UNIVERSITY OF LEICESTER
Associate Teaching Hospital

NHS
Northampton General Hospital
NHS Trust

Quality Account 2020/2021

Introduction

What is a Quality Account?
A Quality Account is published each year with the purpose 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.

We measure the quality of the 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 preparation of our Quality Account was disrupted and made challenging in 2020/21 due to the Covid-19 pandemic. The contributors and editors throughout the year have been re-deployed to assist with other clinical priorities and have had to adapt to changing scenarios in line with national guidance. Similarly, data collection and information for some areas may have been disrupted through the suspension and reduction of some services.

This report follows the guidance set out by the Department of Health.

- Part One
  - Opens with a statement on quality from our Hospital Chief Executive Office Eileen Doyle, 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.
- Part Two
  - Provides details of several Statements of Assurance regarding specific aspects of service provision in order to meet the requirements of NHS England/Improvement.
- Part Three
  - Describes how we performed against the quality priorities set for 2020/21, together with performance against key national

priorities in line with NHS Improvement Risk Assessment Framework.

- The closing section outlines feedback from our key stakeholders and includes a helpful dictionary of abbreviations.

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: ngh-tr.pals@nhs.net

Statement of quality

Dear All,

Welcome to the Quality Account of Northampton General Hospital NHS Trust (NGH) for 2020/21. 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:

- Throughout the Covid-19 pandemic.
- On the deteriorating patient.
- To actively work on reducing patient harms.
- On our Freedom to Speak Up campaign.
- In the maternity modernisation agenda.

We aspire to excellence – the Trust continues with its work:

- Through our collaborative Group model with KGH.
- Through the Pathway to Excellence®.
- With our wards Nursing Assessment and Accreditation programme.
- Towards university teaching hospital status with the College of Life Sciences at the University of Leicester.
- Collaborating with the University of Northampton.

We reflect, we learn, we improve – the Trust continues with its work:

- With the Get It Right First Time (GIRFT) programme.
- To promote incident reporting thereby demonstrating a more positive reporting culture in the trust.

We respect and support each other – the Trust continues with its work:

- With the Supporting our Staff (SoS) initiative across the hospital.

- On 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 Quality Improvement, Patient Safety and Organisational Development teams.
- To develop our staff recognition schemes including the internationally recognised Diseases Attacking the Immune System (DAISY) scheme.
- Remaining 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.
- Supporting staff to work agilely throughout the Covid-19 pandemic.

Despite our commitment to Best Possible Care and the values that drive this we know there is always more to do especially in the challenging environment presented to throughout this year which have increased pressures throughout the system. There has been an unprecedented impact on all services provided during the Covid-19 pandemic.

Despite the challenges faced, and through the continued hard work and dedication of our staff, we continue to work on the majority of our Quality Priorities and are determined to continue to meet any challenges thereby providing the Best Possible Care to our patients.

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.



Eileen Doyle
NGH Chief Executive

Mr Matthew Metcalfe
Medical Director

Sheran Oke
Director of Nursing & Midwifery

Statement of directors' responsibilities

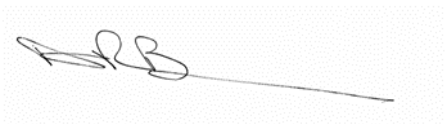
The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

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 are robust and reliable, conform to specified data quality standards and prescribed definitions, and are 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.



Eileen Doyle
NGH Chief Executive

Alan Burns
Chairman

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PART ONE

Our successes

Covid-19

Reflecting on the challenging year we have had, and the decisions taken to help us look after our patients and support our staff.

- We have continually reviewed routine activity to maximise it safely and to respond to the varying phases of the Covid pandemic.
- Worked collaboratively with Three Shires.
- We have supported over 800 people working from home.
- Lateral flow testing has been rolled out to patient facing staff.
- We were one of the first hospitals to do 24/7 Covid-19 testing.
- We had set up a drive through and walk through testing facility.
- We distributed many gifts through kindness offers from our community.
- Our Directors showed their thanks by handing out gifts.
- We had free raffles, with amazing prizes.
- Many recognition awards were given out including our Best Possible Care awards, which was a different but fun event.
- A seven-day nursing hub was put into place to manage staffing.
- We recruited nursing and medical students to support our workforce
- We welcomed new overseas staff.
- We appointed more staff and welcomed hundreds of new volunteers.
- We launched our academic strategy to achieve teaching hospital status.
- We put in place disability and BREXIT networks and appointed a BAME clinical fellow.
- We also gave out Stepping Up awards to any members of staff who went above and beyond.
- We employed medical students as clinical assistants which was a new, mutually beneficial role.
- Coffee and chat were introduced, back to the floor for executive directors now takes place as well as director walk rounds, we have a SOS team and in-house psychology support to listen, help & guide.
- We communicated daily relevant and timely information.
- "OUR SPACE" was put into place, almost overnight.
- We introduced free staff car parking.
- We made estate changes to our wards and departments to protect you and patients.
- We have started to build a new main entrance, Paediatric A&E and a new Critical Care Unit.

- We started to care for patients virtually in their own homes using oximetry.
- We used artificial intelligence to develop an oxygen usage model to make sure we were alerted if we were running low on oxygen.
- We were the second highest recruiter in Covid-19 trials.
- We introduced and expanded our frailty service and increased our same day emergency care service.
- We were one of the first 50 sites nationally to administer the Covid-19 vaccine.

Northampton General Hospital named Health and Wellbeing Employer of the Year at national awards

Northampton General Hospital has been crowned Health and Wellbeing Employer of the Year, at the fifth Our Health Heroes Awards, for its staff wellbeing services that have supported the workforce, both physically and mentally, during Covid-19 and beyond.

Delivered by Skills for Health, the annual Our Health Heroes campaign shines a light on the efforts of healthcare support staff.

Bronwen Curtis, Director of HR and OD, NGH said about winning the award: *"Providing support to our staff is our shared passion and their health and wellbeing is our focus. Our team practices of sharing insights, researching evidence, innovative thinking and collaborative working mean we can provide a wide range of services that meet the diverse and changing needs of our staff. We feel extremely proud that our contribution has been valued."*

The award-winning Health and Wellbeing Collaborative; comprised of a Staff Psychology Service, Health and Wellbeing Service, Occupational Health Service, Support our Staff (SoS) Service, Organisational Development (OD) and Human Resources (HR) Team are truly multidisciplinary in their approach; applying the skills of experienced clinicians alongside those of non-clinical and voluntary staff, to deliver

exceptionally diverse, preventative, and responsive effective outcomes for the entire workforce.

The award was presented by Prerana Issar, Chief People Officer at NHS England and Improvement. On announcing the winner, Prerana said: *"The focus on health and wellbeing is crucial for all employers and staff, now so more than ever, with the additional challenges faced by our NHS people due to the pandemic. And it is a key focus within our NHS People Plan. By recognising those who are going above and beyond to implement wellbeing strategies that are making a real difference to staff, we will hopefully inspire other organisations to do the same."*

The numerous initiatives offered by the Health and Wellbeing Services focus on maximising the emotional, physical, and practical resources available to care for all staff, at every stage of their NGH journey.

Northampton General Hospital Highly Commended at 40th Health Service Journal Awards

NGH has been Highly Commended for the Environmental Sustainability Award at the 40th HSJ Awards.

Following an extensive judging process, undertaken by a wide range of well-respected figures from across the UK healthcare community, NGH has been Highly Commended in recognition of their outstanding contribution to healthcare over the past 12 months – a year which has undoubtedly been one of the most demanding on record for the NHS.

The entry has been based on the hospital-wide actions that have been taken to reduce NGH's environmental impact. These actions include:

- Reduction in carbon emissions from heating, lighting and power in line with NHS targets
- Reduction in the environmental impact of the anaesthetic department through changes in the use of anaesthetic gases
- Removal of over a million pieces of single use plastic each year from the staff restaurants and from the wards
- Enabling home working for over 10% of staff during Covid-19, which has reduced local pollution as well as reducing fossil fuel use
- Introduction of reusable gowns and named, reusable theatre hats

The judges said of NGH: *"The judges could clearly see how the team worked with local organisations and national networks, by being embedded in other strategies rather than just a stand-alone concept. Early engagement work was recognised with the potential of building into a bigger strategy. The service and the patient are evidently at the heart of what they are doing."*

Stroke Service

The NGH Stroke Service was successful in being 1 of 3 sites chosen by NHSE&I to deliver a 2-year pilot of extended stroke rehabilitation through our Community Stroke Team. The pilot ends in March 2022.

The work is varied and involves developing services to improve the long-term rehabilitation for stroke survivors in Northamptonshire. These include developing a service that better supports the psychological needs of our stroke survivors, developing a vocational rehab service, setting up a stroke peer support network and a care re-enablement service. The care service will be looking at how best to provide rehab and care to those individuals with predominantly cognitive impairment.

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PART TWO

Statements of Assurance from the Board

2.1 Review of our Services

During 2020/2021, the usual commissioning and contracting arrangements within the NHS were suspended as part of the response to the Covid-19 pandemic. The Trust's lead commissioners remained NHS Northamptonshire Clinical Commissioning Group (CCG) [formerly NHS Corby CCG and NHS Nene CCG]. NHS Northamptonshire CCG also commissions on behalf of 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.

In addition, the Trust is also commissioned by NHS England for Prescribed Specialised Services such as the provision of a highly specialist urological surgery services, specialist cancer services, neonatal intensive care and other specialised services. Additionally, this contract includes some Secondary Care Dental Services and screening services, including new-born and cancer screening, commissioned on behalf of Public Health England.

The income generated by the relevant health services reviewed in 2020/2021 represents 92.3% of the total income generated from the provision of relevant health services by the Trust for 2020/2021.

Sub-Contracted Services – The Trust as Provider

The Trust also provides a variety of services to other NHS organisations, public sector organisations and private sector companies. During 2020/2021 we provided services to 36 relevant health or support services including:

- St Andrews Healthcare
- Kettering General Hospital NHS Foundation Trust
- Oxford Radcliffe University Hospitals
- Northamptonshire Healthcare NHS Foundation Trust and
- BMI Three Shires Hospital

The services provided includes medical staffing and support services, such as Diagnostics (Pathology and Radiology) or accommodation.

Sub-contracted Services – Provided to the Trust

During 2020/2021, the Trust subcontracted services to 26 organisations for relevant health services. Key contracts include:

- Kettering General Hospital Foundation Trust
- Northamptonshire NHS Foundation Trust
- Backlogs Ltd
- Blatchford Group
- Boots UK Ltd and
- several General Practices (GPs)

These sub-contracted services include:

- Consultant Medical staffing in various specialties
- Therapy services (including paediatric Physiotherapy and Occupational Therapy, Speech & Language Therapy, Dietetics, and Podiatry)
- Community Dermatology Clinics at GP surgeries
- Special Needs Dentistry
- Insourced clinical support within surgical specialties

We also have a range of agreements with voluntary sector providers for services such as hospital education and discharge support.

In addition, the Trust accessed services specifically aimed at supporting the timely access to treatment with BMI Threes Shires hospital via a national contracting arrangement put in place with the independent sector in response to the Covid-19 pandemic.

Contract Quality & Performance Management

Contract and performance management frameworks exist for the main contracts held by the Trust and through these commissioner and provider responsibilities are clearly stated and monitored.

The Trust holds regular contract meetings with sub-contractors to monitor performance against the contract. However, concerns relating to the quality of subcontractors can also be raised at any point in the year and a formal contract meeting will take place to discuss them and address the concerns.

