NHS
Northampton General Hospital
NHS Trust

Quality Account 2023-2024

Dedicated to excellence

Table of Contents

Part 1

Introduction to Northampton General Hospital NHS Trust and Our Statement on Quality

The NGH 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 Mr Palmer Winstanley, Medical Director Mr Hemant Nemade and Chief Nurse 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

Statement on Quality

Welcome to the Quality Account for Northampton General Hospital NHS Trust (NGH) for 2023/24. 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 how we provide high-quality clinical care to our service users, the local population and our commissioners in a balanced and accessible way.

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 which illustrate our commitment to providing the best possible care for patients which remains our overall aim. Our performance metrics evidence the continuous cultural shift which demonstrates an organisation aiming to improve and deliver outstanding patient care.

During the year we celebrated 75 years of the NHS. NGH, formerly a voluntary hospital, became part of the NHS with state funding when it was created in 1948. Since that time we have seen many changes including:

- 1950's – a new outpatients department and extension of the ophthalmic department.
- 1960's – opening of a pioneering new radiotherapy department, a new premature baby unit, the opening of an intensive care unit and a pathology lab.
- 1970's – major extension of the hospital's buildings and the opening of the A&E and an additional 129 beds.

- 1980's – first time performance of key-hole surgery, opening of the second phase of extensions, an artificial limb centre and a new colposcopy clinic.
- 1990's – a new nuclear medicine suite opens as well as an MRI scanning unit. Further developments including a new admissions unit, integrated surgery centre and a stroke unit.
- 2000's – sees the opening of a new oncology centre, a new day case, theatre unit and library.
- 2020's – we welcome a new Paediatric Emergency Department and Critical Care Unit

NGH now has 790 beds, a 24-hour Emergency department caring for more than 140,000 patient each year. In addition we have a full range of district general hospital care and some specialist services including provider cancer and stroke services for the county.

In July 2023 we were successful in achieving Pathway to Excellence designation for the second time from the American Nurses Credentialing Center, being the first hospital in the UK to do this. Being recognised as a designated Pathway to Excellence organisation shows to all our colleagues, patients, our wider community and NHS, that we are dedicated to creating an environment where we can excel in giving safe care to our patients.

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. We have embraced the patient safety culture across our hospital by adopting the nationally mandated Patient Safety Incident Response Framework (PSIRF) which aims to ensure, where a patient safety incident occurs, there is compassionate engagement and involvement, increased learning, proportionate responses and oversight and improvement.

The Trust is pleased that our Summary Hospital-level Mortality Indicator (SHMI) which has been decreasing over a number of years remains, as of the latest published monthly dataset, "below expected" range, which reflects on our commitment to keep our at-risk patients safe and we have continued to work on our Deteriorating Patient plans.

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 are also committed to supporting our staff and volunteers, launching several initiatives to ensure support is available should they need this.

NGH were thrilled to receive an interim Preceptorship Quality Mark from NHS England for the way we support newly registered nurses and nursing associates. It indicates to prospective applicants, patients, carers and the public, that NGH is continually improving support for newly qualified nurses and nursing associates to help them get started in their NHS career.

We continue to our collaborative work 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. We work closely with our colleagues at Kettering General Hospital in our University Hospitals of Northampton Group (UHN) and have

a number of UHN posts that cover both hospitals. We also recruited a joint chair and CEO for the groups, both of which are also chair and CEO at University Hospitals of Leicester (UHL). UHN and UHL already work on many shared services, jointly employ clinicians and deliver world leading research through the Leicester Biomedical Research Centre.

The amazing benefits to patient care of a state-of-the-art surgical robot were showcased at an awareness day at Northampton General Hospital. The £1.7m robot has been used to perform hundreds of potentially life-saving cancer operations and - by using tiny key-hole techniques - helped patients to rapidly get back to normal life.

During the year we announced that NerveCentre was chosen as the preferred supplier of our new Electronic Patient Record (EPR) system. A new EPR system will mean relevant patient information is more easily accessible in one digital place – including blood tests, current medication, medical history, nursing assessments and much more. We currently use millions of pieces of paper a year therefore moving to a digital solution will also reduce our paper usage and help us to be more sustainable. It will also mean improvements to how we care for our patients and an enhanced experience of working at NGH too. This is just the start of the multi-year programme with NerveCentre with roll out likely to commence in 2025 as there is much work to do before then to get ready for the system.

The National Staff Survey results for 2023 were published in March 2024 with over 3,500 staff completing the questionnaires. There is progress shown in the results but there is still work required to be done which will be a continued focus in 2024. On the next page is an infographic which gives a visual overview of the results.

There are also 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.

Palmer Winstanley
Chief Executive

Mr Hemant Nemade
Medical Director

Mrs Nerea Odongo
Chief Nurse

Dedicated to excellence

NHS Staff Survey
Northampton General Hospital

NHS Northampton General Hospital NHS Trust

Summary of the results of the 2023 National Staff Survey, which is carried out every year to give us an understanding of how staff are feeling and their experiences of working at NGH.

Response Rate 60 %

Staff Engagement Score 6.8 / 10

74% of staff said that the care of patients / service users is our organisations top priority — 5% increase on 2022

57% of staff said they would recommend the organisation as a place to work — 5% increase on 2022

58% of staff said that they would be happy with the standard of care if a friend or relative needed treatment — 4% increase on 2022

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
7.2	5.9	6.6	6	5.7	6.2	6.7
0.2 increase	0.4 increase	0.2 increase	0.3 increase	0.4 increase	0.3 increase	0.3 increase

* Data out of 10 - since 2022

Biggest improvements since 2022:

- **47%** of staff said **my organisation is committed to helping me balance my work and home life** — 8% improvement
- **30%** of staff said **there are enough staff at this organisation for me to do my job properly** — 7% improvement
- **53%** of staff said **that teams within this organisation work well together to achieve their objectives** — 7% improvement
- **58%** of staff said **I have adequate materials, supplies and equipment to do my work** — 7% improvement

Biggest deteriorations since 2022:

- **60%** of staff said **I have been discriminated against because of my ethnic background** — 7% deterioration
- **5%** of staff said **I have been discriminated against because of my religion** — 2% deterioration
- **11%** of staff said **that I have personally experienced discrimination at work from patients / service users, their relatives or other members of the public in the last 12 months** — 1% deterioration
- **49%** of staff said **the last time I experienced harassment, bullying or abuse at work I or a colleague report it** — 1% deterioration

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).

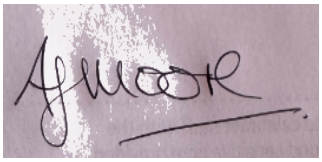
In preparing their Quality Account, directors have taken steps to assure themselves that:

- 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

Chief Executive

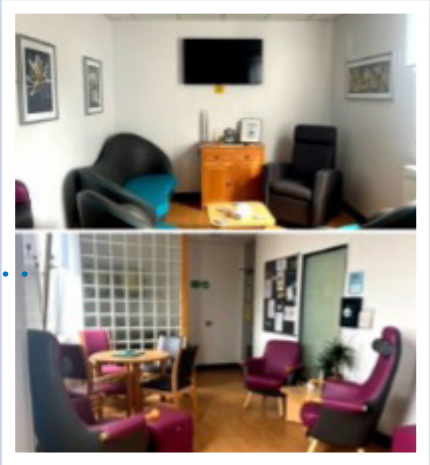


Chair

Successes

April 2023

First two additional Swan rooms opened (on Walter Tull and Allebone wards)



May 2023

OurSpace officially opens – enabling staff to have a quiet reflection area as well as being able to access health and wellbeing services.

June 2023

NGH continued to celebrate staff with the compassionate and sensitive care provided to patients.

July 2023

The NHS is 75 years old

NGH achieves Pathway to Excellence designation for the second time from the American Nurses Credentialling Center – the first UK hospital to do so.

August 2023

Chief Nursing Officer for England Awards presented:

- Gold Award to Liz Summers, Macmillan Cancer lead Nurse
- Silver Award to Tina Taylor, Outreach Lead Nurse and to Maria Sagucio, International Nurse Pastoral Support Facilitator

September 2023

NGH TIDE (Talent Inclusion and Diversity Evaluation) submission qualified University Hospitals of Northamptonshire NHS Group for a Gold Award. Out of 171 entries there were only 15 gold awards.

October 2023

NGH receives an 'Interim Preceptorship Mark' from NHS England

NGH celebrated our Silver Award from the Government's Defence Employer Recognition Scheme for the way we support the armed forces community.

November 2023

November 2023

Announcement that NerveCentre was chosen as the preferred supplier for our new Electronic Patient Record system.

Holly Slyne, Associate Director of Infection Prevention, was selected as a finalist in the Greener Nursing Practice category of the RCN Nursing Awards 2023 – she ran a campaign to cut down on unnecessary use of Personal Protective Equipment at NGH.

December 2023

New in-house Physiotherapy Service launched.

NGH opened its fourth Community Maternity Hub creating a network of hubs covering the whole town.

Jaunary 2024

MBE awarded to Rob Hicks, Consultant Vascular Surgeon for health services to people in Northern Ghana

Hypnotherapy support service commenced

February 2024

NGH goes live with Patient Safety Incident Response Framework

For the first time, NGH used a highly specialised 3D printer to create a customised face mask for a patient with a skin cancer on her nose which otherwise would have needed a surgical intervention, and probably plastic surgery.

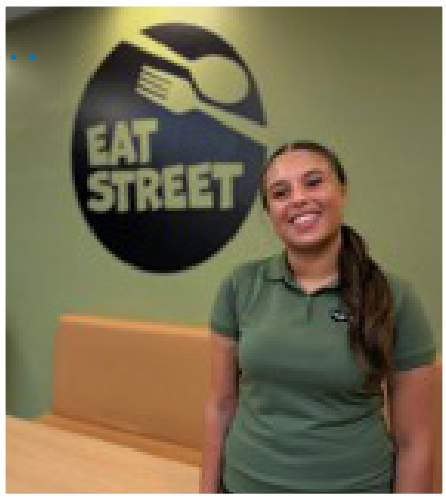
March 2024

March 2024

Project Tony launched introducing a new motorised wheelchair.

EveryBody Moves launched setting out the importance of reconditioning.

Alana Ricketts, Eat Street Food Service Assistant, awarded the Estates and Ancillary Individual Award at the Unsung Hero Awards with te Volunteer Services team shortlisted in the Corporate Services (Team) category.



