Dedicated to excellence

NHS
Northampton General Hospital
NHS Trust

Quality Account 2022/2023

CONTENTS

1

PART ONE

- Introduction
- Statement on Quality
- Successes

1.1. 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.

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 Hemant Nemade and Director of Nursing and Midwifery Mrs Nerea Odongo.
    - We also outline some of our key successes from 2022/23.
- Part Two
    - Provides details of several Statements of Assurance regarding specific aspects of service provision in order to meet the requirements of NHS England.
- Part Three
    - Describes how we performed against the quality priorities set for 2022/23, 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

1.2. Statement on Quality

Dear All,

Welcome to the Quality Account for Northampton General Hospital (NGH) for 2022/23. This Quality Account has been designed to report on the quality of our services. It offers you the chance to find out more about what we do and how well we are performing. Our aim is to describe in a balanced and accessible way how we provide high-quality clinical care to our service users, the local population and our commissioners. It also shows where we could perform better and what we are doing to improve.

In the account 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.

As a hospital, we have continued to focus on developing a culture of safety over the last year, building safety into the heart of all we do. For example, since the appointment of a Patient Safety Improvement VTE specialist in December 2021 the back log of Root Case Analysis (RCA) has been addressed and are now up to date. The current compliance for reviewed RCA's is 98%.

In addition, our Summary Hospital-level Mortality Indicator (SHMI) has been decreasing over the previous 2 years, and as of the latest published monthly dataset shows our SHMI figure is in the "below expected" range, which reflects on our commitment to keep our at-risk patients safe and we have worked steadily to ensure we have a fully completed Deteriorating Patient care plan.

As well as safety, quality of care and patient experience all continue to be a priority at NGH. Earlier in the year, we began using a state-of-the-art Surgical Robot to help improve care for patients and tackle waiting lists impacted by the COVID-19 pandemic. We invested in a £1.7m Surgical Robot, as part of our group clinical strategy, which enables us to perform difficult surgeries in hard-to-reach areas, with better outcomes for patients and shorter stays in hospital.

In the summer of 2022, we were delighted to open our new £15.9 million Critical Care Unit The new unit replaced the old intensive care unit and comprises 16 specialist beds, five specialist isolation rooms, a relative's room, and better facilities for staff to work and rest in.

The Trust was successful in a Macmillan bid to develop a lead to implement the national personalised care agenda. The Trust was also successful in a bid to Macmillan cancer support to develop a dedicated team to implement cancer prehab/rehab for patients prior to surgery and oncological treatment. This will greatly improve clinical outcomes and our cancer patient experience, reflecting the regional gold standards framework.

The quality of the care we provide is heavily reliant on our ability to recruit and retain great people and enable them to develop and flourish. We are working hard to ensure we have a positive culture that actively encourages inclusion and diversity.

We have supported nine international midwives 60 international nurses and have seen our first cohort of international ODPs and AHPs. We were also delighted to be awarded the international pastoral care quality award for providing high standards of pastoral support for our newly recruited international colleagues joining the organisation.

In March 2023 we held our first Groupwide *Dedicated to Excellence* Staff Awards to recognise and celebrate the achievements of some of our teams, amazing staff, volunteers and fundraisers across the University Hospitals of Northampton Group (UHN).

An important part of our collaborative work continues to be working towards achieving ever greater integration, which we are continually working with our partners to deliver. We are also working with our NHS partners to enhance the delivery of care closer to people's homes. There are some commitments that are taking longer than we would like to deliver on. We have made progress in delivering some of the agreed programmes of work, which are outlined in the main body of this report.

We have also made progress in other evolving areas that have been local priorities for NGH in delivering our overall Group Dedicated to Excellence strategy.

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

As well as our determination to ensure we continue to maintain high quality services throughout, over the next 12 months our focus, as always, will be on providing safe and high-quality support and care, at the right time and in the right place for those people who need our services.

Heid Smoult
Chief Executive

Mr Hemant Nemade
Medical Director

Mrs Nerea Odongo
Director of Nursing & Midwifery

1.3. 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.

Heidi Smoult
Chief Executive

Rachel Parker
Chair

1.4. Successes

Awards:

- International Pastoral Care Quality Award
    - The trust has been awarded the international pastoral care quality award for providing high standards of pastoral support for our newly recruited international colleagues joining the organisation.

- Macmillan Awards
    - The Trust was shortlisted for two national Macmillan awards during 2022. We were delighted that the Macmillan social care team was the winner of the "Going above and beyond" catergory and the Macmillan uro-oncology team reached the final of the Macmillan awards for service improvements.

- Colon Capsule Service
    - Our colorectal team have been awarded a highly commended award for their work in setting up the colon capsule service at NGH

Macmillan Bid

The Trust was successful in a Macmillan bid to develop a lead to implement the national personalised care agenda including: holisitc Needs Assessment/Care Planning, End of Treatment Summaries and Health & Wellbeing. There has been an increase in the number of holistic needs assessments undertaken at key stages in the patients pathway, and a slight increase in the number of end of treatment summaries generated. The Trust was also successful in a bid to Macmillan cancer support to develop a dedicated team to implement cancer pre hab/rehab for patients prior to surgery and oncological treatment.This will greatly improve clinical outcomes and our cancer patient experience, reflecting the regional gold standards framework.

Pathway to Excellence

Pathway to Excellence is an international accreditation which focuses on making hospital a positive practice environment where Nurses and Nursing Associates flourish.

Northampton General Hospital were the first UK organisation to achieve Pathway designation in 2018 and we will be the first organisation to achieve re-designation in 2023. Organisations can apply to achieve designation which evidence they have met these standards over a 4-year period.

The only way we can achieve re-designation and keep our Pathway to Excellence Hospital status is to evidence how amazing our Nurses and Nursing Associates are by passing the Pathway to Excellence Survey.

Re-designations means that we are applying to keep our Pathway to Excellence designation and show our commitment to nursing excellence nationally. We are so proud to have been the first hospital to gain designation and we hope that we can keep our designated status.

OurSpace

During the COVID pandemic, we know that our staff valued OurSpace - a space that was created specifically for colleagues to take much needed time out to pause, breathe and relax. Since the loss of this original space, we have been trying to we have been trying to secure an alternative, permanent wellbeing hub for our staff.

We are excited to announce that we have invested in creating a secure and dedicated space which all our staff can use 24 hours a day, 7 days a week via swipe card and will sit within a dedicated staff wellbeing Hub.

Our Space will provide our staff with:

- A place they can go to pause and relax away from their work environment
- A space to connect as a team facilitated and supported by the Trust Health and
- Recognition that 'its ok to not be ok' and to provide a confidential, supportive environment for scheduled appointments with the staff Health and Wellbeing
  services
- An information Hub where staff can find out about the Trust Health & Wellbeing initiatives, workshops and events and how to access confidential staff support

International

- We have supported nine international midwives 60 international nurses and have seen our first cohort of international ODPs and AHPs.
- We are taking part in displaced talent academy supporting refugees from Lebanon as part of national support programme.

2

PART TWO

- Priorities for Improvement
- Statements Relating to Quality of NHS Services Provided

2.1. Priorities for Improvement

As part of our Integrated Business Planning for 2023/24 and in order to set our objectives for the coming year, we have reviewed the strategic priorities as set out in our Dedicated to Excellence strategy. The purpose of the review for 2023/24 planning has been to ensure our strategic priorities are reviewed and updated to reflect the work we are doing collectively across both hospitals within the University Hospitals of Northamptonshire NHS Group (UHN) and specific priorities for each individual hospital. When we set out our Dedicated to Excellence Strategy, we agreed 5 strategic priorities, goals and success measures. The 5 strategic priorities were confirmed as current at the joint Board Development session on the 20 January 2023.

A key aim of our strategic planning is to create a single forward focused view of our priorities and goals that can be used to communicate and engage staff about what we are trying to achieve. By planning our strategic priorities and defining goals, the specific deliverables and Key Performance Indicators can then be determined at organisational level. If achievable, the Trust will look to identify what the achievement expectation is for each year.

Our strategic priorities create a single focus that we can align our enabling strategies and organisational delivery around; ensuring that everyone is working to things that matter the most for our patients and staff. Each of our strategies and the integrated business planning process running in both hospitals will be aligned to these strategic priorities.

Below are the agreed metrics for the next 4 years from 2023/24 onwards.

Area	**2023/24 Updates: 4 year goals set out from April 2023**
People	PP1: Above average national staff survey advocacy scores
People	PP2: Improvement in diversity measures
Patient	P1: Top 10% nationally in the inpatient and cancer surveys
Patient	P2: Positive feedback in local patient feedback and surveys
Patient	P3: Improved complaints performance rates

Quality	Q1: Aspire to no avoidable harm
Quality	Q2: Mortality indices that are best in peer group (SHMI/HSMR/SMR)
Quality	Q3: 100% of wards and outpatients achieve Assessment & Accreditation
Quality	Q4: Reducing clinical variation: • GIRFT - 85% BADS day case • Cardiology – Improvement in Cardiology-specific SHMI • Cancer – Improvement in overall cancer survival rates / Presentation at stage 1 & 2 diagnosis
Systems & Partnerships	SP1: All cancer patients treated in 62 days unless clinically inappropriate
Systems & Partnerships	SP2: Deliver planned and emergency care standards
Systems & Partnerships	SP3: Maximum 92% bed occupancy
Sustainability	S1: Double the number of patients who can participate in research trials
Sustainability	S2: Continue progress towards eliminating our carbon footprint by 2040
Sustainability	S3: Demonstrable improvement in underlying financial performance and effective use of resources, to median benchmark levels or better

PEOPLE Programme of work	Objective(s)	How does this contribute to top aims / metrics?	Delivery metrics	How will we measure this	Baseline	Target / trajectory	Dependencies / risks to delivery
Developing our people	Development of UHN values based leadership competency framework Development of UHN leadership strategy New UHN appraisal Aligned statutory and mandatory training	Increase in manager related staff survey scores (PP1) Increase in EDI related staff scores (PP1, PP2)	No managers going on leadership management programme Appraisal completion rates MAST compliance	Course enrolment data Appraisal completion rates MAST compliance	N/A Appraisal NGH 73% MAST NGH 82%	No completing leadership development interventions Appraisal 85% (5% improvement in year) MAST 85%	Releasing time from operational or clinical delivery to attend leadership programme
Improving health and wellbeing	Aligned offer across both Trusts	Improvement in staff survey score (PP1)	Improved attendance	Sickness absence	NGH 6.1%	By end 2023/24 NGH 5.5% Target 5%	Covid
Dedicated to Excellence – Culture change – inclusion and empowerment	Improved staff experience through an improved culture Improvement in inclusion	Increase in improvement related staff survey scores (PP1) – expect delay to year 2	No. excellence ambassadors recruited Discovery phase to set	Recruitment figures TBD depending on	0 N/A Engagement NGH 6.2	Target: 50 N/A Engagement NGH 6.3	Funding constraints

		Increase in EDI related staff scores (PP1, PP2)	further delivery metrics	discovery output Staff engagement scores			
Clinical and Corporate services collaboration across the Group	Establish framework for People Team to support clinical collaboration People Policy Harmonisation People Partnering and OD and Inclusion objectives with people plan	Support maintenance of PP1, PP2 through clinical collaboration processes	Package of support for workforce data, team readiness for change diagnostic, workforce planning (including writing JD/PSs) and contractual consultation where appropriate as part of collaboration	All People Policies harmonised across the group	6 people policies harmonised as at Jan 2023	April 2025	Industrial relations climate
Delivering a sustainable workforce	Reducing reliance on agency Improving availability of staff	Improvement of PP1 and PP2 by improving resourcing and day to day	Reduced number of agency shifts Reduced vacancy	Agency cost Vacancy rate Time to hire	NGH £27M NGH 9.3% NGH 88 days	NGH £12M Vacancy 8% TTH	Staff engagement Labour market

		experience of staff	through improved workforce planning			NGH 70 days	

PATIENT Programme of work	**Objective(s)**	**How does this contribute to top aims / metrics?**	**Delivery metrics**	**How will we measure this**	**Baseline**	**Target / trajectory**	**Dependencies / risks to delivery**
Patient feedback digital system	Improve visibility of patient feedback and enable action to improve	Improved feedback from patients	Patient feedback received digitally	Outputs from digital system – exact measure to be defined during implementation	N/A – would be provided by the system	N/A – would need defining once system to collect in place	- Funding for procurement
Complaints process & compliance	Align with the new national Ombudsman work and improve processes and ensure learning from themes of complaints	Improving complaints performance	Aligned process & standards across UHN Track learning from complaints	Standard UHN complaints process in place Learning from complaints themes	Not in place TBC following approach	In place TBC following approach development	 An approach will be developed

			Reduction in complaints by complaint theme focus	Complaints performance -no. of complaints per month- IGR	developme nt NGH 24 (Mean 21/23)	TBC	through the CQSPCiC
Clinical collaboration	Ensure patient engagement in all clinical collaboration work Ensure all clinical collaborations have list of issues to be solved / metrics / deliverables focussed on patient experience / outcomes from the service that are tracked	Improved patient feedback (P1)	Patient representati on on each of the clinical collaboration s Clinical collaboration achievement s in support of resolving agreed patient experience / outcome issues	Patient reps on clinical strategy development groups Delivery of patient experience metrics outlined in individual service strategies	3 (in ENT, Cardiology , Cancer) Varies by specialty	In all collaborating specialties Achievement of experience metrics outlined in individual strategies	Resourcing of patient engagement teams
Outpatients	Outpatient communication improvement through the	Improved feedback from patients (P2)	Patient feedback on communicati on in FFT	Outpatients Friends and Family	Jan-23: 94% - NGH	95%	Reliant on delivery of digital solution

	outpatients transformation programme - Digital letters - Improved phone contact		Call drop-rates in Outpatients First-time resolution in call metrics	communication scores Outpatient call answering & resolution rate	Oct-22: 78% calls answered and resolved first time	90%	Risk to delivery given current level of admin vacancies
Improving equality for people of Northampton shire	Ensure all programmes of work have a focus on improving health inequalities and ensure services are provided in the best place	Improved patient feedback (P2)	Consistent approach to embedding health inequalities in programmes All clinical collaborations and transformation programmes have a focus on health inequalities (EIA)	Number of EIAs completed against major programmes	0	100% major programmes (to be defined)	Digital solutions

QUALITY Programme of work	Objective(s)	How does this contribute to top aims / metrics?	Delivery metrics	How will we measure this	Baseline	Target / trajectory	Dependencies / risks to delivery
Deteriorating patient	Improve monitoring and responses to deteriorating patients	Reduction of avoidable harm from delays in responding to deteriorating patients	CQUIN 07- 30% of unplanned critical care unit admissions having a timely response to deterioration , with the NEWS2 score, escalation and response times recorded in clinical notes Compliance rates to set observation frequencies	CQUIN reporting Data from e-Vitals	100% (NGH Q2 22/23) NGH not available across the Trust	30% (CQUIN target-NHSE) >95%	Digital implementation

Medicines management /digital patient records	Implementation and rollout of EPMA system	Reduction in medication errors (avoidable harm)	EPMA and EPR implemented in all wards	EPMA rollout reporting	NGH-no EPMA or EPR	All UHN wards-EPMA and EPR	Digital implementation
Cardiology centre of excellence	Delivery of the Cardiology centre of excellence	Reduces clinical variation and outcomes in cardiology patients	Achievement of objectives in Cardiology CoE 1 year plan NICOR national audit 72 hour NSTEMI standard for both sites	Cardiology Strategy quarterly review updates	NSTEMI: NGH 50%,	90% across group	Clinical and operational pressures
GIRFT	GIRFT programmes	Reduce clinical variation in BADS procedures	Achieve 85% Day Case rates for BADS procedures Delivery of HVLC cases per list	Day case rates Cases per list (Ophth, T&O, Gynae, Uro, Gen Surg, ENT)	Nov-22 71% - NGH ENT – 2.7 GenSurg – 2.0 Uro – 2.7 Gynae – 3.3	85% Targets need developing based on case mix	Clinical and operational pressures