The Trust also reserves the right to make unannounced visits to relevant sub-contracted services to check the quality of service provision.

2.2 Participation in National Clinical Audits

The 12 Month Clinical Audit Plan for 2020-21 was ratified by the Quality Governance Committee (QGC) in March '20 and. This set out the work we were expected to do over this financial year. Unfortunately, Covid-19 had a clear and significant impact on all work across the NHS.

NHS England put out the following directive (which stayed in place for 2020-21) at the beginning of the pandemic:

National Clinical Audits on Quality Account list 2020-21

FINAL SIGNED-OFF WORDING FROM NHSE CONFIRMED 02-04-2020 'All national clinical audit, confidential enquiries [commissioned / funded by NHSEI] and national joint registry data collection can be suspended. Analysis and preparation of current reports can continue at the discretion of the audit provider, where it does not impact front line clinical capacity. All audit data that can be collected during this pandemic will give insights into how Coronavirus has impacted in other areas such as:

- elderly patients (hip fracture, dementia, heart failure)
- those presenting for emergency laparotomy
- those with cancer and diabetes to name but a few.
- Child death database, PICANET and MBRRACE-UK perinatal surveillance will be required for current clinical management and should continue'.

HQIP Covid-19 UPDATED (02-04-2020) guidance to NCAPOP Providers

Despite this directive most of our national clinical audits have continued and the summary of their progress is below.

Type	Description	Q1	Q2	Q3	Q4	Trend of last two quarters
National Audit N=104	Not applicable to NGH	-	-	3	3	=
	Completed	-	-	11	12	↑
	National Audit – Action Plan Overdue[1]	10	11	10	9	↓

	Not compliant[2]	0	0	1	1	=
	National Audit – nothing outstanding	36	17	16	25	↓
	National Audit – On Track		23	24	23	↓
	National Audit – Awaiting Report	21	27	16	14	↓
	National Audit – Action Plan OK	24	15	16	16	=
Red rated items	1	4 cardiology Nas, on risk register, VTE – on risk register, others overdue but not followed up due to Covid-19 pressures.				
	2	Not compliant because we have no fracture liaison service				

In addition to the ongoing audits that recur over time there have been some Covid-19 specific National Audits that our staff have registered and are running during this pandemic. These are not mandatory, but they are still examples of good practice and the will to contribute to learning and improvement throughout healthcare. These are outlined below:

National Audit		
(1) BAOMS Dental Infection Service evaluation during Covid-19 and (2) BAOMS Facial Trauma Service Evaluation during Covid-19	28/05/2020	Current
Management of tonsillitis/quinsy and epistaxis during the Covid-19 pandemic (Iintegrate)	14/04/2020	Current
British Rhinology Society – Covid-19 Safety of Rhinological Surgery Audit	01/06/2020	On Track
Covid HAREM (Had Appendicitis and Resolved/Recurred Emergency Morbidity/Mortality)	30/04/2020	Current
CovidSurg: Outcomes of surgery in Covid-19 infection	14/04/2020	Current
Outcomes of elective cancer surgery during the Covid-19 pandemic crisis: an international, multicentre, observational cohort study (CovidSurg-Cancer)	21/04/2020	Current
Covid-19 PAN (Acute Pancreatitis and Covid-19 pandemic: an observational case control study)	05/05/2020	Current
GlobalSurg-CovidSurg Week: Determining the optimal timing for surgery following SARS-CoV-2 infection	01/09/2020	Current

This year a 'Good Work' item has been introduced on the agenda where we have presentations and give credit to good work in clinical audit. These have included:

- National Joint Registry leads were commended for Excellent Data Quality
- National Adult Asthma Audit
- The Trauma Audit and Research Network (TARN)

These have all been mentioned for the good practice nationally.

2.3 Participation in Clinical Research

Research active hospitals have lower mortality rates and patients benefit from new innovations in diagnostics and treatments enabling the prevention of ill health, earlier diagnosis, better outcomes and faster diagnosis. We now have an approved Academic Strategy that outlines our ambition to become a University Hospital, grow our portfolio of clinical trials and research, develop an emerging Innovation function and leverage our position with the UK Government's investment in Research and Development in the NHS. To align with the Academic Strategy, Research and Development and been renamed as Research and Innovation.

The Research and Innovation Department at Northampton General Hospital is a dynamic, active hub of research activity with an excellent national track record of recruiting patients into the National Institute for Health Research (NIHR) and commercial studies. We are constantly seeking to expand our portfolio of acute specialties and to provide services in the most clinically effective way.

We are a team of 27 clinical and non-clinical research staff working with over 50 Principal Investigators across the hospital. All staff are Good Clinical Practice (GCP) trained and some staff are experienced GCP Facilitators who deliver NIHR courses across the region. Research and Innovation has established links with support departments in pharmacy, medical physics, imaging and pathology, providing the infrastructure required for the timely and efficient set-up of clinical trials.

Research and Innovation works in partnership with the National Institute of Health Research Clinical Research Network for the East Midlands

(EMCRN). Working closely with the EMCRN, we deliver a portfolio of both non-externally funded and commercial trials. These trials consist of high-quality clinical research of national importance and are included on the National Institute of Health Research Portfolio.

NGH recruitment was up by 200% in 2020/21 compared to the previous year and 2,543 patients were successfully recruited. Much of our success was due to the recruitment to urgent public health research trials.

As with all partner organisations in the East Midlands, Northampton General Hospital has made a major contribution to urgent public health research in order to gain a better understanding of Covid-19, its prevention and management. In response to the first wave of Covid-19, a decision was made to temporarily suspend all non-urgent activity so that Research and Innovation resources could be redirected to support urgent public health Covid-19 research and our research activity reflects this. One of these trials was RECOVERY – a randomised trial among adults hospitalised for confirmed Covid-19. Our success has been recognised as one of the top 10 highest recruiting sites in the UK. The RECOVERY trial provided the evidence to support Dexamethasone to reduce deaths in ventilated patients and those receiving oxygen. These ground-breaking results are influencing practice internationally and NGH has played a big part in this trial.

Northampton General Hospital NHS Trust (NGH) has embarked on an exciting journey with Kettering General Hospital NHS Foundation Trust (KGH) to become a University Hospitals Group which will serve the whole of Northamptonshire and beyond through closer alignment and partnership with the University of Leicester and all our other University partners. The Academic Strategy (2020-23) has been developed which sets out how the medical and research departments at both hospitals will be strengthened and coordinated by integrating research, innovation and education into multi-disciplinary training and education to deliver quality improvement in all domains.

Our vision for the Academic Strategy is to improve patient care through excellence in education and research. We will achieve our vision by delivering the following eight objectives:

- Partnering with University of Leicester to become a University Teaching Hospital Group.

- Foster a culture of learning, research and innovation with strong leadership championing the strategy.
- Provide a multi-professional clinical academic programme and improved training and development offer for staff.
- Increase opportunities and resources for innovation and research to be incorporated at the core of our work and clinical practice.
- Build academic, research and digital infrastructure to support and grow innovative clinical education and an increased research portfolio.
- Increase success of research funding from research networks, grant giving bodies and commercial sources.
- Develop closer alignment with all our University partners.
- Develop and promote the academic brand.

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 Accreditation	Pathology – Accreditation reference: 8115	Blood Sciences (incorporates Biochemistry / Haematology / Blood Transfusion / Immunology): Assessed Jan 2021 Microbiology: Assessed Jan 2021 Cellular Pathology / Mortuary – Fully accredited – subject to annual assessment
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 – Assessed Jan 2021 Microbiology – Infectious diseases in pregnancy screening – IDPS – Assessed Jan 2021
QA Cancer Screening Programmes	Pathology	Bowel Screening Breast Screening Cervical Screening

2.5 Commissioning for Quality and Innovation (CQUIN) Income

The operation of the 2020/21 CQUIN scheme was suspended for all providers due to Covid-19.

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. Submissions were suspended due to the Covid-19 pandemic creating a pause in recording and reporting but where possible evidence was still submitted.

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 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

CareQuality Commission

Last rated
24 October 2019

Northampton General Hospital NHS Trust

Northampton General Hospital

	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

CareQuality Commission

Last rated
24 October 2019

Northampton General Hospital NHS Trust

	Inadequate	Requires improvement	Good	Outstanding
Overall rating		▼		
Are services Safe?		Requires improvement		
Are services Effective?			Good	
Are services Caring?			Good	
Are services Responsive?			Good	
Are services Well led?		Requires improvement		
Use of resources		Requires improvement		
Combined rating for quality and use of resources		▼		

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 had to able to demonstrate it has taken action to address these breaches. If not, there was 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 was closed in October 2020 and any final outstanding items moved into other governance processes to monitor and follow up to completion following this meeting. This was discussed and agreed with the Trusts CQC Relationship Manager as all "must do" actions had been completed. Follow up with CQC will continue via Relationship Manager Meetings.

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 American Nurses Credentialing Centre. 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 and Social Care 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 using the toolkit, organisations will be able to reduce the risk of a data breach.

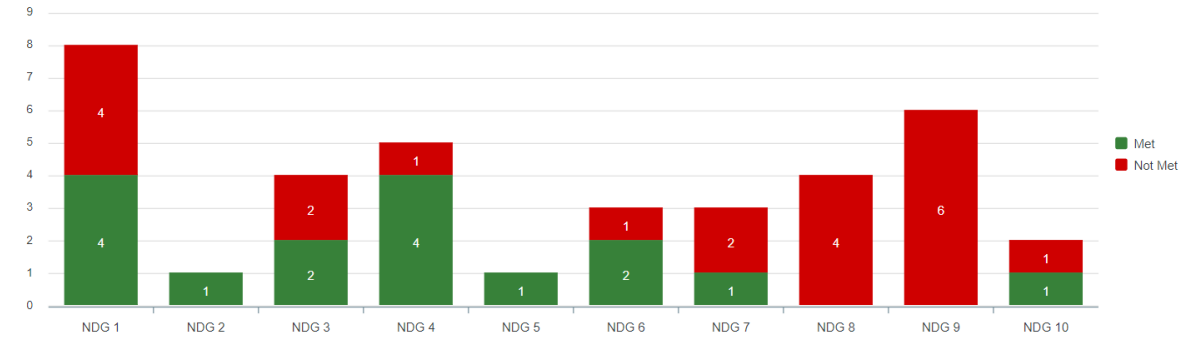
DSP Standards for health and care sets out the National Data Guardian's (NDG) data security standards. Providing evidence and judging whether the Trust meets the assertions, will demonstrate that the Trust is meeting the NDG standards. The NDG data security standards are:

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 42 areas of focus called 'Assertions', each of these has questions requiring evidence that are either mandatory or optional. 37 of these are mandatory for the 30th June 2021deadline.

There are currently 111 mandatory evidence requirements across the DSP toolkit. On the baseline assessment provided on 28 February 2021 the Trust completed 75 of the Mandatory requirements.



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

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. Most of the assertions relate to cyber security and the Tryst has recently recruited a new Cyber Security Manager who will support the completion of these assertions.

The Trust's auditors (TIAA) completed the Trusts DSP Toolkit Audit in February 2021 which is in line the NHSD standard audit criteria for specific assertions. The Trust was able to evidence the items already confirmed as appropriate.

Progress is monitored on an ongoing basis and reported to the Data Governance Group. Whilst several areas are showing as non-compliant, plans are in place, to be achieved before the submission date of 30th June 2021 to address these.

