UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Quality Account 2019/2020

Introduction

What is a Quality Account?

The purpose of this quality account is to illustrate to our patients, their families and carers, staff, members of local communities and our health and social care partners, the quality of services we provide.

The report is published each year. We measure the quality of services we provide by looking at patient safety, the effectiveness of the care and treatment we provide and, importantly, the feedback we receive from our patients.

The year 2019/20 was disrupted due to the Covid-19 pandemic which made the preparation of this Quality Account challenging with contributors and editors having been re-deployed to assist with other clinical priorities. Similarly data collection and information for some areas may have been disrupted through the suspension and reduction of some services.

Part One of this report opens with a statement on quality from our Hospital Chief Executive Office Deborah Needham, Medical Director Mr Matt Metcalfe and Director of Nursing and Midwifery Ms Sheran Oke. We also outline some of our key successes from 2019/20 in maternity, nursing, quality improvement and cancer care, amongst others.

In Part Two, we have provided details of a number of Statements of Assurance regarding specific aspects of service provision. The Trust is required to provide these statements to meet the requirements of NHS Improvement.

Part Three describes how we performed against the quality priorities set for 2019/20, together with performance against key national priorities in line with NHS Improvement Risk Assessment Framework.

The closing section outlines feedback from our key stakeholders.

Thank you for taking the time to read our quality account. If you would like to comment on any aspect of this document, we would welcome your feedback. You can contact us at: pals@ngh.nhs.uk

Statement of quality

Dear All,

Welcome to the Quality Account of Northampton General Hospital NHS Trust (NGH) for 2019/20. We present updates on our progress against our quality priorities for the year in review alongside our priorities for the year ahead. Beyond these, we are delighted to share some of our key achievements during the year, the highlights of which we will touch upon here. These illustrate our commitment to providing the best possible care for patients which remains our overall aim. Our efforts and improvements are framed against our key values.

Patient safety above all else

- The trust has continued to progress well with our work on the deteriorating patient. After the successful trial and implementation of standards of care scores and a deteriorating patient care plan, work is now ongoing to roll this our electronically using our e-ward system.
- We continue to actively work on reducing patient harms
- The introduction of our Freedom to Speak Up campaign has been successful, with a larger than anticipated demand from our staff seeking to have confidential conversations with our Freedom to Speak Up Guardian.
- We have also actively engaged in the maternity modernisation agenda, with the implementation of a care bundle to reduce stillbirths, better management of socially deprived mothers in the community and the completion of all 10 key actions set out to improve maternity care nationally.

We aspire to excellence

- The trust is the first UK hospital to achieve accreditation as a Pathway to Excellence® hospital by the American Nurses Credentialing Centre (ANCC).
- We have seen continued progress with our wards Nursing Assessment and Accreditation programme with increasing numbers of wards achieving the much valued 'Best Possible Care' status. This programme is designed to drive improvements in core quality standards and to motivate the clinical workforce to be proud of

these achievements. During the year we have further extended the standards into outpatient areas and plan in 20/21 to roll out across the Maternity department.

- The trust continues progress on the pathway towards university teaching hospital status with the medical college at the University of Leicester.
- Likewise collaboration with the University of Northampton continues at pace, with the commencement of a Master's Degree in Quality Improvement and Patient Safety (QIPS) in September 2019. This degree programme is delivered by NGH staff, with accreditation from the University of Northampton. It has been acknowledged by the Care Quality Commission (CQC) as an area of "Outstanding" practice within the hospital. Offered to health and social care professionals; graduates of this MSc will be the leaders of tomorrow, equipped with the skillset and knowledge to lead and deliver the complex change the National Health Service (NHS) will be required to deliver.

We reflect, we learn, we improve

- NGH has fully committed to the Get It Right First Time (GIRFT) programme and is in the process of a Trust wide submission plan, with 17 specialties already awaiting final recommendations; stage 4 of a 5 step process. To oversee the implementation and delivery of GIRFT, NGH have appointed a senior Clinical Lead as Associate Medical Director for GIRFT.
- Preliminary data from one of our research studies on the care of children & young people during diabetes transition has shown a reduction in hospital admissions.
- We have seen a continued increase in our incident reporting rate, demonstrating a more positive reporting culture in the trust.
- All staff in the hospital are encouraged to attend QIPS teaching. We have seen almost 1,000 of our staff and students trained in the core concepts of Quality Improvement (QI) in 2019, an increase of more than 700 on the previous year.

We respect and support each other

- We have introduced the Supporting our Staff (SoS) initiative across the hospital. All staff have access to trained and highly-experienced debriefers to support them after traumatic clinical situations or

scenarios as well as any other stressful or difficulty situations (clinical and non-clinical)
- We have well-established programmes for professional and career development for al staff, delivered by our award winning Nursing and Midwifery Practice & Professional Development team and our QIPS and Organisational Development team.
- We continue to develop our staff recognition schemes including the internationally recognised Diseases Attacking the Immune System (DAISY) scheme which recognises and celebrate the compassionate care our nurses and midwives give with nominations coming from patients and families. We have used the same methodology to reward other staff groups for exceptional care through our Everyday Heroes awards.
- We remain a key partner in the Cavell Nurses' Trust membership programme which provides support for UK nurses, midwives and healthcare assistance when suffering a range of distressing circumstances.

Despite our commitment to Best Possible Care and the values that drive this we know there is more to do on many fronts. The challenging environment provided by increasing emergency pressures has stretched our staff and resources and unfortunately we were not able to provide emergency care as quickly as we would like and we continue to focus on this during 2020/21. There has also been an impact on waiting times in other areas and again we are determined to improve this and improve the experience of cancer patients some of whom who wait too long to commence their treatment. We also know that we have more work to do to improve the experience of our patients and our staff.

Looking forward to 2020/21 and after wide consultation with staff and stakeholders we have developed Quality Priorities that we hope will address some of our key issues. Some of these will be extended from previous work and some will be new. These include:

Patient Safety above all else
- Improving the safe management of patients out of hours
- Full implementation of the standards of care scores to reduce levels of harm in deteriorating patients
- Reduce falls, clostridium difficile and pressure ulcer rates
- Better outcomes in Maternity, including a reduction in stillbirths, neonatal death and brain injuries

We Aspire to Excellence

- Improvement in seven day services
- Improve patient experience and communication between our staff and patients
- Improved dementia care
- Reduction in cancelled operations
- Reduction in cancelled or rescheduled outpatient appointments

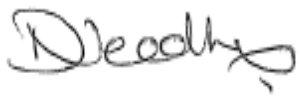
We reflect we learn we improve

- Comprehensive programme of mortality reduction through reviewing deaths
- Introduction of Freedom to Speak Up champions across the organisation to continue with an improved reporting culture
- Better outcomes for the wider health economy through the Making Every Contact Count (MECC) initiative to reduce smoking and alcohol dependency rates in Northamptonshire.

We respect and Support each other

- Reducing medical vacancies
- Reducing nursing and midwifery vacancies
- Increased focus on staff health and wellbeing
- Improved staff recommendation rates

We hope this quality account provides a clear picture of the importance of quality and patient safety at Northampton General Hospital and that you find it informative. To the best of our knowledge we confirm that the information provided in our Quality Account is accurate.



Deborah Needham
NGH Chief Executive

Mr Matthew Metcalfe
Medical Director

Sheran Oke
Director of Nursing & Midwifery

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 they have complied with the above requirements in preparing the Quality Report.

By order of the board.

Deborah Needham
NGH Chief Executive

Alan Burns
Chairman

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PART ONE

Our successes

1.1 Maternity

NGH only maternity service in the East Midlands to meet all 10 safety actions for CNST incentive

The Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme was launched by NHS Resolution in 2018 to incentivise Trust Boards to fund safety initiatives in support of the Government's ambition. 10 maternity safety actions were agreed by the National Maternity Champions and Trusts that were able to demonstrate the required progress against all of the following 10 actions were awarded a Maternity Incentive Scheme payment.

NGH was the only maternity service in the East Midlands who were successful in demonstrating compliance against all 10 maternity safety actions in the first year, and successfully demonstrated compliance in the second year.

The CQC identified the attainment of the 10 standards as an example of "Outstanding" practice in the Trust.

Better Births

Better Births, the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women and their midwives.

Following a number of staff engagement sessions and in conjunction with the

Local Maternity Services Board (LMS), the following continuity models were implemented in November 2019;

- Sapphire Team – case loading team caring for women based at a General Practitioner (GP) surgery within a high Black Asian and minority ethnic (BAME) community with high levels of social deprivation.
- Emerald Team – case loading team also based at a GP surgery within a community with high levels of social deprivation, but also care for families who have suffered the loss of a baby.

1.2 Quality Improvement

MSc Quality Improvement & Patient Safety

MSc Quality Improvement & Patient Safety

Distance Learning option
PG Cert (1 year) and PG Dip (2 year) available
Standalone modules available

Course Highlights

- Only MSc in the UK that is delivered completely on-site in an acute setting
- Work-based dissertation (extended QI project)
- Health-related degree ideal for personal and professional development & career progression

Delivered by
NHS Northampton General Hospital NHS Trust

Working in partnership with
University of Northampton

For more information contact qi@ngh.nhs.uk

MSc Quality Improvement & Patient Safety
Programme Specification

Course Mission Statement
The course is aimed at health and social care professionals who wish to develop a greater understanding and expertise in quality improvement and patient safety with strong emphasis on practical application. Each module will offer a flexible mix of taught elements and project-based learning in their practice, further supported by online learning resources.

Course Modules

Year	Title	Credits	Qualification
1	Fundamentals of Quality Improvement	20	Year 1 PG Cert
	Improvement Methodology	20	
	Measurement and Analysis of Quality Improvement	20	
2	Enhancing Patient Experience with Quality Improvement	10	Years 1 & 2 PG Dip
	Leading and Implementing Change within QI	20	
	Educating for Quality Improvement	20	
	Innovation in Quality Improvement	10	
3	Dissertation—Extended QI Project	60	Years 1, 2 & 3 MSc

Assessment Methods
Students will be assessed through presentations, written assignments, case study presentations, oral vivas and portfolios. MSc students will also be required to design, implement and report on an extended Quality Improvement project as part of their dissertation.

Duration
3 years part-time

Start Date
September

Campus
Northampton General Hospital NHS Trust

Fees
£3150 per annum

Entry Requirements
Students must be employed within a health and social care related environment and have:

- Evidence of achievement of an appropriate healthcare or data related Bachelor's degree with honours.

OR

- Students who do not have a relevant Bachelor's degree must satisfy the University that by virtue of their professional standing, qualification and/or training that they are fit to register for, and to benefit from, their proposed programme of study.

For more information or to make an application
Contact: qi@ngh.nhs.uk

The first cohort of the MSc QIPS commenced in September 2019, marking a landmark achievement for a district general hospital. This is the only Master's degree in the country that is delivered on-site by an acute provider. NGH deliver the programme in partnership with the University of Northampton.

The degree programme is offered to health and social care professionals who wish to develop a greater understanding and expertise in QIPS.

The programme is offered on a part time basis over a three year period. Our principle is that a strong understanding of QI and its application in healthcare is a fundamental requirement for any current or future leader in the modern NHS. Graduates of the degree will be established international experts in healthcare improvement, with the skillset and knowledge to deliver highly complex change.

The next cohort of the degree will commence in September 2020, with a planned admission of 20 further students.

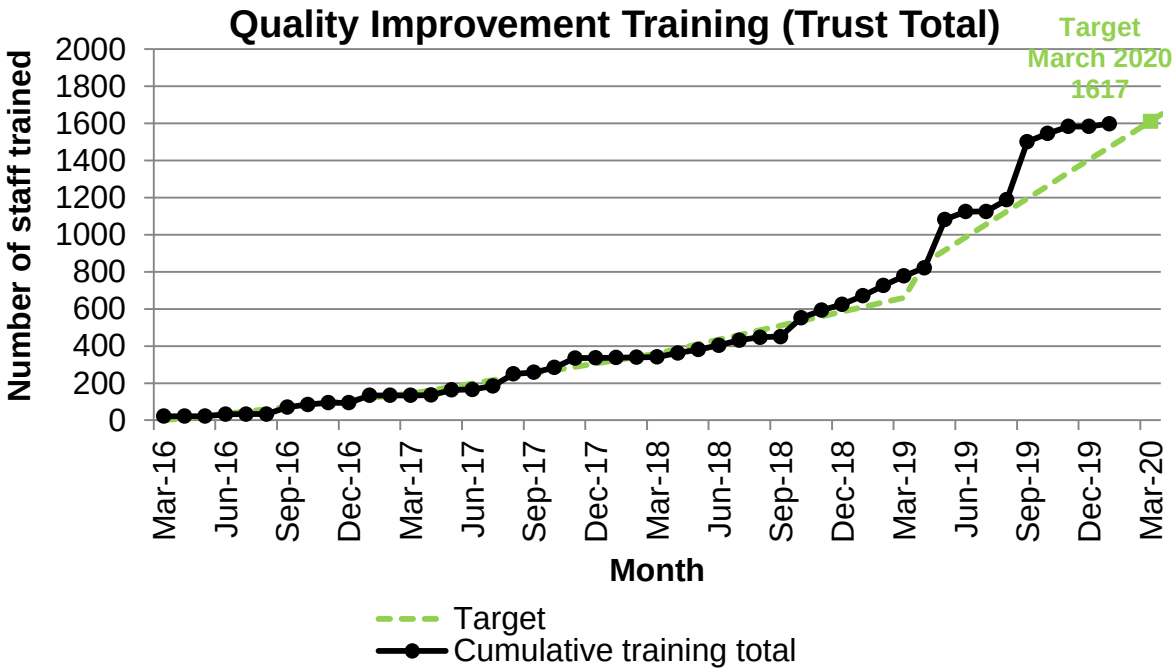
The CQC identified the degree as an example of Outstanding practice in the Trust.

Quality Improvement and Patient Safety Programmes

QIPS
EVERY PERSON
EVERY TIME

Our mantra is that all staff in NGH have two jobs; to deliver care and improve care. Staff have access to a variety of different quality improvement training programmes ranging from a one hour introduction to a five day advanced quality and service improvement programme.

In 2019 we taught 958 staff the fundamental concepts of quality improvement. This is a significant increase on 2018; when we taught 289 staff. This supports our QIPS education aim; to train an additional 2500 staff over a 3 year period between April 2019 and March 2022.



In addition to the quality improvement sessions delivered in NGH, the QIPS team also deliver a variety of academic and professional programmes to staff and students. These include:

- Advanced Clinical Leadership & Management Programme
  In 2019/20 we commenced with our first multidisciplinary advanced leadership programme; the programme was previously only offered to Specialty Registrars. This 10 week programme aims to improve leadership capability and capacity for our leaders of tomorrow. There were 45 participants in the most recent programme, a 50 % increase in numbers from the 2018/19 programme.
- Fundamental Clinical Leadership & Management Programme
  Due to the demand for clinical leadership programme, the QIPS team developed a new programme aimed at more junior staff. This commenced in 2020.
- Junior Doctors' Safety Board
  Incorporated within the foundation programme for FY1 and FY2 doctors, this covers the broader concepts of safety and quality improvement including risk management, clinical incident investigation, human factors, effective leadership and change management. Junior Doctors are supported with the delivery of a QI project as part of this programme.

- Patient Safety Curriculum (Leicester Medical School)
  The QIPS team lead and support the delivery of the Patient Safety Curriculum for all medical students at Leicester Medical School. This curriculum covers professionalism, teamwork, patient safety, human factors, quality improvement and change management.
- Student Selected Components (SSC) (Leicester Medical School)
  Students have the opportunity to study an elective module on QI and Patient Safety on-site in NGH. The *Aspiring to Excellence* SSC is offered to all 5th year students for 3 weeks and the *Creating Excellence* SSC is offered to all 3rd year students for 4 weeks.
- Quality Improvement modules on other development programmes
  - Esther White (delivered by Organisational Development)
  - James Stonhouse (delivered by Organisational Development)
  - Stroke Journey (delivered by the Community Stroke team)
  - RCN Leadership Programme for Nurses and Midwives (facilitated by Practice Development)
  - Band 5 Nursing Programme (delivered by Practice Development)

1.3 Shared Decision Making

Shared Decision Making (SDM) or shared governance is a process that empowers staff and all members of the healthcare workforce to have a voice to enable small and large tests of change to enhance patient care and improve staff wellbeing.

The principles are:

Responsibility – Staff are given the responsibility to lead and manage the process of change based on data from Nursing & Midwifery staff and patients. This will enable staff to contribute to the Trust's vision and objectives at local level.

Authority – Staff are given the authority to make decisions and create change this is recognised and supported throughout the Trust.

Accountability – Staff are accountable for delivering patient care, developing the profession and initiating change.

Equity – Staff have an equal voice and no role is more important than another.

At NGH we use a councillor model; representatives from each SDM Council have dedicated time each month to discuss department and trust wide issues that affect patient care, safety and the environment. The SDM councils started in 2017 with six pilot councils and has grown across the Trust.

The Research and Evidence Based Practice SDM Council was set up using the principles of shared governance and is designed to give front line staff an opportunity to engage in Research and Evidence Based Practice. The council encourages staff to partake in research networks and also, to apply for competitively funded training opportunities. The group has set up a journal club within the Trust from its quarterly meetings. From the group three members have secured competitively funded training opportunities all of which have resulted in projects which have directly benefitted patients and frontline staff.

The SAGE & THYME® foundation level workshop teaches clinical and non-clinical staff of all levels, evidenced based communication skills to provide person-centred support to someone with emotional concerns.

The programme was originally developed to meet level 1 skills requirement described in the 2004 The National Institute for Health and Care Excellence (NICE) guidance 'Improving Supportive and Palliative Care for Adults with Cancer' although the principles are generic. We saw this as an opportunity to enhance our staff's skills further. The workshop reminds staff how to listen and how to respond in a way which empowers the patient. It discourages staff from 'fixing' and demonstrates how to work with the patient's own ideas first. The training is based on research findings on effective communication skills.

Other projects and initiatives from 2019-2020 include:

- Breast feeding room on Gossett
- Garden play area on Paddington
- Garden of Maternity

1.4 Assessment and Accreditation

The Best Possible Care Ward Assessment and Accreditation framework aligns with the Trust's vision and values, the 6 C's practice values and The Chief Inspector of Hospital's Key Lines of Enquiry. Wards and outpatient departments are assessed against 15 standards that describe essential elements of safe, high quality nursing care. Each standard is subdivided into elements of Environment, Care and Leadership. The assessments, undertaken by the Quality Assurance Matron, are unannounced.

Results and the subsequent report are discussed with Wards Sister/ Charge Nurse by the Quality Assurance Matron. A Ward Improvement Plan and any necessary support from Matrons, the OD team, Practice Development Team or buddies are put in place. Reassessment frequency is dependent on the overall assessment grading. A ward that achieves three consecutive green ratings will be recommended to attend a stakeholder Panel for Best Possible Care Ward status.

The Trust currently has 7 'best possible care' wards, and 1 triple green ward. There are 15 green wards and 7 green outpatient areas.

1.5 DAISY Award

The DAISY Award was introduced to honour and recognise the work nurses do for patients and families every day. The DAISY Foundation was established in 1999 in the USA in memory of J. Patrick Barnes who died aged 33yrs from complications of Idiopathic Thrombocytopenic Purpura. The DAISY award provides on-going recognition of the clinical skill and especially the compassion nurses/midwives provide to patients and families all year long.

Since we launched DAISY at NGH in 2017 we have had 30 honourees and over 300 nominations. In 2019 we celebrated our second annual Team award, awarded 3 student awards and had our first DAISY leader award, which was nominated by either the patients/ families or staff.

1.6 Falls, Infection, Tissue Viabilty (FIT) Council Improvements:
The FIT Council commenced the trust wide Wound Collaborative in September 2019 sharing learning and knowledge from across the Trust to improve wound care knowledge and processes.

The FIT Council have successfully implemented the F.I.T Fellowship in October 2019, a pathway for frontline nurses to spend a year working with the three specialities to develop their knowledge in these specialities and also their leadership skills. This role is the first of its kind in the country and is being presented by the F.I.T. team at the Pathway to Excellence Conference in Florida in May 2020.

The Trust has reached within trajectory targets set by NHS England with 0 patients acquiring a Methicillin-Resistant Staphylococcus Aureusis (MRSA) bacteraemia and 14 patients developing Clostridioides difficile (C.Diff) in 2018/2019.

Our falls rates within NGH continue to be consistently below the national average per 1000 bed days for the total number of inpatient falls. The first collaborative falls prevention county wide conference was ran by NGH, Kettering General Hospital NHS Foundation Trust (KGH) and Northamptonshire Healthcare NHS Foundation Trust (NHFT) to promote falls prevention and best practice for patients. Within the Trust the Falls Multidisciplinary Working Group continue to review learning and implement new ideas to improve patient safety.

The NHSE&I Pressure Ulcer collaborative continues. Project work has commenced focusing on specific areas (one of which will be the number of heel related tissue damage).

The second collaborative was held with our colleagues from KGH, NHFT and Three Shires on the 26th November, it was a hugely successful day with a large attendance.

1.7 Pathway to Excellence®

Pathway to Excellence® is an international nursing accreditation system that acknowledges hospitals that put their nursing workforce at the forefront. This system understands that in order to deliver excellence in patient care you must first have a workforce that is enabled to deliver that. The American Nurses Credentialing Center (ANCC) is the body who govern the process and have 6 standards that embody their values.

We have become the first hospital in the UK to receive the Pathway® designated status. We have been internationally recognised as somewhere that supports and develops nurses and the teams around them to provide excellent care. To attain Pathway® designation evidence is submitted against the six standards – SDM, Leadership, Safety, Quality, Wellbeing and Professional Development following acceptance of that evidence all registered staff are sent a survey to confirm the standards are in place. 81% of our registered nurses responded and 26/28 questions were responded to as strongly agree or agree – confirming that NGH is an organisation that recognises its staff and provides a positive practice environment.

1.8 Supporting our Staff (SOS) initiative

SOS is a team of individuals who are committed to supporting all of our staff at NGH after any incident that has been particularly upsetting to them.

They offer a confidential ear for people to discuss their thoughts of the event in a safe environment. The team have been trained to monitor for signs of traumatic stress and are able to signpost to appropriate services if needed. For most people further signposting is not necessary but the initial conversation and follow up have been very positively received.

