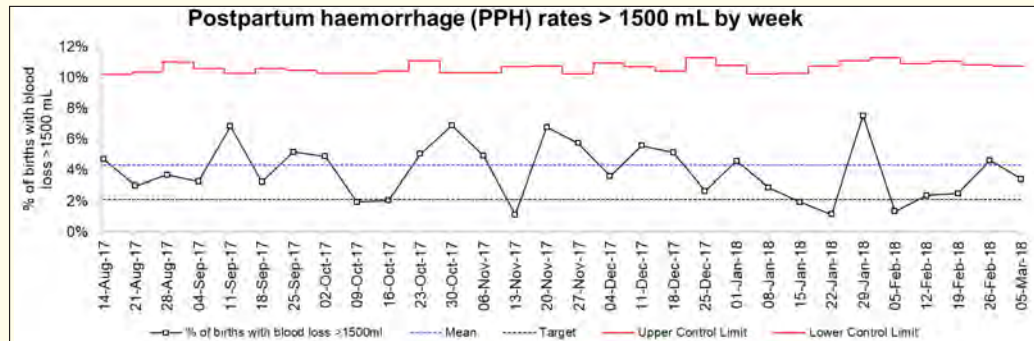
Maternity

- **Postpartum haemorrhage (PPH) rates (> 1500 mL)**
- Postpartum haemorrhage (PPH) is heavy bleeding after birth. The traditional definition of primary PPH is the loss of 500 ml or more of blood from the genital tract within 24 hours of the birth of a baby. Minor PPH (blood loss of less than 1000 mL) is common, affecting 5 in 100 women. PPH in excess of 1500 mL affects every 2 in 100 women, according to national audit data. The publication of the National Maternity Perinatal Audit highlighted that Northampton General Hospital was an outlier for Postpartum Haemorrhage in excess of 1500 mL by more than 2%.
- The first action implemented to reduce the PPH rates was a new drug regime: 1st line management for 3rd stage changing from Syntocinon 10iu/5iu to Syntometrine 5 units IM/IV for all vaginal deliveries (Normal and Instrumental). Any contraindications will continue with Syntocinon as 1st line management. This change was implemented in all areas of delivery (labour ward, the birth centre and home births.) This was implemented at the beginning of December 2017. This change was shared with all maternity staff via daily discussions, team briefings, posters as well as teaching and training.
- The second action implemented was a new regime for all caesarean sections: introduction of Carbetocin as 1st line management for all C-sections, which commenced 18th December 2017. This new regime was shared in a similar manner to the first action, underpinned by further training
- Since the introduction of the first two changes, we have seen a statistically significant reduction in the PPH rates for Vaginal Delivery (>1500 mL) (shown below)



The third action involves the introduction of a new care bundle with risk assessment tool for all patients, which is based on those used in NHS Fife and NHS Wales, who have been commended for their safety within maternity. The final document was implemented in February 2018. Minor amendments were made to the care bundle after a 6 week trial. It has since been adopted for permanent use in the department.

The fourth and final action to reduce PPH rates involves a new training programme for all midwives and MSWs to enable more accurate measurement of blood loss. This will coincide with changes to procurement, including reducing the amount of different swabs sizes available.



Postpartum Haemorrhage Rates

- **Communication**
Evaluation of the perception of the quality and quantity of communication in maternity is ongoing. Data has been collected via online survey and by a QI Patient-Family Partner, who has also validated the responses. Preliminary results (n=51) shows that:
 1. 86 % of staff feel there is good communication in their department
 2. 35 % of staff feel there is good communication in the whole of maternity
 3. 73 % of staff feel there is good communication between their managers and them
 4. 16% of staff feel there is good communication between different departments

The project lead is planning to re-introduce a communication tool (Take 5) to the entirety of maternity. This is a tool used to brief staff during the morning huddle every day of the week on key topics relating to maternity and each department.

- **Midwifery Advocacy Peer Support**
The Head of Midwifery is currently scoping the introducing of a new training programme for staff in maternity. The project aims to optimise the wellbeing of midwives, by developing and delivering a package of 'psychological first aid' and peer support through Professional Midwifery Advocates (PMAs).

This project will develop and pilot an innovative hybrid package of interventions; (psychological first aid and on-going peer support) for support midwives in psychological distress. The package will be designed and developed in collaboration with leading mental health professional Professor Greenberg (Occupational, academic and forensic psychiatrist) and March on Stress (Psychological Health Consultancy).

March on Stress currently offer two excellent different training programmes; TRiM and StRaW®.

- TRiM is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic event.
- StRaW: Sustaining Resilience at Work is a peer support system to detect and prevent occupational mental health issues and boost psychological resilience.
- However, it was felt that midwives required a different programme to TRiM and StRaW, requiring a specifically tailored programme to their occupational needs, covering both aspects of whether the psychological distress was due to exposure to workplace trauma, or the consequence of other occupational stressors (Fig. 1).
- The programme/package will be designed and developed by Professor Greenberg, March on Stress and the senior Midwifery Team at Northampton. The package will be based on the most current research and the growing evidence base around peer support and trauma response.
- March on Stress will deliver the newly designed training programme to the Professional Midwifery Advocates (PMAs*) at Northampton. The PMA team will implement the interventions/package to the midwifery team (and to the wider maternity team as required). The project will include evaluation of the training programme, evaluation of the package of psychological first aid and peer support, both in terms of the experience of delivering the interventions and experience of receiving them.
- This project is innovative in that this has not been previously done before, it uses the newly developed PMA role, the issue is highly current in the light of maternity safety, healthy midwives are paramount for the delivery of high quality maternity care (Perzaro, et al 2015), and if successful has the ability for mass roll out.

We said we would: Provide care that is safe by reducing harm through failure to recognise and treat sepsis

What we achieved:

What: Sepsis is a common and potentially life-threatening condition where the body's immune system goes into overdrive in response to an infection, setting off a series of reactions that can lead to widespread inflammation, swelling and blood clotting, resulting in organ dysfunction and death.

The Parliamentary and Health Service Ombudsman (PHSO) published Time to Act in 2013, which found that recurring shortcomings in relation to the sepsis management included:

- Failure to recognise presenting symptoms and potential severity of the illness
- Delays in administering first-line treatment
- Inadequate first-line treatment with fluids and antibiotics
- Delays in source control of infection
- Delays in senior medical input

At NGH we aim to eliminate delays in antibiotics administration to septic patients by ensuring that patients with deranged early warning scores (EWS) are screened for sepsis both on identification of EWS rise and at entry to the hospital. We also aim to increase antibiotic administration to 90% compliance within 60 mins from diagnosis for patients with red flag sepsis, for both ED and inpatients in line with national 2017/18 CQUIN targets.

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

- The percentage of patients with EWS of 3 or higher, (a) on arrival in ED, and (b) inpatients that are at risk of Sepsis, that are screened. Evidence is gathered from ED FIT forms' screening tool and inpatient clinical notes with reference to Vitalpac, specific monthly reports from Blood Cultures and Coding.
- The percentage of ED and inpatients with one or more red flag symptom (ref: UK Sepsis Trust / NICE guidelines) who are treated with antibiotics within 60 minutes. Evidence is gathered from various sources - individual patient clinical notes, Vitalpac and ePMA.
- There is also a quarterly antimicrobial review which audits from the sample of red flag patients who were treated with antibiotics. This aims to identify the percentage of patients who then had an antibiotic review within 72 hours. Evidence is gathered from ePMA, Coding reports and inpatient red flag audit.

When by: The Sign up to Safety target performance was set to increase screening and time to first antibiotics to 90% within the first year from 2014/2015 baseline with an incremental raise in line with our CQUIN.

Outcome: **CQUIN TARGETS – 2016/17**

- 3 out of 4 CQUIN targets were achieved at Q4 2016/17. As expected, inpatient antibiotic treatment compliance did not achieve the national target of 90%.
- ED treatment target was set locally at 70% and was exceeded by 17%.

CQUIN TARGETS – 2017/18

- In 2017/18, all national targets are more ambitious at 90% compliance across ED and inpatients for both screening and antibiotic treatment within 60 minutes (last year, inpatient antibiotic treatment target was 90 minutes).
- Additionally, the second sample (ABX treatment <60 mins) is linked to the screening sample rather than being an unrelated set of patients as it was in 16/17 – this makes sense.
- Finally, the 72 hour antimicrobial review, while using a sub-set of red flag patients treated with antibiotics, is separated from the other two targets and looks at a smaller sample of 30 across each quarter.

SCREEN EARLY: Patients presenting in ED + inpatients on wards, scoring EWS>3 or above who are screened for Sepsis.

ED sample = 50 / Inpatient sample = 50

CQUIN target Q1-4 2017/18 = 90%

CQUIN CRITERIA	TARGET	QUARTER ONE TOTAL	QUARTER TWO TOTAL	QUARTER THREE TOTAL
ED screened for sepsis = Y	90%	95%	96%	99%
ED - RED FLAG: ABX <60	90%	77%	71%	85%
INP screened for sepsis = Y	90%	96%	92%	91%
INP - RED FLAG: ABX <60	90%	78%	78%	84%
Antimicrobial Review <72 hrs	25% Q1	84%	97%	97%
ABX review < 72 hrs				

TREAT EARLY: Of the screened ED + inpatient samples; all patients with one or more symptom of red flag sepsis treated with antibiotics in less than 60 minutes.

ED sample = All patients with one or more red flag – numbers vary.

Inpatient sample = All patients with one or more red flag – numbers vary.

CQUIN target Q1-4 2017/18 = 90%

Management & Governance:

- Regular feedback to CQUIN Progress Group, Antimicrobial Stewardship Group and Infection Prevention Steering Group & CQEG.
- Performance presented in planned Directorate QI Scorecards (currently being designed)

Staff Engagement:

- Maternity Services' use of their sepsis boxes & tools to be promoted in the Bulletin.
- Screensaver campaigns will continue to recycle key messages for the August 17 and Feb 18 junior doctor intakes, as well as to remind nursing and clinical staff of targets and protocols.
- Junior doctor department training sessions – sepsis sessions will be planned with education leads.
- Simulation Suite continuing to use sepsis scenarios.
- Sepsis guidelines will be distributed to wards during Q4 2017/18.
- Targeted SMS messages for junior doctors – to be planned for quarterly publication – validated by QI before publication.
- Email awareness shots have been sent to heads of directorate/ department and junior doctors.
- Monthly patient notes audits take place on wards when sepsis is briefly discussed with any doctors and nurses who can listen. Posters and screening tools are checked / changed during visits.
- Grand Round promoting Sepsis undertaken in January 2018.

We said we would: Provide care that is safe by reducing harm from failures in care through eliminating hospital acquired Venous Thromboembolism

What we achieved:

What: Venous thromboembolism (VTE) covers two conditions; Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE) and is a clinical priority for the NHS in England. There are around 25,000 preventable deaths due to VTE in the UK each year. The National VTE Prevention Programme’s aim is to avoid preventable harm and death from VTE. The aim of this project is to eliminate all preventable VTE events (excluding maternity).

How Much: We will measure the percentage of preventable VTE events at NGH compared with non-preventable VTE events. We will monitor the number of patients that are assessed within 24 hours, the number that are reassessed and the number that receive the correct medicines. We will also measure the number of staff attending VTE training.

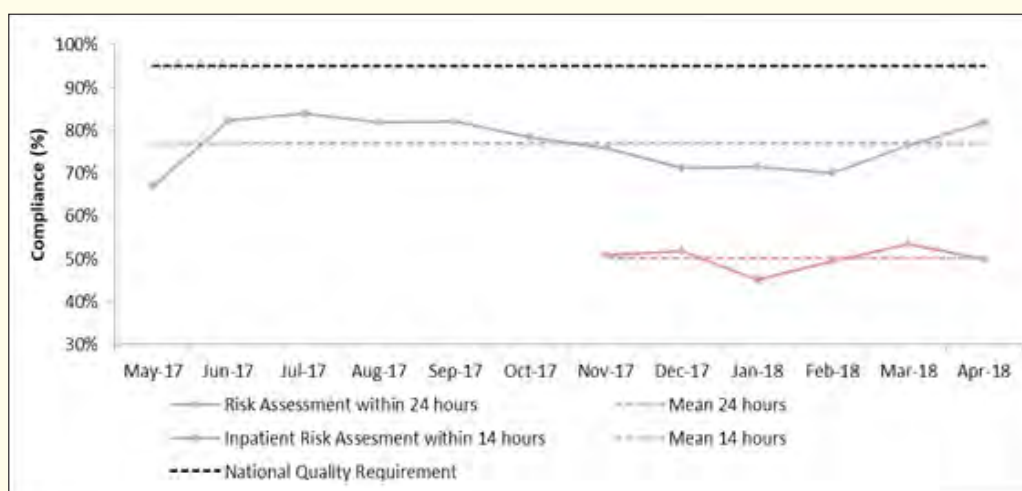
When by: Target performance set at eliminating all preventable Hospital Acquired Thrombosis (HAT) by 2018 (excluding Maternity).

Outcome: Anti-coagulation Nurses continue to deliver VTE mandatory training. At the end of January 2018 the attendance was 87%

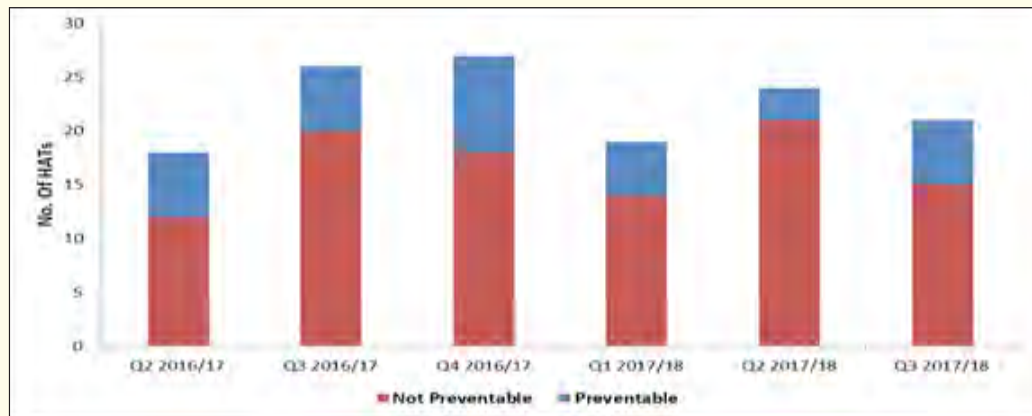
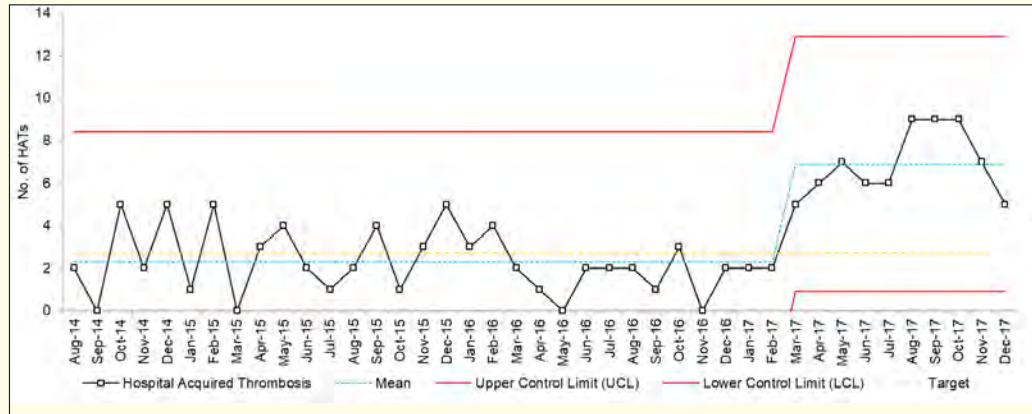
The Thrombosis Committee meeting now takes place every month. Consultants informed of the need to attend to discuss RCAs of any HATS, but due to work commitments, i.e. on call, therefore attendance remains less than desirable. Reminders are sent to staff of the importance of attending but still require some focussed work.

The appointment of Consultant Haematologist with added interest of Anticoagulation is being advertised to further support the service.

VTE assessments are completed on VitalPac and data presented on the Quality Improvement scorecard monthly to the Quality Governance Committee.



The latest NICE guidance recommends that all inpatients should receive a VTE risk assessment by the time of the first consultant review, which should happen within 14 hours. Compliance with these recommendations was 50% during April.



We said we would: Undertaken a communication deep dive to identify key issue areas within the patient journey

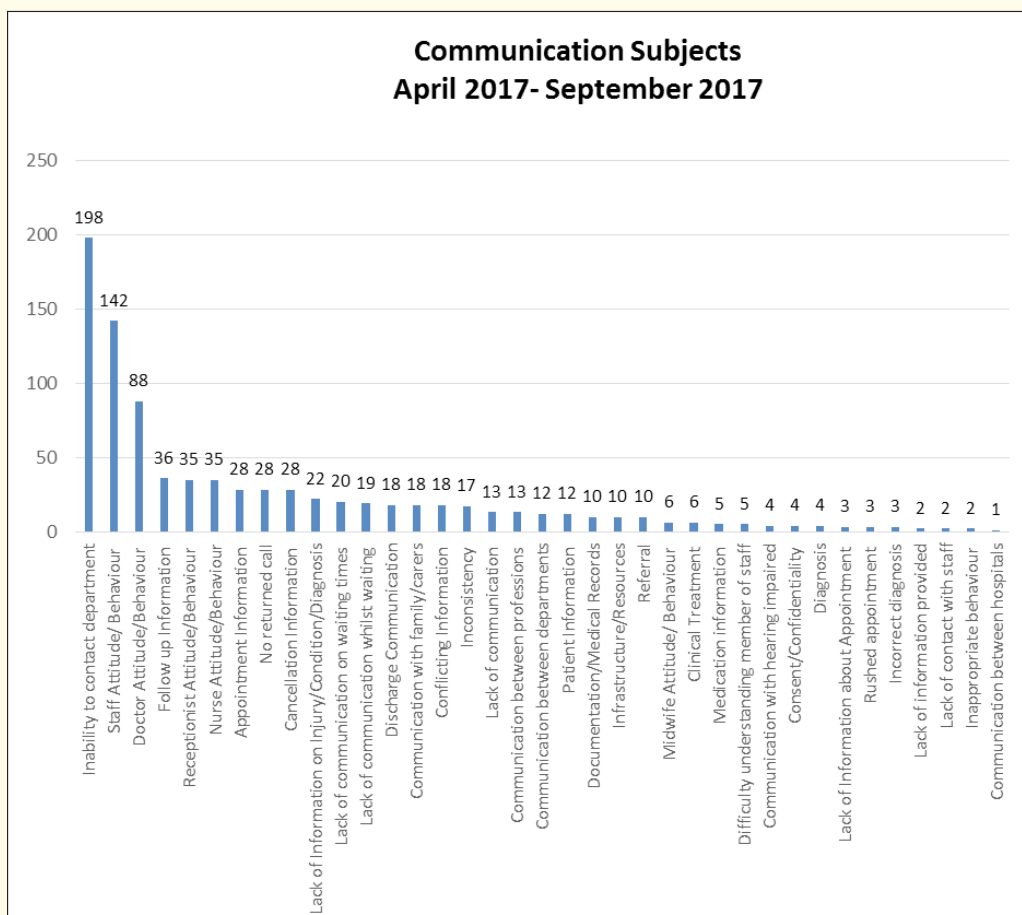
What we achieved:

What:	Undertake a communication deep dive identifying key issues areas from patient feedback
How Much:	6 months of previous of data
When by:	November 2017
Outcome:	Communication is consistently identified by patients as an area of dissatisfaction. This can be evidenced through patient feedback from a number of different sources. As communication in itself is a broad term, it was important to identify what areas of communication are of particular concern to patients, and where within the organisation these are predominately occurring. Therefore, a deep dive has been undertaken to better understand communication issues in more depth and identify areas of focus for improvement work for each of the directorates.

In order to understand the issues around communication, all comments made through the FFT, concerns raised through PALS and Complaints made between the period of April and September 2017 were collated into a spreadsheet. For each comment a subject was applied. In total, 919 comments were analysed for Q1 & Q2.

Row Labels	Count of Communication Subject
Complaints	104
FFT	477
PALS	338
Grand Total	919

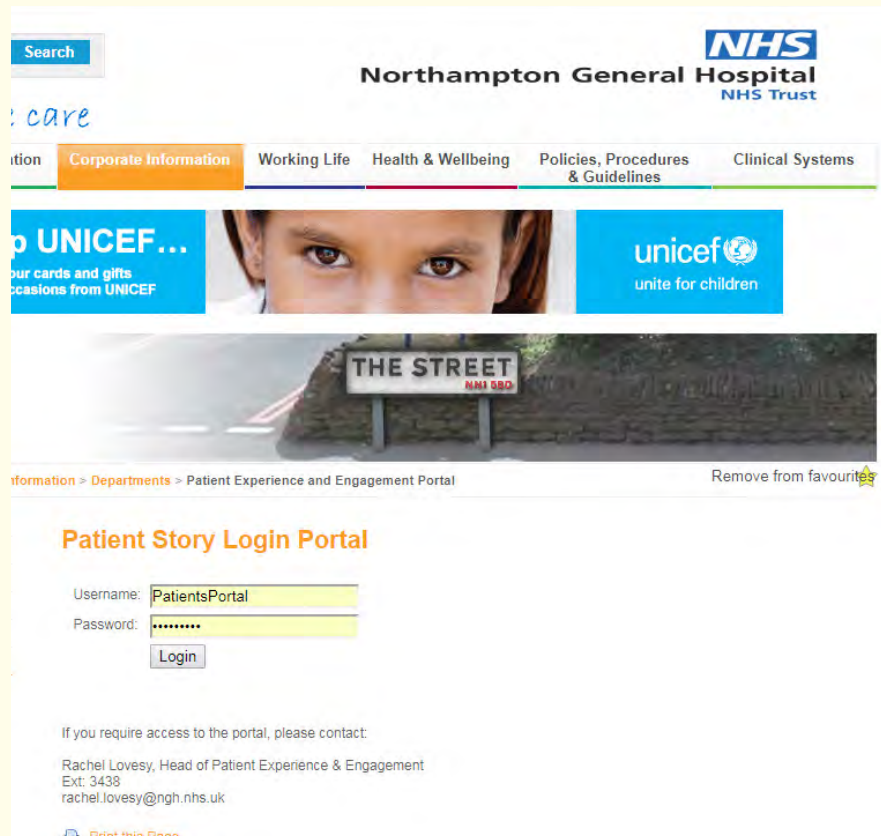
The primary concerns identified by patients were the Inability to contact departments, and Staff attitude & behaviour. This information has been shared with the divisions where the improvements will be led.



We said we would: Create a repository of patient stories

What we achieved:

What:	The creation of a repository of patient stories within the intranet for staff to access
How Much:	Ongoing
When by:	November 2017
Outcome:	It has been identified that using patient stories can be beneficial within a number of different areas. In order to support this work a repository of stories has been created within the Trusts intranet for staff to access. The repository is entitled 'Patient Story Login Portal' and is accessed by a generic password which is provided to staff who wish to access it. Once inside the portal it contains anonymised patient stories under headings of different clinical specialties.