Part 2

Priorities for improvement and statements relating to quality of NHS services provided

Priorities for Improvement

As reported in our 2023/24 Quality Account, as part of our Integrated Business Planning for 2023/24 and in order to set our objectives for the coming year, we reviewed the strategic priorities as set out in our Dedicated to Excellence strategy.

The purpose of the review for 2023/24 planning was to ensure our strategic priorities were reviewed and updated to reflect the work done 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 five strategic priorities, goals and success measures. The five strategic priorities were confirmed as current at the joint Board Development session on the 20 January 2023.

A key aim of the strategic planning was to create a single forward focused view of our priorities and goals that could 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 could 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

Compassion

We care about our patients and each other. We consistently show kindness and empathy and take the time to imagine ourselves in other people's shoes.

Integrity

We are consistently open, honest and trustworthy. We can be relied upon, we stand by our values and we always strive to do the right thing.

Respect

We value each other, embrace diversity and make sure everyone feels included. We take the time to listen to, appreciate and understand the thoughts, beliefs and feelings of others.

Courage

We dare to take on difficult challenges and try out new things. We find the strength to speak up when it matters and we see potential failure as an opportunity to learn and improve.

Accountability

We take responsibility for our decisions, our actions and our behaviours. We do what we say we will do, when we say we will do it. We acknowledge our mistakes and we learn from them.

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 Increase in EDI related staff scores (PP1, PP2)	No. excellence ambassadors recruited Discovery phase to set further delivery metrics	Recruitment figures TBD depending on discovery output Staff engagement scores	0 N/A Engagement NGH 6.2	Target: 50 N/A Engagement NGH 6.3	Funding constraints
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

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
Delivering a sustainable workforce	Reducing reliance on agency Improving availability of staff	Improvement of PP1 and PP2 by improving resourcing and day to day experience of staff	Reduced number of agency shifts Reduced vacancy through improved workforce planning	Agency cost Vacancy rate Time to hire	NGH £27M NGH 9.3% NGH 88 days	NGH £12M Vacancy 8% TTH NGH 70 days	Staff engagement Labour market

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 feed-back digital system	Improve visibility of patient feedback and enable action to improve	Improved feedback from patients	Patient feed-back 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 Reduction in complaints by complaint theme focus	Standard UHN complaints process in place Learning from complaints themes Complaints performance- no. of complaints per month-IGR	Not in place TBC following approach development NGH 24 (Mean 21/23)	In place TBC following approach development TBC	An approach will be developed 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 representation on each of the clinical collaborations Clinical collaboration achievements 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

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
Outpatients	Outpatient communication improvement through the outpatients transformation programme Digital letters Improved phone contact	Improved feedback from patients (P2)	Patient feedback on communication in FFT Call drop-rates in Outpatients First-time resolution in call metrics	Outpatients Friends and Family communication scores Outpatient call answering & resolution rate	Jan-23: 94% - NGH Oct-22: 78% calls answered and resolved first time	95% 90%	Reliant on delivery of digital solution Risk to delivery given current level of admin vacancies
Improving equality for people of Northamptonshire	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

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
Cardiology centre of excellence	Delivery of the Cardiology centre of excellence	Reduces clinical variation and outcomes in cardiology patients	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 Ophth – 4.3 T&O – 2.6	85% Targets need developing based on case mix	Clinical and operational pressures
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 outpatient referrals and cancer pathways.	Supports SP1, SP2	Annual plan diagnostic activity delivery- Performance against the 6-week wating time standard (DM01) Delivery against CDC business case KPIs	DM01 CDC business case benefits realisation	Activity plan	85% (DM01) CDC KPIs	Digital connectivity Recruitment challenges Managing DNA rates
Outpatients' transformation	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 implementation Clinical and operational pressures

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
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%	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

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
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 of Public Sector Decarbonisation Scheme at NGH	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
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

Statements Relating to Quality of NHS Services Provided

Review of Services

During 2023/2024, usual contracting processes have been re-established (having been paused nationally during the covid pandemic). The Trust's lead commissioners remained NHS Northamptonshire Integrated Care Board (ICB). Northamptonshire ICB are 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 (BLMK ICB) and Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB). 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 (please note Secondary Care Dental Services are contracted by NHS England but have been delegated to ICBs for payment purposes)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 2023/2024 represents 90% of the total income generated from the provision of relevant health services by the Trust for 2023/24.

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 2023/2024, the Trust provided services to relevant health or support services including:

- St Andrews Healthcare
- Ramsey Health Care UK
- Oxford Radcliffe University Hospitals
- Kettering General Hospital NHS Foundation Trust
- 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 2023/24, the Trust subcontracted services to 34 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)

Examples of 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 medica reporting ltd 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 be arranged 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.

Participation in National Clinical Audits

Our 2023-24 Annual Programmes of National Clinical Audit is made from the list of national audits that NHS England produce through the Quality Account List every year. These are mandated work for each of the relevant services we provide.

In addition there are other national audits that are not mandatory but do reflect good practice in contributing to developing the UK knowledge base, public health and in allowing us to reflect on our performance and provide assurance to the public. These are carried out by senior staff who use wish to be part of these studies and allow more junior staff to participate and learn about important ways to work on quality.

NHS England expect that each NHS Trust has a single, register of all their audits. This allows for oversight, managing duplication of work and as a source of information for anyone wanting to work on the quality of care we provide. This information comes from that register which supports provision of board, divisional and directorate assurance and quality improvement as necessary in support of the corporate objectives.

This annual Clinical Audit Programme is a rolling schedule of all the clinical audit activity throughout NGH. It includes national projects that continue year on year, new ones, either as single, snapshot audits or on a new longer-term plan. Some are changing to focus on the improvement of services and reflect this quality skill set.

- NHS England agreed the following criteria for 2024-25, which informs the national programmes included on the Quality Accounts List:
- Coverage: collects data from at least 70% of eligible services nationally.
- Collects data on individual patients.
- Publishes comparisons of providers (for example, at trust, hospital, or network level).
- Plans to recruit patients during the forthcoming financial year.
- Reports comparing providers' performance published within 12 months of completion of the most recent clinical event included in the report.
- Outcomes and processes of care are audited against standards, guidelines, or evidence (for example, NICE Quality Standards and Guidelines)
- Below are the agreed metrics for the next 4 years from 2023/24 onwards.

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

National Clinical Audits: 2023 - 24	
National Clinical Audits were participated in	87
(of these) National Clinical Audits on Quality Account List	76

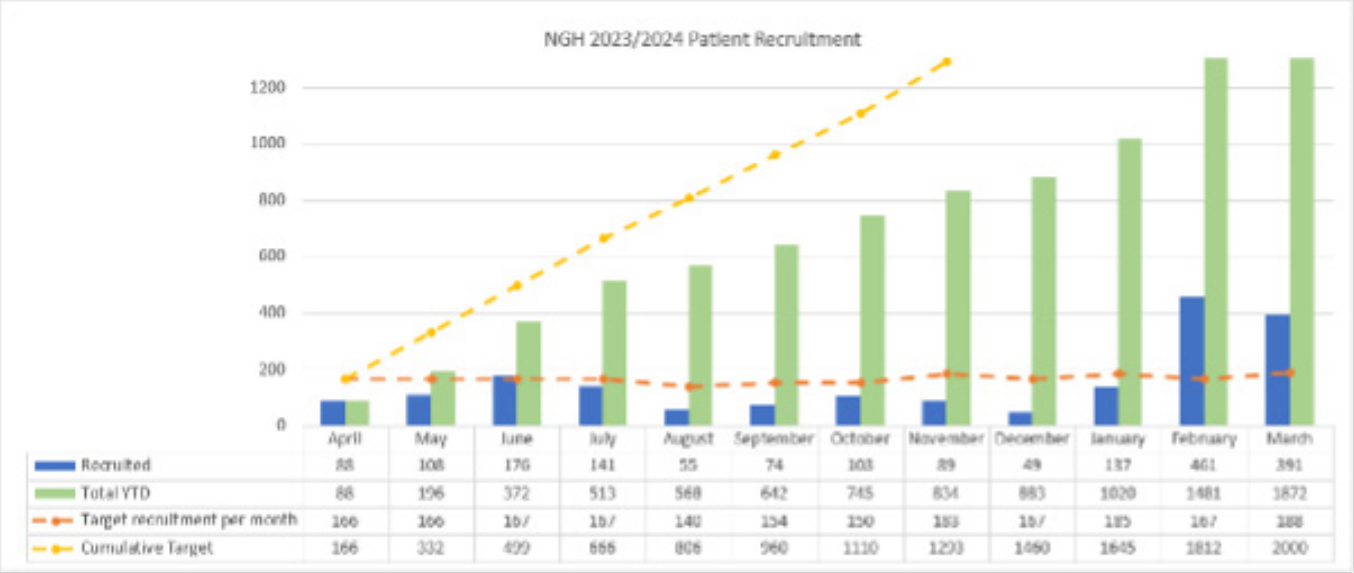
All submissions were made within the externally agreed timescale apart from one (a Royal College Of Emergency Medicine Project). This was due to lead leaving the trust, a change in emails and miscommunication centrally. After a review actions were carried out to minimise the risk of this happening again.

Following submission we receive a report on the findings of the national audits. These are reviewed and assurance provided or improvement identified and governed by the Team and Directorate Clinical Governance.
During the year our programme is monitored by the wider, senior members of the clinical teams with the co-ordination and support of the Governance Department and Clinical Audit and Effectiveness Team therein. Progress reports on this programme of work quarterly to the board's Clinical Quality and Effectiveness Group and through an Annual Report to Quality Governance Committee.

Participation in Clinical Research

Research participation for the year 2022/23 was 1,181. In comparison, 1872 participants were successfully recruited in 2023/24. This marked increased in recruitment has been attributed to the OBS-UK Study which opened to recruitment at NGH on 1st February 2024. OBS-UK will investigate new ways of looking after patients with postpartum haemorrhage and we aim to recruit 300 participants per month over a 35-month period. OBS-UK comes with funding which has opened up an opportunity for a Research Midwife to work in R&I for one day a week for the duration of the study.

NGH opened 3 commercial trials in 2023/24 bringing the total to 4 commercial trials which are open to recruitment. In addition, we have 8 commercial trials with patients in follow-up. An overview of recruitment in 2023/24 is shown in the table below:



We will be recruiting 2* 1.0 WTE new roles – Clinical Research Practitioners at B4. These posts will create a more diversified workforce to introduce non-clinical roles to our research delivery teams. The introduction of these roles will free up Research Nurse time to work on more complex Investigational Medicinal Product (IMP) trials.