The Trust is also working towards Cyber Essentials Plus which is a UK government information assurance scheme operated by the National Cyber Security Centre 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.

The Trust reported six Information Governance serious incidents to the Information Commissioner's Office in 2020 (there were 14 reported in 2019) all of which have been investigated fully at the Trust with

relevant actions identified and implemented (or planned to be implemented) as appropriate in line with the CCG action plan.

We continue to develop tools to ensure compliance with GDPR, the Data Protection Regulation and the Freedom of Information Act and have now embedded the use of a Policy Management System which can enforce policies and training to relevant staff.

The Trust is proud to commit to high expectations for Information Governance and have made excellent progress for a clear culture change towards Data Protection using education and reporting best practice.

2.8 Data Quality

The Data Quality Team aims to provide a foundation for strategic and local management arrangements regarding Data Quality within the Trust to:
"Create a culture and understanding in staff of the value of capturing high quality data in real time to improve patient care. To continually record accurate data to ensure high quality care to all patients, citizens and stakeholders." NHS Digital, Performance evidence delivery framework.

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 need for high quality data.

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.

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. Current – update to date and valid
4. Definition – each data element should have clear meaning and acceptable values (via a data dictionary)
5. Granularity – attributed 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 Regulation (GDPR) principles. This is reported through the Trust Data Governance Group and the Clinical Administration Group with monthly reports to provide relevant assurance to the Board that sufficient measures are in place to monitor the following:

- Data Quality Audit.
- CDS/SUS submission and review via NHS Digital Data Quality report.
- MSDS (Maternity) data generation and submission.
- Monitoring of the DQMI (Data Quality Maturity Index) score.
- Data Quality Kitemark.
- Data Quality Alerting.
- Ensuring that the Knowledge Improvement Team aligns with the Data Quality Strategy.
- Admin Academy Training Statistics.

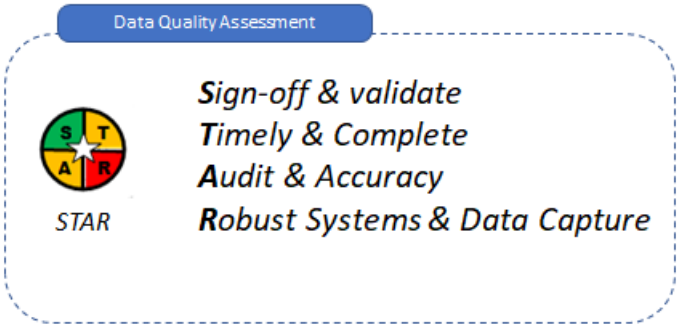
The Data Quality Policy aims to provide a structure for the assurance to improve the quality of data across the trust. The policy has been revised and updated in 2021 to include the Data Quality Kitemark, Data Quality Maturity Index and collaboration tools used with the Knowledge Improvement Team.

To ensure that we maintain data quality, we monitor our data quality metrics and have a number of alerts in place. These are automated alerts that are generated to identify user error and system issues at source. These alerts are designed to reduce the risks associated with human error and increase staff awareness of data quality issues.

The Knowledge Improvement Team ensure frontline staff are trained appropriately with Clinical Systems, using the DQ web form which allows staff to report DQ concerns as appropriate, to develop training spotlights, training packages, screensavers and news bulletins which reflect identified training needs. The Admin Academy (resourced by the

Knowledge Improvement Team) works closely with the DQ team to identify areas of training need and themes arising from training and issues reported. The Admin Academy takes a proactive approach to the improvement of systems training compliance and meets regularly with area managers to discuss findings, celebrate achievements and devise actions for improvement. Regular Admin Academy forums provide an opportunity for staff to share best practice and discuss concerns and issues.

The Data Quality Team is embedding the use of the Data Quality Kitemark which is allowing the team to carry out audits of information assets and data flows that the Trust holds, feeding in to the Trust's Information Asset register which is now published on the Trust Intranet. The STAR rating as a Kitemark will address the data quality domains through scheduled assessments depending on the score achieved.



In addition to the above, NGH are taking the following actions:

- Data Validation, including data items and pathway coding; using specifications given for data submissions to ensure only valid codes are submitted.
- Compliance with Data standards.
- Departmental Visits.
- Direction and guidance in key meetings.
- Close business relationships with Finance, Data and Coding.

2.9 NHS Number of General Medical Practice Code Validity

The Trust submitted records between April 2020 and December 2020 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 20 to Dec 20	Valid NHS Number	Valid GMPC
Inpatients	99.80%	99.99%
Outpatients	99.93%	99.99%
A&E	99.11%	99.66%

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%

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 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 after it is complete but due to the Covid-19 pandemic, it has only been possible to complete the Quarter 3 audit using the full methodology. Therefore, there is only one set of data at the time of writing and the results meet the requirements outlined in the Data, Security and Protection Toolkit guidance.

Q3 2020-21	% Accuracy Including All Error Sources	% Accuracy Excluding Non-Coder Error
Primary Diagnosis	**92.38%**	**94.01%**
Secondary Diagnoses	**84.09%**	**86.44%**
Primary Procedure	**95.04%**	**95.04%**
Secondary Procedures	**91.12%**	**91.12%**

2.11 Learning from Deaths

Number of deaths during the reporting period

The crude mortality at Northampton General Hospital is monitored monthly, alongside the nationally recognised Dr Foster mortality dataset. 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 provision of local community services. The Medical Examiner service and Structured Judgement Review process at NGH provide assurance of patient safety and quality of care at NGH.

During April 2020 – March 2021, 1909 Northampton General Hospital patients died of which 1721 were inpatients and 188 were deaths within the Emergency Department.

Q1	578
Q2	311
Q3	477
Q4	543
Total	**1909**

Medical Examiner Scrutiny of Deaths

From October 2019 the Medical Examiner (ME) system was implemented and a team of highly specialist and experienced individuals commenced their role as Medical Examiners. The ME service works closely with the bereavement team. MEs scrutinise the notes of adult inpatient hospital deaths 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 (MCCD) discusses their proposed cause of death with the ME to come to a final agreed cause. The ME then contacts the next of kin to explain the MCCD and answer any questions they may have, including noting any concerns they may raise, or positive feedback offered. If the ME 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 Office (MEO) sends the details to the Mortality office for them to arrange a formal review of the notes (a structured judgement review) by the clinical team who looked after the patient. The ME and MEO will also advise the doctor completing the MCCD if a coroner referral is required.

The Medical Examiner Service continued to be implemented over 2020-21, and by Q2 > 90% of adult hospital inpatient deaths at Northampton General Hospital were scrutinized by the Medical Examiner team, improving to >95% deaths in the latter part of the year.

Q1	317
Q2	262
Q3	444
Q4	540
Total	**1563**

Reviewing deaths – 2020-21 data

NB: Data supplied is current status for April 2021, and subject to change as further reviews are completed during 2021-22.

244 mortality case record reviews were completed using the Structured Judgement Review Tool (SJR) which is a validated methodology for standardising case note review supported by the Royal College of Physicians.

Structured Judgement Reviews

Q1	97
Q2	60
Q3	68
Q4	19
Total	**244**

Investigating deaths

If, during the 1st SJR review, the overall care of a patient is judged to be poor or very poor the case is referred for a 2nd SJR. These cases are independently reviewed at the SJR2 trust wide challenge meeting by an experienced group of reviewers. All Vulnerable Adult referrals are also reviewed as a parallel process at the Vulnerable Adult SJR2 Mortality & Morbidity Meeting. 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 2020-21, 33 were reviewed as part of the standard SJR2 process and 1 death received an Avoidability of Death Judgement score of 1, 2 or 3 and were therefore judged to be more likely than not to have been due to problems in the care provided to the patient.

At any stage during the mortality review process, cases can be referred to the Review of Harm Group (ROHG) to be reviewed via the trust's standard ROHG review processes.

56 deaths from 2020-21 were referred to the Review of Harm Group. At time of writing, 19 of these cases had simultaneously been referred for SJR and received a completed SJR review.

Of these 56 deaths referred to the ROHG, 22 deaths were declared a Serious Incident, 9 deaths declared a Comprehensive Investigation and 2 further deaths will be investigated as part of a trust wide Thematic Review. There were an additional 6 Serious incidents declared related to local ward outbreaks of Hospital Acquired Covid-19. Every identified patient death with hospital acquired Covid-19 was additionally referred for SJR, as part of an ongoing trust wide Mortality Review into Hospital Acquired Covid-19 deaths.

Feedback on both poor and excellent care is distributed trust wide, to specialty M&Ms and where applicable to individuals to promote learning from deaths.

Neonatal Deaths and Stillbirths

Neonatal Deaths >22 weeks

Q1	3
Q2	2
Q3	1
Q4	2
Total	**8**

Stillbirths >24 weeks

Q1	3
Q2	7
Q3	5
Q4	2
Total	**17**

- During April 2019– March 2020 there were 8 neonatal deaths after 22 weeks of pregnancy and 17 stillbirths delivered from 24 weeks of pregnancy
- 18 qualifying deaths have been reviewed using the Perinatal Mortality Review Tool
- 7 deaths were investigated as serious incidents
- 0 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	25
Q2	7
Q3	10
Q4	14
Total	**56**

- During April 2020 – March 2021 there were 26 deaths of patients with a learning disability
- During April 2020 – March 2021 there were 34 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)
- At time of writing, the care of 28 patients has been reviewed using the Structured Judgement Review tool. The remaining will be reviewed during 2021-22.
- 7 patient deaths, at time of writing, have also been referred to the Review of Harm Group. Of these 7 cases, 1 was declared a serious incident, 1 was declared a comprehensive investigation, and 1 declared part of a trust wide thematic review.
- 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 (LeDeR)

Appendix 1

Learning, Actions and Impact of Mortality

Mortality key work streams 2020-21 and trust wide mortality reviews

Area targeted by review	Data source	Work stream/s	Example of actions taken or proposed
Mortality work stream: Lung Cancer & Secondary Malignancy	Dr Foster data National Audit National Optimal Lung Cancer pathway	Led by Learning from Deaths Group	• Lung Cancer GIRFT review • Review of latest available National Lung Cancer Audit data • Achieving National Optimal Lung Cancer pathway targets • A report on palliative care provision was prepared to consider future demand for palliative care services and business case submitted.

Mortality work stream: Congestive cardiac failure	Dr Foster data National Audit	Led by Learning from Deaths Group in conjunction with Heart Failure Team	• 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 • Submission of business case to expand heart failure team • Development of action plan in conjunction with transformation & quality improvement teams
Mortality work stream: Early diagnosis project	Dr Foster data National Audit	Led by Learning From Deaths Group in conjunction with Clinical Coding & Urgent Care	• Electronic clerking to replace the emergency admission proforma booklet is currently being developed • Planned baseline audits of current documentation of a working diagnosis, with implementation of QI project to achieve 20% improvement above baseline.

Trust wide Mortality Review 14: Hospital Acquired Covid-19 cases	Medical Examiner team	Led by Learning from Deaths Group	• Trust wide Mortality review of all identified deaths caused by hospital acquired Covid-19 infection. • Data collection is ongoing, and the review is expected to be concluded during Q2 2021-22. • Learning themes from this mortality review will be distributed and shared trust wide.
Trust wide Mortality Review 15: Vulnerable Adult Deaths 2020-21	Medical Examiner team	Led by Learning from Deaths Group in conjunction with safeguarding team	• Trust wide Mortality review of all 2020-21 deaths referred to the Vulnerable Adult Mortality & Morbidity Meeting • Data collection is ongoing and will be completed during 2021-22. An interim report analysing Apr-20 – Sep-20 deaths is expected by the end of Q1 2021-22, with the final report completed later in the year. • Learning themes from this mortality review will be distributed and shared trust wide.