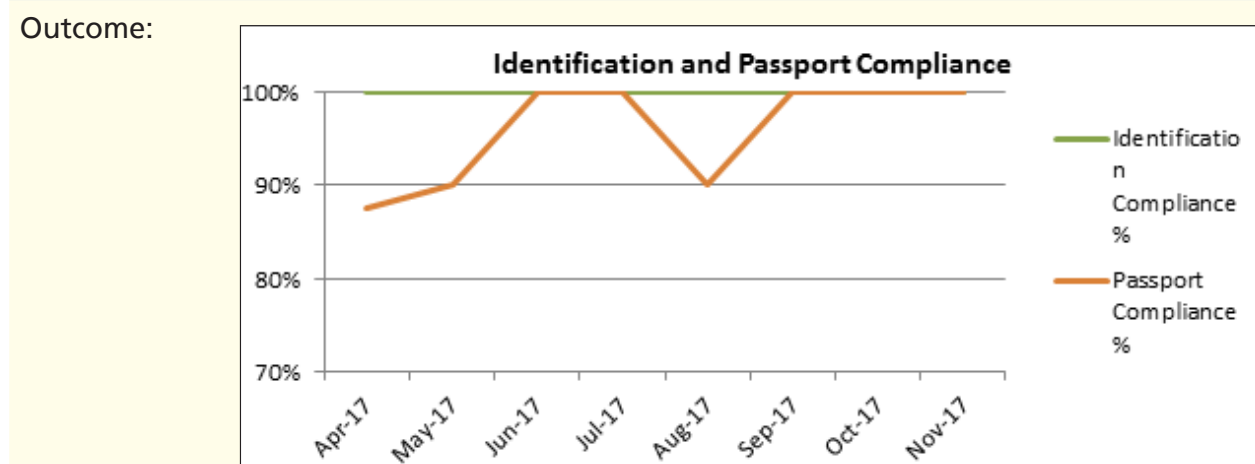
A patient story is read out at each Trust Board and Patient & Carer Experience & Engagement Group (PCEEG). They are also used within Trust Induction and all teaching programmes around patient centred care, where staff are asked to consider certain experiences and whether we effectively provided patient centred care. Patient's stories help bring theory to life. It is expected that the Divisions will begin adding to the repository and also taking from it whenever necessary and the use of patient stories will grow within the Trust.

We said we would: Initiate a set of feedback events

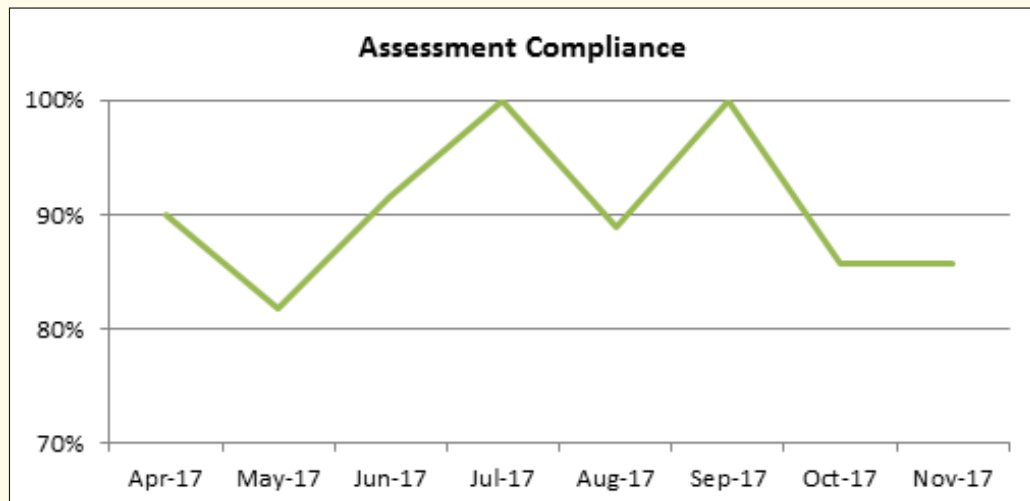
What we achieved:	
What:	Hold feedback events for patients, families and carers
How Much:	As needed
When by:	March 2018
Outcome:	The Annual General Meeting (AGM) was held in September 2017 to share with patient, families, carers and the public the work that has been undertaken within NGH during the course of the year. This was also an opportunity for attendees to share with the hospital their thoughts on future plans. The AGM invitation was sent out via the Patient Experience Team through the Membership Engagement Services (MES) databased which stores the current Trust membership details. Through doing this, the invitation reached more than 1700 people.

We said we would: Identify our Patients with a Learning Disability and ensure Appropriate Documentation is in place to find out how to support them, including any Reasonable Adjustments.

What we achieved:	
What:	All patients with a Learning Disability who are admitted to hospital will be referred to the Learning Disability Liaison Nurse so they receive an appropriate assessment and a hospital passport within 24 hours of admission
How Much:	The hospital aims for continuous improvement by addressing any consistent themes of poor practice to improve patient experience of the hospital
When by:	March 2018



The current snapshot shows the hospital to be consistently above the expected compliance rate (85% in the Quality schedule) in the identification as well as the passport compliance. In August there was one patient who did not have a hospital passport in place within 24 hours of admission.



The current snapshot shows the hospital to be consistently above the expected compliance rate (85% in the Quality schedule) in completing assessments. Where compliance fell below 100% this was due to either one or two people not receiving an assessment within the agreed time frame.

We are making reasonable adjustments to support people with a Learning Disability by:

- Employing a Learning Disability Project Worker – expert by experience to support people with a Learning Disability whilst they are in hospital and also to raise awareness. Feedback from one provider included: *'we were in awe of the care and attention to detail and respect that was given to our resident. Your Liaison Nurse has an excellent approach and having your Learning Disability Support Worker has an added bonus of having a friendly, caring person to talk to.'*
- Having a well-established quarterly LD Steering group in place which is co-chaired by the Learning Disability Project Worker. There is also other service user representation on the group.
- Developing easy read information for specific treatment and care across the hospital.
- Being short-listed for a Nursing Times Award for developing a Theatre Pathway for people with a Learning Disability so bespoke care plans are developed jointly with the patient and their families/carers. Feedback from one parent included: *'it was so much better than our experiences in the past. All the planning made sure it went like a dream.'*
- Working in collaboration with the Learning Disability Partnership Board (LDPB) who is a key stakeholder of the hospital Learning Disability Steering group and being awarded a bronze "Getting on Board award". Feedback from a provider included: *this has been the best experience that I have witnessed with one of our residents going into your hospital. We felt safe from the start with the involvement of the Liaison Nurse and the Learning Disability Support Worker and there was clear evidence that our resident felt the same.'*

We said we would: Improve the Quality of Dementia Care by Raising Awareness and Achieving 90% Completion of Risk Screening to Improve Diagnosis of Patients over 75 Admitted to Hospital

What we achieved:

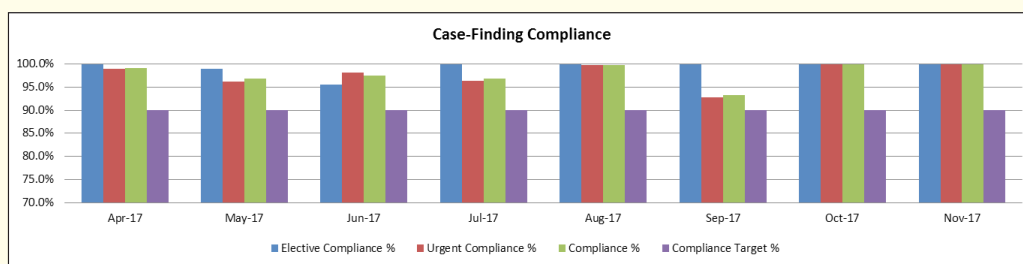
What: Raise awareness of dementia and the importance of early diagnosis in the hospital.

All patients aged 75 and above who are admitted for more than 72 hours are asked the dementia screening questions (Abbreviated Mental Test – AMT). Those who score less than 8 out of 10 have this screening repeated once ready for discharge. If the score remains less than 8, appropriate follow-up is highlighted to the GP within the patient discharge letter.

How Much: The hospital aims to show consistent compliance of 90% of screening all patients over the age of 75 who are admitted for more than 72 hours for identification of dementia.

When by: March 2018

Outcome:



The current snap shot shows the hospital to be consistently above the expected compliance rate in screening the highlighted patient group for dementia as well as following up this screening where required.

Elective compliance refers to those patients who are a planned admission whilst urgent compliance highlights those that came in via routes such as the Emergency Department.

We are improving early diagnosis rates of dementia by:

- Screening all high risk patients who are in hospital for over 72hours. If this screening highlights a cognitive decline it leads to a review prior to discharge. If concerns are still evident then the GP is informed to follow this up in the community.
- Continuing to report data to NHS England via Unify following achievement of the Commissioning for Quality and Innovation (CQUIN) measures for 2016/17
- Highlighted the screening in Tier 1 and Tier 2 dementia training to ensure this is embedded within the organisation
- Ensuring robust governance processes are in place by reporting compliance data within the monthly Director of Nursing, Midwifery and Patient Services report

- Completing the National Dementia audit and monitoring the improvement plan at the bi-monthly Dementia Steering Group
- Championing that all staff complete Tier 1 dementia training.
- Promoting the role of the Dementia Liaison Nurse who provides advice and support across the hospital to patient, carers and staff

We said we would: Aim to Deliver Person-Centred Dementia Care by Listening to Carers Experience through a Specific Dementia Carers' survey.

What we achieved:

What: Understand the needs and experience of carers of people with dementia who are admitted to hospital.

A minimum of 25 carers of people with dementia who are in the hospital are asked each month if they:

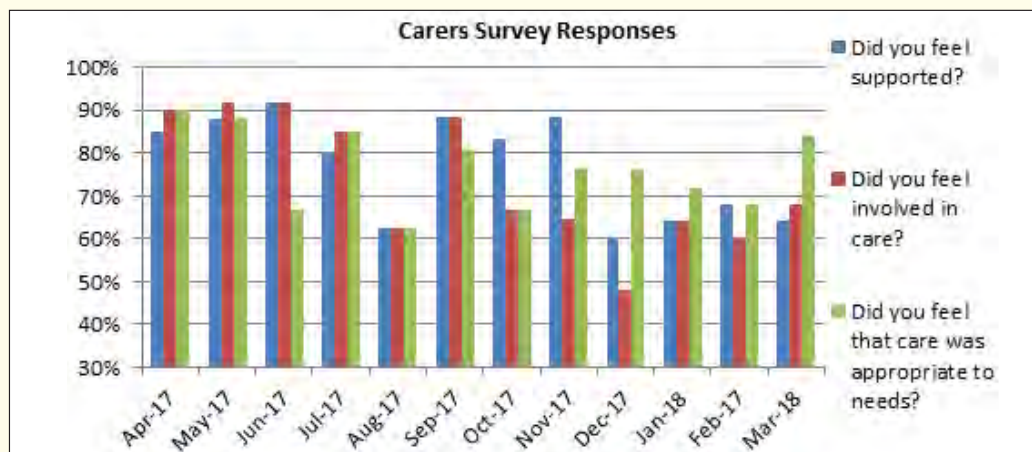
- Feel supported whilst their loved one has been admitted
- Involved with the care their loved one has received
- Feel hospital staff have met their loved one's needs in relation to the impact of dementia

Using the carers feedback work on addressing consistent themes of poor practice to improve patient and carer experience of the hospital.

How Much: The hospital aims for continuous improvement by addressing any consistent themes of poor practice to improve patient and carer experience of the hospital

When by: March 2018

Outcome:



The current snap shot of the data shows varying levels of response for this area with the average response to the above questions being:

- Feeling supported: 83.40%
- Involved: 80.13%
- Care appropriate to need: 77.01%

Carer feedback has included:

“Staff have been supportive to my mother and myself”

“Very helpful, with advice and support”

“On the whole, staff were kind and compassionate”

We are improving the care of patients with dementia by:

- Continuing to collect carers views on their experience following the achievement of the Commissioning for Quality and Innovation (CQUIN) measures for 2016/17
- Revising the survey to include the contact details for the Dementia Liaison Nurse, who can be accessed directly to address any specific clinical concerns
- Feeding responses back to the relevant ward area to aid local awareness and improvement of any concerns raised or highlight good practice
- Including the carer feedback in the monthly Director of Nursing, Midwifery and Patient Services report
- Capturing carers feedback in the hospital Tier 1 dementia awareness training
- Facilitating a Dementia Steering Group which meets bi-monthly to address gaps in practice. This has representation from both internal and external agencies, including carer representation from the voluntary sector
- Supporting the John’s Campaign which is now included in the Trust visitor’s policy and encompasses the values of working with carers to enhance the care and experience of the patient with dementia.

We said we would: Provide care that is safe by reducing harm through improving the quality & timeliness of patient observations

What we achieved:

What: Failure to take patients observations in accordance with their planned and prescribed care can lead to delayed identification of any potential deterioration and therefore potentially delayed treatment.

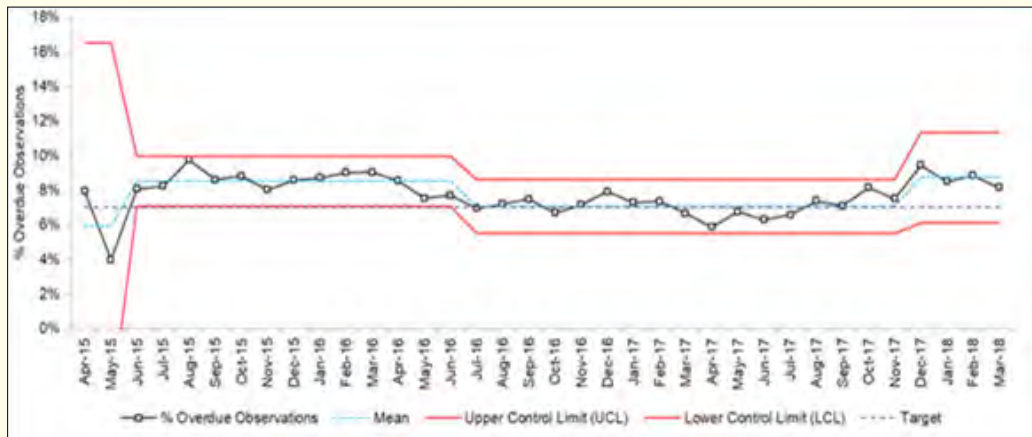
How Much: We will measure all overdue observations data via VitalPac across all adult general wards. We will aim to improve overdue observation rate by 3% to achieve the Trust target of no greater than 7% overdue observations. 2014-2015 Outturn – recorded as an average of 9.14%

When by: Monthly point prevalence audit data has been collected since 2014 and circulated to all adult general wards.

Outcome: Northampton General Hospital has placed a threshold of acceptance at 7%. Any ward that is consistently above that target receives targeted support with additional lessons learnt from performing wards being utilised as good practice examples.

There has been a gradual improvement year on year with targeted support to those wards demonstrating non-compliance including the use of additional IPod's to allow the ward co-ordinators to keep track of when patient observations are due and prompt the appropriate staff accordingly. A gradual roll out of bay tagging as a working principle has demonstrated an improvement towards the 7% trajectory being achieved.

2017-2018 data for end of Q4



The 2014 – 2015 out turn was 9.14%. The mean for 2015 – 2016 is 8.61% demonstrating a .5% improvement against our 3yr Sign up to Safety Project plan. The 2016-2017 data evidences a mean of 7.37%, demonstrating a 1.77% overall improvement and for 2017 – 2018 Q2 6.6% demonstrated a total of 2.48% overall improvement. December late observation data trust wide is 9.44%, however ICT have been asked to validate this data as it is unusually high. This has been validated and confirmed as valid. The data for late observations for March 2018 is 8.16% which demonstrates An overall 0.98% improvement from the baseline.

We said we would: Provide care that is safe by reducing harm through failures in care measured by falls with harm

What we achieved:

What: Falls are the most commonly reported incident in all hospitals in the UK and can cause significant harm. At NGH we implemented a 4 year programme to reduce harm from falls aiming for a 15% reduction by March 2018.

This project was planned to ensure engagement with our staff and patients by:

- Holding regular multidisciplinary falls steering group meetings
- Provide training and teaching for the multi-disciplinary workforce
- Identify falls champions in clinical areas
- Provide bespoke educational training addressing medication and falls risk & introducing a process to review medication that may lead to increased falls
- Reviewing all current processes for post falls review and making the appropriate changes
- Developing a delirium policy to manage patients with confusion

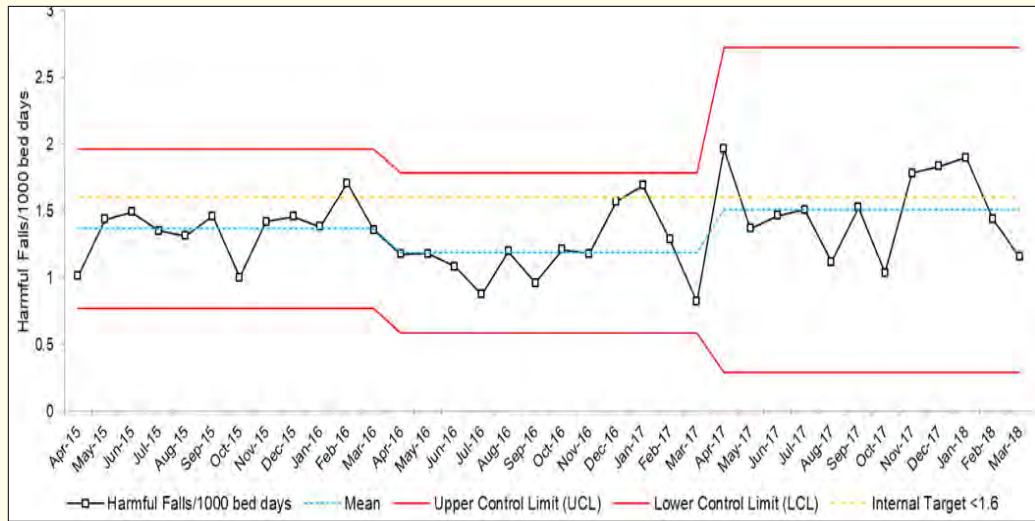
How Much: We aimed to monitor the number of harmful falls per 1000 bed days with a view to reducing them by 15% by March 2018. Falls assessments will be completed within 12 hours of admission in 95% or more patients. Falls care plan will be completed within 12 hours of admission in 90% or more patients. 85% or more of staff to be trained.

2014-2015 Outturn – 1.16 with a target of 0.99/1000 bed days

When by: There are 7 sign up to safety pledges within this project which are monitored and reported monthly. The 4 year programme's success is monitored through until end of March 2018.

Outcome: The graph below demonstrates the number of harmful falls/1000 beds categorised as low, moderate, severe and catastrophic recorded at NGH between April 2015 and March 2018. The graph above demonstrates there has been an increase in the mean average of harmful falls/1000 bed days recorded since April 2017 and March 2018 when compared to the previous financial year of 2016/2017. Over the 17/18 financial year the Trusts total falls rates has reduced and the mean average of moderate severe and catastrophic falls has remained the same as the previous year. These are the most harmful falls that can occur within the Trust.

- **Sign up to Safety 1** - Falls assessment will be completed within 12 hrs of admission in 95% or more patients.
In quarter 4 2017/18 the mean average for completing Falls Risk Assessments is 97% - target achieved
- **Sign up to safety 2** - Falls care plan will be completed within 12 hours of admission in 89% or more patients
In quarter 4 2017/18 the mean average for completing falls care plans is 89% - target achieved



- **Sign up to safety 3** - Review current process for post falls review and make appropriate changes.
- This remains ongoing and there is no update for quarter 4.
- **Sign up to safety 4** - Develop a delirium policy to manage patients with confusion
- Delirium Guidelines have been approved and are available on the Trust intranet.
- **Sign up to Safety 5** - Introduce a process to review medication that may lead to increased falls for patients admitted with a fall, Sign up to safety 6 - Introduce a process to review medication that may lead to increased falls for patients at risk of a fall. The process for referring a patient for a medication review remains the same. Work remains ongoing for auditing the number of medication reviews that are being completed. There has been a new Frailty Pharmacist recruited in quarter 4 and actions surrounding completion of medication reviews has been added to the falls action plan.
- **Sign up to Safety 7** - Falls Prevention Training for staff 85% compliance. During quarter 4 the mean average for Trust Training compliance was 85% - target achieved

We said we would: Reduce harm from hospital acquired pressure ulcers

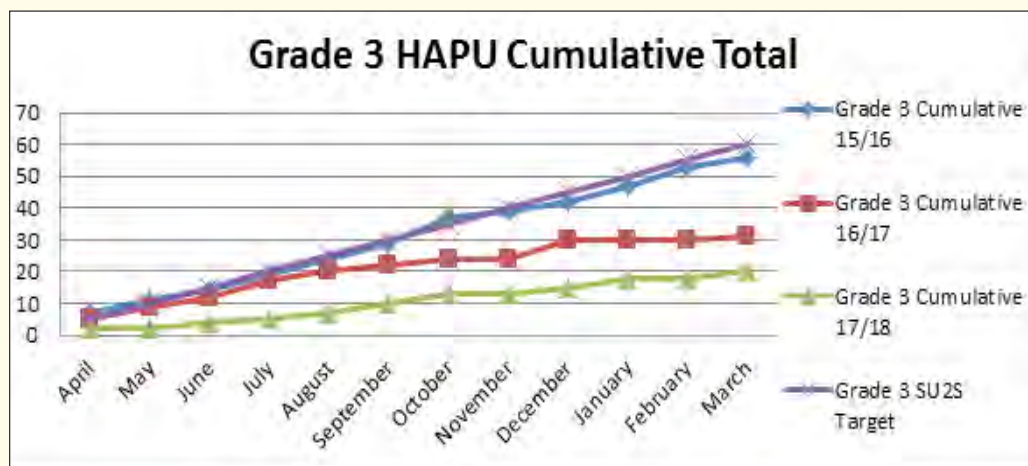
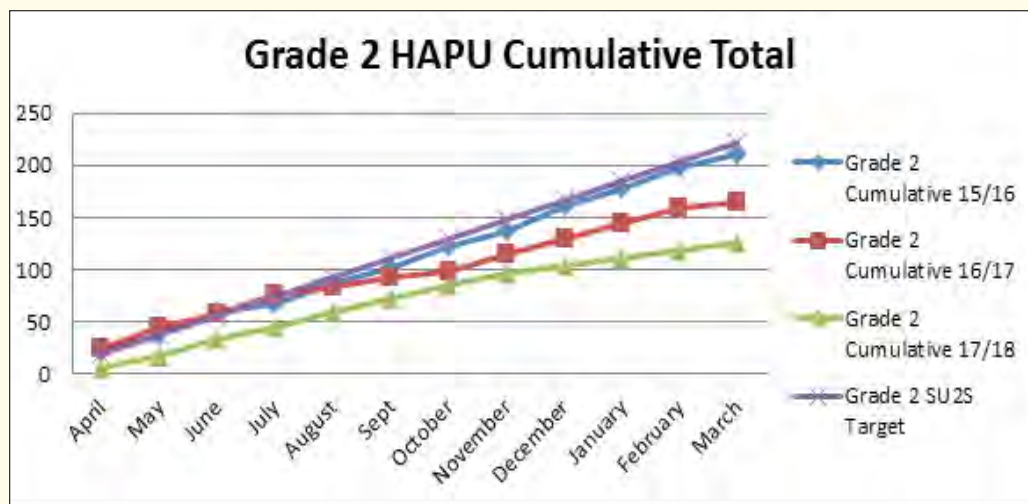
What we achieved:	
What:	To reduce the number of Hospital Acquired Grade 2 & 3 Pressure Ulcers. The Trust will have no Hospital Acquired Grade 4 Pressure Ulcers
How Much:	A continued reduction on 2016-2017 incidence
When by:	By March 31st 2019

Outcome:

	Q2 2016-2017	Q3 2016-2017	Q2 2017-2018	Q3 2017-2018
Grade 2	38	34	29	22
Grade 3	7	1	5	5
sDTI	9	9	9	9
Total	54	42	56	38
Total Without sDTI	45	35	34	27

There were a total of 22 validated grade 2 hospital acquired pressure ulcers (HAPU's) in the period covering January - March 2018 (Quarter 4).

There were a total of 5 validated grade 3 hospital acquired pressure ulcers (HAPU's) in the period covering January - March 2018 (Quarter 4). Although this is more than the same Quarter in 2017, there is still an overall reduction of Hospital Acquired pressure Ulcers in 2017/2018



Countywide TV Forum

As part of the countywide Tissue Viability Forum, and supporting the County Sign up to Safety Improvement Plan, the Tissue Viability Nurse representatives from NGH, KGH & NHFT will meet quarterly as a collaborative group in 2018. This proposed meeting will be held 4 times a year to educate and develop the knowledge and skills of staff in Tissue Viability related subjects.