However, the key challenge affecting the number of studies we are able to participate in remains capacity within our Consultant body with 10% research active. It has been agreed with the Medical Director that funding will be available to incorporate 0.025 PA into Consultant Job Plans for active Principal Investigators. A strategy for implementation and monitoring performance needs to be agreed.

We are concentrating our efforts on developing our research portfolio, increasing recruitment to clinical trials and streamlining the study set-up process to ensure we are meeting national and regional targets. Our aim is to grow the number of studies and opportunities for our patients to engage in research.

Commissioning for Quality and Innovation (CQUIN) Income

A proportion of the Trust's income in 2023/24 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
CQUIN01 – Flu vaccinations for frontline healthcare workers (70-80%)
CQUIN02 - Supporting patients to drink, eat and mobilise (DrEaMing) after surgery (70-80%)
CQUIN03 - Prompt switching of intravenous to oral antibiotic (60-40%) £
CQUIN04 - Compliance with timed diagnostic pathways for cancer services (35-55%)
CQUIN05 - Identification and response to frailty in emergency departments (10-30%) £
CQUIN06 - Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service (0.5-1.5%) £
CQUIN07 - Recording of and response to NEWS2 score for unplanned critical care admissions (10-30%) £
CQUIN08 - Achievement of revascularisation standards for lower limb ischaemia (45-65%)
CQUIN10 - Treatment of non small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway (80-85%)
CQUIN11 - Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery (65-75%)
CQUIN12 - Assessment and documentation of pressure ulcer risk (70-85%) £

Further details of the agreed goals for 2023/2024 and for the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/

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.

NGH had a full inspection in 2019 and 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 Trust had an inspection relating to Falls from the CQC in February 2024, following which NGH produced an action plan to meet the recommendations.

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.

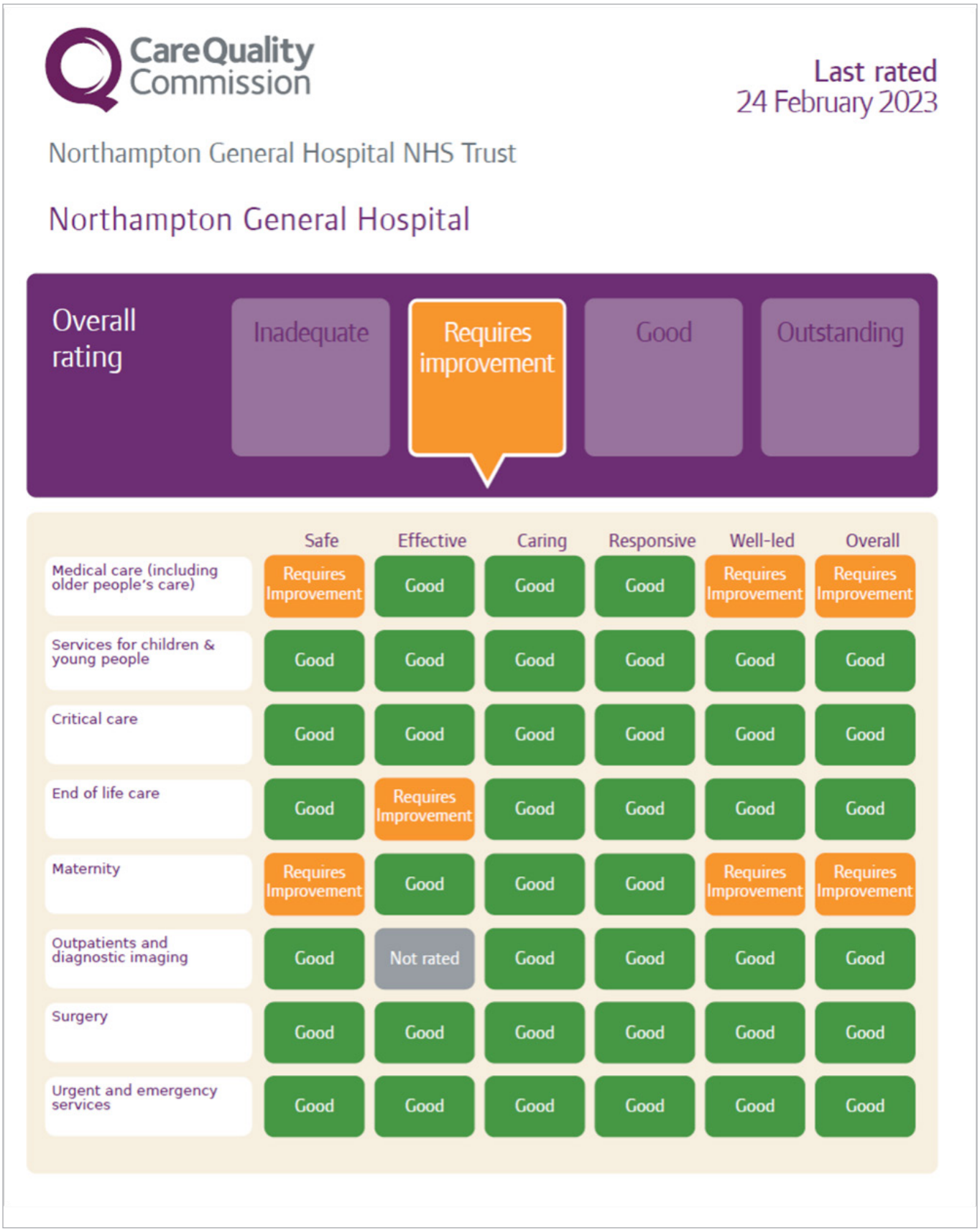
Action the trust MUST take to improve:

- 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

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



	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

Care Quality Commission

Last rated
24 February 2023

Northampton General Hospital NHS Trust

Northampton General Hospital

Overall rating	Inadequate	Requires improvement	Good	Outstanding

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

Data Security and Protection Toolkit Attainment Levels

The Trust utilises 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, this is called the Data Security and Protection (DSP) Toolkit.

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:

- Personal Confidential Data
- Staff Responsibilities
- Training
- Managing Data Access
- Process Reviews
- Responding to Incidents
- Continuity Planning
- Unsupported Systems
- IT Protection
- Accountable Suppliers

DSP Toolkit Dashboard

In the current version of the toolkit, there are 34 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. 108 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 2024, the baseline submission was due on the 29th 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 ensure all will be achieved again before the submission date on the 30th of June 2024.

The Trust's auditors (TIAA) must complete the Trusts DSP Toolkit Audit which is in line with the 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 2024.

The Trust reported 5 Information Governance serious incidents to the Information Commissioner's Office in 2023 (there was 1 reported in 2022) 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 Trust Policy and communications with the ICO.

We continue to develop tools to ensure compliance with GDPR, the Data Protection Act and the Freedom of Information Act and have now procured the use of a Policy Management System which can enforce policies and training to relevant staff. We have also recently published a refreshed Privacy Notice which provides detailed information about how the Trust handles personal data. 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.

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:

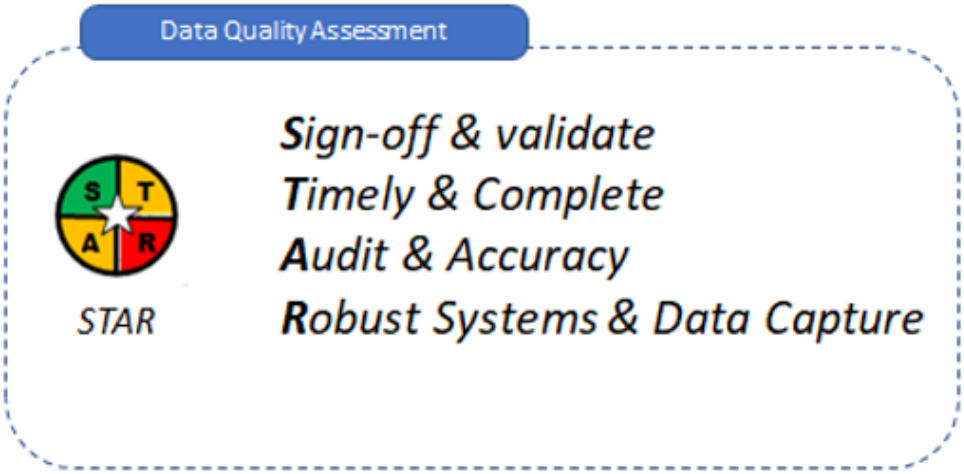
- CDS/SUS submission and review via NHS Digital Data Quality report.
- MSDS (Maternity) data generation, submission, and review by CNST score
- Monitoring of the DQMI (Data Quality Maturity Index) score.
- Review of proposed Data Quality Kitemark and processes for information provisions to ensure accuracy.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

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 Digital Training and Engagement Team.

To ensure that we maintain data quality, we monitor our data quality metrics using a large suite of reports 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 Digital Training and Engagement Team ensure frontline staff are trained appropriately with Clinical Systems, following up on concerns raised by DQ about specific areas/users, developing training spotlights, training packages, screensavers and news bulletins which reflect identified training needs.

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.

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.

Inpatients	Valid NHS Number	Valid GMPC
Apr 23 to Dec 23	99.80%	99.96%
Apr 22 to Dec 22	99.92%	99.99%
Apr 21 to Dec 21	99.85%	99.92%
Apr 20 to Dec 20	99.80%	99.99%
Apr 19 to Dec 19	99.78%	99.99%

Outpatients	Valid NHS Number	Valid GMPC
Apr 23 to Dec 23	99.95%	99.99%
Apr 22 to Dec 22	99.98%	99.99%
Apr 21 to Dec 21	99.96%	100.00%
Apr 20 to Dec 20	99.93%	99.99%
Apr 19 to Dec 19	99.93%	94.55%

A&E	Valid NHS Number	Valid GMPC
Apr 23 to Dec 23	98.90%	100.00%
Apr 22 to Dec 22	99.01%	100.00%
Apr 21 to Dec 21	99.11%	99.80%
Apr 20 to Dec 20	99.11%	99.66%
Apr 19 to Dec 19	99.82%	96.75%

Clinical Coding Error Rate

Clinical coding audit is fundamental to the quality assurance process by rigorously reviewing how consistently and accurately clinical coding standards are being applied. 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 for the Data Security & Protection Toolkit (DSPT) requirement is a 200-patient episode audit per financial year, this aligns with the UHN Clinical Coding Policy (ref: UHN-PO-CR14).

