AGENDA FOR

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR PENNINE ACUTE NHS TRUST

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To: All Members of Joint Health Overview and Scrutiny Committee for Pennine Acute NHS Trust

Councillors : Councillor Norman Briggs, Councillor Joan Davies, Councillor Mark Hackett, Councillor Derek Heffernan, Councillor S Kerrison, Councillor Colin McClaren, Councillor Kathleen Nickson, Councillor Linda Robinson, Councillor S Smith, Councillor Ann Stott and Councillor R Walker

Dear Member/Colleague

Joint Health Overview and Scrutiny Committee for Pennine Acute NHS Trust

You are invited to attend a meeting of the Joint Health Overview and Scrutiny Committee for Pennine Acute NHS Trust which will be held as follows:-

Date:	Tuesday, 30 June 2015
Place:	Peel Room - Elizabethan Suite - Town Hall
Time:	2.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	

AGENDA

1 APPOINTMENT OF CHAIR

2 APPOINTMENT OF VICE CHAIR

3 APOLOGIES FOR ABSENCE

4 DECLARATIONS OF INTEREST

Members of the Joint Committee are asked to consider whether they have an interest in any of the matters on the agenda and, if so, to formally declare that interest.

5 PUBLIC QUESTIONS

Members of the public present at the meeting are invited to ask questions on any matter relating to the work or performance of Pennine Acute NHS Trust. A period of up to 30 minutes is set aside for public questions.

6 MINUTES *(Pages 1 - 6)*

Members of the Joint Health Overview and Scrutiny Committee are asked to approve as a correct record the minutes of the meeting held on 24th March 2015.

7 MATTERS ARISING

Members of the Joint Health Overview and Scrutiny Committee are asked to identify or report on any issues from the minutes of the last meeting, which require further discussion or action, that have not been listed on the agenda.

8 POLITICAL BALANCE REPORT

Members are asked to consider the political make-up of the Joint Committee and whether the necessity for political balance ought to be waived. (Report is attached).

9 DELAYED DISCHARGE *(Pages 7 - 16)*

Representatives from Pennine Acute will report at the meeting. Report attached.

10 SERVICE TRANSFORMATION UPDATE

A verbal update will be given at the meeting.

11 MATERNITY SERVICES UPDATE *(Pages 17 - 20)*

A representative from Pennine Acute will report at the meeting. Report attached.

12 RESPONSE TO THE ELECTIVE ACCESS REPORT *(Pages 21 - 24)*

A response to the Joint Health Overview and Scrutiny Committee report on Elective Access is attached.

13 URGENT BUSINESS

Any other business which by reason of special circumstances the Chair agrees may be considered as a matter of urgency.

14 DATE OF THE NEXT MEETING

The next meeting will be held on Tuesday 6th October 2015 – Manchester Town Hall

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Agenda Item 6

Meeting of: Joint Health Overview and Scrutiny Committee for Pennine Acute Hospitals NHS Trust

Date: 24 March 2015

Present:

Councillor Roy Walker (Bury Council)
Councillor Peter Bury (Bury Council)
Councillor Stella Smith (Bury Council)
Councillor Colin McLaren (Oldham Council)
Councillor Janet Darnbrough (Rochdale MBC)
Councillor Joan Davies (Manchester City Council)

Mr Gavin Barclay: Assistant Chief Executive, Pennine Acute Hospitals NHS Trust
Ms Elizabeth Heeles: Senior Planning Manager, Pennine Acute Hospitals NHS Trust
Mrs Nadine Armitage: Head of Partnerships, Pennine Acute Hospitals NHS Trust
Mr Stuart North: Chief Officer, Bury CCG
Mrs Alice Rea: Joint Health Overview and Scrutiny Officer

PAT0315-1 **APOLOGIES**

Councillor Norman Briggs (Oldham Council)
Councillor Diane Williamson (Oldham Council)

PAT0315-2 **DECLARATIONS OF INTERST**

No declarations of interest were made.

PAT0315-3 **PUBLIC QUESTIONS**

There were no public questions.

PAT0315-4 **MINUTES OF THE LAST MEETINGS**

Members of the Committee were asked to approve as a correct record, the minutes of the meeting held on 27 January 2015.

RESOLVED:

That the minutes of the meeting of the Joint Health Overview and Scrutiny Committee for Pennine Acute Hospitals NHS Trust held on 27 January 2015 be approved as a correct record.

PAT0115-5 **MATTERS ARISING**

PAT0115-7: Additional information on the number of repeat cancellations of elective operations was not recorded by the Trust and the number of elective operations cancelled prior to the day was provided for Members. It was agreed that this information would be included in the review report with a request for the Trust to monitor the cancellations made prior to the date as well as those cancelled on the date.