Most people tend to think of clinical events as a potential reason for referral but really it is anything that has impacted on you personally. This may have been a particularly challenging clinical scenario or error or may be some kind of abuse. If you are not sure get in touch with the SoS team and we can discuss together what the appropriate course of action is.

No member of NGH staff should struggle alone; if something has happened and a staff member is struggling there is a dedicated email for them to use to contact someone.

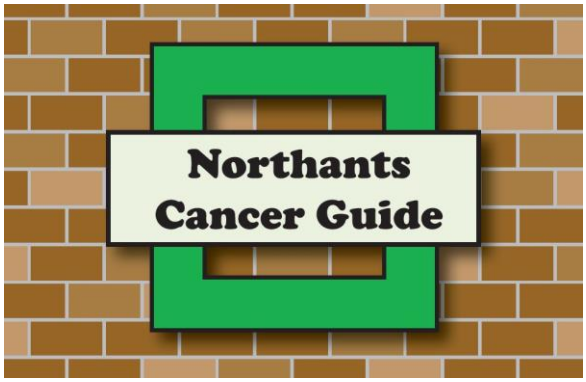
1.9 Launch of new Cancer Directory by Macmillan

WE ARE MACMILLAN. CANCER SUPPORT NHS

Working with Northampton General Hospital and Kettering General Hospital

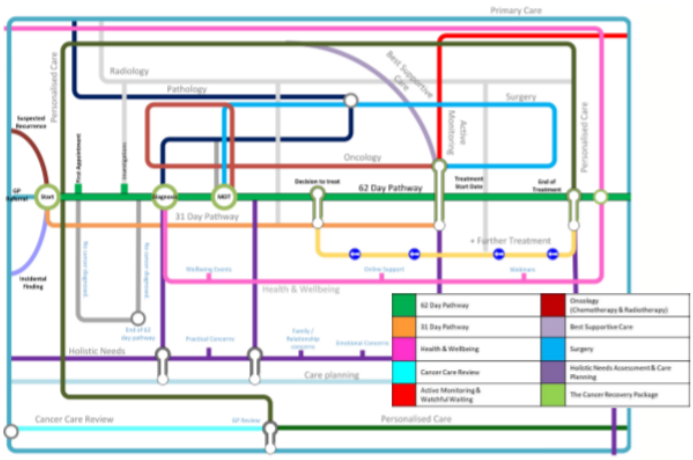
The Macmillan cancer recovery package team was set up at our hospital in April 2018, with a goal to improve the lives of those living with cancer in the county. First introduced by the National Cancer Survivorship Initiative in 2013, the Macmillan cancer recovery package aims to assist people living with a diagnosis of cancer to prepare for the future, identifying their individual concerns and support needs. The aim is to provide the support people need so they can return to as near a normal lifestyle as possible, including returning to work.

Research has shown that in order to help people self-manage their health and wellbeing during and beyond treatment they wanted easily accessible information from the time of diagnosis. The Macmillan team based in NGH have developed a new online service to help patients self-manage their health and wellbeing. It includes a directory of services with links to organisations to help with both practical and emotional concerns, together with a visual map of the cancer pathway to explain the process from referral through to treatment and follow-up.



It can be accessed at – www.northantscancerguide.co.uk

Having completed peer review on the content and sought views from our patient feedback group, the designs have been further developed by the communications and web development teams at NGH. The portal went live in February 2020.



The Cancer Pathway

www.northantscancerguide.co.uk features a map of the cancer pathway. This has been designed to help you navigate your way through your treatment. We understand it can be a daunting time for you and your loved ones and this guide will help to explain the entire process from first appointment through to diagnosis and treatment.

If you have specific queries related to your treatment you should always contact your clinical nurse specialist (CNS) in the first instance.

Overview of Services

www.northantscancerguide.co.uk contains information about different departments within the trusts, including radiotherapy, chemotherapy and nuclear medicine.

You can find out more about the cancer information centre and the drop in services they offer, including a weekly drop in service with Citizens Advice where you can discuss any financial concerns.

You can book on to events such as face to face programmes and webinar sessions that provide lots of advice on your health and wellbeing.

Northants Cancer Guide

Patient Directory

Our patient directory can be found at www.northantscancerguide.co.uk under 'Local Cancer Services'

Here you can access information on local and national support groups and other services. The directory is divided into a number of categories in order to help you find what you need.

This quality improvement project has been accepted for poster presentation at the world's largest healthcare improvement conference – the International Forum on Quality & Safety in Healthcare. The Macmillan team will be presenting and sharing their work on an international platform to more than 3,000 delegates in April 2020.

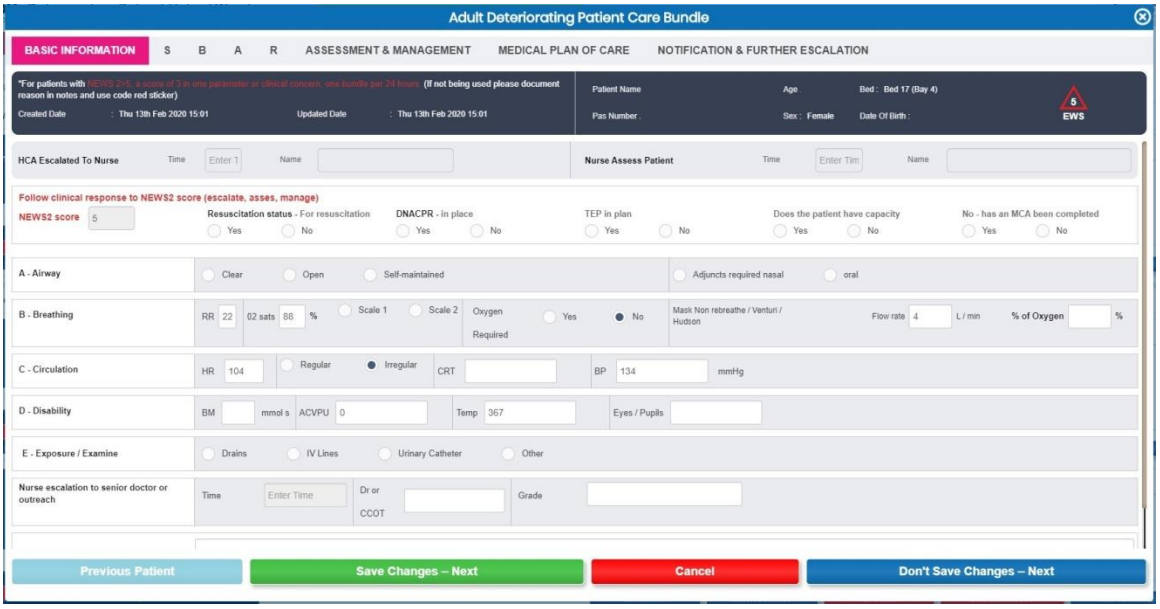
1.10 Progress on our work with the Deteriorating Patient

The successful introduction and implementation of the Deteriorating Patient (DP) care plan in 2018/2019 was measured by the development of Standard of Care (SoC) scores for our acutely unwell patients. Several elements of essential escalation and assessment/treatment of the deteriorating patient are measured through audit and points allocated if those have not been effectively met. The goal is obviously for all of these to be achieved, which means a SoC score of zero, or that "zero harm care" has been delivered to the patient.

Since late last year the team has continued to build on this by incorporating the DP care plan into iBox. iBox is an IT system which has replaced the wards' white boards and provides an interactive view of the

patients in specific areas with up to date information being pulled through from other systems such as CaMIS, ICE and Vitalpac. Using iBox to house the DP care plan will allow real-time audit of the SoC scores enabling the team to identify any areas requiring further training and development as soon as these occur.

A DP virtual ward has also been created which will enable the Critical Care Outreach Team (CCOT) to have an overview of all deteriorating patients across the hospital and monitor/review them as appropriate.



1.11 Improving the transition of care from paediatrics to adults

Diabetes Transition is the process of moving from the Children and Young Persons (CC&YP) diabetes services to the adult diabetes service. This process starts around the age of 16 years (it is talked about as a future event from about 13 years of age) with the transfer to adult services usually happening by the young person's 18th birthday. Most young people with Type 1 Diabetes are diagnosed in childhood, meaning they get to know their paediatric teams extremely well. Therefore the suggestion of moving to another service is equivalent to moving away from cherished family to many young people. The transition process is well known to be a period of vulnerability with increased risk for interruption of care and adverse health outcomes. Poor transition has been associated with higher risks for acute and chronic diabetes related complications. It is essential for the young person to engage in transition and young adult services in order to achieve positive outcomes.

The transition study is looking at whether the use of a structured diabetes transition programme, in the care of young people transitioning from the paediatric to the adult service at the NGH, reduces the number of hospital related episodes and increases attendance at the adult diabetes clinic following transition to the adult service. This structured programme is being delivered by a dedicated transition nurse. This role takes over the diabetes nursing responsibility for young people around their 16th birthday. They guide them through the structured transition programme including being part of the Multi-Disciplinary Team (MDT) during clinic visits to both the paediatric and the adult teams, maintaining contact with the participants by phone/text/email, facilitating support for insulin management, sending reminders for clinic appointments, rescheduling "not attended" clinic appointments quickly, referring to other services as necessary, proving educational materials and providing information on the differences in the structure of adult and paediatric diabetes care. They follow the young people through to the adult clinic and continue to be their diabetes nurse for one year after transition to the adult clinic.

The diabetes cooking event for the patient group and a patient-designed collage about diabetes created by the group

This is an ongoing research project; historical data will be compared with the current ongoing data collection to determine if the transition role has reduced diabetic ketoacidosis admissions at NGH and increased attendance at the young adult clinic. There are currently 46 young people on the transition nurse's caseload with about half in the young adult service under the care of adult diabetes consultants. Ongoing data collection has demonstrated an initial reduction in number of hospital admissions in the patient group.

1.12 Patient Experience

This year we have used our own bespoke patient experience survey based on the national Inpatient & Emergency Department (ED) surveys (alongside the Friends and Family Test (FFT)). The Trust receives feedback each quarter all the way to ward level. This enables a more targeted approach for improvement. For the 2018 national inpatient survey, the trust achieved its lowest number of questions within the 'Worse' than the national average category since 2013. This is an excellent achievement given the increase in pressure seen within all organisations.

We have also established a Right Time Forum to bring together different members of staff to discuss the results from the right time survey. This group is an opportunity for staff to ask questions about the results, look at best practice examples and identify any projects to take forward. There have been many pieces of work undertaken to improve patient experience within the divisions, some examples include:

- Visiting times have been changed so that there is more flexibility for patients' carers, relatives and friends. This has been well received by patients and provides more time throughout the day for discussions with clinicians, as well as easing some of the pressures of car parking.
- The ED implemented A 'Majors Light' process where the patients that would wait longer due to being lower acuity, were now being seen quickly and directed to appropriate services away from the ED.
- The pharmacy department have focussed on patients understanding of medication and have introduced a number of new initiatives to improve this. This includes the introduction of ward based pharmacists within certain wards and an analgesia box within ED to improve response to pain relief.

A cohort of Patient Experience Champions has been recruited. To date, 25 members of team NGH have signed up to become a champion; this includes ward clerks, specialist nurses, healthcare assistants, Northamptonshire carers, discharge coordinators and many more. They are required to attend a quarterly meeting where they will receive information on patient experience within the trust. They are expected to

share this information with their areas and identify small projects they can work on. They have carried out a number of small projects throughout the year, including:

- Creating discharge information boards for patients, these are now live on Walter Tull and Knightley wards
- Installing a patient feedback station within Radiology, displaying results and giving patients an opportunity to provide feedback
- Undertaking a review of finger food boxes for dementia patients (Collingtree ward)
- Creating bespoke bedside information leaflets for patients, including information specific to the ward such as 'Fry-up-Friday' (Talbot Butler ward)

The hospital has been shortlisted for two Patient Experience Network National Awards; the ceremony was due to be held in March 2020.

2

PART TWO

Statements of Assurance from the Board

2.1 Review of our services

During 2019-20, Northampton General Hospital NHS Trust provided and/ or subcontracted NHS services with 10 relevant Health service providers.

During 2019-20, Northampton General Hospital NHS Trust held two key contracts with NHS commissioners to provide services.

- The Trust's lead commissioner is NHS Nene Clinical Commissioning Group (CCG) who also commissions on behalf of NHS Corby CCG, NHS Milton Keynes CCG, NHS Bedfordshire CCG, NHS Leicester City CCG, NHS East Leicester and Rutland CCG and NHS West Leicester CCG. This contract constitutes a range of acute hospital services including elective, non-elective, day case and outpatients.
- The Trust holds a contract with NHS England for Prescribed Specialised Services.

The Trust also provides a variety of services to other NHS organisations, public sector organisations and private sector companies. Key contracts are held with:

- Alliance Medical Limited
- Backlogs Ltd
- Blatchford Group
- Boots UK Ltd
- KGH
- NHFT

The Northampton General Hospital NHS Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services represents 92% per cent of the total income generated by the Northampton General Hospital NHS Trust for 2019/20

2.2 Participation in National clinical audits

NGH is committed to providing Best Possible Care in all its services and endorses participation in clinical audit as part of consistently monitoring, maintaining and improving what we do.

During 2019/20 we were fully involved in 69 / 72 National Clinical Audits and Enquiries that covered the services we provide. The three we haven't are for services not currently provided by NGH.

The table below lists those national quality improvement projects which NHSE&I advises all Trusts to prioritise for participation and inclusion in their Quality Accounts for 2019/20.

MEDICINE DIVISION		
Name of Audit	**Participated Y/N**	**Extent of Participation**
Major Trauma (TARN)	Y	Continuous data collection
Society of Acute Medicine Benchmarking Audit	Y	100%
Assessing Cognitive Impairment in older people - Care in Emergency Departments (RCEM)	Y	100%
Care of children in Emergency Departments (RCEM)	Y	100%
Mental Health Care in Emergency Departments (RCEM)	Y	100%
COPD Pulmonary rehabilitation (NACAP)	Y	Continuous data collection
COPD secondary care (NACAP)	Y	Continuous data collection
National Asthma audit (NACAP)	Y	Continuous data collection
National Lung Cancer Audit	Y	Continuous data collection
National Heart Failure Audit	Y	Continuous data collection
Acute Myocardial Infarction and other ACS	Y	Continuous data collection
Cardiac Rhythm Management	Y	Continuous data collection
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Y	Continuous data collection
National Audit of Cardiac Rehabilitation	Y	Continuous data collection

IBD Registry - Adults	Y	Continuous data collection
Stroke National Audit Programme	Y	Continuous data collection
Falls and Fragility Fractures Programme	Y	Continuous data collection
UK Parkinson's Audit	Y	100%
Diabetes Core Audit	Y	Continuous data collection
Diabetes Inpatient - HARMS	Y	Continuous data collection
Diabetes Inpatient - NADIA	Y	100%
Diabetes Foot care	Y	Continuous data collection
Diabetes Transition Audit	Y	Continuous data collection
National Audit of Dementia (In General Hospitals)	Y	100%
Rheumatoid and Early Inflammatory Arthritis	Y	Continuous data collection
National Audit of Seizure Management	Y	100%

SURGICAL DIVISION		
Name of Audit	**Participated Y/N**	**Percentage Participation**
Adult Critical Care - Case Mix Programme (ICNARC)	Y	Continuous data collection
National Emergency Laparotomy Audit (NELA)	Y	Continuous data collection
National Joint Registry (Hip, knee, ankle, elbow and shoulder primary and revision procedures)	Y	Continuous data collection
Elective Surgery (National PROMS Programme)	Y	Continuous data collection
National Vascular Registry (NVR)	Y	Continuous data collection
National Bowel Cancer Audit (NBOCA)	Y	Continuous data collection

National Oesophago-gastric Audit Cancer (NOGCA)	Y	Continuous data collection
National Prostate Cancer Audit	Y	Continuous data collection
Breast Cancer in Older Patients	Y	Continuous data collection
Falls and Fragility Fracture Programme - National Hip Fracture Database (NHFD)	Y	Continuous data collection
National Ophthalmology Audit (Cataract surgery)	Y	Continuous data collection
Nephrectomy Audit (BAUS)	Y	Continuous data collection
Percutaneous Nephrolithotomy (BAUS)	Y	Continuous data collection
Cystectomy & Radical Prostatectomy	N	Service not provided
UK Registry of Endocrine and Thyroid Surgery	Y	Continuous data collection
Perioperative Quality Improvement Programme (PQIP)	Y	Continuous data collection
Head and Neck Audit (HANA) Data collected but project stopped July 2019	Y	Continuous data collection

WCOHCS DIVISION		
Name of Audit	**Participated Y/N**	**Percentage Participation**
Female Stress Urinary Incontinence (BAUS)	Y	Continuous data collection
Perinatal Mortality Surveillance (MBRRACE)	Y	Continuous data collection
National Maternity and Perinatal Audit (NMPA)	Y	Continuous data collection
National Neonatal Audit Programme	Y	Continuous data collection
Paediatric Asthma (NACAP)	Y	Continuous from June'19
Paediatric Diabetes (NPDA)	Y	Continuous data collection

National Care at the End of Life (NACEL)	Y	June – October'19 - 100%
UK Cystic Fibrosis Registry	Y	Continuous data collection
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Y	Snapshot to April '19 – 100%
IBD Registry - Paediatrics	Y	Continuous data collection

CSS DIVISION and Trust wide		
Name of Audit	**Participated Y/N**	**Percentage Participation**
Serious Hazards of Transfusion (SHOT):	Y	Continuous Data collection.
Surgical Site Infection Surveillance Service	Y	Continuous Data collection.
National Cardiac Arrest (ICNARC)	Y	Continuous Data collection.
Fracture Liaison Service Database	N	No service at NGH
Learning Disability Mortality review	Y	Continuous Data collection
Seven day hospital services survey	Y	100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Y	Continuous Data collection

National Confidential Enquiries - NCEPOD		
Name of Audit	**Participated Y/N**	**Percentage Participation**
Pulmonary Embolism	Y	100%
Long term ventilation in under 25 year	Y	100%
Bowel Obstruction	Y	100%
Young People's Mental Health	Y	100%
Out of Hospital Cardiac Arrest	Y	100%
Dysphagia in Parkinson's Disease	Y	100%

The Provider is a member of the following Screening Programmes	
East Midland Children's Cancer Network	Breast Screening Programme
Haemoglobinopathy Clinical Network	Downs Syndrome Screening Programme
Thalassaemia and Sickle Cell Antenatal	New Born Hearing Screening Programme
GOSH led Congenital Heart Disease Network	Bowel Cancer Screening Programme
East Midlands Children's and Young People Cancer Network	Central New-born Network for Neonatology (East Midlands New-born Network)
Cervical Cancer Screening Programme	Blood Grouping & Antibody Testing in Pregnancy
The East Midlands Critical Care Network	Retinal Screening Programme
East Midlands Cardiac & Stroke Network	Cervical Cytology Screening Programme
East Midlands Cancer Network	Thalassaemia & Sickle Cell Screening Programme
Leicestershire Northamptonshire Rutland Cancer Network - EM Cancer Network	Infectious Diseases in Pregnancy Screening Programme
Leicester Renal Network	Chlamydia Screening Programme
TARN	Foetal Anomaly Screening
East Midlands Major Trauma Network	New Born Blood Spot Screening
Midlands Critical Care and Trauma Network	New Born and Infant Physical Examination
Midlands Critical Care & Trauma Network	Diabetic Retinopathy
NHS Digital	Abdominal Aorta Aneurysm Screening

2.3 Participation in clinical research

NGH is a research-active hospital which is striving to support the vision of providing the "Best Possible Care" and to meet its statutory duty for 'promoting research, innovation and the use of research evidence' (Health and Social Care Act, 2012). We are proud of our research history which is well established and embedded in the Trust with a history that stretches back to the 1980s.

Research is an integral part of our mission to constantly improve and be able to offer better care for patients. We see research as fundamental to everything we do which is embedded in the delivery of care.

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 our commitment to testing and offering the latest medical treatments and techniques to our patients.

Research and Development (R&D) falls within the Division of Clinical Support Services and is led by the Clinical Director of R&D, and managed by the Head of R&D. The Department is comprised of a generic team of 24 highly-qualified and dedicated Research Nurses, Research Physicians, Administrators and more recently, an Apprentice, delivering and supporting research activity across the Trust. NGH works in partnership with the East Midlands Clinical Research Network which provides the infrastructure that allows research to take place so that patients can benefit from new and better treatments.

The number of patients receiving NHS services provided by NGH that have been recruited to participate in research approved by a Research Ethics Committee for the period 01/04/2019 to 29/02/2020 is 613 patients into 37 commercial and non-commercial trials registered on the NIHR portfolio.

The R&D department actively promotes both non-externally funded and commercial research which will ultimately improve patient care and enhance our national profile as a high-performing district general hospital. As evidenced by the Department of Health (DH) Strategy 'Best Research

for Best Health', research is part of the core business of the NHS. The quality of care depends on research-based evidence, and anyone using the NHS can expect to be offered opportunities to take part in studies relevant to their needs.

We are constantly seeking to expand our portfolio of acute specialties and to provide services in the most clinically effective way. Our vision is to work with our partners at the leading edge of healthcare, realising the research potential in all areas of our hospital for the benefit of our patients and staff.

Our aspiration is that every clinical area will be engaged in high quality research and every patient and member of staff should have the opportunity to be part of a research study.

2.4 Accreditation schemes

The following services have undertaken the following accreditation schemes during 2019/20. Participation in these schemes demonstrates that staff members are actively engaged in quality improvement and take pride in the quality of care they deliver.

SCHEME	SERVICE	ACCREDITATION STATUS
MHRA – Regulatory Body	Blood Transfusion	Compliant – annual compliance report submitted
Baby friendly initiative	Obstetrics	Full
ISO9001:2015 for Chemotherapy, Radiotherapy & Radiotherapy Physics	Oncology & Haematology	Full
JACIE for HPC Transplant	Oncology & Haematology	Autologus and allogeneic Transplantation in Adult Patients, Collection of HPC, Apheresis, Cell Processing – Minimally Manipulated
HTA - Regulatory Body	Post Mortem Services	Compliant – Licence 12253
Clinical Pathology	Pathology	Blood Sciences,

Accreditation		Immunology, Microbiology
Clinical Pathology Accreditation – replaced by the international standard ISO15189 which is managed by UK Accreditation Service (UKAS)	Pathology	Blood Sciences (incorporates Biochemistry / Haematology / Blood Transfusion / Immunology), Microbiology, Cellular Pathology / Mortuary
Quality Assurance (QA) Screening Programmes	Pathology	• Haematology – Sickle cell and thalassaemia (SCT) screening programme • Microbiology – Infectious diseases in pregnancy screening – IDPS
QA Cancer Screening Programmes	Pathology	• Bowel Screening • Breast Screening • Cervical Screening

2.5 Commissioning for quality and innovation income

A proportion of the Trust's income in 2019/20 was conditional, based on achieving quality improvement and innovation goals. These goals were agreed between the Trust and the person or body who entered into a contract, agreement or arrangement for the provision of relevant health services, through the Commissioning for Quality and Innovation Income (CQUIN) payment framework.