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 must:

- 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.

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 is used for adult inpatients

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.

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.

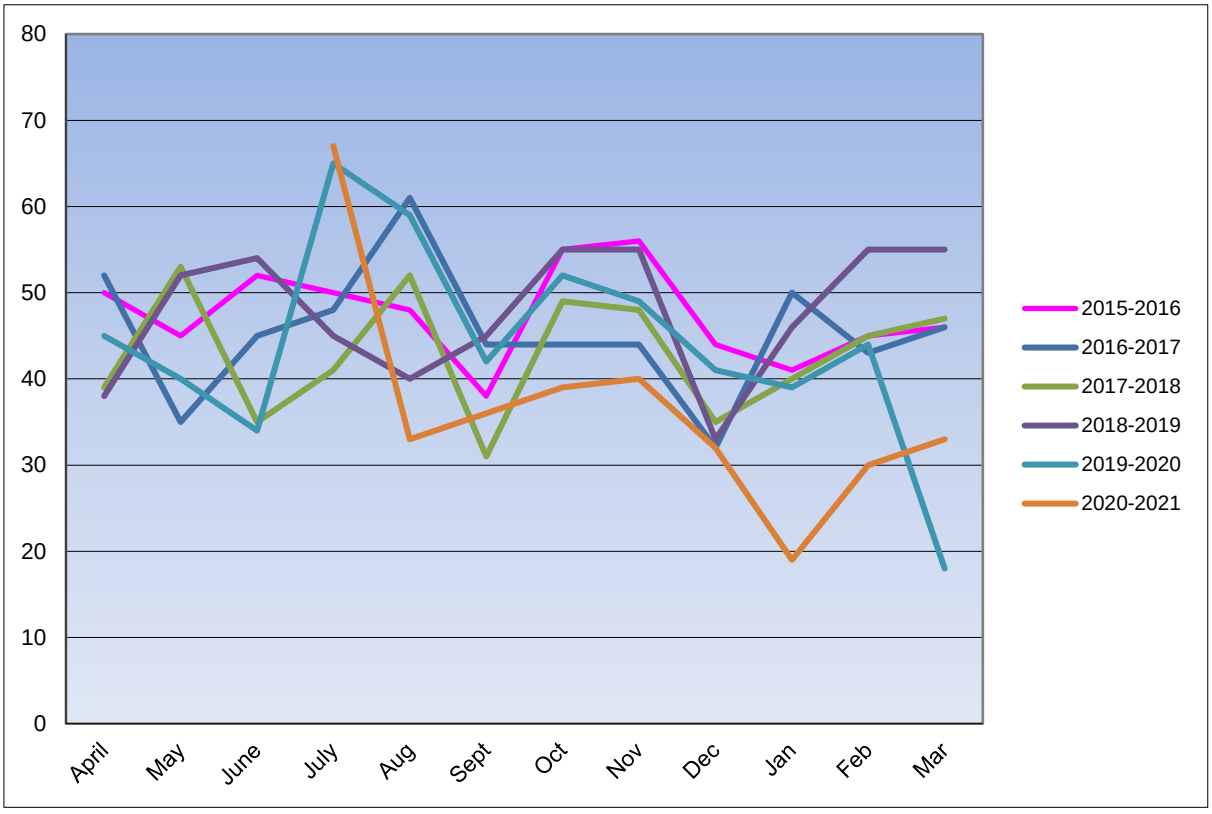
The Trust received a total of 329 written complaints that were investigated through the NHS Complaints Procedure from 1 April 2020 to 31 March 2021, which compares with 528 complaints received for the same period during the previous financial year.

Total no of complaints for the year	329*
(Versus 2019/2020)	(528)
Average response rate	99%
Total no of complaints that exceeded the renegotiated timescale	1
Complaints that were still open at the time that the information was prepared (9th July 2020)	32
Total patient contacts/episodes	599,080
Percentage of complaints versus number of patient contacts/episodes	0.05

**Due to Covid-19, the NHS Complaints procedure was paused nationally from the end of March 2020 until the end of June 2020. All new complaints were triaged in order to identify those relating to safeguarding issues, serious care concerns and potential incidents. All complainants were kept informed and invited to contact the Trust if they wished to proceed with their complaint once the pause was lifted.*

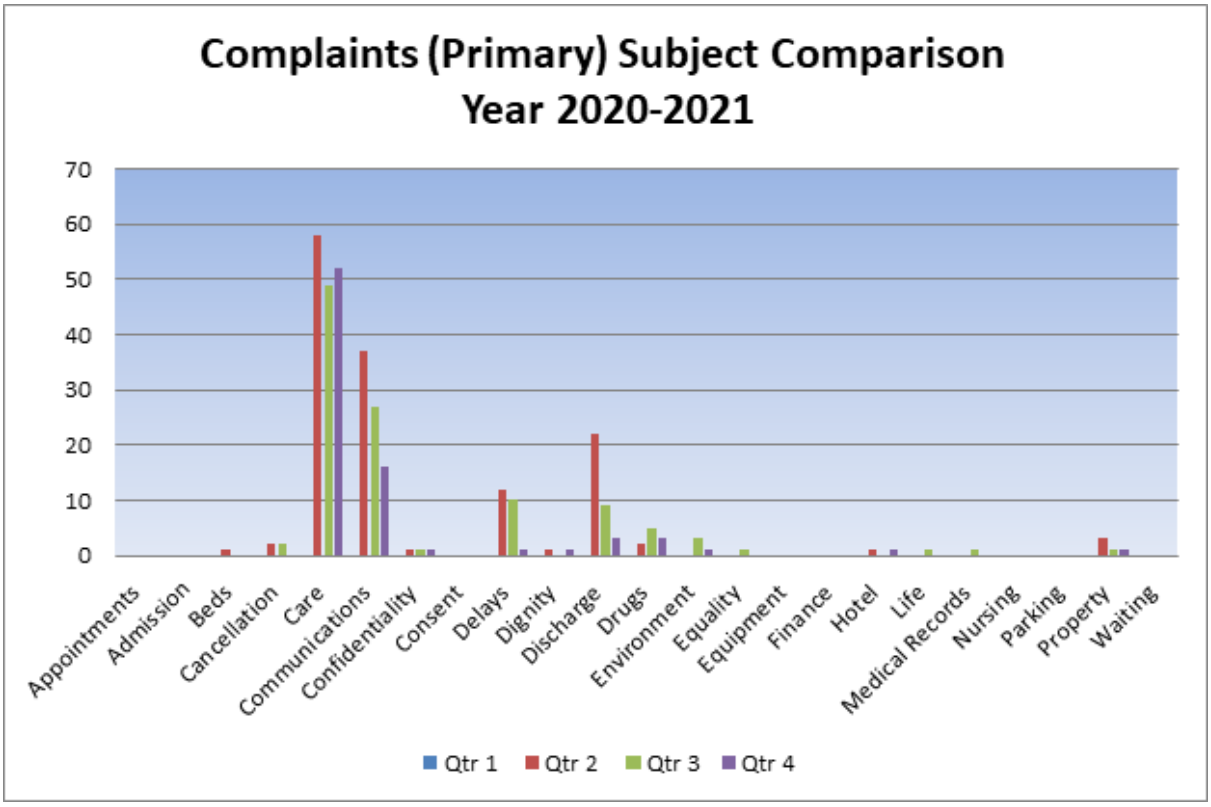
The complaints timescales were further revisited in December 2020 and January 2021 when they were temporarily extended. This was to support clinical staff providing direct care to acutely unwell patients. All complainants were contacted and kept informed during this period.

Number of complaints



Trend Analysis

The following chart provides the themes emerging from complaints:



What we achieved in 2020/21 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 99%. This has been an outstanding achievement given the challenges faced within this financial year in terms of dealing with a global pandemic and the continued increase in the complexity of complaints received.
Staffing	One new member of staff recruited with ongoing training in place.
Processes	Process charts have been developed for key tasks including the following areas: • Opening a new complaint • Triaging new complaints

	• Escalation process • Datix • Local resolution • Reporting • Preparing statements • Reopened complaints
Systems	Datix Cloud implemented across the Trust including Complaints and PALS.
Support to other departments	Staff redeployed through Covid-19 as follows: • Implemented and operated a Relative Helpline (7-day service) • Working with PALS during periods of increased activity • Supporting the Bereavement Service during periods of increased activity

2.14 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 have 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 have 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 19 – Sep 20	101	2	100	117	68
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 10 for the period October 2019 to September 2020 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 19 – Sep 20	40.0%	36.5%	60.0%	8.0%
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 2020/21	**NGH Quality Account 2019/20**	**Reporting Period 2019/20 Average**	**Reporting Period 2019/20 High**	**Reporting Period 2019/20 Low**
• Hip replacement surgery - primary (EQ-5D™ Index)	N/A	* (provisional Apr19 to Sep19)	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)	N/A	* (provisional Apr19 to Sep19)	* (provisional Apr19 to Sep19)	* (provisional Apr19 to Sep19)	* (provisional Apr19 to Sep19)
• Knee replacement surgery - primary (EQ-5D™ Index)	N/A	0.342 (provisional Apr19 to Sep19)	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)	N/A	* (provisional Apr19 to Sep19)	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)

The indicators have been updated with no change to the existing methodology and published in February 2021.

Period	Indicator Value NGH	Indicator Value National Average	Indicator Value National High	Indicator Value National Low
Patients aged 0-15				
2019/20	13.8	12.5	56.7	2.2
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				
2019/20	15.7	15.8	37.7	1.9
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
2019/20 (Hospital stay: 01/07/2019 to 31/07/2019; Survey collected 01/08/2020 to 31/01/2020)	61.7%	67.1%	84.2%	59.5%
2018/19 (Hospital stay: 01/07/2018 to 31/07/2018; 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 31/07/2017; 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
2020	72.0% (Acute and Acute & Community Trusts)	73.0% (Acute and Acute & Community Trusts)	92.0% (Acute and Acute & Community Trusts)	50.0% (Acute and Acute & Community Trusts)
2019	75.0%	77.0% (Acute Trusts)	90.0% (Acute Trusts)	48.0% (Acute Trusts)
2018	68.6%	71.3% (Acute Trusts)	87.3% (Acute Trusts)	39.8% (Acute Trusts)
2017	69.0%	70.0% (Acute Trusts)	86.0% (Acute Trusts)	47.0% (Acute Trusts)
2016	68.0%	69.0% (Acute Trusts)	85.0% (Acute Trusts)	49.0% (Acute Trusts)
2015	52.0%	69.0%	85.0%	46.0%

NGH is reviewing the scores in order to improve the rates, and so the quality of its services. The data are being fed through the trust's 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)

NHS England has confirmed that the data available from December 2020 onwards reflect feedback collected during the Covid-19 pandemic, while, also, implementing the new guidance after a long period of suspension of FFT data submission. The number of responses collected is, therefore, likely to have been affected. Some services may have collected fewer FFT responses, or been unable to collect responses at all, because of arrangements in place to care for Covid-19 patients.

We have therefore omitted this data for 2020/21.