PAT0115-9: Information about the Trust's future reconfiguration proposals would be provided at the first meeting in the next municipal year (Tues 30 June).

PAT0115-5: Further reminders had been sent to local authorities asking for information about procedures for dealing with conflicts of interest and CCG Commissioning. Responses to date were tabled.

PAT1115-10: Responses, to date, about problems with cancellations of GP appointments were tabled.

PAT0315-6 **ANNOUNCEMENTS/UPDATES**

The JHOSC had received information about senior staffing changes within the Trust. A Member asked if this was a normal turnover rate or a result of changes being made by the new Chief Executive. The Assistant Chief Executive said that it was a mixture of changes to the structure within the Trust and the retirement of the Director of Human Resources and the Medical Director alongside the relocation of the Chief Nurse to a post nearer her home. It was agreed that the implementation of the new senior staffing structure would be monitored by the JHOSC in six months time.

The JHOSC has received and noted the CCGs' response to the review report of End of Life Care within the Trust. It was agreed that the implementation of the recommendations would be monitored in one year's time.

The Trust confirmed that the draft Quality Account would not be available until after 26 March, when it would go to the Trust Board. The draft would be sent to the JHOSC for its commentary soon after it had been approved by the Trust Board and there would be 30 days for the commentary to be submitted.

RESOLVED:

1) That the implementation of the new senior staffing structure would be monitored by the JHOSC in six months time.

2) That the implementation of the recommendations of the JHOSC's End of Life Care review would be monitored in one year's time.

PAT0115-7 **ELECTIVE ACCESS**

The JHOSC had received a draft review report for approval. The report was agreed with the inclusion of amendments suggested by the Trust, the strengthening of the recommendation for the CCGs about timely discharge of patients and the inclusion of any relevant information about timely discharge of patients from the CCG.

RESOLVED:

That the draft review report on Elective Access be approved with the amendments and additions minuted.

PAT0315-8 **TIMELEY DISCHARGE OF PATIENTS FROM HOSPITAL**

The JHOSC had requested information about the actions being taken by the CCGs to ensure the timely discharge of patients from hospital and reduce 'bed blocking'.

The Chief Officer, Bury CCG reiterated the information he had given at the last meeting about the reasons why patients were not discharged from hospital when medically ready, resulting in 'bed blocking'.

He said that on any given day there were between 100 and 120 patients fit for discharge in Trust hospital beds. He provided some information about Fairfield General Hospital, citing problems with discharging patients to East Lancs as the major reason for delays in discharge. He did not provide any information about the other Trust hospitals.

He felt the situation would be eased if local social work teams could undertake the work required for discharge on behalf of the patient's home social work team, but there would be a need for proper agreements to be in place for this to happen. He then gave some anecdotal examples of problems with patients' physical environment causing delay in discharge. He felt that the Greater Manchester Devolution might give opportunities to address these issues but that a lot of work had been done through the social care re-ablement funding. Winter pressures had not helped the situation and he felt the ineffective flu vaccine had exacerbated the situation this winter.

He reported that the situation was better with discharges from North Manchester General, where acute services and community services were provided by the same organization and appeared better integrated.

A Member asked if there were other options of accommodation whilst patients waited for adaptations to their home physical environment. She was advised that there were some facilities but that numbers were not sufficient for the winter months. Another Member asked if care packages were cancelled when people were in hospital, as she had heard that there could be delays in reinstating care packages. She was advised that transition to a different level of care could cause delays but that the Chief Officer did not know if care packages were cancelled on hospitalization. He added that he thought the re-ablement target of six weeks might need to made more intensive initially to try to speed the process up and that procedures needed to be worked out to move patients to a temporary setting whilst awaiting a particular placement.

A Member said that this was a key issue that had to be addressed by the CCGs. The cost grounds alone made it imperative that patients could be discharged but provision of both urgent and elective care by hospitals was being compromised and it was not good for patients or their families for them to remain in hospital any longer than was necessary. She accepted the reasons given were complex and valid but felt urgent action was needed now to tackle the issue. She remained particularly concerned about care packages, whether they were cancelled and whether the providers were able to recruit enough staff given the low wages and poor conditions of employment that many care workers experienced.

Another Member felt that it was important to look at the wider issue for the Trust but also at the local issue for the residents of each local area to establish where action was needed and what action was needed.

A Member added that actions that could be taken quickly should be implemented to at least reduce the problem. He asked if the model that seemed to be working well for North Manchester General Hospital could be replicated in other areas. The Chief Officer, Bury CCG advised the JHOSC that there would be a report in the summer assessing what has worked well and what has not worked across the area.