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 2023/24	97%	96.5%	93%	89%

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 2023 – March 2024, 1,660 patients at NGH died, of which 1,468 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	369	40	409
Q2	323	29	352
Q3	382	66	448
Q4	394	57	451
Total	**1,468**	**192**	**1,660**

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 1 April 2023 – 31 March 2024, 1,590 deaths at NGH were scrutinised by the ME team, this accounted for 100% of deaths referred to the ME & Bereavement service. The MCCD was issued within 5 days of referral for 99.5% of cases.

Q1	338
Q2	352
Q3	445
Q4	455
Total	**1,468**

Reviewing deaths – 2023-24 data
NB: Data supplied is status as of 3 May 2024, and subject to continuous change.
228 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	61
Q2	52
Q3	71
Q4	44
Total	**228**

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 2023-24:

44 cases have been reviewed as part of the 2nd stage review process.

4 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.

32 deaths from 2023-24, with a graded harm of "severe" or "death", have been referred both for clinical incident and for SJR or specialty M&M review.

22 were declared a Serious Incident (SI) or Patient Safety Incident Investigation (PSII).

2 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	2
Q4	2
Total	**8**

Stillbirths >24 weeks

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

- From 1st April 2023– 31st March 2024 there were 8 neonatal deaths after 22 weeks of pregnancy and 8 stillbirths delivered from 24 weeks of pregnancy.
- 2 deaths have been declared a serious incident investigation.
- At time of writing, 12 reviews have been fully completed using the Perinatal Mortality Review Tool. The remainder are due to be completed in 2024.
- 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)

- From 1st April 2023 – 31st March 2024 there were 15 deaths of adults with a learning disability or autism. There were 19 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 all 30 patients has been reviewed using the Structured Judgement Review tool and presented at the Vulnerable Adult M&M Meeting. The remaining 4 cases will be reviewed and discussed in 2024.
- 7 deaths were also referred for clinical incident review. 1 case was declared a Serious Incident (SI) 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.

Period	Inpatient Deaths	ED Deaths	Total
Q1	2	4	6
Q2	4	7	11
Q3	4	3	7
Q4	5	5	10
Total	**15**	**19**	**34**

Appendix 1

Learning, Actions and Impact of Mortality
Mortality Key workstreams 2023-24 & 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 biannually (or as required) to Learning from Deaths Group • Successful business case for permanently funded Specialist Palliative Care team in Urgent Care (SPUCS).
Trust-wide Mortality Review 15: Learning from Deaths in Vulnerable Adults	Mortality Governance team Safeguarding team	Led by Learning from Deaths Group in conjunction with Safeguarding Team	• Reports 3-6 monthly to Learning from Deaths Group • Vulnerable Adult Improvement plan was completed in 2023-24, with plan for areas of non-compliance to be overseen via the Mental Capacity Steering Group. • Annual thematic analysis of learning from SJRs in Vulnerable Adult to continue.

Trust-wide Mortality Review 16: Acute Kidney Injury (AKI)	Telstra Health UK Mortality Governance team 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 • AKI improvement plan is in progress, with monthly updates shared at the Deteriorating Patient Operational Group. • Workstream to continue throughout 2023-24
Trust-wide Mortality Review 17: Learning from Deaths - Perinatal reviews	Maternity Team PMRT review process Mortality Governance Team Incident Review Group	Led by Learning from Deaths Group in conjunction with Maternity team	• Reports to Learning from Deaths Group quarterly • Thematic analysis of the learning from Perinatal Mortality Reviews (2022-23 cases) shared with Learning from Deaths Group, Maternity & Neonatal teams
Trust-wide Mortality Review 18: Learning from SJRs (2022-23) – thematic analysis of 300+ reviews	Mortality Governance Lead Specialty M&Ms	Led by Learning from Deaths Group	• Learning shared with Learning from Deaths Group, Patient Safety team and to specialty M&Ms across the trust • Future plans in 2024-25 for closer alignment of M&M process with Patient Safety team processes.

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(s) are encouraged to participate in any review that the Trust's Incident Review Group (IRG) deems require a systems-based incident response, as per the current Patient Safety Incident Response Framework (PSIRF). The patient/relevant person(s) are also offered the opportunity to meet with members of the incident response team to discuss and question the reviews findings.

Management of Complaints

Compliments, Comments, Complaints, Concerns (4C's) and suggestions from the patient, service user, or their representative are encouraged and welcomed. All feedback is welcomed as it is used to improve our services.

In the first instance members of the public are encouraged to share their views and experiences, positive or negative by speaking with a member of staff. Whilst most problems can be dealt with at this stage, in some cases those using our services may feel more comfortable speaking with someone not directly involved in their care.

The Patient Advice & Liaison Service (PALS) is a free, confidential and independent service located within the main hospital building within two designated locations. The patient, service user or their representative can contact our PALS team by post, email, telephone or in person. PALS aim to resolve issues informally on behalf of members of the public which can be particularly helpful if the issue is urgent and action is required immediately, such a problem with the treatment or care a patient is receiving. PALS are also able to provide guidance on how to make a complaint and to signpost individuals to other services.

The Complaints Team work very closely with PALS and will ensure that where possible local resolution is considered / attempted before a complaint is raised. The Trust works in accordance with the 'Local Authority Social Services and National Health Service Complaints (England) Regulations 2009' and the NHS Standards published by the Parliamentary & Health Service Ombudsman.

Overall responsibility and accountability for the management of complaints lies with the 'Responsible Person'. At NGH this is the Chief Nurse. The 2009 regulations allow us to delegate the relevant functions of the Responsible Person and Complaints Manager to our staff where appropriate. We do this to ensure we are able to provide an efficient and responsive service. We have processes in place to make sure that the responsible person and relevant senior managers regularly review insight from the complaints we receive, along with other forms of feedback on our care and service.

We ensure that Complaints & PALS teams know and comply with all relevant legislation, make information available in a *format that people understand, make sure everyone knows when a complaint is a serious incident, legal issue or safeguarding and what action must be taken. All team members are strongly committed to duty of candour and there is a culture of being open and honest should something go wrong and that we listen and learn from complaints to improve services.

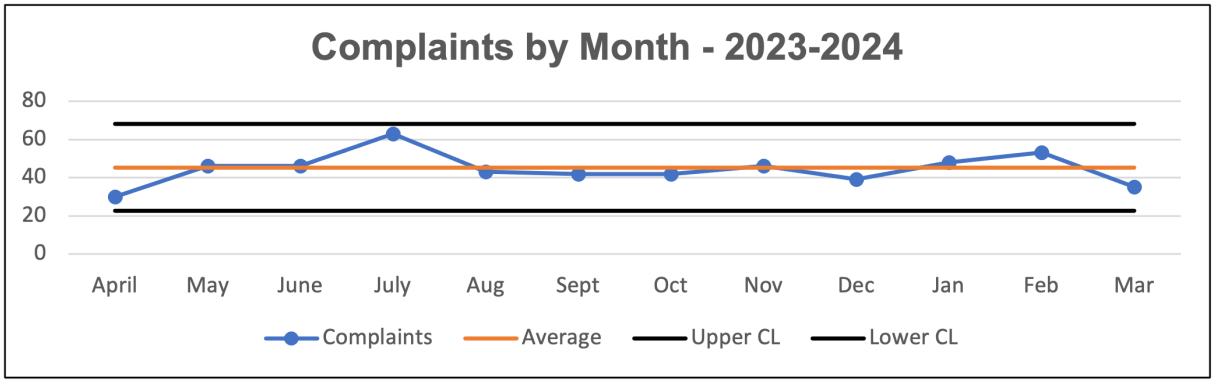
*We consider all accessibility and reasonable adjustment requirements of people who wish to make a complaint or raise a PALS concern in an alternative way. We will record any reasonable adjustments we make.

The Trust received a total of 533 written complaints that were investigated through the NHS Complaints Procedure from 1 April 2023 to 31 March 2024, which compares with 492 complaints received for the same period during the previous financial year.

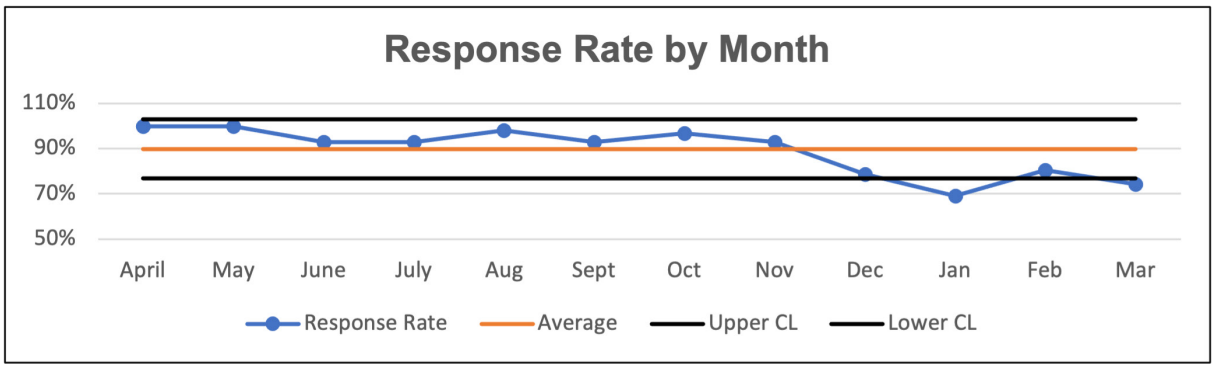
Total no of complaints for the year **2023/2024**	**533**
(Versus 2022/2023)	(492)
Percentage change from 2022/2023 to 2023/2024	**8%**
Total no of complaints that required a renegotiated timescale, agreed by the complainant	**318**
Average response rate including agreed extension of time	**89%**
Average response rate excluding agreed extension of time	**53%**
Total no of complaints that exceeded the renegotiated timescale	**66**
Complaints that were still open at the time that the information was pre-pared (5th April 2024)	**143**
Total patient contacts/episodes*	**1,467,870**
(Versus 2022/2023)	(758,473)
Percentage of complaints versus number of patient contacts/episodes	**0.04%**
(Versus 2022/2023)	0.06%

