Dedicated to excellence

NHS
Northampton General Hospital
NHS Trust

Quality Account 2021/2022

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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 has been disrupted and made challenging in 2021/22 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 Officer Heidi Smoult, Medical Director Mr Matt Metcalfe and Interim Director of Nursing and Midwifery Mrs Debra Shanahan.
    - We also outline some of our key successes from 2021/22 in pharmacy, nursing and surgery 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 2021/22, 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 (NGH) for 2021/22. 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.

This year marks also the formal adoption of new trust values as part of the University Hospitals of Northamptonshire (UHN) group, the values of courage, compassion, respect, accountability and integrity. Similarly, and as part of the adoption of the UHN strategy – "Dedicated to Excellence" we have aligned our priorities with those of Kettering General Hospital. The UHN priorities are defined in relation to patients, quality, partnerships, sustainability and people. This quality account will reflect the commitments to improve in particular for the domains of patient and quality.

The patient priority is in essence that patient experience improvements will be shaped by the patient voice. The quality priority includes an ambition towards zero avoidable patient harm and the lowest mortality among a peer group of hospitals.

Unsurprisingly the priorities agreed for NGH prior to the group strategy adoption map well across to the quality and patient priorities in Dedicated to Excellence – the key opportunities to improve for our patients remain largely the same. This quality account updates on our NGH quality journey framed by the NGH quality priorities prior to group priority adoption. Next year the story will be told through the group lens.

We are delighted that the sustained investment in additional clinical staff in particular to support non-elective pathways, alongside our continued programme of work to respond effectively to deteriorating patients has led to a substantial reduction in our hospital mortality.

We are delighted to have attained university hospital status, and as part of that have recruited record numbers of patients into studies, and to have improved the experience of our medial trainees and students, record numbers of whom are placed with us. We have worked with Health Education England to be a lead site for the adoption of technology enhanced learning in the East Midlands. We have recruited our third year cohort for the Quality Improvement MSc which we offer in partnership with the University of Northampton.

There are some commitments that are taking longer than we would like to deliver on, including the improvements to venous thrombo-embolism (VTE) prophylaxis through an electronic prescribing system that supports optimal practice. We have mitigated against this by appointing a VTE nurse and are confident that the electronic solution we are looking for will be something in place by the time of the next quality account.

We are Dedicated to Excellence, and where we are not there yet we are committed to improve. We are immensely proud of our staff for all they have done and continue to do for our patients through the most challenging of times.

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.

Mr Matthew Metcalfe
NGH Deputy Chief Executive

Mr Hemant Nemade
Interim Medical Director

Mrs Debra Shanahan
Interim 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.

Mr Matthew Metcalfe
NGH Deputy Chief Executive

Alan Burns
Chairman

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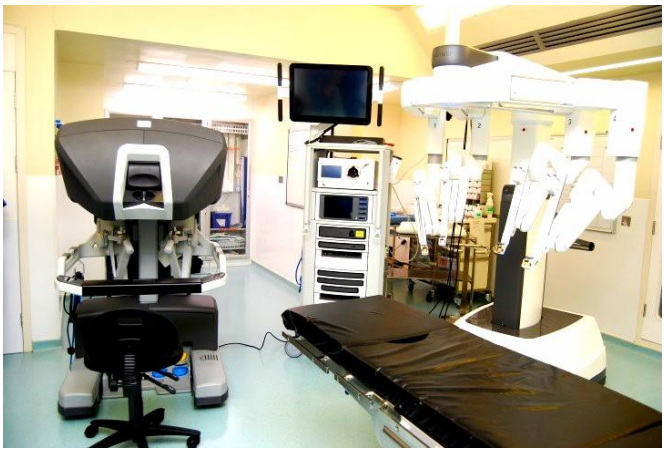
PART ONE

Our successes

Surgical Robot

The Surgery Division successfully implemented Robotic Surgery in March 2022 with the robotic assisted radical prostatectomies (RARPs – treatment for prostate cancer). Surgeons operate four robotic arms using a console which enables them to carry out very precise and minimally invasive surgery. The robotic service will continue to develop across other surgical specialities (colorectal, H&N and gynae) this year. To have operationalised the service within two months of receiving the funding is a huge achievement for the General & Specialist Surgery Directorate and Surgery Division and Trust as a whole.



Colon Capsule Endoscopy

In June 2020, clinical guidance on triaging patients with lower gastrointestinal symptoms was published. This guidance supported the use of Colon Capsule Endoscopy in patients with NG12 specified symptoms and a Faecal Immunochemical Test (FIT) result of between 10-100 ug/gm. Essentially the capsule camera travels down into the intestines, filming all the way and can help detect bowel cancer and help diagnose other inflammatory conditions like Crohn's disease and in most cases it avoids the need for patients to have a colonoscopy which is a more invasive procedure. The National Cancer Team allocated funding to support Cancer Alliances to establish pilot CCE clinics and we commenced ours here at NGH on the 1 July 2021. This has been a huge success for the Trust, staff and most importantly the patients.

Pharmacy Robot

The Trust procured and installed a replacement pharmacy robot which had the following features:

- Up to 2,160 packs can be picked from or loaded into the robot per hour
- GS1 and 2D barcode compliant

- It’s the only robotic dispensing solution that allows the construction of L-shaped configuration, maximising the available space
- It uses a twin system of chaotic and channel fed storage maximising the available pack space and dispensing speed in the robot
- It can store up to 35,000 packs (dependant on pack sizes stored) compared to our previous robot which managed 18-20,000 so we have almost doubled capacity and made better use of the space (this robot is 1.5 times bigger than the previous robot but designed for best fit).
- Robot stock accuracy is generally accepted as greater than 98% accurate, open shelf systems struggle to achieve anywhere near 80% and typically top out at 60% accurate
- Out of hours remote dispensing facility
- automatic ordering from the robot to wholesalers and automatic ordering from ward automated cabinets to pharmacy robot are possible

Dedicated Ward Pharmacy

Dedicated Ward Pharmacy (DWP) is considered the gold standard clinical pharmacy service and has been implemented at NGH across medical and surgery admissions, frailty and some inpatient medical wards as year one of a four-year programme to introduce the service across the Trust. This service embeds clinical pharmacy teams within the multidisciplinary care team with resultant quality, safety and financial benefits. The highlight benefits are:

- Reduced omitted doses of medicines and medication errors
- Improvement in patient experience
- More discharges earlier in the day
- VTE and falls risk assessments completed
- Patient counselling
- Readmission avoidance
- Release medical and nursing time at ward level
- Waste reduction (in medicines supply, reuse and in deprescribing / medicines switches)

HSJ Partnership Award

We have been shortlisted for the HSJ Partnership award for Asthma Home monitoring. What we did was to set up a home monitoring service where patients are given an electronic peak flow meter, sats probe and thermometer and a mobile from which they can upload observations. The nurses specialising in asthma can review the data sent in by the patients

and advise them on medication adjustments, discuss their management plan and can also train them in inhaler technique. The patients found this a very valuable service and we had amazing feedback. We have also reduced bed days attributed to asthma.

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PART TWO

Statements of Assurance from the Board

2.1 Review of our Services

During 2021/2022, normal commissioning and contracting arrangements within the NHS remained suspended for another financial year as part of the response to the Covid-19 pandemic. Provider Trusts continued operating under implied contracts with commissioners based on the fact that the NHS Terms and Conditions apply even without a formal contract in place. The Trust's lead commissioners are NHS Northamptonshire Clinical Commissioning Group (CCG). NHS Northamptonshire CCG also commissions on behalf of Bedfordshire Luton and Milton Keynes 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. The Specialised Services contract includes some secondary care dental and health screening services, including new-born and cancer screening, commissioned on behalf of Public Health England.

The income generated by the relevant health services in 2021/2022 represents 92% of the total income generated from the provision of relevant health services by the Trust for 2021/2023.

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 2021/2022 we provided services to 28 relevant health or support services including:

- St Andrews Healthcare
- Ramsey Health Care UK
- 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 2021/2022, 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
- Several insourced clinics to recover waiting lists

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 at BMI Threes Shires hospital specifically aimed at supporting timely access to treatment 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 their contracts. 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

Previous Annual Programmes of National Clinical Audit was disrupted by COVID-19 under direction of NHS England. Over 2021-22 the same situation has occurred but business as usual has become more resilient. This paper sets out the programme of clinical audit activity during 2021-22 for Northampton General Hospital as required by NHS England. It includes all the National Audits we were contractually obliged to deliver as part of last year's statutory work as set out by our commissioners.

Participation in NHSE's Quality Account list of National Audits is mandatory under the Quality Schedule and NHSE state an expectation that each Trust has a single, register of all their live audits. This information comes from that register which supports provision of board assurance and quality improvement as necessary to support the corporate objectives.

This annual Clinical Audit Programme is a 12-month rolling schedule of all the clinical audit activity that NGH participated in and includes a number of projects that continue year on year and some new ones, either as single, snapshot audits or a new longer-term plan.

The mandatory Quality Account work was published in January 2021. NHS England has agreed the following Quality Accounts list inclusion criteria for 2021-22:

- Coverage: collects data from at least 70% of eligible services nationally
- Data: collected on individual patients
- Comparisons of providers (trusts, hospitals, networks)
- Plan to recruit patients during the following financial year
- Public reporting: comparing providers' performance published within 12 months of completion of the most recent clinical event (excluding events outside of the project's control)
- Outcomes and processes of care being audited must be based on rigorous evidence

NCA Programmes on '21-22 QA	65
NCA projects on '21-22 QA	73
Total NCAs ongoing at NGH over '21-22	91

NCEPOD on 2021-22 QA	5
NCEPOD not on QA but worked upon over '21-22	11
Total Projects not applicable to NGH	3
National Projects ongoing at NGH	99

Over the year our programme is monitored through the clinical teams at Directorate and Divisional Governance Meetings with the co-ordination and support of the Clinical Audit and Effectiveness Team. The Clinical Audit and Effectiveness Group provide progress reports on this programme of work quarterly to CQEG and an Annual Report to Quality Governance Report. Within the Quality Account there are 65 overarching National Clinical Audit Programmes but some of these include more than one audit project.

Furthermore, there are a number of nationally run audits that are not on the Quality Account that our clinicians choose to be part of for their development along with assurance and improvement of care. National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) projects are on the Quality Account while they are in progress nationally. But the work after publication of each report can continue within our system because of ongoing improvements and audits.

Type	Description of each project	'21-22	(Total) & Trend from '20-21
All National Audits N=99	National Audit – Extreme Risk	1	(3) ↓
	National Audit Action Plan Overdue	1	(3) ↓
	Not compliant	4	(4) =
	National Audit - On Track	63	(67) =
	Completed	23	(13) ↑
	National Audit - Awaiting Report	20	(17) ↑

2.3 Participation in Clinical Research

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 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 32 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.

Plans to support innovation and the generation of new research is being progressed at a local level to facilitate the University Hospitals of Northamptonshire to sponsor its own research. Specialty areas such as diabetes, oncology, stroke and respiratory will welcome Clinical Academics and these posts will be supported with the development of new research ideas, optimising opportunities to collaborate with partners in Kettering General Hospital and University Hospitals of Leicester.

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.
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.

Another exciting development is our partnership with the Leicester Clinical Research Facility (CRF). The Leicester CRF team will support and train

colleagues at Northampton General Hospital to recruit their patients into early clinical trials for the first time.