This project will enhance collaborative working across all trusts in Northamptonshire. It will be used as a platform where new ideas and strategies can be shared as well as providing an opportunity to share patient stories and best practice.

National Health Service Improvement (NHSI) initiatives

NHS Improvement has relaunched its "Stop the Pressure" Programme, nationally. The aim of the national programme to drive further improvement in the levels of pressure damage, which remains one of the key remaining patient safety challenges across all healthcare settings in the NHS.

The TV Team accepted an invitation by NHSI to participate in a PU Collaborative, due to commence in October, however due to the response received (over 75 organisation accepted the invitation) we have not been selected to partake on this occasion.

We said we would: Reduce the number of patients with Trust attributable Clostridium difficile infection

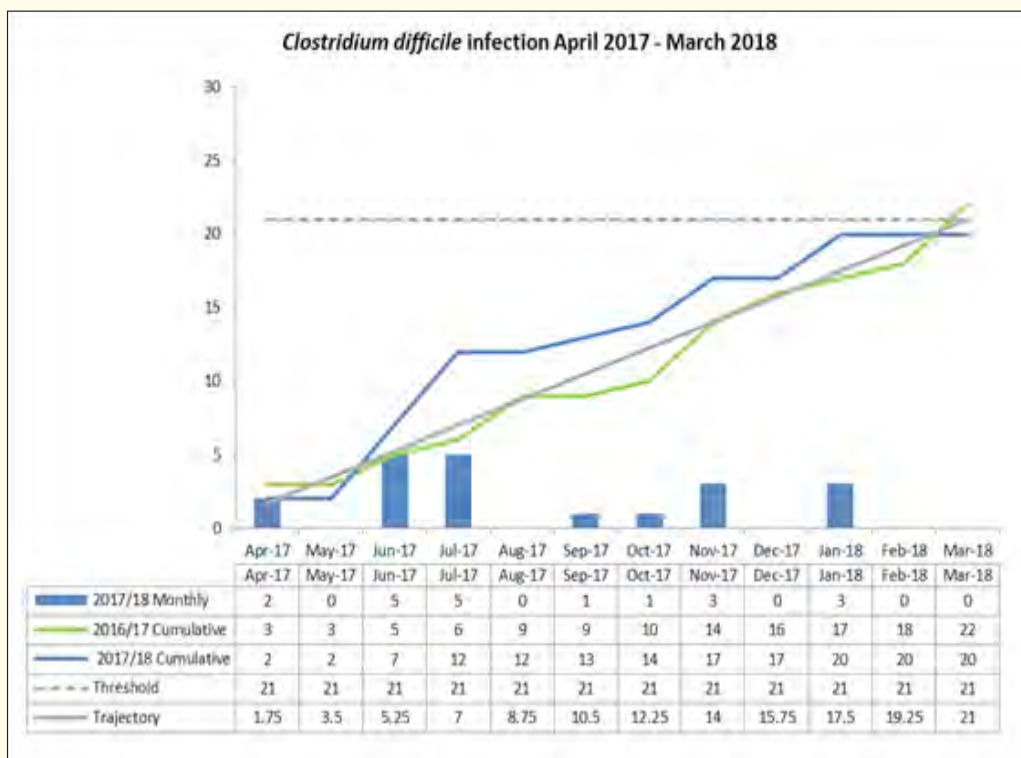
What we achieved:

What: Reduce the number of Clostridium difficile infection (CDI)

When by: March 2018

Outcome:

- In 2017/18, 20 patients developed Trust attributable CDI. All 20 patients have been reviewed by the local Clinical Commissioning Group (CCG) and there were no lapses in care identified. This is a reduction from 21+1 patients in 2016/17.
- NGHT progressed this priority by:
- Completion of a Clostridium difficile infection improvement plan which was monitored monthly through the Infection Prevention Steering Group (IPSG).
- An internal Surgical Division C.diff collaborative identified ways to reduce the risk of C.diff acquisition. This change package included sporicidal wipes to clean equipment used by isolated patients, yellow triangles to highlight infection on the ward boards, offering squash to patients on drinks rounds, reminding staff to send a sample for type 6 faecal specimens and the use of antibiotic stickers in the medical notes to prompt an antibiotic review. This was scaled up and spread across the Adult inpatient wards in October.



- The weekly C.diff round continues where patients with C.diff acquisition are reviewed by the Consultant Gastroenterologist, Consultant Microbiologist, Antimicrobial Pharmacist, and a member of the Infection Prevention & Control Team.
- NGH continues to provide enhanced cleaning with a focus on frequently touched points for a ward which has a patient or patients who present a high risk of cross-infection to reduce the risk.

We said we would: Provide care that is safe by reducing harm by reducing hospital acquired Meticillin sensitive *Staphylococcus aureus* (MSSA) bloodstream infections.

What we achieved:

What: Reduce the number of patients with MSSA

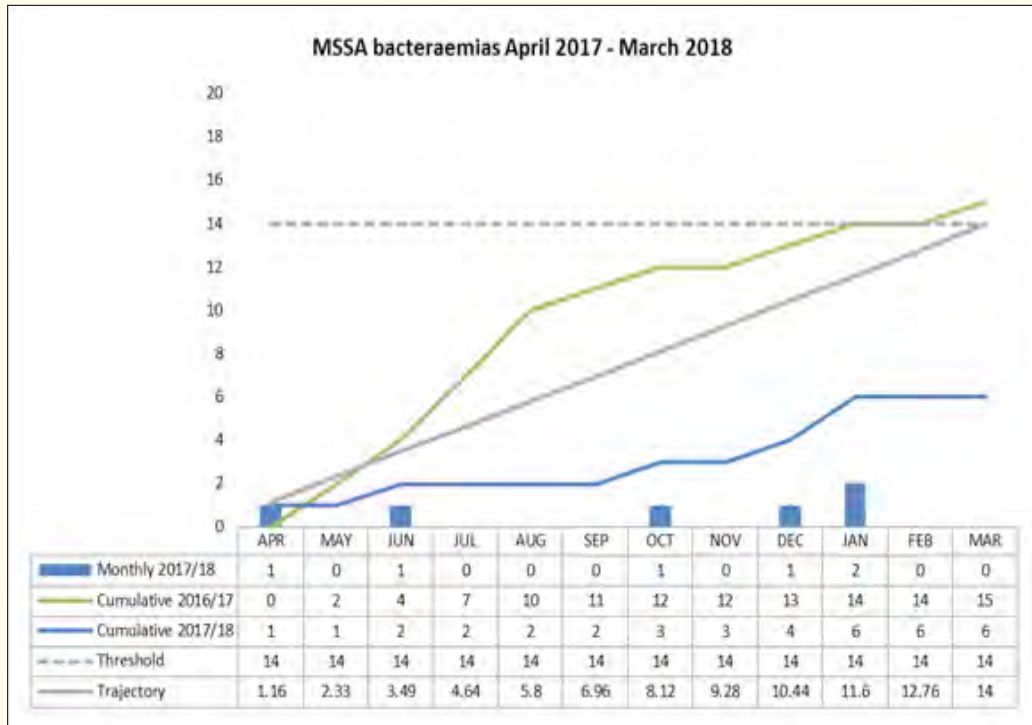
When by: March 2018

Outcome:

- In 2017/18, 6 patients developed a Trust attributable MSSA bacteraemia. This is a 60% reduction from 15 in 2016/17.

Northampton General Hospital Trust progressed this priority through:

- Completion of the MSSA bacteraemia reduction plan for 2017/18.
- Post Infection review meeting within 48 hours for every case of NGH trust attributable MSSA bacteraemia.
- Discussion of all incidents at the monthly Infection Prevention Operational Group.
- Lessons learnt and MSSA patient cases shared across the Trust through Infection Prevention Team patient safety alerts and ward huddle sheets.



- Annual ANTT (Aseptic Non-Touch Technique) refresher training included into mandatory IPC training for all relevant clinical staff from April 2017.
- All patients who are MSSA positive in manipulated sites e.g. wound, PEG, line site, skin swab are prescribed decolonisation treatment to prevent the patient from becoming bacteraemic.

We said we would: Stay below National average for Trust acquired Catheter Related Urinary Tract Infections.

What we achieved:

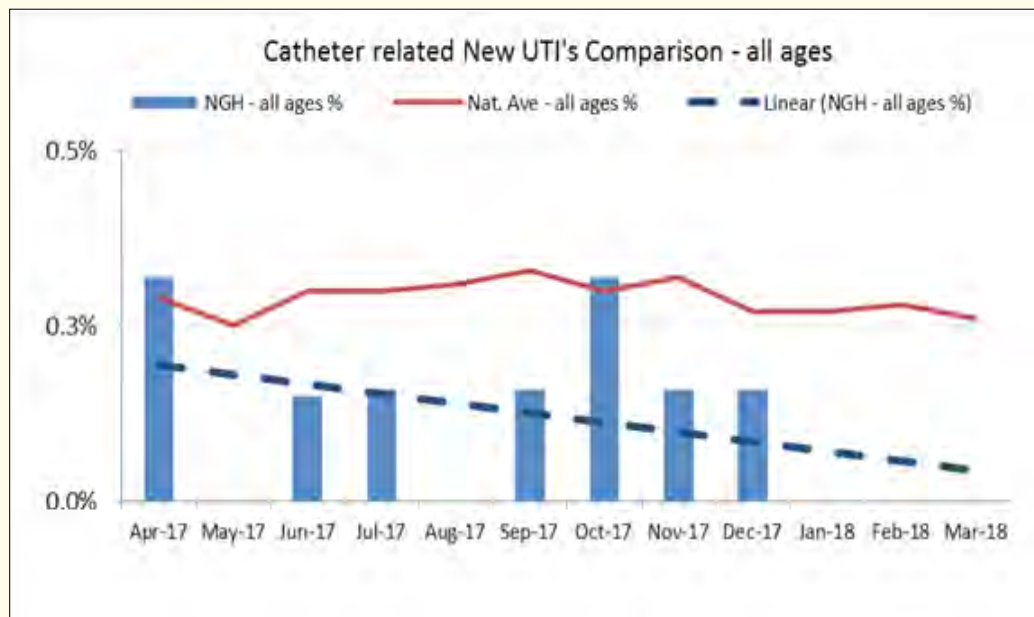
What: Stay below the national average for Catheter Related Urinary Tract infections

When by: March 2018

Outcome: In 2017/18, 7 patients were identified with a Trust attributable catheter related urinary tract infection as part of the monthly Safety Thermometer audit. This is a 42% reduction from 12 in 2016/17.

Northampton General Hospital (NGH) Trust progressed this priority by:

- Completing a catheter related urinary tract reduction plan.
- A Trustwide catheter campaign was performed in April 2017.
- Screensavers and posters were disseminated to promote HOUDINI.
- Ward safety huddles attended to promote HOUDINI and best practice.



- Annual ANTT (Aseptic Non-Touch Technique) refresher training included into mandatory IPC training for all relevant clinical staff from April 2017.
- Catheter packs were launched in November in urgent Care and the Emergency Department.
- An algorithm for managing patients with positive urine dipsticks and suspected/confirmed urinary tract infections has been produced.

General Improvements in 2017/18

Quality Improvement

We have made Quality Improvement (QI) work a key point of focus to improve the care that we provide to our patients and have described this in our Quality Improvement Strategy. To ensure that the learning can be captured and shared across the Trust, we developed a central repository that is supported by the QI team. This provides a library of projects & ideas that may benefit from further project work/development and will reduce areas of duplication & replication. This has been an important development for our organisation as it will particularly highlight work that is sustainable and can be transferred between teams to become business as usual.

During 2016/17 we had more than 40 projects across the Trust which were supported by our QI team some examples of which are listed below:

- Improving Nurse Knowledge of Acute Kidney Injury
- Improving early Discharge by earlier engagement with family/carers
- Reducing the amount of inappropriate cannula's
- Improving the accessibility of patient observations on admission unit ward rounds
- Doctor Toolbox
- Documentation of cardiac arrest management in out of hours cardiac arrest
- Standardisation of procedure specific equipment trays
- Improving Electronic Discharge Notification (eDN) completion in Urology.
- Effectiveness of the falls assessment form
- Improving access to gynaecology equipment for emergency assessment
- Improving accessibility to common guidelines
- Introducing a discharge system for medically fit for patients who requiring four times daily intravenous antibiotics
- Improving surgical handover
- Medical Emergency Team trial
- Improving the efficiency of giving medications by 25% on Holcot ward
- Night team handover
- Care of the patients on the stroke pathway who are 'nil by mouth'
- Improving the paging system
- Rapid tranquilisation
- Support of the Trust rollout of the SAFER bundle
- Improving accessibility of bedside sharps disposal
- Situation, Background, Assessment, Recommendation (SBAR) communication tool implementation
- Improving compliance with Venous Thromboembolism (VTE) risk assessment
- Improving medical weekend handover plans
- Introducing a daily '10 minute conversation' for the emergency team
- Improving access to emergency protocols
- A multidisciplinary approach to learning from error

Reflecting the high level of QI activity, the Trust submitted 17 projects for consideration by the Patient First conference. In all, we made 49 conference submissions this year, with 18 of these being shortlisted for presentation and the Trust received 4 QI awards.

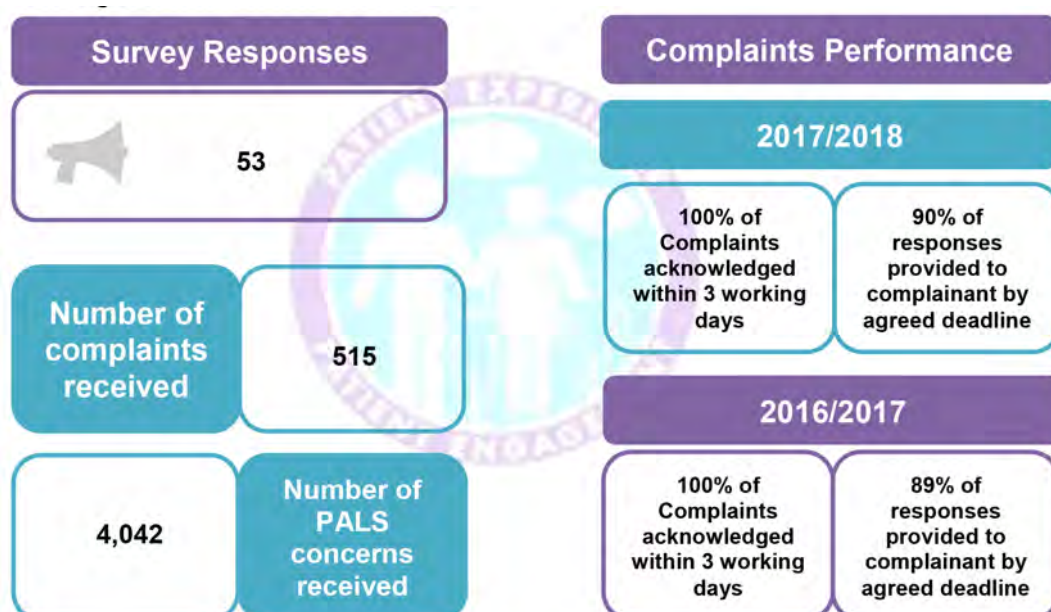
We made 25 submissions of QI work carried out by our junior doctors which were accepted for the 2017 International Forum on Quality & Safety in Healthcare.

More recently we have had 12 submissions accepted for presentation at the Patient Safety Congress:

- Introducing a '10 Minute Conversation' – Improving Communication within the Adult Cardiac Arrest Team
- Improving Nursing Knowledge of Acute Kidney Injury
- Reducing the risks associated with blood transfusion: the experience of implementing patient blood management at Northampton General Hospital
- Easing the stress of rotation through the development of the Dr Toolbox mobile app and the introduction of a formal handover
- Improving Access to Emergency Protocols
- Improvement of Service Provision through the Introduction of Gynaecology Emergency Bags at Northampton General Hospital
- Improving intravenous Fluid Prescribing
- Learning from Errors - A Multi-disciplinary Approach within the Simulation Suite
- Improving the Efficiency of the Administration of Medication on an Acute Medical Ward
- Introducing Point of Care Simulations at Northampton General Hospital
- Improving the disposal of sharps
- Improving VTE re-assessment compliance

This work comes from across the multidisciplinary team and reflects the desire of all of our staff to seek innovative ways of improving the care we provide.

Learning from Patients Feedback



Collecting Feedback

The Trust has three main methods for actively collecting patient feedback each month. This is based around a three-pronged approach:

- The National Friends & Family Test (FFT)
- The Real Time Survey
- The Mini-National Right Time Survey

Real Time Survey – Update

The survey is undertaken by senior members of the corporate nursing team within designated wards each month; we call this group 'Keep Connected' as it enables the staff to spend time interacting with patients. The most beneficial aspect of the survey was the support it gave to our elderly patients. Examples of changes made include placing sleep well kits into welcome packs, fixing troublesome doors and ensuring patients are asked how they slept in the morning.

Right Time Survey – Mini National Survey

As with the Real Time Survey, the Right Time Survey uses a number of questions which have been taken from the National Inpatient Survey and the National A&E survey. This allows for the organisation to directly compare the results with the national results. The Right time survey is issued to 600 patients in Inpatients and 600 in ED, two weeks post discharge. It provides information down to ward level, which the national surveys are not able to do. This has been hugely beneficial for the Divisions as it has provided areas of key focus.

CQC National Inpatient Survey Focused Improvement Work

From the results of the National Inpatient survey the following initiatives have been implemented;

Pharmacy Helpline to support medication use

Patients state they don't receive enough information about their medication at discharge. Therefore a Pharmacy Helpline has been established. The helpline has been included within a medication leaflet which is now included within every TTO bag from Pharmacy for patients when they leave hospital.

Patient & Carer Information Folder

A Patient & Carer Information Folder has been implemented throughout the Adult and Childrens Inpatient wards. This contains information on the day to day running of the hospital and the patient journey. The Folder has been reviewed by patients to ensure it contains the right information.

Leaving Hospital Leaflet

A leaving hospital leaflet has been created to ensure patients are aware of the process required to ensure they leave hospital with all the information they need.

Making better use of patient experience data for health service improvement (US-PEx) National Research Project

The Trust was one of 7 hospitals selected nationally to partake in a national project between the University of Oxford and the Picker Institute. It focussed on understanding how NHS frontline staff use feedback to improve, with the intention of developing national tools.

Creton Ward took part in the project. Surveys were undertaken pre and post intervention. Results showed a statistically significant improvement in 8 questions.

Patient Experience Network National Award (PENNA)

Each year, the Patient Experience Network hold a National Awards ceremony where they invite NHS organisations to submit proposals based around a number of categories. For the 2016 awards NGH submitted and won two awards. The Trust has once again been shortlisted within the PEN National Awards within three categories.

Patient Engagement

Patient & Family Partners

Patient & Family Partners are being established within the hospital to ensure that patients, families and carers are represented within the decision making processes. Patient & Family Partners are all registered as volunteers to ensure they are able to effectively co-produce with staff. Plans are afoot for greater representation within many different departments within the organisation including pharmacy and strategy & partnerships. To ensure we establish effective engagement a PFP is supporting the creation and implementation of the programme.

Communication

Following the deep dive undertaken in 2017, each of the division's directorates received information on where within their departments communication was an issue. In 2018/2019 the focus will be on making improvements within these areas to the direct benefit of patients.) It is expected that with Communication being one of the hospitals biggest issues, a targeted focus should see improvements within all 3 surveys collected within the hospital.

Discharge

Patients experience of discharge has been identified as a focus area for improvement within the data received within 2017/2018. To tackle this, an Experience Based Co-Design (EBCD) project will be undertaken, ensuring true coproduction between staff and patients to identify lasting solutions.

What We Are Proud Of

Nursing & Midwifery Professional & Practice Development

Professional development and lifelong learning is an important pillar in our Nursing & Midwifery Strategy and Pathway to Excellence® journey, providing opportunities to develop skills and knowledge to fulfil potential, in a practice education environment that invests in our current and future nursing & midwifery workforce. Delivery of preceptorship, junior sister/charge nurse and sister/charge nurse development programmes and 2017 saw the introduction of a new development programme for our established staff nurses and senior staff nurse recognition.

Supporting our nursing & midwifery workforce for the future including a comprehensive international preceptorship programme taking our new international colleagues through the required objective structured clinical examination (OSCE) assessment: achieving an overall pass rate (first and second attempt) of 95%, one of the highest in the UK.

The first cohort of nine nurses on the RCN Clinical Leadership Programme (CLP) successfully concluded in October 2017. This is a prestigious programme primarily focusing on the five pillars of transformational leadership which has led to an RCN Clinical Leadership Alumni.



Nursing & midwifery students are our workforce of the future we are leading the way with an innovative model to enhance their practice learning experience. Practice Learning at Northampton (PL@N) aligns with the new Nursing & Midwifery Council (NMC) standards for pre-registration standards. This has translated into students expressing a high level of support, reduction in student attrition and a positive impact on recruitment.

Trainee Nursing Associates continue to develop their knowledge, skills and competence in line with the national curriculum. Nursing Times Awards: finalist Theatre Nursing Development Pathway



Volunteer Service

Our volunteer service continues to utilise volunteers to enhance and support staff who provide the best possible care to our patients.

There are approximately 130 volunteers within the Trust with roles including; end of life, our award winning bedside book club and buggy driving with all volunteers undertaking mandatory training and other bespoke preparation to ensure they are fully skilled to undertake their duties. Volunteers come from across Northamptonshire and are recruited using a process which is in line with the Lampard recommendations and the NHS standards and includes safeguarding training for Children and Adults.



We continue to have a high presence on the wards, with our volunteers being respected and supported by NGH staff. During 2017 we have introduced volunteers in to 7 additional wards and we expect this to grow in the future with our continuous recruitment of additional volunteers. In addition to supporting more wards the Trust volunteer service has now been adapted to include the very popular Buggy and guide service which undertakes on average 260 journeys for our patients and visitors each week. Alongside this service we have also recruited our new early bird volunteer who has been working within the trust to support the discharge of patients.

The recruitment of new volunteers remains strong, with the effective use of social media, the support of our local community and external companies who provide us with advertising free of charge.

We will continue to expand and grow the service to ensure that our patients and staff have additional support throughout 2018 and that the volunteer service can continue to support NGH.



Springfield Urgent Treatment Centre

Northampton General Hospital NHS Trust opened its co-located Urgent Treatment Centre (Springfield House UTC) on 29th November 2017 and it is located adjacent to Emergency Department.

The UTC is a pivotal clinical element of the Emergency and Urgent Care Pathway. Approximately, 30% of all emergency presentations do not require the clinical expertise of the Emergency Department. These patients are best seen, treated and discharged through our Urgent Treatment Centre and this then frees up clinical time in Emergency Department for clinically unwell patients to be seen in a timely manner. Patients are seen in the Emergency Department by a senior clinician (paramedic or nurse) as the first contact, they are then streamed against national and local guidance to this area. The Urgent Treatment Centre is staffed by General Practitioners and Advanced Nurse Practitioners who also work to the National 4 hour Urgent Care Standard.

Since its introduction we are seeing 20% of all emergency presentations through this area, an increase from the 14% seen when the service was based in the Emergency Department. Within the next 12 months it is forecast that we will be able to see 30% of all our presentations through Urgent Treatment Centre.

Sonographers - 100% passed the strict criteria for quality assurance with their foetal anomaly scanning

Between 11 weeks and 2 days and 14 weeks and 1 day of pregnancy patients are offered a screening test to estimate the chances that the fetus is affected with Down's, Edwards' and Patau's syndrome. The ultrasound component of this test is the nuchal translucency scan which requires two specific measurements; one of the length of the fetus from head to bottom and one of the membrane and fluid behind the fetal neck.

Quality assurance is essential in order to minimise harm and maximise benefits of screening because inaccurate measurements can alter the risk factor calculation with serious consequences.

To ensure that each Sonographer is meeting the national standards monthly image review is undertaken on random images within the department and every six months all

of these measurements produced by each Sonographer are sent to the external agency Down's Syndrome Quality Assurance Support Service (DQASS) for assessment. From this each Sonographer is assigned a red, amber or green flag status which indicate the bias of the dataset which is the extent of the measurement deviation from the Fetal Medicine Foundation (FMF) reference curve.