The CQUINs, shown below, agreed with our commissioners contain milestones which must be met in order for the Trust to claim achievement.

SCHEME	
CCG 1: Antimicrobial Resistance	CCG 1a: Lower urinary tract infections in older people
	CCG 1b: Antibiotic prophylaxis in colorectal surgery

CCG 2: Staff Flu Vaccinations	
CCG 3: Alcohol and Tobacco	CCG 3a: Screening
	CCG 3b: Tobacco brief advice
	CCG 3c: Alcohol brief advice
CCG 7: Three high impact actions to prevent hospital falls	
CCG 11: Same Day Emergency Care (SDEC)	CCG 11a: Pulmonary embolus
	CCG 11b: Tachycardia with atrial fibrillation
	CCG 11c: Community acquired pneumonia
Medicines Optimisation	

Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/

Local Quality Requirements

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 CCG commissioners.
We provide assurance to our commissioners quarterly on local quality requirements by submitting evidence and demonstrating where we meet the requirements. These are named below with submissions being suspended due to the Covid-19 pandemic creating a pause in recording and reporting.

Goal	Threshold
LQR01.1	Patient Safety – Learning from Incidents
LQR01.2	Patient Safety - VTE
LQR01.3	Patient Safety – Falls
LQR01.4	Patient Safety – Mortality
LQR01.5	Patient Safety – Discharge Information

LQR01.6	Patient Safety – Outpatient Letters
LQR01.7	Patient Safety – Cancer Patients with a Long Waiting Time
LQR01.8	Patient Safety - Incidents
LQR01.9	Patient Safety – Nursing Metrics
LQR01.10	Patient Safety – WHO Checklist
LQR01.11	Patient Safety – NEWS2
LQR01.12	Patient Safety – Pressure Tissue Damage
LQR02.1	Patient Experience – End of Life
LQR02.2	Patient Experience – Learning Disabilities
LQR02.3	Patient Experience – Patient Experience
LQR02.4	Patient Experience – Complaints/PALs
LQR03.1	Clinical Effectiveness - Policies
LQR03.2	Clinical Effectiveness - NICE
LQR04.1-4.8	Safeguarding
LQR05.1-5.6	Collaborative Working
5.8	Subcontracted Services
LQRSepsis	Sepsis

2.6 Care Quality Commission (CQC)

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.

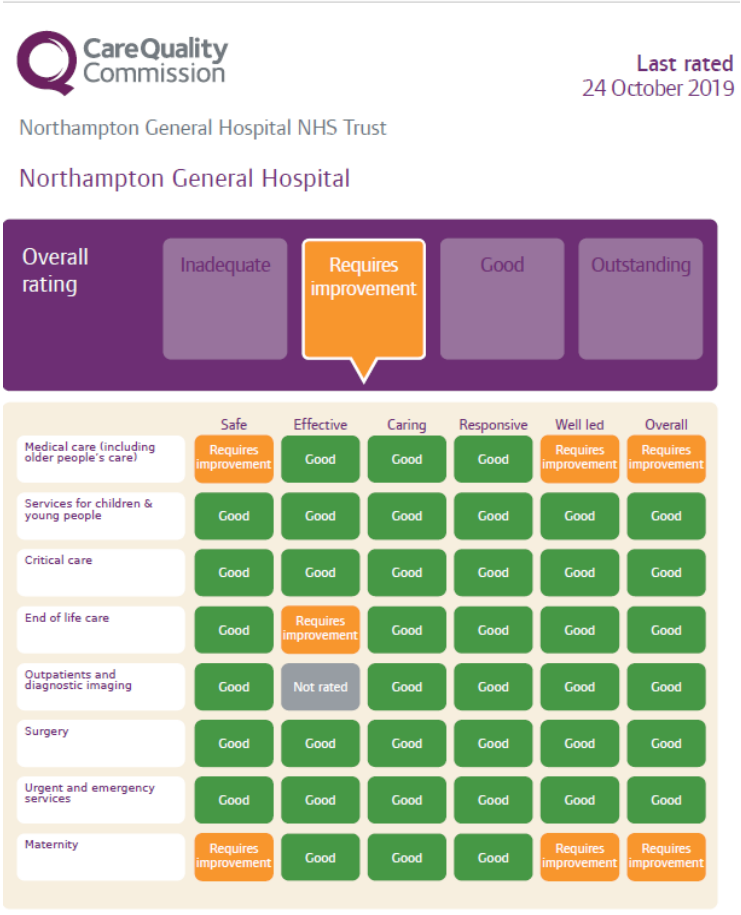
The Trust was inspected by both NHSE&I for a Use of Resources inspection (June 2019) and also by CQC for a Quality Inspection (June/ July 2019), this included a review of well-led at trust level. This was the first Use of resources inspection for the Trust. The CQC inspected the core services of Medical care (including older people's care), Urgent and Emergency services and Maternity. The Trust received a rating for each core service inspected, for well-led at trust level and an overall quality rating; this was combined with the rating for the Use of resources inspection to give an overall rating for the Trust. The rating changed from Good to Requires improvement for Medical care (including older people's

care) and Maternity. The rating for Urgent and emergency services remained as Good. Overall, the Trust was rated as requires improvement for Use of resources, Safe, and Well-led. The overall rating for the Trust has changed from Good to Requires improvement. The tables below show the ratings at core service level and the overall Trust position.

The final reports were published on 24th October 2019. Three reports were published:

- Provider report
- Evidence appendix (to support the provider report)
- Use of resources report

The reports are available on the CQC website and https://www.cqc.org.uk/provider/RNS/reports



	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care (including older people's care)	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Services for children & young people	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Maternity	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

The Trust was issued with three requirement notices by CQC. A requirement notice is issued when a service is found to be in breach of one of the fundamental standards of care; the standards below which care must never fall. These fundamental standards are linked to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Trust must be able to demonstrate it has taken action to address these breaches. If not, there is the potential for further enforcement action to be taken against the Trust (warning notice) or prosecution (with qualifications).

The summary detail of the three requirement notices is provided in the table below.

Core service	Regulation	Brief detail
Medical care (including older people's care)	Regulation 12 (2) (g): The proper and safe use of medicines	Staff not always ensuring the proper and safe management of medicines
Maternity	Regulation 12 (2) (g): The proper and safe use of medicines	Staff not always following systems and processes when prescribing, administering, recording and storing medicines
Maternity	Regulation 16 (2): Receiving and acting on complaints.	Information on how to make a complaint was not seen at the time of the inspection

A trust-wide Improvement Plan was developed by the executive team to address the 'must' and 'should' actions in the report. The Improvement Plan also links to relevant sections of the NHSE&I Undertakings actions where these mirror the 'must' do and 'should' do actions. The table below summaries the 'must' do and 'should' do actions. All 'must' do actions have been completed, with only should do actions remaining outstanding. The Improvement Plan is presented to Executive meetings and the Quality Governance Committee on a monthly basis. Bi-monthly updates are presented at Public Trust Board.

'Must' do/ 'Should' do	Quality or Use of resources report	Core service or Trust wide
3 'Must' do actions	Quality report	1 Medical care 2 Maternity
11 'Should' do actions	Quality report	Trust wide
4 'Should' do actions	Quality report	Urgent and Emergency Services
11 'Should' do actions	Quality report	Medical care (including older people's care)

3 'Should' do actions	Quality report	Maternity
7 'Should' do actions	Use of resources report	Trust wide

Whilst the reports raised many concerns, there were some areas of outstanding practice noted in the quality report. These were:

- The hospital was accredited by UNICEF UK as being a baby friendly hospital for the second time in March 2019
- NGH was the only maternity service in the East Midlands to successfully demonstrate compliance against all ten maternity safety actions set out by the clinical negligence scheme for trusts maternity incentive scheme, which was launched by NHS Resolution in 2018
- The trust was awarded international accreditation status of the Pathway to Excellence program from the ANCC. In November 2018, the trust became the first UK hospital to receive the award which recognises health care organisations that provide a positive practice environment for nurse and midwives
- The trust had collaborated with a local university to develop a three-year, part time masters level degree programme in quality improvement

2.7 Data security and protection toolkit attainment levels

The Data Security and Protection (DSP) Toolkit is an online tool that enables organisations to measure their performance against data security and information governance requirements which reflect legal rules and Department of Health policy.

All organisations that have access to NHS patient information must provide assurances that they are practicing good information governance and use the DSP Toolkit to evidence this by the publication of annual assessments.

The toolkit enables The Trust to measure their compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

Where partial or non-compliance is revealed, organisations must take appropriate measures, (e.g. assign responsibility, put in place policies, procedures, processes and guidance for staff), with the aim of making cultural changes and raising information governance standards through year on year improvements.

By assessing itself against the standard, and implementing actions to address shortcomings identified through the use of the toolkit, organisations will be able to reduce the risk of a data breach.

DSP Standards for health and care sets out the National Data Guardian's (NDG) data security standards. Providing evidence and judging whether the Trust meets the assertions, will demonstrate that the Trust is meeting the NDG standards. The NDG data security standards are;

1. Personal Confidential Data
2. Staff Responsibilities
3. Training
4. Managing Data Access
5. Process Reviews
6. Responding to Incidents
7. Continuity Planning
8. Unsupported Systems
9. IT Protection
10. Accountable Suppliers

DSP Toolkit Dashboard

There are 44 areas of focus called 'Assertions', each of these has questions requiring evidence that are either mandatory or optional. 40 of these are mandatory for the 31 March 2020 deadline.
There are currently 116 mandatory evidence requirements across the DSP toolkit. On the baseline assessment provided on the 31 October 2019 the Trust completed 64 of the Mandatory requirements.

There are 16 additional mandatory requirements in this 2020 toolkit, the majority of which are enhancements to cyber security. The Head of Data Quality Security and Protection has an integral role within the IT Team, which ensures a firm focus of Data Security and Protection and Cyber Security at the Trust.

The Trust's auditors (TIAA) completed the Trusts DSP Toolkit Audit in February 2020 which gave the Trust an overall assessment rating of reasonable. Three actions, 1 of which is urgent, have been identified, all of these actions will be taken forward together with internal measures to develop and improve with a plan in place to address as appropriate.

During 2018/19, the Chief Information Officer was appointed to the role of Senior Information Risk Owner and the Medical Director continued as our Caldicott Guardian.

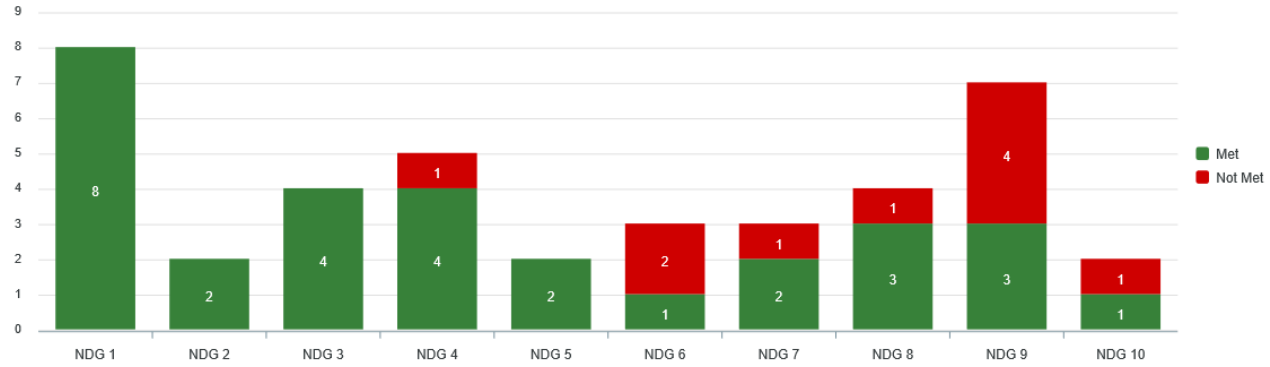
The Trust reported 13 Information Governance incidents to the Information Commissioner's Office in 2019 and has reported a further four incidents in 2020 (to July 2020)

Progress
Progress dashboard and reports
103 of 116 mandatory evidence items provided
28 of 44 assertions confirmed
Your assessment status (if you were to publish now)
Standards NOT Met

We recognise that the culture of the organisation needs to align with the need for good Information Governance and are making excellent progress for education and reporting. We continue to develop tools to ensure compliance, including the use of a Policy Management System which can enforce policies and training to relevant staff.

The Trust is also working towards Cyber Essentials Plus which is a UK government information assurance scheme operated by the National Cyber Security Centre (NCSC) that encourages organisations to adopt good practice in information security. It includes an assurance framework

and a simple set of security controls to protect information from threats coming from the internet.



2.8 Data quality

NGH have a dedicated team that focus on data quality to ensure that data meets high standards across the 7 domains of data:

1. Timeliness – determined by how the data is to be used/collected;
2. Consistent – Reliable and the same across all organisations and applications;
3. Currency – update to date and valid;
4. Definition – each data element should have clear meaning and acceptable values (via a data dictionary);
5. Granularity – attributes values should be defined at the correct level of detail;
6. Precision – data values or data output should be precise enough to support the process;
7. Relevant – data to be meaningful to the performance of the process;

The team work under the authority of the Head of Data Quality Security and Protection who ensures we address General Data Protection Rules (GDPR).

- Data Quality Audit.
- Data Quality Policy.
- Reference File Management.
- CDS/SUS generation and submission.
- Data Quality Kitemark (based around three core activities being performed and assessed by the auditors).

- Data Quality Alerting (Automated alerts that are generated to identify user error and system issues at source).
- Close collaboration with the Knowledge Improvement Team (to ensure frontline staff are trained appropriately).

We manage data to a strategic goal of building a single version of the Truth which is of quality to enable the Trust to be information led.

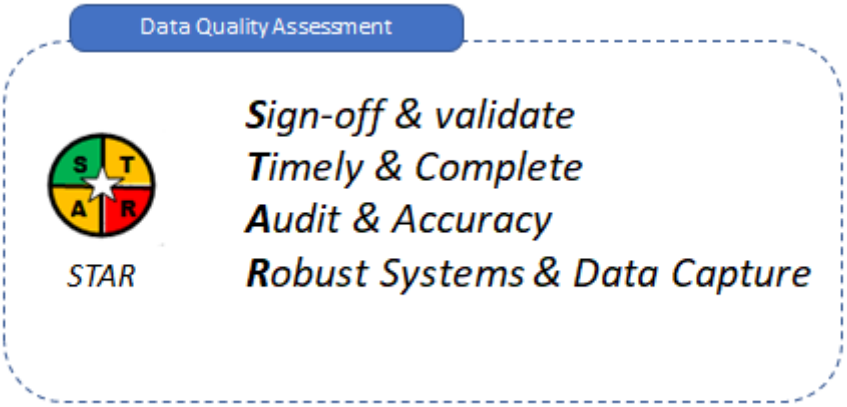
We have published a Data Quality Policy to ensure all staff are aware of their responsibilities towards Data Quality.

To ensure that we maintain data quality, we monitor our data quality metrics and have a planned pipeline of work to build automation and reduce the risks associated with human error.

To ensure that data is of the highest standard, NGH are taking the following actions;

- Data Validation, including data items and pathway coding;
- Monitoring metrics from known areas of interest, such as misdirected mail, missing PAS ID, missing codes where they would be expected, late entered data, NHS number duplicates and mergers required, rebooking, etc.;
- Compliance with Data standards;
- Compliance with data protection laws;
- Data Quality Training;
- Departmental Visits;
- Direction and guidance in key meetings;
- Close business relationships with Finance, Data and Coding.
- Use of external comparison tools – Data Quality Maturity Index
- Introduction Data Quality Kitemark

The Data Quality Team has recently published a Data Quality Kitemark which will allow the team to carry out an internal audit of information asset and flows that the Trust holds. The STAR rating as a kitemark will address the data quality domains through periodic assessment.



The quality of data and information is paramount to good decision making. This process is designed to help staff build information of quality and help users understand the quality of the data. There may be times when good quality data is not available and users need to understand that their decisions may be based on data that is not totally right.

2.9 NHS number of general medical practice code validity

The Trust submitted records between April 2019 and December 2019 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 - Apr 19 to Dec 19	Valid NHS Number	Valid GMPC
Inpatients	99.78%	99.99%
Outpatients	99.93%	94.55%
A&E	98.82%	96.75%

Period - Apr 18 to Dec 18	Valid NHS Number	Valid GMPC
Inpatients	99.75%	100%
Outpatients	99.90%	99.98%
A&E	98.64%	95.84%

2.10 Clinical coding error rate

Clinical coding audit is fundamental to the quality assurance process by rigorously reviewing how coding standards are being applied and how consistently. It allows retrospective amendments of incomplete or inaccurate data but more crucially, provides a learning and feedback tool whereby individuals can embed outcomes within their own practice. It can also be used to identify inconsistencies across a department that do not necessarily amount to an error but improve the quality of information produced. Furthermore, clinical coding audit findings often identify recommendations that benefit the Trust as a whole e.g. improved clinical record keeping or data quality errors.

The minimum requirement as specified under DSP requirements is a 200 patient episode audit per financial year. At NGH, there is a rolling quarterly audit program undertaken whereby approximately 300 episodes are formally audited each quarter in accordance with the latest national audit methodology.

However, there are varying mechanisms of audit and a variety is important to provide a comprehensive approach that suits the needs of the department and the Trust. As such, the reality is that a far larger number of episodes are audited in an informal manner.

Each quarter is audited once it is complete so at the time of writing, there are three completed quarters for 2019/20 and the results below meet the mandatory requirements outlined in the DSP guidance.

Q1 2019-20	% Accuracy Including All Error Sources	% Accuracy Excluding Non-Coder Error
Primary Diagnosis	**90.28%**	**90.28%**
Secondary Diagnoses	**90.04%**	**91.23%**
Primary Procedure	**96.26%**	**96.26%**

Secondary Procedures	**91.88%**	**92.85%**

Q2 2019-20	% Accuracy Including All Error Sources	% Accuracy Excluding Non-Coder Error
Primary Diagnosis	**91.28%**	**91.28%**
Secondary Diagnoses	**91.76%**	**91.81%**
Primary Procedure	**92.00%**	**93.00%**
Secondary Procedures	**89.66%**	**90.12%**

Q3 2019-20	% Accuracy Including All Error Sources	% Accuracy Excluding Non-Coder Error
Primary Diagnosis	**95.52%**	**95.69%**
Secondary Diagnoses	**96.69%**	**96.92%**
Primary Procedure	**96.23%**	**96.23%**
Secondary Procedures	**93.68%**	**93.68%**

2.11 Learning from deaths

Number of deaths during the reporting period

The number of deaths at NGH is monitored monthly however the number of deaths each month cannot be used to judge the quality of care provided because it does not take into account important information about the patients, the hospital and local services. The screening and review process at NGH along with monitoring of Dr Foster data gives more meaning to the number of deaths by adding context such as the age of the patient, how ill the patient was on admission, if the patient was known to have any other illnesses before admission and the impact of social care provision in the community.

During April 2019 – March 2020 1697 Northampton General Hospital patients died of which 1,581 were inpatients and were deaths within the Emergency Department.

Q1	390
Q2	384
Q3	490
Q4	433
Tot	**169**

Screening deaths

In December 2017, The Trust introduced a process for screening of adult deaths to select cases for review and identification of learning. During April 2019 – March 2020 the notes of 1,093 deaths were screened by Screeners or scrutinized by Medical Examiners. From October 2019 onwards a number of the screeners began their duties as Medical Examiners.

Q1	35
Q2	29
Q3	26
Q4	17
Tot	**1093**

Reviewing deaths

143 mortality case record reviews were completed using the Structured Judgement Review (SJR) Tool which is a validated methodology for

standardising case note review supported by the Royal College of Physicians.

A Trust wide review of 100+ consecutive deaths in December 2019 is currently in progress. At time of writing data collection is not yet complete and therefore these figures have not been included in the data. The review is expected to be completed by end of Q2 2020-21.

SJRs

Q1	53
Q2	39
Q3	32
Q4	19
Tot	**143**

Investigating deaths

If the overall care of a patient is judged to be poor or very poor the case is reviewed again using the SJR2 tool by a group of experienced reviewers which meets bimonthly. A consensus decision on the standard of care and the avoidability of death is made using the Avoidability of Death Judgement Score:

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

Of those patients who died in 2019/20, and were reviewed as part of the standard SJR2 process no deaths received an avoidability of death judgement score of below 4 and were therefore judged to be more likely than not to have been due to problems in the care provided to the patient.

At the time of writing there are six outstanding SJR2 cases for review with five from six deaths being referred for a second review in Q4 2019/20. The current Trust wide review of December 2019 deaths will also identify further cases and these reviews are scheduled for September 2020.

No cases from 2019/20 were referred to the Review of Harm Group (RoHG). During 2019/20 deaths a further 8 deaths from 2018/19 received a second SJR because of concerns over the quality of care. Of these two deaths were referred to the RoHG and one death was investigated as a Serious Incidents and one death was subject to a comprehensive investigation which was de-escalated due to lack of evidence that any delay had contributed to the death. One death was judged to be probably avoidable.

Feedback on both poor and excellent care is given to both specialty M&Ms and individuals to promote learning from deaths.