The JHOSC requested statistics about what was happening and where for the next meeting in June (numbers of delayed discharge at each Trust hospital, patient's home area and reasons for delay).

RESOLVED:

That the CCGs provide statistics about what was happening and where, on delayed discharge, for the next meeting in June (numbers of delayed discharge at each Trust hospital, patient's home area and reasons for delay).

PAT0315-9 **PARTNERSHIPS**

The JHOSC received information from the Head of Partnerships, Pennine Acute Hospitals NHS Trust about the work she is doing on Stakeholder Mapping and how the JHOSC could contribute to this work.

The newly appointed Head of Partnerships at Pennine Acute Hospitals NHS Trust, Nadine Armitage, introduced herself and her role to the JHOSC. She explained that it was a new post aiming to build on and strengthen existing relationships between the Trust and its stakeholders. She was working to identify the key stakeholders across the Trust footprint and recognised that scrutiny, both at joint and at local level was one of the Trust's key stakeholders. She would also be working with the CCGs, Health and Wellbeing boards and Healthwatch.

The Chairman asked about the mapping of stakeholders and was informed that this would involve identification of stakeholders and then mapping how they are involved in decision making, recognising that local authorities have multiple functions, including the health scrutiny function.

Members felt it was important to look at stakeholders outside the footprint, both patients from outside the area and services offered outside the area, and that the CCGs were major stakeholders.

The Chairman proposed a meeting between himself, the JHOS Officer, the Head of Partnerships and the Assistant Chief Executive to look at ways of taking this partnership forward and including it in the JHOSC's workplan.

RESOLVED:

That the Chairman, the JHOS Officer, the Head of Partnerships and the Assistant Chief Executive would meet to look at ways of taking this partnership forward and including it in the JHOSC's workplan.

PAT0315-10 **WORKPLAN 2015/16**

Members had received proposals for the workplan for the next municipal year for consideration. The Chairman said that he had met with the JHOS Officers to discuss the proposals for a workplan and hoped that the proposals identified important areas but allowed scope for items that arose during the year.

A Member commented that transport would remain an important area for the JHOSC and it was agreed that the workplan be accepted, with the inclusion of items raised at this meeting.

RESOLVED:

That the proposed workplan be agreed with the inclusion of items raised during the meeting.

PAT015-11 **URGENT BUSINESS**

There were no items of urgent business

PAT0315-12 **DATE OF THE NEXT MEETING**

The next meeting will be held on Tuesday 30 June 2015 at 2.00pm, in Bury.

Further meetings will be held on:
Tuesday 6 October 2015 in Manchester
Tuesday 5 January 2016 in Oldham
Tuesday 22 March 2016 in Rochdale

Agenda Item 9

The Pennine Acute Hospitals NHS
NHS Trust

Title of Report	Report on Delayed Discharges at the Pennine Acute Hospitals NHS Trust
Executive Summary	The paper outlines the operational challenge of managing delayed discharges. The paper describes the current processes to manage delayed discharges, the reasons for delays and the current actions that are being taken to address the issues. A new discharge planning group with multi agency support has been formed to improve discharge planning and minimise delays.
Actions Requested:	The Committee are asked to note the report and support the on-going actions identified in the paper.

Name	Joanne Moore	
Job Title	Divisional Director Medicine	
Month and Year	9th June 2015	

For queries contact: Nadine Armitage
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The Pennine Acute Hospitals NHS Trust

The Pennine Acute NHS Trust

Report on Delayed Discharges for Bury and Joint Health Overview & Scrutiny Committees

Introduction

This paper has been produced at the request of the Joint Health Overview & Scrutiny Committee and outlines the operational challenges in managing patient delayed discharges across the Pennine Acute Hospitals Trust footprint. Processes are in place to monitor delays daily in conjunction with key partners. However, there continues to be a number of challenges and opportunities for further reducing the numbers of delays to ensure patients return home, or to other services, at the earliest opportunity to liberate acute beds.

1. Definitions

There are two types of delayed discharge which are monitored and managed closely across the health economies on a daily basis. The first group are the Delayed Transfers of Care (DTOC) which are externally Sitrep reportable to bodies including Trust Development Agency (TDA) and Monitor. The data also contributes to the Better Care Fund (BCF) and AQUA dataset. These are agreed each day by a multi-disciplinary team including acute, community and LA colleagues and there are financial penalties applicable to the Local Authorities. The official definition of a Delayed Transfer of Care is:

a) A clinical decision has been made that patient is ready for transfer AND
b) A multi-disciplinary team decision has been made that patient is ready for transfer AND
c) The patient is safe to discharge/transfer.