Period	NGH	National Average	National High	National Low
Inpatient				
2020/21	Full year data unavailable due to Covid-19			
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)				
2020/21	Full year data unavailable due to Covid-19			
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 20/21	Data collection/publication suspended due to Covid-19			
Q3 20/21	Data collection/publication suspended due to Covid-19			
Q2 20/21	Data collection/publication suspended due to Covid-19			
Q1 20/21	Data collection/publication suspended due to Covid-19			
Q4 19/20	Data collection/publication suspended due to Covid-19			
Q3 19/20	95.00%	95.33%	100.0%	71.59%
Q2 19/20	95.25%	95.47%	100.0%	71.72%
Q1 19/20	95.34%	95.63%	100.0%	69.76%
Q4 18/19	95.10%	95.64%	100.0%	74.03%

Q3 18/19	95.45%	95.61%	100.0%	54.86%
Q2 18/19	94.95%	95.48%	100.0%	68.67%
Q1 18/19	90.98%	95.63%	100.0%	75.84%
Q4 17/18	96.61%	95.23%	100.0%	67.04%
Q3 17/18	95.92%	95.36%	100.0%	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%

- *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
2020/21	N/A	N/A	N/A	N/A
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.

- *Patient Safety*

Period	NGH	National Average	National High	National Low
The number of patient safety incidents reported within the trust - (Acute Non- Specialist)				
Oct 19 – Mar 20	5,468	8,549	22,340	1,271
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)				
Oct 19 – Mar 20	44.4	81.2	110.2	15.7
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)				
Oct 19 – Mar 20	29	37.6	93	0
Apr 19 – Sep 19	35	36.6	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)				
Oct 19 – Mar 20	0.53%	0.33%	1.49%	0.00%
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%

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 and through learning events where possible.

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

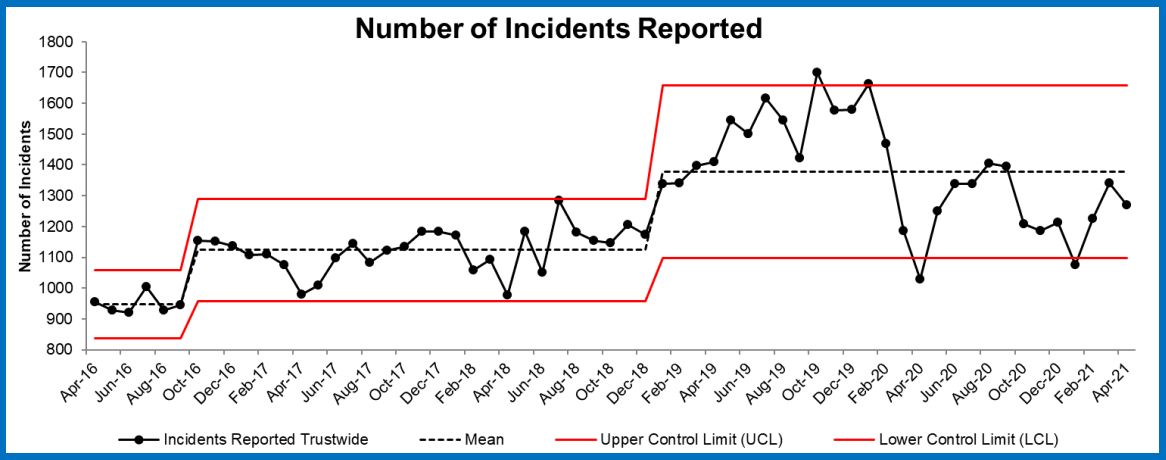
5. **Outcomes in maternal & neonatal care**
   Improve the safety outcomes of maternal and neonatal care. Reduce the rate of still births, neonatal death and brain injuries occurring by 20% from 2019/20 baseline by 2020/21

Review of last year's Quality Priorities

Our progress on each of these five success factors is outlined in detail below. The success and ongoing work as displayed in our three-year Quality Priority plan has been affected due to the Covid-19 pandemic and we have included below the areas where we have been able to collect the data.

SUCCESS FACTOR 1 – Safety Culture

Metric – 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.

Metric – Safety Huddles

Throughout the year the Safety Huddle has continued and has been key to having an overview of the trust, in particular during the Pandemic. As part of the Safety Huddle the nursing workforce is a key part of the safety agenda.

Recognising the significant effect that the pandemic was having on our workforce due to 'shielding', virus related sickness (Covid-19, anxiety/stress, pregnancy) and other sickness, and the need to proactively manage our nursing workforce across the Trust the senior nursing team set up the Nurse Staffing Hub in Wave I.

The 'Hub' co-ordinates the nursing staff across the wards in accordance to the acuity & dependency of our patient utilising SafeCare and professional judgment. The Hub, led by a Matron, and supported by clinical staff that are non-patient facing, also manages staff sickness, advising on screening, support and wellbeing of our staff.

In Wave II the Hub has been even more critical to the fundamental safety of our patients and staff. As the Trust has moved into the next stage of the pandemic many of the wards can no longer support supernumerary co-ordinators and since November Ward Sisters have been in the ward's establishment 'numbers' i.e. working within the team, taking a workload. Since December many of our Matrons have also worked clinically to support those areas that require additional clinical support due to reduced staffing capacity.

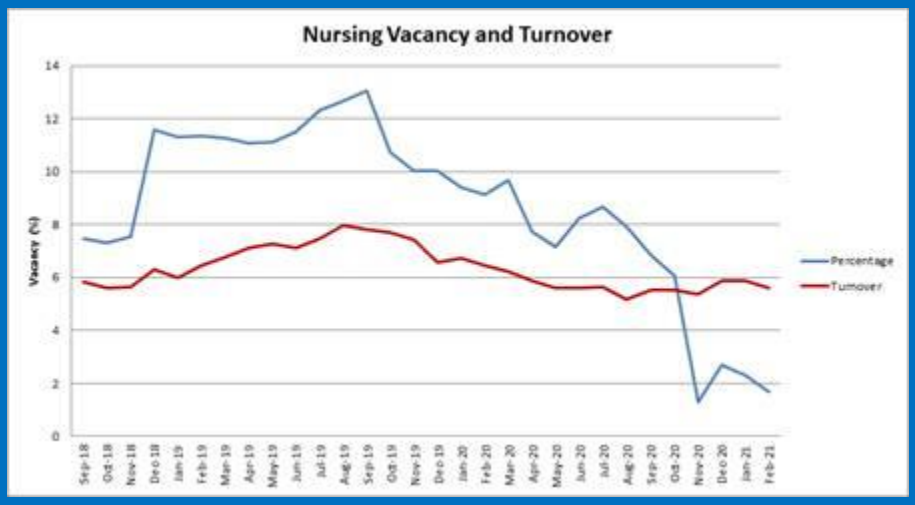
The Staffing Hub co-ordinates the Safety Huddle each morning and is attended (remotely) by A.D.N., Matrons & IPC. Using the SafeCare data (patient acuity and dependency), ward allocation due to Covid-19 and bed occupancy, and professional judgement of the senior nursing team the Hub re-allocate staff to mitigate risk and maintain the safest levels of staffing.

The Safety Huddle is repeated at 1300hr, reviewed by the Matrons at 1600 and with the Night Practitioners at 1900hr, thus providing support throughout the day & night. A Standard Operating Procedure was developed, ratified and has been updated for Wave II to support the Hub process.

Metric – Nurse Vacancies

Registered Nurse (RN) supply and demand remains one of the most challenging workforce issues and risks at local and national level with a significant number of RN vacancies across the NHS. In 2019/20 Northampton General Hospital (NGH) had a RN vacancy factor of 13% (August 2019), which equated to over 200 vacancies. This was against a landscape of reducing numbers of student nurses joining full-time University programmes. There was a reduction in the intake of student nurses onto the University of Northampton Adult Nursing Programme and a consequential reduction in the number of student nurses on placement

at NGH. This had a direct impact on the future recruitment pool for NGH as traditionally this had been the main local recruitment pipeline of newly qualified RN workforce for the Trust.



In spite of the back drop of a global pandemic, recruitment and retention has been successful at NGH during the 2020/21 period, reducing our RN vacancy rate from 13% to 3% and our Health Care Assistant (HCA) vacancy rate from 14% to 8% due to a number of initiatives. The Director of Nursing, Midwifery & Patient Nursing Services has lead and supported the following work streams - an international nurse recruitment campaign, intensive HCA recruitment, HCA related retention initiatives and continuation of the Talent Academy (supporting those HCAs to progress through the apprenticeship pathway to ultimately enable access to RN training) and a robust preceptorship programme and return to practice initiatives.

Metric – Staffing Establishment

Within the Trust there is an Annual Nurse Staffing Establishment Review Programme is in place to support the alignment of establishment reviews and a Standard Operating Procedure for nursing & midwifery has been developed and approved by the 'previous' Workforce Committee and Finance & Planning Committee to support this process.

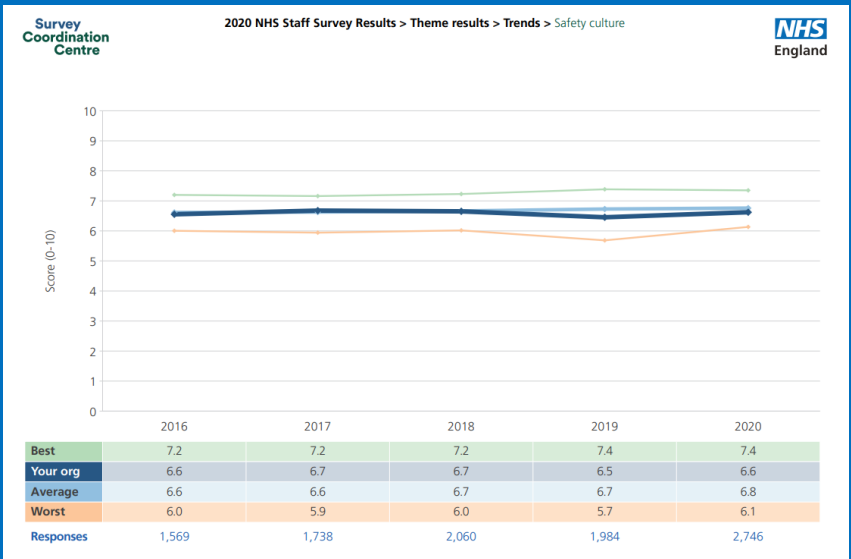
This year's nurse staffing establishment review reflects many of the principles of NQB 2016 and NHSI 2018 recommendations, within the limitations of the pandemic. It has not been practical, or possible, to undertake a 'normal' audit collection during this period of the

pandemic. Therefore, a pragmatic approach was taken working with the Ward Sisters, Matrons and Associate Directors of Nursing.

The Matrons were asked to meet with their Ward Sisters and review the current establishment and consider the changing needs of the patient's case mix and service needs, based on their 'normal/previous' case mix. This was always going to be difficult because the wards have all changed so considerably over the previous 9 months. However, a baseline of establishment for 'professional judgement' was obtained and with verification from the A.D.N. this has been submitted as the nurse staffing review. The review was shared with the People Board as part of the reporting process within the Trust.

Due to the significant changes in location of many of the medical wards the main changes in the establishment were related to the re-alignment of the nursing workforce with the newly allocated wards. It was recommended that there were increases in the number of healthcare assistants to support the complex and dependent patients which will be supported through the Trusts Business Cycle programme.