*Please note that additional categories are included this year

Number of complaints

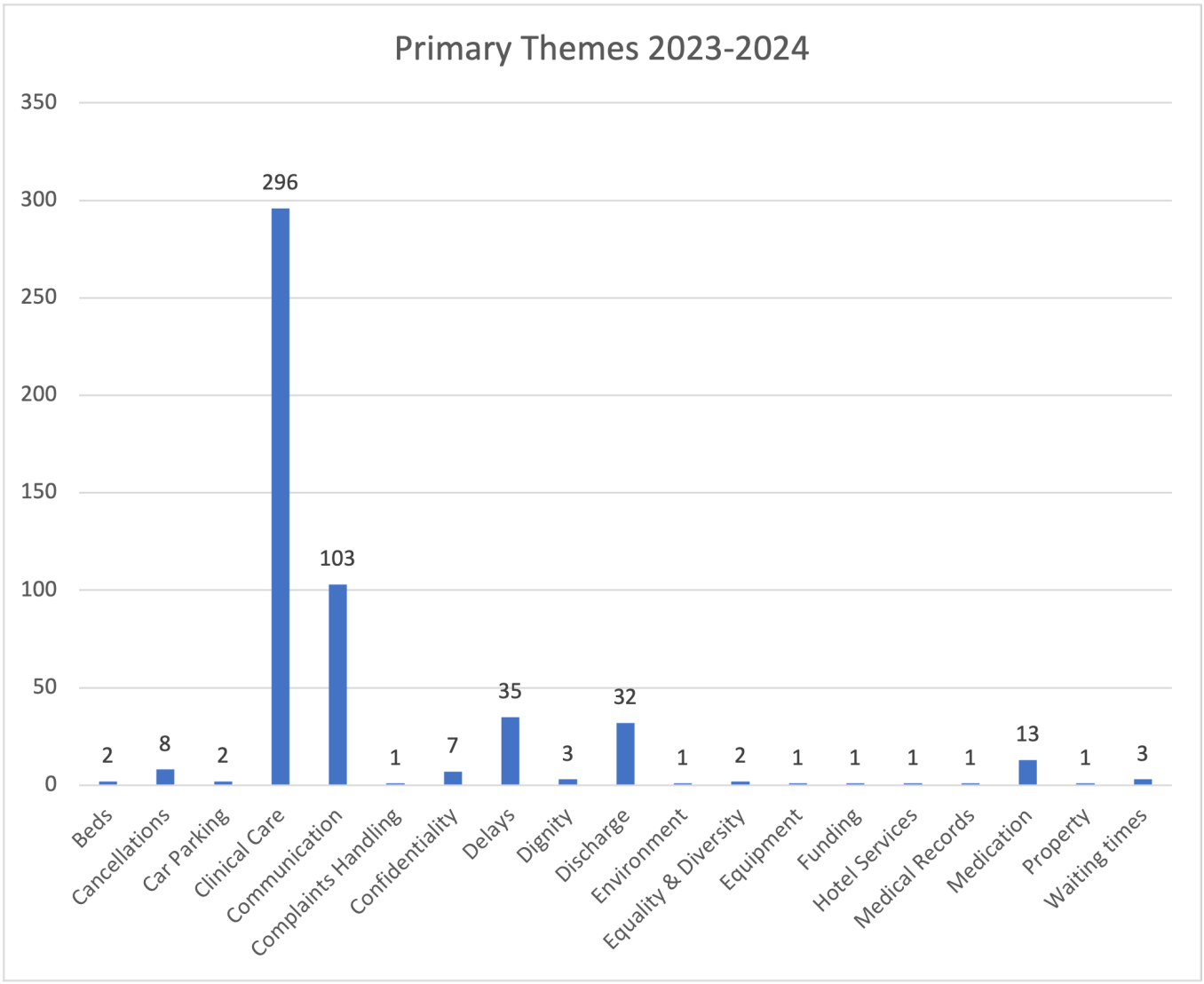


Response rate



Trend Analysis

The following chart provides the themes emerging from complaints:



Response rate

Subject:	Commentary:
Internal processes	Development of a fully electronic complaints handling plan. Review of the timeframes in use. Use of SharePoint for internal monitoring documents. Inclusion of information (on acknowledgement letters) i.e. Mental Health Support details, Veterans Aware, updated Advocacy information.
Triage	All new complaints continue to be 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 processes or safeguarding.
Staffing	The Complaints team have experienced several challenges due to resources and increased activity. Staffing numbers have constantly changed due to long term sickness and maternity leave.
Reporting	Complaints data is incorporated into the following reports: • Monthly scorecard reporting / IGR • Monthly Patient Experience divisional workbooks • Quarterly Complaints & Concerns report (PCEEG)* • Quarterly Group Quality Report – Patient Experience • Annual KO41a report (DOH) • Annual report - Trust • Quality Account *The report has been completely redesigned this year
Virtual Huddle Boards	A virtual huddle board has been introduced within both PALS and Complaints. This provides instant and visible information regarding the status within both services including available resources, workload, location of each complaint, outstanding work, and timeframes.
Digital Letters Process	The Complaints team are currently implementing a digital solution for letters of response which require Executive review and sign off. The aim of this is to make the process more efficient and effective and reduce the length of time between the start and completion of the process.
Learning from Complaints	A new process has been introduced to ensure that the learning from complaints is captured.
Datix	A number of improvements have been made to the Datix system to provide options to capture additional information i.e. assigning specific points to an individual (including the total number of points) and reporting requirements. This remains ongoing at present.

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.

Domain 1 – Preventing people from dying prematurely.

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 22 – Sep 23	85	2	100	120	72
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 Value	NGH Banding	National Average	National High	National Low
Oct 22 – Sep 23	54%	42%	66.0%	15.0%	72
Oct 21 – Sep 22	53.0%	40.0%	65.0%	12.0%	64
Oct 20 – Sep 21	42.0%	39.43%	63.0%	12.0%	71
Oct 19 – Sep 20	40.0%	36.5%	60.0%	8.0%	68
Oct 18 – Sep 19	41.0%	36.0%	59.0%	12.0%	69
Oct 17 – Sep 18	40.8%	31.1%	64.0%	10.7%	69
Oct 16 – Sep 17	41.1%	31.61%	59.8%	11.5%	73
Oct 15 – Sep 16	36.62%	29.74%	56.26%	0.39%	69
Oct 14 – Sep 15	25.9%	26.6%	53.5%	0.19%	65
Oct 13 – Sep 14	26.6%	25.32	49.4%	0.0%	59

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 2022/23	NGH Quality Account 2021/22	Reporting Period 2022/23 Average	Reporting Period 2022/23 High	Reporting Period 2022/23 Low
Hip replacement surgery - primary (EQ-5DTM Index)	N/A (provisional Apr22-Mar23)	0.519 (final Apr20 to Mar21)	0.468 (provisional Apr22-Mar23)	0.530 (provisional Apr22-Mar23)	0.378 (provisional Apr22-Mar23)
Hip replacement surgery - revision (EQ-5DTM Index)	N/A (provisional Apr22-Mar23)	* (final Apr20 to Mar21)	0.430 (provisional Apr22-Mar23)	0.525 (provisional Apr22-Mar23)	N/A (provisional Apr22-Mar23)

	NGH Performance		National Performance		
	Reporting Period 2022/23	NGH Quality Account 2021/22	Reporting Period 2022/23 Average	Reporting Period 2022/23 High	Reporting Period 2022/23 Low
Knee replacement surgery - primary (EQ-5DTM Index)	N/A (provisional Apr22-Mar23)	0.286 (final Apr20 to Mar21)	0.354 (provisional Apr22-Mar23)	0.409 (provisional Apr22-Mar23)	0.233 (provisional Apr22-Mar23)
Knee replacement surgery - revision (EQ-5DTM Index)	N/A (provisional Apr22-Mar23)	* (final Apr20 to Mar21)	0.275 (provisional Apr22-Mar23)	N/A (provisional Apr22-Mar23)	N/A (provisional Apr22-Mar23)

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				
2022/23	12.8	12.8	37.7	3.7
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+				
2022/23	15.0	14.4	46.8	2.5
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 they are reviewing the future presentation of the NHS Outcomes Framework indicators. As part of this review, the annual publication has been delayed.

Period	Indicator Value NGH	Indicator Value National Average	Indicator Value National High	Indicator Value National Low
Patients aged <16				
2021/22	N/A	N/A	N/A	N/A
2020/21	N/A	N/A	N/A	N/A
2019/20 (Hospital stay: 01/07/2019 to 31/07/2019; Survey collected 01/08/2020 to 31/01/2020)	61.7%	67.1%	84.2%	59.5%
2018/19 (Hospital stay: 01/07/2018 to 31/07/2018; Survey collected 01/08/2018 to 31/01/2019)	64.0%	67.2%	85.0%	58.9%
2017/18 (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%

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

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

2023: percentage of staff selecting Agree or Strongly Agree out of those who answered the question (question 25d) - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.

2021 & 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.

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
2023	58.4%	63.3%	88.8%	44.3%
2022	54.6% (Acute and Acute & Community Trusts)	61.2% (Acute and Acute & Community Trusts)	86.4% (Acute and Acute & Community Trusts)	39.2% (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)

Period	NGH	National Average	National High	National Low
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%

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.

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. The data is only published per month and not as a whole year equivalent.