					Ophth – 4.3 T&O – 2.6		
A&A	Increase areas who have A&A accreditation	Increasing wards and outpatients achieving accreditation	Number of wards with A&A accreditation	Number of wards at each level of accreditation	Current number at each level	Improved number of wards at top 2 levels of accreditation by 10%	Accreditation team staffing
Implementation of Patient safety strategy	To deliver the national patient safety strategy	Q1:Aspire to no avoidable harm Q2: Mortality indices that are best in peer group	PSIRF metrics	PSIRF metrics	As per PSIRF baseline-in line with implementation process	Full roll out in line with national timelines	Digital implementation Recruitment System engagement

SYSTEMS & PARTNERSHIPS Programme of work	**Objective(s)**	**How does this contribute to top aims / metrics?**	**Delivery metrics**	**How will we measure this**	**Baseline**	**Target / trajectory**	**Dependencies / risks to delivery**
Community Diagnostic Centres	Providing diagnostic capacity in community settings, increased access for	Supports SP1, SP2	Annual plan diagnostic activity delivery-Performance against the	DM01 CDC business case benefits realisation	Activity plan	85% (DM01) CDC KPIs	Digital connectivity Recruitment challenges

	outpatient referrals and cancer pathways.		6-week wating time standard (DM01) Delivery against CDC busines s case KPIs				Managing DNA rates
Outpatients' transformati on	Transforming our outpatient services, optimising our clinical pathways, streamlining our admin and improving communication with our patients	Delivering planned care standards	Annual plan outpatient first activity delivery Outpatient New:FU ratio Aligned outpatient pathways across UHN	IGR Outpatient programme reporting	Activity plan NGH: 2.33 None aligned	Activity plan NGH: 2.10 10 specialties aligned	Digital implementatio n Clinical and operational pressures
Theatre productivity	Delivery of the theatre productivity programme	Improved utilisation of theatres supports delivery of elective care activity standards	Theatres utilisation Annual plan elective care activity delivery	Theatres utilisation (inc turnaround) Elective activity compared to 19/20	Feb-23: 89% - NGH Activity plan	95% Activity plan	Theatre staffing Theatre staffing

							System plans for bed occupancy
Cancer centre of excellence- Clinical Collaboration	Delivery of the cancer centre of excellence	Supports SP1 and SP2	Annual plan cancer trajectory delivery	Cancer waiting times performance Cancer CoE objectives reported through Quality priority	62 days Jan 23 NGH 49% FDS Jan 23 NGH 79%	62 days-85% FDS 75%	Diagnostic capacity System pathway review / redesign to include referral patterns / criteria
Virtual wards	Delivery of the Northamptonshire virtual ward programme		Annual plan virtual ward delivery	System VW business case monitoring	240	356	System plans for virtual wards
Urgent and emergency care	Delivery 76% ED Quality Standard	Improved use of virtual wards reduces length of stay for patients, contributing towards delivery of emergency care standards	Annual plan A&E performance delivery	76% (national ask) 92 Bed Occupancy	NGH – 60% NGH – 100%	76% 92%	System plans for bed occupancy Delivery Internal flow plans for bed occupancy

SUSTAINABILITY Programme of work	Objective(s)	How does this contribute to top aims / metrics?	Delivery metrics	How will we measure this	Baseline	Target / trajectory	Dependencies / risks to delivery
Sustainability Group	Create a Group approach to Sustainability	To monitor and drive delivery of trust Green Plans	Delivery of agreed Green Plan objectives and action plans	Green Plans have agreed actions in place	Green Plans actions National carbon reporting	Green Plans actions National carbon reporting targets	Site/activity growth Capital investment Sufficient staff resource
Green plans	Delivery of each Trust's Green plan recommendations Improved oversight of system Green plan	Delivery of carbon footprint reduction	Delivery of Green Plan objectives and action plans	Green Plans have agreed actions in place	Green Plans actions National carbon reporting	Green Plans actions National carbon reporting targets	Site/activity growth Capital investment Sufficient staff resource
Decarbonisation	Development of a decarbonisation plan for each site Delivery of Public Sector Decarbonisation Scheme at NGH	Delivery of carbon footprint reduction	Delivery of decarbonisation plan objectives and action plans On time delivery	Track through Group Sustainability meeting Reporting to Group SDC	National carbon reporting Programme delivery of energy schemes to SDC	National carbon reporting targets Programme delivery of energy schemes to SDC	Site/activity growth Capital investment Sufficient staff resource

			of Public Sector Decarbonisation Scheme at NGH				
Use of resources	Internal improvement in productivity Delivery of annual plan Benchmarking product. / efficiency – model hospital & post covid analytics	Enables effective use of resources	Variance from financial plan Cost per weighted activity unit	IGR metric Model Health System	Annual plan 19/20: NGH: £3,337	Annual plan Target TBD	Operational and clinical pressures Recruitment challenges resulting in high agency spend Low operational productivity and low visibility of productivity data
Efficiencies programmes	To support a robust programme of deliverable efficiencies schemes	Enables effective use of resources	Variance from savings plan	Finance data from efficiencies PMO	N/A	4%	Operational and clinical pressures Challenges ensuring that schemes

							deliver cost out savings Challenge identifying schemes for delivery
Clinical collaboration	To enable clinical collaboration through removal of financial barriers to collaboration: - Alignment of budgets to services as management structures align - Visibility to clinical leads of the budgets for their service across both Trusts	Enables effective use of resources	Reduction of any financial barriers to clinical collaboration	Collaboration benefits realisation	N/A	To be agreed	Alignment of budget management across services

2.2. Statements Relating to Quality of NHS Services Provided

2.2.1. Review of our Services

During 2022/2023, usual contracting processes have begun to be re-established having been paused nationally during the covid pandemic. The Trust's lead commissioners remained NHS Northamptonshire Clinical Commissioning Group (CCG). On 1 July 2022, as part of a series of national changes to the way health and care services are planned, the CCG ceased to exist and our lead commissioner became NHS Northamptonshire Integrated Care Board (ICB). Northamptonshire ICB are now the statutory body responsible for local NHS services, functions, performance and budgets and is made up of local NHS trusts, primary care providers, and local authorities. they also commission services from the Trust on behalf of Bedfordshire Luton and Milton Keynes Integrated Care board, NHS Leicester, Leicestershire and Rutland (LLR). 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 2022/2023 represents 90% of the total income generated from the provision of relevant health services by the Trust for 2022/2023.

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 2022/2023, the Trust provided services to 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 2022/23, the Trust subcontracted services to 25 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)
- Histopathology
- Community Dermatology Clinics at GP surgeries
- Special Needs Dentistry
- Immunology Consultant Support
- 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 procured via the national Independent Sector Framework arrangements.

Contracted Support Services
The Trust commissions 4Ways Healthcare Limited for the provision of Radiology Reporting services.

The Trust also has a few contracts with Medicines Homecare providers which has included:

- Healthcare At Home
- Bionical Solutions Limited
- Lloyds Pharmacy Clinical Homecare
- Pharmaxo

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.

2.2.2. Participation in National Clinical Audits

The 2022-23 Annual Programmes of National Clinical Audit (NCA) has returned to business as usual following the disruption from COVID-19. This programme of clinical audit activity during 2022-23 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 and divisional assurance and quality improvement as necessary in support of 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 national projects that continue year on year and some new ones, either as single, snapshot audits or on a new longer-term plan.

The final version of the Quality Account was published in December 2021 NHS England agreed the following Quality Accounts list inclusion criteria for 2022-23:

- 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

The Annual Programme was agreed to and signed of at Clinical Audit Group and ratified at the Board's clinical quality meeting, the Quality Governance Committee.

National Clinical Audits Programmes on '22-23 QA	52
National Clinical Audits within these programmes	71
Total NCAs ongoing at NGH over '22-23*	95
NCEPOD on 2022-23 QA	5
Total NCAs not applicable to NGH	5

* This includes Audits from previous years that are still being used to drive changes or be continued but are no longer on the Quality Account

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 the board's Clinical Quality and Effectiveness Group and an Annual Report to Quality Governance Committee. Within the Quality Account there are 52 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	Project status at year end	'21-22	'22-23	Trend
All Live National Audits [N=95]	National Audit – Extreme Risk	1	1	=
	National Audit Action Plan Overdue	1	1	=
	Not fully compliant	4	5	↑
	National Audit - On Track*	63	72	↑
	Completed	23	28	↑
	National Audit - Awaiting Report	20	16	↓

*National Audit - On Track = data collection / submission is in progress or complete and action plans are being worked upon

2.2.3. Participation in Clinical Research

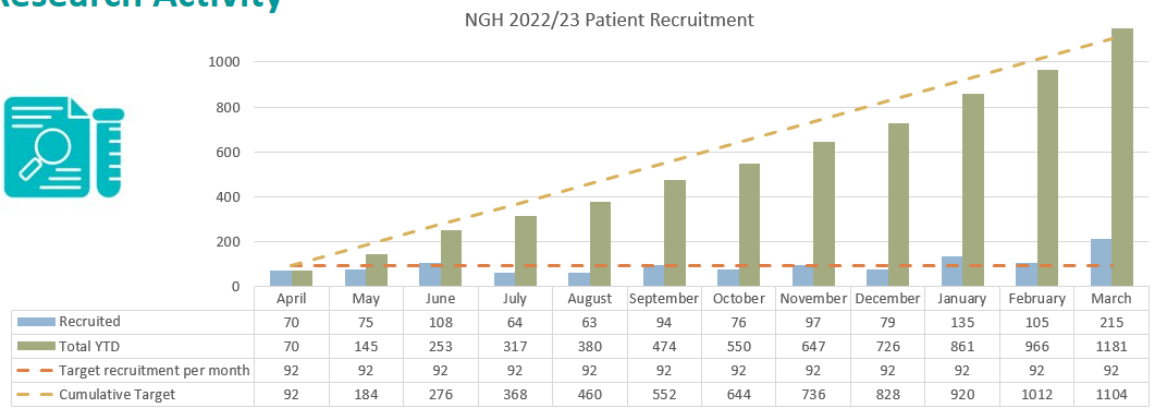
Research participation for the year 2022/23 was 1,181. Within the East Midlands region, NGH is 7th out of 17 regards patient recruitment data. In addition, we have 11 studies that are a top ten recruiting site nationally, including four studies that are the top recruiter.

We have appointed our first Clinical Academic post – a Professor in Diabetes that specialises in Obesity.

We became part of the Leicester National Institute for Health Care Research (NIHR) Biomedical Research Centre and Clinical Research Facility. This gives our patients more opportunities to participate in research and supports our workforce with access to training and fully funded PhDs. We will be developing a joint Personal Public Involvement Strategy, due for publication in June 2023. Our partnership with University Hospitals of Leicester goes from strength to strength as we align our processes and policies to support Research and Innovation.

From April 2023, NGH will be part of the East Midlands Evidence Repository (EMER) which publishes details of grants and publications we are involved in. We hosted our first Midwifery placements this year with plans to increase placement opportunities for both Nurses and Midwives during 2023/24.

Research Activity



	April	May	June	July	August	September	October	November	December	January	February	March
Recruited	70	75	108	64	63	94	76	97	79	135	105	215
Total YTD	70	145	253	317	380	474	550	647	726	861	966	1181
Target recruitment per month	92	92	92	92	92	92	92	92	92	92	92	92
Cumulative Target	92	184	276	368	460	552	644	736	828	920	1012	1104

2.2.4. Commissioning for Quality and Innovation (CQUIN) Income

A proportion of the Trust's income in 2022/23 was conditional, based on achieving quality improvement and innovation goals. These goals were agreed between the Trust and the person or body who entered into a contract, agreement or arrangement for the provision of relevant health services, through the Commissioning for Quality and Innovation Income (CQUIN) payment framework. Due to the change from the CQC to ICBs the penalty of not achieving the targets was removed.

The CQUINs, shown below all had to be reported against. The five marked £ agreed with our commissioners contain milestones which must be met in order for the Trust to claim achievement.

CQUIN
CCG1 – Flu Vaccination update (70-90%) £
CCG2 - Appropriate antibiotic prescribing for UTI in adults aged 16+ (40-60%)
CCG3 - Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions (20-60%) £
CCG4 - Compliance with timed diagnostic pathways for cancer services (55-65%)

CCG5 - Treatment of community acquired pneumonia in line with BTS care bundle (45-70%) £
CCG6 - Anaemia screening and treatment for all patients undergoing major elective surgery (45-60%)
CCG7 - Timely communication of changes to medicines to community pharmacists via the discharge medicines service (0.5-1.5%) £
CCG8 - Supporting patients to drink, eat and mobilise after surgery (60-70%) £
CCG9 - Cirrhosis and fibrosis tests for alcohol dependent patients (20-35%)
PSS1 - Achievement or revascularisation standards for lower limb Ischaemia (40-60%)
PSS2 - Achieving high quality Shared Decision Making (SDM) conversations (65-75%)

Further details of the agreed goals for 2022/2023 and for the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/

Local Quality Requirements

The quality requirements are set out in Schedule 4 of the NHS Contract and are collectively known as the Quality Schedule. They are split into six quality sections which include Operational Standards and National Quality Requirements. They also include Local Quality Requirements which are agreed locally with our CCG commissioners.

We provide assurance to our commissioners quarterly on local quality requirements by submitting evidence and demonstrating where we meet the requirements. 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	Patient Safety
LQR02	Patient Experience
LQR03	Clinical Effectiveness
LQR04	Safeguarding
LQR05	Collaborative Working

2.2.5. Care Quality Commission (CQC)

NGH is required to register with the CQC under the Health and Social Care Act 2008 its current registration status is Requires Improvement. NGH 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). The last inspection related to Maternity services in November 2022 and looked at "Safe" and "Well-Led".

The current rating for NGH overall is "Requires Improvement". The tables below show the ratings at core service level and the overall Trust position.

Care Quality Commission

Last rated
24 February 2023

Northampton General Hospital NHS Trust

Northampton General Hospital

Are services

Safe?	Requires improvement
Effective?	Good
Caring?	Good
Responsive?	Good
Well-led?	Requires improvement

The Care Quality Commission is the independent regulator of health and social care in England. You can read our inspection report at https://www.cqc.org.uk/location/RNS01

We would like to hear about your experience of the care you have received, whether good or bad. Call us on 03000 61 61 61, e-mail enquiries@cqc.org.uk, or go to www.cqc.org.uk/share-your-experience-finder

Find out what we have changed since we received this rating from CQC:

Care Quality Commission

Last rated
24 February 2023

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
Maternity	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
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

In relation to the 2019 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.

The CQC performed a focused Inspection in Maternity Services at NGH on the 30 November 2022. The final CQC Report was received by the Trust on 17 February 2023. The overall rating for Safe and Well-Led remained unchanged at 'Requires Improvement' and the final report is available at www.cqc.org.uk/directory/RNS.