Metric – Staff Survey – Safety Culture

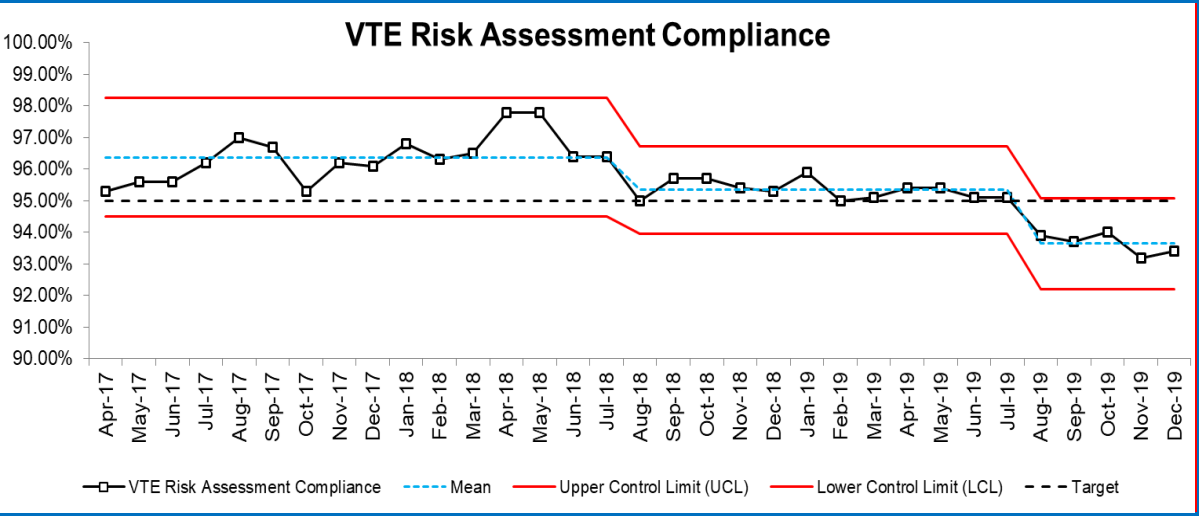


	2016	2017	2018	2019	2020
Best	7.2	7.2	7.2	7.4	7.4
Your org	6.6	6.7	6.7	6.5	6.6
Average	6.6	6.6	6.7	6.7	6.8
Worst	6.0	5.9	6.0	5.7	6.1
Responses	1,569	1,738	2,060	1,984	2,746

There has been a small increase in the average score for safety culture in our organisation (6.5 to 6.6). This data is reported by NHS England as part of the national Staff Survey and has been collected and reported annually since 2015.

SUCCESS FACTOR 2 – Preventable Harm

Metric – 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. Problems with updating ePMA have led to its withdrawal and therefore we have not been able to use a forcing function for VTE risk assessment. Instead we have added the VTE risk assessment to the paper prescription drug chart which is in use. The most recent manual audit across all wards of the Trust demonstrated that 75% patients now receive a risk assessment.

Metric – Pressure ulcers

Category	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Category 2	5	7	10	5	9	17	17	11
Category 3	0	0	0	0	1	0	0	1
Category 4	0	0	0	0	0	0	0	0

Category	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
DTI	3	1	4	3	4	10	2	5
Unstageable	1	3	1	5	2	3	1	1

Summary

The Tissue Viability Team (TVT) is currently not working to a trajectory; this was due to be reassessed by Tissue Viability in collaboration with Informatics but was put on hold due to required focus on service demand during the Covid-19 pandemic.

The past year has seen some spikes in incidence of hospital-acquired pressure ulcers; these have corresponded directly with the UK's first and second waves of Covid-19. Outside of these peaks, pressure ulcer rates have remained within expectations.

Actions

The TVT continues to work with the wards, with regard to clinical support and training. Training presentations are being adapted to optimum compatibility with virtual sessions via Teams, and the TVT is also working with Communications to make training tools available on Moodle.

The Tissue Viability workbook is now available but is being reassessed for virtual completion and marking in adherence with Infection Control guidance.

The Patient Safety leaflet (focussing on pressure ulcer prevention) has been approved for printing.
Additional skincare guidance (for both patients and staff) has been distributed to wards/units by way of wipe able posters during both Covid-19 peaks.

The TVT continues to conduct MDT working with Tissue Viability colleagues across the county to facilitate shared learning, especially with regard to the effects of Covid-19 on skin integrity.

Apr-20	6.40
May-20	5.52
Jun-20	5.09
Jul-20	4.12
Aug-20	4.63
Sep-20	3.50
Oct-20	3.47
Nov-20	3.36
Dec-20	5.26
Jan-21	4.94
Feb-21	4.33
Mar-21	6.06

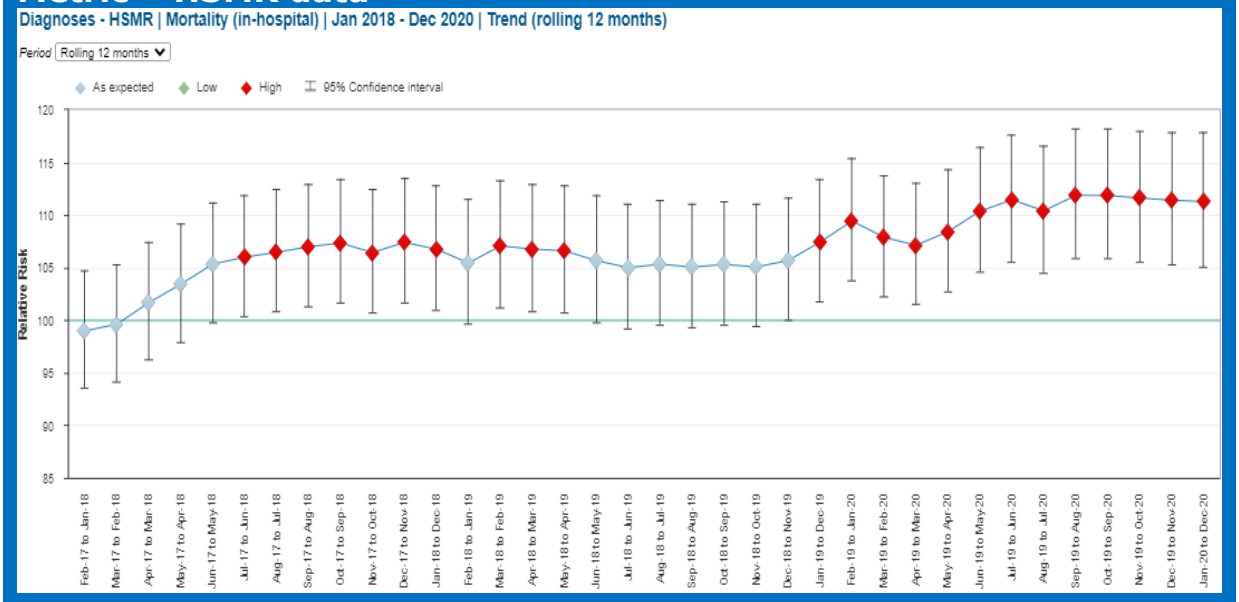
Metric – Falls

There were 2 months April 2020 and March 2021 where the falls/1000 bed days was above the trusts internal target of 5.5. In April this was due to a disproportionate change in bed days compared to falls rates due to the Covid-19 response. There was a 20 percent reduction in falls incidents but a 40 percent reduction in bed days. In March 2021 this was due to an increase in witnessed falls due to complex mobility needs of patients. Over the next 12 months the falls prevention

team will be implementing changes identified in the rest action plan being collaboratively worked on by the Falls Multidisciplinary Working Group.

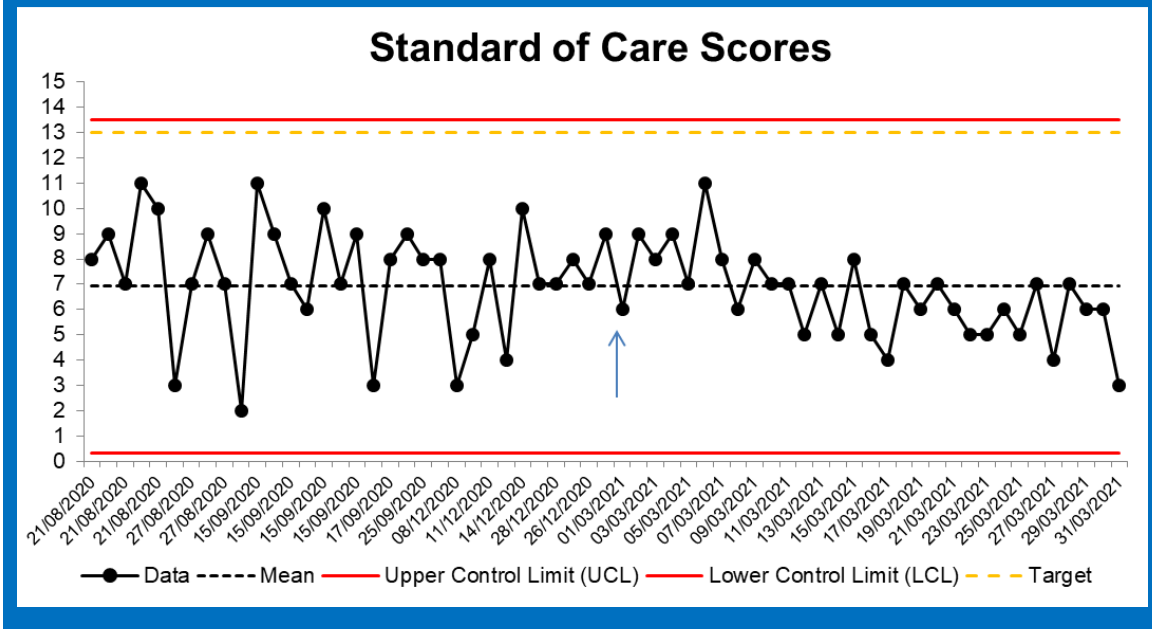
SUCCESS FACTOR 3 – Effective and Efficient Outcomes

Metric – HSMR data



HSMR has been increasing since the Jan19 – Dec19 period, and the last 12 months have moved from 'as expected' to a 'higher than expected' range.

Metric – Standard of Care Scores



The Standards of Care (SoC) scoring system that was developed and manually tested, provided objective data around the standard of care given to deteriorating patients in the Trust. Prior to 1st March 2021 SOC scores were calculated following manual data collection on patients with a National Early Warning Score (NEWS) score of greater than seven. These manual scores formed the baseline. The SOC scores demonstrated that the implementation of the Deteriorating Patient Care plan was inconsistent and there was no safety net to ensure all patients received a safe bundle of care at the time of deterioration. The data collection was limited by clinical pressures and provided no opportunity for real time intervention.

The electronic task list on Ibox was launched on 1st March 2021; this provides a real-time mean average SOC score for all patients with a NEWS greater or equal to 5 or when a nurse concern has initiated the task list. The task list provides an automatic prompt to ensure an essential bundle of care is provided to all patients with a high NEWS, that can be overseen by a member of the Critical Care Outreach team. Automatic real-time reporting allows for the opportunity for the Patient Safety Improvement team to direct responsive targeted interventions into clinical areas once a theme has been identified with the aim of intervening before harm occurs to the patient.

Metric – Smoking and Alcohol

Due to the Covid-19 Pandemic all face to face meetings were stopped and the focus of the organisation has been on managing the pandemic. Therefore, the Smoking & Alcohol agenda has been limited. However, as we start to move out of the pandemic we are reviewing the 'Making Every Contact Count' terms of reference with the group to see what is actually required and needed by the services and the Trust for our patients & staff. This work has just commenced.