Neonatal Deaths and Stillbirths

Neonatal Deaths >22 weeks

Q1	1
Q2	1
Q3	0
Q4	1
Total	**3**

Stillbirths >24 weeks

Q1	2
Q2	2
Q3	8
Q4	2
Total	**14**

- During April 2019 – March 2020 there were three neonatal deaths after 22 weeks of pregnancy and 14 stillbirths delivered from 24 weeks of pregnancy
- All qualifying deaths have been reviewed using the Perinatal Mortality Review Tool
- No deaths were investigated as serious incidents

- No deaths reviewed using the Perinatal Mortality Review Tool scored a Grade D (deaths judged more likely than not to be due to a problem in care)

Patients with a learning disability or severe mental illness:

Q1	7
Q2	6
Q3	1
Q4	5
Total	**19**

- During April 2019 – March 2020 there were nine deaths of patients with a learning disability
- During April 2019 – March 2020 there were ten deaths of patients with a severe mental illness (defined at NGH as a patient admitted to NGH from a mental health trust or a patient detained under the mental health act)
- The care of 15 patients has been reviewed using the Structured Judgement Review tool. The remaining 4 patients will be reviewed in 2020-21.
- All patients with a learning disability have been referred to the national mortality review process for learning from deaths of patients with a learning disability.

Introduction of Medical Examiners

The NGH Medical Examiner system began in October 2019, in readiness for the National statutory implementation from April 2020. The Trust initially employed six Medical Examiners and one Medical Examiner Officer, with a further two Medical Examiners recruited in Quarter 4.

The Medical Examiner service is based in the Bereavement Suite and works closely with the bereavement service. They scrutinise the notes of patients when they die to provide an independent opinion on the cause of death. They also judge the care given to the patient. The doctor who is completing the medical certificate of the cause of death discusses their proposed cause of death with the Medical Examiner to come to a final agreed cause. The Medical Examiner then contacts the next of kin to explain the medical certificate of the cause of death and answer any

questions they may have, including noting any concerns they may raise or positive feedback offered.

If the Medical Examiner has concerns regarding care given to a patient either following the scrutiny of the notes or as raised by the next of kin the Medical Examiner Officer sends the details to the Mortality office for them to arrange a formal review of the notes (a SJR) by the clinical team who looked after the patient. The Medical Examiner and Medical Examiner Officer will also advise the doctor completing the medical certificate of the cause of death if a coroner referral is required.

In Q4 approximately 40% of patient deaths were scrutinised as described. This will increase as the number of Medical Examiners expands and they become more experienced, as well as continuing improvements in the efficiency of the process.

Appendix 1

Learning, Actions and Impact of Mortality Case Note Review in 2019/20

Mortality case note review is completed using the SJR tool at both directorate/ specialty level and at Trust wide level in response to Dr Foster alerts or other concerns. The table below gives examples of actions taken following mortality case note review.

Area targeted by review	Data source	Work stream/s	Example of actions taken or proposed
High HSMR since December 2019 - Case note review of deaths in December 2019	100+ notes will be reviewed using standard SJR methodology	Led by Mortality Review Group	• All cases requiring a second SJR will be reviewed and discussed at a meeting scheduled for September 2020. • The final report and action plan will be circulated trust wide in Autumn 2020

Sepsis	Dr Foster data and Trust wide mortality case note review 10	Sepsis/ Deteriorating Patient Board	• On-going training including FYI/FY2 teaching programmes; Simulation Suite offering training doctors, nurses, medical students, always includes sepsis case • Emergency Department Audit of compliance with Sepsis CQUIN standards monthly • Coding of all deaths continues to be reviewed by sepsis lead and head of clinical coding
Respiratory failure, insufficiency and arrest	Dr Foster data and directorate mortality case note review	Led by Respiratory Team	• Non-invasive Ventilation (NIV) Group formed involving respiratory and anaesthetic clinicians to share rota • Increased number of respiratory consultants planned • Training video produced to aid training • Blood gas machine purchased for Respiratory Ward
Cancer diagnosis alerts	Dr Foster data	Mortality Review Team / Dr Foster	• Triangulation of Dr Foster data with SHMI has identified that mortality is within the expected range for SHMI but has alerted in Dr Foster. • A deep dive looking at the deaths revealed that patients transferred to

			hospices are counted as 'hospital deaths' by Dr Foster but as deaths in the community by SHMI. This is a significant number of deaths and has contributed to alerts. • Comparison with peers indicates that most acute hospitals do not have their local hospices as hospital transfers but as discharges.
Secondary Malignancy – delivery of palliative care Secondary Malignancy	Dr Foster data and directorate mortality case note review	AMD/ Palliative Care	• Palliative care stickers introduced to aid coding in documentation of specialist palliative care • An Outpatient direct from GP pathway for patients with suspected malignancy of unknown origin has been agreed with the CCG. This should reduce the number of patients admitted with a new diagnosis of cancer enabling them to be referred directly to community palliative care services. • A deep dive into deaths revealed that approximately a quarter of deaths were in hospices • A report on palliative care provision was prepared to consider

			future demand for palliative care services
Congestive Heart Failure	Dr Foster data	Led by Heart Failure Team	• Initial review of clinical documentation and coding • Review of data in conjunction with data from the Heart Failure National Audit and National Confidential Enquiry looking at the management of patients with acute heart failure • Review of bedside Clinical Guideline for use at NGH • Clinical Senate review and Action Plan which incorporates the above
Comorbidity Capture	Screening and data review.	Clinical Coding/IT Review.	• A refinement of the Electronic Discharge Notification prompts is planned to obtain further specificity of coding • Electronic clerking to replace the emergency admission proforma booklet is currently being developed including possible forced prompts for better data capture
Datix database for hospital deaths	Review of mortality administration processes	Mortality Review Team/ Corporate Governance	• Implementation of the Datix-Cloud Mortality Module is underway to enable reliable systems to capture all deaths and stages of the mortality review processes • System is due to go live in Q4 2020/21

2.12 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 has produced a patient/relative Duty of Candour information leaflet which can be used in all areas except maternity, where a different maternity specific leaflet is being devised.

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

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 during an incident.
A patient information leaflet has been devised for adult inpatients (excluding maternity patients).

Patients and/or their relevant person are encouraged to participate in any investigations that the Trust's 'Review of Harm Group' deems 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 CCG.

2.13 Management of complaints

Compliments, Comments, Complaints, Concerns (4Cs) and suggestions from patients, carers and the public are encouraged and welcomed. Should patients, carers or members of the public be dissatisfied with the care provided by this Trust they have a right to be heard and for their concerns to be dealt with promptly, efficiently and courteously. The Trust welcomes all forms of feedback and information which is used to improve the service that is provided to the local community.

The 4Cs process is about patient choice and the Trust's wish to ensure that where possible any of the 4Cs raised are responded to swiftly and locally by staff. If the individual is dissatisfied with the outcome then they must be offered one of the following options:

- Speak to a senior member of staff (i.e. Matron, Manager)
- Contact PALS for on the spot support, advice and information
- Make a complaint through the NHS Complaints Regulations

The aim is always to achieve local resolution where possible and the above should be used as an escalation process where appropriate and with the agreement of the individual. The Trust recognises that the information derived from complaints and concerns provides an important source of data to help make improvements in hospital services. Complaints and concerns can act as an early warning of failings in systems and processes which need to be addressed.

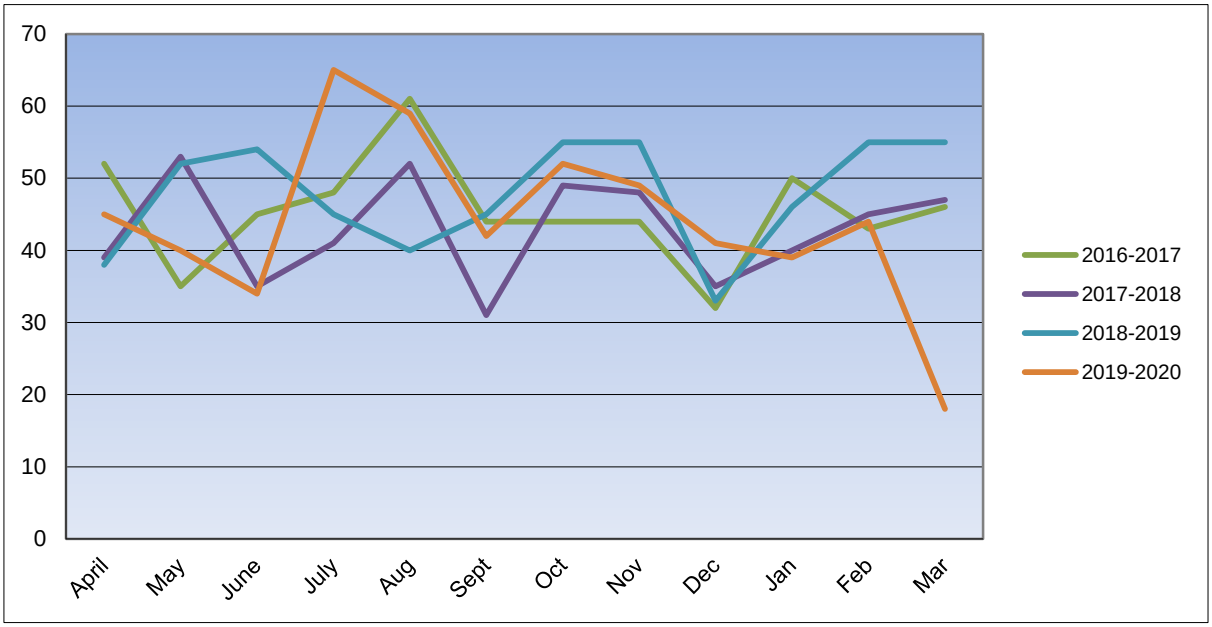
The Trust received a total of 528 written complaints that were investigated through the NHS Complaints Procedure from 1 April 2019 to 31 March 2020, which compares with 573 complaints received for the same period during the previous financial year.

Total no of complaints for the year	528
(Versus 2018/2019)	(573)

Average response rate	92%
Total no of complaints that exceeded the renegotiated timescale	44
Complaints that were still open at the time that the information was prepared (9th July 2020)	10*
Total patient contacts/episodes	750,865
Percentage of complaints versus number of patient contacts/episodes	0.07

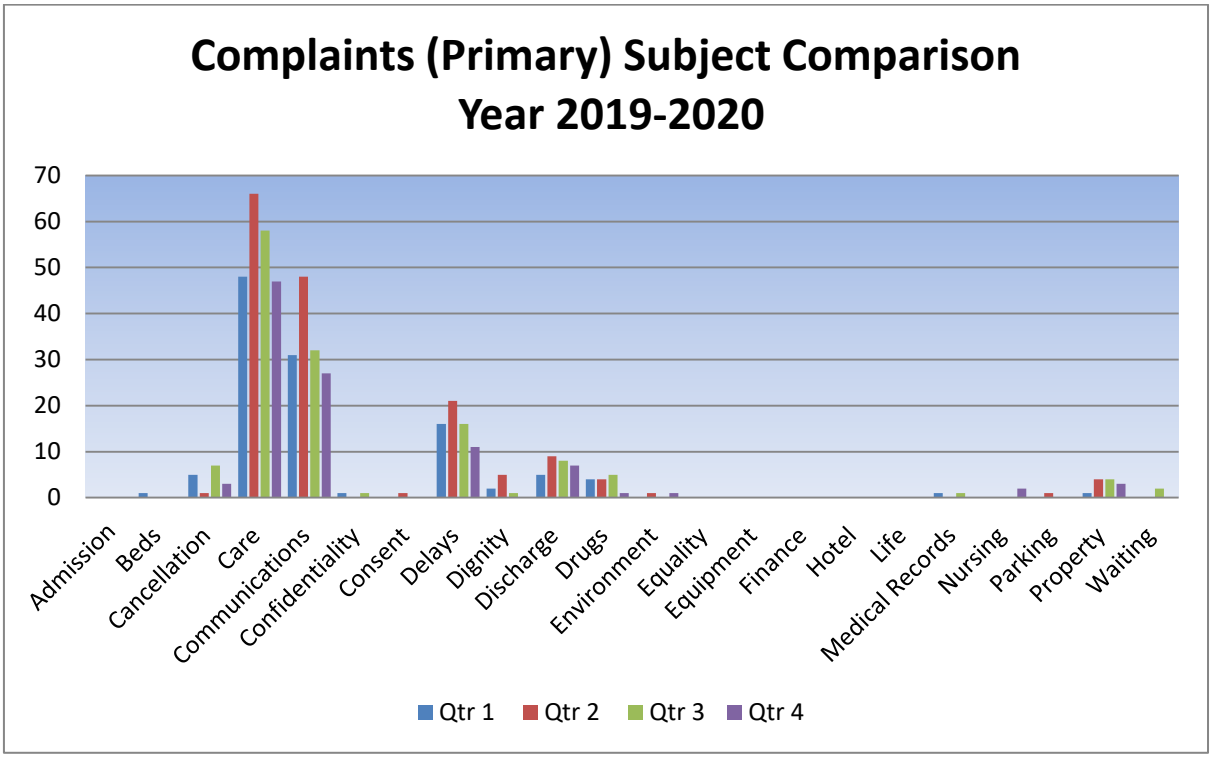
**Due to CoVID-19, the NHS Complaints procedure was paused nationally from the end of March 2020 until the end of June 2020. All complainants were contacted and invited to contact the Trust if they wished to proceed with their complaint once the pause was lifted. When the Complaints Procedure was restarted on the 29 June 2020 10 complaints remained on-going from the previous reporting year.*

Number of complaints



Trend Analysis

The following chart provides the themes emerging from complaints:



What we achieved in 2019/20 to improve complaints management

Subject:	**Commentary:**
Trust response rate	The Complaints team has achieved its 'green' (90% or above) target during the reporting year with an average of 92%. This has been an outstanding achievement given the challenges faced within this financial year in terms of training new staff, a restructure and the continued increase in the complexity of complaints received.
Staffing	• 1 new member of staff now fully trained • Complaints Officers were realigned with Divisions and where possible attend Divisional / Directorate Governance meetings.
Training	Staff have attended the following training: • Appraisal workshops • Mental Health awareness / support sessions for staff • Safeguarding

	• Complaints Officer successfully completed a supervisory development programme • Staff in Complaints have been trained to cover in PALS & Bereavement
Learning	• The learning from complaints is communicated to staff across the organisation through monthly reporting processes
Processes	• All complaint files are now managed electronically with only a base file used for approval and review purposes
Support to other departments	• Ad hoc support provided to PALS & Bereavement when staffing has been reduced (maternity cover / annual leave) • The Head of Complaints, PALS & Bereavement provides development support through training workshops for bands 5, 6 & 7 nursing staff
Local networking	A local network meeting has been set up with complaints leads for each Trust regularly in attendance to ensure the sharing of best practice and maintain good working relationships.

2.14 Freedom to speak up

FREEDOM TO SPEAK UP

Staff at Northampton General Hospital are encouraged to speak up through their line managers or if they feel unable to do so are able to make direct contact with the Trusts Freedom to Speak Up Guardian or one of the Values Ambassadors by telephone, personal approach or email. The Freedom to Speak Up Guardian and Values Ambassadors will support staff to raise concerns and will maintain their anonymity if requested. Staff can also report concerns anonymously via the DATIX reporting system.

Feedback is provided directly to staff raising concerns as to progress with their case but also the outcome when any investigation is completed. Feedback is provided face to face. If the concern is raised anonymously, other methodologies can be utilised e.g. patient safety messages to

update all Trust staff of a revised process or to reiterate appropriate processes.

The Trust Guardian will ensure any reports of detriment are dealt with robustly with staff supported accordingly.

The Freedom to Speak Up Guardian and Values Ambassadors are happy to hear any concerns over quality of care, patient safety or bullying and harassment and will signpost staff appropriately to others eg.HR processes.

The Respect and Support Information Hotline is accessible for all staff in the Trust as part of the ongoing work that is available through the Respect and Support Campaign. The purpose of the hotline is to signpost a member of staff to the different interventions available in the Trust. These interventions have been developed through the campaign to provide support when the member of staff has concerns about an individual's behaviour or has relationship difficulties with others they work with. The hotline is a way of giving the member of staff an opportunity to talk through their issues with a trained individual and it is intended to provide the member of staff with options other than a formal process.

2.15 Seven day services

NHS England committed to providing a 7 day service across the NHS by 2020. The expectation is that all in-patients admitted through Non-Elective routes, have access to consistent and equal clinical services on

each of the 7 days of the week, at the time of admission and throughout the stay in an acute hospital bed.

Since the work the Clinical Audit Team did in 2018/19 we have carried out a further iteration as directed centrally (August – September 2019). The output of this work is set out below.

The 7 Day Service work is not one of our contracted audits (Quality Account 2020/21) and since completing the work below the central support and direction has been withdrawn. The essence of these standards still features throughout work across NHSE&I and NGH but the specific structure is no longer part of required scrutiny or reporting which ended November 2019.

Seven Day Standards Audit Autumn 2019

Methodology: Following the last audit we revised the methodology so we had a more representative section of our patients, this was a larger sample than NHSE advised but we felt the prior given approach did not allow us to understand enough about our performance. We discussed this and got agreement from NHSE.

An audit of non-elective admissions for the period 4 September 2019 – 10 September 2019 was carried out by selecting a sample of cases from a daily list in order of admission time to obtain a target of 62 cases for weekdays and 50 cases for weekends. A sample size calculator was used to determine the minimum sample based on 95% confidence limits. This resulted in the weekend sample being much larger than the spring audit which included only 20 weekend admissions.

The standard exclusions were applied including Maternity, patients with a length of stay <14 hours and patients transferred from another hospital. A total of 116 admissions were audited (66 for weekdays and 50 for the weekend). To ensure that the overall performance is representative of the weekday and weekend admissions a weighted average was used when combining the weekday and weekend data to reflect that 72% of admissions were on weekdays and 28% at weekends.

A separate audit of stroke and vascular admissions was carried out with a larger sample than the minimum threshold of 10 per service. 21 stroke

admissions and 20 vascular admissions were audited. The period of admission was 14 August 2019 to 10 September 2019 for stroke patients and 19 June 2019 to 10 September 2019 for emergency vascular admissions.

Clinical Standard 2

Time from admission to 1st consultant review by day of the week (based on day of admission):

Admission	Weekday	Weekend	Total
Number of patients reviewed by a consultant within 14 hours	55	42	97
Number of patients reviewed by a consultant outside of 14 hours or not reviewed by consultant	11	9	20
Total admissions	66	51	117
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	83%	82%	Adjusted total compliance 83%

Time from admission to 1st consultant review by day of the week (based on day of admission):

Admission	Mon	Tues	Wed	Thu	Fri	Sat	Sun
Number of patients reviewed by a consultant within 14 hours	5	14	14	9	13	18	24
Number of patients reviewed by a consultant outside of 14 hours or not reviewed by consultant	3	2	2	2	2	5	4
Total admissions	8	16	16	11	15	23	27
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	63%	88%	88%	82%	87%	78%	86%

Time from admission to 1st consultant review by admitted specialty:

	Weekday		Weekend		Total	
Specialty	Total	compliance %	Total	compliance %	Total	compliance %

Acute Internal Medicine	35	86%	29	90%	42	89%
Cardiology	3	100%	1	100%	4	100%
General Surgery	12	92%	7	86%	19	89%
Haematology	1	0%	1	100%	2	50%
Obstetrics & Gynaecology	2	50%	1	100%	3	67%
Oncology	2	0%	3	100%	5	60%
Ophthalmology	1	100%	0		1	100%
Paediatric Medicine	3	67%	2	0%	5	40%
Stroke Medicine	1	100%	1	100%	2	100%
Trauma and Orthopaedics	3	100%	1	100%	4	100%
Urology	3	67%	5	40%	8	50%
Vascular Surgery	0					

RAG ratings: **90% and above** / **70-90%** / **50-70%** / **below 50%**

Clinical Standard 8

Patients who required twice daily reviews and received twice daily consultant directed reviews:

	Weekday	Weekend	Total
Twice daily reviews required & received	9	3	12
Twice daily reviews required & not received	0	0	0
Total number of daily reviews	9	3	12
Percentage Receiving required twice daily reviews	100%	100%	100%

Patients who required once daily reviews and received once daily consultant directed reviews:

	Weekday	Weekend	Total
Once daily reviews required & received	228	62	290
Once daily reviews required & not received	4	21	25

Total number of daily reviews	232	83	315
Percentage Receiving required once daily reviews	98%	75%	92%

Patients who required once daily reviews and received a consultant directed review by day of the week:

Admission	Mon	Tues	Wed	Thu	Fri	Sat	Sun	Total
Once daily reviews required & received	42	35	32	31	35	25	26	226
Once daily reviews required & not received	0	0	2	0	1	10	12	25
Total number of daily reviews	42	35	34	31	36	35	38	251
Percentage Receiving required once daily reviews	100%	100%	94%	100%	97%	71%	68%	90%

Specialist Services Hyper-acute Stroke: Standard 2 Time to consultant review

Admission	Weekday	Weekend	Total
Number of patients reviewed by a consultant within 14 hours	14	7	21
Number of patients reviewed by a consultant outside of 14 hours or not reviewed by consultant	0	0	0
Total admissions	14	7	21
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	**100%**	**100%**	**100%**

Standard 8: Patients who required once daily reviews and received daily consultant directed reviews:

	Weekday	Weekend	Total
Once daily reviews required & received	57	20	77
Once daily reviews required & not received	0	0	0
Total number of daily reviews	57	20	77
Percentage Receiving required once daily reviews	**100%**	**100%**	**100%**

Specialist Services Emergency Vascular Services: Standard 2 Time to consultant review

Admission	Weekday	Weekend	Total
Number of patients reviewed by a consultant within 14 hours	16	4	20
Number of patients reviewed by a consultant outside of 14 hours or not reviewed by consultant	4	0	4
Total admissions	20	4	24
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	**80%**	**100%**	**83%**

Standard 8: Patients who required twice daily reviews and received twice daily consultant directed reviews

	Weekday	Weekend	Total
Twice daily reviews required & received	4	4	8
Twice daily reviews required & not received	0	0	0
Total number of daily reviews	4	4	8
Percentage Receiving required twice daily reviews	**100%**	**100%**	**100%**

Patients who required once daily reviews and received daily consultant directed reviews

	Weekday	Weekend	Total
Once daily reviews required & received	53	23	76
Once daily reviews required & not received	0	1	1
Total number of daily reviews	53	22	75
Percentage Receiving required once daily reviews	**100%**	**96%**	**99%**

Trends in compliance Spring 2017 – Autumn 2019

	Spring' 17	Autumn' 17	Spring' 18	Spring' 19	Autumn '19
Standard 2: Time to 1st consultant review	75%	72%	90%	88%	83%
Standard 5: Access to consultant	89%	N/A	97%	97%	N/A

diagnostics					
Standard 6: Access to consultant interventions	89%	N/A	100%	100%	N/A
Standard 8: Ongoing daily consultant review	90%	N/A	87%	Once / day 90% Twice / day 100%	Once / day 100% Twice / day 100%

2.16 Statements of assurance for selected core indicators

Performance Against National Quality Indicators

The National Quality Board requires reporting against a small, core set of quality indicators for the reporting period, aligned with the NHS Outcomes Framework. 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 18 – Sep 19	97	2	100	118	69

Oct 17 – Sep 18	104	2	100	127	69
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 97 for the period October 2018 to September 2019 as demonstrated in the table above. Unlike Hospital Standardised Mortality Ratio (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 18 – Sep 19	41.0%	36.0%	59.0%	12.0%
Oct 17 – Sep 18	40.8%	31.1%	64.0%	10.7%
Oct 16 – Sep 17	41.1%	31.61%	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* - (adjusted average health gain)
  - Hip replacement surgery
  - Knee replacement surgery
  - Groin hernia surgery
  - Varicose vein surgery

	NGH Performance		National Performance		
	Reporting Period 2018/19	**NGH Quality Account 2018/19**	**Reporting Period 2018/19 Average**	**Reporting Period 2018/19 High**	**Reporting Period 2018/19 Low**
• Hip replacement surgery - primary (EQ-5D™ Index)	* (provisional Apr19 to Sep19)	* (provisional Apr18 to Sep18)	0.474 (provisional Apr19 to Sep19)	0.561 (provisional Apr19 to Sep19)	0.405 (provisional Apr19 to Sep19)
• Hip replacement surgery - revision (EQ-5D™ Index)	* (provisional Apr19 to Sep19)	* (provisional Apr18 to Sep18)	* (provisional Apr19 to Sep19)	* (provisional Apr19 to Sep19)	* (provisional Apr19 to Sep19)
• Knee replacement surgery - primary (EQ-5D™ Index)	0.342 (provisional Apr19 to Sep19)	0.401 (provisional Apr18 to Sep18)	0.348 (provisional Apr19 to Sep19)	0.434 (provisional Apr19 to Sep19)	0.261 (provisional Apr19 to Sep19)
• Knee replacement surgery - revision (EQ-5D™ Index)	* (provisional Apr19 to Sep19)	* (provisional Apr18 to Sep18)	0.330 (provisional Apr19 to Sep19)	0.328 (provisional Apr19 to Sep19)	0.196 (provisional Apr19 to Sep19)

N.B. - Where N/A is stated, this information has not been made available by NHS Digital at the time of publication. * No scores available for fewer than 30 records.