This group are defined as:

- Awaiting completion of assessment
- Awaiting public funding
- Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)
- Awaiting residential home placement or availability
- Awaiting nursing home placement or availability
- Awaiting care package in own home
- Awaiting community equipment and adaptations
- Patient or Family choice
- Disputes
- Housing – patients not covered by NHS and Community Care Act

Table 1 below shows the number of reportable delays by site and for the Trust for 2014/15 as compared to other LA's and Greater Manchester Trusts.

Table 1: Sitrep delays 2014/15

Delayed Days Patient Snapshot by Local Authority

	2014/2015											
Local Authority	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Blackburn With Darwen UA	4	19	24	12	11	16	9	13	36	28	11	11
Blackpool UA	12	15	9	8	15	14	18	22	11	18	17	17
Bolton	31	10	16	22	15	11	8	7	8	12	23	14
Bury	14	11	24	15	12	25	18	7	5	7	9	12
Cheshire East	31	21	35	39	35	41	38	39	33	36	41	36
Cheshire West And Chester	18	29	21	21	16	25	20	39	21	20	21	21
Cumbria	38	45	50	47	35	44	48	38	34	41	52	39
Halton UA	14	6	9	4	6	2	5	7	9	11	8	10
Knowsley	3	5	6	12	3	4	10	4	3	7	1	7
Lancashire	81	120	118	98	134	133	140	90	117	135	105	107
Liverpool	39	45	37	32	31	27	31	45	33	34	32	35
Manchester	32	43	35	30	54	54	37	42	41	37	44	48
Oldham	9	6	4	7	7	5	7	11	9	11	5	8
Rochdale	16	8	18	18	10	16	17	13	12	13	13	14
Salford	9	19	20	14	2	6	20	16	23	21	13	10
Sefton	23	18	9	21	12	17	16	11	11	10	14	16
St Helens	4	3	6	5	6	4	0	2	6	9	8	4
Stockport	10	13	9	10	14	22	14	14	16	27	21	11
Tameside	8	5	4	2	5	11	8	8	9	32	31	45
Trafford	15	42	29	34	40	48	30	26	51	39	42	41
Warrington UA	20	27	10	21	22	28	22	9	13	16	30	24
Wigan	28	34	29	20	21	28	17	21	14	14	17	15
Wirral	9	9	4	8	4	8	6	5	8	8	6	8
Regional Neighbours	**468**	**553**	**526**	**500**	**510**	**589**	**539**	**489**	**523**	**586**	**564**	**553**

Delayed Days Patient Snapshot by Trust

	2014/2015											
Trust	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Bolton NHS Foundation Trust	24	6	13	18	10	8	2	6	6	10	21	11
Bridgewater Community Healthcare NHS Trust	2	0	1	0	1	3	0	0	0	0	1	1
Central Manchester University Hospitals NHS Foundation Trust	6	10	9	11	28	33	10	29	29	21	31	38
Greater Manchester West Mental Health NHS Foundation Trust	7	3	3	4	2	1	1	5	4	2	5	3
Manchester Mental Health And Social Care Trust	13	10	7	6	10	9	1	14	12	8	7	9
Pennine Acute Hospitals NHS Trust	33	27	44	38	34	45	9	24	16	21	17	27
Pennine Care NHS Foundation Trust	15	8	8	9	9	16	2	14	18	12	27	24
Salford Royal NHS Foundation Trust	12	27	22	22	12	12	0	18	27	35	25	21
Stockport NHS Foundation Trust	10	14	10	6	14	19	0	12	11	20	19	13
Tameside Hospital NHS Foundation Trust	3	2	2	0	2	0	3	3	3	27	14	27
The Christie NHS Foundation Trust	0	0	0	0	1	0	0	0	0	0	1	1
University Hospital Of South Manchester NHS Foundation Trust	21	50	40	34	41	55	16	19	48	43	40	30
Wrightington, Wigan And Leigh NHS Foundation Trust	24	32	22	16	11	20	0	16	6	6	2	0
Greater Manchester Area Team	**170**	**189**	**181**	**164**	**175**	**221**	**44**	**160**	**180**	**205**	**210**	**205**