In December 2017, the DQASS report awarded every Sonographer within Radiology a green flag status, which is assigned when bias is less than or equal to 0.10mm, and is only achieved by 5-10% of Trusts.

This is a direct result of the continued hard work of the whole team and proves that NGH offers an excellent service to these patients.

More information on this screening test can be access using the link below: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/443865/FASP_ultrasound_handbook_July_2015_090715.pdf

Fit to Sit

The Emergency Department has re-launched of 'Fit to Sit' as part of everyday working.

Fit to Sit to begins from the patients home with engagement from the ambulance service, to encourage patients walking from ambulances or chair transport rather than trolleys (collaboration with East Midlands Ambulance Service clinical and education leads to encourage this has begun).

There should be relevant communication between patients, ambulance personnel and nurses regarding mobility, clinical presentation and whether Fit to Sit. Patients from FIT (assessment area) encouraged to sit once assessed and investigations made with posters to propose and encourage the notion of Fit to Sit

Soft chairs have been purchased for the waiting area, using charities monies, to make sitting more comfortable and help prevent pressure sores. Water machines have been ordered for waiting areas, plus other comfort-related input to encourage sitting including magazines and racks.

Information about Fit to Sit is shared at department huddles among nursing and medical staff. There is a Matron clinical lead offering and suggesting sitting and an initiative to move patients to the Clinical Observation Area in a chair.

Nursing and Midwifery Recognition

There is now compelling evidence that through the introduction of a values and behaviours recognition scheme healthcare providers can "drive up" clinical standards and create meaningful recognition for nurses and midwives. Hence, NGH introducing the international DAISY Award for extraordinary nurses and midwives.

Recognition for compassionate care from patients, families/carers and/or colleagues demonstrates to the registrant the importance of the role that they do. An international award with criteria based around the Trust values and vision further celebrates the provision of Best Possible Care and raises the profile of nursing and midwifery locally, nationally and internationally.

The millennial effect is well documented and the literature identifies the need to provide frequent, meaningful and structured feedback to all staff groups but primarily generation Y and Z. Therefore, to recognise individual contributions staff can be nominated by their Ward Sister/Charge Nurse and/or team to attend 'Tea with the Director of Nursing'. To date this event has recognised the individual contributions of over 70 members of the nursing and midwifery team. Within local areas various recognition schemes are in place for contributions made by staff or when they have been recognised for their excellence in care and going above and beyond – these recognition schemes not only come from patients and the public but from the multi-disciplinary team and are particularly pertinent in areas that are not necessarily frontline.



Shared Decision Making

The concept of Shared Decision Making (SDM) was first introduced to NGH in November 2016 and had been steadily developing over the last year. SDM is a culture change that encourages frontline staff to have a voice and to be involved in the decision-making process from the beginning. At NGH we use a councillor model, where representatives from each area form a council and are given dedicated time each month to work on projects that impact patient safety, the environment and patient and staff experience. There are three types of council – ward, speciality and themed councils. They all feed back into the Leadership Council, which is chaired by Carolyn Fox (Director of nursing, midwifery and patient services). The members of each council can be of any grade or designation and there should be a fair representation of each area/department.



To date there are 11 active staff councils at NGH that sit alongside and feed into the Leadership Council. Five further councils are in the process of starting and have decided to hold their first council meeting after they have completed the next training sessions this December 2017. Going forward, training dates have been planned bimonthly and now consist of two full days. Multiple projects have already been completed to improve patient care and experience and many more are underway. Below are examples of projects that the councils have been and are currently working on:

EAU (was Creaton)	Have completed multiple projects to reduce noise@night, including getting rubber covers fitted on door hinges. Working on staff morale to reduce stress levels and purchasing a massage chair for breaks
Maternity Council	Arranged for herbal and decaffeinated tea to go on drinks trolley. Looking at revamping and redesigning outside areas to create safe, relaxing places for patients to use
ITU Council	Arranged for a hostess to give out meals so patients don't miss out. Looking at possibility of creating a patient shower room/toilet to improve dignity and privacy
Newly Qualified Forum	Working on a welcome pack from new starters to aid their transition into the trust, have visited University of Northampton to speak to third year students about NGH

Paediatric council	Quick win by getting apple juice alongside orange juice onto their drinks rounds. They are now working on stickers for EDNs to show the last time analgesia or antibiotics were given to improve medication safety
Stroke Council	Glucometers not being cleaned so new posters displayed and wipes placed in each box to prompt. Looking at halving treatment room to create quiet room for specialist reviews and breaking bad news
#FIT (Falls, IPC, TVN)	Standardizing how data is presented to areas and creating a FIT review tool for post harm. Trialling safety crosses to show days of no harm and data as a monthly picture to better represent harms and aid morale
Theatre Council	Successfully got a TV installed into day case unit, looking at covering windows in Manfield Theatre dirty room so Willow patients can't look in
Abington Council	Working on creating a dementia friendly day room to improve patient care and safety
A&E Council	Ordered 10 new chairs for patients spending long periods of time in the waiting area. Working on informing patients about the flow of the department – creating leaflets and signage

Consultant Connect

The Consultant Connect Telephone Advice & Guidance service has been running at NGH for the last year. The service allows GPs to speak directly to specialty consultants at NGH about patient specific issues, without forcing the GP to go through a switchboard or bleep system. Because of the speed of this system the GP can make the call whilst the patient is still with them, allowing the GP and the consultant to agree a care plan there and then. This is a great benefit to the patient, often providing immediate reassurance and a reduction in unnecessary appointments at both the GP practice and reducing the numbers of patients being sent to A&E



The NGH management team, in partnership with Nene CCG, were quick to understand the benefits of the system for healthcare provision across Northamptonshire. The system was originally launched in four high referral specialties, Cardiology, Gastroenterology, General Surgery, and Respiratory Medicine, before being expanded to include Ambulatory Care, Elderly Care and Paediatrics.

Since launch, the service has received around 740 calls from GPs, with around 60% of the calls resulting in the patient's care being kept with the GP.

The NGH service is a great example of primary and secondary care working together to improve patient outcomes in Northamptonshire.

The Best Possible Care Accreditation and Assessment Framework

This process provides the Trust with assurance that the quality and safety of care is being monitored using the 'Best Possible Care' framework and that action is being taken where any fundamental standards of care are not being met.

The framework is designed around fifteen standards and aligns with the CQC essential standards. Each of the standards contain between 10 and 20 individual elements that are assessed. Each standard is then rated as Red, Amber or Green dependent on the number of positive and negative answers. The Ward then receives an overall rating of Red, Amber or Green that is based on the results of the fifteen standards as detailed in the table below.

Red	6 red standards
Amber	3-5 red standards
Green	2 red standards and 8 or more green standards Standard 15 must be green
Best Possible Care Ward	3 consecutive green assessments

At the end of the assessment process the result and feedback is provided to the Ward Sister/ Charge Nurse and any urgent patient safety concerns are escalated and resolved immediately. The ward sister/charge nurse is responsible for formulating a robust action plan that is agreed with the Matron and the relevant Associate Director of Nursing (ADNs).

The results and action plans from the assessment contribute to individual service reviews, and the data collated as a whole provide the Board with comprehensive information regarding care delivery within the organisation.

The Best Possible Care Assessment and Accreditation works at various levels:

- Patients - Receive the 'best possible care'
- Ward teams - Develop ownership and promotes healthy competition between wards
- Division - Can assess nursing care in their areas
- Trust Board - Demonstrates the quality of nursing care across the Trust

Assessment and Accreditation commenced in May 2016 and continues to go from strength to strength. We now have two wards (Cedar Ward and Althorp Ward) that have achieved 'Best possible care Blue ward status with two further wards in the process of applying for this prestigious accolade.

Assessment and Accreditation is also being rolled out in other areas of the Trust and pilots have been completed in the Emergency Department and a number of Out-patients Departments. There are further plans to continue the roll out in Critical Care, Paediatrics, Theatres and Maternity

Cedar Ward Sister Stacey Cheney receiving the first 'Best Possible Care' award from Dr. Sonia Swart (CEO).

Wards have to achieve three consecutive assessments that are rated as 'Green'.

The assessments take place every six months, which indicates that the ward is consistently achieving high standards of quality and safety with regards to patient care.



Our first 'Best Possible Care' Ward being presented with their award

Collaboration with University of Northampton

The benefits of greater affiliation between Northampton University and NGH were formalised and strengthened as part of Quality Improvement agenda at NGH.

A Memorandum of Understanding was agreed. The formal collaboration of Northampton University and Northampton General Hospital Trust provided an overarching framework for closer working and formal collaborations between the parties. Both organisations have an interest in biological, medical and health related research and Quality Improvement and a common goal of engaging in and delivering research for the benefit of the wider health economy population.

The purpose of collaborative working bringing research into practice and vice versa is to underpin the development of what is hoped will become a long-term research and Quality improvement co-operation between both organisations with a common interest in public service and improving communities based in Northampton and further afield.

The commonality of the wide spectrum of trust concerns and priorities and the alignment to the research work that students have developed has been welcomed and is used as a framework to develop ongoing projects and areas of mutual interest. The simplicity of work based projects being over seen by a clinical consultant and an academic is a similar model that has been introduced in NGH as part of the Patient Safety and QI work which remains in place and has proved to be very successful.

One of the overarching aims over the forthcoming year is for NGH to develop multi-professional learning and whole team quality improvement teaching, which again will ultimately benefit patients. The above reflects the objectives of the Institute of Health and Wellbeing, and both organisations can capitalise on this shared interest.

The university and the hospital work collaboratively on a variety of projects drawing on each other's strengths to improve patient care and outcomes. Joint working facilitates staff and students from both organisations to collaborate across a range of subject areas

MSc – Patient Safety & Quality Improvement

The QI team have developed a Master's degree programme in Quality Improvement & Patient Safety. A unique post-graduate course offering unprecedented access to clinical quality improvement processes and facilities has been launched jointly by Northampton General Hospital NHS Trust and the University of Northampton. The course, an MSc in Quality Improvement & Patient Safety, is the first of its kind in the United Kingdom to be taught within a hospital rather than a university and will incorporate hospital-based study including NGH's acclaimed simulation centre where everyday scenarios can be recreated for training purposes.



The University Validation Panel commended NGH and the University of Northampton programme development team for the excellence of the programme design and for the well-thought out and well-written module specifications.

The course is aimed at healthcare professionals and managers who wish to develop a greater understanding and expertise in patient safety and quality improvement with a strong emphasis on practical application. This would be supported by developing the candidates level of expertise by undertaking a project supported by both academic and clinical mentorship at NGH (size of project dependent upon award being studied).

The course is classed as a premium level course which as such should attract international students as well as within the UK. The course will have 3 distinct entry and exit points:

1. PG Certificate
2. PG Diploma
3. MSc

A few of the unique selling points for this course are:

- The collaborative model between the University and the hospital. As such students will benefit from a unique programme which will see each student participating in dedicated study; hospital based quality improvement processes; shadowing of hospital quality and safety leaders & offer strong mentorship from the quality improvement team through to successful completion of their academic award with encouragement to produce scholarly publications and conference submissions.
- Use of the Simulation Suite at the hospital which has three simulation rooms with observational capacity. Varying forms of simulation modality will be utilised across a number of the MSc modules to expose students to aspects of human factors that can influence their practice. It will also be utilised to help develop their QI projects, predict issues before they occur and receive peer review.

- Introducing innovation in practice. The course will aim to develop innovative ideas and approaches through to practice. It will also platform current approaches and teaching innovation e.g. the use of musical intelligence to aid clinical practice.

A major strength of this course is the collaborative model already in place between the university and the hospital. This means students will benefit from a unique programme centred around hospital-based quality improvement processes and incorporating shadowing of hospital quality and safety leaders and mentorship from the quality improvement team, in addition to the usual student support offered by the university

Modules will be taught through a blended learning approach including: lectures, workshops, seminars, on line materials, and the hospital's simulation centre. Students will be assessed through presentations and written assignment, reports, simulated case studies and dissertation. MSc students will also be required to design, implement and report on an extended quality improvement project.

The MSc is entirely in keeping with our desire to align the whole hospital around achieving QI excellence.

Collaboration with Health Education England (HEE)

HEE funded Tier 2 Pilot site

Northampton General Hospital has been delivering a bespoke modular course for Registrar development since 2012.

The course fundamentally aims to provide Registrars with a sense of the wider issues facing the NHS and the local issues related to hospital medicine. The modular course introduce ST's to the management and leadership issues and skill set required to perform effectively as a Consultant, including sessions within the Simulation Suite specifically addressing how to manage behaviours and related human factors.

The course introduces and builds on ST's knowledge and skills for quality improvement (QI) (also acknowledging current and previous QI work from the Quality Improvement Safety Board (QISB) – & 'Aspiring to Excellence' 5th year medical student programmes).

The ST's are asked to lead and deliver a patient safety, patient experience or clinical outcome based quality improvement project utilising the Institute for Healthcare improvement (IHI) approach "science of Improvement" which is a unique approach on improving quality, safety, and value in health care.

NGH has been awarded funding to deliver the above across the STP as a pilot for Specialist trainees in both acute and general practice. The pilot will be evaluated utilising the EMLA framework during February 2018.



System Strategic Approach to Cancer

The Trust is committed to improving cancer patients’ outcomes both in terms of survival and experience of care. The Trust is part of the Midlands and East Cancer Alliance and a key stakeholder in the local Sustainability and Transformation Partnership (STP) of which Cancer is a core work stream. This includes prevention strategies, screening and early diagnosis, delivery of evidence based treatment, living with and beyond cancer, palliative and supportive care and end of life care.

The Trust has identified a number of quality priorities. These include working collaboratively with primary care to improve primary prevention and early detection of cancer to avoid occurrence of disease and thus ensuring more people are diagnosed earlier. We have identified a number of priority pathways that we are transforming for example lower GI and prostate cancer pathways, to deliver consistently high quality sustainable services focussed around the patients. We continue to work with local partners and voluntary groups to support people living with cancer. The focus is on developing cancer care reviews in primary care, sharing treatment summaries and developing cancer recovery packages.

The Trust completed self-declarations for each Cancer Multi-Disciplinary Team (MDT) in line with the national Cancer Quality Surveillance Programme (QSP). This programme covers all aspects of quality including patient safety, patient experience, clinical effectiveness and outcomes. Ten out of the thirteen tumour sites reported 100% compliance against the QSP measures. The remaining three tumour sites have developed detailed action plans to meet the standards required.

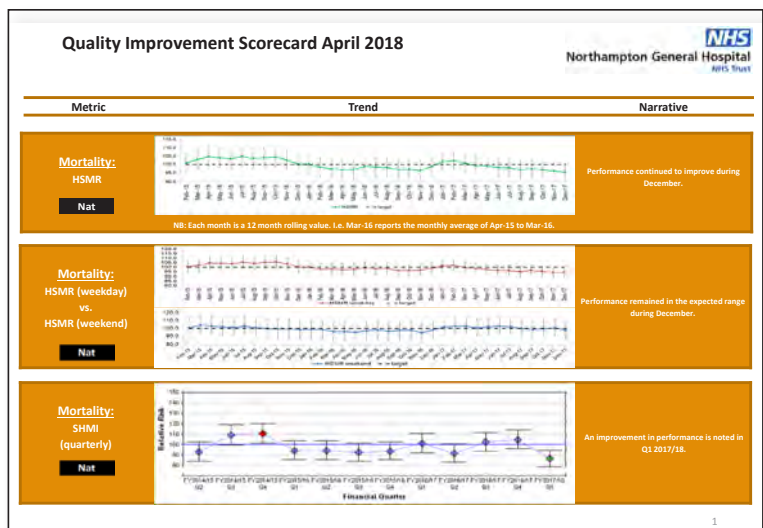
All tumour sites undertook their annual general meeting which highlighted the achievements in improving the patient experience despite a busy and challenging year. This was reflected in the results of the 2016 national cancer patient experience survey where patients rated their overall care as excellent/very good in line with the national average. National initiatives to improve particular pathways have been discussed and are in the process of being developed as part of their annual work programme, these include Lung, Prostate and Lower GI.

The Trust have been on an improvement journey for its cancer services in the past 12 months, this is being reflected in our ongoing performance, but more importantly influencing the care and experience of our patients.

Quality Improvement reporting

The Quality Improvement (QI) metrics encompassed within the quality improvement scorecard support and underpin the Quality Improvement Strategy to deliver harm free, cost efficient and effective care. The improvement work identified was developed building on the successful work from the Patient Safety Strategy and review and acknowledgment of recommendations from the Francis report and the Berwick review.

The QI scorecard should be read as an adjunct to the corporate scorecard focussing on the key principles of



science improvement and the application of control charts in supporting improvement initiatives.

We have aligned the key projects within the Sign up to Safety portfolio as Quality Priorities for 2016 – 2017, reinforcing the Trust's commitment to the Sign up to Safety Improvement Plan. Each quality priority is underpinned by a series of work streams that will enable us to both deliver and measure successful outcomes. This large cross-system based work supports our most important clinical priorities and will help us achieve our aim to reduce avoidable harm by 50% by March 2018 from March 2015 baseline.

The ambition of the 'Sign up to Safety' Campaign directly aligns with the Trust key Quality Goals, and our commitment to 'getting it right for every patient'. The Quality Priorities for 2017/18 identified within the quality improvement scorecard are year two of a three year phased programme were we deliver an accelerated and focussed 12 months project which can be revised and expanded on an annual basis.

Progress from our Improvement work is presented using Run and Control Charts to Understand Variation. Our view is "a picture is worth a thousand words". This is a fundamental concept for quality improvement. Rather than relying on data tables, it is best to make a picture of the data and let the picture do the talking. Plotting data over time offers insights and maximizes the learning from any data collected by revealing patterns and improvement opportunities

Developing strategic partnerships with the University of Leicester Medical School (College of Life Sciences)

NGH has been building on and strengthening the existing relationship between NGH and the University of Leicester College of Life Sciences (Medical School). The main objective is to complement and further develop teaching and health sciences research in a way which supports the needs of clinical medicine at NGH. This is building on the existing teaching programme at NGH.

We plan to;

- Provide academic leadership in teaching and clinical and translational sciences at NGH by facilitating the co-ordination of academic activities
- Facilitate the increase in medical student numbers within the school of medicine by NGH offering additional undergraduate teaching opportunities including significant more ward based apprenticeship opportunities.
- Improve retention and new recruitment of medical, allied health professionals and scientific staff
- Build on the current strengths of both institutions to establish a world-class centre of excellence.

Progress to date

- Established NGH/University of Leicester Medical School strategic partnership board
- Agreed on the academic support structure required to underpin the development of NGH as a University Hospital
- Review our options for accommodation to meet the increasing students' requirements including teaching rooms, student accommodation and appropriate accommodation and resources for academic and associated admin staff
- Agreed two joint Associate Professor posts to be advertised

Leadership & Safety for Doctors in Training, Nursing Staff and Allied Health Professionals

- **QISB** - The Quality Improvement Safety Board (QISB) – previously known as the Junior Doctor Safety Board (JDSB) – is formed following each new intake of junior doctors in August of each year. This year the QISB has been opened up to all staff, irrespective of grade or designation.
- **Aspiring to Excellence Programme** – NGH have been offering this bespoke course to 5th year medical students for 7 years. The course teaches the students the fundamentals of safety science and focuses on one main theme each year for project focus. The students receive a series of lectures and interactive sessions on a number of aspects of the project theme and QI methodology as well as including patient experience.
- **Registrar Leadership & Management Tier 2 Programme** – In 2017, this programme was offered to all registrars within the East Midlands in partnership with HEE. The programme is a ten week modular course modular. The Registrars are encouraged to challenge and question the safety principles and processes in place and lead on a project that demonstrates their understanding of how to implement a quality improvement initiative interacting with the appropriate personnel to deliver a sustainable change.
- **Nursing Development Programme** – The QI team deliver bespoke training to Band 5, Band 6 and Band 7 nurses on this programme. The sessions range from an hour long introduction to QI and the Model for Improvement to a morning session which also includes project process and data analysis.
- **Francis Crick Development Programme** – A day session into quality improvement and project process to equip NGH senior managers with the knowledge and resources to deliver and sponsor a quality improvement project in their work area.
- **Consultant Development Programme** – A four hour session delivered to newly qualified or appointment consultants on the essentials for delivering and supporting quality improvement in their specialties.

Our aim is to encourage staff of all disciplines to join the various programmes on offer and be supported to undertake a quality improvement project, through to conference submission and possible publication. All participants are supplied with teaching of QI principles and methodology and guidance in submitting their work to conferences and publications.

Quality Improvement Project Update:

QISB – There are 53 members within the multi-disciplinary 2017/2018 cohort. The group includes; Admin staff, Managers, Nurses, AHP's and Doctors, and the programme included 3 sessions on QI methodology and the basics of how to undertake a successful QIP.

The following projects are currently being supported:

<p>SMART Aim: To improve the 'effectiveness' of the Lung MDT by 20% by April 2018 from the September 2017 baseline</p> <p>Division: W/C/OH</p> <p>Project Lead: Admin led</p> <p>Outcome Measure: 'Effectiveness' of the MDT – Staff Survey & availability of data (performance status & spirometry)</p>	<p>Project update: Lung MDT is seen to be too long with too many patients being discussed unnecessarily or without appropriate clinical information to support decision making. Various PDSA cycles have taken place which include changing the location of the MDT, changing the format of the agenda to include further information, and the production of an MDT referral form. This is an on-going project, however we have already seen an improvement in the information available on the MDT agenda. Further changes are planned before April and surveys will be repeated to evaluate the 'effectiveness' of the MDT. This project will be presented at the International Forum on Quality & Safety in Healthcare later this year.</p>
<p>SMART Aim: To reduce the number of contaminated blood cultures taken across the hospital to below 3% by August 2018</p> <p>Division: CSS</p> <p>Project Lead: Junior Doctor led</p> <p>Outcome Measure: % contaminated (false positive) blood cultures</p>	<p>Project update: The rate of blood culture contamination at NGH is currently above the NICE guidelines. This project is aiming to reduce this rate which will impact on patient care as well as having a financial impact. PDSA cycles have already taken place including educating staff. Ward or department leads to deliver regular refreshers are also planned. From the data collected following the changes the contamination rate in the Trust appears to be reducing already, with work on going to ensure this improvement continues.</p>
<p>SMART Aim: To improve compliance to prophylactic topical decolonisation administration on three general surgical wards by 50% from the August 2016 baseline, by March 2018</p> <p>Division: CSS</p> <p>Project Lead: Nurse led</p> <p>Outcome Measure: Compliance to prophylactic topical decolonisation administration</p>	<p>Project update: To protect surgical patients from infection, the MRSA Policy requires all patients on surgical ward to be prescribed and administered prophylactic topical decolonisation treatment. Audits showed compliance was poor prior to this project. Several PDSA cycles have taken place during 2017 which included training by the IPC team, prompt stickers being put in notes and a reduction in the types of treatment prescribed. The most significant change has been gaining approval for nursing team to administer the prophylaxis without prescription. Overall a significant improvement in compliance has been seen this year and we expect to exceed the SMART aim by April</p>

<p>SMART Aim: To increase the number of patients receiving rapid rituximab infusions in the day case unit for rheumatological conditions by 20% by July 2018.</p> <p>Division: Medicine</p> <p>Project Lead: Doctor Led</p> <p>Outcome Measure: Number of patients receiving rituximab infusions.</p>	<p>Project update: The aim of this project is to introduce a rapid infusion protocol for rituximab. This will reduce the time taken for the infusion and therefore the patients time in the day case unit. Protocols from other hospitals have been reviewed and following discussions with colleagues from Pharmacy and Rheumatology a guideline has been produced. A checklist was also produced and Nurse training on the new procedure has taken place. This project is ongoing with the protocol in the process of being introduced.</p>
<p>SMART Aim: By September 2018, to reduce the number of rejected referrals for pelvic & abdominal ultrasound examinations in NGH by 50%</p> <p>Division: CSS</p> <p>Project Lead: AHP Led</p> <p>Outcome Measure: Number of rejected referrals for pelvic and abdominal ultrasound</p>	<p>Project update: A guideline was developed in collaboration with KGH and the CCG, using current literature and departmental protocols. This guideline was shared with primary care colleagues for reference when they request ultrasounds, and they were informed that requested would only be accepted at NGH in accordance with the guideline. The guideline has been revised and updated several times following feedback from colleagues. The next step is to introduce prompts on the ICE referral system to alert users to the guidelines and to offer educational assistance to referrers. This ongoing project will reduce low yield examinations which do not benefit patients and take up significant time and resources that can be put to better use.</p>

Registrar Management Development Programme 2017:

This year's 10 week modular programme encompasses the following sessions:

- Course introduction and QI Methodology & the Project Process
- QI Measures & Data Collection and Project Proposals & Examples
- Finance Masterclass
- Management & Leadership from a Consultant Perspective
- What's happening in the NHS – How do we respond?
- Simulation Suite – What it feels like to be a Consultant!
- Your Presentation Sucks! Improving your presenting skills
- Working together, Primary & Secondary Care
- Simulation Suite – Team Communication, Documentation & Clinical Notes
- Project Presentations

NGH and the East Midlands Patient Safety Collaborative

The Patient Safety Collaboratives (PSC) were launched by NHS England at a national event in October 2014. East Midlands Academic Health Sciences Network (EMAHSN) held a stakeholder event to share priorities in March 2015.