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)

N.B. There is an on-going review by NHS Digital of emergency readmissions indicators across frameworks, and the Compendium of Population Health readmissions indicators have been updated and published in May 2019. As part of the update, certain elements of the

existing specification have been updated to align with other frameworks (NHS Outcomes Indicator Set and CCG Outcomes Indicator Set), e.g. length of time to readmission will be 30 days and mental health admissions will not be excluded. The below indicators have been included for the percentage of patients readmitted to any hospital in England within 30 days of being discharged from hospital after an emergency admission during the reporting period; aged0 to 15 and 16 or over for all providers.

Period	Indicator Value NGH	Indicator Value National Average	Indicator Value National High	Indicator Value National Low
Patients aged 0-15				
2018/19	14.9	12.5	69.2	1.8
2017/18	13.6	11.9	32.9	1.3
2016/17	14.4	11.6	68.4	2.7
2015/16	13.5	11.5	80.5	2.6
2014/15	14.7	11.4	52.7	1.2
2013/14	15.0	11.3	136.8	4.2

Period	Indicator Value NGH	Indicator Value National Average	Indicator Value National High	Indicator Value National Low
Patients aged 16 and over				
2018/19	15.7	14.6	57.5	2.1
2017/18	11.6	12.4	41.2	1.6
2016/17	12.2	11.9	229.5	35.7
2015/16	10.8	1..9	163.0	1.1
2014/15	10.2	11.4	190.7	1.8
2013/14	9.6	11.2	33.3	1.0

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

- *Responsiveness to the personal needs of patients*

Period	Indicator Value NGH	Indicator Value National Average	Indicator Value National High	Indicator Value National Low
2018/19 (Hospital stay: 01/07/2018 to 31/07/2019; Survey collected 01/08/2018 to 31/01/2019)	64.0%	67.2%	85.0%	58.9%
2017/18 (Hospital stay: 01/07/2017 to 31/07/2018; Survey collected 01/08/2017 to 31/01/2018)	65.1%	68.6%	85.0%	60.5%
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
2019	75%	77% (Acute Trusts)	90% (Acute Trusts)	48% (Acute Trusts)
2018	68.6%	71.3% (Acute Trusts)	87.3% (Acute Trusts)	39.8% (Acute Trusts)
2017	69.0%	70% (Acute Trusts)	86% (Acute Trusts)	47% (Acute Trusts)

2016	68.0%	69% (Acute Trusts)	85% (Acute Trusts)	49% (Acute Trusts)
2015	52.0%	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				
2019/20	Full year data unavailable due to Covid-19			
2018/19	92.7%	N/A	N/A	N/A
2017/18	93.0%	95%	100%	75%
2016/17	91.1%	96%	100%	80%
March 2016	85.4%	67%	93%	38%
March 2015	78.0%	95%	100%	78%

Period	NGH	National Average	National High	National Low
Patients discharged from Accident and Emergency (types 1 and 2)				
2019/20	Full year data unavailable due to Covid-19			
2018/19	96.3%	N/A	N/A	N/A
2017/18	88.8%	88%	100%	66%
2016/17	86.7%	87%	100%	45%
March 2016	85.4%	84%	99%	49%
March 2015	85.0%	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** (Acute Trusts)	**National High** (Acute Trusts)	**National Low** (Acute Trusts)
Q4 19/20	Data collection/publication suspended due to Covid-19			
Q3 19/20	95.00%	95.33%	100%	71.59%
Q2 19/20	95.25%	95.47%	100%	71.72%
Q1 19/20	95.34%	95.63%	100%	69.76%
Q4 18/19	95.10%	95.64%	100%	74.03%
Q3 18/19	95.45%	95.61%	100%	54.86%
Q2 18/19	94.95%	95.48%	100%	68.67%
Q1 18/19	90.98%	95.63%	100%	75.84%
Q4 17/18	96.61%	95.23%	100%	67.04%
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**
2019/20	16.6	N/A	N/A	N/A
2018/19	5.4	11.7	79.7	0

2017/18	7.5	14	91	0
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)				
Apr 19 – Sep 19	5,246	8,349	21,685	1,392
Oct 18 – Mar 19	4,156	7,153	22,048	1,278
Apr 18 – Sep 18	3,207	7,417	23,692	566
Oct 17 – Mar 18	3,800	5,175	19,897	1,311
Apr 17 – Sep 17	3,085	4,975	15,228	1,133
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)				
Apr 19 – Sep 19	40.8	80.5	103.8	26.3
Oct 18 – Mar 19	31.7	69.5	95.9	16.9
Apr 18 – Sep 18	25.4	69.8	107.4	13.1
Oct 17 – Mar 18	28.8	42.5	124.0	24.9
Apr 17 – Sep 17	23.5	42.8	111.6	23.4
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	39.0	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 severe harm or death - (Acute Non- Specialist)				
Apr 19 – Sep 19	35		95	0
Oct 18 – Mar 19	22	31.9	72	0
Apr 18 – Sep 18	33	33.0	87	0
Oct 17 – Mar 18	33	18.8	78	0
Apr 17 – Sep 17	19	18.3	92	0
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)				
Apr 19 – Sep 19	0.66%	0.43%	1.59%	0.00%
Oct 18 – Mar 19	0.52%	0.44%	0.32%	0.00%
Apr 18 – Sep 18	1.02%	0.44%	0.36%	0.00%
Oct 17 – Mar 18	0.87%	0.37%	1.56%	0.00%
Apr 17 – Sep 17	0.62%	0.37%	1.55%	0.00%
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%	2.00%	0.00%
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.

3

PART 3

Progress on our Quality Priorities

3.1 Our quality priorities

Aim: Provide the Best Possible Care 2019-2021 **Quality Priorities**

Key Success Factors	Enablers & Measures	19/20 Yr 1	20/21 Yr 2	21/22 Yr 3
Improve the safety culture at NGH by 10% from the baseline	# incidents reported +/- categories	COM	→	→
	# medical vacancies		COM	→
	# nursing vacancies		COM	→
	Staff speaking up, disclosure – "speak up champion"	COM	→	→
	Staff health and wellbeing	COM	→	→
	Safety huddles (content meaningful), code red status reporting & VPac data	COM	→	→
	Staff survey elements of safety culture	COM	→	→
	Board to Ward visits – relaunch	COM	→	→
	Hospital at night		COM	→
	7 day hospital services (4 core standards)	COM	→	→
Reduce the number of preventable harm events by 10% from 2018 baseline	VTE risk assessment compliance NICE compliance	COM	→	→
	Reduction in c-diff	COM	→	→
	Reduction in pressure ulcers	COM	→	→
	Reduction in falls +/- with harm	COM	→	→
	SOC scores		COM	→
Efficient and effective outcomes Eliminate preventable early patient deaths by 10% from baseline	HSMR data (as expected or below range)	COM	→	→
	SMR – Congestive Cardiac Failure		COM	→
	Deteriorating patient care plan use/activity	COM	→	→
	Specialist palliative care team referrals (nurse and doctor)	COM	→	→
	MECC – smoking cessation		COM	→
	MECC – alcohol dependence interventions		COM	→
Improve patient experience of care by 15% from 2018 baseline	Cancer experience	COM	→	→
	Patient communication	COM	→	→
	Outpatient appointment cancellations / changes		COM	→
	Patients with a dementia diagnosis will receive an appropriate diet as outlined within John's Campaign	COM	→	→
	Dementia training – Tier 1 dementia training	COM	→	→
	Cancelled operations		COM	→
	Staff and Patient FFT	COM	→	→
	GIRFT – completion of action plans for urology & orthopaedics	COM	→	→
Improve the safety outcomes of maternal and neonatal care. Reduce the rate of still births, neonatal death and brain injuries occurring by 20% from 19/20 baseline by 20/21	Reducing smoking in pregnancy		COM	→
	Risk assessment, prevention and surveillance of pregnancies at risk of foetal growth restriction (FGR)		COM	→
	Raising awareness of reduced foetal movement		COM	→
	Effective foetal monitoring in labour		COM	→
	Reducing preterm birth		COM	→

Key
COM = commence
→ = continue

Quality Priorities

Last year we set our Quality Priority "provide the Best Possible Care" underpinned by five success factors:

1. **Safety Culture**
   Improve the safety culture at NGH by 10% from the baseline

2. **Preventable Harm**
   Reduce the number of preventable harm events by 10% from 2018 baseline

3. **Effective and Efficient Outcomes**
   Efficient and effective outcomes that will eliminate preventable early patient deaths by 10% from baseline

4. **Patient Experience**
   Improve patient experience of care by 15% from 2018 baseline

5. **Outcomes in maternal & neonatal care**
   Improve the safety outcomes of maternal and neonatal care. Reduce the rate of still births, neonatal death and brain injuries occurring by 20% from 2019/20 baseline by 2020/21

Review of last year's Quality Priorities

Our progress on each of these five success factors is outlined in detail below.

SUCCESS FACTOR 1 – Safety Culture

We said we would:

Improve the safety culture at NGH by 10% from the baseline

In 2019/20 we:

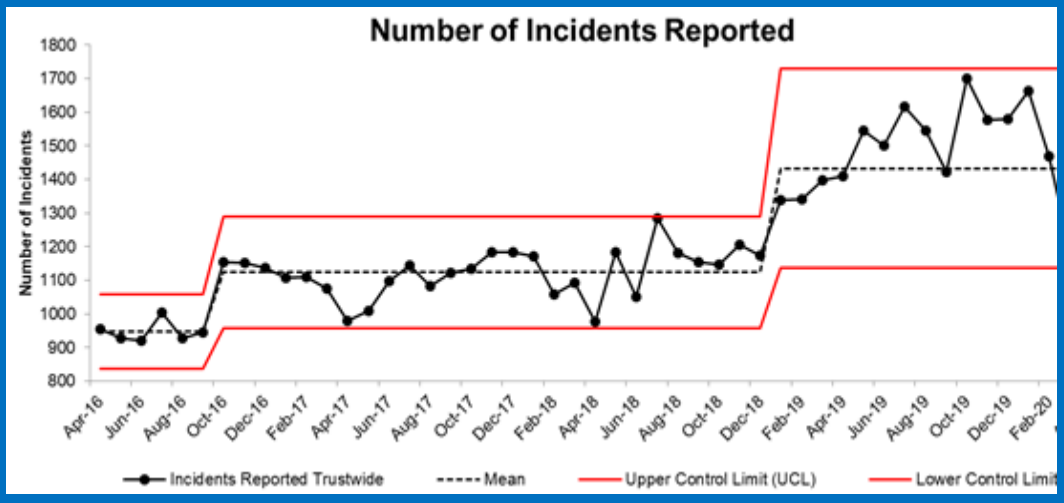
- Have seen an increase in the number of incidents reported and a more open and honest reporting culture in the Trust is reflected in the increase in Freedom to Speak Up cases.
- Have introduced Values Ambassadors and the Respect and Support Information Hotline as part of the Respect and Support Campaign.
- Over the past three years a range of opportunities for staff to learn more about our plans to improve and invest in their health and wellbeing have been introduced. We have provided practical options for members of staff to participate in a wide range of activities, with the emphasis on providing them with visible and tangible opportunities to support and improve their health and wellbeing.
- Safety huddles are led by a senior nurse within the organisation each day and attended by the most senior nurse or midwife for each ward/unit. The huddle agenda covers key safety topics including staffing levels, deteriorating patients, safeguarding and key risk factors. The pro forma used to document and record this information has been amended and expanded through several PDSA cycles.
- Trialled a central point of access for all night calls; all requests were made to the Nurse Night Practitioners instead of bleeping the junior doctors. The aim of this was to reduce the number of disturbances through the bleep system to junior doctors overnight.
- Bi-annual audits of four seven-day services priority standards have been completed to identify areas for improvement. Given the rate of progress over the year the Trust is expected to be on track to achieve these standards by 2020.

Three enablers under this success factor will be reported in next year's Quality Account:

- Medical vacancies
- Nursing vacancies
- Hospital at night

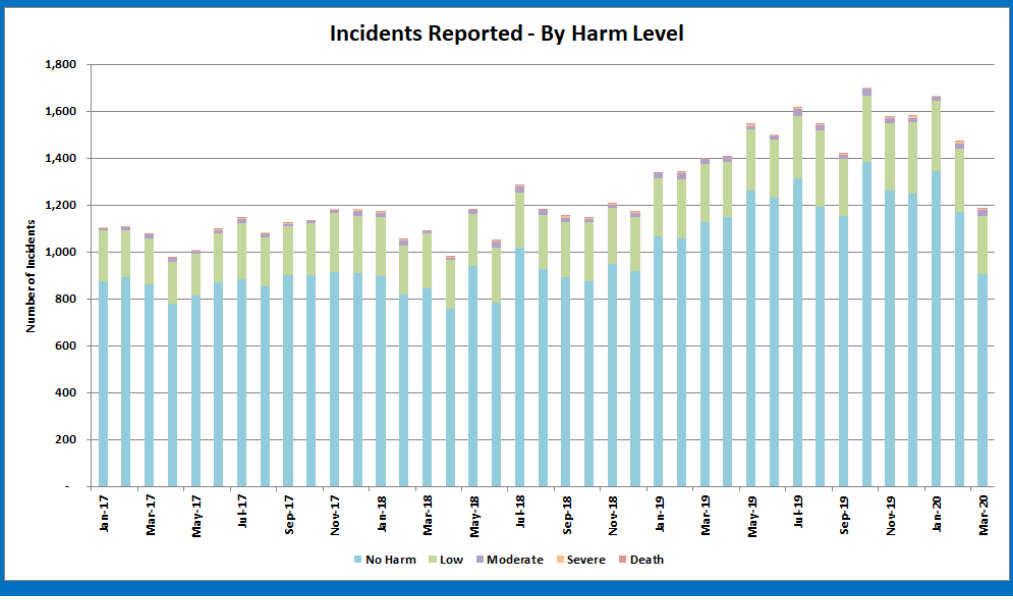
Results (as at quarter 3)

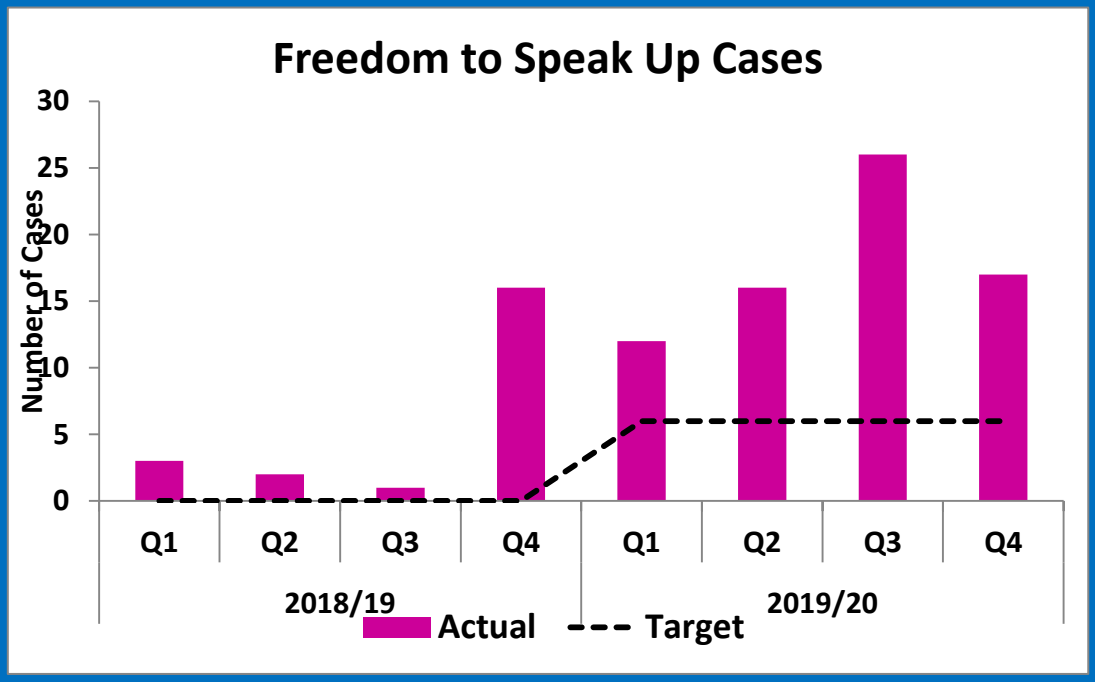
Metric 1a – Number of incidents reported



To encourage a positive safety culture, it is important that any accident or unexpected event is reported and investigated to understand why things go wrong and how to prevent and mitigate reoccurrence. Staff are encouraged to report issues via Datix, leading to an open and fair culture without fear of reprisal. The chart above shows a statistically significant increase in the number of incidents reported. The majority of incidents reported are no harm or low harm incidents, as seen in the breakdown below.

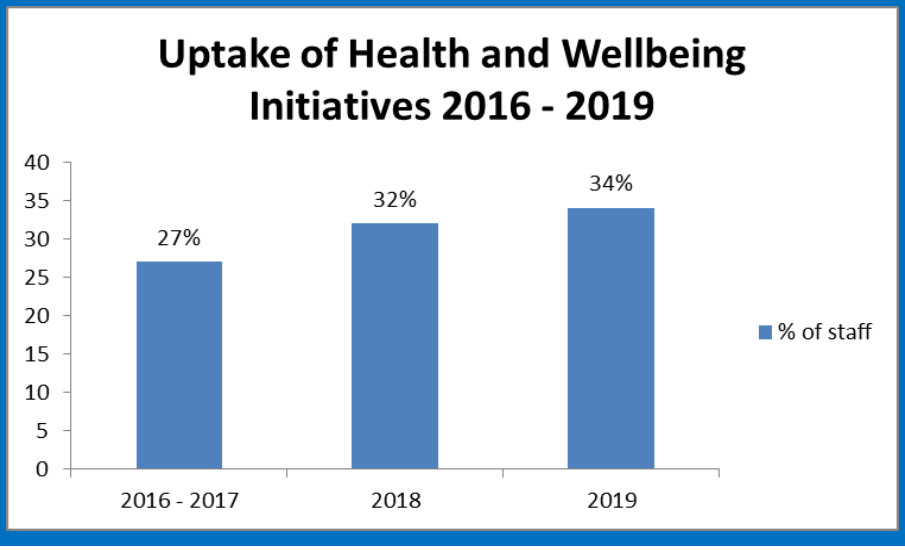
Metric 1b – Staff speaking up





Staff at NGH are able to raise concerns through their lines managers. If unable to do this, they can make direct contact with the Trust's Freedom to Speak Up Guardian and Value Ambassadors, who will support them to raise concerns, anonymously if requested. To reflect a change in Trust culture as a result of the roll out of Freedom to Speak up champions it is anticipated that the number of cases reported will increase as the Trust becomes more open to the concept of reporting concerns, leading to an open and honest reporting culture. An increase in the number of case can be seen in the chart above.

Metric 1c – Staff Health & Wellbeing



Year on year there has been an increase in staff uptake of initiatives. There is a comprehensive annual programme in place incorporating extensive physical and emotional wellbeing initiatives as well as more specialist health and wellbeing initiatives.