It is important to state that our 'Stop Smoking' & 'Substance 2 Solutions' colleagues have continued to provide a limited service to our patients and referrals, although initially small, have started to increase.

SUCCESS FACTOR 4 – Patient Experience

Metric – Cancer Experience

Participation in the 2020 National Cancer Patient Experience Survey is voluntary. NGH is taking part however, there will be no national comparison.

Regarding the 2019 action plan. Trailing real time patients survey focus on 5 key areas including communication, information, administration, privacy and dignity and overall experience. This will go onto the cancer dashboard and enable teams to recognise where they are doing well and where a deep drive is required to understand the issues raised by patients and we are the first hospital in the region to do this.

Successful application to work with the national cancer improvement collaborative related to one aspect of the results of the 2019 National cancer Patient Experience survey. Focussed on Q20 "Patients find it easy or quite easy to contact their CNS. Developed driver diagram for improvement and implemented change actions. SPC chart demonstrated statistical improvements in patients being able to access their CNS and local survey suggested an improvement from 72% (2019 NCPES) to 85% in February 2021.

Personalised Care and Support

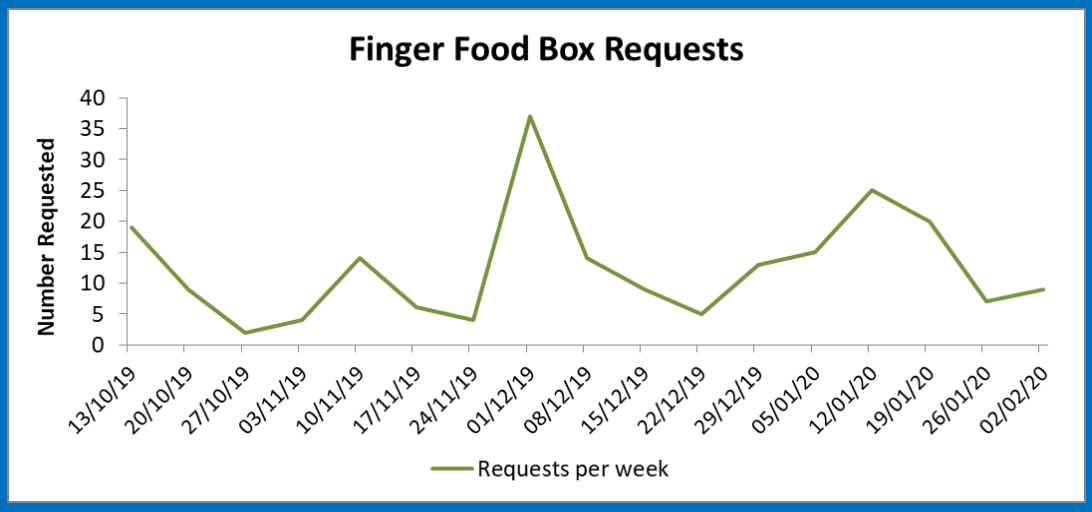
- Remote monitoring implemented in breast and prostate cancer, will go live in colorectal once additional nurse has been recruited
- Moved to webinars/videos to support health and wellbeing rather than face to face during the pandemic, more videos to support patients top 10 concerns on the Northants cancer guide
- Breast live event held in December with over 100 participants registered. Second one planned for later this month
- Piloting generic live events in Upper GI, Head and Neck and Haematology
- Increase in number of Holistic Needs Assessments generated in last 12 months
- Slow increase in number of End of Treatment Summaries
- HOPE program run remotely with positive feedback from patients – first in the region to do this

- Implementation of nurse led triage to improve the patient pathway in prostate and colorectal cancer
- Appointed an additional cancer nurse in skin to support the implementation of tele-dermatology
- Implementation of nurse led triage for CUP
- Additional nurse posts to support standalone CNS's holders and services under pressure
- Successful bid for rarer tumour CNS
- NGH worked with EM Cancer Alliance to develop a proposal to improve psychological support for cancer patients that is with STP leads to look at implementation

Metric – Patient Communication

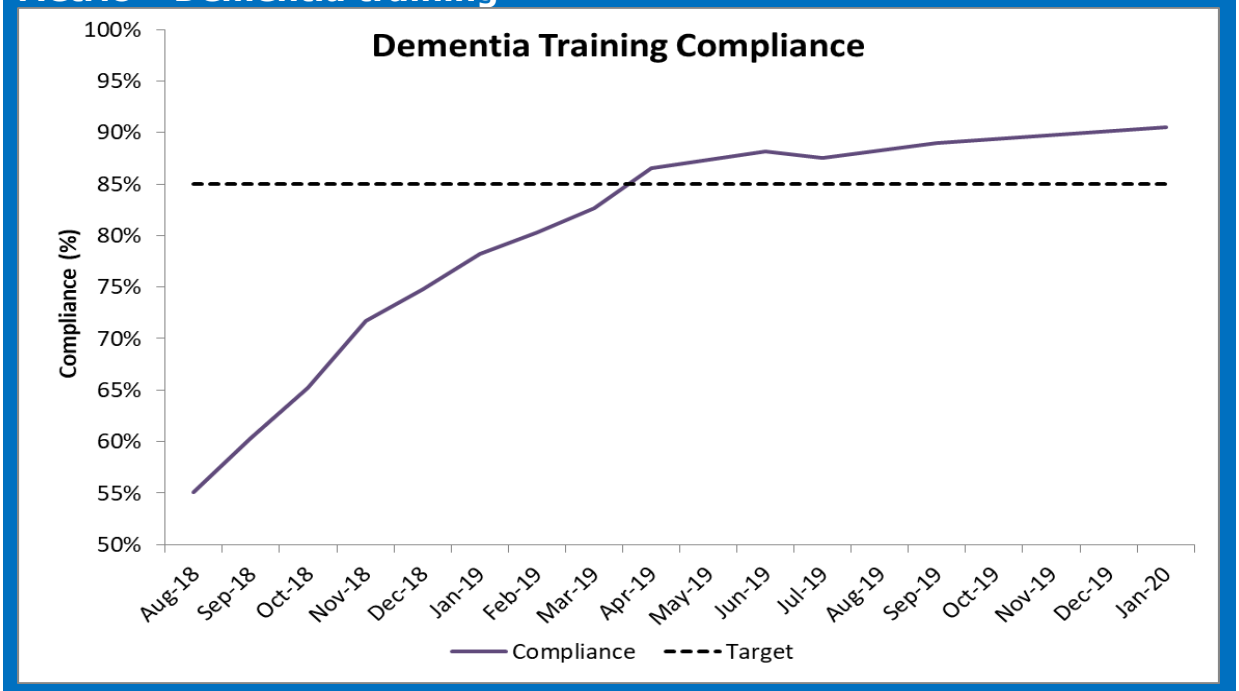
Unfortunately, we had to suspend the "right time" survey when the pandemic started as it was a postal survey and it was felt patients leaving their homes to post it back to us was not the right course of action. In addition to this, the national surveys were suspended, and we felt it was best to follow suit as the right time survey follows the same methods.

Metric – Dementia – appropriate diet



This piece of work was suspended during Covid-19. However, the newly appointed Dementia Liaison Nurse has re-commenced this piece of work which has included meeting with catering staff. The hospital nutritional group will be key in terms of taking this piece of work forward.

Metric – Dementia training



All face to face training is currently suspended since the beginning of the pandemic in March 2020 apart from healthcare assistant training. However, the Dementia Liaison Nurse has continued to receive workbooks for both tier one and tier two. Therefore, the current training compliance figure for tier one training is 55% for the Trust.

Metric – Friends and Family Test (FFT)

When the pandemic was declared, NHS England issued a stop for collection methods, which required the handing out and handing back of paper and iPads. For NGH this meant the loss of postcards across the entire hospital, which accounts for a third of all responses received, and iPads within Radiology. The Patient Experience Team were still able to collect feedback by using SMS messaging and Automated Calls and further methods were introduced including QR codes on mini postcards and posters.

The Friends & Family Test recommenced nationally on 1 December 2020 and the first submission nationally took place on 15 January 2021. At present, the hospital is still not collecting via postcards, however each ward now has an electronic tablet which contains a link to the FFT survey on it. In addition to this, the hospital has set up several FFT surveys via QR codes which are included within mini postcards and posters. Areas

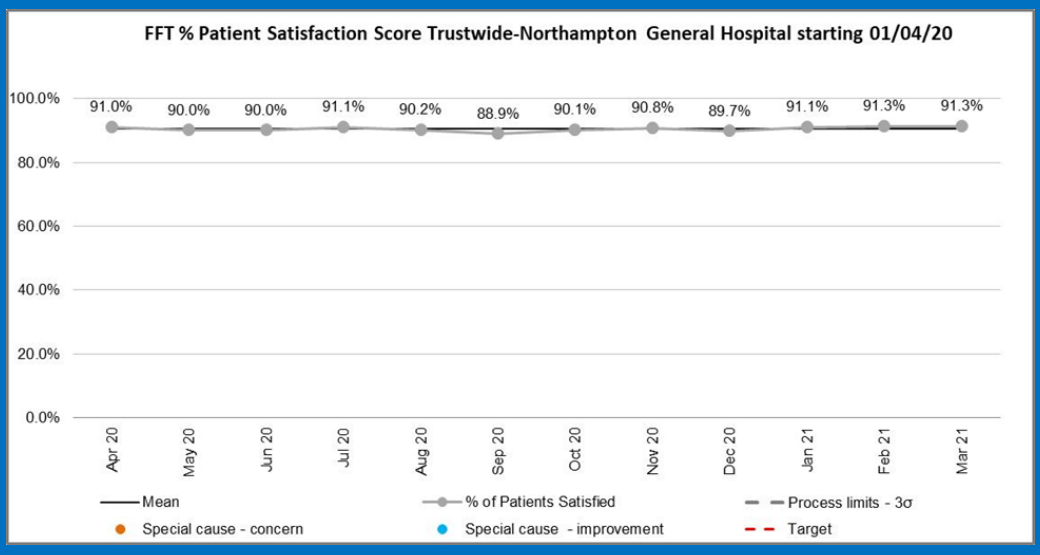
which now have these include radiology, breast screening and the vaccination centre.

From 1 December 2020, a new question was officially launched nationally asking patients *'Overall, how was your experience of our service'*, with 6 response options varying from Very Good to Very Poor. The change in question and options means the FFT now produces a Satisfaction Score, as opposed to the Recommendation Rate. It should be noted that with the change in the question nationally, hospitals are also not to compare themselves against national averages and they also no longer have to collect and report response rates.