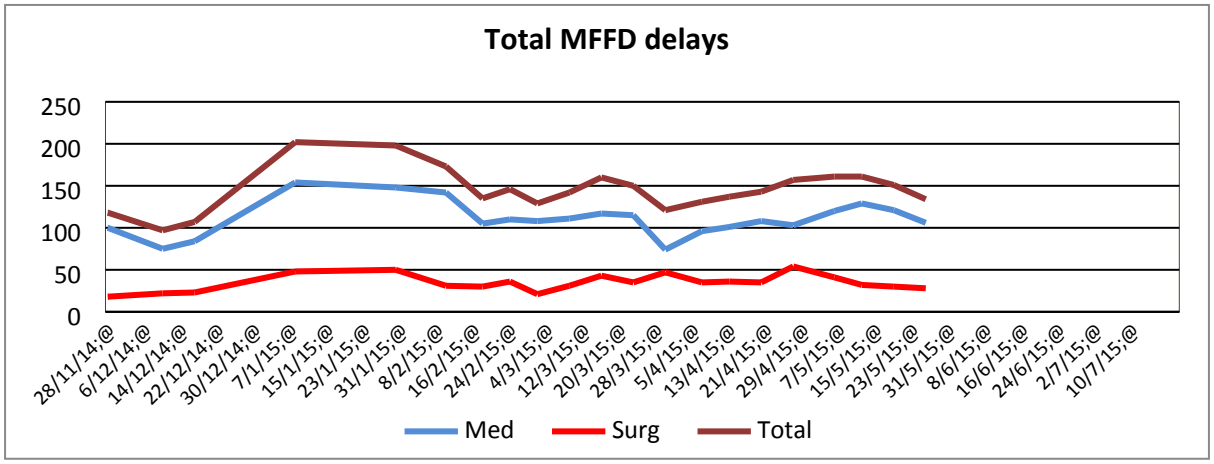
The second group of delays are those defined as Medically Fit For Discharge (MFFD) which is a much larger group than those which are externally reportable. The Trust Development Authority's (TDA) definition for medically fit patients is:

A patient that is medically fit for discharge is where a clinical decision has been made that the patient is ready to transfer. This is from a medical perspective only (usually the consultant or team that the patient is under). The patient therefore has not had a MDT decision at this point, and the patient may require further therapy or social care input prior to an MDT agreement and therefore not a reportable Delayed Transfer of Care delay. (TDA, 2015)

The Trust monitors the MFFD data on a daily basis and it is shared with partner organisations and commissioners 3 times per week. On average, across all hospital sites including Rochdale Infirmary, there are between 120 and 150 MFFD patients in the hospital at any time representing around 20% of the bed stock. Within this figure, approximately 80% are medical patients and 20% surgical patients. The medical patient delays are generally the most complex to resolve as are frail elderly patients with complex morbidities and care needs. It should be noted that the figure does not reflect those patients who are medically fit but have simple needs that do not require additional assessment.

Graph 1 below shows the most recent information since November 2014 covering the last 6 month period. It can be seen that at its peak over the extremely busy Christmas and New year period, the MFFD numbers rose to around 200 patients.

Graph 1: Summary MFFD patients last 6 months



2. MFFD Detail

The MFFD delays are collected daily in a total of 17 categories but for ease are summarised into 8 which largely follows the organisational splits. For the period Nov 2014 – May 2015 the distribution of delays is shown in Graph 2 and summarised as a proportion of total delays in Table 2 across the four PAHT sites.

Graph 2: Trend of MFFD delays by type

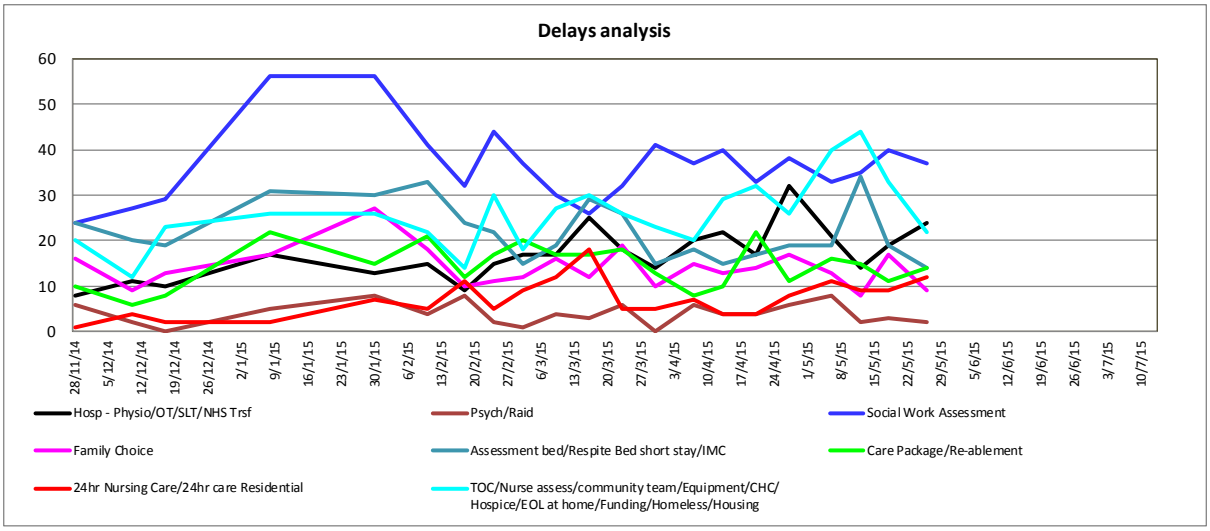


Table 2: Types of delays and proportion of patients delayed across all hospital sites