The CQC requested that a written report of the actions the Trust was going to take to meet the Health and Social Care Act 2008, associated regulations and any other legislation that have been identified that the Trust is in breach of, be developed and submitted to the CQC by the 24 March 2023 for the 'must do' and should do' actions from the inspection. The action plan was completed and submitted

The CQC gave the following reasons for keeping the rating for the focused inspection as 'Requires Improvement':

- Not all midwives and medical staff had completed level 3 safeguarding training or training in infection prevention and control
- Staff did not consistently complete checks of specialist equipment and there were some out of date and missing items on emergency trolleys
- Staff did not always fully and accurately completed records in relation to antenatal appointment and birthing plans
- The service did not always have enough staff to care for women and keep them safe or to support their choices in birthing options
- Infection, prevention and control was not always followed to reduce the risk of infections, from the environment and the use of PPE

However:

- The service had enough staff to care for women and keep them safe. Staff had undertaken mandatory training in some key areas and skills. They worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well

- The service managed safety incidents well and learned lessons from them
- Staff understood the service's vision and values, and work was in progress to support the culture of the unit to promote these

The CQC has identified the following '**Must do'** and '**should do'** actions' for the Maternity services.

Action the trust MUST take to improve:

- The trust must ensure the premises used by the service provider is safe to use for their intended purpose and are used in a safe way. 12 (2) (d
- The trust must ensure the reduction of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;12 (2) (h)
- The trust must follow appropriate guidance in the proper and safe management of medicines; 12 (2)(g)
- The trust must ensure the security of the unit is reviewed in line with national guidance. Regulation 12
- The trust must ensure staff complete mandatory, safeguarding and maternity specific training in line with the Trust's own target. Regulation 12(1)(2).
- The trust must ensure staff complete regular skills and drills training, especially in relation to birthing pool evacuation. Regulation 12(1)(2) (c)

Action the trust SHOULD take to improve:

- The trust should ensure there are the required staff to implement a robust system in maternity triage to include escalation process, monitoring and documentation.
- The trust should ensure the required staffing to enable women to have a choice of birthing options which include the Barratts birthing unit and home birthing.
- The trust should ensure the culture of the service continues to be addressed to ensure staff are listen to and measures put in place to improve the wellbeing of staff.
- The trust should ensure systems were in place to ensure audits were consistently reviewed and actions taken to address any identified concerns

The Inspection Team also identified areas of good practice within the services.

- The report acknowledged that the Matron Clinic had been recognised as an celebration point in the Ockenden Report 2022, and the PMA supporting over 600 women with their outside guidance birthing plan, and postnatal birth reflections.
- The continuity of care team who supported people with 'cultural needs', providing them with continuity of care in the antenatal and postnatal period

2.2.6. 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 36 areas of focus, called 'Assertions', falling into the National Data Guardian Standards. Within each assertion there are items which require evidence and an indication of completion. 113 of the evidence items are mandatory.

The toolkit can be updated throughout the year, but a baseline and final submission must be made within the year. In 2023, the baseline submission was due on the 28th February and the final submission is due on the 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. The majority of assertions relate to cyber security and the DSP Team works closely with the Cyber Team to ensure all the assertions are met.

Progress is monitored on an ongoing basis and reported to the Data Security and Protection Group. Whilst several areas are showing as non-compliant, plans are in place, to be achieved before the submission date on the 30th of June 2023.

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 at the last audit. The Trust is confident that it will again complete the DSP Toolkit with all standards met in 2023.

The Trust reported 1 Information Governance serious incident to the Information Commissioner's Office in 2022 (there were 4 reported in 2021) 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 ICB 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 Data Security and Protection and have made excellent progress for a clear culture change towards Data Protection using education and reporting best practice.

2.2.7. 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 UHN Data Security and Protection Group (DSPG)with quarterly reports to provide relevant assurance to the Board that sufficient measures are in place to monitor the following:

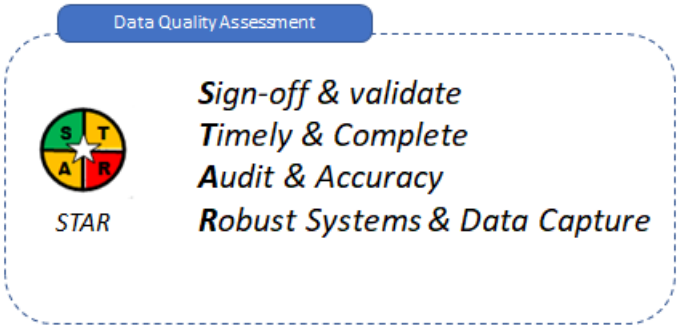
- CDS/SUS submission and review via NHS Digital Data Quality report.
- MSDS (Maternity) data generation, submission, and review by CNST score
- Monitoring of the DQMI (Data Quality Maturity Index) score.
- Review of proposed Data Quality Kitemark and processes for information provisions to ensure accuracy
- Data Quality Alerting.
- Ensuring that the Knowledge Improvement Team aligns with the Data Quality principles.
- 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 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 will embed the use of a Data Quality Kitemark once agreed, to allow 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 once agreed, 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.

- Direction and guidance in key meetings.
- Close business relationships with Finance, Data and Coding.

2.2.8. 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 22 to Dec 22	Valid NHS Number	Valid GMPC
Inpatients	99.92%	99.99%
Outpatients	99.98%	99.99%
A&E	99.01%	100.00%

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%

2.2.9. Clinical Coding Error Rate

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

The minimum requirement as specified under Data Security & Protection (DSP) requirements is a 200-patient episode audit per financial year.

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.

The DSP audit was undertaken using a registered NHS Digital CCS approved Clinical Coding Auditor. The results of the audit demonstrate an excellent standard of both diagnostic and procedural coding accuracy.

Northampton General Hospital	Primary diagnosis correct %	Secondary diagnoses correct %	Primary procedure correct %	Secondary procedures correct %
DSPT Audit 2022/23	98.50%	98.50%	95.00%	95.10%

2.2.10. Learning from Deaths

Number of deaths during the reporting period

The crude mortality at Northampton General Hospital (NGH) is monitored monthly, alongside the national mortality dataset provided by Telstra Health UK. 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.

During the 12-month period April 2022 – March 2023; 1,705 patients at NGH died, of which 1,513 were inpatients and 192 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	390	53	443
Q2	315	34	349
Q3	409	62	471
Q4	399	43	442
Total	**1,513**	**192**	**1,705**

Medical Examiner Scrutiny of Deaths

The Medical Examiner (ME) service and Mortality review process provide assurance of patient safety and quality of care at NGH. From October 2019 the ME service was implemented across the trust. The Medical Examiners are a team of highly specialist and experienced individuals who scrutinise the notes of hospital deaths to provide an independent opinion on the cause of death. The ME service also works closely with the bereavement team. The doctor who is completing the Medical Certificate of the Cause of Death (MCCD) discusses their patient with the ME to come to an agreed cause of death. The ME service will also advise the doctor completing the MCCD if a referral to the coroner is required. The ME then contacts the next of kin to explain the MCCD and answer any questions they may have, including noting any concerns raised or positive feedback offered.

The Medical Examiner also provides a judgement on the care given to the patient. If concerns are raised, either following scrutiny of the notes or upon discussion with the next of kin, the ME service refers the case to the mortality governance team. A nationally standardised case-note review, known as a structured judgement review, is completed by the designated clinical team or, if required, an independent specialist clinician.

Between 1st April 2022 – 31st March 2023; 1,692 deaths at NGH were scrutinised by the ME team, this accounted for 99% of deaths referred to the ME & Bereavement service. The MCCD was issued within 5 days of referral for 99% of cases.

Q1	420
Q2	350
Q3	455
Q4	467
Total	**1692**

Reviewing deaths – 2022-23 data

NB: Data supplied is status as of 5th May 2023, and subject to change.

212 mortality case record reviews to date have been completed using the Structured Judgement Review Tool (SJR), a validated national methodology for standardising case-note review, supported by the Royal College of Physicians.

Completed Mortality case reviews (1st SJR, 2nd SJR, Vulnerable Adult SJR):

Q1	72
Q2	62
Q3	55
Q4	23
Total	**212**

Investigating deaths – 2nd stage reviews and clinical incident mortality reviews

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 Morbidity & Mortality 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

At time of writing, of those patients who died in 2022-23:

- 45 cases have been reviewed as part of the 2nd stage review process.
- Three completed 2nd stage reviews have been graded with an Avoidability of Death Judgement score of 1 – 4 and were also referred for clinical incident review.

At any stage (Medical Examiner, 1st stage or 2nd stage review) cases may be referred for a clinical incident review, if significant concerns with care are identified. Cases can also be independently referred for clinical incident review, in parallel to the mortality review process.

- 31 deaths from 2022-23, with a graded harm of "severe" or "death", have been referred both for clinical incident and for SJR or specialty M&M review.
- 13 were declared a Serious Incident investigation and 3 a Comprehensive Investigation.
- Eight clinical investigations (inpatient deaths with a harm grading of "severe" or "death"), at time of writing, have been completed. The remainder are due to be completed in 2023.
- 0 clinical investigations, at time of writing, have concluded that the death was more likely than not due to a problem with the hospital care provided to the patient.

To promote learning from deaths, feedback from both poor and excellent care case reviews are distributed trust-wide, to specialty M&Ms and where applicable to individual clinicians.

Neonatal Deaths and Stillbirths

Neonatal Deaths >22 weeks

Q1	1
Q2	3
Q3	0
Q4	1
Total	**5**

Stillbirths >24 weeks

Q1	3
Q2	2
Q3	6
Q4	0
Total	**11**

- From 1st April 2022– 31st December 2022 there were five neonatal deaths after 22 weeks of pregnancy and 11 stillbirths delivered from 24 weeks of pregnancy.
- Five deaths have been declared a serious incident investigation.
- At time of writing, 11 reviews have been fully completed using the Perinatal Mortality Review Tool. The remainder are due to be completed in 2023.
- 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)

Adults with a Learning disability (LD), Autism or severe mental illness (MH)

Period	LD/Autism Deaths	MH Deaths	Total
Q1	3	3	6
Q2	2	0	2
Q3	4	2	6
Q4	5	2	7
Total	**14**	**7**	**21**

- From April 2022 – March 2023 there were 14 deaths of adults with a learning disability or autism. There were seven deaths of patients with a severe mental illness (patients admitted from a mental health trust or detained under the mental health act).
- All patients have been referred to the national mortality review process for learning from deaths of patients with a learning disability or autism (LeDeR programme).
- At time of writing, the care of 16 patients has been reviewed using the Structured Judgement Review tool. The remainder are due to be completed in 2023.

- Four deaths were also referred for clinical incident review. One case was declared a serious incident and 0 cases were declared a comprehensive investigation.
- 0 completed investigations have concluded that the death was more likely than not due to a problem in the hospital care provided to the patient.

Appendix 1

Learning, Actions and Impact of Mortality
Mortality Key workstreams 2022-23 & Trust-wide Mortality Reviews

Area targeted by review	Data source	Work stream/s	Example of actions taken or proposed
Mortality workstream: Palliative Care	Telstra Health UK National Audit	Led by Learning from Deaths Group in conjunction with palliative care team	● Reports quarterly to Learning From Deaths Group ● National Audit of Care at End of Life (NACEL) 2022 report shared – strong NGH performance ● Achievements of Specialist Palliative Care team in Urgent Care (SPUCS) presented at Grand Round in 2023, business case for permanent funding submitted ● System improvements for capturing & coding patients who receive palliative care fully implemented

Trust-wide Mortality Review 15: Learning from Deaths in Vulnerable Adults	Mortality Governance team Medical Examiner Safeguarding team	Led by Learning from Deaths Group in conjunction with Safeguarding Team	● Reports quarterly to Learning From Deaths Group ● Full mortality review of deaths in vulnerable adults (2020 & 2021) shared trust-wide in 2022 ● Vulnerable Adult Improvement plan commenced in Q1 2022-23 ● Follow-up thematic review of learning from deaths in Vulnerable Adults (2022 deaths) shared trust-wide and presented at Grand Round in 2023. ● Workstream to continue throughout 2023-24
Trust-wide Mortality Review 16: Acute Kidney Injury (AKI)	Telstra Health UK Mortality Governance team Medical Examiner Clinical Coding Patient Safety team Incident Review Group	Led by Learning from Deaths Group in conjunction with the Patient Safety team and Clinical Coding	● Reports to Learning From Deaths Group biannually ● Mortality review of deaths in patients with acute renal failure (AKI) completed by Patient Safety, Clinical Coding & Mortality Governance teams in Q1 2022-23 and shared trust-wide ● AKI improvement plan commenced in 2022-23 ● Successful recruitment of 2 AKI & Sepsis specialist nurses ● Mortality alert for acute renal failure resolved in Q4 2022-23 ● Workstream to continue throughout 2023-24

2.2.11. 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.

A Duty of Candour refresh is being considered for 2023/24 and further training is being looked at to assist with meeting the statutory requirements. 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 and this is being updated to reflect changes within processes. 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.

2.2.12. 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

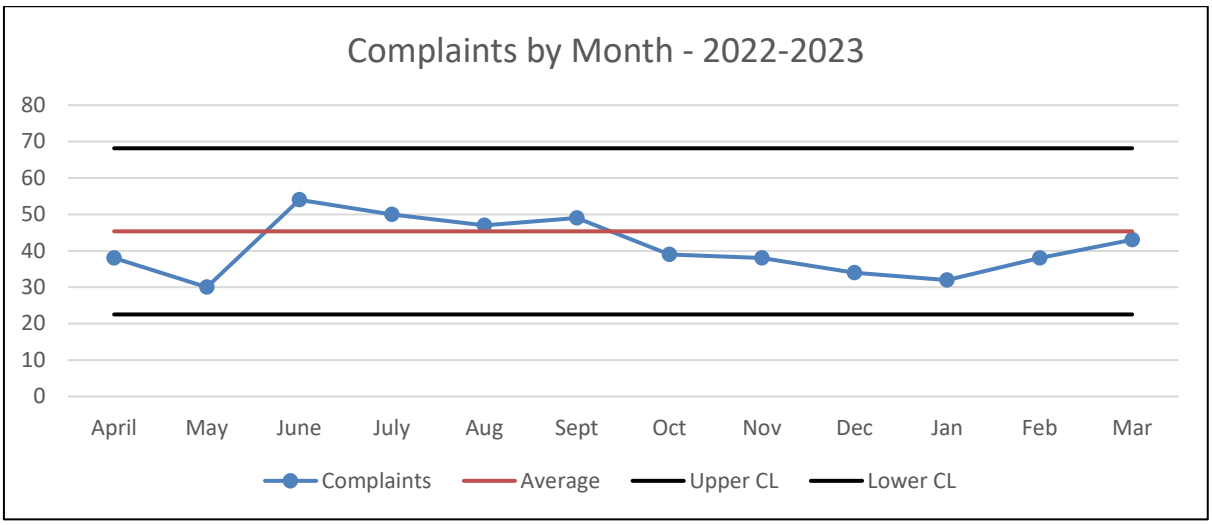
The aim is always to achieve local resolution where possible and the above should be used as an escalation process where appropriate and with the agreement of the individual. The Trust recognises that the information derived from complaints and concerns provides an important source of data to help make 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 492 written complaints that were investigated through the NHS Complaints Procedure from 1 April 2022 to 31 March 2023, which compares with 455 complaints received for the same period during the previous financial year.