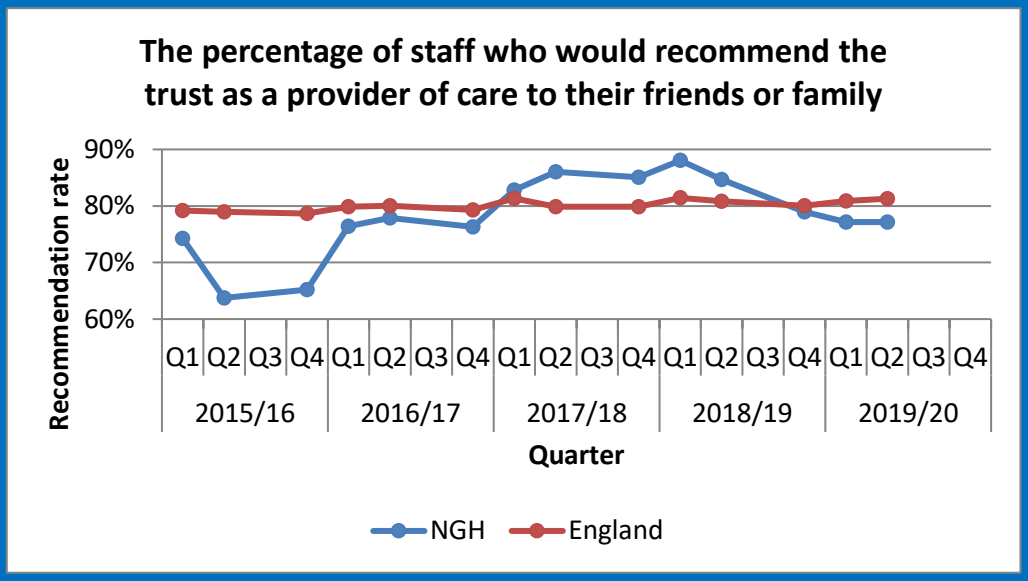
Trust wide Patient Satisfaction Score

As we now have 12 data points since the question changed, new SPC charts have been created. Once >12 data points have been entered, control limits will show within the SPC and we will begin to see whether changes within data are statistically significant.

The SPC chart below reflects satisfaction scores throughout April 2020 – March 2021. Satisfaction scores have remained between 88%-91%. On comparing the figures since April, satisfaction scores average 90.5%. Once control limits have been established, we will be able to identify whether any changes seen within the data are statistically significant. New targets will be agreed within the Patient & Carer Experience & Engagement Group (PCEEG) and reported through the hospital's corporate scorecard.



Metric – 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.

The current work being done to improve the recommendation rate includes online development opportunities and support for individuals and teams to build their resilience and ability to adapt to the demands and change that has occurred because of the Covid-19 pandemic. Monthly online sessions and team interventions on civility and respect to raise awareness of the impact of incivility, what unprofessional behaviours may look like and how to address unprofessional behaviour. The SOS team continue to provide support for individuals and teams and are providing care spaces aimed to facilitate recovery from Covid-19. As part of this support the OD team have designed a restoring teams leaders pack that guides managers through a series of structured conversations they can facilitate for their teams. OD and SOS have led restoration weeks using this model for all of the following teams: theatres, critical care, therapies and Max Fax. Further supported sessions are planned for other areas including ED.

We now have a newly designed open area for staff and a purpose built 'Our Space' is shortly to begin to be done. Both of these provide a space for staff to go and spend time away from the pressure of work in a safe and attractive space.

Metric – GIRFT

The Table below shows the overall position with GIRFT in the Trust as of April 2021. Two new deep dives were completed in 20/21 in Gastroenterology and Plastic Surgery. We are in the process of prioritising our outstanding plans and the new deep dives requested by GIRFT for 21/22 as well as strengthening our internal governance process.

GIRFT Work-stream Status	n.
Completed plans	5
Plans in progress	16
New Deep Dives to be scheduled 21/22	7
Elective Delivery Programme work-streams	3
Deep Dives not yet due	4

Metric – Outpatients

The outpatient project has been split into 3 main phases.

Phase one is seeking to improve our IT systems which are directly linked to outpatients. These include the roll out of Eclinic as our video consultation platform, a clinical room booking application and a specific outpatient dashboard amongst others.

Phase two, which will run in parallel to phase one, is the centralisation of the new referral pathway and all the administrative functions linked with this.

Phase 3 will focus on ascertaining what other functions/services lend themselves well to being centralised and then with agreement moving forward with centralising those. The contact centre has been established

for the Surgery division but alongside phase two we would also look to expand this function across the other divisions.

These work streams 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. The Outpatient directorate also wishes to ensure that face to face appointments are kept to a minimum so that 50%+ of all outpatient appointments are held virtually.

Phases one and two will be completed between 2021/22.

SUCCESS FACTOR 5 – Outcomes in maternal & neonatal care

Metric - Reducing smoking in pregnancy.
Due to the Covid-19 pandemic, Carbon Monoxide monitoring was suspended on the advice of PHE as it is an aerosol generating procedure. Carbon Monoxide monitoring recommenced in December 2020 and was undertaken in 88% of all bookings in March 2021. 100% women who smoke at booking were referred to the Stop Smoking Services on an opt-out basis. The uptake on this is feedback to the healthy lifestyle midwife. All women who smoke offered serial growth scans. The number of women who smoke at booking and delivery are monitored on the maternity dashboard

Metric - Risk assessment.
There is now a mandatory section within Medway for birth centile, so this is now 100%. Ongoing audit of missed cases of SGA/FGR, 100% of cases are audited. Gap E-learning compliance is currently ongoing and is currently at 60%.

Metric – Information
Reduced fetal movement leaflets are given to all women between 16-28/40. These are given in their own language. This is audited on a weekly basis. This is currently 98% compliant.

Metric – Intrapartum Care
100% of staff that give intrapartum care are up to date with annual fetal monitoring training. Weekly CTG meeting every Wednesday that is open to all staff.

Metric – Stillbirth

All women at risk of Stillbirth receive 150mg Aspirin at booking. Ongoing work to reducing pre-term birth guideline. Project underway for uterine artery Doppler scan for women at risk of pre-term birth at their anomaly scan. We have implemented a Stillbirth bundle dashboard.

Metric – Pregnancy Booking Line

February 2021 saw the launch of the Pregnancy Booking Line. Pregnant women ring this number to book their pregnancy and speak directly to a midwife who then triage the requirement for urgent Obstetric referral. There are now 4 Continuity of Care (CoC) teams, with plans to launch a 5th team following successful recruitment. 25% 0f pregnant women are now on a CoC pathway.

Metric - Leadership

The Midwifery leadership has been strengthened which incorporates an Intrapartum Matron and currently recruiting for a Consultant Midwife with a lead for high risk. We have a dedicated a Matron for Continuity of Care and a Digital IT Midwife to support safety and IT integration it within maternity services.

Metric – National Agenda

The Maternity Services are currently working towards delivery of the National Agenda i.e. CNST and Better Births and the Ockenden immediate actions.

APPENDIX 1

Northampton County Council Overview and Scrutiny Committee

West Northamptonshire Council was established on 1st April 2021 and became responsible for scrutinising the planning and provision of health services in the local authority area from this date. Northamptonshire County Council was responsible for this function during 2020/21.

Northamptonshire County Council previously operated a model for Overview & Scrutiny (O&S) based on a single O&S Committee with a remit 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 included the statutory function for health scrutiny. In practice, at the request of the Commissioners appointed to improve the finance and governance of Northamptonshire County Council, the Committee's work during 2020/21 focussed solely on matters within the areas set out above. This meant that the Committee did not carry out work that could be used as the basis for detailed comments on local healthcare providers' draft Quality Accounts for this period.

This response in itself should not be interpreted as representing or implying a comment on the specific Quality Account concerned or on the healthcare provider responsible for producing it.

Healthwatch Northamptonshire response to Northampton General Hospital NHS Trust (NGH) draft Quality Account 2020/21

Like many others, the usual work of Healthwatch Northamptonshire was disrupted during the pandemic-affected year of 2020/21. We shifted our focus to both communicating important news and guidance about coronavirus and the impact on local services and to finding out about people experiences of accessing health and care services during the initial lockdown and the easing of restrictions in the summer. We were able to share these findings rapidly with Northampton General Hospital and others to help them hear valuable patient experiences while their own feedback collecting and complaints processes were paused or limited. Whilst there were difficulties, we congratulate the Trust on maintaining good services to those who were receiving care, such as from the chemotherapy and haematology teams. 78% of those that were care for by the hospital were satisfied with their care and told us about caring and compassionate staff, well-organised systems and feeling safe, and having good care.

We were also able to carry out a virtual visit of maternity services at NGH in 2020 and thank the Trust and department for facilitating this visit.

Healthwatch Northamptonshire believes that this Quality Account demonstrates the ways that NGH is seeking to provide the best quality care, as well as an open and honest culture. We acknowledge the progress NGH has made against their 2019/20 to 2021/22 Quality Priorities, despite the limitations and difficulties faced, and the ways they have had to adapt during the year. We look forward to seeing further progress next year.

We are pleased to see the many ways NGH gathers and uses patient experience feedback, including seeking opportunities for co-production, and acknowledge that they were still able to gather some patient feedback during 2020/21. We look forward to continuing to work with them and supporting them in their efforts to improve patient care and experience. We also encourage the hospital to value the experience and knowledge of informal carers and to promote the presence of Northamptonshire Carers workers within the hospital.

During 2020-21, the Integrated Care System (ICS) for Northamptonshire has continued to develop, including new transformation projects to improve the health and wellbeing outcomes for older people across the county - Integrated Care Across Northamptonshire (ICAN). We are pleased to see NGH involved in this joined up work with partners across the county in addition to the hospital group collaboration with Kettering General Hospital.

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. : Sheran.oke@ngh.nhs.uk

Francis Crick House
Summerhouse Road
Moulton Park
Northampton
NN3 6BF

Switch Board: 01604 651100

Dear Simon

14th June 2021

Re: Quality Account 2020/21

Thank you for providing us with the opportunity to comment on your annual quality report for 2020/21. The report has been reviewed by NHS Northamptonshire Clinical Commissioning Group.

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.

The trust has chosen not to include information on Seven day services and Freedom to speak up, we recognise that this may be due to the impact of the Covid 19 pandemic.

Because the trust has set priorities for 2019-2022 the narrative achievement and performance against indicators and performance thresholds against these and future plans are all contained within section 3 rather than part 1. It is commendable that the trust has continued to make progress against some indicators despite the pandemic and most helpful to see how they plan to reset against others to take them forward into 2021/22.

NHS Northamptonshire Clinical Commissioning Group looks forward to continuing to work closely with the Trust in 2021/22 and support their ambition to sustain high quality standards of care for people who use services.

Yours sincerely

Angela Dempsey
Chief Nurse & Quality Officer
NHS Northamptonshire CCG

APPENDIX 2 Abbreviations

	4Cs	Compliments, Comments, Complaints, Concerns
A	A&E	Accident and Emergency
	ACS	Ambulatory Care Service
B	BAME	Black Asian and minority ethnic
C	CCG	Clinical Commissioning Group
	C.Diff	Clostridium Difficile
	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
D	DH	Department of Health
	DAISY	Diseases Attacking the Immune System
	DNA	Did Not Attend
	DP	Deteriorating Patient
	DSP	Data Security and Protection
E	ED	Emergency Department
	EMCRN	National Institute of Health Research Clinical Research Network for the East Midlands
	ePMA	electronic prescribing medicines administration
	EWS	Early Warning Score
F	FFT	Friends and Family Test

G	GIRFT	Get It Right First Time
	GCP	Good Clinical Practice
	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
M	MDT	Multi-Disciplinary Team
	MECC	Making Every Contact Count
	MRI	Magnetic resonance imaging
	MUST	Malnutrition Universal Screening Tool
N	NCC	Northamptonshire County Council
	NCEPOD	National Confidential Enquiry into Patient Outcome and Death
	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
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
	SSKIN	Surface, Skin inspection, Keep moving, Incontinence/moisture, Nutrition/hydration
T	TARN	Trauma Audit Research Network
V	VTE	Venous Thromboembolism

Prepared by

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

ngh-tr.nghgovernance01@nhs.net

June 2021