The PSC commitment is to build Capability in Quality Improvement, grow Leaders for Safety and improve the Safety Culture of organisations. NGH have welcomed the new PSC operating model to support the development of system level patient safety aims in each STP footprint and are leading on this work on behalf of the county.

NGH introduced and lead a countywide improvement plan working with other care providers across teams to identify aims, measures and adoption of QI methodology in order to make the quality interventions as successful as possible focussing on the 'deteriorating patient'. The overarching aims of the collaborative were reiterated to reduce avoidable harm through the delivery in improvement in three key areas:

- Reduce avoidable harm from failures or omissions in care
- Prevent incidents in healthcare by sharing and learning
- Working collaboratively to improve patient safety

The above would be approached using QI methodology at a system level and this would be further formalised with the circulation and approval of the memorandum of understanding for sign off by CEO's.

The above work stream has been transferred to the CCG to build upon and sustain and has been dovetailed into the Countywide Patient Safety Forum.

The PSC are funding two 2 bursaries for candidates to access the Quality Improvement and Patient Safety MSc at NGH. The course is aimed at healthcare professionals and managers who wish to develop a greater understanding and expertise in patient safety and quality improvement with a strong emphasis on practical application.

Capturing QI at NGH

A central repository has been developed to capture QI work that is supported by the QI team. This repository provides a library of projects & ideas that may benefit from further project work/development but should reduce areas of duplication & replication.

This has been an important development for the organisation as it will highlight work that is demonstrating sustainability and can be transferred to teams and become business as usual.

All new projects are required to have a project proposal template completed which highlights the identified problem and maps with strategic fit. The project will then be supported by members of the QI team, through to completion, and to conference submission.

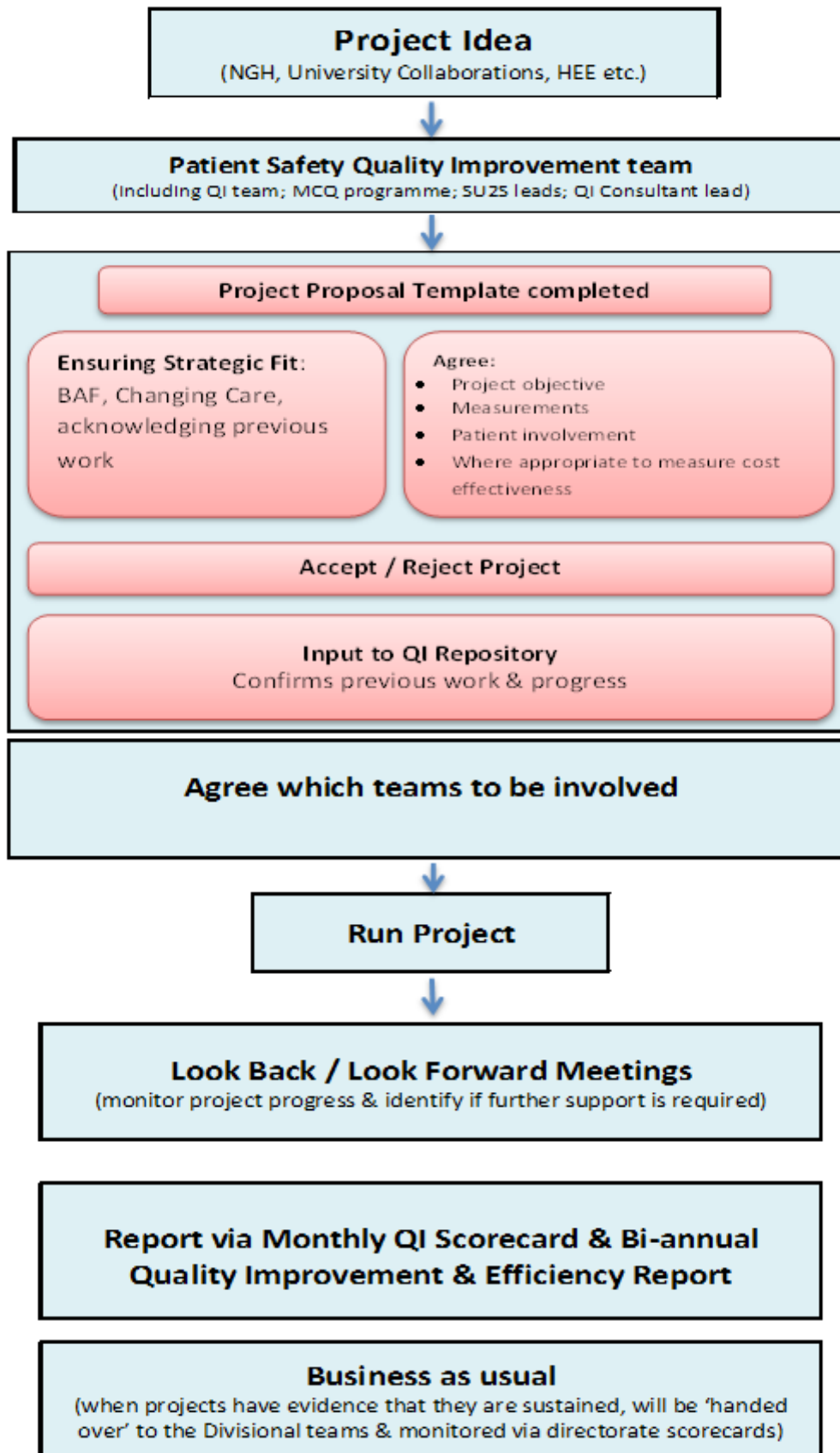
We will:

- Measure how many QIP's running each year
- Measure how many QIP's submitted to conferences

What changes can we make aimed at improvement?

- All projects entered into the central repository will have support from the QI team
- A project proposal template (PPT) will be completed by each individual or team that wishes to undertake a QIP
- All QIP work will be entered into the repository to tell the story and timeline of the project.
- All QIP's will be supported and encouraged to be at the standard for appropriate conference submissions and entered into the Awards Repository and celebrated through appropriate comms.





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Quality Improvement Project Update:

Both the central and awards repositories have been developed this year.

There are currently 55 projects being supported by the QI team and a further 8 where the Change Package has been implemented, some of which have demonstrated sustainability.

Change Package implemented / demonstrated sustainability

- AKI - Improving Nursing Staff Knowledge of AKI
- Atrial fibrillation in ED
- CRISIS quality of referrals
- Gynae Bags - Improving the service provision through the introduction of Gynae emergency bags.
- Jaundice Clinic
- Omnicell Medication - efficiency of medication on Holcot ward
- Paediatric Clerking Pro forma - improve documentation on admission
- Ten Minute Conversation

Ongoing Projects

- AKI - improving the monitoring of patients with AKI on Creaton Ward (Fluids, Urinalysis)
- AKI Patient Leaflet
- Anaemia - Reducing the admissions for pts presenting with symptomatic chronic-onset anaemia requiring blood transfusions (Ferinject)
- Analgesia in ED
- Antibiotic Prescription Duration
- Bleepsheet
- Blood Culture Contamination
- Blood Results from EMAS patients
- Bowel Irrigation Continuation
- Buddy Ward system
- Concussion screening
- Daily plan
- Dermatology consent
- FIT team (falls, IPC and TVN)
- Food Waste on Allebone ward
- Gynae - Taking Responsibility
- Hand Therapy DNAs
- Incontinence Pads
- IV Fluids
- Level 1 Pathway (MAU)
- Lung MDT
- Magic Nurse
- Mandatory Training Junior Doctors
- Manual Vacuum Aspiration
- Medical Education for Core Medical Trainees
- MMTs on validation
- MUST Score compliance in Collingtree ward
- Nurse Authorisation of Blood Products in Haematology

- Diabetes - care of young people with Type 1 Diabetes undergoing transition
- Disease modifying therapy
- Doctors Initiative - Trust grade doctors
- Dr Toolbox 17-18
- Drug Library ITU
- Easy eDischarge
- Endoscopy turnaround times
- Pleural procedures - Improving post-procedure care for patients undergoing Pleural puncture
- PoC - EAU/Benham
- PPH rates
- Right iliac fossa pain
- Rituximab Infusions
- Sick Day Guidance (GP AKI)
- Stethoscope hygiene
- O2 Therapy
- Paed/Infant BLS Leaflet
- Pascal - AE EDCOA
- Pascal - AE Rapid Assessment paed
- Pascal - AE Work Culture
- Patient safety app
- Stock management (GP practice)
- Stroke Patient Updates
- The Treatment Room
- Time Critical Medicines
- Topical prophylaxis compliance in surgery
- Ultrasound referrals
- Verbal handover (17/18)

Projects submitted for awards

In Q1 NGH presented 7 projects to the International Forum on Quality & Safety in Healthcare 2017, the largest of any UK hospital.

In Q2 the QI team presented 12 projects at the Patient Safety Congress – 2 of these projects won the best in category prize for 'Best Practice to Reduce Risk of Harm' and 'Effective Teamwork'. One of these projects also won the Best Poster prize at this Competition.

NGH are the most successful organisation in the UK for this conference. The second most successful organisation presented 3 projects.

Within Q3 there have been 32 projects submitted to the International Forum on Quality & Safety in Healthcare; 21 from the Quality Improvement Safety Board, 5 from the Registrar Leadership and Management programme, 3 from Allied Health professionals, 2 from the Aspiring to Excellence and 1 from Nursing staff.

In Q3 NGH won the award for best project in the service development category at the Early Pregnancy Conference.

QI strategy and Quality Improvement Scorecard

The quality improvement strategy seeks to build upon the successive improvements in quality which we have made at NGH. It has been developed with input from staff through focus groups and the lessons learnt from complaints, serious incidents and asking staff what quality means for them. We have incorporated the recommendations of the Francis Report, Berwick Review and the principles from the Sign up To Safety Campaign that aims to make the NHS the safest health care system in the world.

Quality can mean different things to different people. By 'delivering high quality care', we want to provide efficient services to our patients that are safe, effective, compassionate and innovative as well as offering value for money. Our patients and staff have told us what we need to improve in order to deliver the best possible care which we have developed into campaign pledges and our quality improvement plans. Quality and safety are important to every-

one at NGH. This strategy aims to give our staff a clear focus and reflects the importance and commitment the Trust Board places on the quality of care, and the requirement to continually improve to meet the evolving demand and expectation of our patients and staff.

Northampton General Hospital (NGH) has signed up to a national campaign that aims to make the NHS the safest healthcare system in the world. We are committed to achieving this through a collaborative effort from staff, who are in everyday contact with patients; and by getting it right for every patient, every time. We recognise that it is important to aim for excellence and that quality must be the cornerstone of our values. The NGH Quality Improvement Strategy 2015-18 describes how we will achieve the aspirations we have for our services. Within the strategy we have identified a programme for quality improvement (both derived locally and nationally mandated) to be delivered across the three year period.

Through this work, we will demonstrate a year on year improvement in our services against baseline measures in the benchmarks that have been identified. We have used the 'Sign Up To Safety' campaign measures as the framework for the Quality Improvement Strategy. This emphasises the importance of listening to our patients, carers and staff, learning from our successes as well as when things go wrong. We have focused on areas where there is a clear need for improvement and will continue to build on the work that has already begun.

We have joined 'Sign Up To Safety' because the campaign mirrors what we are seeking to achieve with our in-house patient safety and Quality Improvement programmes: the delivery of harm-free care for every patient; and the championing of a culture of openness and honesty meeting the expectations and demands from our patients within current real term funding, while at the same time improving quality.

The Quality Improvement Strategy highlights the importance of developing capability by providing training on quality improvement on an on-going basis, commensurate with the role of the individual. Wherever possible, our focus will be on the integration of health services across traditional health service boundaries to improve performance, access, value for money and the experience of care for our local population.



The Trust has supported a wide range of projects underpinned by the Organisational Effectiveness Strategy "Connecting for Quality" and our Safety Strategy. A number of improvements have been achieved including, improved hospital mortality, surviving sepsis, infection control education and practice, and early identification and escalation of the deteriorating patient, which have been strengthened by service improvement and redesign, development of staff and organisational capability. This work now needs to be extended to ensure greater involvement from all staff and a greater focus on sustainability.

There is a need to support more training in improvement methodology, more development of teams and more focus on the key role of leadership development.

Quality Improvement in Practice.

The improvement work in patient safety and quality is led through the MD and DNS.

Mortality Review Group

- Current Position:
 - The Mortality Review Group oversees all aspects of the monitoring, screening and review of deaths.
 - Mortality Screeners were introduced (Dec 17) to provide a screening service for all adult deaths and select those where review would be most beneficial.
 - The Structured Judgement Review Tool has been gradually rolled out across the Trust to move towards a standardised method for mortality case note review. Training to use the tool has been cascaded for Trustwide reviews and to some directorates and specialties.
 - The NGH Mortality Dashboard was published for the first time in Q3 2017/18.
- Mitigation/ actions:
 - Recruitment of more Mortality Screeners.
 - Quality Assurance of screening and review process.
 - Further training sessions in use of Structured Judgement Review Tool.
 - Strengthen communication with Review of Harm Group to ensure ease of referral and feedback for cases requiring investigation.
- Most proud of:
 - The newly formed screening team has worked well together to develop and improve a new process at a busy time of year. The screening process is under continual review and improvement and the team are flexible and open to changes and new challenges.

Undertaking and standardising Comprehensive Geriatric assessment (CGA) on Medical assessment units

- Best Practice Initiative:
 - To undertake and standardise CGA process on Benham/EAU
 - As a multidisciplinary team to collaboratively design a CGA that effectively covers each individual component of a CGA when frail elderly patients are referred for assessment.
 - Produce a document to be utilised by staff and share with community partners (including a medication review to highlight issues of safety and concordance) along with making recommendations to plan safe care and discharge.
- Current Position:
 - MDT agreement on format following initial trail
 - Awaiting print of 200
 - Relevant departments to be updated when available for use
 - Aim to share CGA data with Collaborative Care Team colleagues, initially by scan & email
 - Long term aim to input data electronically and have links to share information with community promptly and enable our community colleagues to update. Improving efficiency by sharing data on vulnerable patient group

- Mitigation / actions:
 - Delay in printing re funding
 - Issues re data sharing and systems access
- Most proud of:
 - MDT teamwork delivered CGA and improvised the process including producing new document to standardise the care
 - The potential opportunity to share comprehensive information with community colleagues, improving efficiency, quality of care and safety.

AKI - Improving Nursing Staff Knowledge of AKI

- Current Position:
 - Improved basic AKI knowledge of our nursing staff from an initial baseline of 42% to 92 % in April 2017.
 - AKI awareness session delivered monthly within the Clinical Skills Week for new Staff Nurses joining the NGH Team.
- Mitigation / actions:
 - Offer different modes of trainings to “reach” as much nursing staff as possible
 - Visual information and alerts included on Vital Pac to flag up those patients with AKI and their stage.
- Most proud of:
 - NGH AKI Q.I project displayed at International Quality and Safety Forums
 - More than 300 staff nurses have attended the AKI awareness session over the last 2 years
 - Developed the AKI care bundle and AKI guideline to offer support and guidance on AKI assessment and management.
 - AKI training is now being requested from wards and departments, to be included in their “away days”
 - Collaborating with Northampton University to deliver AKI awareness session to 3rd year students.
 - Now delivering AKI training sessions to Junior Doctors.

Pleural Procedures Room

- Current Position:
 - Prior to October patients, with unilateral pleural effusions, had procedures done all over the hospital unsupervised and unchecked. Multiple patient safety issues occurred and a number of complaints were submitted. I have introduced with the support of the registrars a pleural procedures room where we are able to safely insert under ultrasound guidance aspirate needles and drains.
- Mitigation / actions:
 - Best practise guidelines
 - Patient leaflets / consent forms
 - Procedure checklist
 - Post procedure nursing care checklist.
 - Audit trail. All patients with a unilateral pleural effusion are discussed with a member of the respiratory team (Registrar or Consultant) who then supports or undertakes a pleural investigation (aspirate or drain) in the pleural procedures room

under pleural ultrasound. This is to improve patient safety, reduce infection and maintain an audit trail. This is a new innovation.

- Most proud of:
 - Package of care improving patient safety

Planning/Job Planning M&UC

- Current Position:
 - 60% job plans achieved 2nd stage sign off at end of Q4, 2017/18 cycle year
 - Target for 95% of job plans to have achieved 3rd stage sign off at end Q1 2018/19 cycle year
- Mitigation / actions:
 - Service planning for all areas undertaken by end Q4 2017/18 cycle year for 2018/19 cycle year
 - Job planning policy in place following consultation and agreement
 - Work and support Directorate leads to ensure effective team approach to job planning undertaken
 - Job plans mutually agreed, updated on system and signed off by end Q1
 - Any appeal dealt with promptly in line with job planning policy
- Most proud of:
 - Collaboration of Clinical Directors/Clinical Leads and Directorate Managers to provide information, design and own service plans
 - Professional accountability of individuals and services to ensure patient safety
 - Job plans mutually agreed, aligned to service needs and reflective of Trust requirements

Dare to Share Learning Events

- Best Practice Initiative:
 - The governance team to hold regular events sharing the learning from serious incidents
- Current Position:
 - Learning from serious incidents presented by staff involved in the incident sharing their own experiences
 - Multidisciplinary attendance
 - Staff feedback is collated
 - Attendees are encouraged to document the learning that they will take away and share with their colleagues
- Most proud of:
 - Shortlisted in the Clinical Governance & Risk Management in Patient Safety category of the Patient Safety Awards
 - Supporting the journey to deliver the best possible care
 - Open dialogue with all attendees

Priorities for Improvement in 2018/19

The Quality Improvement Strategy has been updated and formalised to encompass the quality improvement plans from the Sign up for Safety campaign and the demand for quality improvement education and training whilst acknowledging Changing Care@NGH supported by the QI team as another quality and efficiency vehicle.

The 2018/19 QI priorities have been revised and refined to reflect five key work streams:

- Patient Safety
- Patient Care
- Venous thromboembolism (VTE) and Hospital-acquired venous thromboembolism (HAT)
- Performance
- Professional Standards

The focus to strengthen and further develop organisational capability by providing training on quality improvement to individuals, teams and leaders who will deliver the strategy supports our corporate work ethic that we all have two jobs at NGH, “to deliver care and improve care”.

The strengthened network to lead and facilitate collaborative working locally and regionally makes this Quality improvement strategy significantly different from those before.

To further support and strengthen the delivery of the Quality improvement Strategy the Trust will align teams currently working to improve safety, quality and efficiency to create a multidisciplinary and multitalented Quality Improvement (QI) Team.

Each of the projects and/or work streams identified to achieve our strategic aims and corporate goals will be led by an operational member of staff selected for their specialist knowledge and practical experience of the subject matter and supported by a member of the QI team.

The formalisation of a strengthened QI team provides a focussed resource to support projects directly and to train staff to understand the wider leadership, management and behaviour issues that can assist with or hinder change.

A series of workshops and improvement forums will ensure the work can be shared and key projects are presented to ensure that all our staff can be encouraged and empowered to continue to positively effect change.

The quality improvement metrics encompassed within the Quality Improvement Scorecard support and underpin the Quality Improvement Strategy to deliver harm free, cost effective and efficient care. The improvement work identified was developed building on the successful work from the Patient Safety Strategy and review and acknowledgement of the recommendations from the Francis Report and the Berwick review. The QI Scorecard should be read as an adjunct to the corporate scorecard focusing on the key principles of improvement and the application of control charts in supporting improvement initiatives.

Progress from our improvement work is presented and produced in run and control charts to understand variation. Rather than relying on data tables its best to make a picture of the data and let the picture do the talking. Plotting data over time offers incites and maximises the learning from any data collected, by revealing patterns and improvement opportunities.

The Improvement projects and outcomes from the work streams within the Junior Doctors Education Programme will be incorporated into Divisional Quality Improvement Scorecards to improve transparency for clinical teams, to support the Junior Doctor workforce and further align their work with Directorate and Divisional Quality Improvement plans.

Research and development

Northampton General Hospital is a research activity hospital. We believe being a research active hospital supports the vision of providing the “Best possible care”
Where are we now

The number of patients that were recruited during the 17/18 financial year who participated in research approved by a research ethics committee was 1038 patients into 52 trials registered on the National Institute of Health Research portfolio. We had a large number of other patients participating in research which is classed a student research – this supports some of the graduate staff within the Trust taking higher degrees for their personal development which also provide the Trust with evidence to support our clinical questions.

Some of our notable success this year, include recruiting the first global patient to a medical device study for children with type 1 diabetes. Northampton saw the first patient in Europe with a specific cancer to receive a new investigational medical product. We have looked at blood pressure in the over 65 in intensive care and we have welcomed on board our gastroenterology team who are looking at inflammatory bowel disease. We are proud to say we have research ongoing in all the clinical directorates.

Participation in clinical research demonstrates the Trust’s commitment to improving the quality of care we offer and to making our contribution to wider health improvement. We have demonstrated our engagement with the National Institute for Health Research (NIHR) by participating in a wide range of clinical trials. This is consistent with our commitment to transparency and desire to improve patient outcomes and experience across the NHS. Our engagement with clinical research also demonstrates NGH’s commitment to testing and offering the latest medical treatments and techniques to our patients.

What is our future

Within the Trust there is a strong desire to develop our research capacity and capability, this is because Research active Trusts have a lower risk adjusted mortality for acute admission (1) . Furthermore a recent systematic review suggested that engagement with research by individuals and healthcare organisation increased the likelihood of a positive impact on health care performance.(2). The literature tell us that patients in research active organisation have better health outcomes because research participation leads to accumulate knowledge , develops infrastructure and brings in resources and skill that can be used to improve clinical care

So to support this, the Trust are investing in R&D and have set clear target for year on year growth

1. Research Activity and the Association with Mortality <https://www.ncbi.nlm.nih.gov/pubmed/25719608>
2. Hanney S, Boaz A, Jones T, Soper B. Engagement in research: an innovative three-stage review of the benefits for health-care performance. Health Serv and Deliv Res. 2013;1(8).

Statements of assurance from the Board

Review of services

During 2017/18 NGH provided and/or sub-contracted 72 NHS services.

The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of NHS services by NGH for the reporting period 2017/18.