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. Our 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. The strategy describes the key objectives to achieve University Hospital status. This strategy sets out how we will:

- Attract, retain and develop the country's top talent. Putting our staff and patients at the heart of its development by improving the training and development we offer.
- Enable us to work more effectively with our health and care partners to collectively improve access, quality and consistency across local patient pathways and services.
- Establish robust estates and digital infrastructure to support innovative clinical education and research.
- Foster a culture of inclusivity and learning, with strong leadership championing the strategy.
- Increase number of patients included in clinical trials and success of funding from research networks, grant giving bodies and commercial sources.

2021/22 has been another challenging year in how we respond to rapidly undertaking research to support the national COVID-19 research portfolio whilst continuing to develop our research portfolio in other areas to ensure an even distribution of research activity and support across our hospital Group.

From April 2021 to March 2022, 1,885 patients were recruited to clinical trials at Northampton General Hospital. Much of our success has been due to the recruitment to urgent public health (COVID-19) research trials, and in particular, the ISARIC CCP Clinical Characterisation Protocol. Data collected for this important trial has provided dynamic data in near real time to policy makers, characterised COVID-19 disease in adults and children, described the magnitude and variation of hospital acquired

infection by site and region, and developed tools to identify people most at risk of deterioration and death.

2.4 Accreditation Schemes

The following services have undertaken the following accreditation schemes during 2021/22. 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
QA Cancer Screening Programme	Endoscopy	Bowel Screening
IHEEM	Endoscopy	Decontamination audit from the Authorisation engineer for decontamination for the trust – yearly last one March 2022
JAG accreditation	Endoscopy	Yearly submission online - last one November 2022 waiting outcome 5yearly actual visit due 2024
Bowel Screening	Pathology	Process implemented in April 21 to put measures in place ensuring bowel screening samples easily accessible to consultants – Feb 22 update process is working well.
Cervical Screening	Pathology	Q3 data submitted in Feb 22, Cervical board meeting taking place march (this month)
Breast Screening	Pathology	Last Kettering/Northants screening meeting 6/12/21 – next meeting scheduled for 4/4/21
Antenatal Screening Programme:	Pathology	

• Infectious disease in pregnancy screening • Sickle cell and thalassaemia (SCT) screening		• March 22 – Work ongoing to streamline reporting to ensure no positive are missed • March 22 – No update
For the Nursing Pathway to Excellence: Head and Neck Ward Accreditation	Head & Neck	November 2021 - Green
For the Nursing Pathway to Excellence: Maxillo Facial Ward Accreditation	Head & Neck	February 2022 – Green
ISO9001:2015 for Chemotherapy, Radiotherapy & Radiotherapy Physics	Oncology & Haematology	ISO9001:2015 assessment from 13th & 14th January 2022. Two minor non-conformances from previous assessment May 2021 closed. 1 new minor non-conformance raised (copied below) which is being managed via the existing directorate documented process. Full report shared with O&H managers and Trust Governance Facilitator 17th January 2022. Next ISO9001:2015 assessment 7th & 8th June 2022.
JACIE for HPC Transplant	Oncology & Haematology	JACIE – accreditation has been extended to 5 years instead of 4 due to the pandemic, therefore full re-accreditation inspection now due May 2025. No time yet specified for interim assessment that was due May 2022, but JACIE will notify when re-planned. Separate inspection will occur for CAR-T cell therapy to be added as an additional scope to

		current accreditation - at present there is no time frame for this.
HTA	Oncology & Haematology	date unknown for next external inspection – likely during 2022/23.
VMD	Oncology & Haematology	date unknown for next external inspection – possibly during 2022.
Environment agency	Oncology & Haematology	took place Weds 10 November 2021 - no actions, recommendations or non-conformances expected.

2.5 Commissioning for Quality and Innovation (CQUIN) Income

The operation of the 2021/22 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 24 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

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 be able to demonstrate it has taken action to address these breaches. Failing to do so would mean 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 programme 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

In the current version of the toolkit, there are 38 areas of focus, called 'Assertions'. Within each assertion there are items which require evidence and an indication of completion. 110 of the evidence items are mandatory. The assertions fall into 10 areas in line with the National Data Guardian Standards.

The toolkit can be updated throughout the year, but a baseline and final submission must be made within the year. In 2022, the baseline submission was due on the 28 February and the final submission is due on 30th June.

The Data Security and Protection Team work closely with the Digital Team, to ensure a firm focus of Data Security and Protection and Cyber Security at the Trust. Most of the assertions relate to cyber security and the Trust has a Cyber Security Manager who supports the completion of these assertions.

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 2022 to address these.

The Trust's auditors (TIAA) must complete the Trusts DSP Toolkit Audit which is in line the NHSD standard audit criteria for specific assertions. The DSP Team has engaged fully with the auditors and received a 'standards fully met' outcome for the 2021 Audit.

The Trust has now achieved Cyber Essentials 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 set of security controls to protect information from threats coming from the internet.

The Trust reported 4 Information Governance serious incidents to the Information Commissioner's Office in 2021 (there were 6 reported in 2020) 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. Furthermore, The Trust is using excellent tools to ensure compliance with Data Sharing and Data Protection Impact Assessments which ensure the Trust operates in a clear and transparent manner, with Data Protection by Design and Default at the forefront.

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 teamwork under the authority of the Group Head of Health Intelligence 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.

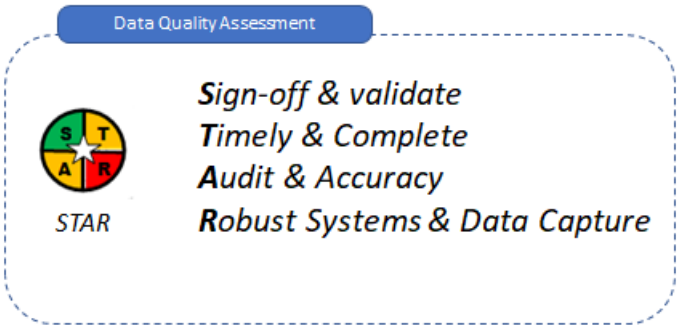
The Data Quality Policy aims to provide a structure for the assurance to improve the quality of data across the trust. The policy was updated in 2021 to include the Data Quality Kitemark, Data Quality Maturity Index and collaboration tools used with the Knowledge Improvement Team.

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 into 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 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 21 to Dec 21	Valid NHS Number	Valid GMPC
Inpatients	99.85%	99.92%
Outpatients	99.96%	100.00%
A&E	99.11%	99.80%

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	99.82%	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 as a whole e.g. improved clinical record keeping or data quality errors.

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

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

Each quarter is audited after it is complete, and a total percentage of the year thus far is included:

Overall 2021-2022	% Accuracy Including All Error Sources	% Accuracy Excluding Non-Coder Error
Primary Diagnosis	91.78%	91.78%
Secondary Diagnoses	86.29%	86.29%
Primary Procedure	94.15%	94.15%
Secondary Procedures	90.51%	90.51%
Q3 2021-22	**% Accuracy Including All Error Sources**	**% Accuracy Excluding Non-Coder Error**
Primary Diagnosis	94.00%	94.00%
Secondary Diagnoses	93.04%	93.04%
Primary Procedure	97.12%	97.12%
Secondary Procedures	91.41%	91.41%
Q2 2021-22	**% Accuracy Including All Error Sources**	**% Accuracy Excluding Non-Coder Error**
Primary Diagnosis	92.05	92.05
Secondary Diagnoses	82.22	82.81
Primary Procedure	92.02	92.02
Secondary Procedures	87.29	87.29

2.11 Learning from Deaths

Number of deaths during the reporting period

The crude mortality at Northampton General Hospital (NGH) is monitored monthly, alongside the national Dr Foster mortality dataset. 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 Mortality review process provide assurance of patient safety and quality of care at NGH.

During April 2021 – March 2022, 1,538 Northampton General Hospital patients died, of which 1336 were inpatients and 202 were Emergency Department (ED) deaths. The ED total includes out of hospital deaths registered at NGH via the ambulance service.

Period	Inpatient Deaths	ED Deaths	Total
Q1	304	39	343
Q2	299	48	347
Q3	382	59	441
Q4	351	56	407
Total	**1336**	**202**	**1538**

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. ME's 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 ME officer (MEO) sends the details to the mortality office for them to arrange a formal case-note 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.

In 2021-22 1505 deaths at Northampton General Hospital were scrutinised by the Medical Examiner team, this accounted for 99% of deaths referred to the ME & Bereavement service.

Q1	333
Q2	346
Q3	425
Q4	401
Tot	**1505**

Reviewing deaths – 2021-22 data

NB: Data supplied is current status on 11th May 2022, and subject to change during 2022-23.

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

Completed Structured Judgement Reviews (1st SJR, 2nd SJR & Vulnerable Adult SJR2):

Q1	56
Q2	40
Q3	40
Q4	28
Tot	**164**

Investigating deaths

If, during the 1st SJR review, the overall care of a patient is judged to be poor, the case is referred for a 2nd independent SJR. These cases are 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 Morbidity & Mortality (M&M) Meeting. For 2nd stage reviews, 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 2021-22, 24 were reviewed as part of the 2nd stage review process. 4 cases were graded with an Avoidability of Death Judgement score of 1 – 4 and were referred to the Review of Harm Group for further evaluation.

If, at any stage during the mortality review process (Medical Examiner, 1st stage or 2nd stage review) significant concerns with problems in care are identified, then cases are referred to the Review of Harm Group (ROHG), to be reviewed via NGH's clinical governance pathway. Patient deaths can be referred to ROHG via several different routes.

To date**,** 43 deaths from 2021-22 have been referred both to ROHG and also via the mortality pathway for specialty M&M case review. Of these 43 referrals, 23 cases were graded harm as "death" and a clinical investigation has been declared. 19 were declared a Serious Incident, 0 declared a Comprehensive Investigation, and 4 a Case-note Review. There were an additional 11 Serious Incident investigations declared related to local ward outbreaks of Hospital Acquired Covid-19 (HACI).
To date, a total of 12 investigations (harm grading of "death") from 2021-22 have been completed (5 SIs, 3 CNRs and 4 HACI ward outbreaks). 1 death has been concluded to have been more likely than not due to a problem in the care provided to the patient.
Feedback on both poor and excellent care is distributed trustwide, to specialty M&Ms and where applicable to individuals to promote learning from deaths.