Delay Category	% of Patients Delayed
Social Work Assessment	26%
Long Term Health Services in Community	18%
Community Bed	16%
Therapy Assessments	12%
Family Choice	10%
Care Package/Re-ablement Service	10%
24hr Nursing Care/24hr care Residential	5%
Mental Health Services	3%
Total	**100%**

This data illustrates that patients awaiting a social work assessment is the most common reason for medically fit patients continuing to occupy an acute bed. However what must be considered as part of that process are patient's capacity to consent to assessment and ongoing care. This is a statutory requirement of the Mental Capacity Act 2005, in addition some of the delays are from LA's outside of the NE sector. It should also be noted that once an assessment has been completed the patient is likely to then need a service on discharge such as a care package or residential placement, which may lead to further delays should best interest meetings be needed.

It should also be noted that the number of days that a patient may occupy an acute hospital bed whilst medically fit is not collected daily. For some patients the delay can be relatively short and others much longer e.g. a patient requiring a therapy assessment is generally likely to be resolved faster than a patient requiring a nursing home placement.

The data is also captured by site and by Local Authority. This can of course change daily, however a snap-shot analysis of the most recent information from 3rd June 2015 shows the distribution as follows:

Table 3: Number of medical MFFD by site

Site	No. of medically fit patients	% of beds occupied by med fit patients	Proportion of total delays
ROH	33	16%	29%
NMGH	26	15%	23%
FGH	50	28%	43%
RI	6	33%	5%
Total	**115**	**20%**	**100%**

Table 4: Distribution of medical MFFD by local authority area and hospital site

Site	No. of medically fit patients	Proportion of total delays
Manch	8	7%
Bury	39	34%
Rochdale	35	30%
Oldham	29	25%
Other	4	3%
Total	**115**	**100%**

This data suggests a positive correlation between the number of delays in total and the distribution of patients across the four hospitals sites. The area with the lowest number of delayed discharges is Manchester with only 16 % of delayed discharges residing in the Manchester locality. It is also clear on a daily basis that delays are extended for those patients who are not on their local site.

There are some factors relating to the surgical and medical activities that differ across the Trust sites which may contribute to differences in delays e.g. All Acute and Stroke rehabilitation services area now centralised at FGH.

3. Current position

The reasons for the delays across all the sites are multi-factorial and community and LA partner organisations are working with the Trust to develop and implement solutions. Each site has a local economy action plan to improve A&E access performance and flow of

patients through the hospital beds and within the plans there are a variety of actions relating to this specific issue.

There are examples of very good collaborative working across the PAHT footprint to reduce the delay. The Assistant Director of Social Care for Bury Local Authority chairs an economy-wide Discharge Group which has senior representation from all organisations. This group has recently been re-energised and re-focused with commitment from all partners. At NMGH all staff involved in the discharge process from acute, community and local authority work as an integrated team based on the site and line-managed on a daily basis by one Trust manager. The much lower number of delays for Manchester LA and fewer delays in total for the NMGH site reflect this.

Staff are co-located on the FGH site, and soon completion of IT works will mean better access for staff to wireless to enable hot desking.

The Delayed Discharges Act made it a requirement that where the delay is attributed to a local Authority the Acute Trust could fine that Authority. This has not been consistently applied across the country. The Care Act 2014 provides flexibility in the discharge arrangement in that it makes it possible to not fine the LA but consider how to invest monies/ resources differently to support better discharge planning.

There remain however a number of challenges and areas for improvement including:

a) *Acute Trust*

- Accurate and consistent completion of referral forms to other organisations at ward level; this includes improving understanding of the multiple pathways available for patients on discharge
- Improvement of internal communications and escalation where progress has not been made
- Robust use of ambulatory care pathways to increase emergency admission avoidance
- Setting discharge dates on admission consistently

b) *Local Authority partners*

- Issues regarding resources and availability of social work staff to attend each site every day
- Care Provider capacity for intermediate care and reablement and different admission criteria across the NE sector
- Working towards a discharge to assess model
- Working on single site discharge
- One single trusted assessor documentation
- Consistent 7-day working
- Cross boundary cover for social workers

c) *Community partners*

- Capacity of Transfer of Care team to assess patients for Intermediate Care in addition to urgent Fast Track Continuing Health cases
- Capacity for delivery of IV antibiotics and fluids in care homes and community to prevent admission
- Capacity to discharge to assess rather than assess to discharge
- Cross boundary cover for nurse assessors

d) CCG's

- IV therapy services
- CHC funding without prejudice

4. Future partner working

Partners across the Pennine Acute footprint are continuing to work together on solutions to address the delays including:

- Working towards the one single site discharge (based on a recent pilot in UHSM). This will be driven through NE Sector discharge group.
- Working towards 7 day working for local authority
- Wider provision of reablement slots and packages of care
- Joint working agreement signed by all partners for CHC screened patients

The Health Scrutiny committee is asked to note this report.