<p>The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.</p> <p>27.1</p>	<p>During April 2017 – March 2018 1636 of Northampton General Hospital patients died.</p> <p>This comprised the following number of deaths which occurred in each quarter of that reporting period: 363 in the first quarter; 334 in the second quarter; 430 in the third quarter; 509 in the fourth quarter</p>
<p>The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.</p> <p>27.2</p>	<p>By 8th May 2018, 172 case record reviews and 4 investigations have been carried out in relation to 172 of the deaths included in item 27.1. In 4 cases a death was subjected to both a case record review and an investigation.</p> <p>The number of deaths in each quarter for which a case record review or an investigation was carried out was: 58 in the first quarter; 26 in the second quarter; 54 in the third quarter; 34 in the fourth quarter</p>
<p>An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.</p> <p>27.3</p>	<p>4 representing 2.3% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.</p> <p>In relation to each quarter, this consisted of: 0 representing 0% for the first quarter; 2 representing 7.7% for the second quarter; 1 representing 1.8% for the third quarter; 1 representing 2.9% for the fourth quarter.</p>

	<p>These numbers have been estimated using the Avoidability of Death Judgement Score</p> <p>Score 1 Definitely avoidable Score 2 Strong evidence of avoidability Score 3 Probably avoidable (more than 50:50) Score 4 Possibly avoidable but not very likely (less than 50:50) Score 5 Slight evidence of avoidability Score 6 Definitely not avoidable</p> <p>These cases are discussed at a Trustwide Mortality Review Group bimonthly and a consensus decision reached. If Avoidability of Death Score is Grade 1,2 or 3, the death is judged more likely than not to have been due to problems in the care provided to the patient. These cases are referred to RoHG.</p>
<p>A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3. 27.4</p>	<p>See Appendix 1</p>
<p>A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4). 27.5</p>	
<p>An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period. 27.6</p>	
<p>The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.</p> <p>27.7</p>	<p>117 case record reviews and 0 investigations completed after 01.04.17 which related to deaths which took place before the start of the reporting period.</p>

<p>An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.</p> <p>27.8</p>	<p>0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the same method detailed in section 27.3.</p>
<p>A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8</p> <p>27.9</p>	<p>No change as 0 new deaths identified in 27.8.</p>

Appendix 1

Learning, Actions and Impact of Mortality Case Note Review in 2017/18

Care of Elderly Annual M&M summary

- Identified the need for enhanced use of advanced care planning, earlier consideration of DNAR and TEP and the importance of early communication with the patient and their next of kin. The M&M have planned teaching sessions for Advanced Care Planning and an audit of DNAR forms to look for communication with next of kin. Use of the Amber Care Pathway has been increased.

Rest of Soft Tissue (diagnostic/ minor)

- Chest drains should be inserted by the right person in the right place. Following the review the lead Consultant submitted a proposal for the use of the Clinic Room on the Respiratory Ward for this purpose and a new guideline has been written and is now in place.

Skin and Subcutaneous tissue infection

- Poor monitoring and documentation of fluid balance and urine output was identified. This had already been recognised by the nursing team and this report fed into that work stream.

Secondary Malignancy

- The future aim is to reduce the number of cases where the dying process is either not recognised or recognised too late. This is being addressed through teaching rounds from the Palliative Care team and a case presentation which demonstrated the improvements needed was presented to a Grand Round with a Trust wide audience.

Learning Disability M&M

- Mental Capacity Assessment is not routinely completed before a Do Not Resuscitate order is completed. This work stream was already being addressed Trustwide by the safeguarding team. In addition an easy read document has been developed which explains issues around end of life care, treatment escalation plans and do not resuscitate orders.

Emergency Department Annual M&M summary

- Recognition of a specific acute surgical emergency was identified as an issue and in response the team have developed a flow chart for the recognition of this condition in the Emergency Department.

Acute and Unspecified Renal Failure

- A multidisciplinary group is working on several themes, including identification and handover of patients with Acute Kidney Injury (AKI) between clinical teams, flagging of nephrotoxic drugs, improved monitoring of fluid balance. A ward based trial is taking place of a new electronic fluid balance tool
- There has been a trust wide presentation of the investigation at a Grand Round, followed by educational lectures by the AKI nurse specialist and Consultant Nephrologist

Sepsis

- Clinical guidelines have been re-written , linking in with Sepsis National CQUIN
- Understanding of the implications of the changes in national coding rules, working closing with the Clinical Coding team

Process Improvements

- Introduction and refinement of the screening process continues
- Emphasis is placed on feeding back examples of excellent care to clinical teams – this is well received
- A good quality first SJR is very important in identifying problems in healthcare and work continues to improve clinical training in this
- A Trustwide Mortality Case Note Review Body had been established for 2nd Stage Reviews
- Specialty M&M groups are invited to the Mortality Review Group to provide an annual update - Oncology M&M has been refreshed , the urgent care M&M has increased consultant leadership.
- There have been improvements in the escalation process to the Review of Harm Group (RoHG) of those reviews which conclude that death was more likely than not to be due to a problem in healthcare. These are now formally dated and sent to RoHG with a completed initial assessment form.

Implementation for Seven Day Services

Northampton General Hospital is committed to ensuring that patients admitted as an emergency receive high quality consistent care whatever day they enter the hospital.

The four national priority standards we are working to are:

- All patients should be reviewed by a consultant within 14 hours of admission to hospital (standard 2)

- All in patients will have 7 day access to diagnostic tests within 1 hour for critical patients, 12 hours for urgent patients, and 24 hours for non urgent patients (**standard 5**)
- All in patients should have 24 hour access to consultant led diagnostic interventions (**standard 6**)
- All in patients should receive ongoing daily reviews (**standard 8**).

Northampton General Hospital has participated in the regular NHS England 7 Day services national audit to measure progress against the clinical standards since it started in 2016. The following table shows our progress and a comparison with the national picture:

standard	NGH 2016			NGH 2017			National 2017		
	weekday	weekend	7 days	weekday	weekend	7days	weekday	weekend	7days
2	70%	73%	71%	79%	67%	75%	73%	70%	72%
5	83%	59%	76%	95%	82%	89%	100%	92%	96%
6	82%	67%	77%	89%	89%	89%	95%	92%	94%
8	88%	80%	87%	99%	65%	90%	91%	70%	85%

Over 2017 there was an improvement in 7 day provision across all 4 priority standards. Major achievements during 2017 were introducing a network arrangement for provision of interventional radiology services, increasing in patient access to routine ultrasound and MRI lists at weekends, and installation of a CT scanner dedicated to in patient investigations. Progress has also been made in introducing daily consultant ward rounds – this project will be completed in 2018. Plans to increase the number of consultants admitting emergency patients have also been agreed and will be rolled out in 2018.

Plans to increase the number of consultants admitting emergency patients have also been agreed and will be rolled out in 2018.

Implementing Duty of Candour

The introduction of the CQC Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust 1, which recommended that a statutory duty of candour be introduced for health and care providers.

To meet the requirements of Regulation 20, the Trust has to:

- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of our knowledge, is true of all the facts we know about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.
- Offer an apology.

- Follow up the apology by giving the same information in writing, and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person.

The Trust continues to ensure that there is a clear process in place for Duty of Candour not only for the staff but also for the patients. A staff information leaflet was already in use within the Trust, however the Clinical Governance Team identified that there was a gap within the information available to patients and/or their relevant person. As a result the Clinical Governance Team has produced a Duty of Candour patient information leaflet which has currently been shared with the representatives of other Trusts within the region at the Countywide Patient Safety Forum. The aim is to agree a Countywide leaflet to ensure that patients are receiving a consistent and clear approach to this process.

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

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

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

The Trust continues to demonstrate compliance with Duty of Candour to the Clinical Commissioning Group (CCG).

Participation in National Clinical Audits and National Confidential Enquiries

Northampton General Hospital is committed to undertaking effective clinical audit across all clinical services and this is a key element for developing and maintaining high quality patient-centred services. Northampton General Hospital participated in over 95% of eligible projects included in the 2017/18 Quality Account list published by the HealthCare Quality Improvement Partnership (HQIP), on behalf of NHS England.

The Quality Account list includes a diverse range of projects, including National Audits that collect data both continuously and over a specified period of time (snapshot audits). Some of the larger projects have developed to include several different work streams for example questions about the structure of the service provided (organisational questionnaires), questions about the process of individual patient care (case note reviews) and questions about the patient experience (patient questionnaires).

The 2017/18 Quality Account list of eligible national audits and confidential enquiries are summarised in below. Percentage participation is included for snapshot audits. National reports (including hospital specific and individual consultant specific results where appropriate) are published at varying intervals. There were over 40 applicable reports published relating to national clinical audit and NCEPOD between 1 April 2017 and 31 March 2018. The Department of clinical audit and effectiveness monitors the publication of these reports and distributes them to the appropriate clinical leads. The clinical leads are asked to review the report, discuss the findings with their colleagues, make recommendations (if required) for changes to current practice, and return an Action Plan to the department.

Many National Audits demonstrate we are continuing to deliver excellent clinical care when compared with national figures. Only occasionally do we receive “outlier status” notification, informing us that the Trust requires improvement in a particular area. We then have a robust internal process for reviewing our clinical practice, identifying gaps in service provision, and supporting directorates as required to incorporate positive changes to clinical care.

Described below are some examples of some of the changes and learning we have identified following the publication of National Clinical Audit reports during 2017/18.

- Clinical Effectiveness
 - Sentinel Stroke National Audit Programme: measures the Key Indicators of the quality of a Stroke Service and NGH continues to perform very well. Over the course of 2017/18 rapid access to CT scanning has been rated as “A” (the highest level possible).
 - Myocardial Ischaemia National Audit Project (MINAP): We are consistently performing well above national average: (i) Secondary prevention Target >90%, NGH – 100%. Compared with National results of 88.5 – 99%. (II) Door to Balloon: National target <90 minutes; NGH achieved 94% against national average of 91.5%. (III) Call to balloon: National target < 150 minutes; NGH achieved this 87.5% against national average of 80.5%.
- Patient Safety
 - National Maternity and Perinatal Audit: In 2017/18 we received “outlier status” notification for our rates of post-partum haemorrhage (PPH) in the. A detailed review, followed by implementation of changes to our current practice and commencement of a 12 month quality improvement project, was presented to the Clinical Quality and Effectiveness Group (CQEG) in response to our outlier status. We anticipate a significant improvement in our rates of PPH over the 2018/19 year.
- Patient Experience
 - The End of Life Team has used the 2015 Care of the Dying Audit to launch a teaching programme for staff to help support patients and their relatives/ carers. Changes to the patient care plan focus on documentation of the patient’s wishes. The team routinely gather feedback from relatives/ carers after the death to help them improve the service they provide. We will be re-auditing our End of Life Care in 2018/19.
- Service Improvement
 - National Heart Failure Audit: We have expanded the team since the previous audit with 2 full time Heart Failure consultants with weekly MDT to ensure patients not on cardiology wards or seen in a nurse led clinic have expert review. Key performance indicators in 2017 showed:
 - Mortality rates have fallen significantly
 - Application of diagnostic tests remain high
 - Prescribing rates for disease modifying drugs for those with heart failure with reduced ejection fraction have increased
 - The proportion of patients admitted to cardiology wards remain static but more patients on general wards have input from a heart failure specialist team which has increased to 80%
 - More patients have specialist nurse input.

- Communication
 - National Neonatal Audit Project data continues to show how well the team at NGH respond to the needs of parents by communicating with them as soon as possible after a baby is admitted to the neonatal unit.
 - For services that are shared between different healthcare providers, national audits can help providers come together to discuss the findings and improve care. For example the Cardiology Teams from NGH meet regularly with their colleagues from KGH to discuss Adult Cardiac Interventions Audit data (NICOR).
- Data quality and Documentation
 - National Lung Cancer Audit: We received “outlier status” notification in 2017/18. Upon review, this was felt by the clinical lead to be predominantly due to data quality and documentation issues, rather than quality of care received. Our status was presented to the Clinical Quality and Effectiveness Group. Northampton General hospital has been invited to participate in a 2017 “data refresh” by the national audit body, which may have a positive effect on the initial results.
- Resources and staff recruitment
 - Several National Audits in 2017/18 have had difficulties with full participation due to resources and / or staff recruitment. The department has been fully involved in supporting the clinical leads and to raise awareness at divisional level. Examples include:
 - National Diabetes Core Audit: Meetings to facilitate required IT support
 - COPD – secondary care: Business case prepared for extra full-time audit staff
 - National Heart Failure Audit: Staff allocated “protected” admin time to participate

National Audit Mortality and Consultant Level Data

In 2017/18 there were 8 audits which published mortality data for NGH. This data could be specific to a service or to an individual consultant and is intended to signpost whether the service or the individual is performing “better than expected”, “as expected” or “worse than expected”. If a particular service or consultant is noted to be an “outlier” (data suggests they might be performing worse than expected) then this is investigated further.

The following audits published service level mortality data in 2017/18. Performance in all was at the “as expected” level.

- National Emergency Laparotomy Audit (NELA)
- National Hip Fracture Database (Part of the Falls and Fragility Fractures audit)
- National Vascular Registry (NVR)
- National Joint Registry (NJR)
- British Association of Urological Surgeons (BAUS)
- Intensive Care National Audit and Research Centre (ICNARC)

- National Bowel Cancer Audit Project (NBOCAP)

Data from the UK Perinatal Mortality Report (MBRRACE) was reviewed in further detail as published standardised and adjusted mortality rates suggested that NGH rates has previously been '10% higher than the average' when compared to similar sized units. It was noted that the sample size or number of patients was very small. All of these patients and the care they received has been reviewed in detail by the neonatal team to ensure that all possible learning has been identified and changes to practice made where necessary.

The following audits published individual consultant level data in 2017/18. Performance in each case was "as expected".

- National Vascular Registry (NVR)
- National Joint Registry (NJR)
- British Association of Urological Surgeons (BAUS) – Nephrectomy
- National Bowel Cancer Audit Project (NBOCAP)

Medicine & Urgent Care Division		
Name of Audit	Participated Y/N	Percentage Participation
Major Trauma (TARN)	Y	Continuous data collection
Fractured Neck of Femur (RCEM)	Y	100%
Pain in Children (RCEM)	Y	100%
Procedural Sedation in Adults (RCEM)	Y	100%
COPD Pulmonary rehabilitation	Y	100%
COPD secondary care	Y	Continuous data collection Data entered for Q2 and Q3; currently being entered for Q4
National Lung Cancer Audit	Y	Continuous data collection
National Heart Failure Audit	Y	Continuous data collection Data entry issues due to staff resources in 2017/18 – now resolved
Acute Myocardial Infarction and other ACS (MINAP)	Y	Continuous data collection
Cardiac Rhythm Management	Y	Continuous data collection
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Y	Continuous data collection
IBD Registry	Y	Continuous data collection Data entry issues due to staff resources – now resolved
Stroke National Audit Programme (SSNAP)	Y	Continuous data collection
FFFAP Patient Falls	Y	100%
UK Parkinson's Audit	Y	100%
Diabetes Inpatient	Y	100%
Diabetes Foot care	Y	100%

Surgery Division		
Name of Audit	Participated Y/N	Percentage Participation
Adult Critical Care (Case Mix Programme)	Y	Continuous data collection
National Emergency Laparotomy Audit (NELA)	Y	Year 3 – 100% Year 4 – Data collection ongoing
Hip, knee and ankle replacements (National Joint Registry)	Y	Data collection ongoing
Elective Surgery (National PROMS Programme)	Y	Data collection ongoing
National Vascular Registry	Y	Data collection ongoing
Bowel Cancer (National Bowel Cancer Audit Programme)	Y	Data collection ongoing
Prostate Cancer Audit	Y	Data collection ongoing
Oesophago-gastric Cancer (National O-G Cancer Audit)	Y	Data collection ongoing
Falls and Fragility Fracture Programme - National Hip Fracture Database	Y	Data collection ongoing
National Ophthalmology	Y	Data collection ongoing
Endocrine and Thyroid National Audit	Y	Data collection ongoing
Nephrectomy Audit	Y	Data collection ongoing
Percutaneous Nephrolithotomy	Y	Data collection ongoing

Women's, Children's, Oncology, Haematology & Cancer Services Division		
Name of Audit	Participated Y/N	Percentage Participation
Female Stress Urinary Incontinence	Awaiting confirmation	
Perinatal Mortality (MBRRACE)	Y	Continuous data collection
National Maternity and Perinatal Audit	Y	Continuous data collection
National Pregnancy in Diabetes	Y	Continuous data collection
National Neonatal Audit Programme (NNAP)	Y	Continuous data collection
Paediatric Diabetes (NPDA)	Y	Continuous data collection
IBD Paediatric Audit of Biological Therapies (IBDR)	Y	Continuous data collection

Clinical Support Services and Trustwide		
Name of Audit	Participated Y/N	Percentage Participation
FRe-audit of red cell and platelet transfusion in haematology	Y	100%
National comparative audit of transfusion associated circulatory overload (TACO)	Y	100%
National Cardiac Arrest (ICNARC)	Y	Continuous Data collection
Fracture Liason Service Database	N	No FLS service at NGH – business case being prepared to address
Learning Disability Mortality review programme	Y	Continuous data collection
Seven day hospital services self-assessment survey	Y	100%

NCEPOD		
Name of Audit	Participated Y/N	Percentage Participation
National Confidential Enquiries (NCEPOD)	Y	Young People's Mental Health – 100%
		Non-invasive Ventilation – 100%
		Chronic Neurodisability – Data collection ongoing
		Cancer in Children, Teens and Young Adults – Data collection ongoing

Local Clinical Audit

Northampton General Hospital is committed to improving clinical quality, patient experience and patient safety across all clinical services by undertaking regular quality clinical audit. In 2017/18 there has been a particular focus on audit against NICE Quality Standards; this focus will continue into the upcoming 2018/19 financial year.

Over the 2017/18 financial year, 180 regional and local clinical audits were registered on our database, including 32 specifically against NICE guidance. We are committed to constantly reviewing the service we provide to facilitate and support the provision of high quality audit across the trust. Examples of this include:

- All registered audits must have a nominated clinical supervisor (e.g. Consultant) to supervise the audit;
- All completed audits must produce an audit report and action plan, outlining details of our compliance against recognised standards and recommendations / plans for improvement, before a certificate of completion is issued;
- Clinical audit advice is provided by the Department of clinical audit and effectiveness to support staff across the trust as required;
- Annual Audit Presentation Day, our trust-wide clinical audit competition to showcase individual high quality audits over the previous year across the Trust. Highlights from our 2017/18 presentation day are summarised in section 4.

Examples of local clinical audits:

- Emergency Department procedural sedation in adults (1st Prize, Audit Presentation Day)
 - Safe sedation is a key component of procedural sedation of any Emergency Department (ED). Improving sedation/analgesia increases the success rate of many procedures, enhances the patient's experience and care by reducing pain and procedure time, reduces hospital admissions, pressure on theatre and costs.
 - The purpose of the audit was to monitor ED documented procedural sedation practice in adults and quantify improvements made, and also to determine how the "Safe Sedation Proforma" in current use can be modified and service improvements instituted in order to reach RCEM standards contributing for patient safety.
 - Documentation of procedural sedation in ED did not meet the set standards of RCEM sedation audit. Although 5 of the 7 standards used had same or better results this year when compared with previous data from 2015, there is still room for improvement.
 - Our first step was to reevaluate the "Safe sedation proform" and make appropriate changes to increase compliance when it comes to document procedural sedations. Changes were finalised in June/2017. The next step will be using doctors and nurses teaching sessions to raise awareness about importance of safe sedation in ED and to introduce the new form. Our final goal will be to re audit procedural sedation in adults in 2018 and also submit our results to RCEM given there will be a national re-audit next year. This will be a great opportunity to show improvement in our procedural sedation
 - This audit has been a great tool to track ED performance against RCEM standards regarding procedural sedation and to highlight deficiencies in documentation. The results of this audit and our aims demonstrate our commitment to improve patient care in ED which will eventually have an impact in other specialities and overall NGH performance.

- Protecting patients from CRUTI (2nd Prize, Audit Presentation Day)
 - Urinary tract infections (UTIs) are the second largest single group of healthcare associated infections in the UK, amounting to 17.2% (PHE, 2011) of all healthcare associated infections. Therefore there are EPIC guidelines (2014) and a NICE Quality Standard 61 (2014) that makes recommendations for best practice to protect patients from catheter-related UTIs.
 - To monitor the prevalence of catheter-related UTIs and determine whether this is a cause for concern within the trust, the Infection Prevention and Control Team (IPCT) undertake regular point prevalence audits. Aim(s): To reduce catheter related urinary tract infections (CRUTIs) to patients across the Trust through adherence to an evidence-based care bundle for urinary catheters.
 - A Trustwide point prevalence audit was completed in February 2017 and September 2017 to determine the number of patients in the Trust with an indwelling urinary catheter in situ that was inserted during their admission and whether the aforementioned standards were met for each patient that met this inclusion criteria.
 - Following low scores in the February audit the IPC Team: Changed the IPC catheter care audit tool that the wards self-assess monthly; Included catheter care and recording on VitalPAC in the IPC workbook and ROK training;
 - Initiated annual ANTT training including emptying a catheter bag for HCAs; Reaudited in September 2017
 - Findings were discussed at the Infection Prevention Operational Group and then the Infection Prevention Steering Group. They were also reported to Clinical Quality and Effectiveness Group through the IPC report.

Participation in Clinical Research

Northampton General Hospital is a research activity hospital. We believe being a research active hospital supports the vision of providing the “Best possible care”

The number of patients that were recruited during the 17/18 financial year who participated in research approved by a research ethics committee was 1038 patients into 52 trials registered on the National Institute of Health Research portfolio. We had a large number of other patients participating in research which is classed a student research – this supports some of the graduate staff within the Trust taking higher degrees for their personal development which also provide the Trust with evidence to support our clinical questions.

Some of our notable success this year, include recruiting the first global patient to a medical device study for children with type 1 diabetes. Northampton saw the first patient in Europe with a specific cancer to receive a new investigational medical product. We have looked at blood pressure in the over 65 in intensive care and we have welcomed on board our gastroenterology team who are looking at inflammatory bowel disease. We are proud to say we have research ongoing in all the clinical directorates.

Participation in clinical research demonstrates the Trust’s commitment to improving the quality of care we offer and to making our contribution to wider health improvement. We have demonstrated our engagement with the National Institute for Health Research (NIHR) by participating in a wide range of clinical trials. This is consistent with our commitment to transparency and desire to improve patient outcomes and experience across the NHS. Our

engagement with clinical research also demonstrates NGH's commitment to testing and offering the latest medical treatments and techniques to our patients.

Within the Trust there is a strong desire to develop our research capacity and capability, this is because Research active Trusts have a lower risk adjusted mortality for acute admission (Research Activity and the Association with Mortality <https://www.ncbi.nlm.nih.gov/pubmed/25719608>). Furthermore a recent systematic review suggested that engagement with research by individuals and healthcare organisation increased the likelihood of a positive impact on health care performance.(Hanney S, Boaz A, Jones T, Soper B. Engagement in research: an innovative three-stage review of the benefits for health-care performance. Health Serv and Deliv Res. 2013;1(8)).

The literature tell us that patients in research active organisation have better health outcomes because research participation leads to accumulate knowledge , develops infrastructure and brings in resources and skill that can be used to improve clinical care.

So to support this, the Trust is investing in R&D and have set clear target for year on year growth.





Use of Commissioning for Quality and Innovation (CQUINs) payment framework

NHS Nene Commissioning Group is the Trust's main commissioner. We receive part of our income from them through an agreed CQUIN scheme where prior to the start of the financial year negotiations take place to agree specialist projects which bring about innovative quality improvement for our patients. Our CQUIN agreements with them are both local agreements and part of a national agenda.

In 2017/18 NGH agreed two local CQUINs and six national CQUINs equating to seven strands. NGH also holds a contract with commissioners known as Specialised Commissioners who are NHS England – Midlands and East. This contract is for specialised treatments that are commissioned on a regional or national basis. In 2016/176 NGH agreed three specialist CQUINs.

The CQUINs agreed with our commissioners contain milestones which must be met in order for the Trust to claim achievement. Each CQUIN is outlined below together with the RAG status of achievement.