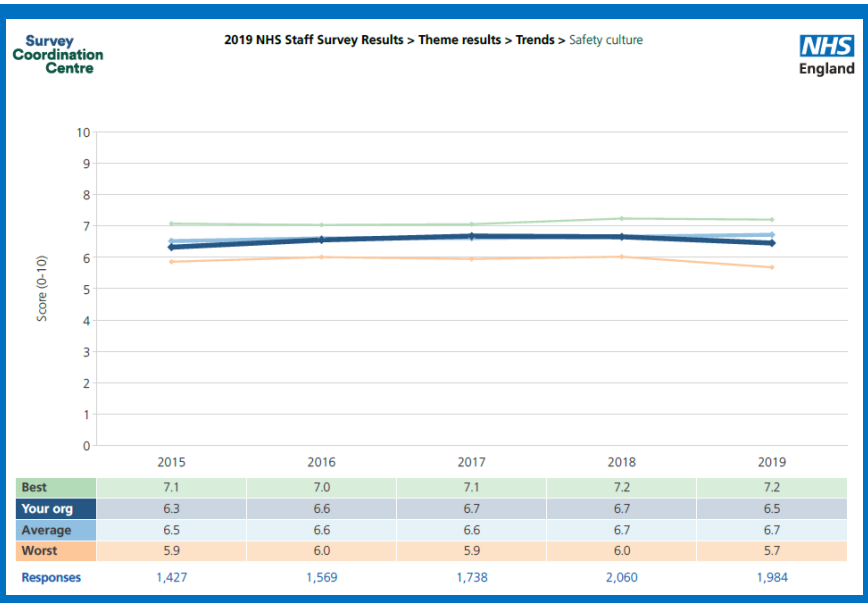
Keeping staff engaged and initiatives relevant is essential to a successful programme. Our staff have helped us develop the annual programme through the annual health and wellbeing survey, feedback questionnaires at events and feedback from health and wellbeing initiatives. Introductions to new initiatives over the past 18 months have included yoga sessions and menopause workshops amongst others.

Metric 1d – Safety Huddles

The morning Safety Huddles are led by a senior nurse within the organisation each day, including w/ends, and attended by the most senior nurse or midwife for each ward/unit. The huddle agenda covers key safety topics including staffing levels, deteriorating patients, safeguarding, TVN, Falls and IPC is present and discusses relevant issues. The patient safety issues are captured on SafeCare on a daily basis by the Ward Staff and reviewed at the Safety Huddle.

Following the meeting a summary of the Staffing is sent out by the A.D.N. to the group and reflects any staff changes made based on the discussion regarding staff availability and patient safety. The summary also highlights any staffing issues to be addressed at the 1300hr Staffing meeting and confirms the Matron who is covering the 'Clinical Late shift' and the On-Call Sister.

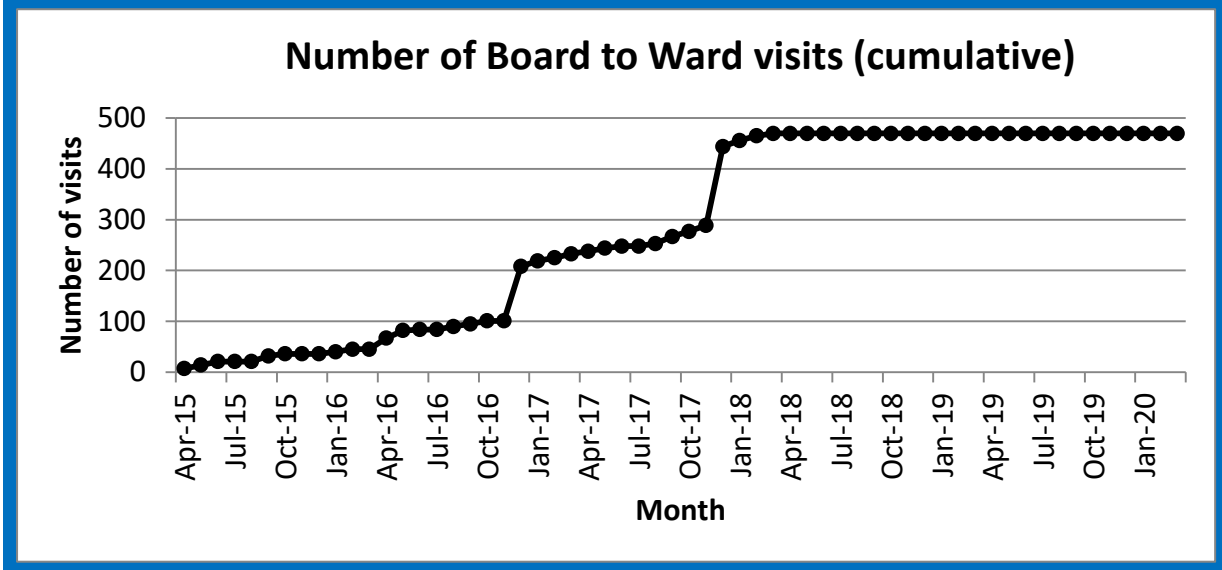
Metric 1e– Staff Survey – Safety Culture



	2015	2016	2017	2018	2019
Best	7.1	7.0	7.1	7.2	7.2
Your org	6.3	6.6	6.7	6.7	6.5
Average	6.5	6.6	6.6	6.7	6.7
Worst	5.9	6.0	5.9	6.0	5.7
Responses	1,427	1,569	1,738	2,060	1,984

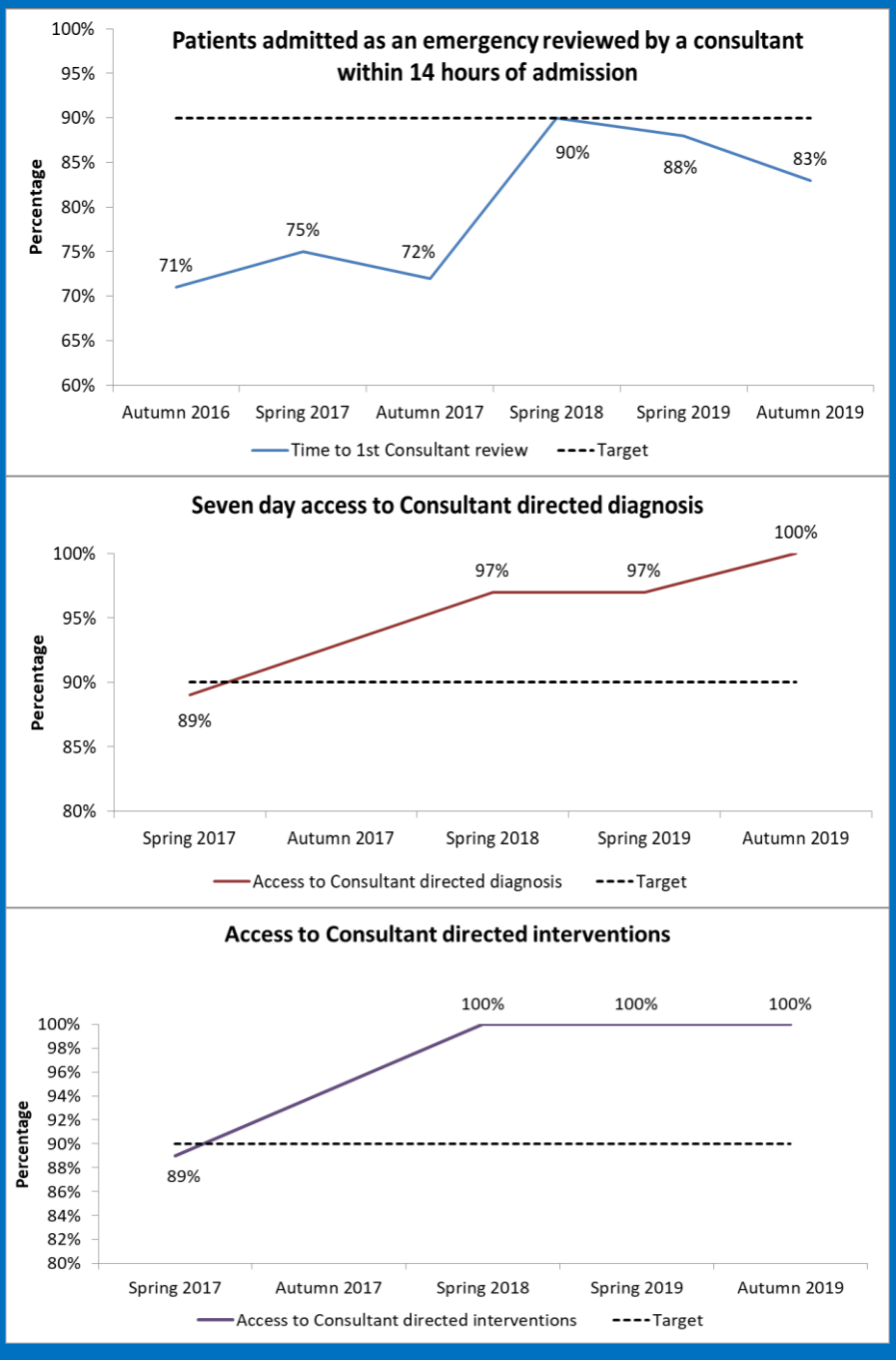
There has been a small decrease in the average score for safety culture in our organisation (6.7 to 6.5). This data is reported by NHS England as part of the national Staff Survey and has been collected and reported annually since 2015.

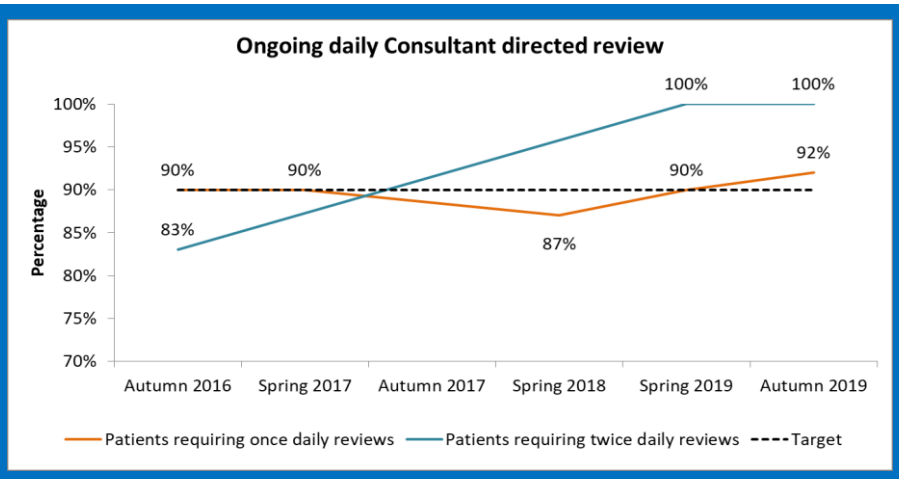
Metric 1f – Board to Ward



There have been no formal board to ward visits since April 2018, when responsibility for this metric changed.

Metric 1g – 7 Day Services





NHS England have committed to ensuring consistent care for all emergency admissions, whatever day they enter hospital. Ten clinical standards have been developed to define what seven day services should achieve. Four of these have been identified as priorities based on the potential positive affect of patient outcomes. These are:

- Standard 2 – All patients admitted as an emergency to be reviewed by an appropriate consultant within 14 hours of admission
- Standard 5 - Seven day access to consultant directed and reported diagnostics
- Standard 6 - Twenty-four hour access to consultant directed interventions e.g. endoscopy, emergency surgery etc.
- Standard 8 - All patients to be reviewed daily via a consultant delivered ward round and those who meet level 2 and 3 ICU criteria to be seen twice daily

These standards are audited and reported biannually with the above charts showing the latest performance for each of the priority standards as of Autumn 2019. The Trust is currently meeting three of the four standards, with further work required to ensure emergency patients are consistently reviewed by a Consultant within 14 hours.

Further improvements we need to make are:

- Medical vacancies - Over the coming year greater presence on the Best of Both Worlds initiative will be worked towards as a means of attracting medical vacancies to relocate into Northamptonshire. Best of Both Worlds is a collaborative initiative undertaken with regional Trusts to attract candidates into the region through a specially developed web based microsite. Agency reduction meetings have commenced with Finance, Workforce and Divisional representatives, which scrutinise temporary staffing and in doing help drive permanent

recruitment activity. Of the current 24 Consultant vacancies, the Trust currently has 14 Consultants in clearance and Consultant Interview panels are scheduled on a monthly basis over the next 12 months. Conversations with deanery are on-going in order to improve the numbers of Junior Doctors that are allocated to the Trust. Conversations are also ongoing with agencies regarding permanent recruitment but also converting temporary medical staff to permanent medical staff.

- Nurse vacancies - Address our current nursing vacancies. Nationally there is a shortage of nurses and midwives and within the Trust Nursing & Midwifery is the largest group of the Trust workforce. On-going links with our Northamptonshire schools, colleges and universities continues to maximise our local and regional recruitment support and this is important for future staff who may not have the necessary qualifications to enter directly into nurse training. Therefore the Trust has a number of career pathways to support individuals to gain on-going qualifications while gaining invaluable 'on-the-job experience. Although we continue to recruit locally and across the region the Trust Board has supported an Overseas recruitment plan to bring 150 nurses from India or the Philippines. The group will consist of approximately 25-30 staff on each cohort to arrive at the trust. The nurses will have intensive training to pass the necessary Nursing & Midwifery Council criteria to work in the UK, and once they have passed the relevant tests will be able to work as part of the clinical team within 6-8 weeks. Continue with our proactive recruitment campaign for Health Care Assistants and provide the training for the national 'Care Certificate' to ensure that we have a consistent standard of education for our newly appointed staff.
- Further recruitment of Values Ambassadors to increase the accessibility to staff to further increase Freedom to Speak up cases.
- Complete annual Health & Wellbeing survey which will influence plans for the following year
- Safety culture - Re-evaluate the staffing establishment reviews, following feedback from staff through the staff survey and executive ward rounds. This is to reduce staff moves during times of immense operational pressure. Enhance goal clarity in the organisation – acknowledging capacity pressure has a significant impact. Use the local findings of the staff survey relating to safety culture in order to share best practice and learn from one another. Schwartz Rounds - Schwartz rounds will provide staff with a space to talk about their thoughts and feelings on certain discussion topics, and open an opportunity for reflection.
- Board to ward will recommence from April 2020. The executive team will visit one clinical area each month to discuss a key quality/safety

theme. Themes will be identified through staff and patient consultation

- Hospital at night - Continuing with the new Central Point of Access at nights in order to reduce the disturbances to junior doctors. All night requests are made to the Nurse Night Practitioners who monitor and filter ward requests in order to streamline care. Evaluating the scope of the Nurse Night Practitioner team in order to ensure sufficient resource is allocated a night. Reviewing task allocation between day, twilight and night teams in relation to operational management. This includes a review of who should be responsible for daily staffing issues review. Evaluating the provision of IT resources at night, to ensure staff have access to the technology they need in their roles.

SUCCESS FACTOR 2 – Preventable Harm

We said we would:
Reduce the number of preventable harm events by 10 % from 2018 baseline

In 2019/20 we:

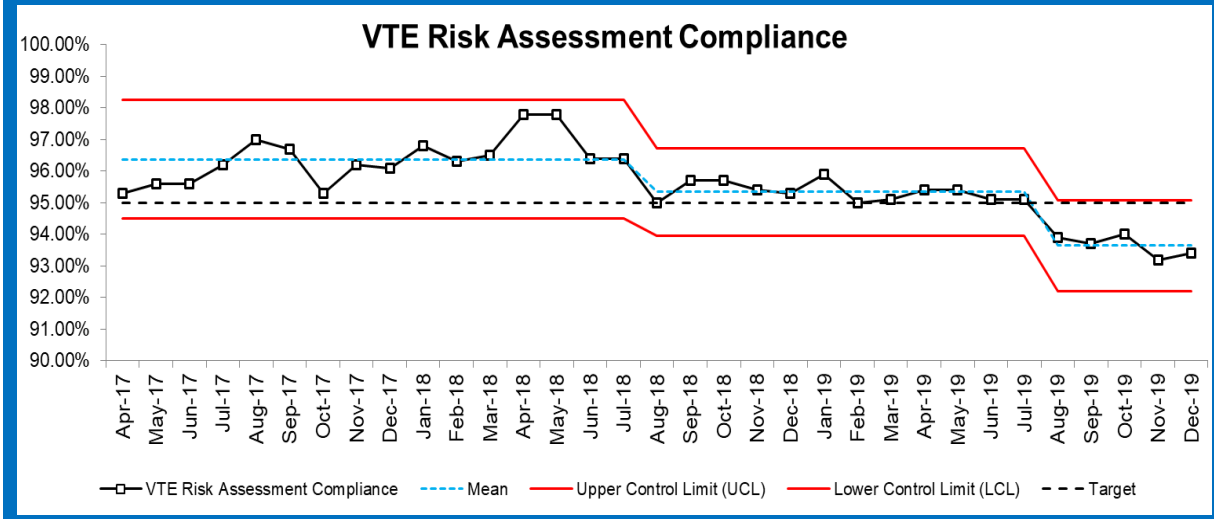
- VTE - Have worked with our e-prescribing provider to develop a risk assessment forcing function built into the prescribing system. This will replace the current risk assessment process on the vital signs IT system. Given that the new function will require prescribers to complete the assessment prior to prescribing non-emergency medication, it is anticipated we will see a significant increase in assessment compliance. This change in system goes live in 2020.
- C. Diff - The Infection Prevention & Control Team have developed the C.Diff plan. Key objectives from this have been to develop a process for sharing and learning from the community onset cases, prevention of urinary tract infections, hospital acquired pneumonia and wound infections, proton pump inhibitor review process, antibiotic prescribing and prompt faecal sampling in Urgent Care.
- Pressure Ulcers - Introduced the new "FIT" fellowship in October 2019. The FIT developed this pathway for frontline nurses to spend a year working with the three specialities to develop their knowledge in these specialities and also their leadership skills. This role is the first of its kind in the country and is being presented by the F.I.T. team at the Pathway to Excellence Conference in Florida in May 2020. Held the 2nd collaborative with our colleagues from KGH, NHFT and Three Shires on the 28th November 2019, it was a hugely successful day with a large attendance. Have seen an increase in complex wounds, increasing the workload for the tissue viability team. To meet this demand we have appointed additional WTE in the tissue viability team. The NHS Improvement Pressure Ulcer collaborative continues. Project work has commenced focussing on specific areas (one of which will be the number of heel related tissue damage).
- Falls - Data collection for the national falls CQUIN recommendations 'three high impact actions to prevent hospital falls'. This has led to changes in how lying standing blood pressures are recorded, mandatory rationale for prescribing on electronic systems and an increase in the availability of walking aids. The Falls core care plan is completed on admission to the Trust for patients highlighted as having falls risk factors. This care plan has been reviewed and is being implemented across all adult inpatient areas. the changes allow for easier documentation of patients falls prevention needs and

multidisciplinary involvement in care planning. A trust wide Standardised operating procedure for the availability and provision of walking aids has been ratified. The inpatient falls prevention training has been reviewed and a role specific analysis completed. All non-medical staff are now completing face to face training. A county wide falls prevention conference was put together with the falls leads from NGH, KGH, and NHFT. Over 80 delegates attended from across the county and speakers delivered a number of topics sharing best practice for falls prevention. Recommendations from a thematic review included reviewing education for staff on mobilising patients on oxygen, reviewing advice on enhanced observations and introducing frailty scoring. A standard operating procedure has been developed by the Trusts lead for Oxygen, the enhanced care risk assessment has been updated to include more advice on the levels of observation to be considered for patients at risk of falling and frailty scoring has been included on the new falls core care plan and training commenced.

One enabler under this success factor will be reported in next year's Quality Account:

- Standards of care (SOC) scores

Results (as at quarter 3)
Metric 2a – VTE risk assessment



We have seen a gradual decline in compliance for VTE risk assessment in our organisation over the past 6 months. We expect to see compliance meet our target value of 95 % after the introduction of a forcing function risk assessment on the e-prescribing system. This will fully commence in

April 2020.

Metric 2b – Clostridium difficile

	2019/20 Healthcare Onset Healthcare Associated	2019/20 Community Onset Healthcare Associated
APR	2	1
MAY	3	2
JUN	1	3
JUL	2	3
AUG	2	1
SEP	1	1
OCT	2	2
NOV	2	3
DEC	2	0
JAN	3	0
FEB	2	2
MAR	1	3

From 1 April 2019, NHSI introduced new C. difficile infection (CDI) objectives and case descriptors. Prior to this, hospital associated CDI were cases that were detected in the hospital three or more days after admission. Following 1 April 2019, hospital associated CDI are cases that are both detected in the hospital two or more days after admission and cases that occur in the community, either within two days of admission or when the patient has been an inpatient in the Trust in the previous four weeks.

Metric 2c – Pressure ulcers

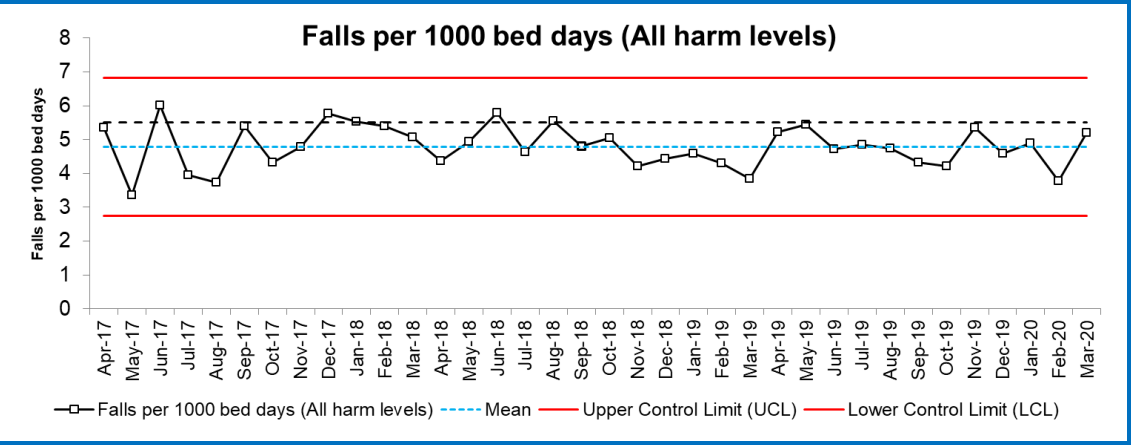
Category	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
Category 2	14	14	10	28	13	9	5	5
Category 3	0	0	0	0	1	0	0	0
Category 4	0	0	0	0	0	0	0	0

Category	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
DTI	8	11	3	10	5	2	4	3

Unstageable	2	4	4	4	5	4	0	1

The number of hospital acquired pressure ulcers has remained within the expected limits during the last 12 months.

Metric 2d – Falls



The falls rate remains within the expected limits and below the national average.