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)

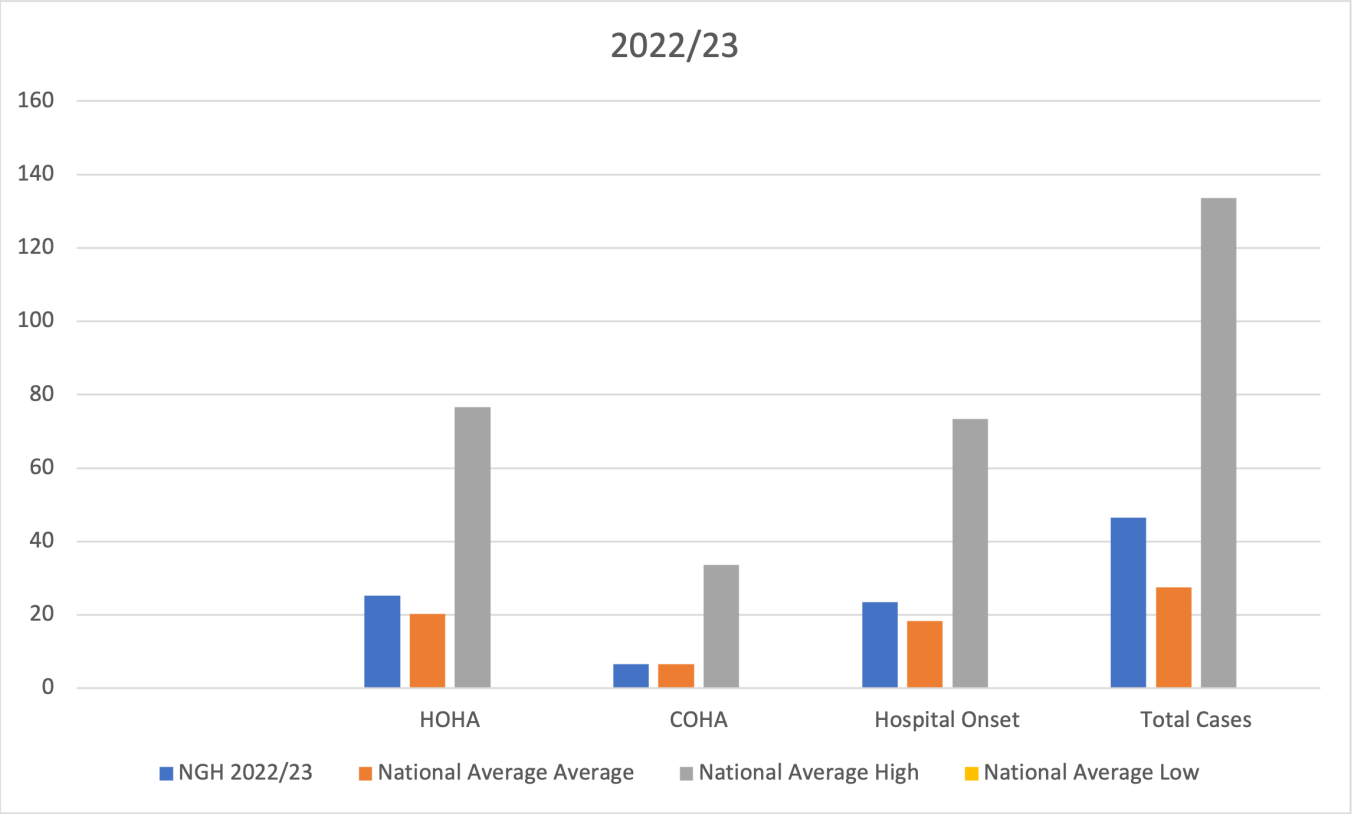
Following requests to restart the VTE data collection, the collection underwent an assurance process which included consultation with data providers. Following the feedback, the VTE data collection will be reinstated from April 2024, with the first submission due in July 2024

Period	NGH	National Average (Acute Trusts)	National High (Acute Trusts)	National Low (Acute Trusts)
Q4 23/24	Data collection/publication suspended due to Covid-19			
Q3 23/24	Data collection/publication suspended due to Covid-19			
Q2 23/24	Data collection/publication suspended due to Covid-19			
Q1 23/24	Data collection/publication suspended due to Covid-19			
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)

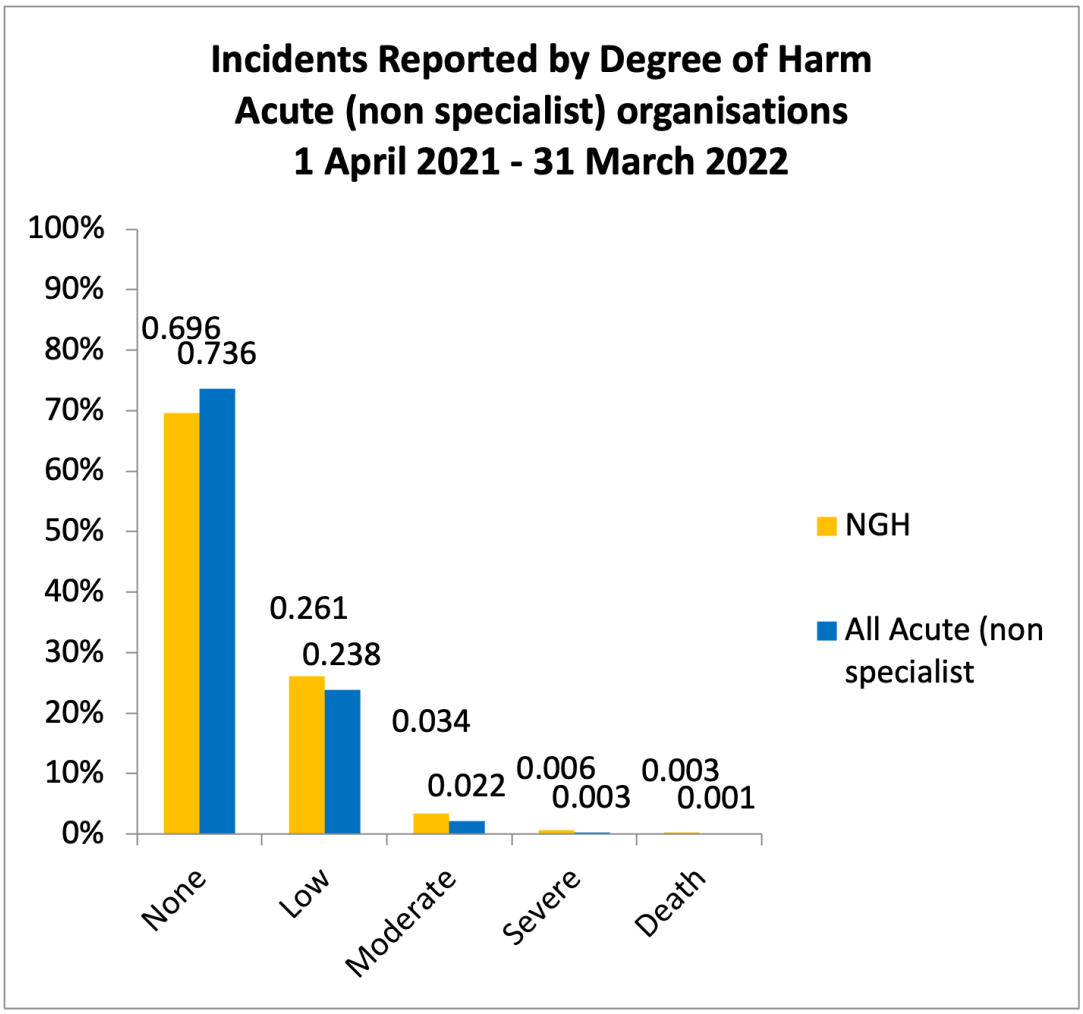
Clostridium Difficile allocation criteria in accordance with: Clostridium Difficile infection objectives for NHS organisations in 2020/21, changes to criteria commenced in April 2019 as below.

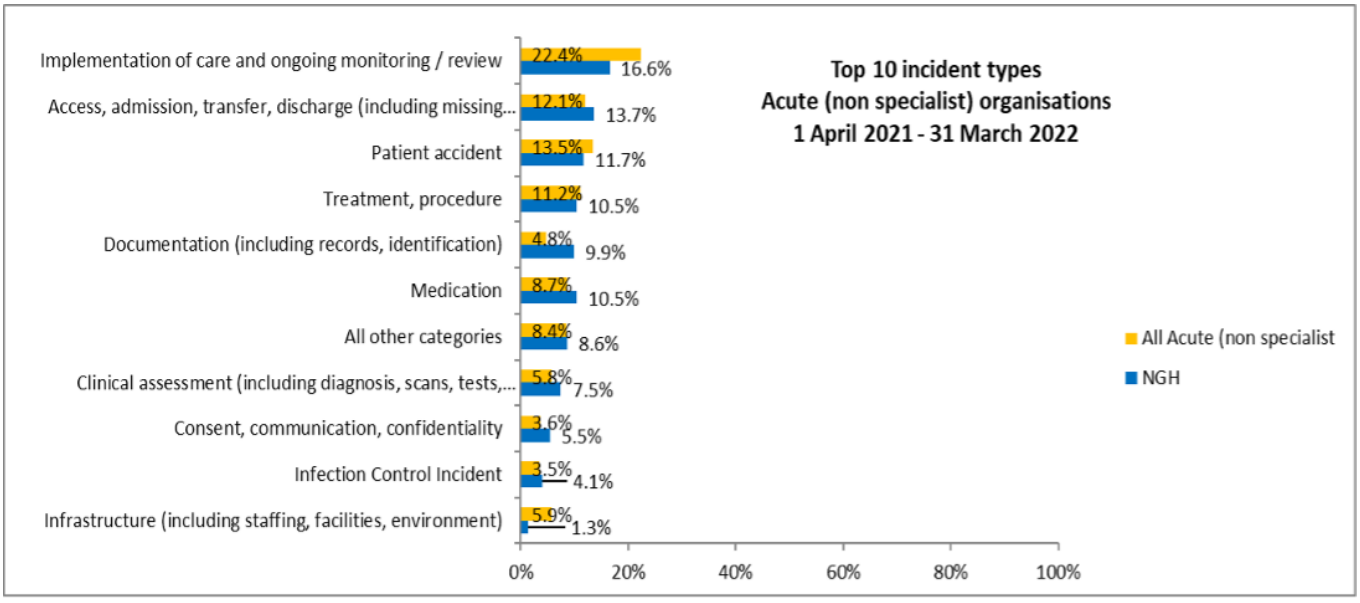
- HOHA: Hospital onset Healthcare associated: cases that are detected in the hospital three or more days after admission.
- COHA: Community onset Healthcare associated: cases that occur in the community when the patient was most recently discharged from the same reporting trust the previous 28 days.
- COIA: Community onset indeterminate association: cases that occur in the community when the patient has been an inpatient in the trust reporting the case between 29 and 84 days prior to the specimen date (not relevant to NGH)
- COCA: Community onset community associated: cases that occur in the community when the patient has not been an inpatient in the trust reporting the case in the previous 84 days (not relevant to NGH)