Neonatal Deaths and Stillbirths

Neonatal Deaths >22 weeks

Q1	2
Q2	0
Q3	0
Q4	3
Total	**5**

Stillbirths >24 weeks

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

- During April 2021– March 2022 there were 5 neonatal deaths after 22 weeks of pregnancy and 8 stillbirths delivered from 24 weeks of pregnancy
- 13 qualifying deaths have been reviewed using the Perinatal Mortality Review Tool
- 4 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 (LD) or severe mental illness (MH):

Period	LD Deaths	MH Deaths	Total
Q1	3	0	3
Q2	1	0	1
Q3	2	2	4
Q4	3	1	4
Total	**9**	**3**	**12**

- During April 2021 – March 2022 there were 9 deaths of patients with a learning disability
- During April 2021 – March 2022 there were 3 deaths of patients with a severe mental illness (defined as a patient admitted from a mental health trust or a patient detained under the mental health act)
- At time of writing, the care of 5 patients has been reviewed using the Structured Judgement Review tool. The remaining will be reviewed during 2022-23.
- 3 patient deaths, at time of writing, have also been referred to the Review of Harm Group. Of these 3 cases, 1 was declared a serious incident, 0 was declared a comprehensive investigation, and 1 declared a case-note review. The 3rd case was initially declared a serious incident and then de-escalated upon further 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 workstreams 2021-22 & Trustwide Mortality Reviews

Area targeted by review	Data source	Work stream/s	Example of actions taken or proposed
Mortality workstream: Lung Cancer & Respiratory	Dr Foster data National Audit National Optimal Lung Cancer pathway GIRFT recommendations	Led by Learning from Deaths Group in conjunction with Medicine Division	• Lung Cancer GIRFT recommendations • Review of latest available National Lung Cancer Audit data • Achieving National Optimal Lung Cancer pathway targets • Respiratory GIRFT recommendations • Workstream to continue in 2022-23
Mortality workstream: Congestive cardiac failure	Dr Foster data National Audit	Led by Learning from Deaths Group in conjunction with Cardiology and Transformation 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 • Workstream formally closed April 2022, for departmental follow-up

Mortality workstream: Working 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. • Implementation of Board Round project • Workstream closed from LFDG remit Nov-21; to report direct to CQEG
Mortality workstream: Palliative Care	Dr Foster data National Audit	Led by Learning from Deaths Group in conjunction with palliative care team	• Review and improvements instigated for Palliative Care Coding • Palliative care service provision report prepared and business case submitted • Introduction of specialist palliative care service for Urgent Care • National audit data presented • Development of iCAN and Ibox • Progression with access to System One (primary care data) • Workstream to continue in 2022-23

Trustwide Mortality Review 14: Hospital Acquired Covid-19 (HACI) cases	Medical Examiner team Review of Harm Group	Led by Learning from Deaths Group in conjunction with Infection, Prevention & Control team	• Trustwide Mortality review of all identified deaths caused by hospital acquired Covid-19 infection. • The review was completed and report shared in August 2021 • Learning from HACI deaths was presented at Grand Round in September 2021, in conjunction with presentations by the Infection Prevention & Control and Respiratory teams
Trustwide Mortality Review 15: Vulnerable Adult Deaths 2020-21	Medical Examiner & Safeguarding team	Led by Learning from Deaths Group in conjunction with Safeguarding Team	• Trustwide Mortality review of all 2020-21 deaths referred to the Vulnerable Adult Mortality & Morbidity Meeting • Data collection completed; final report completed May 2022 alongside trust recommendations. • Thematic learning shared both trustwide at NGH and with the countywide LeDeR and End of Life steering groups • Case presentation at Dare to Share (April 2022 and June 2022) • Actions for improvement to be followed up in 2022-23

Trustwide Mortality Review 16: Acute Kidney Injury & Sepsis	Dr Foster Data Medical Examiner Review of Harm Group	Led by Learning from Deaths Group in conjunction with the Patient Safety team and Clinical Coding	• Mortality Review declared in February 2022 following a Dr Foster Mortality Alert for Acute and Unspecified Renal Failure and Septicaemia • The review will include 3 sections: (i) Clinical Coding review (ii) Mortality & ROHG case review (iii) Patient Safety team review • Final report and recommendations for improvement to be completed and circulated by end of Q1 2022-23

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.

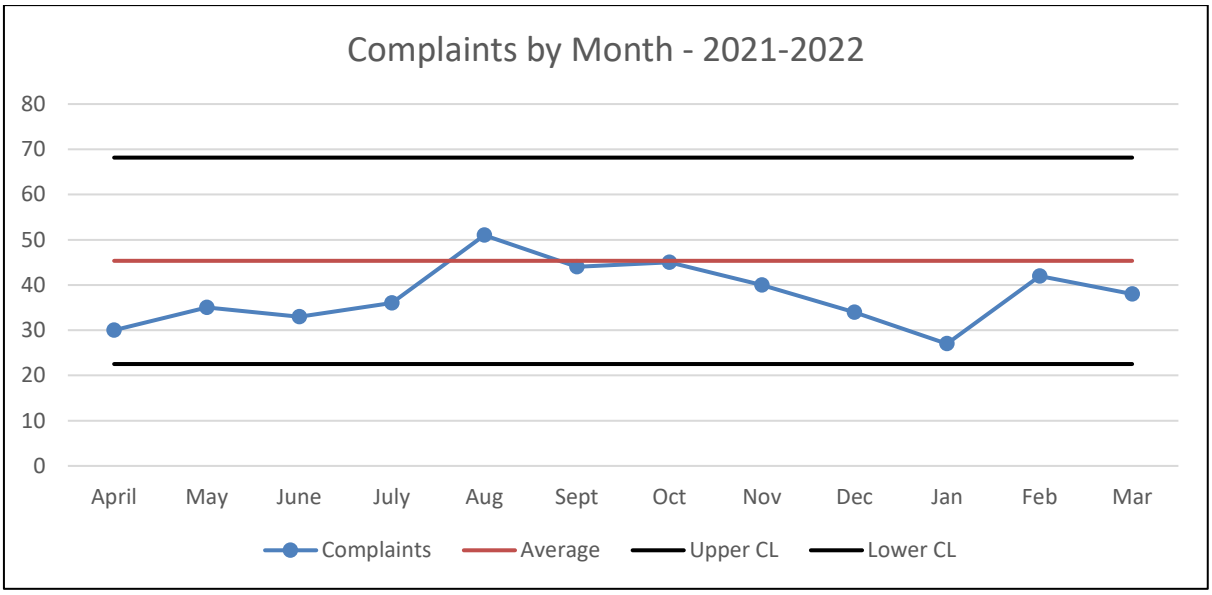
Complaints and concerns can act as an early warning of failings in systems and processes which need to be addressed.

The Trust received a total of 455 written complaints that were investigated through the NHS Complaints Procedure from 1 April 2021 to 31 March 2022, which compares with 329 complaints received for the same period during the previous financial year.

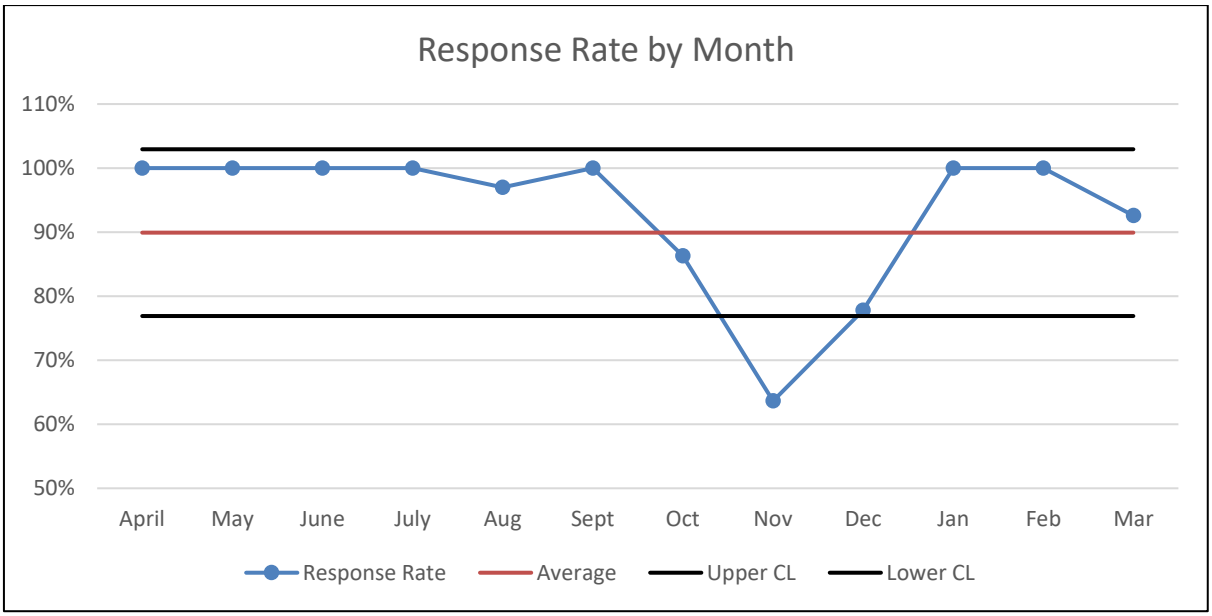
Total no of complaints for the year	455
(Versus 2020/2021[1])	(329)
Average response rate	93%
Total no of complaints that required a renegotiated timescale, agreed by the complainant	166
Total no of complaints that exceeded the renegotiated timescale	36
Complaints that were still open at the time that the information was prepared (8th April 2022[2])	151
Total patient contacts/episodes	710,480
Percentage of complaints versus number of patient contacts/episodes	0.06%

[1]The NHS Complaints Regulations were paused from March-June 2020 due to the COVID-19 pandemic.
[2]The complaints timescales were regularly revisited during the year 2021-2022 and were temporarily extended on two occasions. 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

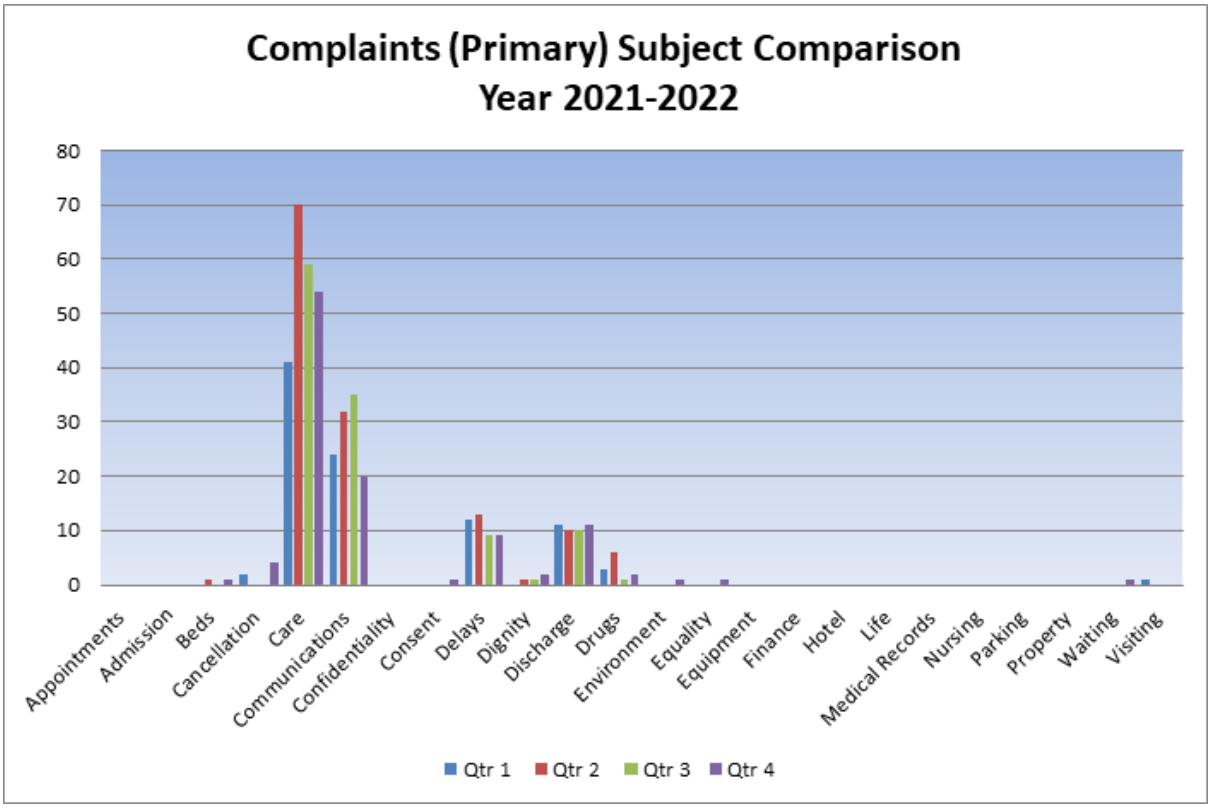


Response rate



Trend Analysis

The following chart provides the themes emerging from complaints:



What we achieved in 2021/22 to improve complaints management:

Subject:	**Commentary:**
Trust response rate	The Complaints team has achieved its 'green' (90% or above) target for the majority of the reporting year with an average of 93%. This has been a good achievement given the challenges faced once again in terms of dealing with a global pandemic and the continued increase in the complexity of complaints received.
Triage	The complaints team triage all new complaints that are received in the department. This process enables the team to identify any complaints that require urgent escalation for immediate resolution and those that require investigation through the Trust's Clinical Governance process.
Staffing	The effects of the last two years through a global pandemic have impacted the Complaints team. There have been periods of absence for some staff and the team has been provided with support through the Trust's SOS service.
Reporting	Complaints data is incorporated into the following reports: Monthly scorecard reporting Monthly Patient Experience divisional workbooks Monthly Director of Nursing report Quarterly Complaints & Concerns report (PCEEG) Quarterly Quality Governance Committee Quarterly KO41a report (DOH) Annual report Quality Account
Systems	Datix iCloud is used to enter all complaints data but has required a number of system improvements.
Support to other departments	Staff have regularly been providing support to the Trust's PALS team due to an increased level of activity during the last 6 months. Support is also provided to clinical divisions with regard to complaints handling, support, advice and training.