Further improvements we need to make are:

- A Standards of Care (SoC) scoring system has been developed and manually tested, to provide objective data around the standard of care given to deteriorating patients in the Trust. SOC scores are currently calculated following manual data collection on patients with a EWS score of greater than seven. These manual scores will form the baseline from which we will endeavour to make improvements during 2020/21. The Trust is working to develop electronic generation of the SOC scores, after which the focus will move to improvement to standard of care for deteriorating patients.
- The introduction and roll-out of a forcing function for VTE risk assessment on our e-prescribing system, as outlined previously.
- C.Diff delivery plan for 2020/21 will continue to focus on a process for sharing and learning from the community onset cases, prevention of urinary tract infections, hospital acquired pneumonia and wound infections, proton pump inhibitor review process, antibiotic prescribing and prompt faecal sampling in Urgent Care.
- The introduction SSKIN ambassadors across the hospital, to promote tissue viability at a local level. Development of a new training workbook for tissue viability, which is currently being trialled in Care

of the Elderly wards.

- Over the next 12 months the falls prevention team will be reviewing practice against the new national audit on inpatient falls audit data collection tool made available in January 2020. Any actions required will be added to the falls prevention action plan to work on collaboratively with the falls multidisciplinary working group.
- A Standards of Care (SoC) scoring system has been developed and manually tested, to provide objective data around the standard of care given to deteriorating patients in the Trust. SOC scores are currently calculated following manual data collection on patients with an Early Warning Score (EWS) score of greater than seven. These manual scores will form the baseline from which we will endeavour to make improvements during 2020/21. The Trust is working to develop electronic generation of the SOC scores, after which the focus will move to improvement to standard of care for deteriorating patients.

SUCCESS FACTOR 3 – Effective and Efficient Outcomes

We said we would:
Efficient and effective outcomes. Eliminate preventable early patient deaths by 10 % from baseline

In 2019/20 we:

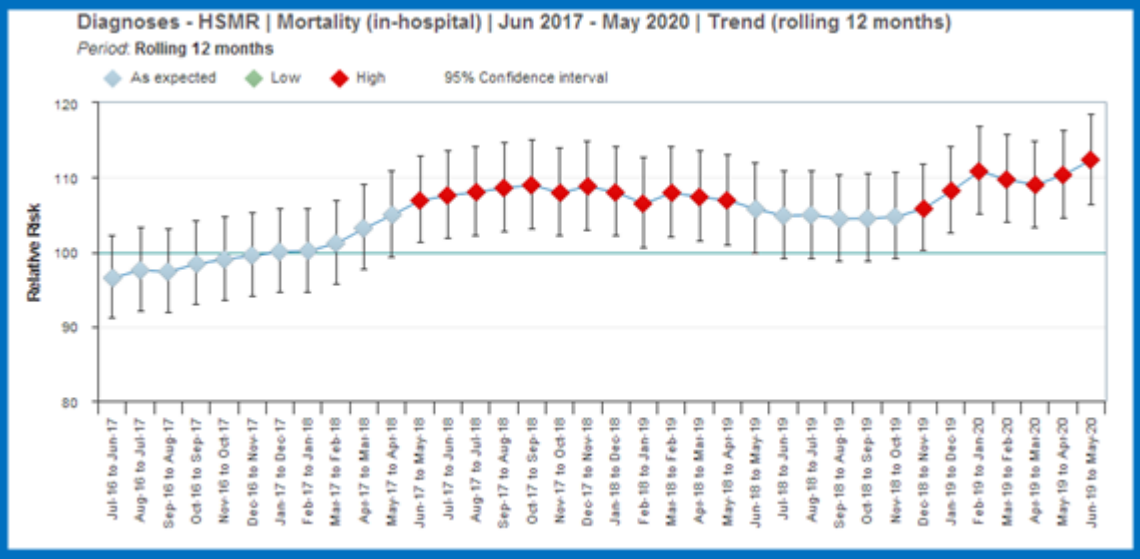
- Returned to within the expected range for our HSMR after an increase in 2018/19.
- Implemented a new DP care plan. The impact of this measured by the development of SoC scores for our acutely unwell patients. Several elements of essential escalation and assessment/treatment of the deteriorating patient are measured through audit. If appropriate and effective treatment was not provided, then a point is allocated. Best practice treatment and management of a deteriorating patient would score zero.
- Further development the initial concept of a DP care plan by developing an electronic tool on iBox. iBox is an IT system which has replaced the wards' white boards and provides an interactive view of the patients in specific areas with up to date information being pulled through from other systems such as CaMIS, ICE and Vitalpac. Using iBox to house the DP care plan will allow real-time audit of the SoC scores enabling the team to identify any areas requiring further training and development as soon as these occur.
- Created a DP "virtual ward", which will allows the Critical Care Outreach Team to have an overview of all deteriorating patients across the hospital and monitor/review them as appropriate.
- Service provided for patients with Specialist Palliative and End of Life care needs developed to provide resources and training across the Trust. Seven day service expanded to include bank holidays without an increase in nursing numbers. Referrals now made via Careflow system.

Three enablers under this success factor will be reported in next year's Quality Account:

- SMR – congestive cardiac failure
- MECC – smoking cessations
- MECC – alcohol dependence interventions

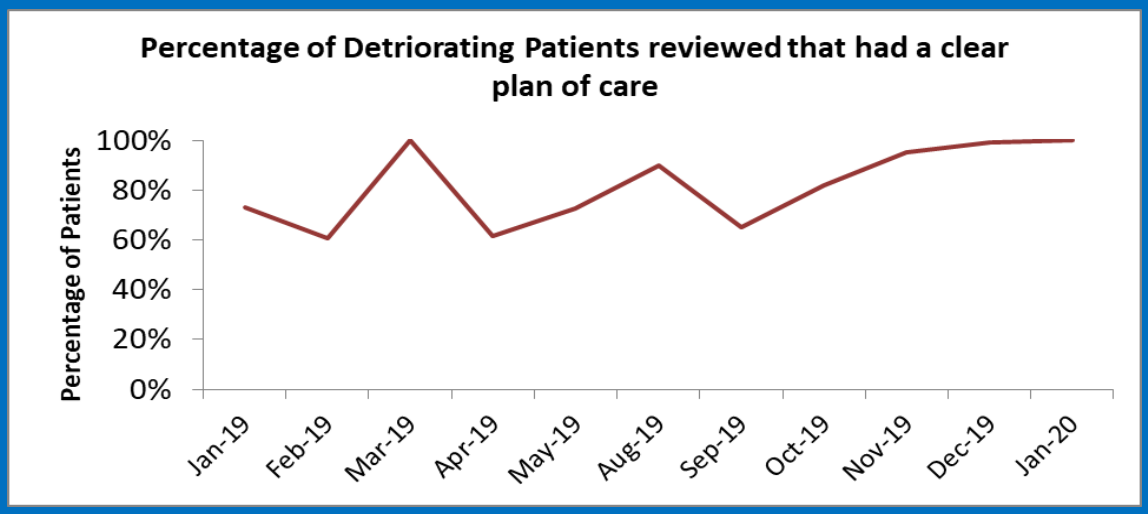
Results (as at quarter 3)

Metric 3a – HSMR data (as expected or below range)



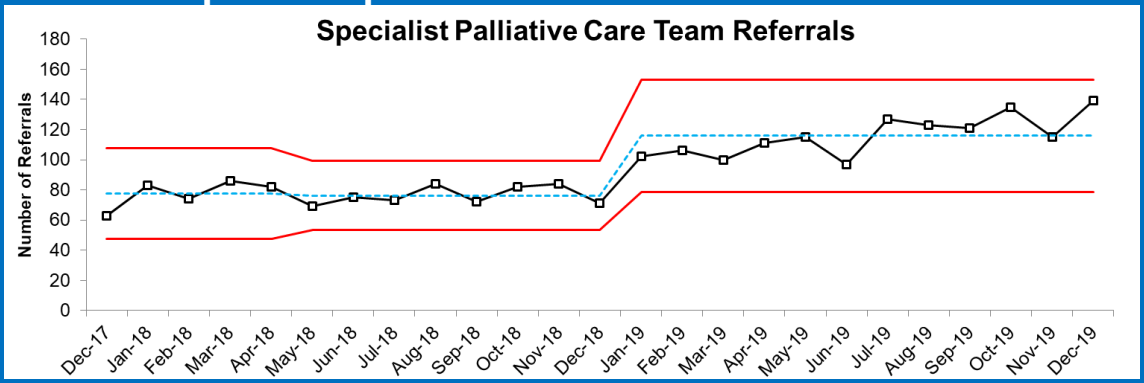
The HSMR has returned to within the expected range (i.e. a relative risk of 100) after an increase in the previous year.

Metric 3b – Deteriorating patient care plan use



The implementation of a DP care plan has been successful, with consistently high usage across the hospital. In areas where the plan is not used, there is clear evidence of effective management of deteriorating patients. We anticipate a continued improvement in this metric with the move to an electronic solution on iBox.

Metric 3c – Specialist palliative care team referrals



Data is collected by the specialist palliative care team.

Further improvements we need to make are:

- Use of from real-time data on the DP from iBox will be used to implement pro-active interventions. Our key interventions include point-of-care/in-situ simulations to address recurrent issues using the Standards of Care scores.
- Implement Palliative Outcome Scales that will help us identify the more complex and unstable patients within the case load so that these can be prioritised and wards supported to provide generalist level of palliative and end of life care.
- Continue with our progress related to smoking cessation and alcohol dependency in the county. Over the last few years the Trust has focused our support to patients to improve their own 'health and wellbeing' by raising awareness of the health effects of smoking and alcohol intake / use. We have provided training for our clinical staff to enable them to sensitively ask patients about their smoking and alcohol consumption use and facilitate a 'brief intervention discussion' to support those patients that may want to consider reducing their alcohol intake or to stop smoking.
- Work more closely with our Stop Smoking Service & Substance to Solutions to arrange on-going training and visits to our patients when individuals have identified that they would like additional support, beyond their immediate care in the hospital, to review their drinking or smoking habits.

SUCCESS FACTOR 4 – Patient Experience

We said we would:
Improve patient experience of care by 15% from 2018 baseline

In 2019/20 we:

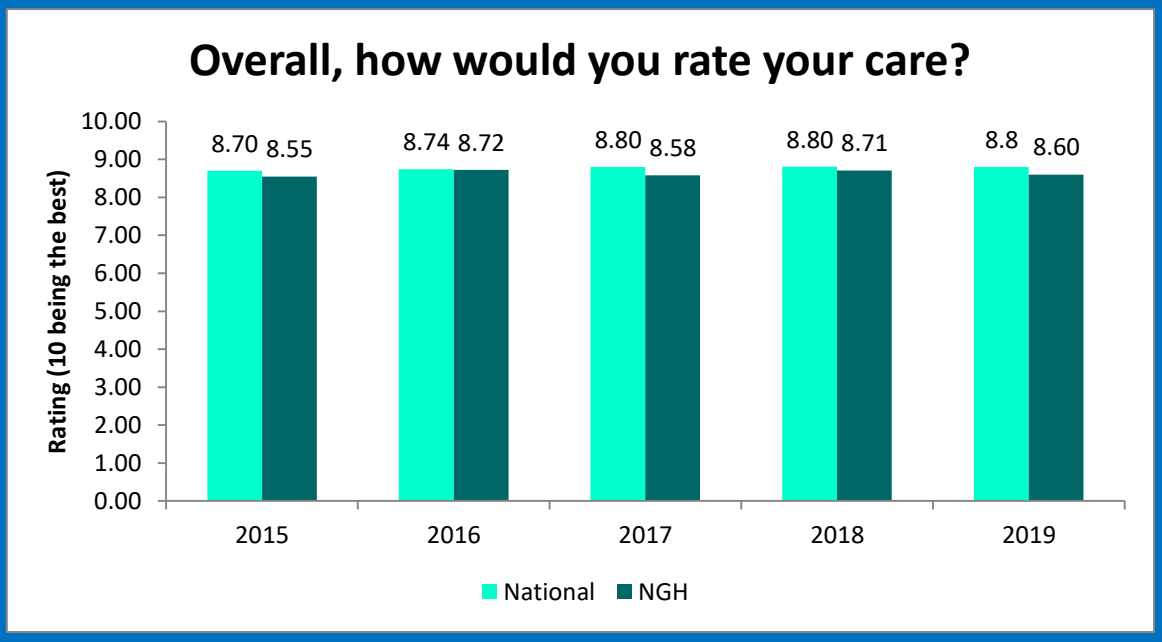
- Key staff responsible for the care and management of cancer patients, given access to National Cancer Experience Survey results to develop local plans and address issues. Developed a full time Cancer Navigator Role. Developed a timetable to run HOPE programme during 2020. Trained additional HOPE facilitators
- Nutrition Working group reviewed finger food presentation, content and ordering process and audit of finger food box orders completed. Draft finger food action plan devised and awaiting feedback from nutrition group.
- Dementia training recorded electronically by Training and Development from April 2019 onwards.
- The "Summer of Engagement" was ran in August and September 2019, offering NGH staff an opportunity to suggest areas for improvement in relation to their work experience. More than 1000 members of staff contributed. A 2020 People Plan has been designed to action issues raised as part of the "Summer of Engagement". This was endorsed by Trust Board in November 2019.
- A number of further actions relating to staff satisfaction has been developed including the appointment of a Head of Diversity and Inclusion and establishment of Diversity and Inclusion and LGBTQ networks. Actions relating to wellbeing include new Occupational Health staff to support Mental Health issues and introduction of flexible working reviews and monthly gatherings.
- Introduced our own bespoke patient experience surveys, giving feedback at ward level with enables targeted improvement. Right Time Forum established to discuss survey results and identify projects. Patient Experience Champions recruited, 25 multi-professional staff to date, who share patient experience with departments and carry out small projects. Shortlisted for two National Awards.
- Have increased the number of urology and orthopaedic GIRFT actions that have been delivered.

Two enablers under this success factor will be reported in next year's Quality Account:

- Outpatient appointment cancellations / changes
- Cancelled operations

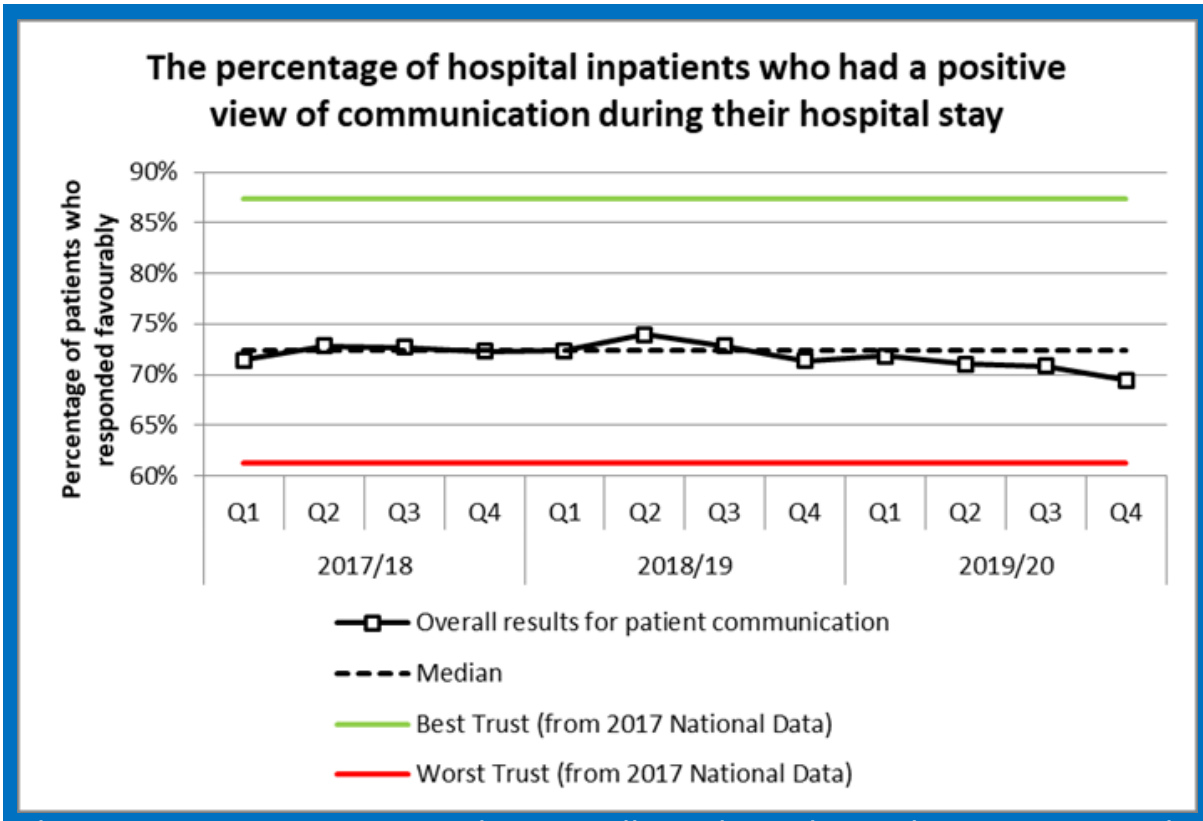
Results (as at quarter 3)

Metric 4a – Cancer Experience



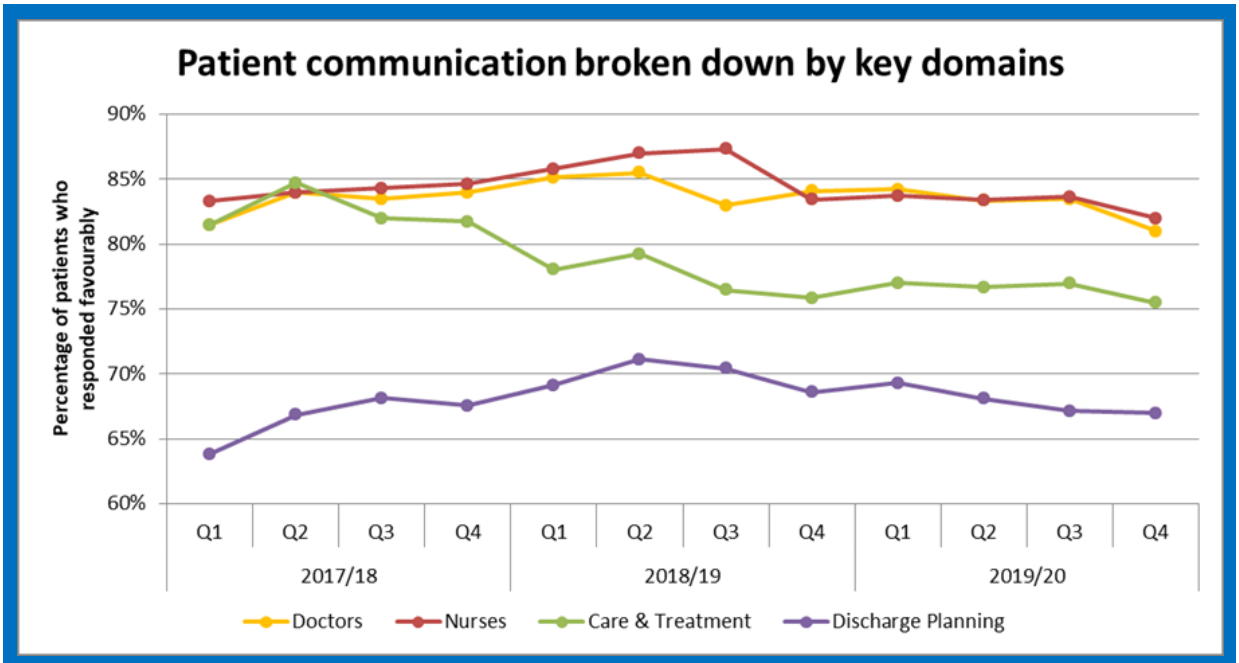
The cancer experience dataset is collected and reported as part of the National Cancer Patient Experience Survey. The Cancer Patient Experience Survey is conducted by Quality Health on behalf of NHS England. The aim of the survey is to provide insight on patient experience of cancer care. The NGH satisfaction rating for their overall quality of care remains in line with national average, with a marginal improvement between 2017 and 2018.

Metric 4b – Patient Communication

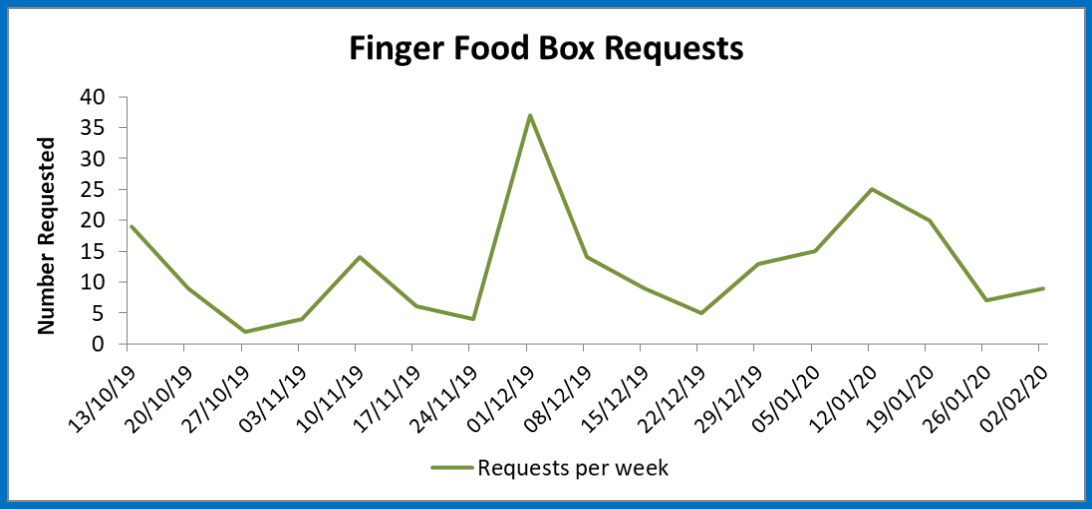


The patient communication data is collected via the Right Time national inpatient survey. Eighteen questions relating to communication have been collated and reported in the above graph. There has been no significant change in the proportion of patients who answered positively in relation to communication during their care. NGH data remains approximately halfway between the worst and best performing Trusts, as per the 2017 national dataset.

In order to further understand the dataset, we have split the questions by their national domains: Doctors, Nurses, Care & Treatment and Discharge Planning. There has been a general, continued decline in the communication questions related to care & treatment, with all other domains remaining steady or improving. This is shown below.