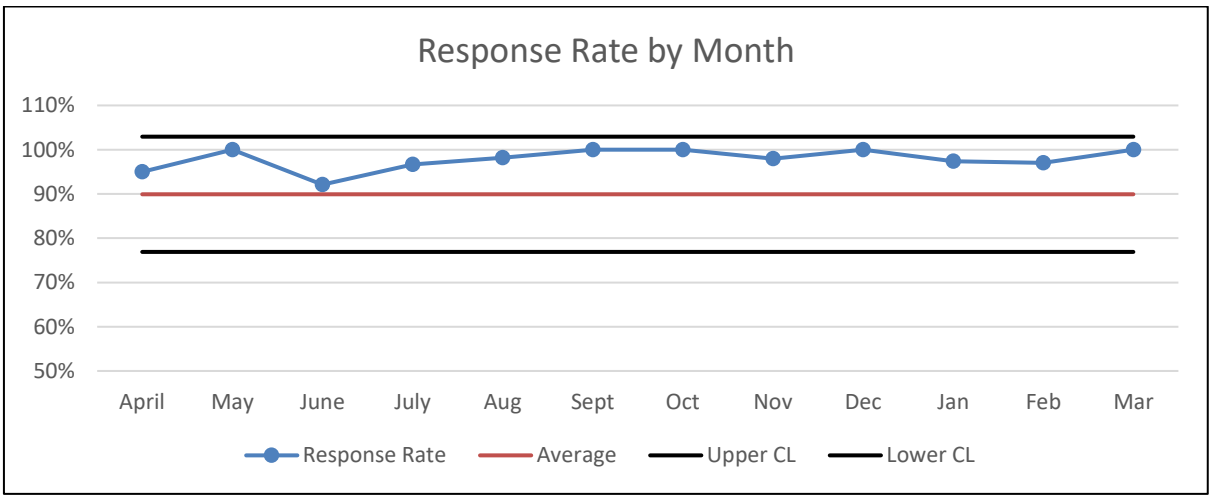
Total no of complaints for the year	492
(Versus 2021/2022)	(455)
Total no of complaints that required a renegotiated timescale, agreed by the complainant	88
Average response rate including agreed extension of time	98%
Average response rate excluding agreed extension of time	80%
Total no of complaints that exceeded the renegotiated timescale	36
Complaints that were still open at the time that the information was prepared (19th April 2023)	150

Total patient contacts/episodes	758,473
(Versus 2021/2022)	(710,480)
Percentage of complaints versus number of patient contacts/episodes	0.06%

Number of complaints

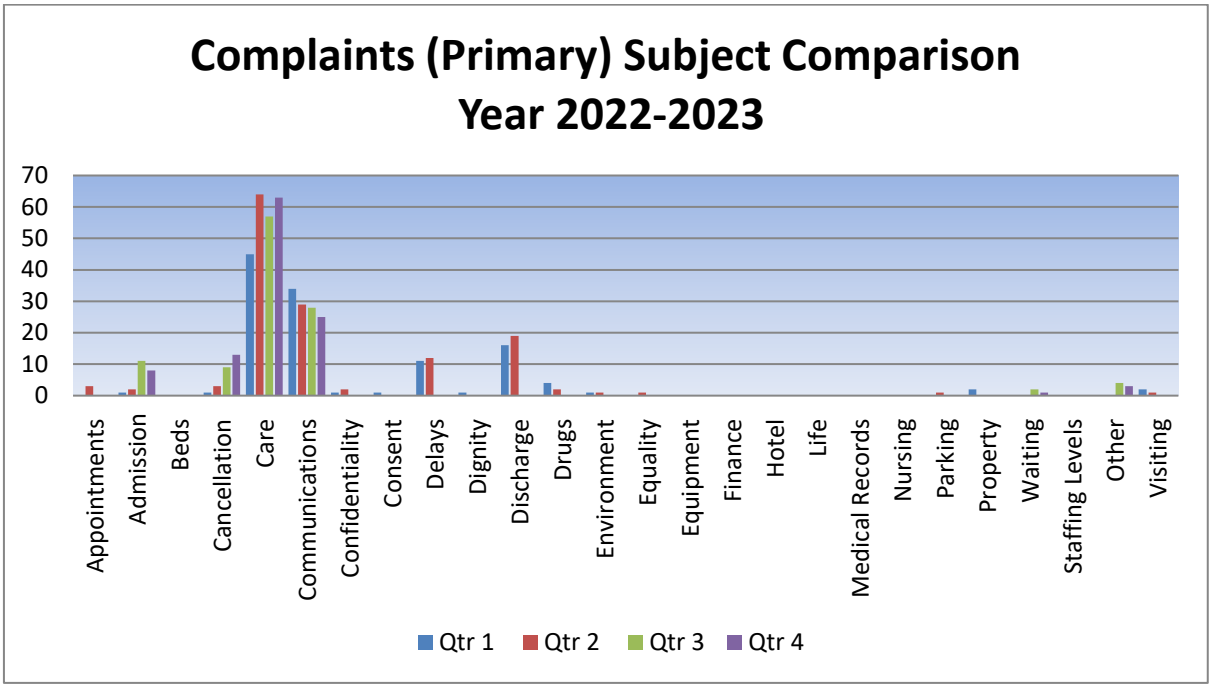


Response rate



Trend Analysis

The following chart provides the themes emerging from complaints:



What we achieved in 2022/23 to improve complaints management:

Subject:	**Commentary:**
Trust response rate	When <u>including</u> extension of time requests the Complaints team has achieved its 'green' (90% or above) target for the majority of the reporting year with an average of 98%. However, when <u>excluding</u> extension of time requests this was reported as 80%, which is below target and is in the 'red'. Complaints have only recently started reporting on both including and excluding extension of time requests to maintain consistency with the reporting across the UHN group.
Triage	All new complaints that are received in the department are formally triaged by an experienced member of the Complaints team. 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 or to Safeguarding.

Staffing	The Complaints team have experienced a number of challenges within the service due to resource and increased activity. Staffing numbers have constantly changed due to vacant posts, long term sickness and maternity leave.
Reporting	Complaints data is incorporated into the following reports: - Monthly scorecard reporting / IGR - 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 Cloud is used for all complaints reporting and is currently in the process of being reviewed / revised to allow a more digital approach to be adopted.
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 12 months. Support is also provided to clinical divisions regarding complaints handling, support, advice and training.

2.2.13. 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 21 – Sep 22	90	2	100	123	64
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 21 – Sep 22	53.0%	40.0%	65.0%	12.0%
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

In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time so the latest available data has been included below.

	NGH Performance		National Performance		
	Reporting Period 2021/22	**NGH Quality Account 2021/22**	**Reporting Period 2020/21 Average**	**Reporting Period 2020/21 High**	**Reporting Period 2020/21 Low**
• Hip replacement surgery - primary (EQ-5D™ Index)	N/A	0.459 (final Apr20 to Mar21)	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)	N/A	* (final Apr20 to Mar21)	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)	N/A	0.255 (final Apr20 to Mar21)	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)	N/A	* (final Apr20 to Mar21)	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 <16				
2021/22	13.4	12.5	46.9	3.3
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+				
2021/22	15.6	14.7	142	2.1
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*

Following the merger of NHS Digital and NHS England on 1st February 2023 we are reviewing the future presentation of the NHS Outcomes Framework indicators. As part of this review, the annual publication which was due to be released in March 2023 has been delayed

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	61.7%	67.1%	84.2%	59.5%

(Hospital stay: 01/07/2019 to 31/07/2019; Survey collected 01/08/2020 to 31/01/2020)				
2018/19 (Hospital stay: 01/07/2018 to 31/07/2018; Survey collected 01/08/2018 to 31/01/2019)	64.0%	67.2%	85.0%	58.9%
2017/18 (Hospital stay: 01/07/2017 to 31/07/2017; Survey collected 01/08/2017 to 31/01/2018)	65.1%	68.6%	85.0%	60.5%
2016/17 (Hospital stay: 01/07/2016 to 31/07/2016; Survey collected 01/08/2016 to 31/01/2017)	61.1%	68.1%	85.2%	60.0%
2015/16 (Hospital stay: 01/07/2015 to 31/07/2015; Survey collected 01/08/2015 to 31/01/2016)	65.5%	69.6%	86.2%	58.9%
2014/15 (Hospital stay: 01/06/2014 to 31/08/2014; Survey collected 01/09/2014 to 31/01/2015)	66.5%	68.9%	86.1%	59.1%
2013/14 (Hospital stay: 01/06/2013 to 31/08/2013; Survey collected 01/09/2013 to 31/01/2014)	68.6%	68.7%	84.2%	54.4%

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*
  - *2022:* percentage *of staff selecting Agree or Strongly Agree for question 23d - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.*
  - *2021:* percentage *of staff selecting Agree or Strongly Agree for question 23d - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.*
  - *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
2022	54.6%	61.2%	86.4%	39.2%

	(Acute and Acute & Community Trusts)	(Acute and Acute & Community Trusts)	(Acute and Acute & Community Trusts)	(Acute and Acute & Community Trusts)
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% (Acute Trusts)	87.3% (Acute Trusts)	39.8% (Acute Trusts)
2017	69.0%	70.0% (Acute Trusts)	86.0% (Acute Trusts)	47.0% (Acute Trusts)
2016	68.0%	69.0% (Acute Trusts)	85.0% (Acute Trusts)	49.0% (Acute Trusts)
2015	52.0%	69.0%	85.0%	46.0%

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

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

Period	**NGH**	**National Average**	**National High**	**National Low**

Inpatient				
2021/22	Full year data unavailable			
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			
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**	**National High**	**National Low**

		(Acute Trusts)	(Acute Trusts)	(Acute Trusts)
Q4 22/23	Data collection/publication suspended due to Covid-19			
Q3 22/23	Data collection/publication suspended due to Covid-19			
Q2 22/23	Data collection/publication suspended due to Covid-19			
Q1 22/23	Data collection/publication suspended due to Covid-19			
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
2022/23	N/A	N/A	N/A	N/A
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 22 – Mar 23	N/A	N/A	N/A	N/A
Apr 21 – Sep 22	N/A	N/A	N/A	N/A
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 22 – Mar 23	N/A	N/A	N/A	N/A
Apr 21 – Sep 22	N/A	N/A	N/A	N/A
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 22 – Mar 23	N/A	N/A	N/A	N/A
Apr 21 – Sep 22	N/A	N/A	N/A	N/A
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 22 – Mar 23	N/A	N/A	N/A	N/A
Apr 21 – Sep 22	N/A	N/A	N/A	N/A
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

- **Review of Quality Performance**

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

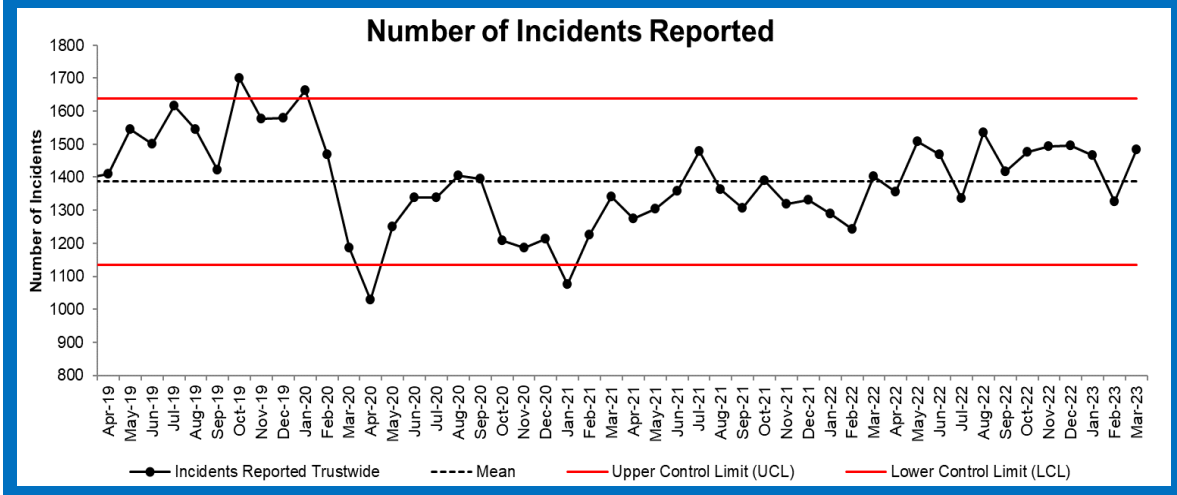
3.2. Review of last year's Quality Priorities

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

We have made progress in delivering some of the agreed programmes of work, however we recognise that we have not delivered on all the delivery programmes defined from 2021-2023. Part of the reason for this is that we have not kept the priorities alive and tracked delivery against all regularly throughout the year and some of our goals and focus for delivery were not fully defined. In some instances, no clear delivery plans or key performance indicators were set. There will be several reasons for this, and we have instead made progress in other evolving areas that have been local priorities for NGH in delivering our overall Dedicated to Excellence strategy. We should also acknowledge that there have been a number of competing and challenging national and local priorities and any strategy must remain agile and evolves with challenges and opportunities that arise.

3.2.1. SUCCESS FACTOR 1 – Safety Culture

Metric – Number of incidents reported



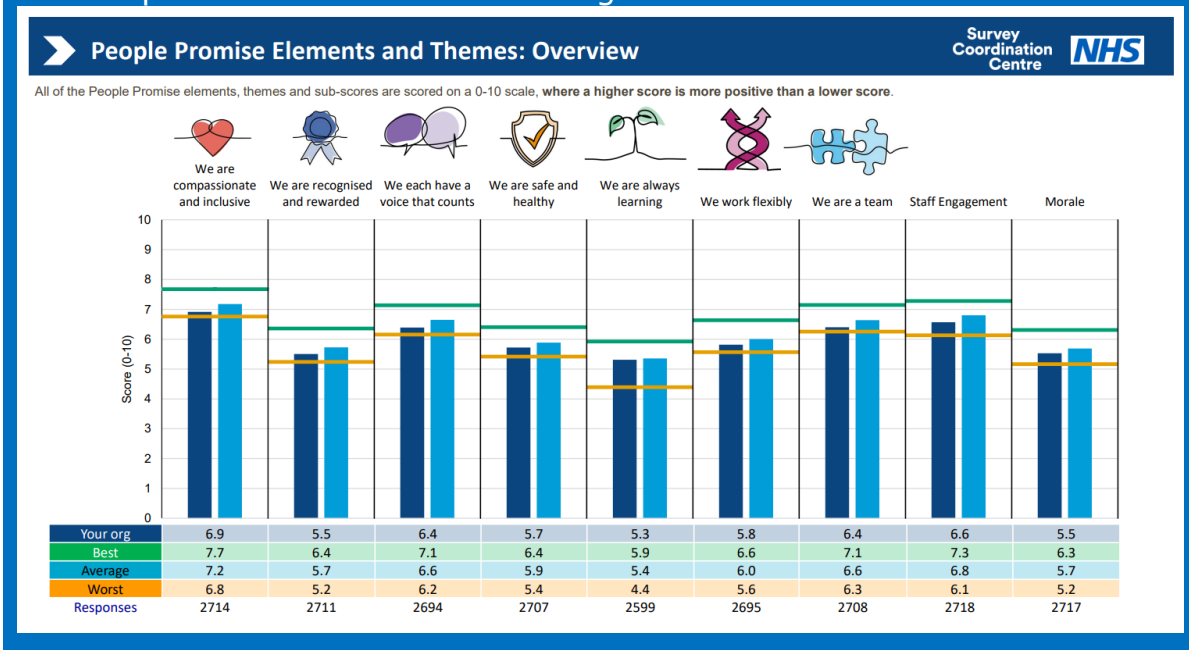
To encourage a positive safety culture, it is important that any accident or unexpected event is reported and investigated to understand why things go wrong and how to prevent and mitigate reoccurrence. Staff are encouraged to report issues via Datix, leading to an open and fair culture without fear of reprisal.

Metric – Safety Huddles

Throughout the year the Safety Huddle has continued and has been key to having an overview of the trust staffing, patients' acuity and dependency and emerging safety concerns. As part of the Safety Huddle the nursing workforce is a key part of the safety agenda.
Safety and Staffing continues to be managed as a Trust wide risk through the Safety Huddle each morning at 08.30. It is attended (remotely) by A.D.N., Matrons, midwives, ward managers, 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 08.30 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 – Staff Survey
NHS National staff survey is a key piece of intelligence which ran at Northampton General Hospital NHS Foundation Trust from Tuesday 20 September to Friday 25 November 2022 with 2,723 colleagues taking part representing 47.5% of NGH workforce. This compares with the national median average of 44.5% and marks a slight increase from 2021. The results are then reviewed against 10 themes looking at how we compare with the national averages as follows:



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	6.9	5.5	6.4	5.7	5.3	5.8	6.4	6.6	5.5
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	2714	2711	2694	2707	2599	2695	2708	2718	2717

3.2.2. 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, aged 16 years and over, must be risk assessed. People aged 16 and over who are in hospital and assessed as needing pharmacological VTE prophylaxis must receive the first dose as soon as possible and within 14 hours of decision to admit to hospital.