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 20 – Sep 21	93	2	100	119	71
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 20 – Sep 21	42.0%	39.43%	63.0%	12.0%
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 2021/22	**NGH Quality Account 2020/21**	**Reporting Period 2021/22 Average**	**Reporting Period 2021/22 High**	**Reporting Period 2021/22 Low**
• Hip replacement surgery - primary (EQ-5D™ Index)	0.459 (final Apr20 to Mar21)	N/A	0.462 (final Apr20 to Mar21)	0.574 (final Apr20 to Mar21)	0.393 (final Apr20 to Mar21)
• Hip replacement surgery - revision (EQ-5D™ Index)	* (final Apr20 to Mar21)	N/A	0.333 (final Apr20 to Mar21)	0.413 (final Apr20 to Mar21)	0.253 (final Apr20 to Mar21)
• Knee replacement surgery - primary (EQ-5D™ Index)	0.255 (final Apr20 to Mar21)	N/A	0.308 (final Apr20 to Mar21)	0.389 (final Apr20 to Mar21)	0.181 (final Apr20 to Mar21)
• Knee replacement surgery - revision (EQ-5D™ Index)	* (final Apr20 to Mar21)	N/A	0.215 (final Apr20 to Mar21)	0.230 (final Apr20 to Mar21)	0.207 (final Apr20 to Mar21)

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				
2020/21	12.1	12.4	64.4	2.8
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				
2020/21	16.3	13.9	21.7	5.5
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
2020/21	N/A	N/A	N/A	N/A
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	65.1%	68.6%	85.0%	60.5%

(Hospital stay: 01/07/2017 to 31/07/2017; Survey collected 01/08/2017 to 31/01/2018)				
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%

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

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 friend*
  - *2021:* percentage *of staff selecting Agree or Strongly Agree for q21d - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. for year*
  - *2015-2020:* 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
2021	61.6% (Acute and Acute & Community Trusts)	66.5% (Acute and Acute & Community Trusts)	89.4% (Acute and Acute & Community Trusts)	43.5% (Acute and Acute & Community Trusts)
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%	87.3%	39.8%

		(Acute Trusts)	(Acute Trusts)	(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)
    - Data submission and publication for the Friends and Family Test (FFT) restarted for acute and community providers from December 2020, following the pause during the response to COVID-19.
    - Data from December 2020 onwards reflects 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				
2021/22	Full year data unavailable			
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)				
2021/22	Full year data unavailable			
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 21/22	Data collection/publication suspended due to Covid-19			
Q3 21/22	Data collection/publication suspended due to Covid-19			
Q2 21/22	Data collection/publication suspended due to Covid-19			
Q1 21/22	Data collection/publication suspended due to Covid-19			
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
2021/22	N/A	N/A	N/A	N/A
2020/21	13.1	15.7	80.6	0
2019/20	8.7	13.2	37	0
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 20 – Mar 21	N/A	N/A	N/A	N/A

Apr 20 – Sep 20	N/A	N/A	N/A	N/A
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

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

Period	NGH	National Average	National High	National Low
The rate (per 1,000 bed days) of patient safety incidents reported within the trust - (Acute Non- Specialist)				
Oct 20 – Mar 21	N/A	N/A	N/A	N/A
Apr 20 – Sep 20	N/A	N/A	N/A	N/A
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

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

Period	NGH	National Average	National High	National Low
The number of such patient safety incidents that resulted in severe harm or death - (Acute Non- Specialist)				
Oct 20 – Mar 21	N/A	N/A	N/A	N/A
Apr 20 – Sep 20	N/A	N/A	N/A	N/A
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

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

Period	**NGH**	**National Average**	**National High**	**National Low**
The percentage of such patient safety incidents that resulted in sever harm or death - (Acute Non- Specialist)				
Oct 20 – Mar 21	N/A	N/A	N/A	N/A
Apr 20 – Sep 20	N/A	N/A	N/A	N/A
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%

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

NGH has taken the following action to improve the 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

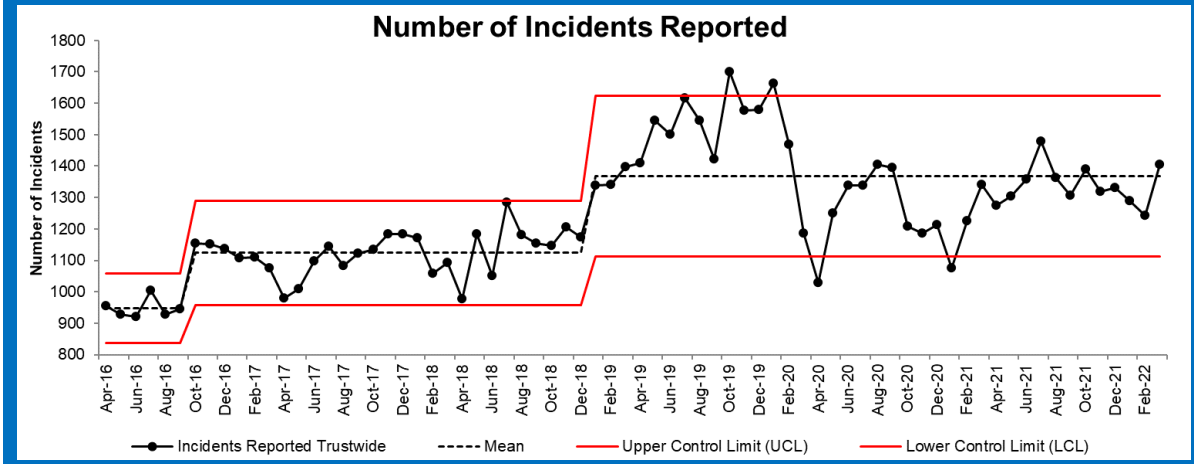
5. **Outcomes in maternal & neonatal care**
   Improve the safety outcomes of maternal and neonatal care. Reduce the rate of still births, neonatal death and brain injuries occurring by 20% from 2019/20 baseline by 2020/21

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 and continued in Wave II.

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

As the Trust has moved into the next stage of the pandemic many of the wards could no longer support supernumerary co-ordinators and Ward Sisters have been in the ward's establishment 'numbers' i.e. working within the team, taking a workload. Many of our Matrons have also worked clinically to support those areas that require additional clinical support due to reduced staffing capacity. As the positive impact of the vaccination program released shielding staff back into patient facing roles the 'Hub' closed on 30 April 2021.

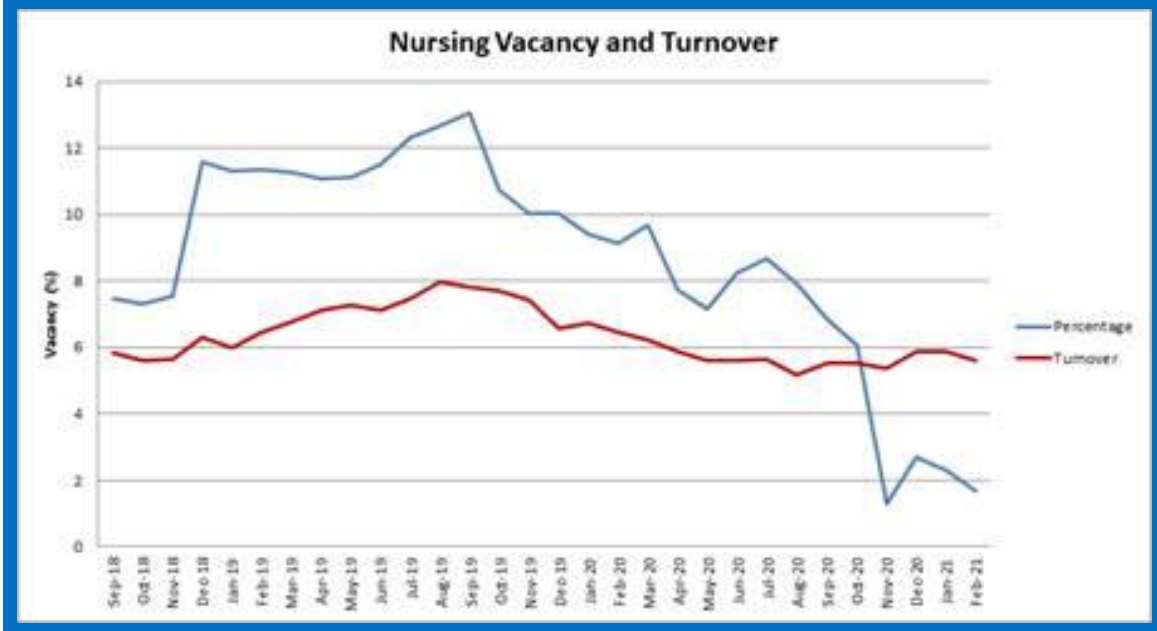
Safety and Staffing continues to be managed as a Trust wide risk through the Safety Huddle each morning at 08.30 and more recently 08.15. It is attended (remotely) by Associate Directors of Nursing, Matrons, safeguarding, and IPC. Using the SafeCare data (patient acuity and dependency), ward allocation due to Covid-19 and bed occupancy, and professional judgement of the senior nursing team the matrons re-allocate staff to mitigate risk and maintain the safest levels of staffing.