TYPE	CQUIN INDICATOR NAME	Q1	Q2	Q3	Q4
LOCAL	1. STP				
	2. Control Total				
NATIONAL	1a. Improving staff health and wellbeing: Improvement of health and wellbeing of NHS staff				
	1b. Improving staff health and wellbeing: Healthy food for NHS staff, visitors and patients				
	1c. Improving staff health and wellbeing: Improving the uptake of flu vaccinations for front line staff within Providers				
	2a. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Timely identification of sepsis in emergency departments and acute inpatient settings				
	2b. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Timely treatment of sepsis in emergency departments and acute inpatient settings				
	2c. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Antibiotic review				
	2d. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Reduction in antibiotic consumption per 1,000 admissions				
	4. Improving services for people with mental health needs who present to A&E				
	6. Offering advice and guidance				
	7. NHS e-Referrals				
8. Supporting proactive and safe discharge					
SPECIALIST	Medicines Optimisation				
	Multi-system auto-immune rheumatic MDT				
	Clinical Engagement				

KEY:  No milestone  Milestones met
 Milestones partially met  Milestones not met

The CQUINs for 2017/18 have been agreed with our Commissioners and the Trust has two local CQUINs, six themed national CQUINs equating to 11 strands of work and three specialist CQUINs.

National CQUINs
1a. Improving staff health and wellbeing: Improvement of health and wellbeing of NHS staff
1b. Improving staff health and wellbeing: Healthy food for NHS staff, visitors and patients
1c. Improving staff health and wellbeing: Improving the uptake of flu vaccinations for front line staff within Providers

2a. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Timely identification of sepsis in emergency departments and acute inpatient settings
2b. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Timely treatment of sepsis in emergency departments and acute inpatient settings
2c. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Antibiotic review
2d. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis): Reduction in antibiotic consumption per 1,000 admissions
4. Improving services for people with mental health needs who present to A&E
6. Offering advice and guidance
7. NHS e-Referrals
8. Supporting proactive and safe discharge
9. Preventing Ill Health - Alcohol and Tobacco
Specialised CQUINs
IM3. Multi-system auto-immune rheumatic diseases MDT clinics, data collection and policy compliance
GE3. Hospital Pharmacy Transformation and Medicines Optimisation
Public Health CQUIN
1. Clinical Engagement

Local Quality Requirements

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

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

Quality Requirement	Threshold 17-19
End of Life Care	To help deliver person-centred End of Life Care through integration within and between providers of healthcare along the pathway.
Patient Safety	1) National Information
	2) Incidents
	3) Policy
	4) Discharge Information
	5) Outpatient Letters
	6) Mortality & Morbidity
	7) Cancer Patients with a long waiting time

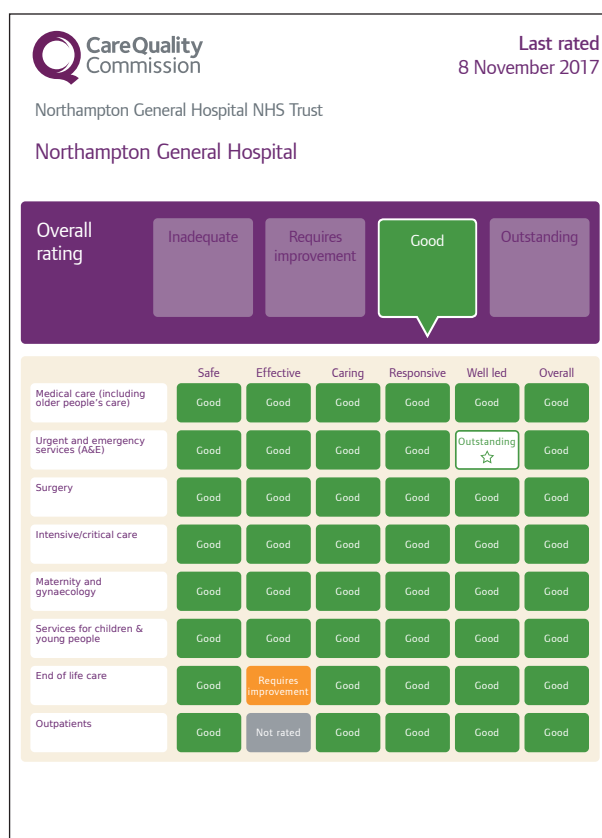
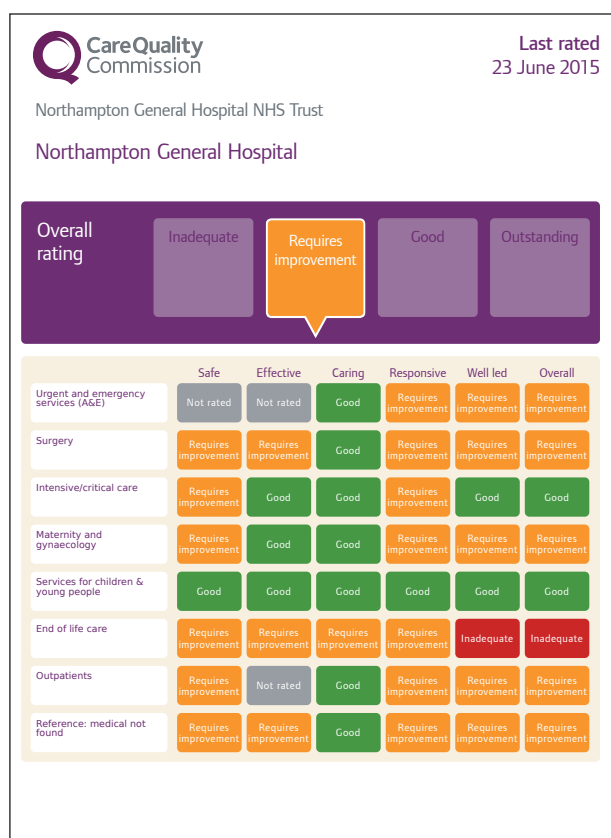
Learning	1) The provider will demonstrate a learning culture from ward to board.
	2) Review action taken towards implementation of NICE technical appraisal guidance, within three months of publication. Review action taken towards implementation of all other NICE guidance and Quality Standards that are judged to be appropriate to the Trust as a provider of acute care
	3) Evidence of learning from concerns about patient care raised by GPs and/or trust
Quality care for Patients with a Learning Disability	Implementation of actions from the Learning Disability 'Better Healthcare Plan'
Patient Experience	1) Evidence that patient experience is of equal importance as clinical quality and patient safety
	2) Evidence of learning from complaints and PALs enquiries
	3) Evidence of learning from National and regional surveys
Nutrition and Hydration	1) 95% of patients have completed MUST score within 24 hours 2) 95% of eligible patients have individualised care plan
WHO surgical checklist	All patients undergoing a surgical procedure to have all stages of the WHO checklist completed
National Early Warning Score (NEWS)	Report on the percentage of patients that have NEWS undertaken within required time period and percentage of patients whose NEWS triggers need for review who are reviewed.
Safeguarding Children	Implementation of Early Help Assessment (EHA), Section 11 Audit /Audits and Agreed Assurance Framework, Learning Supervision
Safeguarding Adults	Safeguarding Alerts Dashboard, Quality Monitoring Visits, SAAF, Safeguarding Alerts Dashboard, Quality Monitoring Visits, Learning, Supervision, Appropriate use of Mental Capacity Act (2005), Assessments and Deprivation of Liberty Safeguards, Training
Workforce	a) Assurance provided that 85% of all staff (including Drs & AHP) have received appraisals, mandatory and essential to role training b) Provider is compliant with the expectations in relation to nursing and midwifery and care staffing and capability as laid out in ' <i>How to ensure the right People with the right skills are in the right place at the right time</i> '.
VTE	As per Service Condition 22 the following will be required and monitored: 1. All patients receive VTE prevention in line with the NICE Quality standards. 2. Root cause analysis will be undertaken on all cases of hospital associated thrombosis.
Pressure Tissue Damage	2016/17 data to be used to set baseline of numbers of hospital acquired grade 2/3/4. Trust to agree ongoing improvement for the year in April 2017 (to be repeated for 2017/18) To continue to participate in countywide work to prevent pressure tissue damage.

Service Specifications	Assurance that all service specifications included in the 2017/19 contract are being implemented.
Quality Assurance regarding any trust sub-contracted services (list of services to be provided by the trust)	Assurance that all services sub-contracted by the trust have been fully quality monitored with any areas of concern investigated

Care Quality Commission (CQC)

Journey from Requires Improvement to Good

NGH is registered with the CQC under the Health and Social Care Act 2008 and currently has no conditions attached to registration under section 48 of the Health and Social Care Act 2008. The Care Quality Commission (CQC) inspected NGH twice in 2017, the first 3 day inspection took place in February and the second during July 2017, they followed these up with an unannounced one day visit in August 2017. The most recent report published in November 2017 was an excellent outcome for the Trust. Each of the eight core services was rated as good, along with an overall good rating for each of the five domains (safe, effective, caring, responsive and well-led) and for the Trust overall. Significant progress had been made from the previous ratings from 2014 (see diagram below).



How did the Trust achieve this? By the input and involvement of all staff from the frontline to executive level. Everyone had a part to play. The positive change in rating was through a three year journey of improvement involving everyone. Services reviewed the reports, identified areas to action and with the support of the Compliance Team an improvement plan was developed. At a senior level, reviews took place to consider improvements to the processes used across the Trust, particularly in relation to patient safety. Ahead of the CQC

visit, mock inspections, focus groups and briefing sessions helped support staff, with their final preparations.

The culmination of the three year journey was the recognition by CQC, of the improvements made to the safety and quality of care provided to patients, both within the 2017 report and the revised ratings. Some key highlights from the report were:-

'We found the trust has taken significant action to meet the concerns raised from the January 2014 inspection, particularly in establishing an inclusive and supportive staff culture with a clear focus on patient safety.'

'Despite very high bed occupancy over time and on the days of the inspection, the commitment to the safety and quality of care and treatment for patients was clearly demonstrated by all staff at all levels.'

'The level of staff support, respect and commitment to each other was clearly evident in all areas. Staff referred to the 'Team NGH' spirit and culture and were proud of this. Staff were proud of the organisation as a place to work and spoke highly of the culture.'

Everyone at NGH is very proud of what has been achieved, but equally keen to keep progressing and improving care for patients. Work has already begun on continuing the improvements on our 'Journey from Good to Outstanding'.

Implementing Duty of Candour

The introduction of the CQC Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust 1, which recommended that a statutory duty of candour be introduced for health and care providers.

To meet the requirements of Regulation 20, the Trust has to:

- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of our knowledge, is true of all the facts we know about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.
- Offer an apology.
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person.

The Trust continues to ensure that there is a clear process in place for Duty of Candour not only for the staff but also for the patients. A staff information leaflet was already in use within the Trust, however the Clinical Governance Team identified that there was a gap within the information available to patients and/or their relevant person. As a result the Clinical Governance Team has produced a Duty of Candour patient information leaflet which has currently been shared with the representatives of other Trusts within the region at the Countywide Patient Safety Forum. The aim is to agree a Countywide leaflet to ensure that patients are receiving a consistent and clear approach to this process.

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

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

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

The Trust continues to demonstrate compliance with Duty of Candour to the Clinical Commissioning Group (CCG).

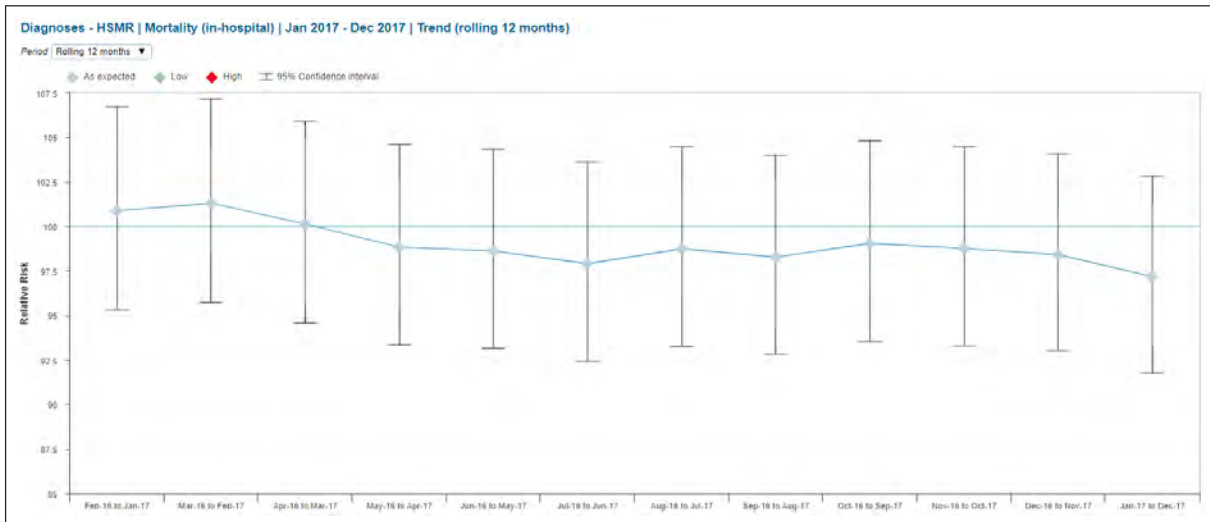
Hospital Mortality Monitoring

Northampton General Hospital uses three key mortality metrics which are benchmarked against all other hospitals in England and examine patient outcomes. These metrics are provided to the Trust by Dr Foster™ and the Health and Social Care Information Centre (HSCIC):

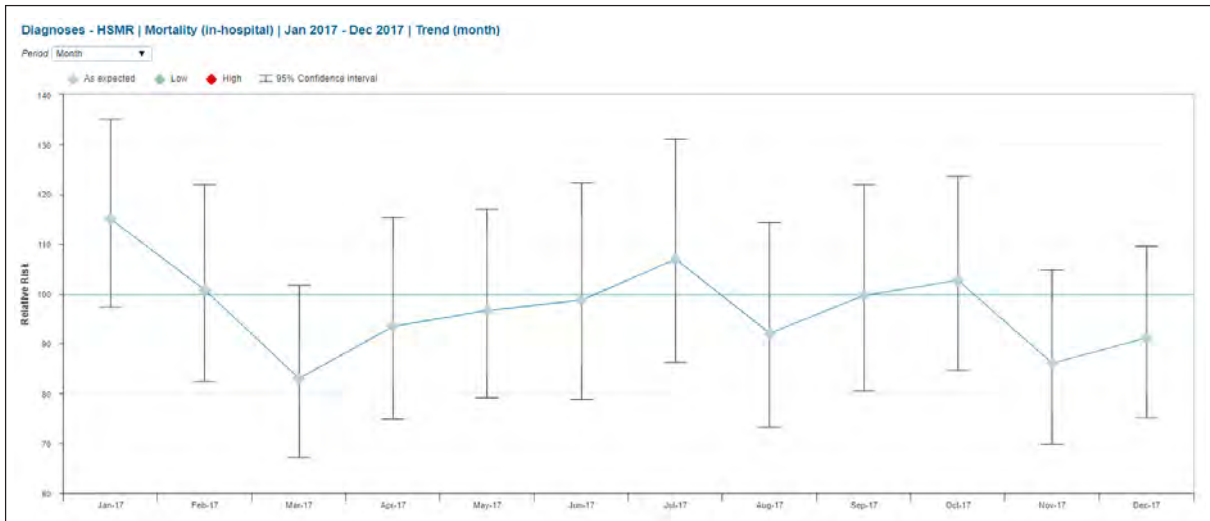
- The HSMR [Hospital Standardised Mortality Ratio] analyses mortality from the 56 most common and serious conditions which result in more than 80% of deaths which occur in hospital. The Standardised Mortality Ratio can be quoted as a percentage or ratio relative to the number of deaths that would have been expected to occur based on what is known about the patients that were admitted to hospital. A hospital that is performing 'as expected' would have an HSMR that is equal to 100. If the HSMR is higher than 100, then there is a higher reported mortality ratio. An HSMR that is less than 100 suggests that the mortality is low than would have been expected.
- The HSMR 100 looks at all hospital deaths. Both mortality indicators are case mix adjusted, taking into account the age of each patient and their general health before their admission to hospital.
- The Standardised Hospital Mortality Index (SHMI) provides similar information to the MSHR but also includes patients who have recently been discharged from hospital (in the previous 30 days)

This information is under continuous review to identify areas of adverse performance which require further analysis and investigation. The analysis is presented to the Mortality Review Group each month and to the Clinical Quality and Effectiveness Group by the Associated Medical Director. The Medical Director reports to the Trust Board on mortality and planned actions in relation to any areas of concern through the Quality Governance Committee.

The HSMR is reported 3 months in arrears. During the year to December 2017 the HSMR has remained within the 'as expected' range: at 97.2:

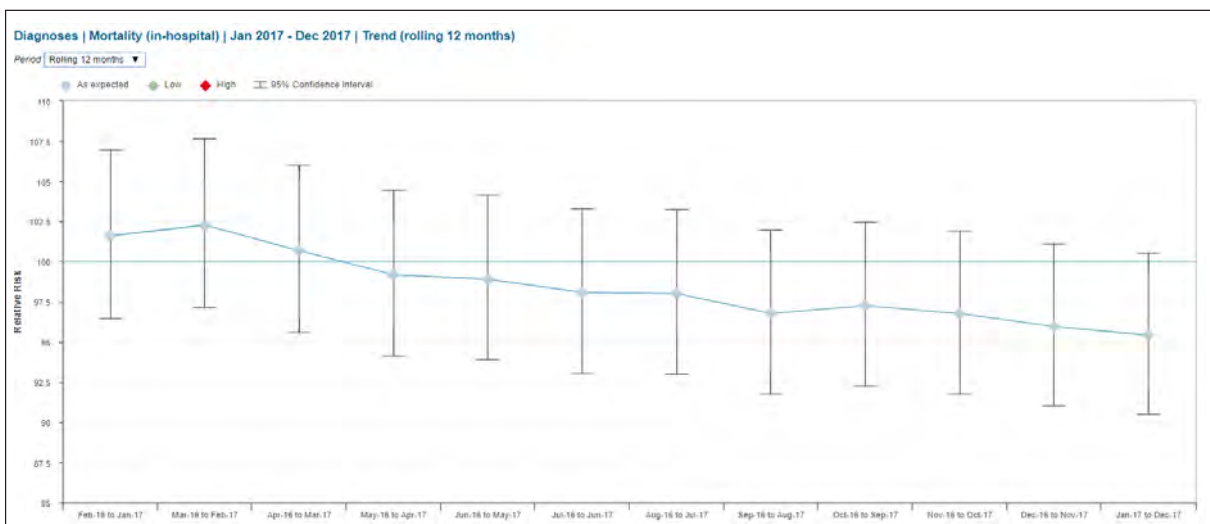


The monthly variation in the standardised mortality ratio over this 12 month period is shown below:



Due to the shorter monthly time frame there is more variation seen. The monthly Trust results have also remained in the as expected range.

The HSMR-100 metric which covers all diagnoses shows a similar pattern to that of the HSMR:



The Standardised Hospital Mortality Index (SHMI) has also remained in the 'as expected' range. The most recent update of the SHMI for the year from October 2016 to September 2017 was 97.0.

Data Quality

NHS Number and General Medical Practice Code Validity

The Trust submitted records between April 2015 and January 2016 to the Secondary Users Service for inclusion in the national Hospital Episode Statistics (HES) database which are included in the latest published data outlined below and compared to the previous year's results.

Period – April16 – Dec 16	Valid NHS Number	Valid GMPC
Inpatients	99.6%	100%
Outpatients	99.8%	99.9%
A&E	98.2%	99.5%

Period - Apr17 to Dec 17	Valid NHS Number	Valid GMPC
Inpatients	99.7%	100%
Outpatients	99.9%	99.9%
A&E	98.4%	99.8%

Comparison	Valid NHS Number	Valid GMPC
Inpatients	0.1%	0.0%
Outpatients	0.1%	0.0%
A&E	0.2%	0.3%

Information Governance Toolkit attainment levels

The Information Governance Toolkit is the mechanism through which the NHS and other partner organisations demonstrate their compliance with a number of information governance requirements. The IG toolkit comprises of standards to which all NHS organisations and Private Sector Health Partners must self-assess and submit its compliance on a yearly basis.

There are currently 45 standards within the Acute Trust framework. These are within six assurance categories:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Secondary Use Assurance
- Corporate Information Assurance

For each standard a score from 0 – 3 must be achieved:

- NR = Not Relevant

- 0 = Standard not in place in the organisation.
- 1 = Policies are in place for the standard.
- 2 = Policies are effectively communicated and the processes are evident.
- 3 = Processes are audited and reviewed to ensure they are followed, understood and remain fit for purpose.

All submissions are graded as either 'satisfactory' or 'not satisfactory'. To be classed as satisfactory, all requirements must meet a minimum of level 2.

The Information Governance Toolkit version 14.1 was completed and submitted on 30th March 2018 with an overall score of 67% and a return of 'Satisfactory'.

Internal auditors, TIAA audited a random sample of 10 requirements and provided recommendations in relation to the submission. The recommendations included

- 112 – Information Governance training
The toolkit target set by NHS Digital is for 95% of all staff to be trained in IG on an annual basis. This has not previously been achieved. The target was made compulsory in the version 14 release of the IG Toolkit. The Trust has now achieved 95% training compliance.
- 202 – Confidential personal information sharing
This element of the IG Toolkit states that there are conditions that must be met when processing personal information. In addition, where personal information is held in confidence (e.g. details of care and treatment), the common law requires the consent of the individual concerned or some other legal basis before it is used and shared. Staff must be made aware of the right of an individual to restrict how confidential personal information is disclosed and the processes that they need to follow to ensure this right is respected. TIAA stated that the Trust has essentially met Level 2 compliance.
- 206 – Confidential personal information monitoring
This element of the IG Toolkit states Organisations should ensure that access to confidential personal information is monitored and audited locally and in particular ensure that there are agreed procedures for investigating confidentiality events. TIAA stated that the Trust has essentially met Level 2 compliance.

During 2017/18, the Director of Corporate Development, Governance and Assurance retained the role of Senior Information Risk Owner and the Medical Director continued as our Caldicott Guardian. The Trust reported three Information Governance incidents to the Information Commissioner's Office in 2017/18

Clinical Coding Error Rate

NGH was not subject to a payment by Results clinical coding audit by the Audit Commission during the reporting period.

- Background
 - An audit was internally commissioned by Northampton General NHS Trust to fulfil the Information Governance (IG) Toolkit requirement 505 and the associated objectives are clearly defined to support this purpose. The toolkit requirement states that there should be established procedures in place for regular quality inspections of the coded clinical data using the Clinical Classifications Service (CCS) Clinical Coding Audit Methodology to demonstrate compliance with the clinical classifications

OPCS-4 and ICD-10 and national clinical coding standards and the organisation's commitment to continual improvement of its coded data. The clinical coding audits are undertaken by a CCS approved clinical coding auditor.

- In the audit, each of the 3 bed-holding clinical Divisions have been selected for audit which included all associated inpatient sub-specialties. This represents a snapshot of all inpatient coded data.
- In addition to this yearly audit, there is a cycle of audit both random (individual coders quarterly) and targeted (monthly) undertaken by management staff which covers a minimum of 100 Consultant episodes each month.
- NGH was not subject to an externally commissioned clinical coding audit at any time during the reporting period.
- Objectives
 - To assess Trust-wide inpatient coding performance against recommended achievement levels for Information Governance Toolkit Requirement 505.
 - To review the coded information for accuracy and adherence to national standards.
 - To identify a baseline measure of accuracy for continuous improvement.
 - To analyse the information provided to the coders at the time of the coding with the information contained in the case notes at the time of audit.
 - To make recommendations where appropriate, to improve the quality of the coded clinical data.
- Methodology
 - The individual episode data was selected at random across each of the 3 Division's activity. The sample period was quarter 1 of 2017-18 and comprised a minimum of 80 spells for each Division.
 - The auditors carried out the audit strictly adhering to the Clinical Coding Audit Methodology Version 11.0 in order to satisfy the Information Governance requirement 505.
- General Findings
 - The overall results for the 310 episodes (270 spells) audited reached IG level 2 requirements across all areas. In some areas, notably procedural coding, the percentages are above level 3 IG requirements.
 - The primary diagnosis and secondary procedure scores were where the largest percentage of error was noted. Of the primary diagnosis errors found, 9 were incorrect at 3rd character level, 10 at 4th character level and 4 were present but incorrectly sequenced in a secondary field. The majority of secondary procedural errors were due to subsidiary site and laterality codes being omitted.
 - Financially, there was minimal change in the value of the episodes following audit.