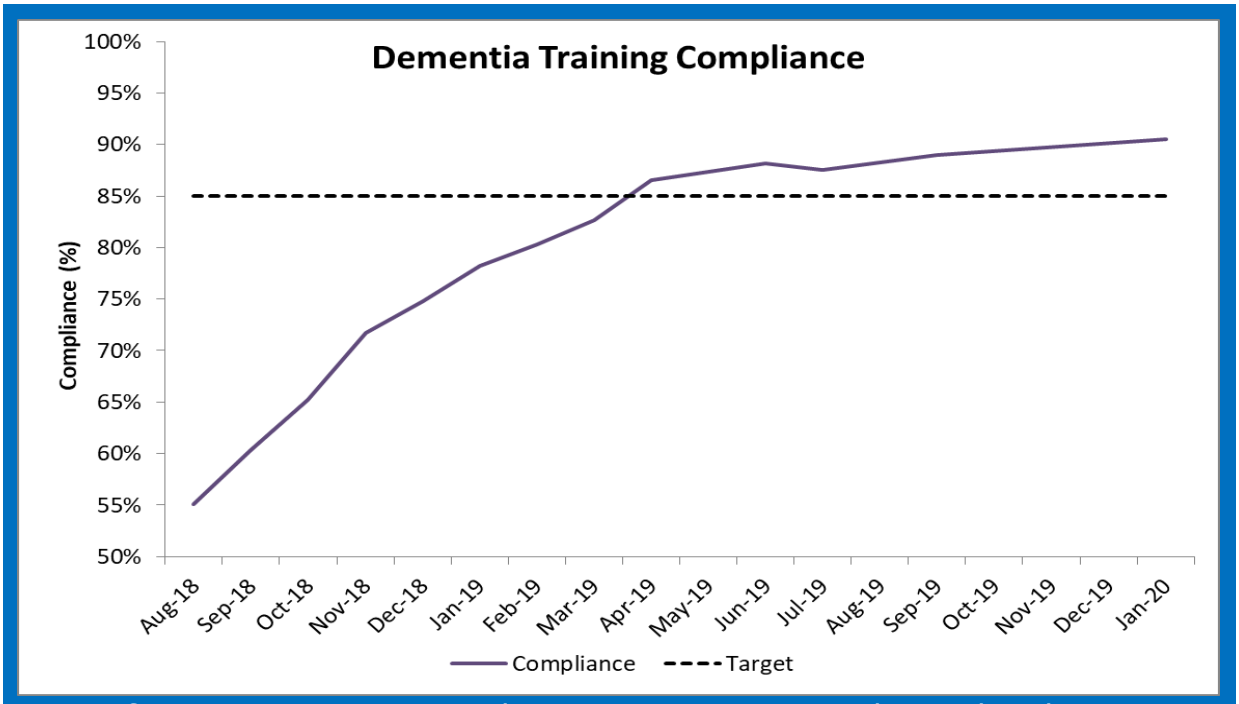


Metric 4c – Dementia – appropriate diet



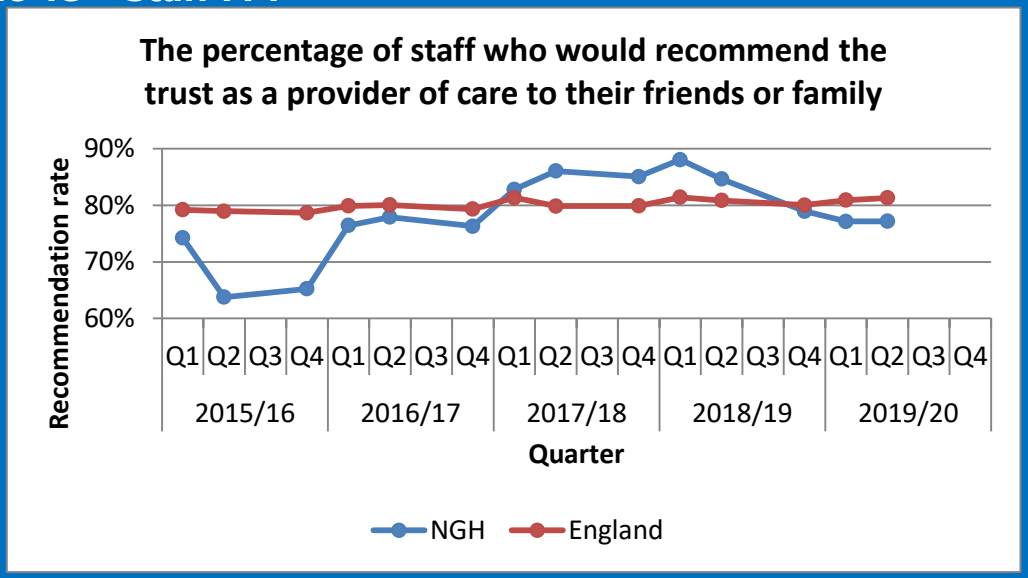
A point prevalence audit of finger food box requests was completed between October 2019 and February 2020. People with dementia often experience problems with eating and drinking – these finger food boxes enable patients to eat at any time of the day or night.

Metric 4d – Dementia training



A significant improvement in dementia training compliance has been seen, with compliance remaining above target throughout 2019/20.

Metric 4e – Staff FFT

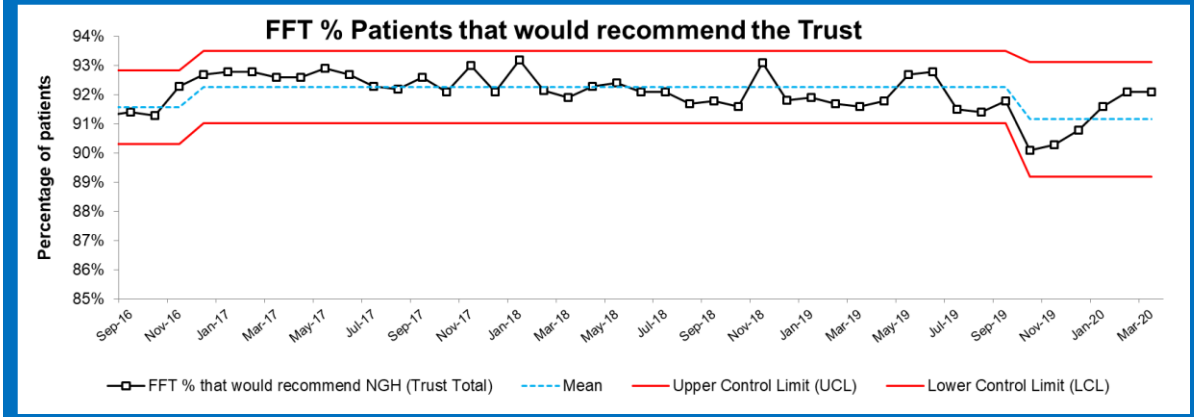


There has been a continued reduction in the recommendation rate since Quarter 1 of 2018/19. There was no collation of the Staff FFT for Q3 (October 2019 - December 2019) as this is the National Staff survey period.

Quarter 4 Staff FFT test did not get collated due to COVID -19, there is a temporary suspension of the submission of FFT data to NHS England and Improvement from all settings. We were advised we do not need to keep

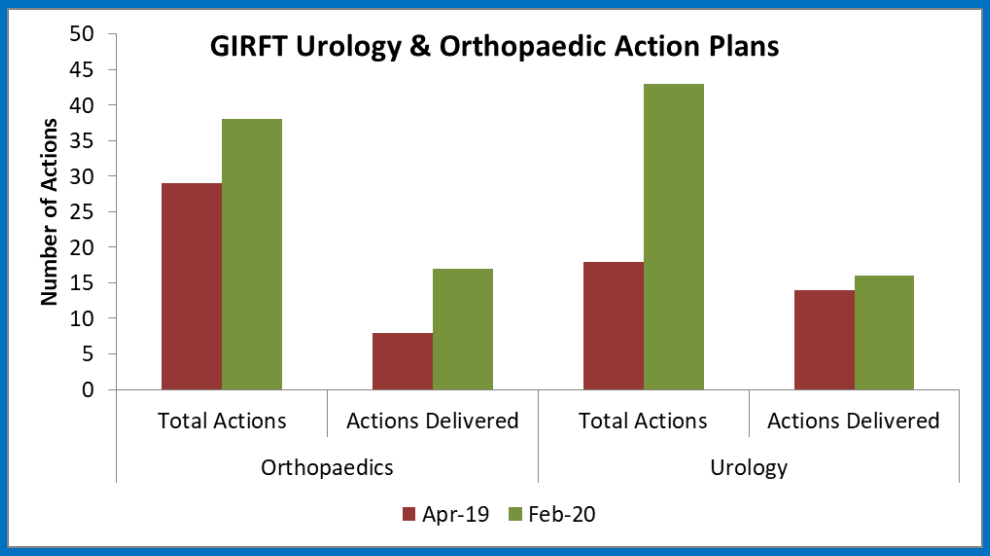
a count of responses collected during the suspension.

Metric 4f – Patient FFT



The decline in the recommendation rates can be attributed to the trust pressures. All comments from the FFT are themed to identify where patients' are finding the highest levels of dissatisfaction. It is evident from reviewing these, that increased waiting times and lack of communication during busy periods has a significant impact on the experience of patients. The trust will continue to review this and identify ways of supporting patients during this time.

Metric 4g – GIRFT



Throughout the year we have seen an increase in the number of actions allocated to Orthopaedics and Urology and an increase in the number of

actions delivered.

Further improvements we need to make are:

- Cancer experience - Implement personalised care and support for Cancer patients in line with national directives, to include:
    - Implementing E-HNS utilising a recognised tool
    - Developing a robust process to generate End of Treatment Summaries
    - Provide access to health and wellbeing events
    - Develop patient information webinar to support self-management
- Cancer experience - Improve information and support for cancer patients by:
    - Working with Maggie's to develop a centre attached to NGH
    - Working with Cancer Alliance to improve access to psychological support across the county
- Changes to the FFT – NHS England have announced changes to the FFT from the 1st of April. These will all be implemented at NGH, providing a fresh start for collecting patient feedback and making improvements.
- Patient Experience Framework - The patient experience framework was created by NHS England/Insight and allows organisations to identify the areas they need to focus on in order to achieve 'Outstanding' patient experience. The framework will be completed and from this, a set of objectives identified to shape the future for patient experience. This will work closely with the Quality Strategy.
- Thematic Triangulation – A large piece of thematic triangulation has been undertaken, incorporating 5 national surveys and looking at common themes found within each of them. From this, a number of exec led action plans have been created. These will continue to be monitored through the Patient & Carer Experience & Engagement Group (PCEEG).
- Patient & Family Partners - Further patient and family partners are being recruited to improve patient representation within the hospital and move towards coproduction. A Meet and Greet is planned for April 2020 where patient representatives will be invited in to meet one another and the patient experience and engagement team to plan further activities and hear of the goals of the organisation in regards to engagement.
- Coproduction Training – The Trust has ambitions to improve its coproduction with patients and the first stage of achieving this, is providing staff with the skills to engage well with patients. A training programme will be produced to give staff these valuable skills.
- Staff FFT - Better communication around the outcomes of Shared

Decision Making initiatives. Review the divisional structures, including possible role redesign. Support divisions to implement local initiatives using data from the national staff survey. Learn from successes of teams with high scores from the national survey. Provide targeted organisational development support to underperforming or achieving areas, following the success in Oncology and Cardiology. Implement a cultural awareness campaign in Facilities. Create open/quiet spaces for staff.

- Outpatient cancellations/rescheduled appointments - We have begun a programme of work that sees the integration of outpatient services under a newly formed Outpatient Directorate. This workstream will deliver significant operational and financial efficiencies through reducing DNA rates, improving new to follow-up ratios, reducing clinic cancellations and streamlining outpatient appointment booking processes. We have commenced with work to establish a central Contact Centre for outpatients, which will be fully established from June 2020.

A theatres productivity working group has been established to deliver the theatre productivity programme. Initial objectives include reducing the on the day avoidable and non-avoidable cancellations by the hospital.

SUCCESS FACTOR 5 – Outcomes in maternal & neonatal care

We said we would:
Improve the safety outcomes of maternal and neonatal care. Reduce the rate of still births, neonatal death and brain injuries occurring by 20% from 2019/20 baseline by 2020/21

All enablers under this success factor will be reported in next year's Quality Account:

- Reducing smoking in pregnancy
- Risk assessment, prevention and surveillance of pregnancies at risk of foetal growth movement
- Awareness of reduced foetal movement
- Effective foetal monitoring in labour
- Reducing preterm birth

Results
Outcomes for this success factor will be reported in 2020/21.

Further improvements we need to make are:

- Reducing Smoking in Pregnancy - Ongoing Quality Improvement project and audit into compliance of Carbon Monoxide readings at booking appointment and 36 weeks. Working on an IT solution to enable feedback from Stop Smoking Service on Women not accessing the service, to ensure we are compliant with Saving Babies Lives Care Bundle version 2
- Risk Assessment, prevention and surveillance of pregnancies at risk of foetal growth restriction – ongoing audit into missed cases of SGA/FGR using the Perinatal Institute's Standardised Clinical Outcome Review (SCOR). To improve centile submission rates this will become a mandatory field within the Medway system. Compliance with GAP E-Learning regarding this is being monitored and will be added to appraisals as it is now mandatory.
- Raising Awareness of Foetal Movements – An animation information video is going to be developed for use on the Trust website and Facebook page.
- Effective foetal monitoring in labour – ongoing Foetal Monitoring session being held twice a month for staff
- Reducing preterm births – majority of recommendations already in place. Aspirin dosage for women at risk of preterm birth to be increased from 75mg to 1560mg.

How our quality account was prepared

Priorities for Improvement

The traditional domains of quality include safe, effective, patient centered care and our quality priorities use these domains as a basis but take this further by focussing on continual improvement and aims to ensure that all our staff strive for excellence in all that they do and believe and support the organisational focus on delivering the "Best Possible Care".

We have listened to what our staff have told us is important to them, we have acknowledged lessons learnt from serious incidents complaints and concerns and we understand that we need to identify quality priorities that will maintain the progress achieved to date.

We will further improve the progress and outcomes to eliminate avoidable harm whilst using different approaches to increase the health and wellbeing of our patients and staff, responding to our patients and carers on what they consider to be important.

The five key work streams for our quality priorities are:

- Improving the safety culture at NGH by 10% from baseline
- Reduce the number of preventable harm events by 10%from 2018 baseline
- Efficient and effective outcome that will eliminate preventable early patient deaths by 10% from baseline
- Improve patient experience of care by 15% from 2018 baseline
- Improve the safety outcomes for maternal and neonatal care Reducing the rate of still births, neonatal death and brain injuries occurring by 20% from 2019 baseline by 2021

APPENDIX

APPENDIX 1 Statements from stakeholders

healthwatch Northamptonshire

Healthwatch Northamptonshire response to Northampton General Hospital NHS Trust (NGH) draft Quality Account 2019/20

During 2019/20 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. We are also grateful to the Trust for welcoming members of Young Healthwatch Northamptonshire to the visit the hospital as part of the national Takeover Day, allowing them to have an insight into the workings of NGH.

Healthwatch Northamptonshire believes that this Quality Account demonstrates in detail the progress NGH has made against their 2019/20 Quality Priorities during the year as well as an open and honest culture.

We appreciate the pressures on the Trust during 2019/20 and more so during 2020/21 and feel that focussing on the same quality priorities over a three-year period is therefore appropriate.

Healthwatch Northamptonshire supports all the priorities set out by Northampton General Hospital and can see the need for all of them, specifically priority 4 - Improve patient experience of care by 15% from 2018 baseline. We look forward to continuing to work with them to learn from patient feedback and support them in their efforts to improve patient experience. The value of good communication with patients and relatives is the most common theme to the patient feedback we receive, and we know that NGH recognises this and is seeking to improve communication across the Trust.

Healthwatch Northamptonshire understands the pressures that have been placed on Northampton General Hospital due to COVID-19 and the impact that this would have had on staff wellbeing. We are pleased to see an increase in uptake of wellbeing initiatives by staff from 2016 to 2019 and hope that the Trust has been able to support its staff even more in 2020.

During 2020, the way that we work with NGH has had to evolve due to the COVID-19 pandemic and as such we have carried out a virtual visit of maternity services with future virtual visits planned across other areas of the hospital.

We welcome the opportunity to continue to work with NGH in areas that involve adult, children and young people to ensure that patient and public feedback is valued and leads to improvements across the Trust.

Kate Holt

CEO, Connected Together CIC (contract holder of Healthwatch Northamptonshire)

UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

NHS
Northamptonshire
Clinical Commissioning Group

Att. Simon Hawes
Corporate Governance Manager
Northampton General Hospital NHS Trust
Governance Department
Cliftonville
Northampton
NN1 5BD

By Email : Simon.Hawes@ngh.nhs.uk
c.c. : michelle.metcalfe@ngh.nhs.uk

Francis Crick House
Summerhouse Road
Moulton Park
Northampton
NN3 6BF

Switch Board: 01604 651100

8th December 2020

Dear Simon

Re: Quality Report 2019/20

Thank you for providing us with the opportunity to comment on your annual quality report for 2019/20. The report has been reviewed by NHS Northamptonshire Clinical Commissioning Group.

I would like to take this opportunity to thank all staff at the trust for their hard work throughout such a challenging time this year.

It is noted that the report was reviewed whilst in draft format and that this report has been complied during the time of the Covid 19 pandemic and that this impacted on the collation of information due to the redeployment of staff.

Information on the participation in national clinical audits and confidential enquiries is included. It may be helpful to include actions that have been taken in response to these.

Narrative achievement against the quality priorities for 2019/2020 and performance against indicators and performance thresholds is included within the report. It may be useful to include additional information about when targets have or have not been achieved.

NHS Northamptonshire Clinical Commissioning Group looks forward to continuing to work closely with the Trust in 2020/21 and support ambitions to sustain high quality standards of care for people who use services.

Yours sincerely

Angela Dempsey
Chief Nurse & Quality Officer
NHS Northamptonshire CCG

Northamptonshire County Council

Mr Simon Hawes
Corporate Governance Manager
Northampton General Hospital NHS Trust
Governance Department
Cliftonville
Northampton NN1 5BD

Please ask for: James Edmunds
Tel: 07500 605276
Date: 15th December 2020

Dear Mr Hawes,

Northampton General Hospital NHS Trust Draft Quality Account 2019/20

Response from the Northamptonshire County Council Overview & Scrutiny Committee

Northamptonshire County Council operates a model for Overview & Scrutiny (O&S) based on a single O&S Committee with a remit that is focussed on the following areas:

- Delivery of Northamptonshire County Council's budget and savings plans
- Development of the Council's future budget proposals
- Major risks to the Council, the local community and the county
- Engagement, alignment and support for the Council's improvement plans

The O&S Committee's remit formally includes the statutory function for scrutinising the planning and provision of health services in Northamptonshire. In practice, at the request of the Commissioners appointed to improve the finance and governance of the Council, the Committee's work during 2019/20 has focussed solely on matters within the areas set out above.

The O&S Committee Chair and Vice Chairs therefore consider that the Committee is not in a position to provide detailed comments on local healthcare providers' draft Quality Accounts / Reports for 2019/20. This response in itself should not be interpreted as representing or implying a comment on the specific Quality Account / Report concerned or on the healthcare provider responsible for producing it.

Yours sincerely,

Councillor Victoria Perry
Vice Chair, Overview & Scrutiny Committee

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Northamptonshire County Council

Councillor Jim Hakewill
Vice Chair, Overview & Scrutiny Committee

Councillor Chris Stanbra
Vice Chair, Overview & Scrutiny Committee

APPENDIX 2 Abbreviations

	#	Fracture
	4Cs	Compliments, Comments, Complaints, Concerns
A	A&E	Accident and Emergency
	AKI	Acute Kidney Injury
	ACS	Ambulatory Care Service
	ANCC	American Nurses Credentialing Centre
B	BAME	Black Asian and minority ethnic
	BP	Blood Pressure
C	CCG	Clinical Commissioning Group
	CC&YP	Children and Young Persons
	C.Diff	Clostridium Difficile
	CEM	College of Emergency Medicine
	CIP	Cost Improvement Programme
	COPD	Chronic Obstructive Pulmonary Disease
	CNST	Clinical Negligence Scheme for Trusts
	CQC	Care Quality Commission
	CQUIN	Commissioning for Quality and Innovation
	CCOT	Critical Care Outreach Team
D	DH	Department of Health
	DAISY	Diseases Attacking the Immune System
	DNA	Did Not Attend
	DP	Deteriorating Patient
	DSP	Data Security and Protection

	DTOC	Delayed Transfer of Care
E	ED	Emergency Department
	ePMA	electronic prescribing medicines administration
	EWS	Early Warning Score
F	FFT	Friends and Family Test
	FIT	Falls, Infection, Tissue Viabilty
	FY1/2	First Year 1/2
G	GIRFT	Get It Right First Time
	GDPR	General Data Protection Rules
	GMPC	General Medical Practice Code Validity
	GP	General Practitioner
H	HSMR	Hospital Standardised Mortality Ratio
	HWN	Healthwatch Northamptonshire
K	KPI	Key Performance Indicators
	KGH	Kettering General Hospital NHS Foundation Trust
L	LMS	Local Maternity Services
M	MDT	Multi-Disciplinary Team
	MECC	Making Every Contact Count
	MRI	Magnetic resonance imaging
	MRSA	Methicillin-Resistant Staphylococcus Aureusis
	MUST	Malnutrition Universal Screening Tool
N	NCC	Northamptonshire County Council
	NCEPOD	National Confidential Enquiry into Patient Outcome and Death
	NCSC	National Cyber Security Centre

	NDG	National Data Guardian
	NGH	Northampton General Hospital NHS Trust
	NHFT	Northamptonshire Healthcare NHS Foundation Trust
	NHS	National Health Service
	NHSE&I	National Health Service England and National Health Service Improvement
	NICE	The National Institute for Health and Care Excellence
	NIHR	National Institute for Health Research
P	PALS	Patient Advice and Liaison Service
	PROMs	Patient Reported Outcome Measures
Q	QI	Quality Improvement
	QIPS	Quality Improvement and Patient Safety
R	R&D	Research and Development
	RoHG	Review of Harm Group
S	SDM	Shared Decision Making
	SHMI	Summary Hospital-level Mortality Indicator
	SJR	Structured Judgement Review
	SoC	Standard of Care
	SOS	Supporting our Staff
	SSC	Student Selected Components
	SSKIN	Surface, Skin inspection, Keep moving, Incontinence/moisture, Nutrition/hydration
T	TARN	Trauma Audit Research Network
V	VTE	Venous Thromboembolism

Prepared by

Governance

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

September 2020