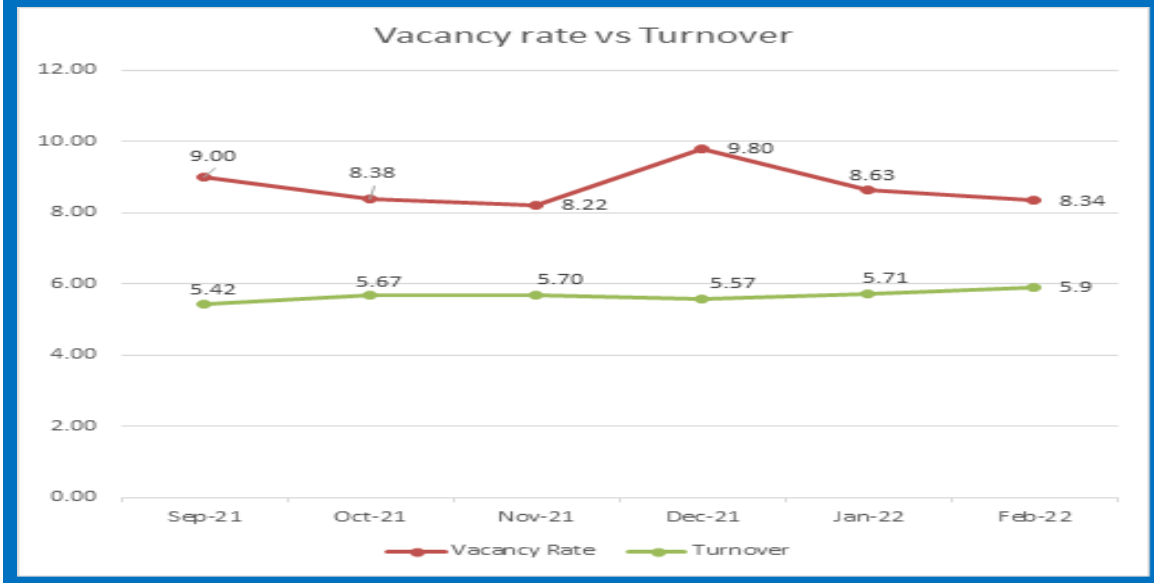
The Safety Huddle is repeated at 12.45, reviewed by the late Matrons at 16.00 with the late duty Sister and with the Night Practitioners at 19.00, thus providing support throughout the day & night. A Standard Operating Procedure was developed, ratified and has been updated. Reports are generated from the Night practitioners and following the 08.15 and 12.45 meetings. The late Safety Matron will also provide assurance to the Senior Nurse Team via WhatsApp after the 19.00 handover.

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 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

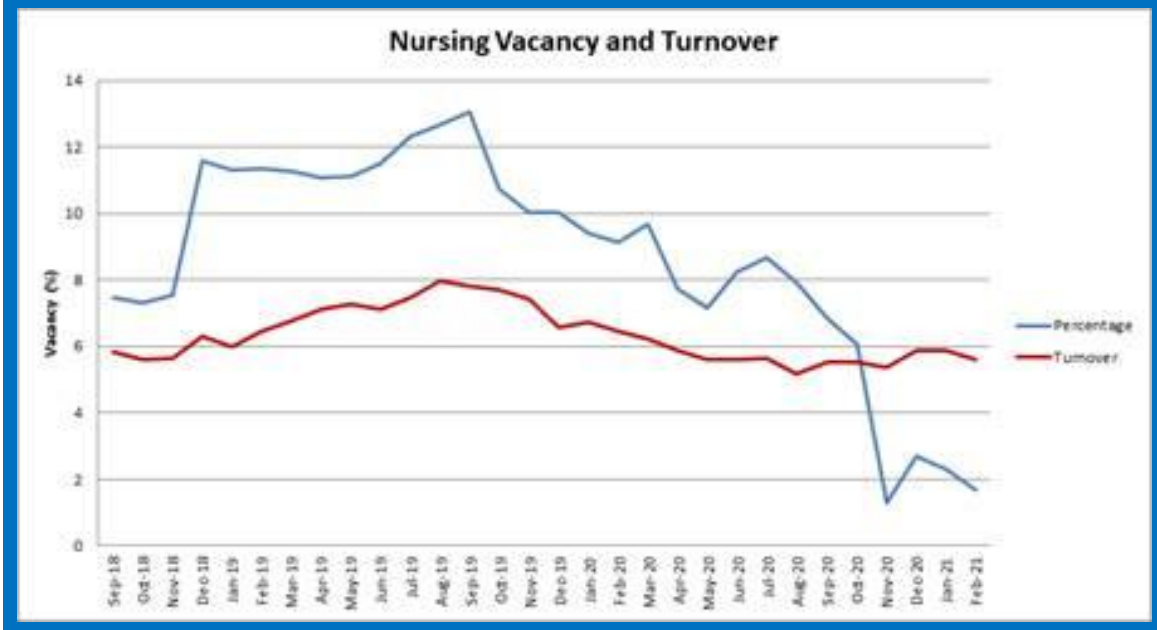
pool for NGH as traditionally this had been the main local recruitment pipeline of newly qualified RN workforce for the Trust.





In spite of the backdrop of a global pandemic, recruitment and retention has been successful at NGH during the 2021/22 period. The RN and Healthcare Assistant (HCA) vacancy initially increased following an establishment review and funding for additional posts in clinical areas but now stands at 6% for RNs and 17% for HCAs. 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 including the recent appointment to provide pastoral support 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.
We will have successfully met our 2021 IEN commitment by 18 March 2022, with 105 IEN recruited and arrived at NGH. The international recruitment collaborative has successfully submitted and been awarded funds to support ongoing international recruitment of nurses for 2022 with the commitment to 60 further nurses in 2022/23.



In spite of the backdrop 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 led 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.

The data collection period took place 4 October- 31 October 2021 for 25 ward areas not including A&E, Paediatrics or ITU. The Methodology used was collection of SNCT data over 28 days, professional judgement, quality care indicators and collated additional duties.

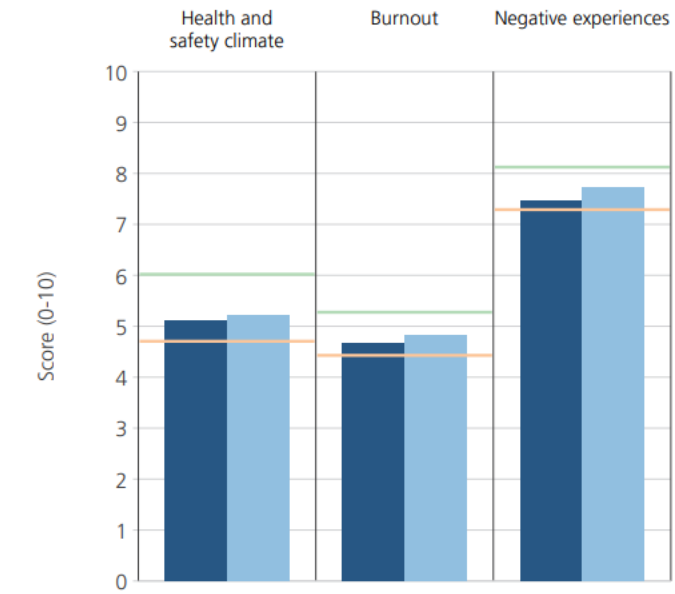
Following the data collection each ward area was discussed at a Professional review meeting with Deputy Director of Nursing, Associate Director of Nursing, Lead Nurse for Workforce, Matron and Ward sister Charge nurse.

This was always going to be difficult because the wards have all changed so considerably over the previous year. It needs to be recognised that whilst the Trust is still working within the parameters of the pandemic, the data collected through SNCT will differ from previous times. This is due to bed reduction due to social distancing and closures due to outbreaks; higher levels of acuity, outbreaks and service need to meet requirements for example blue pathways. There have been changes in location and speciality of some medical and surgical wards and the main changes in the establishment are related to the re-alignment of the nursing workforce with the newly allocated wards. This is in addition to the increase in acutely unwell patients that the Trust is regularly seeing in Urgent Care.

However, a baseline of establishment for 'professional judgement' was obtained and with verification from the A.D.N. A final review is planned between the Associate Director of Nursing, the Director of Nursing and the Deputy Director of Nursing in March 2022 and will inform a business case.

In 2022/23 there are plans to move into a new Critical Care unit and open an 8 bedded Respiratory/ medical HDU

Promise element 4: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Best	6.0	5.3	8.1
Your org	5.1	4.7	7.5
Average	5.2	4.8	7.7
Worst	4.7	4.4	7.3
Responses	2,410	2,407	2,401

Metric – Staff Survey – We Are Safe and Healthy

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. Safety Culture is now aligned to the 'we are safe and healthy' People Promise element. There has been a decrease in the average score from the 2020 safety culture score in our organisation when compared to the health and safety climate score recorded in the 2021 survey (6.6 to 5.1). 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

Hospital-acquired Venous Thromboembolism (HAT) covers all VTE that occurs in hospital and within 90 days after a hospital admission. It is a common and potentially preventable problem. Hospital-acquired VTE accounts for thousands of deaths annually in the NHS, and fatal pulmonary embolism remains a common cause of in hospital mortality. Nationally HAT accounts for 50% to 60% of all VTE seen. Treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with a considerable cost to the health service. The evidence suggests that in England around 25,000 people die a year from VTE in hospital. Improvement in patient safety can be achieved through:

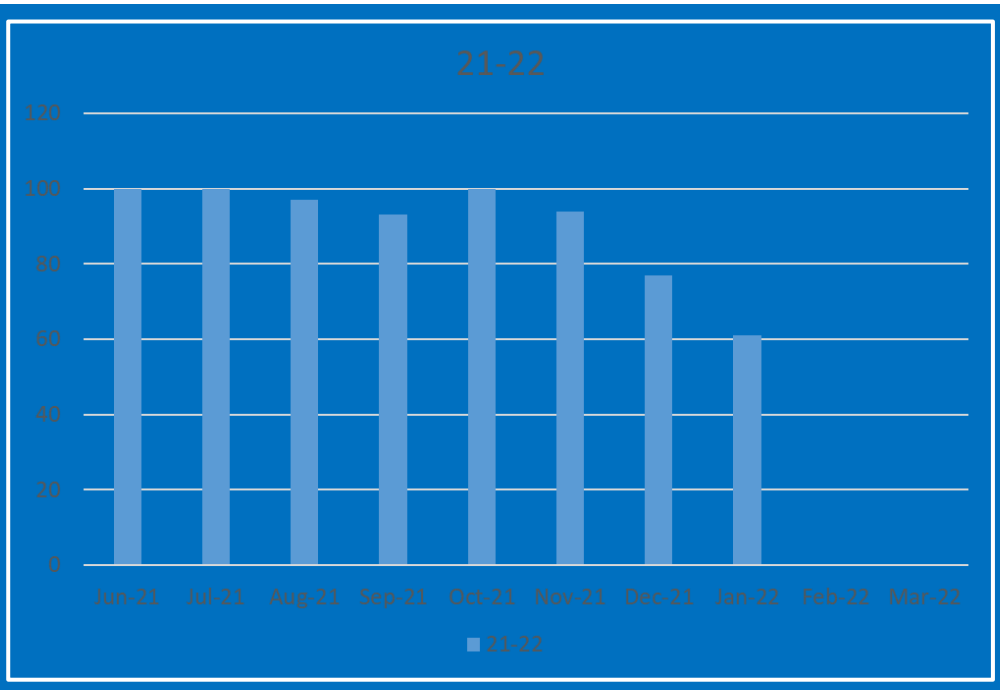
- Risk assessment, when the risk of developing a VTE is balanced against the risk of bleeding
- Correct thromboprophylaxis prescribing

All patients must be risk assessed. People aged 16 and over who are in hospital and assessed as needing pharmacological VTE prophylaxis must receive this as soon as possible and within 14 hours of hospital admission.

Since the appointment of a Patient Safety Improvement VTE specialist in December 2021 significant progress has been made in clearing the back log of RCAs. The current compliance for reviewed RCA's is 91%.
The aim is to see VTE events in real time whilst still an inpatient and perform an RCA, if the trust is considered to have contributed to wards harm, then duty of candour will be performed at this time to comply with the 10-day ruling. All wards have been encouraged to submit a DATIX when a new VTE event is reported to aid with this process. An improved drug charts was implemented in March 2022 to improve VTE assessment and to enable the trust to capture accurate order data alongside promoting patient safety. Education and posters have been used to promote the usage of weight adjusted low weight molecular Heparin in the trust to improve patient outcomes and reduce HATs.