June 2015

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The Pennine Acute Hospitals NHS Trust

Maternity Services – Briefing for Local Authorities & HOSCs

1. Background

The Pennine Acute Hospitals NHS Trust provides inpatient maternity services from North Manchester General Hospital and The Royal Oldham Hospital. Approximately 10,000 babies are delivered per year across these two dedicated multi-million pound purpose-built women and children's units.

Following the appointment of the Trust's new Chief Executive in April 2014, and prior to a full review of the Trust's serious incident policy and processes, a system was introduced whereby all SUIs (serious untoward incidents) were notified to the Chief Executive and Executive Directors within 24 hours and discussed at the Senior Management Team (SMT) on a weekly basis. This ensured the Trust could take any immediate corrective action required and reduce risk. This process highlighted several incidents within maternity services. The incidents reported were reviewed through the Trust's own root cause analysis and serious incident processes and any immediate improvements or actions required were implemented. However, to ensure that we left no stone unturned we commissioned an external review of nine incidents which had occurred within maternity services (6 neonatal and 3 maternal deaths). These should be seen in the context of approximately 10,000 births in a year between The Royal Oldham Hospital and North Manchester General Hospital (including home births).

The terms of reference for the review were agreed by the SMT and the Trust Board of Directors.

2. Review Findings

In summary, the findings of the external review were:

- The population of women cared for at Pennine Acute Trust is diverse and challenging and includes a significant number of high risk and vulnerable women.
- There are clearly areas of good practice which are appropriately noted and acknowledged and which should be widely shared.
- The three maternal deaths did not appear to be the result of deficiencies in care.
- The serious incidents were thoroughly and comprehensively reviewed by the Trust and there was a clear, honest and open approach to identifying failings.

3. Recommendations

There were twelve recommendations made within the review, which are outlined below:

1. Staffing issues where safety is compromised must be appropriately escalated, and must include involvement of the duty Supervisor of Midwives.

2. Managers must ensure that the process for escalating concerns is clear.

3. The process for employing and managing locum doctors should be reviewed.

4. The directorate should review its management of obesity in pregnancy, labour and the postnatal period, and that guidelines are appropriately implemented.

5. All serious incident reports should be 'quality checked' before submission, to ensure that the root cause clearly established.

6. Recommendations made by the serious incident review panel must be clear and unambiguous.

7. Where individual failings have been identified, the reports must demonstrate that training / educational needs have been considered.

8. Senior managers must ensure that training / educational needs are addressed where leadership has failed.

9. Serious incident reviews must be signed off by a nominated senior manager from the appropriate specialty.

10. The directorate should ensure that all mandatory training is up to date for all disciplines of staff, including record keeping and interpretation of CTG.

11. All available methods should be used to ensure that standards of documentation are improved where necessary.

12. The Trust must be assured that a robust system is in place to ensure the regular and timely review, implementation and audit of guidelines in accordance with Trust policy.

Whilst many areas identified for improvement by the external reviewers had already been addressed, further scrutiny and improvement is required around some areas of clinical risk management, clinical leadership, obesity management and serious incident investigations. It is important to note that the Trust did not wait for the external review before taking action to reduce risk and improve services. In addition, the Trust also commissioned a review of staffing levels.

4. Improvement Plan

A comprehensive improvement plan was developed to address the issues identified in the external review. The implementation of the improvement plan for our maternity services is being led by our Chief Nurse and Acting Medical Director and individual actions are being put in place by a whole team of doctors, midwives staff and managers. Implementation is being overseen by the maternity incident management group.

5. Communication and Engagement

The Trust was very conscious of the need to ensure that the families of the cases reviewed were informed first and that discussions were held in a sensitive and supportive manner. Plans were being developed so that these discussions could be held with the families. However, the content of the external review was disclosed, by an unknown source, to the media before the plans to meet with the families could be put into place. The press (Manchester Evening News) only gave the Trust 24 hours to make contact with the families before they published the story. This was an inadequate period of time for meaningful communication. We were only able to make telephone contact with the families and alert them to the fact that there had been a review undertaken and offer them the opportunity to meet with us.