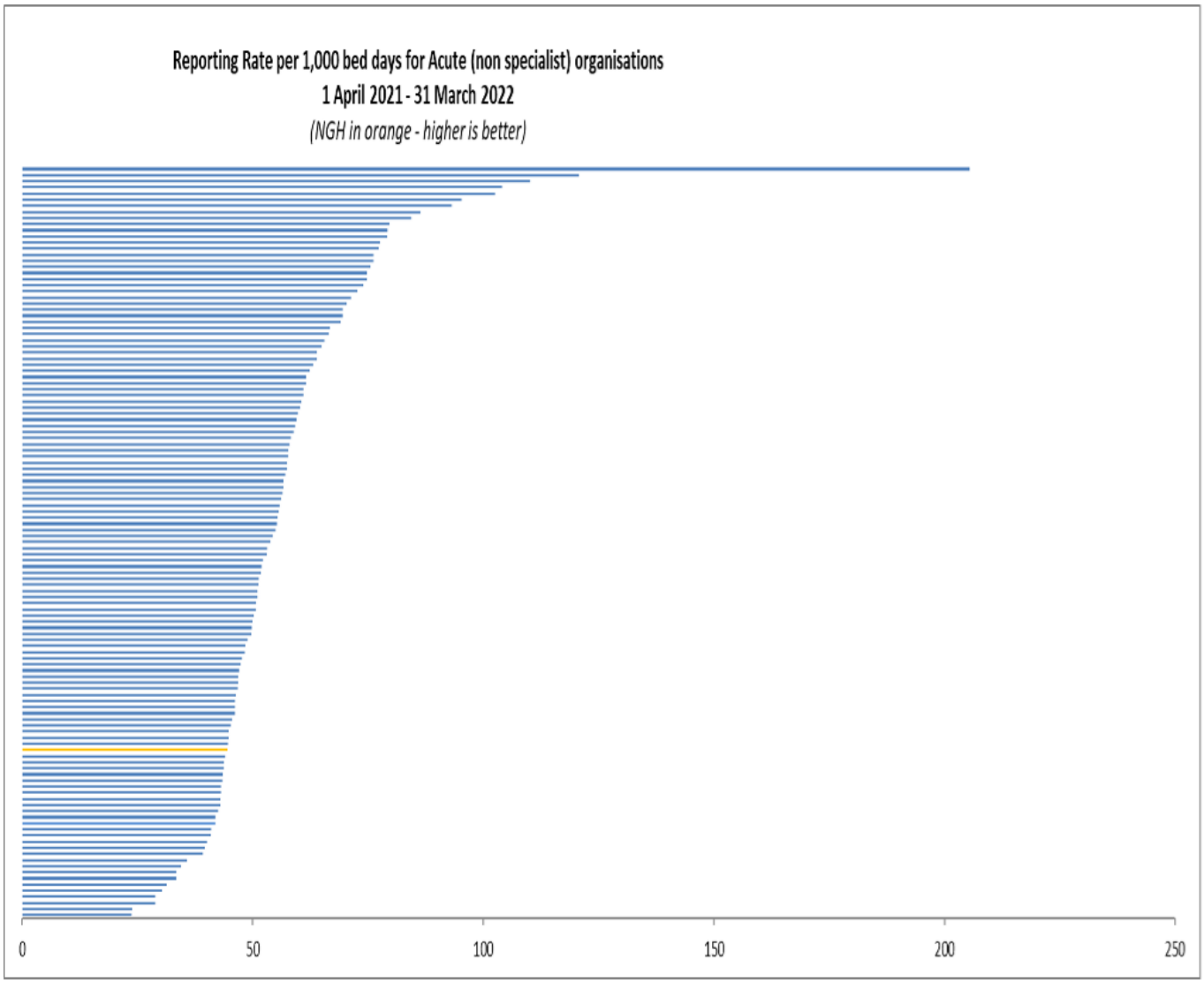


- Patient Safety

Due to the introduction of PSIRF it is now not possible for like for like comparisons of data especially due to the changing requirements of incident reporting systems and the change in terminology and recording requirements. Below is the last report of NRLS data.


Incidents Reported by Degree of Harm
Acute (non specialist) organisations
1 April 2021 - 31 March 2022
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0.696
0.736
0.261
0.238
0.034
0.022
0.006
0.003
0.003
0.001
None
Low
Moderate
Severe
Death
NGH
All Acute (non specialist


Top 10 incident types
Acute (non specialist) organisations
1 April 2021 - 31 March 2022
Implementation of care and ongoing monitoring / review
22.4%
16.6%
Access, admission, transfer, discharge (including missing...
12.1%
13.7%
Patient accident
13.5%
11.7%
Treatment, procedure
11.2%
10.5%
Documentation (including records, identification)
4.8%
9.9%
Medication
8.7%
10.5%
All other categories
8.4%
8.6%
Clinical assessment (including diagnosis, scans, tests,...
5.8%
7.5%
Consent, communication, confidentiality
3.6%
5.5%
Infection Control Incident
3.5%
4.1%
Infrastructure (including staffing, facilities, environment)
5.9%
1.3%
0%
20%
40%
60%
80%
100%
All Acute (non specialist
NGH



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.

Part 3

Review of Quality Performance

Review of Quality Performance

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.

PEOPLE Programme of work	Objective(s)	Baseline	Target / trajectory	Current Position
Developing our people	Development of UHN values based leadership competency framework Development of UHN leadership strategy New UHN appraisal Aligned statutory and mandatory training	N/A Appraisal NGH 73% MAST NGH 82%	No completing leadership development interventions Appraisal 85% (5% improvement in year) MAST 85%	March 2024 136 on current UHN leadership programmes Appraisal - NGH 77% MAST - NGH 89%
Improving health and wellbeing	Aligned offer across both Trusts	NGH 6.1%	By end 2023/24 NGH 5.5% Target 5%	March 2024 KGH 4.84% NGH 4.53%
Dedicated to Excellence – Culture change – inclusion and empowerment	Improved staff experience through an improved culture Improvement in inclusion	0 N/A Engagement NGH 6.2	Target: 50 N/A Engagement NGH 6.3	Excellence ambassadors = NFA Remove from plan Engagement scores for National Staff Survey 2023 NGH 6.8
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	6 people policies harmonised as at Jan 2023	April 2025	12 UHN policies On target to align all policies by April 2025

PEOPLE Programme of work	Objective(s)	Baseline	Target / trajectory	Current Position
Delivering a sustainable workforce	Reducing reliance on agency Improving availability of staff	NGH £27M NGH 9.3% NGH 88 days	NGH £12M Vacancy 8% TTH NGH 70 days	March 2024 NGH £24.94M 7.1% FYE Vacancy NGH 9.07% TTH NGH 92.5 days

PATIENT Programme of work	Objective(s)	Baseline	Target / trajectory	Current Position
Patient feedback digital system	Improve visibility of patient feedback and enable action to improve	N/A – would be provided by the system	N/A – would need defining once system to collect in place	Realisation of digital system being considered
Complaints process & compliance	Align with the new national Ombudsman work and improve processes and ensure learning from themes of complaints	Not in place TBC following approach development NGH 24 (Mean 21/23)	In place TBC following approach development TBC	In the last 12 months (reporting year 2023-2024) the Trust has reported on complaints response times in two ways; including agreed extension of time requests and excluding agreed extension of time requests. There is not a set method of reporting the response rate, it is the choice of each Trust. Here at NGH, we report on both methods to maintain a consistent approach with our colleagues at Kettering General Hospital. From the 1 April 2023 through to the 31 March 2024, when agreed extension of time requests are included our average complaints performance is 89%, which is 1% below the Trust target of 90% or above and when agreed extension of time requests are excluded the response performance is 53% which is 37% below our target of 90% and above.
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	3 (in ENT, Cardiology, Cancer) Varies by specialty	In all collaborating specialties Achievement of experience metrics outlined in individual strategies	Clinical collaboration continues with Head and Neck service snow being provided collaboratively. Other services will follow in due course.

PATIENT Programme of work	Objective(s)	Baseline	Target / trajectory	Current Position
Outpatients	Outpatient communication improvement through the outpatients transformation programme - Digital letters - Improved phone contact	Jan-23: 94% - NGH Oct-22: 78% calls answered and resolved first time	95% 90%	The Trust will be carrying out more work on its transformation plans to drive efficiencies and delivery of excellent patient care, with particular focus on Elective recovery, Outpatient transformation and benefits from working with System partners as part of the Integrated Care Board (ICB).
Improving equality for people of Northamptonshire	Ensure all programmes of work have a focus on improving health inequalities and ensure services are provided in the best place	0	100% major programmes (to be defined)	NGH EDI will continue and we are committed to providing the EDI team and Staff Networks the necessary support to continue the invaluable work they do to build a truly great place to work and receive care. During 2023-24, NGH continued to work to and review our progress against our Equality, Diversity and Inclusion Strategy 2021-2024. We have met each of our statutory reporting duties and an annual Equality report will be produced and published on our website in line with the Public Sector Equality Duties (PSED).

QUALITY Programme of work	Objective(s)	Baseline	Target / trajectory	Current Position
Deteriorating patient	Improve monitoring and responses to deteriorating patients	100% (NGH Q2 22/23) NGH not available across the Trust	30% (CQUIN target-NHSE) >95%	The deteriorating patient task list performance continues to positively support early recognition and review of deteriorating patients. We have consistently met the CQUIN target: Q1 – 67% Q2 – 48% Q3 – 70% Q4 – 60%
Medicines management / digital patient records	Implementation and rollout of EPMA system	NGH-no EPMA or EPR	All UHN wards-EPMA and EPR	Under negotiation, it is within the Digital team's workplan relating to EPR.