In addition, patient information on the prevention of blood clots in hospital has been designed and is currently being reviewed by the Patient Information Group. A Graduated Compression Stocking is currently being trialled across 4 wards in the trust with an aim to go to print in the coming month. A Graduated Compression Stocking patient information leaflet has been formulated to use in conjunction with this and is currently being reviewed by the Patient Information Group.

Percentage compliance per month.



RCA tracker to date.

	Number of cases identified from radiology	Number of cases reported from mortuary	Number of cases reported from Datix	Number of cases reported from other source	Total	Total reviewed	% closed
Jun-21	15	7	1	0	23	23	100
Jul-21	22	3	0	2	27	27	100
Aug-21	29	1	0	0	30	29	97
Sep-21	24	3	0	1	28	26	93
Oct-21	23	2	0	1	26	26	100
Nov-21	32	1	0	0	34	32	94
Dec-21	20	1	0	1	22	17	77
Jan-22	24	2	1	1	28	17	61

Metric – Pressure ulcers

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Cat 2	**11**	**6**	**11**	**8**	**13**	**11**	**13**	**5**	**16**	**16**	**14**	**6**	**12**
Unstageable	**2**	**5**	**1**	**1**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**2**	**1**
Cat 3	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**3**	**0**	**1**	**1**
Cat 4	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**

DTI	**5**	**4**	**2**	**4**	**3**	**2**	**3**	**11**	**9**	**9**	**5**	**9**	**10**

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.

Metric – Falls
Throughout 2021-2022 falls per 1000 bed days remained below the trust target of 5.5.

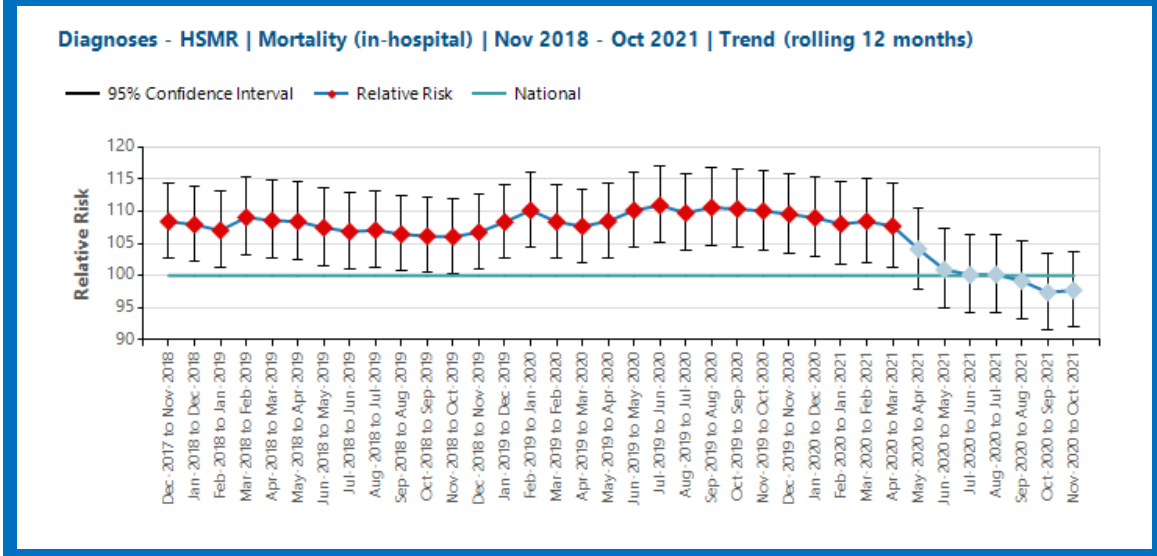
Apr-21	4.52
May-21	3.91
Jun-21	3.97
Jul-21	4.07

Aug-21	4.25
Sep-21	3.68
Oct-21	3.70
Nov-21	4.44
Dec-21	4.97
Jan-22	4.56
Feb-22	5.34
Mar-22	3.84

SUCCESS FACTOR 3 – Effective and Efficient Outcomes

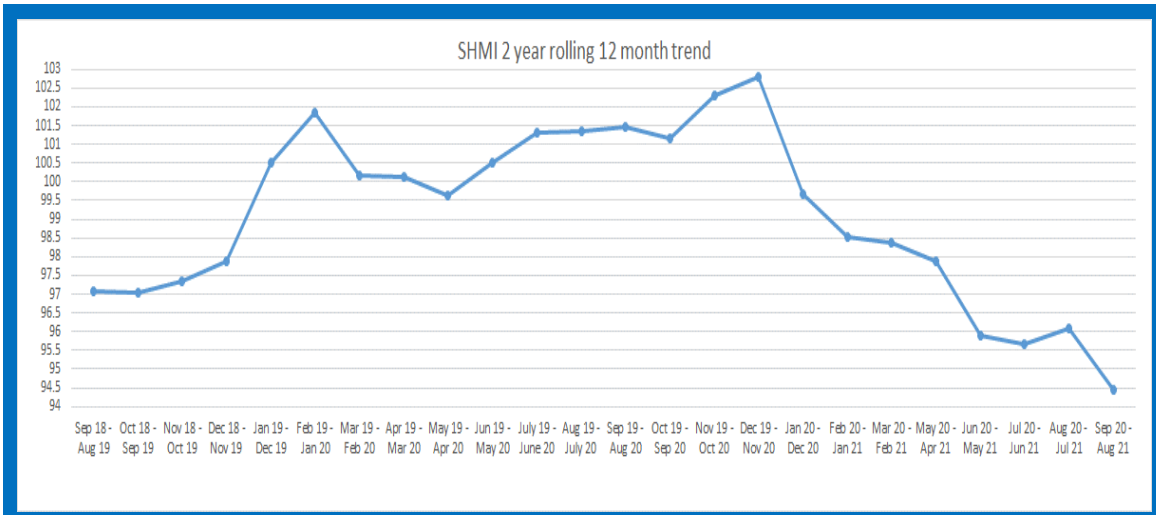
Metric – HSMR data

HSMR has decreased from the 'higher than expected' to 'as expected' range since the May20 – Apr-21 data period. The Trust is 1 of 3 Trusts (within the peer group of 8) with an HSMR in the 'as expected' range. The crude rate is 2.9% (vs 3.2% for the peer group).



Metric – Summary Hospital-level Mortality Indicator (SHMI)

SHMI has continued in the "as expected" (band 2) range throughout the published data period.



Metric – Standard of Care Scores (SOC)

SOC scores were designed as the measurement to assess compliance and monitor completion of each core task. The completion of each task equated to 1 point, therefore a score of 13 would reflect a fully completed Deteriorating Patient care plan.

Prior to the launch of the ibox task list, a manual retrospective audit of Deteriorating Patient paper care plans was completed by the Resuscitation and Simulation team. This was limited by resource and unable to provide a continuous data set therefore limiting the potential for identification of themes for learning and improvement. The design for the Deteriorating Patient SOC dashboard was to include daily average SOC score summary for all wards (Figure 1)

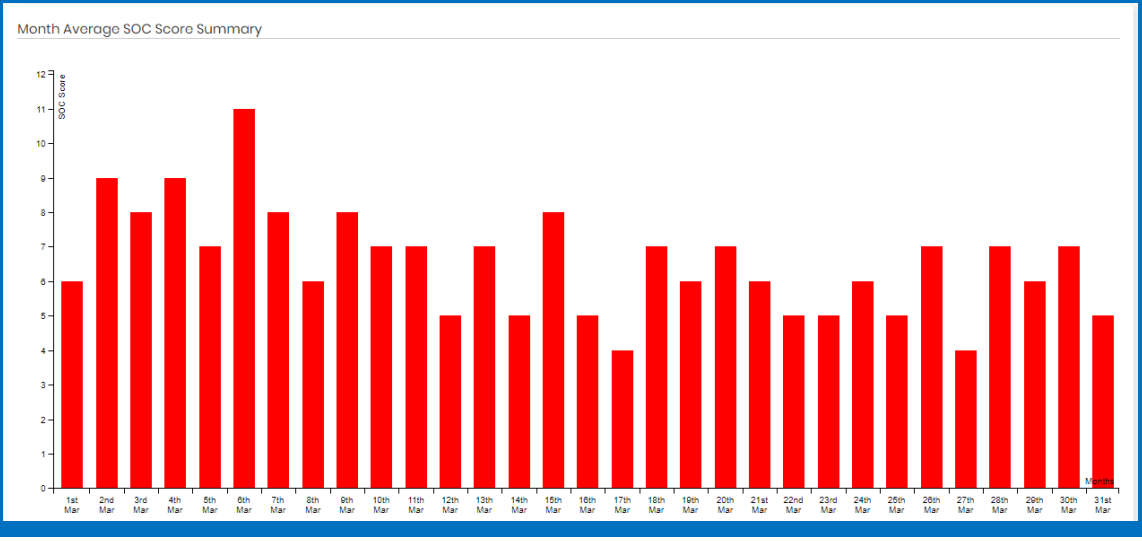


Figure 1: Month Average SOC Summary

With live data, it became apparent that the data being displayed represented individual interactions with tasks within a 24 hour period. This not only meant a single task list could be counted as a denominator more than once but also penalised appropriate care when a patient episode was correctly recognised to be not for escalation, or when a high NEWS occurred close to midnight.

Following this finding a manual audit was conducted using the same methodology as previous. 107 task lists were chosen at random generated between March-June 2021 and reviewed (Figure 2)

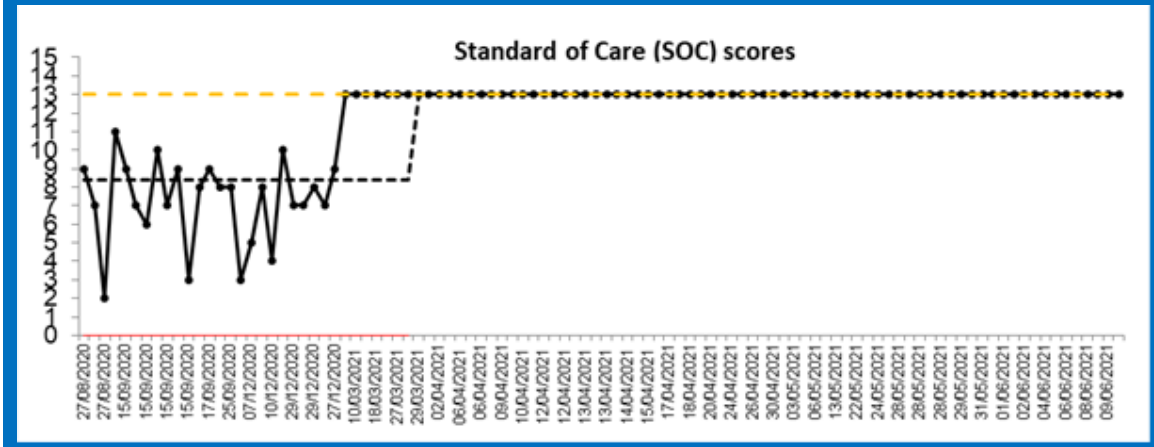


Figure 2: SOC scores

The results confirmed the electronic forcing function design successfully led to the completion of all tasks and consistent maximum SOC scores (13). This methodology does not consider the time response from identifying an episode of deterioration (NEWS >5 and automatic generation of a task list) and the completion and confirmation of the appropriate bundle of care. Analysis of this showed that although all of the tasks were completed, the time to completion varied, and was not always within the initial 24 hour target.