Since the appointment of a Patient Safety Improvement VTE specialist in December 2021 the back log of RCAs has been addressed and are now up to date. The current compliance for reviewed RCA's is 98%.
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, funding has been awarded

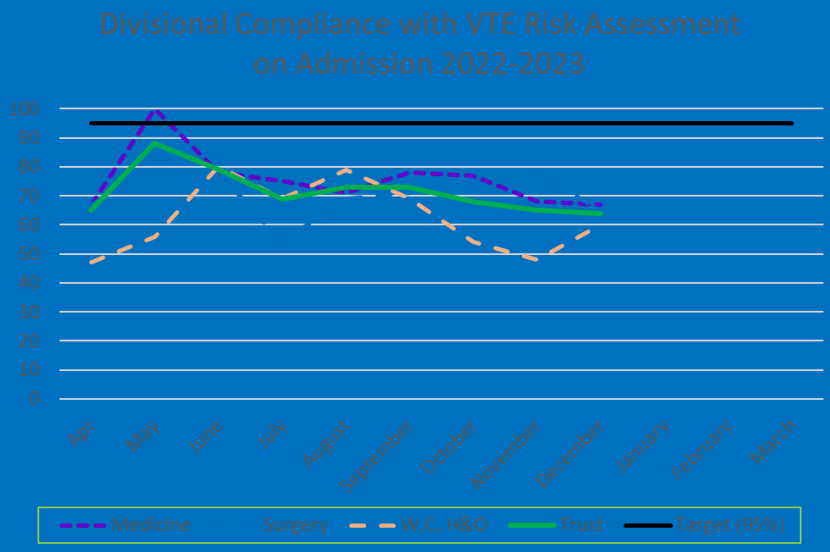
through Pathway to Excellence and Prophylactic Enoxaparin dosing cards are being developed for all junior doctors joining the Trust to promote safe prescribing across adult inpatients and Obstetrics.

Enoxaparin (Inhixa) leaflets have been introduced across the Trust to provide patients with information and injection technique on discharge. Furthermore, an additional leaflet has been introduced to ensure safe continuation of branded Enoxaparin in the community thus improving safer administration in the community by patients and carers.

The Lower Limb Immobilization Pathway Assessment is under review and in the final stages. This will improve the patient journey by giving Rivaroxaban (NICE NG89 1st choice for prophylaxis in lower limb immobilization) to patients who are suitable instead of enoxaparin.

A patient information leaflet on the prevention of blood clots in hospital has been designed and is in use across all adult wards. In addition, an accessible VTE patient information has been developed and is available for use in the Trust.

Graduated Compression Stocking and Intermittent Pneumatic Compression Garment skin integrity care plans are in use across adult wards in the Trust. A Graduated Compression Stocking patient information leaflet has been formulated to use in conjunction with these garments.



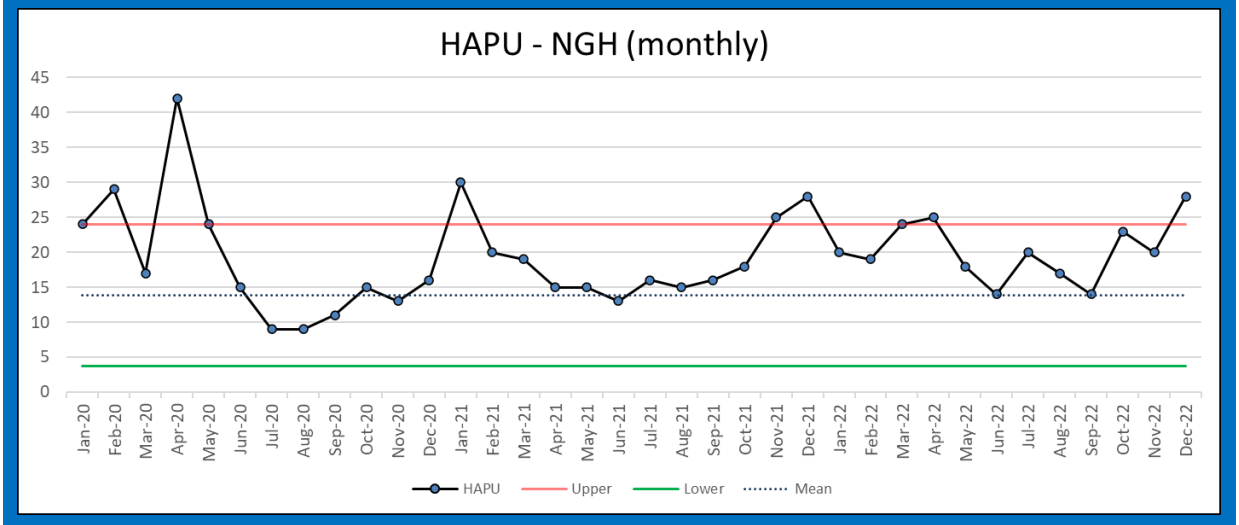
RCA tracker 2021-2022

	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	Number of SI declared
Jun-21	15	7	1	0	23	23	100	0
Jul-21	22	3	0	2	27	27	100	0
Aug-21	29	1	0	0	30	30	100	0
Sep-21	24	3	0	1	28	28	100	0
Oct-21	23	2	0	1	26	26	100	0
Nov-21	32	1	0	0	34	34	100	0
Dec-21	20	1	0	1	22	22	100	0
Jan-22	26	2	1	1	30	30	100	0
Feb-22	26	2	0	0	28	28	100	0
Mar-22	18	0	0	0	18	18	100	0

RCA tracker 2022-2023

	Number of cases identified from radiology	Number of cases radiolgy out of hours	Number of cases reported from mortuary	Number of cases reported from Datix	Number of cases reported from other source	Total	Total reviewed	% closed	Number of SI declared
Apr-22	10		0	0	2	12	12	100	0
May-22	14		0	0	1	14	14	100	0
Jun-22	10		0	0	0	10	10	100	0
Jul-22	13	4	0	0	0	17	17	100	0
Aug-22	18	4	0	0	2	24	24	100	0
Sep-22	12	0	0	0	0	12	12	100	0
Oct-22	8	1	2	0	0	11	11	100	0
Nov-22	9	1	3	0	0	13	12	92	0
Dec-22	5	2	2	0	1	10	10	100	0
Jan-23	3	0	0	0	3	3	1	33	0

Metric – Pressure ulcers



	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Category 2	16	14	6	12	9	11	8	11	9	6	10	9	18
Category 3	1	0	1	1	1	0	0	1	1	0	0	0	0
Category 4	0	1	0	0	0	0	0	0	0	0	0	0	0
Unstageable	2	0	2	1	2	1	2	3	0	4	7	3	5
DTI	10	5	9	10	11	6	4	6	8	4	6	7	5

Summary
The past three years, we have 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, and recent resurgence in cases of Covid-19, RSV and Flu. 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. Some wards reporting higher levels of harm have received additional, targeted support.
During heightened IPC restrictions, training presentations were adapted for optimum compatibility with virtual sessions via Teams, and the TVT worked with Communications to make training tools available on Moodle.

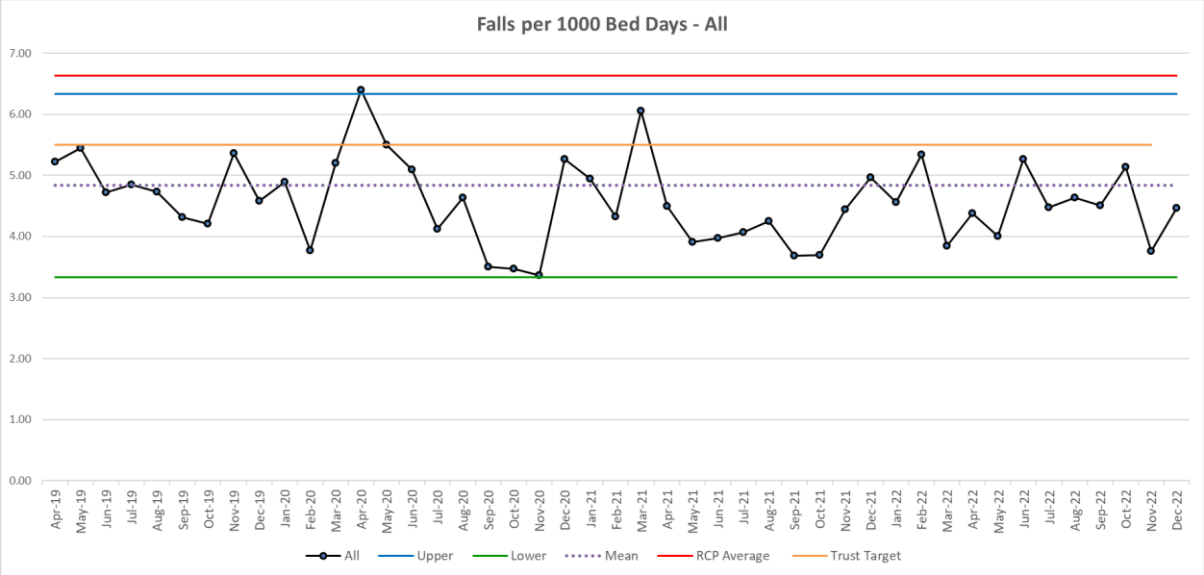
Face-to-face training recommenced in line with IPC guidelines in 2022, and is offered whenever possible and appropriate. The TVT are ensuring virtual training remains updated, in case it is required in the face of future outbreaks.

The Patient Safety leaflet (focussing on pressure ulcer prevention) has been rolled out Trust-wide and is accessible to wards via e-Procurement. A Wound Care plan has also been rolled out, and a new MASD care plan is in the final stages of completion ahead of trial on wards with high incidence.

TVNs have attended sharp debridement and other clinical skills courses, and are individually pursuing higher educational qualifications. We will shortly be recruiting a second full-time, permanent TVN to the team, bringing our staffing to a 2.4.

The TVT continues to conduct MDT working with Tissue Viability colleagues across the county to facilitate shared learning. We also continue to host Steering Groups every 6-8 weeks with various members of both the Nursing Team and further involvement from MDT.
To improve collaborative, cross-specialism working and fluidity of patient care, we have also been encouraging doctors, consultants and students to contact us for shadowing sessions to improve their wound knowledge, and our mutual understanding.

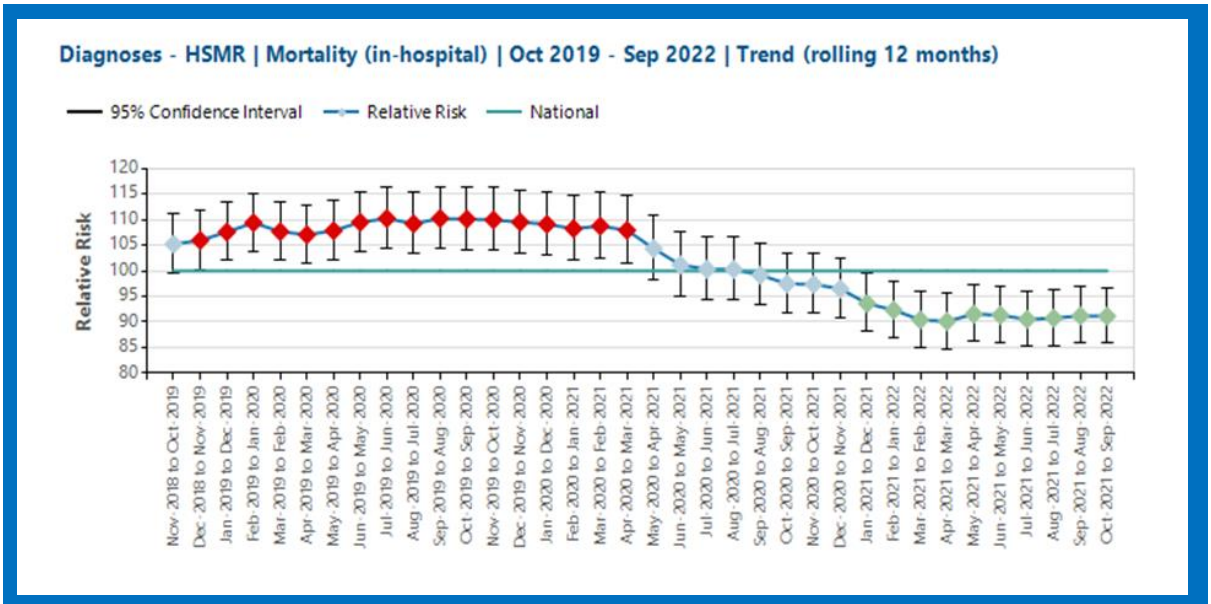
Metric – Falls
There has been a year on year decrease from 2019-2022 in the mean average of falls/1000 bed days, the 22-23 data won't be available until the end of March, currently the mean average is 4.52 so is likely to show an increase from last year.



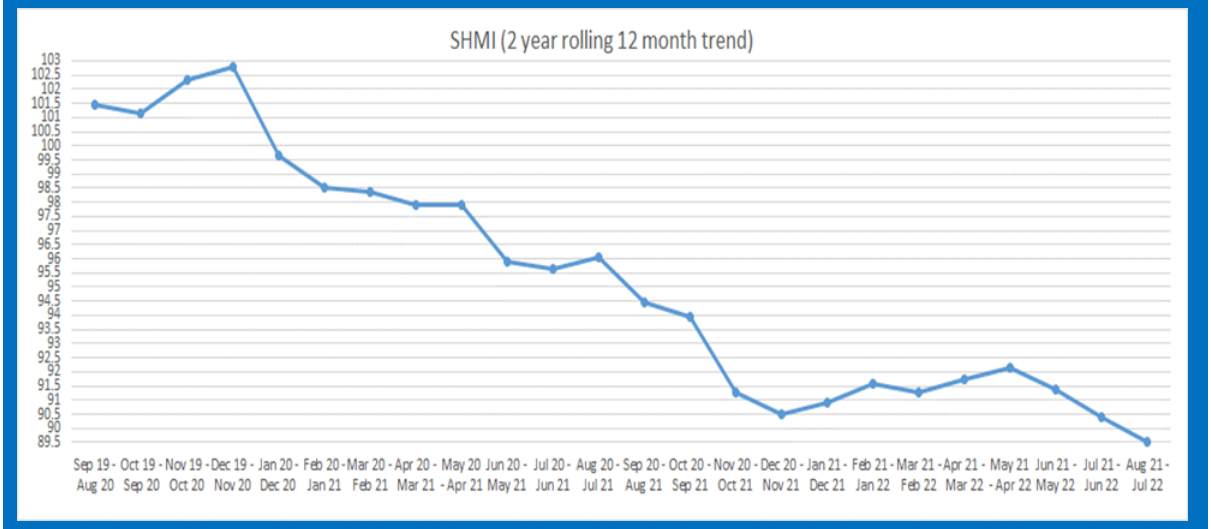
3.3.3. SUCCESS FACTOR 3 – Effective and Efficient Outcomes

Metric – HSMR data
The HSMR has been decreasing since the Jul19 – Jun20 period, and now remains within 'below expected' ranges.