OVERALL	% Accuracy Including All Error Sources	% Accuracy Excluding Non-Coder Error
Primary Diagnosis	92.67%	93.11%
Secondary Diagnoses	92.22%	92.88%
Primary Procedure	94.73%	94.73%
Secondary Procedures	93.27%	93.27%
Divisional	% Accuracy Including All Error Sources	% Accuracy Excluding Non-Coder Error
Medicine & Urgent Care		
Primary Diagnosis	90.88%	92.22%
Secondary Diagnoses	93.22%	94.40%
Primary Procedure	95.05%	95.05%
Secondary Procedures	94.31%	94.31%
Surgery		
Primary Diagnosis	92.68%	92.68%
Secondary Diagnoses	94.79%	95.50%
Primary Procedure	93.11%	93.11%
Secondary Procedures	93.05%	93.05%
Womens, Childrens & Oncology		
Primary Diagnosis	94.44%	94.44%
Secondary Diagnoses	88.66%	88.74%
Primary Procedure	96.02%	96.02%
Secondary Procedures	92.45%	92.45%

- Themes of good practice noted:
 - Good standard of stroke coding with evidence of clinical collaboration in the coding process.
 - Excellent provision of clinical information for neonatal babies leading to good coded data.
 - Good use of electronic and paper records within Oncology to allow complete and robust coding.
- Sources of error:
 - Primary diagnosis errors due to incomplete application of the full 4 step coding process.
 - Diagnostic errors around the coding of postoperative external cause codes.
 - Some errors noted around the coding of sepsis following the coding standard change on 1st April 2017.
 - Multiple procedural errors relating to the sequencing and coding of subsidiary site codes.

- Conclusions
 - The overall results met the required standard to reach IG level 2 across every Division which is a good sign.
 - There were particular areas identified where the coding was of a very good standard and this correlated with good information provision to the coders and this should be actively pushed and promoted as a means to improving coded data.
 - Errors were generally spread across specialties and varied in type of error made. There were some themes which were repetitive which will need to be addressed with actions. Specifically, these were around postoperative complication cause codes and subsidiary site codes and both will be easily modified through some refreshing on standards.
 - It should be noted that between the audit taking place and the coding of the sample audited, there has been some turnover of coding staff with an additional four trainee coders added to the department.
 - Along with the two vacancies, this is going to present a significant challenge in maintaining the standards of coding demonstrated and will need to be specifically addressed.
- Actions Undertaken
 - Refreshed the department on the coding standard DCS.XIX.7: Postoperative complications and disorders.
 - Refreshed the department on the coding standards PCSZ1: Site codes and PCSZ2: Laterality of operation (Z94).

Performance Against National Quality Indicators

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

Performance data for NGH is included together with the NGH data from the 2014/15 Quality Account. Where available, data has been provided showing the national average as well as the highest and lowest performance for benchmarking purposes. All information for the reporting period has been taken from the Health and Social Care Information Centre and the links provided therein.

For the following information data has been made available to the Trust by NHS Digital. Where this has not been available, other sources have been used and these sources have been stated for each indicator.

In accordance with the reporting toolkit the trust can confirm that it considers that the data contained in the tables below are as described, due to them having been verified by internal and external quality checking

Domain 1 – Preventing people from dying prematurely and Domain 2 – Enhancing quality of life for people with long term conditions

- Summary Hospital-Level Mortality Indicator (SHMI) – (value and banding of the SHMI)

Period	NGH Value	NGH Banding	National Average	National High	National Low
Oct 16 – Sep 17	97	2	100	125	73
Oct 15 – Sep 16	95	2	100	116	69
Oct 14 – Sep 15	102	2	100	117	65
Oct 13 – Sep 14	98	2	100	119	59

*SHMI banding:

- SHMI Banding = 1 indicates that the trust's mortality rate is 'higher than expected'
- SHMI Banding = 2 indicates that the trust's mortality rate is 'as expected'
- SHMI Banding = 3 indicates that the trust's mortality rate is 'lower than expected'

The Trust has an 'as expected' SHMI at xxxxx for the period October 2016 to September 2017 as demonstrated in the table above. Unlike HSMR, the SHMI indicator does include deaths 30 days after discharge and therefore patients, including those on palliative care end of life pathways, who are appropriately discharged from the Trust.

NGH has taken the following actions to improve this rate and quality of its services; regularly analysing mortality data and undertaking regular morbidity and mortality meetings to share learning across the Trust and externally through countywide morbidity and mortality meetings.

- Palliative Care Coding – (percentage of patient deaths with palliative care coded at either diagnosis or specialty level)

Period	NGH	National Average	National High	National Low
Oct 16 – Sep 17	41.1%	36.61%	59.8%	11.5%
Oct 15 – Sep 16	36.62%	29.74%	56.26%	0.39%
Oct 14 – Sep 15	25.9%	26.6%	53.5%	0.19%
Oct 13 – Sep 14	26.6%	25.32%	49.4%	0.0%

NGH has taken the following actions to improve this rate and quality of its services; by prioritising end of life care and placing greater importance on palliative care

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

- Patient Reported Outcome Measures scores (PROMs) - (adjusted average health gain)
 - Hip replacement surgery
 - Knee replacement surgery
 - Groin hernia surgery
 - Varicose vein surgery

	NGH Performance		National Performance		
	Reporting Period 2017/18	NGH Quality Account 2016/17	Reporting Period Average	Reporting Period High	Reporting Period Low
• Groin hernia surgery (EQ-5DTM Index)	0.115 (finalised Apr 16 to Mar 17)	0.116 (provisional Apr16 to Dec16)	0.086 (finalised Apr 16 to Mar 17)	0.135 (finalised Apr 16 to Mar 17)	0.006 (finalised Apr 16 to Mar 17)
• Varicose vein surgery (EQ-5DTM Index)	0.109 (finalised Apr 16 to Mar 17)	N/A (provisional Apr16 to Dec16)	0.091 (finalised Apr 16 to Mar 17)	0.154 (finalised Apr 16 to Mar 17)	0.010 (finalised Apr 16 to Mar 17)
• Hip replacement surgery - primary (EQ-5DTM Index)	N/A (provisional Apr17 to Sep17)	0.488 (provisional Apr16 to Dec16)	0.464 (provisional Apr17 to Sep17)	22.356 (provisional Apr17 to Sep17)	0.471 (provisional Apr17 to Sep17)
• Hip replacement surgery - primary (EQ-5DTM Index)	N/A (provisional Apr17 to Sep17)	N/A (provisional Apr16 to Dec16)	0.204 (provisional Apr17 to Sep17)	N/A (provisional Apr17 to Sep17)	N/A (provisional Apr17 to Sep17)
• Knee replacement surgery - primary (EQ-5DTM Index)	N/A (provisional Apr17 to Sep17)	0.300 (provisional Apr16 to Dec16)	0.327 (provisional Apr17 to Sep17)	N/A (provisional Apr17 to Sep17)	N/A (provisional Apr17 to Sep17)
• Knee replacement surgery - revision (EQ-5DTM Index)	N/A (provisional Apr17 to Sep17)	N/A (provisional Apr16 to Dec16)	0.419 (provisional Apr17 to Sep17)	N/A (provisional Apr17 to Sep17)	N/A (provisional Apr17 to Sep17)

N.B. - Where N/A is stated, this information has not been made available by NHS Digital at the time of publication.

NGH has taken the following action to improve the rates, and the quality of its services by further developing the work undertaken in theatres.

- *Emergency re-admissions to hospital within 28 days of discharge* - percentage of patients readmitted to hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust)

Period	NGH	National Average	National High	National Low
Patients aged 0-15				
2017/18	N/A	N/A	N/A	N/A
2016/17	N/A	N/A	N/A	N/A
2015/16	N/A	N/A	N/A	N/A
2014/15	N/A	N/A	N/A	N/A
2013/14	N/A	N/A	N/A	N/A
2012/13	N/A	N/A	N/A	N/A
2011/12	13.15%	10.01%	13.58%	5.10%

N.B. - Where N/A is stated, this information has not been made available by NHS Digital at the time of publication.

Period	NGH	National Average	National High	National Low
Patients aged 16 and over				
2017/18	N/A	N/A	N/A	N/A
2016/17	N/A	N/A	N/A	N/A
2015/16	N/A	N/A	N/A	N/A
2014/15	N/A	N/A	N/A	N/A
2013/14	N/A	N/A	N/A	N/A
2012/13	N/A	N/A	N/A	N/A
2011/12	11.15%	11.45%	13.50%	8.96%

N.B. - Where N/A is stated, this information has not been made available by NHS Digital at the time of publication.

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

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

- Responsiveness to the personal needs of patients

Period	NGH	National Average	National High	National Low
2016/17 (Hospital stay: 01/07/2016 to 31/07/2016; Survey collected 01/08/2016 to 31/01/2017)	61.1%	68.1%	85.2%	60.0%
2015/16 (Hospital stay: 01/07/2015 to 31/07/2015; Survey collected 01/08/2015 to 31/01/2016)	65.5%	69.6%	86.2%	58.9%
2014/15 (Hospital stay: 01/06/2014 to 31/08/2014; Survey collected 01/09/2014 to 31/01/2015)	66.5%	68.9%	86.1%	59.1%
2013/14 (Hospital stay: 01/06/2013 to 31/08/2013; Survey collected 01/09/2013 to 31/01/2014)	68.6%	68.7%	84.2%	54.4%

NGH continues to review patient experience and build on the work currently being undertaken across the Trust.

- Staff who would recommend the trust to their family or friends – (percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends)

Period	NGH	National Average	National High	National Low
2017	69%	70% (Acute Trusts)	86% (Acute Trusts)	47% (Acute Trusts)
2016	68%	69% (Acute Trusts)	85% (Acute Trusts)	49% (Acute Trusts)
2015	52%	69%	85%	46%

NGH is reviewing the scores in order to improve the rates, and so the quality of its services. The data is being fed through the trusts divisional structure with the aim to join it with patient experience. The trust aims to increase staff engagement and hope to develop a triangulation between performance, experience and engagement.

- Friends and Family Test – Patient - (percentage recommended)

Period	NGH	National Average	National High	National Low
Inpatient				
2017/18	93%	96%	100%	75%
2016/17	91.1%	96%	100%	80%
March 2016	85.4%	67%	93%	38%
March 2015	78%	95%	100%	78%

Period	NGH	National Average	National High	National Low
Patients discharged from Accident and Emergency (types 1 and 2)				
2017/18	88%	88%	100%	66%
2016/17	86.7%	87%	100%	45%
March 2016	85.4%	84%	99%	49%
March 2015	85%	87%	99%	58%

NGH has taken the following actions to improve the percentages, and the quality of its services by encouraging a culture of reporting throughout the Trust.

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

- Venous Thromboembolism – (percentage of patients who were admitted to hospital and who were risk assessed, for venous thromboembolism)

Period	NGH	National Average	National High	National Low
Q3 17/18	95.92%	95.36%	100%	76.08%
Q2 17/18	94.84%	95.25%	100%	71.88%
Q1 17/18	95.56%	95.20%	100%	51.38%
Q4 16/17	95.90%	95.46%	100%	63.02%
Q3 16/17	95.87%	95.57%	100%	76.48%
Q2 16/17	95.25%	95.45%	100%	72.14%
Q1 16/17	94.10%	95.74%	100%	80.61%
Q4 15/16	95.2%	96%	100%	79.23%

NGH has taken action to improve the percentages and the quality of its services, by further developing systems to ensure risk assessments are reviewed and promoted. The aim is that all patients, who should have a VTE risk assessment carried out, have one 100% of the time.

- Rate of Clostridium difficile (C.Diff) infection - (rate per 100,000 bed days of cases of C.Diff infection, reported within the Trust amongst patients aged 2 or over)

Period	NGH	National Average	National High	National Low
2017/18	7.5	N/A	N/A	N/A
2016/17	8.7	12.9	82.7	0
2015/16	12.7	14.9	67.2	0
2014/15	11.8	14.6	62.6	0
2013/14	10.2	14.0	37.1	0

N.B. - Where N/A is stated, this information has not been made available by NHS Digital at the time of publication.

NGH has taken the following actions to improve the percentages, and the quality of its services by sending stool samples in a timely manner, prompt isolation of patient's with diarrhoea and improving antimicrobial stewardship.

- Patient Safety

Period	NGH	National Average	National High	National Low
The number of patient safety incidents reported within the trust - (Acute Non- Specialist)				
Oct 16 – Mar 17	4,335	6,707	14,506	1,301
Apr 16 – Sep 16	3,830	6,575	13,485	1,485
Oct 15 – Mar 16	3,538	4,335	11,998	1,499
Apr 15 – Sep 15	3,722	4,647	12,080	1,559

Period	NGH	National Average	National High	National Low
The rate (per 1,000 bed days) of patient safety incidents reported within the trust - (Acute Non- Specialist)				
Oct 16 – Mar 17	33.3	64.3	69.0	23.1
Apr 16 – Sep 16	30.8	40.9	71.8	21.1
Oct 15 – Mar 16	28.4	39	75.9	14.8
Apr 15 – Sep 15	31.1	39.3	74.7	18.1

Period	NGH	National Average	National High	National Low
The number of such patient safety incidents that resulted in sever harm or death - (Acute Non- Specialist)				
Oct 16 – Mar 17	13	34.7	92	1
Apr 16 – Sep 16	13	33.6	98	1
Oct 15 – Mar 16	18	34.6	94	0
Apr 15 – Sep 15	6	19.9	89	2

Period	NGH	National Average	National High	National Low
The percentage of such patient safety incidents that resulted in sever harm or death - (Acute Non- Specialist)				
Oct 16 – Mar 17	0.10%	0.36%	0.53%	0.01%
Apr 16 – Sep 16	0.33%	0.51%	1.73%	0.02%
Oct 15 – Mar 16	0.51%	0.40%	2.0%	0%
Apr 15 – Sep 15	0.16%	0.43%	0.74%	0.13%

The results show that the trust is below the national average for the level of harm. NGH has taken the following action to improve the percentages and rates, and so the quality of its services by further encouraging an open reporting culture. This is being done through regular engagement with staff via newsletters, through learning events such as Dare to Share and regular attendance at ward and department meetings.

Review of Activity 2017/18

Activity	2016/17	2017/18	Difference	% Difference
Emergency inpatients	47,701	46,060	-1,641	-3%
Elective inpatients	5,634	5,135	-499	-9%
Elective day cases	42,393	41,842	-551	-1%
New outpatient attendances – consultant led	105,790	107,518	1,728	2%
Follow-up outpatient attendances – consultant led	208,420	231,637	23,217	11%
New outpatient attendances – nurse led	27,758	27,877	119	0%
Follow-up outpatient attendances – nurse led	101,938	83,169	-18,769	-18%
Total number of outpatient DNAs	36,708	35,778	-930	-3%
Patients seen in A&E	116,183	122,582	6,399	6%
Number of babies born	4,867	4,762	-105	-2%
Average length of stay (in days)	4.52	4.93	0.41	9%

Private & Confidential

Carolyn Fox
Director of Nursing, Midwifery & Patient Services
Northampton General Hospital NHS Trust
Cliftonville,
Northampton
NN1 5BD

Francis Crick House
6 Summerhouse Road
Moulton Park
Northamptonshire
NN3 6BF

TEL: 01604 651100

29th May 2018

Dear Carolyn,

Re: Quality Account 2017-18

Thank you for submitting your draft Quality Account; we welcomed the opportunity to review this. The Quality Account submitted by the Trust has been subject to a detailed review by NHS Nene and NHS Corby Clinical Commissioning Groups (CCGs); ensuring that the data and information reported in the account matches data submitted to the CCGs.

Please find attached the draft review agreed by myself on behalf of the CCGs. This will be formally approved by our Joint Quality Committee on 12 June 2018 and I will notify you of any changes at this time.

We look forward to continuing to work closely with the Trust in 2018-19.

Yours sincerely



Dr Matthew Davies
Medical Director

Enc.

c.c. Simon Hawes
Caroline Corkerry

Northampton General Hospital NHS Trust Annual Quality Account – CCG Feedback May 2018

The Northampton General Hospital NHS Trust (NGH) annual quality account for 2017/18 has been reviewed by NHS Corby and NHS Nene CCGs. It is noted that the report was reviewed in draft.

While the Quality Account references contain the trust's overview of the quality of relevant health services it provided or sub-contracted during 2017/18 it does not contain detail on the processes in place to review and act upon quality information for sub contracted services (p77).

There is no statement or declaration at the end of Part One, signed by the Chief Executive, that to the best of their knowledge the information in the document is accurate. We recognise that this may be because the document has been provided to the CCGs in draft form. We look forward to reviewing this section in the final document.

NHS Corby and NHS Nene Clinical Commissioning Groups support the 2017/18 quality priorities as set by the trust in relation to improving patient safety, clinical effectiveness and patient experience.

The Quality Account identifies how the trust intends to measure improvement.

Information on the participation in national clinical audits and confidential enquiries is included. No explanation for not participating in national ophthalmology audit is provided.

The achievement for the Commissioning for Quality and Innovation (CQUIN) schemes for 2015/16 and 2016/17 is detailed within the report. The Trust position within the report for 2017/18 should be updated in the final report to reflect the year-end position. It would be helpful to include the impact of implementation of CQUINs on patient care.

Nationally mandated elements are included in the report together although the section on learning from deaths is absent in the draft version provided. The CCGs are aware of the work the trust has undertaken in this area and look forward to reviewing this section once included. The CCGs also recognise and welcome the work undertaken by the trust to demonstrate an improvement in the CQC rating.

Achievement against the quality priorities outlined in the report is noted.

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



Northamptonshire County Council

FAO: Simon Hawes
Corporate Governance Manager
Northampton General Hospital
Cliftonville
Northampton
NN1 5BD

Please ask for: Jenny Rendall
Tel: 01604 367560
Our ref:
Your ref:
Date: 17 May 2018

Dear Simon

Re: Quality Account 2017-18

The NCC Health Adult Care & Wellbeing Scrutiny Committee formed a working group of its members to consider a response to your Quality Accounts 2017-18. Membership of the working group was as follows:

- Councillor Eileen Hales MBE
- Councillor Chris Smith-Haynes
- Councillor Chris Stanbra
- Mr Andrew Bailey (Northamptonshire Carers Voice Representative)

The working group also considered the following in relation to all quality accounts:

- It was felt it would be useful for Scrutiny to receive summary quarterly updates from providers of progress data against the key actions taken to deliver the objectives set in the Quality Account for that year. This would be consistent with the Department of Health guidance that discussions between OSCs and providers of the Quality Accounts should be conducted throughout the reporting year.
- It might be useful if a statement was included that stated how NGH viewed its position in terms of security of data.

The working group considered how far the quality account was a fair reflection of the healthcare services provided by NGH, based upon members' knowledge of the provider. The formal response from the Health Adult Care & Wellbeing Scrutiny Committee based on the working group's comments is as follows:

- It was felt the quality account was difficult to read and it included a lot of text.
- It would be nice to have included a summary of priorities.

Northamptonshire County Council
Democratic Services
County Hall
Northampton NN1 1AT

w. www.northamptonshire.gov.uk
t. 01604 367560
f. 01604 236223
e. Jrendall@northamptonshire.gov.uk



Northamptonshire
County Council

- The graphs in relation to HATS on page 31 didn't look good.
- The Priorities for Improvement was inconsistent in that some achievements were listing what, when and outcome but not how it was to be achieved.
- The working group were disappointed that domain 4 – ensuring that people have a positive experience of care appeared to be worsening.
- The information given in page 4 was considered good.
- The working group considered the simulation suite to be a good development and were pleased to see involvement with the University of Northampton.
- The Learning Disability Officer appeared to be getting good feedback.
- It was good to see the progress in the CQC National Inpatient Survey Focused Improvement Work.
- The Springfield Urgent Treatment Centre was considered to be a good positive development.
- Developing contracts with the nearby care homes was considered to be a good sensible move.
- It was good to see the trust looking for initiatives to solve or ease the problems in the health economy such as the Consultant Connect. They were clearly trying very hard to improve the flow of patients with limited resources.
- It was hoped the Learning from Deaths information would follow as this was important.
- The commitment to research was considered good.

Please do not hesitate to contact Democracy Officer, Jenny Rendall should you have any queries relating to this response, whose contact details can be found at the bottom of the first page of this letter.

Yours sincerely

On behalf of the Health, Adult Care & Wellbeing Scrutiny Committee

Councillor Eileen Hales MBE
Chairman of the Quality Accounts Working Group

Healthwatch Northamptonshire statement on Northampton General Hospital NHS Trust (NGH) draft Quality Account 2017/18

The role of Healthwatch Northamptonshire is to support, challenge and assist our healthcare providers to improve current and future services for the people of Northamptonshire. During 2017/18 Healthwatch Northamptonshire has continued to represent the public and work with NGH through attending the Patient and Carer Experience and Engagement Group (PCEEG) and providing patient feedback. Our Young Healthwatch visit to the children's wards was also a valuable opportunity to talk to patients and staff and to learn about good practice, thank you to NGH for facilitating this visit.

Healthwatch Northamptonshire believes that this Quality Account demonstrates the progress NGH has made against their 2017/18 Quality Priorities/Quality Improvement Strategy and appreciate the details of the many quality improvement initiatives that have taken place during the year.

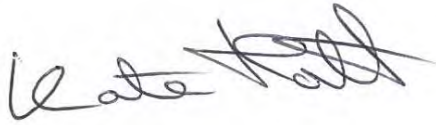
We believe NGH has chosen appropriate Quality Priorities for 2018/19 by linking them to their three-year Quality Improvement Strategy in order to embed change within the Trust.

Through attendance at the PCEEG we have seen the continued improvement in how patient experience feedback is collected and acted upon and we support NGH as they continue to focus on ensuring this feedback leads to improvement and learning. We have also had the opportunity to give feedback on patient leaflets.

The feedback we receive from members of the public relating to services provided by NGH is varied and much of it relates to specific examples of care. Other themes commonly raised are communication, delays and discharge, all which NGH have also identified as areas for improvement. We pass on all the issues raised with us to NGH and thank them for valuing this feedback and looking into these issues where appropriate. Together with Deafconnect, we raised the issue of a Deaf patient who was diagnosed without a proper assessment due to the hospital not using an interpreter. Following this complaint Deafconnect attended the first Disability Champions meeting at NGH and is working with them to improve access to British Sign Language (BSL) interpreting services and embed Deaf awareness across the trust. We encourage the trust to continue to develop the BSL translation services available to patients.

We congratulate NGH for the progress they have made to move to a rating of 'Good' following their recent CQC inspection, which reflects much hard work by both management and staff. We also note that the Trust was shortlisted for three Patient Experience Network National awards.

We welcome the opportunity to continue to work with NGH to help the trust to maintain a good and improving service.

A handwritten signature in black ink, appearing to read 'Kate Holt', with a stylized flourish at the end.

Kate Holt

CEO

Connected Together CIC (contract holder of Healthwatch Northamptonshire)



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

We are required to perform an independent assurance engagement in respect of Northampton General Hospital NHS Trust's Quality Account for the year ended 31 March 2018 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following indicators:

- Clostridium Difficile Infections ; and
- Friends and Family test Patient Element Survey.

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

Respective responsibilities of the Directors and the auditor

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

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2017 to June 2018;
- papers relating to quality reported to the Board over the period April 2017 to June 2018;
- feedback from the Commissioners dated 29 May 2018;
- feedback from Local Healthwatch dated 31 May 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 04 June 2018;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated July 2017;
- the latest national staff survey dated 9 October 2017;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2018;
- the annual governance statement dated 25 May 2018;
- the Care Quality Commission's Intelligent Monitoring Report dated 08 November 2017; and

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

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

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

Assurance work performed

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

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

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

Limitations

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

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

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

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



for and on behalf of
KPMG LLP
Chartered Accountants
31 Park Row
Nottingham
NG1 6FQ

29 June 2018

Abbreviations

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

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



Prepared by Quality Improvement

Northampton General Hospital NHS Trust,
Cliftonville, Northampton NN1 5BD.
www.northamptongeneral.nhs.uk

April 2018