This finding prompted the shift in focus from SOC score to Task Response Time

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, in 2021/22 we have actively engaged in the ICS Long Term plan for Tobacco Dependency, working with KGH and Public Health Northamptonshire. The goal of the project is a Tobacco Dependency Treatment pathway that offers timely, effective, specialist support to ensure that patients remain smoke free whilst under the care of the NHS, with the hope that many of these individuals will continue on this path once discharged from care. This is one of the 4 key priorities of the new ICS with a real focus on respiratory, cardiology and maternity services. As an organisation we have;

- Recently appointed 2 Smoking Cessation Advisors
- Started to review the prescribing of products to support smoking cessation
- Started to review our No Smoking Policy

It is important to state that our 'Stop Smoking' & 'Substance 2 Solutions' colleagues have continued to provide a limited service to our patients throughout the Covid-19 pandemic 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.

Results - 287 patients responded (58%). There was improvement in 3 out of the 6 questions on the National Cancer Dashboard including:

- Patient definitely involved as much as they wanted in decisions about care and treatment
- Patients given the name of a CNS who would support then through treatment
- Patients found it easy or quite easy to contact their CNS

The score remained the same at 86% for being treated with respect and dignity while in hospital. There was a slight decrease in the score related to who to contact on discharge from hospital but remained over 90%. Dissatisfaction related to general practice definitely did everything they could to support patient during treatment . Down from 58 – 48%

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.
138 patients responded to the real time cancer patient experience survey during 2021. Overall results were positive with 74% rating their care as very good and 13% as good. 6% rated neither good or bad and 7% poor. Individual concerns raised by patients were referred to the appropriate service to investigate and address with the patient

Word cloud

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.

Winners of the national PENN award 2021 for the work undertaken with the National Cancer Improvement Collaborative. Able to demonstrate sustained improvement in patients being able to contact CNS from baseline score of 45% to 87%. Local survey indicated that 100% of patients liked the information sticker developed as part of the change

program. Hits on webinar platform went from 25 to over 1,000 following development of video's to support patient self-management strategies including management of distressing symptoms including incontinence and rectal dysfunction.

Personalised Care and Support

- Remote monitoring implemented in breast and prostate cancer, will go live in colorectal once additional nurse has been recruited
- Remote monitoring now live in colorectal cancer
- 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
- Development of dedicated U-tube channel with video's and webinars to support self-management through the cancer pathway
- Breast live event held in December with over 100 participants registered. Second one planned for later this month
- Regular live breast events with panel of experts in order for patients to asks any questions related to their cancer or treatment. Prostate cancer live event held in November and live event for carers of patients living with pancreatic cancer held in August
- Increase in number of Holistic Needs Assessments generated in last 12 months the number of holistic needs assessment continues to increase with more stage of the pathway addressed
- Slow increase in number of End of Treatment Summaries this remains slow with clinicians but the addition of CNS's and therapeutic radiographers undertaking summaries has increased the overall number
- HOPE program run remotely with positive feedback from patients – first in the region to do this. Face to face HOPE program re-instated with online support still available
- 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. Thanks to Macmillan funding no longer have a site specific standalone CNS posts providing continuity of care and a seamless service for patients
- Successful bid for rarer tumour CNS appointed and commenced in post on 21st February Successful bid to develop Macmillan neuro-oncology nurse to support patients living with a brain tumour

- 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 funding issues bid being relooked at
- Increase in the number of webinars and video to support self-management through the cancer pathway
- Pilot of dedicated prehab program before colorectal surgery. Results indicate reduced length of stay and reduction in unplanned admissions to hospital. National publication being presented by colorectal surgeon. . Aim to roll out to oncology part of the pathway in colorectal cancer. Business case to develop prehab for all cancer patients
- Offering health and wellbeing program as part of Macmillan information centre including dedicated walk and talk group, yoga and complimentary therapy

Metric – Patient Communication
Engaging with patients and families and acting on feedback has been a challenge this year due to the continuation of the Covid-19 pandemic. This necessitated the halting of open visiting to the organisation.

- FFT – For 2021/22, From April 2021 – February 2022 (no data yet for March), there were **772** comments related to Communication. Of these, **523** comments related to Attitude & Behaviour, **176** related to communication with the patient and **51** related to Communication with the patient over the telephone. There were **15** comments related to communication with the relative.
- Right Time Survey results (Inpatient Journey Survey) - The Right Time Survey was stopped in March 2020, at the start of the pandemic. This was due to the fact that the general public would have had to leave their homes to post their responses, which was not safe to do so at the time. Data collection for the survey resumed in January 2021 and was rebranded with a new name, Inpatient Journey Survey.

Where we are doing well: Throughout the year the Trust had **2** questions that were within the **Top 20%** when compared nationally. This was in relation to having enough privacy when being examined or treated and being able to sleep at night due to hospital lighting.

Where we need to improve: Throughout the year the Trust had a number of questions that were within the **Bottom 20**% and covered most areas of the survey. These were around being able to take medication when needed, explanation of ward changes in the night, understanding answers from staff, having confidence and trust in

doctors, how much information about the patient's condition/treatment was given and being involved in decisions about care or treatment. There were also questions around being given enough notice about when patients were going to leave hospital and explanation of medication side effects.

The Trust had 2 questions that were in the Worse than Worst Trust. These were around having confidence and trust in the doctors treating patients, and around explanation of how to take medications after leaving hospital.

Feedback is shared throughout the MDT across all divisions. Work is being undertaken to improve communication particularly on discharge and in urgent care. The Trust has also invested in more ward-based pharmacists. The hope is that as visiting restrictions start to relax the opportunity to communicate with families will reinforce information given at the bedside.

Despite the pandemic we were able to hold 3 patient engagement events throughout 2021/2022:

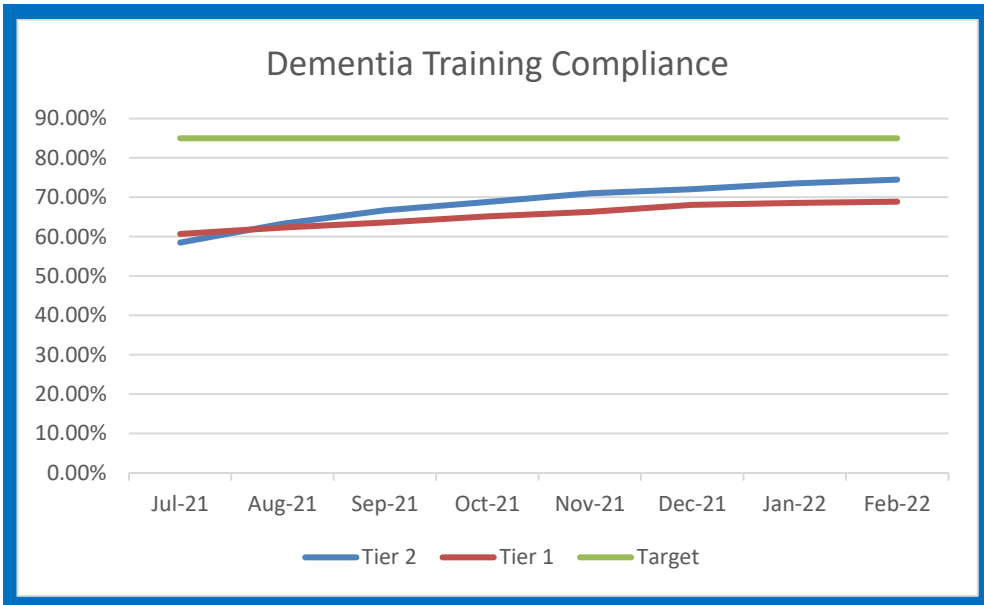
- Clinical Pathway Review & Redesign – ENT April 2021
- Learning Disability Listening Event – October 2021
- Emergency Department -December 2021

Metric – Dementia – appropriate diet

People with dementia often experience problems with eating and drinking – the finger food boxes enable patients to eat at any time of the day or night. It was identified that the current finger food offer, needed to be improved. The Dementia Liaison Nurse has been working alongside Speech and Language Therapy department (SALT), Dietitians, and the Catering Department.

This project has been suspended due the national shortage of fuel, lack of delivery drivers and covid-19. All new menu changes were suspended by the catering department. A new finger food menu has been proposed and the Nutrition and Catering Group will continue to take this piece of work forward.

Metric – Dementia training



A gradual improvement to compliance in dementia training has been observed throughout 2021-2022. Face to Face training was suspended due to covid-19 and was restarted in January 2022. A training package of workbooks and face to face training remains in place. The current training compliance figure for Tier one is 68.9% and Tier 2 is 74.5%.

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. The hospital reinstated FFT postcards at the end of June 2021 and started collecting the feedback in July 2021.

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 must collect and report response rates.

Trust wide Patient Satisfaction Score

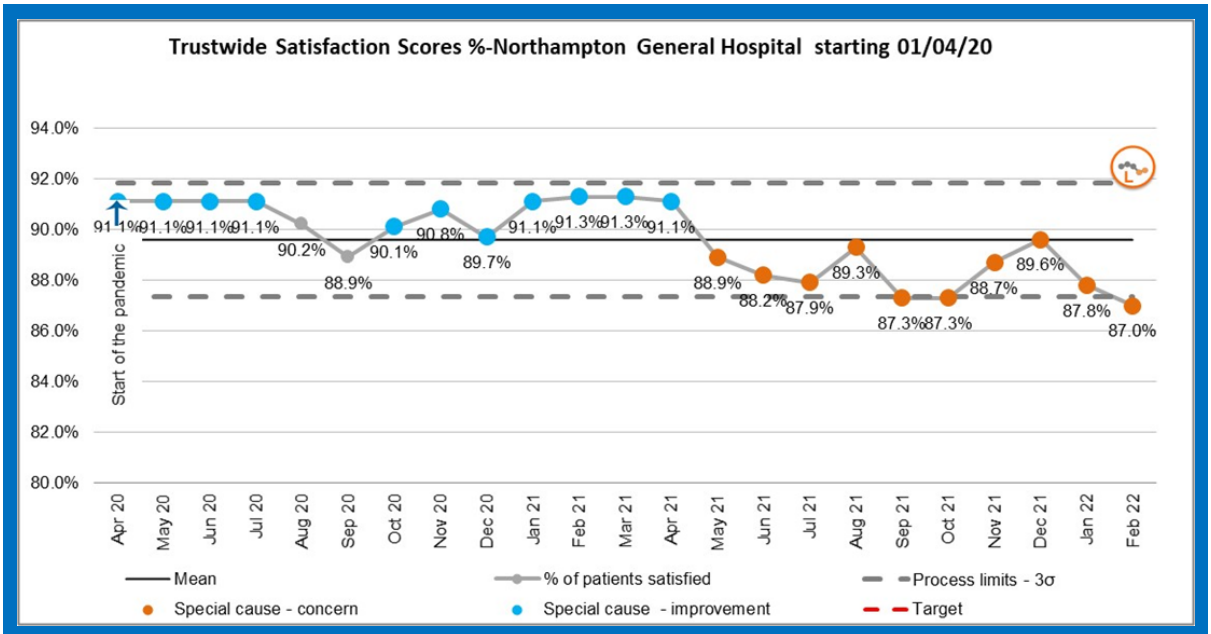
As we now have 12 data points since the question changed, new SPC charts have been created. Now that we have >12 data points entered, control limits now show within the SPC and we can see whether changes within data are statistically significant.

The SPC chart below reflects satisfaction scores throughout April 2020 – Feb 2022.