The Trust is one of two trusts (within the peer group of 8) with an HSMR in the 'below expected' range. The crude rate is 2.8% (vs 3.2% for the peer group).



Metric – Summary Hospital-level Mortality Indicator (SHMI)
SHMI has been decreasing over the previous 2 years, and as of the latest published monthly dataset lies in the "below expected" range



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)

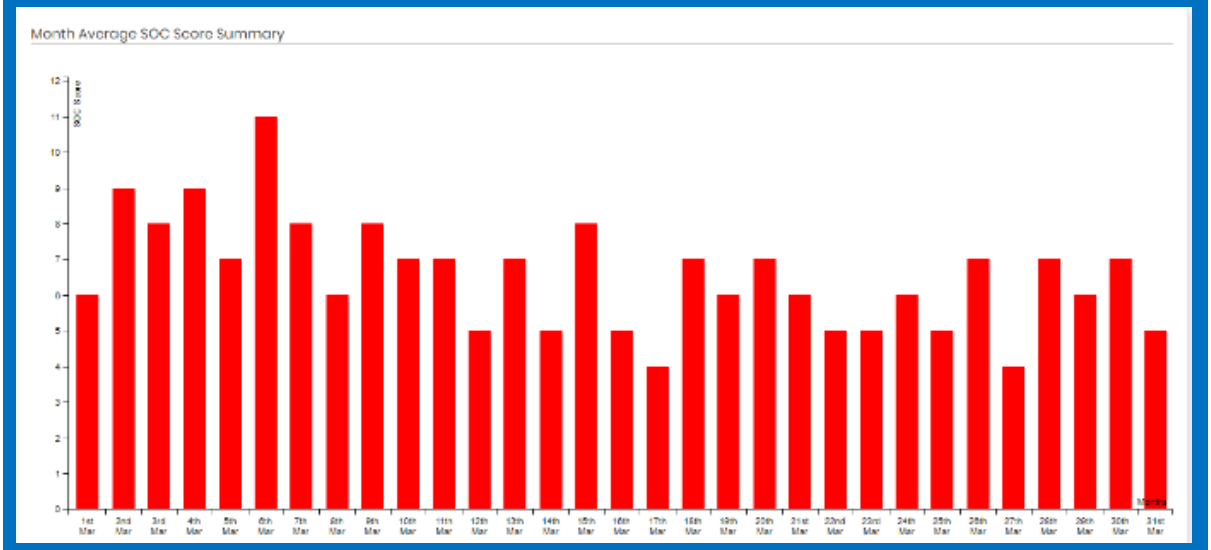


Figure 1: Month Average SOC Summary

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)

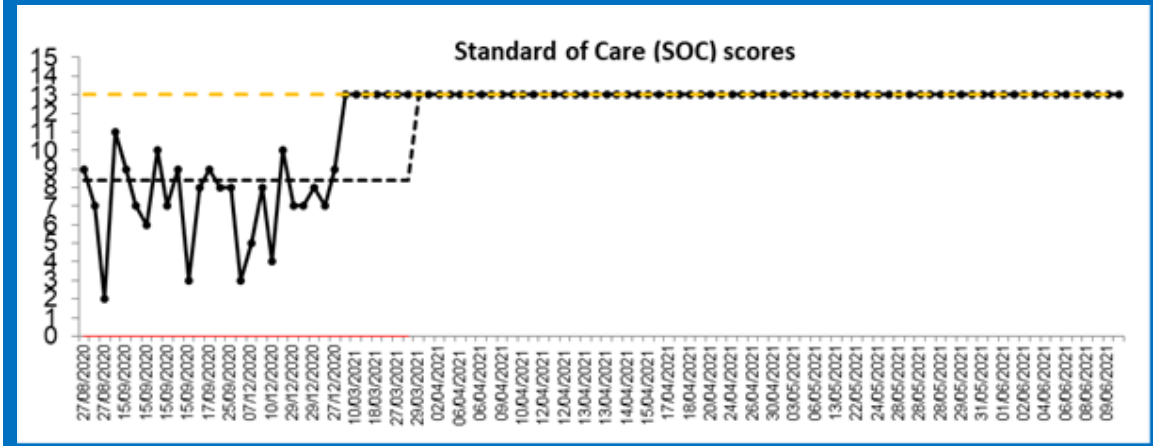


Figure 2: SOC scores

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
At NGH, an in-house Tobacco Dependency Team two dedicated tobacco dependency advisors were recruited, and the service began to operate in late May 2022.

The success of this is demonstrated by an increase in referrals to both the in-house team and the LSSS, as well as the number of successful quits. For example, September - 'quit rate at 2 months', equated to a 75% success rate. Originally, the team targeted cardiac and respiratory wards and broadly advertised the service. However, we believe there is scope to improve referral rates and expand the service further.
At NGH, the current most significant barrier is the lack of a screening tool in all inpatient areas. This is estimated go live mid next year in some of these areas.

The smoking cessation teams at NGH, has only been operational for 6 months, but has already been responsible for the following.

1. In house smoking cessation team created,
2. A referral pathway, and criteria, for inpatients to access and start NRT was implemented,
3. Development of a Nicotine Replacement Therapy – Patient Group Direction (NRT – PGD), that allows all inpatients over the age of 18, to be assessed for NRT within 4 hours of admission, and for that NRT to be supplied and administered by a suitably trained professional,
4. A patient information sheet has been created, that is given to all patients whom NRT has been supplied. This explains how to use NRT correctly,
5. A comprehensive smoking assessment that all smokers are required to have, and we intend to develop this further as part of this BTS Quality Improvement Programme,

6. Promotion of the NCSCT Very Brief Advice, has been rolled out Trust wide,
7. A teaching program for the role out of NRT PGD has been created,
8. A QR code and associated Microsoft Form, to capture smoking referrals. We also intend to develop this further as part of the QI project.
9. Us at Northampton General Hospital have been accepted for a BTS QI Project Nationally which is a huge achievement to be accepted for.

In November 2022, NGH recruited a Maternity TTA as part of the recommended LTP Maternity Pathway.

3.3.4 SUCCESS FACTOR 4 – Patient Experience

Metric – Cancer Experience
The Trust scored negatively outside the expected range for patients being able to easily contact their Clinical Nurse Specialist (CNS) in prostate cancer in the results of the 2019 National Cancer Patient Experience Survey. The Cancer Lead Nurse set up a project group. The knowledge and skills of the project group were identified to assign tasks to the most appropriate member of the team to ensure success and share the actions amongst the group

The group recruited two men with lived experience of prostate cancer who had been through the pathway. The aim was to work as equal partners to explore different ways of working to ensure patients had access to the specialist nurses and the information and support to self-manage aspects of their care through the pathway.

The project group met remotely once a week, chaired by the Cancer Lead Nurse a formal agenda was generated with input from the team and an action log was recorded to keep the project on track. Each member had the opportunity to provide an update ensuring effective communication and provide support to overcome any challenges.

Baseline data was collected to determine the percentage of patients/carers who were able to speak directly to the nurse specialist team and understand the reason for contacting the service. The results of a four week audit of patient/carer contacts indicated that 45% of calls were answered directly. The main method of contact was via a landline; with 55% of patients leaving messages on the answerphone. Patient's/carers contacted the nurse specialists for a variety of reasons,

the highest percentage of calls related to diagnostics, new or exacerbation of symptoms and general information/support. Deeper analysis of the results, suggested that patients had unanswered questions related to diagnostic procedures, questions about treatment options, appointment queries and used the service to report side effects of oncological treatment instead of contacting the dedicated Oncology Emergency Assessment Unit, potentially impacting negatively on their health and wellbeing

The group developed the Driver Diagram with clear SMART objectives and primary and secondary drivers to implement the change actions. The group agreed a robust methodology to measure the impact of the change actions including qualitative and quantitative data.

Change ideas were measured using the PDSA cycle at the weekly meeting and the Driver Diagram was updated to reflect the audit cycle. Ideas grow as the project developed and the team had the opportunity to test new ways of working as part of the project.

A Statistical Process Chart was used to measure improvement and understand the variation in change. This method was chosen because it is a simple tool that clearly demonstrates trends, whether the change idea is making a difference and if that change is sustainable.

The SPC chart illustrated the percentage of calls directly answered by the nurse specialists before the change ideas were implemented. An annotation shows when the interventions commenced and the data demonstrated a statistical improvement from the time of implementation of the change ideas from 48% to 93% of calls answered directly after 3 months of the project launch

The number of views of the dedicated video's/webinars to support self-management strategies was captured electronically to estimate the usage of the material. The data demonstrates an increase in the number of hits since the start of the initiative from 29 to over 1,000 hits in November 2021.

A patient experience survey was undertaken 6 months after the change actions were implemented to elicit the views of patients about the individual changes and measure the percentage of patients who found it easy/quite easy to contact their CNS. The result indicated an improvement from 72% to 85% related to this question

The project commenced in September 2020 in the middle of the pandemic. This impacted on the ability to meet as a project group face

to face. The group had to develop the skills to use teams as a method of communication and build relationships quickly in order to become as effective team. Weekly meetings helped establish a rapport where everyone had the opportunity to participate in the discussion and feedback on work they were leading on. It was essential to encourage the men with lived experience to feel valued members of the group. Every effort was made to listen to the patient's voice and ensure all ideas were agreed as a group. The patient representatives had access to local support groups enabling the patient's voice to be heard

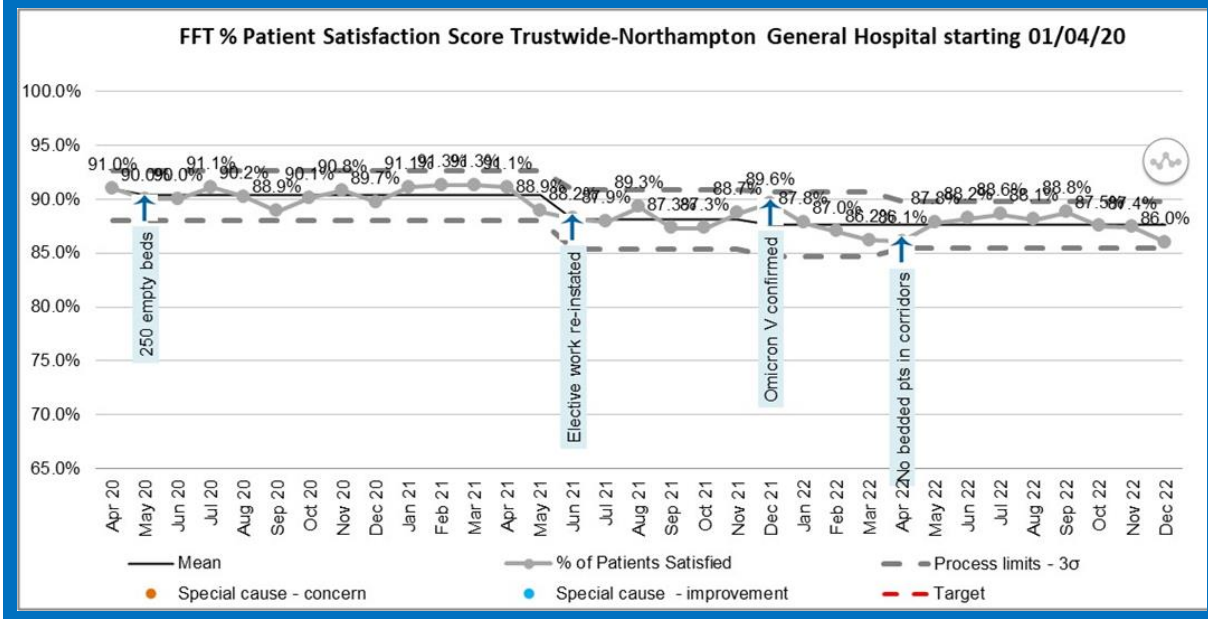
The development of a dedicated daily contact clinic impacted on the nurse specialist workload particularly during period of absence. This was discussed during the project meetings, where the CNS's were able to share their concerns. It was agreed to evaluate the benefits of the clinic as part of the patient survey. Results suggested that men found it more beneficial to have different methods of communication therefore the clinic was discontinued.

Metric – Patient Communication
Engaging with patients and families and acting on feedback has been a challenge since the start of the Covid-19 pandemic in 2020. This necessitated the halting of open visiting to the organisation on various occasions. To ensure patients and their families were able to stay in touch when visiting was restricted or limited various projects were implemented such as Letters to Loved ones, Patient property drop-off processes, use of video calls with assistance by the volunteers if needed, etc.
Although we had to stop collected patient feedback in person and on postcards, the Trust still maintained the Friends & Family Test (FFT) feedback service via text SMS messages and telephone. The postcard FFT surveys were then reintroduced across the Trust in June 2021.

Trust wide satisfaction score
The SPC chart below reflects satisfaction scores throughout April 2020 – December 2022. In September 2022, The Patient Experience Team worked with the Divisional and Directorate leads (along with the Infection Prevention Lead) to clarify dates that significant events occurred for the Emergency Department areas, Inpatient wards, Day Case units and Outpatient Departments. This was to ensure that we can accurately monitor patient satisfaction along with quality improvement by annotating significant events that have occurred throughout this timescale and moving forward.

April 2022– December 2022 (update)

From April 2022 to date, the data points are within normal variation (common cause). From May 2022 to November 2022, there was improvement within the satisfaction scores with the data points lying on or above the mean. It should be noted that the data point for December 2022 is lying below the mean and near the lower process limit but is within normal variation.
From April 2020 to date, satisfaction scores have remained between 86% - 91%. On comparing the figures since April 2020, satisfaction scores average 87.6%.



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 – Friends and Family Test (FFT)
FFT – For 2020/21, From April 2020 – March 2021 there were **620** comments related to Communication. Of these, **353** comments related

to Attitude & Behaviour, **136** related to communication with the patient and **103** related to Communication with the patient over the telephone. There were **16** comments related to communication with the relative.

FFT – For 2021/22, From April 2021– March 2022 there were **860** comments related to Communication. Of these, **577** comments related to Attitude & Behaviour, **200** related to communication with the patient and **59** related to Communication with the patient over the telephone. There were **17** comments related to communication with the relative.

FFT – For 2022/23, From April 2022 – December 2022 there were **689** comments related to Communication. Of these, **453** comments related to Attitude & Behaviour, **166** related to communication with the patient and **52** related to Communication with the patient over the telephone. There were **18** comments related to communication with the relative.

Inpatient Journey Survey (Previously the Right Time Survey)
The Right Time Survey was stopped in March 2020, at the start of the pandemic. This was because 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.

April 2021-March 2022
Where we are doing well: Throughout the year, the Trust had **4** 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 and noise at night from staff.

Where we need to improve: Throughout the year, the Trust had several 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.
Throughout the year, the Trust had **4** questions that were in the **Worse than Worst Trust**. These were around having confidence and trust in the doctors' treating patients, explanation of how to take medications after leaving hospital and patients receiving help from staff to eat meals.

April 2022 – December 2022 (Qtrs. 1 and 2)

Where we are doing well: Throughout Qtrs. 1 and 2, the Trust had **3** questions that were within the **Top 20%** when compared nationally. This was in relation to patients being able to sleep at night due to hospital lighting and noise from staff.

Where we need to improve: Throughout Qtrs. 1 and 2, the Trust had several 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, explanation of medication side effects and being treated with respect and dignity.
The Trust had **1** question that was in the **Worse than Worst Trust**. This question was around staff involving patients in decisions about their care and treatment.
Feedback is shared throughout the MDT across all divisions with each division providing action plans and updates at the Patient, Carer, Experience & Engagement Group as well as within their own Patient Experience Divisional Meetings.