QUALITY Programme of work	Objective(s)	Baseline	Target / trajectory	Current Position
Cardiology centre of excellence	Delivery of the Cardiology centre of excellence	NSTEMI: NGH 50%,	90% across group	With the creation of our Cardiology Centre of Excellence our aim is that this integrated service will be known nationally for exemplary outcomes, excellent patient and staff experience, and complexity of caseload. It will provide safe, effective cardiology care for everyone in Northamptonshire across both of our hospital sites. Our completion date for this work is three years away.
GIRFT	GIRFT programmes	Nov-22 71% - NGH ENT – 2.7 GenSurg – 2.0 Uro – 2.7 Gynae – 3.3 Ophth – 4.3 T&O – 2.6	85% Targets need developing based on case mix	We have received positive feedback from the regional GIRFT team on the development of our GIRFT delivery plan.
A&A	Increase areas who have A&A accreditation	Current number at each level	Improved number of wards at top 2 levels of accreditation by 10%	All inpatient adult and inpatient wards have been assessed using the Assessment & Accreditation tools, but Critical Care has not been formally assessed.
Implementation of Patient safety strategy	To deliver the national patient safety strategy	As per PSIRF baseline- in line with implementation process	Full roll out in line with national timelines	PSIRF implmented February 2024

SYSTEMS & PARTNERSHIPS Programme of work	Objective(s)	Baseline	Target / trajectory	Current Position
Community Diagnostic Centres	Providing diagnostic capacity in community settings, increased access for outpatient referrals and cancer pathways.	Activity plan	85% (DM01) CDC KPIs	KGH and NGH have jointly secured national funding and drawn up plans for three new Community Diagnostic Centres (CDCs) for the county, to improve access to vital imaging, pathology, endoscopy and other diagnostic and physiological measurement tests. Opening in 2024/25, the CDCs will be located at Corby and Kings Health in Northampton, and provide much-needed capacity to support the diagnosis and treatment of many conditions including cancer and heart disease amongst other diseases. The CDC locations were chosen considering densely populated areas of the county, where there is a high index of multiple deprivation bringing improvements to the health of our population. A third CDC is planned for early 2025 which will include Endoscopy services and will provide capacity for future imaging demand across the county. The exact location is yet to be finalised and will be in the west of the County. In the meantime, both KGH and NGH are delivering activity for MRI, CT, Non-Obstetric ultrasound, echocardiograms, phlebotomy and plain film Xray through temporary solutions which have contributed to Trusts achieving the national target for 2023/24 to see 85% of patients within 6 weeks.
Outpatients' transformation	Transforming our outpatient services, optimising our clinical pathways, streamlining our admin and improving communication with our patients	Activity plan NGH: 2.33 None aligned	Activity plan NGH: 2.10 10 specialties aligned	104.3% of plan NGH: 2.06 2 specialties aligned
Theatre productivity	Delivery of the theatre productivity programme	Activity plan NGH: 2.33 None aligned	Activity plan NGH: 2.10 10 specialties aligned	Mar-24: 93% - NGH 99.3% of plan

SYSTEMS & PARTNERSHIPS Programme of work	Objective(s)	Baseline	Target / trajectory	Current Position
Cancer centre of excellence- Clinical Collaboration	Delivery of the cancer centre of excellence	62 days Jan 23 NGH 49% FDS Jan 23 NGH 79%	62 days-85% FDS 75%	The standard set was for Trusts to reach 70% by March 2024. This will not be achieved and is likely to be the target again for 24/25. We continue to overachieve against the 28-day faster diagnosis stand-ard and for the last published data in December in the East Midlands NGH was: • 28 Day Faster Diagnosis **1st** • 62 Day Performance **3rd** • 31 Day Performance **2nd** NGH are again part of the Galleri trial this year which is a simple blood test that can detect more than 50 cancers which could po-tentially revolutionise cancer care through early detection and diag-nosis.
Virtual wards	Delivery of the Northamptonshire virtual ward programme	240	356	Supports P2, SP2 & 3 (improves patient flow and occupancy through avoidable admissions and early discharge), S2 88.8% occupancy achieved (Feb 24) 356 beds by end of March 2024 (on track)
Urgent and emergency care	Delivery 76% ED Quality Standard	NGH – 60% NGH – 100%	76% 92%	Improvements to internal processes and collaborative working within the local health system contributed to the length of stay for patients awaiting community and social care, reducing by 12 days, comprising two days from internal processes and ensuring our patients were declared medically fit earlier in pathways, and 10 days from the system working. This was achieved through the early agreement of comprehensive packages to support pathways at the start of the year.

SUSTAINABILITY Programme of work	Objective(s)	Baseline	Target / trajectory	Current Position
Sustainability Group	Create a Group approach to Sustainability	Green Plans actions National carbon reporting	Green Plans actions National carbon reporting targets	The installation of an air source heat pump, solar panels and a new heating network has been com-pleted - commissioning to be completed by September 2024. Carbon emissions from inhaled an-aesthetic gases reduced with the full removal of desflurane. Nitrous oxide emissions from thea-tres have decreased. Clinical waste segregation is im-proving, with overall levels of clini-cal waste reduced by 10%. Recycling has increased by 15%. The Trust has delivered, in partner-ship with Vital Energi, year 2 of the government funded PSDS scheme. Green Team Competition resulted in projected savings of £250,000. AD of IPC awarded Green Nurse of the Year by the Royal College of Nursing. IPC team were Highly Commended in the HSJ Awards. A Carbon Management Plan (CMP) was undertaken and completed in March 2024.
Green plans	Delivery of each Trust's Green plan recommendations Improved oversight of system Green plan	Green Plans actions National carbon reporting	Green Plans actions National carbon reporting targets	
Decarbonisation	Development of a decarbonisation plan for each site Delivery of Public Sector Decarbonisation Scheme at NGH	National carbon reporting Programme delivery of energy schemes to SDC	National carbon reporting targets Programme delivery of energy schemes to SDC	
Use of resources	Internal improvement in productivity Delivery of annual plan Benchmarking product. / efficiency – model hospital & post covid analytics	Annual plan 19/20: NGH: £3,337	Annual plan Target TBD	Focus on delivering Efficiencies and Workforce control
Efficiencies programmes	To support a robust programme of deliverable efficiencies schemes	N/A	4%	Current focus on delivering efficiences and workforce control
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	N/A	To be agreed	Clinical collaboration continues with Head and Neck services now being provided collaboratively. Other services will follow in due course.

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Healthwatch North and West Northamptonshire's Response to the NGH Quality Account for 2023-2024

Healthwatch appreciates the opportunity to respond to the NGH Quality Report 2023-2024. We enjoyed reading about the positive impact your services have had on the communities of Northamptonshire and surrounding districts.

We are pleased to see the switch to a new Electronic Patient Record (EPR) system. This innovation will make patient information easily accessible in one place and significantly reduce the hospital's paper use.

The NGH Staff survey results were insightful. It was encouraging to note improvements in staff satisfaction and teamwork towards achieving objectives. However, we are concerned about the 7% increase in staff experiencing discrimination based on their ethnic background, now totalling 60%. This issue suggests that NGH can do more to address ethnic and cultural barriers and provide training on Equality, Diversity, and Inclusion (EDI). Nonetheless, we congratulate NGH on their Gold Award for the NGH TIDE submission, indicating progress in EDI efforts.

We are also pleased with the aim to reduce reliance on agency staff and improve the availability of NGH staff, as this will contribute to a sustainable workforce. Consistent staffing ensures a sense of continuity of care, which is highly valued by service users.

Improving the visibility of patient feedback is another commendable priority. This initiative will encourage patients to share their experiences, knowing their voices are heard and valued.

The focus on enhancing the complaints process to align with new national standards and processes used across UHN is appreciated. However, a clear baseline and timeline would be helpful to understand the improvement plan better.

The proposed delivery of a Cardiology Centre of Excellence is promising. It will likely improve outcomes for cardiology patients and increase the number of day cases.

We noted the CQC rating for NGH requires improvement, particularly within Maternity services. Healthwatch conducted a visit to Maternity services last year and made recommendations for improvement. We would like to inquire about the timescale for these necessary improvements.

While we commend the Data Security and Protection Team's focus on GDPR compliance, it is concerning to read about the five serious data breaches this past year, compared to one the previous year. It is reassuring that the Trust will continue to develop tools to maintain GDPR compliance.

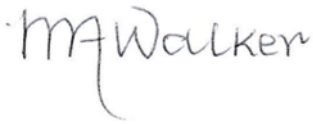
The development of new Community Diagnostic Centres (CDCs) within the county is encouraging. These new sites will improve access to vital imaging, pathology, endoscopy, and other diagnostic tests. Locating these centres in high-deprivation areas should positively impact the health of our local population. It is great to see NGH involved in these initiatives. Meanwhile, NGH's efforts to deliver diagnostic services and achieve the national target of seeing 85% of patients within six weeks are commendable.

The creation of OurSpace, providing staff with a quiet area and access to health and wellbeing services, is a positive step towards ensuring staff feel valued and supported.

During our visit to the Ophthalmology department at NGH in February 2024, we provided recommendations for improvement and highlighted positive aspects. We appreciate NGH's proactive response to our recommendations and look forward to reviewing the changes made later this year.

Overall, we found this Quality Account to be thorough, transparent, detailed, and well-presented.

Yours Sincerely,



Morcea Walker MBE, DL
Chair

On behalf of Healthwatch North and West Northamptonshire

West Northamptonshire Council

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The draft Quality Account was circulated to members of the West Northamptonshire Council Adult Social Care and Health Overview and Scrutiny Committee (the statutory health scrutiny committee) ahead of a Committee meeting on 24 June 2024. Committee members were given the opportunity at that meeting to raise any points that they thought the Committee should make as feedback on the draft Quality Account. However, the Committee did not identify any comments that it wished to make.

APPENDIX 2 Abbreviations

	4Cs	Compliments, Comments, Complaints, Concerns
A	A&A	Assessment and Accreditation
	A&E	Accident and Emergency
C	CDC	Community Diagnostic Centre
	C.Diff	Clostridium Difficile
	CQC	Care Quality Commission
	CQUIN	Commissioning for Quality and Innovation
D	DSP	Data Security and Protection
E	ED	Emergency Department
	EDI	Equality, Diversity and Inclusion
	ePMA	electronic prescribing medicines administration
	EPR	Electronic Patient Record
F	FFT	Friends and Family Test
I	ICB	Integrated Care Board
	IGR	Integrated Governance Report
	IRG	Incident Review Group
K	KPI	Key Performance Indicators
	KGH	Kettering General Hospital NHS Foundation Trust
M	MCCD	Medical Certificate of the Cause of Death
	ME	Medical Examiner
	M&M	Mortality and Morbidity
N	NDG	National Data Guardian

	NEWS	National Early warning Score
	NGH	Northampton General Hospital NHS Trust
	NHS	National Health Service
	NICE	The National Institute for Health and Care Excellence
	NIHR	National Institute for Health Research
P	PALS	Patient Advice and Liaison Service
	PMO	Programme Management Office
	PSII	Patient Safety Incident Investigation
	PSIRF	Patient Safety Incident Response Framework
R	RCN	Royal College of Nursing
S	SDC	Sector Decarbonisation Scheme
	SHMI	Summary Hospital-level Mortality Indicator
	SI	Serious Incident
	SJR	Structured Judgement Review
U	UHL	University Hospitals of Leicester
	UHN	University Hospitals of Northamptonshire NHS Group
	UK	United Kingdom
V	VTE	Venous Thromboembolism
W	WTE	Whole Time Equivalent

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