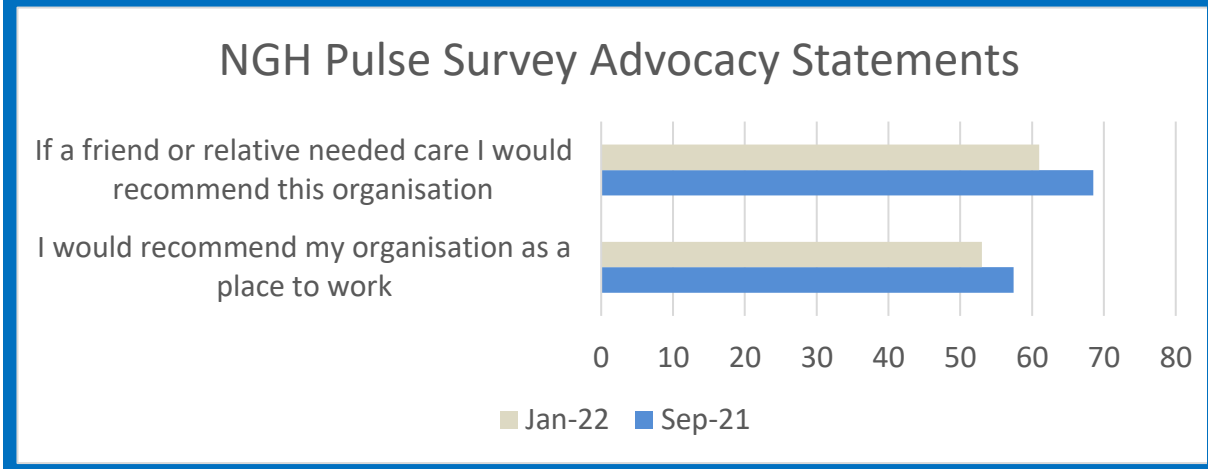
April 2021- February 2022

From April 2021 to date, there has been a significant change in satisfaction scores, with 10 data points lying below the average mean with the data point for February 2022 lying below the lower process limit (LPL). This is unusual and may indicate a significant change in process. This process is not in control.

From April 2021 to date, satisfaction scores have remained between 87% - 91%. On comparing the figures since April 2021, satisfaction scores average 88.5%.



Metric – People Pulse



The people pulse replaced the advocacy questions in the family friends questionnaire in 2021.

In September 2021 just over 68% of people would recommend the organisation as a place to receive care, and above 57% as a place of work.

Advocacy across the group declined in the most recent pulse survey with 61% recommending the organisation for care and 53% as a place of work.

Metric – GIRFT

The Table below shows the overall position with GIRFT in the Trust as of April 2022.

- For the Completed plans, we are awaiting data from GIRFT directly.
- Plans in progress – from 33 specialties on our list, 18 are active (had deep dives and follow up meeting are being arranged)
- New Deep Dives that were scheduled for 21/22 – Cardiology (27.05.21), Neonatology (14.12.21), AGM (13.12.21), Dermatology (04.03.22), Lung Cancer (14.06.21)
- Elective Delivery Programme work-streams – Ophthalmology, ENT and Orthopaedics
- Deep Dives not yet due - Plastic Surgery and Burns, Rheumatology, Vascular, Litigation, Renal, Respiratory, Anaesthetic Perioperative Meds, Paediatric Critical Care, Imaging and Radiology, Endocrinology, Paediatric Surgery, Oral and Maxillofacial

GIRFT Work-stream Status	n.
Completed plans	n/a
Plans in progress	18
New Deep Dives to be scheduled 21/22	5
Elective Delivery Programme work-streams	3
Deep Dives not yet due	12

Metric – Outpatients

The Outpatient services at Northampton General Hospital is provided by the individual directorates as an integral part of their patient treatment pathways. Northampton general hospital also has a dedicated Outpatient Directorate whose role is to standardise, optimise and centralise where necessary, parts of the outpatient pathway to ensure that we have a patient oriented, optimised and seamless service.

The outpatient directorate currently provides an outpatient contact centre for the surgical specialities. It handles patient enquiries about outpatient appointments. This filters the number of calls that the individual directorates receive, thus improving efficiency. The aim of the directorate is to expand the provision of the contact centre to the medical specialities. The directorate also has plans to expand the range of services to be provided by the contact centre to include services such as Email query response and virtual appointment waiting room management. The details will be scoped in this financial year with a plan to write business cases for the investment required.

The outpatient directorate has also been championing non face to face outpatient appointments within the trust. The directorate liaises with IT and the video consultation provider to ensure that any problems with access is resolved promptly. There are plans to run video consultation training sessions locally and to contribute to regional training programmes which Northampton general staff can then access.

The outpatient directorate will continue the roll out of the text reminder service which informs patients of their upcoming outpatient appointments with a text reminder. This has already shown results with reduction in DNA rates and will continue to be introduced to other areas according to the roll out plan.

The outpatient services of the group have received substantial funds from the Targeted Investment Fund (TIF). This is a joint project with dedicated transformation and IT input along with external support from Moorhouse consultancy.

The tools bought with the TIF will be key to enhancing the outpatient experience of patients and clinicians. The tools will facilitate digital triage and outcoming; centralised room booking and improved room utilisation; digital check in via kiosks and app; wayfinding and patient flow management; direct call of patients by clinicians; improved digital dictation solution with the ability to directly transcribe dictation with high fidelity and digital letters being sent to patients.

The procurement and the initial implementation of a variety of tools to improve patient experience and pathway efficiency is currently underway. The wider roll out to all outpatient areas and support to ensure that these tools are utilised to maximise their potential will be the key focus of the Outpatient services and the directorate in 2022-23.

SUCCESS FACTOR 5 – Outcomes in maternal & neonatal care

Metric - Reducing smoking in pregnancy.
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 Fetal Surveillance Midwife and Matron for Patient Safety and QI. 90% of bookings in March 2022 had a CO recording taken and documented. The Trust has introduced CO monitoring at every contact for all women. 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.

Metric – Information
Reduced fetal movement leaflets are given to women between 16-28 weeks pregnant, this is currently measured as 95%. These are given in their own language, measured as 100%. This is audited on a weekly basis.

Metric – Intrapartum Care
100% of staff that give intrapartum care are up to date with annual fetal monitoring training. CTG masterclass training introduced. Twice weekly CTG meeting 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 implemented for uterine artery Doppler scan for women at risk of pre-term birth at their anomaly scan. Implementation of a Stillbirth bundle dashboard.

Metric - Leadership

The Midwifery Leadership has been strengthened to incorporate the following new posts:

- Consultant Midwife
- Head of Midwifery (to commence in 2022)
- Governance Lead Matron.
- Matron for QI

There were 2 RCM awards presented to Maternity Services in 2021:

- Excellence in Maternity Care during a Global Pandemic
- Excellence in Race Matters

Metric – National Agenda

Successful submission of CNST year 3 Safety Actions
Submission of benchmark against the 7 immediate and essential actions of the Ockenden report.

Metric – Learning from Incidents

Maternity services and ED undertook a joint Trust wide 'Dare to Share' presentation regarding the care of pregnant women in ED

APPENDIX 1
Stakeholder Feedback

West Northamptonshire Council

Democratic Services
West Northamptonshire Council
One Angel Square
Angel Stree
Northampton
NN1 1ED
0300 126 7000
www.westnorthants.gov.uk | james.edmunds@westnorthants.gov.uk

Mr Simon Hawes
Head of Governance
Northampton General Hospital NHS Trust
Governance Department
Cliftonville
Northampton
NN1 5BD

27th May 2022

Dear Mr Hawes

Draft Quality Account 2021/22

West Northamptonshire Council was established on 1st April 2021 and has since been responsible for scrutinising the planning and provision of health services in the local authority area. This scrutiny function is carried out by the Council's People Overview and Scrutiny Committee. The need to set up the new Committee and for it to scrutinise topics from across the breadth of its remit has necessarily limited the amount of health scrutiny work that it has done in 2021/22 that could otherwise have provided a basis for detailed comments from the Committee on local healthcare providers' draft Quality Accounts.

The People Overview and Scrutiny Committee has considered the aims and development of the Northamptonshire Integrated Care System and the delivery of the Integrated Care across Northamptonshire programme as part of its scrutiny work during the past year. Committee members recognise the benefits that more joined up working is intended to deliver and the need also to deal with the practical challenges that might affect the realisation of these outcomes. I encourage Northampton General Hospital NHS Trust to ensure that the priorities for 2022/23 set out in its Quality Account fully reflect and support the development of effective integrated services in Northamptonshire.

Yours sincerely,

Councillor Rosie Herring
Chair, People Overview and Scrutiny Committee

Healthwatch North and West Northamptonshire statement on Northampton General Hospital NHS Trust draft Quality Account 2021/2022

Healthwatch North and West Northamptonshire believes that this Quality Account demonstrates the ways that NGH is seeking to provide the best quality care for patients despite the increase in demand. We are very pleased that NGH has achieved university hospital status and is involving more and more patients into studies.

It is essential that NGH continues to review and improve the patient and carer experience across the Trust.

The feedback Healthwatch North and West Northamptonshire receives from patient, families and members of the public is shared with NGH via anonymised reports. We thank NGH for acknowledging and valuing this feedback and for looking into the issues particularly with regards to communication and care.

In relation to the PALS service, we appreciate how NGH has remained ambitious in responding to all complaints within a timely manner despite the significant operational pressures of the pandemic.

We look forward to continuing to work with NGH over the coming year to support them in ensuring high quality, safe and inclusive patient-centred care. We believe that the chosen quality priorities are appropriate and make good use of the Trust's data and experience.

NHS
Northamptonshire
Clinical Commissioning Group

Our Ref : AD/SB

16th June 2022

Francis Crick House
Summerhouse Road
Moulton Park
Northampton
NN3 6BF

Switch Board: 01604 651100

By Email Only

Dear Simon

Re: Quality Account 2021/22

Thank you for providing us with the opportunity to comment on your annual quality report for 2021/22. The report has been reviewed by NHS Northamptonshire Clinical Commissioning Group.

It is noted that the report was reviewed whilst in draft format and whilst the trust has utilised some elements of the format requirements, they haven't followed this throughout the account.

We would like to congratulate the trust on being shortlisted for the HSJ Partnership award for Asthma Home monitoring. It is also really positive to see that despite the impact of the pandemic the trust has reduced its registered nurse vacancy factor from 13% to 6%. The CCG recognises the positive impact for patients of using robotic surgery. We can see that this will offer shorter waiting times and an enhanced experience for patients.

The trust has chosen not to include information on Seven-day services and Freedom to speak up, we recognise the impact of the Covid 19 pandemic on the collation of data for the core indicators however the trust has not been clear on the actions they plan to take to make improvements in the future. Data around mortality was not available within the draft report so cannot be commented on.

The trust has included its narrative achievement and performance against the 2019-2022 indicators within section 3 rather than part 1. We note that the trust made some progress against some indicators despite the pandemic, and it is positive to note that where possible mitigations have been put into place.

The account states that the priorities have been aligned with Kettering General Hospital as part of the University Hospitals of Northamptonshire (UHN) Group. There is a statement that; 'The patient priority is in essence that patient experience improvements will be shaped by the patient voice. The quality priority includes an ambition towards zero avoidable patient harm and the lowest mortality among a peer group of hospitals.' However, it is not clear how these priorities are being defined or how the trust plans to monitor and report against achievement of these.

The quality team looks forward to receiving updates through the quality review meetings of the progress made in year against their quality priorities.

Yours sincerely

Angela Dempsey
Chief Nurse and Quality Officer
Northamptonshire Clinical Commissioning Group

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	HCA	Healthcare Assistant
	HSMR	Hospital Standardised Mortality Ratio
	HWN	Healthwatch Northamptonshire
I	IPC	Infection Prevention and Control
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
	RN	Registered Nurse
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

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