Listening Events
Despite the pandemic we were able to hold 3 patient engagement events throughout 2021/2022 and a further 9 patient and carer listening events since April 2022:

- Clinical Pathway Review & Redesign **–** ENT April 2021
- Learning Disability Listening Event – October 2021
- Emergency Department -December 2021
- Talbot Butler Ward inpatients – April 2022
- Autistic Patients Listening Event – September 2023
- Learning Disability Listening Event in collaboration with Kettering General Hospital – October 2022
- Autistic Patients Listening Event in collaboration with Kettering General Hospital – October 2022
- Macmillan Patient Information Centre Focus Group – October 2022
- Oncology Services Patient Focus Group – October 2022
- Macmillan Patient Information Centre Focus Group (Patient Prospectus) – January 2023
- 2 x Dementia Patient & Carer Listening Event – January 2023

Between April 2020 and April 2022, most of the staff training for patient experience had to be either cancelled, scaled back or delivered online

due to the pandemic. However, since April 2022 all sessions have been delivered on a face-to-face basis and the topic of patient communication always forms a big section of the training event. Staff cohorts that attend the training include the following:

- Shared Decision Making Councils
- Band 5 Nurse Training
- Band 6 Nurse Development Training
- Pathway to Excellence - Evidence Based Practice Course / Patient & Public Involvement

Trust wide Patient Satisfaction Score

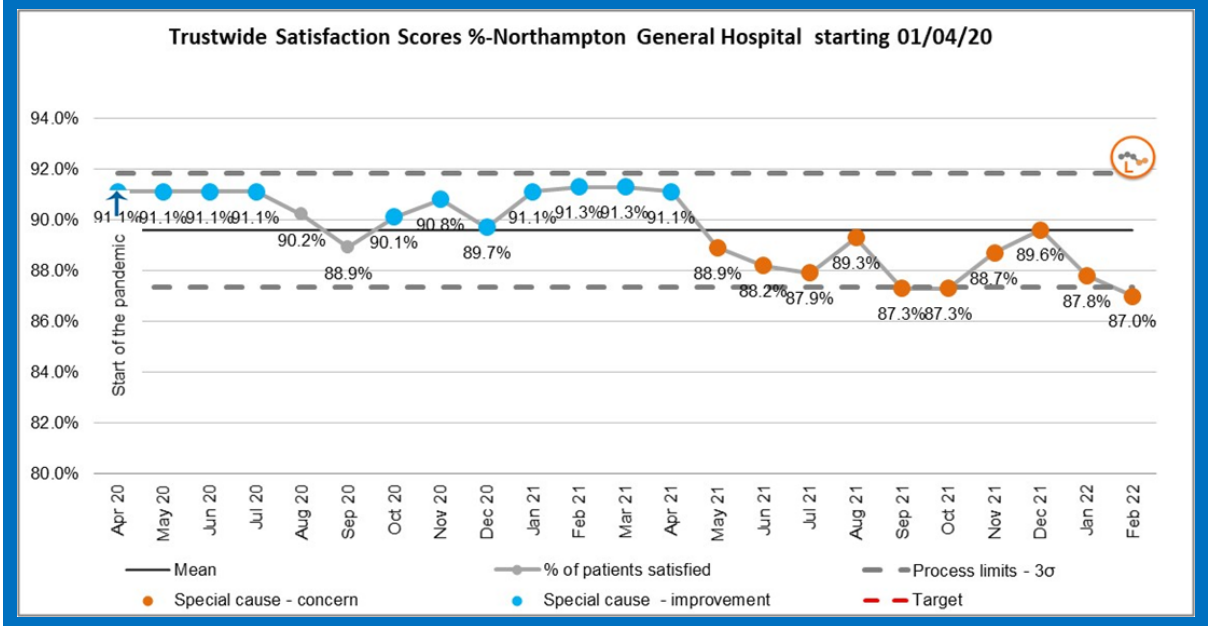
As we now have 12 data points since the question changed, new SPC charts have been created. Now that we have >12 data points entered, control limits now show within the SPC and we can see whether changes within data are statistically significant.

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.

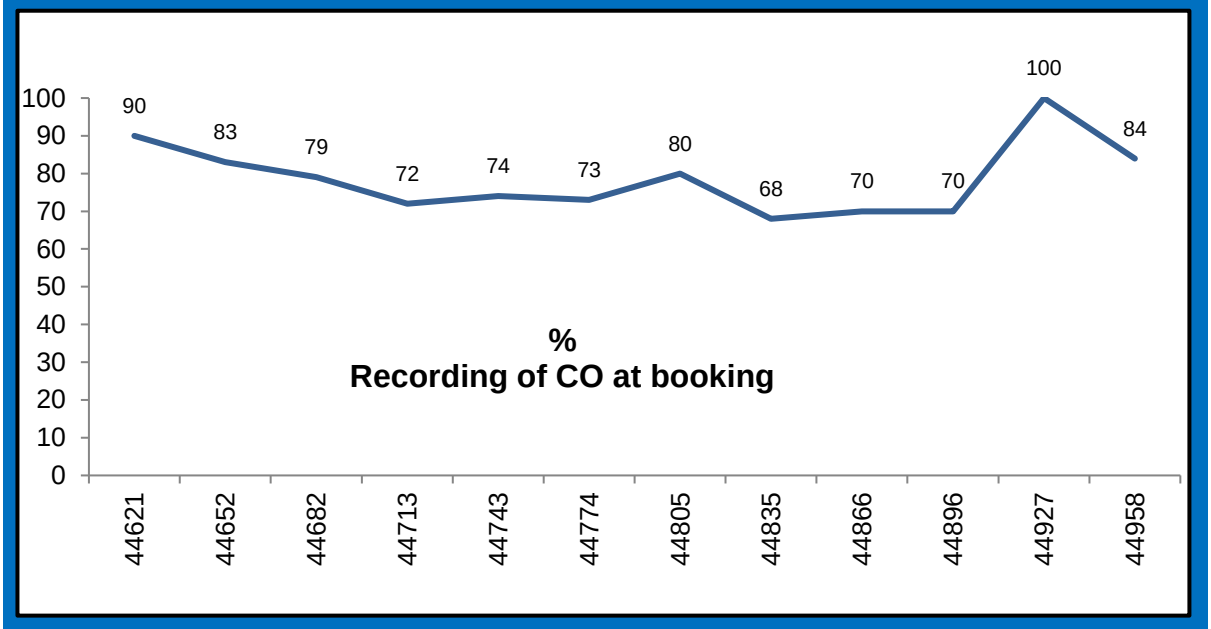
From April 2021 to date, satisfaction scores have remained between 87% - 91%. On comparing the figures since April 2021, satisfaction scores average 88.5%.



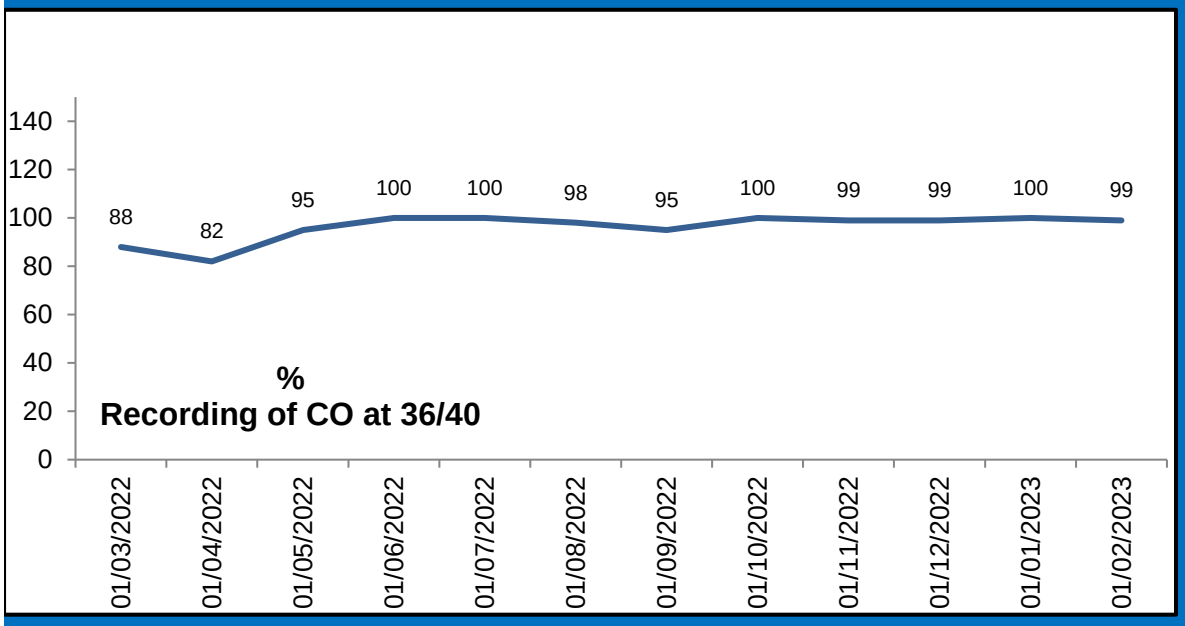
3.3.5. SUCCESS FACTOR 5 – Outcomes in maternal & neonatal care

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.

	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Recording of CO at Booking	90 %	83 %	79%	72 %	74 %	73 %	80 %	68 %	70 %	70 %	100 %	84 %	



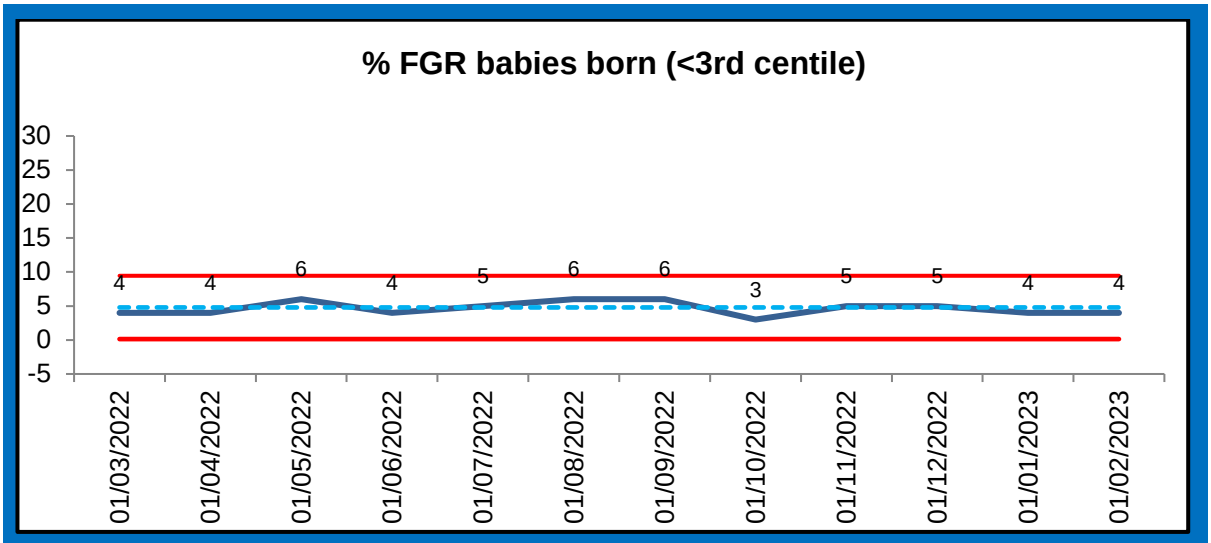
	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Recording of CO at 36/40	88 %	82 %	95%	100 %	100 %	98 %	95 %	100 %	99 %	99 %	100 %	99 %	

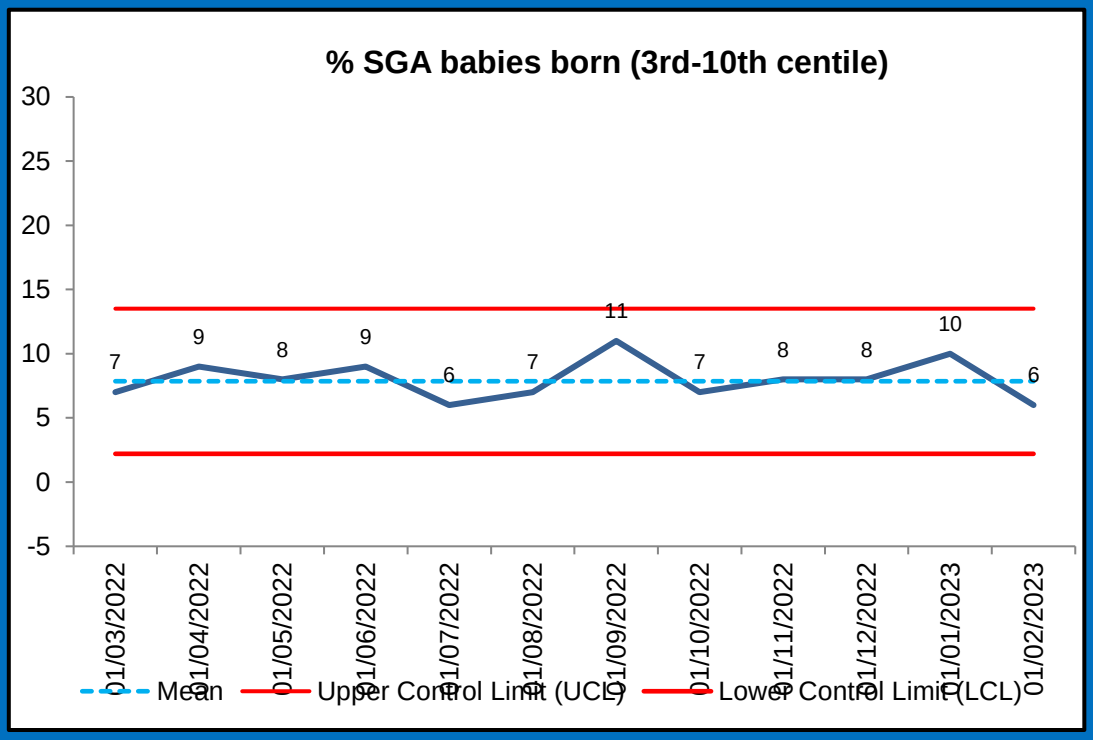


Metric - Risk assessment.

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.

	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
FGR babies born (<3rd centile)	4%	4%	6%	4%	5%	6%	6%	3%	5%	5%	9%	8%	
SGA babies born (3rd-10th centile)	7%	9%	8%	9%	6%	7%	11%	7%	8%	8%	28 %	9%	



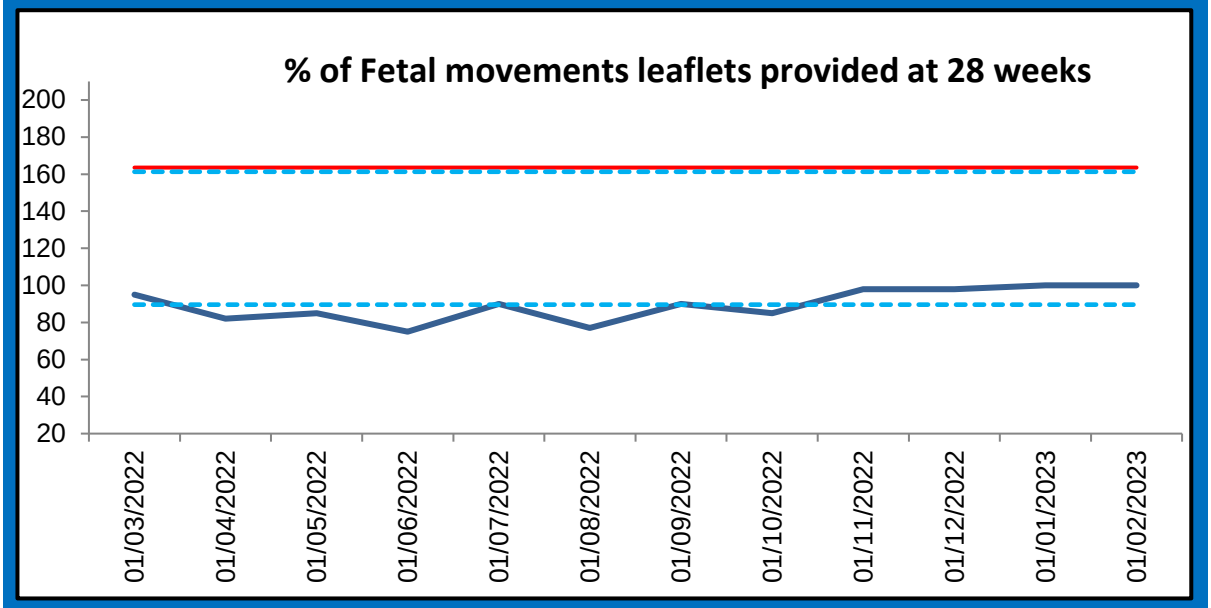


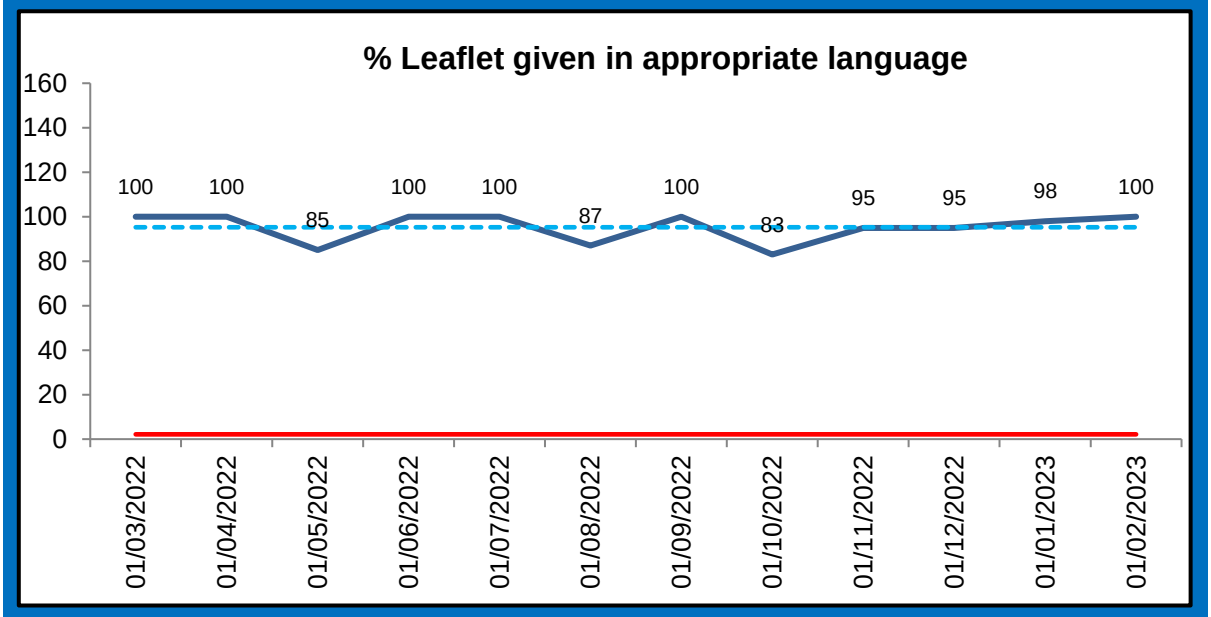
Metric – Information

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.

	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
RFM Leaflet given	95%	82%	85%	75%	90%	77%	90%	85%	98%	98%	100%	100%	

RFM Leaflet given in appropriate language	100 %	100 %	85 %	100 %	100 %	87 %	100 %	83 %	95 %	95 %	98 %	100 %





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:
Deputy Director of Midwifery
Matron for Maternity Inpatient Services
Obstetrics:

- Allocated PAs for Risk and Governance
- Clinical Director – 2PA
- Governance Lead – 1PA
- Risk Management Lead - 0.5 PA (This also includes PMRT and ATAIN Lead role)
- Labour Ward Lead – 1PA
- Clinical Effectiveness / guidelines: 0.5 PA
- Saving Babies Life Leads
    - Fetal Surveillance Lead: 1PA
    - Fetal Movement and Smoking lead: 0.5PA
    - Fetal Growth Restriction Lead: 0.5 PA
    - Preterm Birth Lead: 0.5 PA
- 0.5 PA is allocated (total 4 PA) for Local Governance work which includes MIRF, Panel for CI/ SI etc, PMRT, ATAIN

Metric – National Agenda
Delivered compliance with two Safety Actions - Safety Action 2: 'Are you submitting data to the Maternity Services Data Set to the required standard?' and Safety Action 7 'Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?'. Partial compliance declared for the remaining eight Safety Actions. £87,588 requested in additional funding to support implementation of Safety Actions 1, 3 and 10

CNST Progress MIS Y4 (2022/23)
Delivered compliance with two Safety Actions - Safety Action 2: 'Are you submitting data to the Maternity Services Data Set to the required standard?' and Safety Action 7 'Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?'. Partial compliance declared for the remaining eight Safety Actions. £87,588 requested in additional funding to support implementation of Safety Actions 1, 3 and 10

Safety Action	Progress with achievement
SA1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	
SA2: Are you submitting data to the Maternity Services Data Set (MSDS) to the requires standard?	
SA3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the ATAIN programme?	
SA4: Can you demonstrate an effective system of clinical workforce planning to the required standard?	
SA5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
SA6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	
SA7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your MVP to coproduce local maternity services?	
SA8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last year in line with the Core Competency Framework?	
SA9: Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bimonthly with Board level champions to escalate locally identified issues?	
SA10: Have you reported 100% of qualifying cases to HSIB and to the NHS Resolutions Early Notification Scheme?	

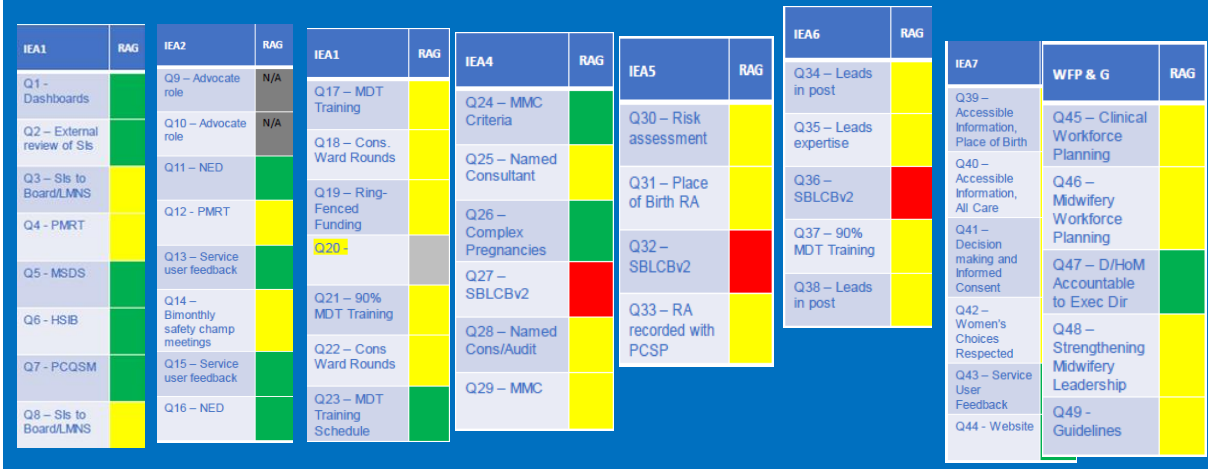
Elements	Progress with achievement
E1: Reducing Smoking in Pregnancy	• Compliant with CO2 score recording above 90% at booking and 83% at 36 weeks and 78% for all antenatal contacts • Maternity Tobacco Dependency Advisor appointed

	• All Midwives trained on providing brief advice on Smoking cessation and referral pathways • Next Steps: Move CO2 score recording for all appointments to Careflow once WiFi in the Community Hubs is in place
E2: Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction	• Ongoing audit into missed SGA /FGR using perinatal institutes standardise clinical outcome review • Detection for Quarter 3 below national average • Implementation of GROW 2.0 in progress
E3: Raising awareness of reduced fetal movement	• Tommy's leaflets available in all languages • Quarter 3 compliance with the discussion relating to fetal movement above 90% • New triage pathway has supported an increase in compliance with managing women presenting with reduced fetal movements
E4: Effective fetal monitoring during labour	• 95.5% of Midwives and 100% of Doctors providing Intrapartum care have completed fetal monitoring training and passed competency assessment The 'Fresh Eyes' review process is embedded with compliance at 95% at Quarter 3
E5: Reducing preterm births	• NGH specific IUT transfer guidance aligned with East Midlands clinical network IUT pathway is in place • Pre-term Birth Lead Midwife commenced in post January 2023 • Working progress to increase compliance with the administration of antenatal steroids and optimisation of the pre-term infant

Ockenden 1, 2 and Insight Visit

Action Plan in progress. Further Ockenden insight visit planned for July 2023

IEA	i	ii	iii	iv	v	vi	vii	viii
1) Enhanced safety								
2) Listening to women and families	N/A	N/A						
3) Staff training and working together								
4) Managing complex pregnancy								
5) Risk assessment throughout pregnancy								
6) Monitoring fetal well-being								
7) Informed consent								
Workforce Planning								
Guidelines								



Submission of benchmark against the 7 immediate and essential actions of the Ockenden 1 and 2 report in progress.

East Kent

EAST KENT RECOMMENDATIONS	TRUST ACTIONS
Team Working & Professionalism	OD supporting leadership on cultural work in maternity services at NGH Work has been completed to support MDT training during Training Week. Psychological safety and human factors embedded into the MDT training. Senior Leaders and Obstetricians currently going through Human Factors Training Town Hall and Unit meetings in place

Compassion	Meet the Matron clinics in place with feedback of themes to clinical teams PMA sessions, as well as discussion of themes from PMA sessions shared with the MDT team during training week Monthly meetings between HoM/DDoM/HR Business Partner with the Lead PMA to share themes coming from PMA sessions
The importance of a learning culture	Learning from incidents SIs and Datix shared by the Patient Safety Midwives as part of their presentation on training week Scenarios from practice used as training scenarios Maternity Messages newsletter shared by Patient Safety midwives
Hearing the voice of patients	MVP in place Work is required to support the MVP to representative of the cross-cultural nature of women who use the NGH maternity services Meet the Matrons clinic to support women's choice Individualised plans for care for women requesting care outside of guidance

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.

BSOTS	2022/5706		
Escalation	2022/5706	2022/9848	2022/512
CTG Interpretation	2022/5706	2022/9848	2022/512
Blood Test Results/Follow Up Appointments	2022/9841	2022/9840	
Placental Histology	2022/9906		

Later Bookers transferring care from another Country	2022/9840	2022/14709	

APPENDIX 1 Stakeholder Feedback

NHS
Northamptonshire
Integrated Care Board

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

Tel: 01604 651100

Date: Tuesday 21st June 2023

Dear Elaine Dolden

Re: Quality Account 2022/23

Thank you for providing us with the opportunity to comment on your annual quality account for 2022/23. The report has been reviewed by NHS Northamptonshire Integrated Care Board

The report was reviewed whilst in draft format and the trust have recognised that they have not delivered against all programmes that went across 2021-23. The trust should be commended for their honesty in stating that; 'we have not kept the priorities alive and tracked delivery against all regularly throughout the year and some of our goals and focus for delivery were not fully defined. In some instances, no clear delivery plans or key performance indicators were set.' The trust have identified 15 challenging priorities that they aim to achieve over the next four years and have included how these will be monitored. To ensure that they maintain traction it might be helpful for the trust to identify what the achievement expectation is for each year.

It is positive to note some the achievements that the trust has made in the last year including their successful Macmillan bid, the development of 'OurSpace' a safe space for staff and progress against the re-designation of 'Pathway to Excellence'.

Prior to publication the trust may wish to review the information in regarding clinical audits, national confidential enquiries and local audits to ensure that it is clear the numbers and percentages of levels of participation and the learning that has been implemented following participation in these. The trust has included some very useful data as part of the learning from deaths process but should also include information about themes and actions taken. They may also wish to include additional information about the actions they are taking following the CQC visit to maternity services in 2022.

The trust has included most of the required datasets, and in addition to this some useful information about complaints responses and learning. We would recommend the trust reviews the availability of NRLS data prior to publication.

NHS Northamptonshire Integrated Care Board supports the trusts ambition to sustain high quality standards of care for people who use both their services and the services that they subcontract. The quality team looks forward to receiving updates through the year against the progress being made against the quality priorities.

Kind regards

Yvonne Higgins
ICB Chief Nursing Officer

Cc: Emma Clarke, Senior Quality Improvement and Assurance Manage

West Northamptonshire Council

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

21 June 2023

Dear Mr Hawes

Draft Quality Account 2022/23

West Northamptonshire Council appoints an Overview and Scrutiny committee to carry out the authority's statutory responsibilities for scrutinising the planning and provision of health services in the authority area. During 2022/23 this was the People Overview and Scrutiny Committee. The Council has since reorganised its Overview and Scrutiny committees for 2023/24.

The People Overview and Scrutiny Committee had a wide-ranging remit covering adult and children's social care, public health, education and housing in addition to health scrutiny. This influenced the amount of health scrutiny work that the Committee was able to carry out in 2022/23 that could, in turn, inform detailed comments on local healthcare providers' draft Quality Accounts.

The People Overview and Scrutiny Committee has considered the continuing development of the Integrated Care System in Northamptonshire. The Committee has also scrutinised the outcomes being delivered by the Integrated Care across Northamptonshire (iCAN) transformation programme. Committee members recognise the importance of key principles involved in these areas of work, including joining up services at local level, supporting independent living, and maximising the benefit of the collective resources available to the health and social care system in Northamptonshire. I encourage Northampton General Hospital NHS Trust to ensure that its strategic priorities and progress towards associated goals support these key principles as fully as possible.

Yours sincerely,

Councillor Rosie Herring
Chair, People Overview and Scrutiny Committee (2022/23) and Adult Care and Health Overview and Scrutiny Committee (2023/24)

Connected Together
First for Community Engagement

healthwatch
North Northamptonshire
West Northamptonshire

Response to Northampton General Hospital Quality Accounts 2022/2023

Healthwatch North and West Northamptonshire would like to congratulate NGH on its successful awards and the work done to support newly recruited staff and the development of a Wellbeing Hub for all staff.

We are pleased that patients have more opportunities to participate in research and staff have access to training and fully funded PhDs.

We are also pleased to see the detailed information on Duty of Candour and that a refresh is planned for 23/24; and that feedback is welcomed as an 'early warning' that systems and processes need to be addressed. It is however disappointing that care, communications and discharge remain the highest causes of complaints.

We are pleased to see that the 'Safety Huddle' has continued throughout the hospital to support the management of staffing, safety and risk.

We acknowledge the vast amount of work being done to improve quality of care across the hospital and that learning from incidents is a priority. It is also good that patients or another relevant person are encouraged to participate in investigations by the Review of Harm Group.

We appreciate the openness and honesty of these Quality Accounts and wish you success with your priorities and goals to improve patient safety and the culture and environment for staff.

Healthwatch North and West Northamptonshire Advisory Board
3rd July 2023

Connected Together
First for Community Engagement
Healthwatch North Northamptonshire and
West Northamptonshire
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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
U	UHN	University Hospitals of Northamptonshire NHS Group
V	VTE	Venous Thromboembolism

Prepared by

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2023