Since publication of the review we have now put in place a full communication and disclosure plan and have maintained contact with those families who have indicated a desire for contact. We have shared the relevant section of the external review report which concerns their loved one with those families who have requested to receive it. The Trust is also supporting staff to ensure they are kept informed and updated about the review and outcomes. We have also communicated with the relevant health bodies including our four local Clinical Commissioning Groups, NHS England, the Trust Development Authority and the Care Quality Commission.

6. Media Interest

Following disclosure, by an unknown source, of the content of the external review to the media, the Manchester Evening News (MEN) carried the story over the Easter weekend (3 April 2015). The story was subsequently reported in a number of national newspapers and on the BBC and ITV regional news bulletins. A follow-up piece was covered in the MEN on 18 April 2015 covering an apology by the Trust to those families involved in the review where mistakes and the standards of care fell short of what is expected.

Below is a copy of the statement which the Trust has provided to the media. This is also available on the Trust website at www.pat.nhs.uk

Trust press statement

Gill Harris, Chief Nurse at The Pennine Acute Hospitals NHS Trust, said:
"Childbirth is a life changing event for any women and their family. Obstetric care is considered high risk, particularly for some women, and by its nature unpredictable. However, as midwives, doctors and healthcare professionals it is our job to ensure we minimise the chance of avoidable harm to provide the safest care for women and their babies and an experience that meets their expectations.

"For this reason, we believe that it was right and responsible for the Trust to commission an external review, in addition to our own internal reviews, to look at the details and circumstances surrounding a small number of maternity cases at our hospitals, to leave no stone unturned and to learn any lessons as well as ensure any mistakes are not repeated. We did not wait for the external review to make improvements to our care as we aim to be an organisation that continually learns and improves.

“We are always keen to learn from others to improve the care our staff provides and so we are also working with another large hospital trust outside of Greater Manchester to share learning across our two organisations. We know we can learn from other hospitals as we develop our services and equally other Trusts can learn from us.

“Where the Trust has made mistakes and the standards of care have fallen short of what both our staff and patients expect, we are deeply sorry and are committed to learning and improving all aspects of care we provide. We will work closely with individual families concerned to ensure we learn from their experiences and are also working closely and collaboratively with our local commissioners and partners in acting on the outcomes of both our internal and external reviews. We are committed to being open and transparent to patients, the public and with our staff. We are committed to using this feedback to help us achieve the highest standards of maternity care.

"We deliver around 10,000 babies each year at our maternity units at The Royal Oldham Hospital and North Manchester General Hospital and I would like to reassure the public that our maternity services at our hospitals are safe. If any expectant mother has a concern then they should contact and speak in confidence with their designated midwife.”

7. Scrutiny and Assurance

As a result of the media interest NHS England held a Quality Scrutiny Group on 16 April 2015. This meeting comprised senior representatives from NHS England, the four local Clinical Commissioning Groups, the Trust Development Authority and the Care Quality Commission. As a result of that meeting NHS England confirmed that they were assured that the Trust's maternity services are safe. Specifically NHS England wrote to the Trust on 24 April 2015 stating that the clear process of managing the matters arising from the external review report will be through the Trust's maternity incident management group and that the group will be co-chaired by the Trust's Chief Nurse and by a CCG Chief Officer. The letter went on to state that this would be the process for assuring the quality and safety of maternity services in the Trust.

The Trust's maternity incident management group meets every fortnight. As stated above, it is co-chaired by Gill Harris, Chief Nurse and Stuart North, Chief Officer of Bury CCG. A number of senior Trust staff and representatives of our four local CCGs, the TDA and NHS England are members of the group. The external representatives provide a high level of scrutiny of the actions being undertaken by the Trust and the CCG representatives report back to their own governing bodies.

One of the major actions in the Trust's Improvement Plan has been to agree partnership working with staff from The Newcastle upon Tyne Hospitals NHS Foundation Trust (which has a highly respected maternity service) who have agreed to take part in a shared learning arrangement ("twinning") across the two organisations. This programme will be led by the Trust's Chief Nurse. This is a really important and positive partnership that sits very well within the context of the national maternity review announced by NHS England last month.

The Care Quality Commission produces data on perinatal mortality ratios. The CQC's latest analysis shows the Trust is not an outlier for perinatal mortality rates and that perinatal mortality ratios at the Trust are similar to expected.

8. Advice for patients/public

The Trust delivers 10,000 babies each year at its purpose-built maternity units at North Manchester General Hospital and The Royal Oldham Hospital, including our specialist Level 2 (high dependency special care baby unit) and Level 3 (neonatal intensive care unit).

The Trust is keen to reassure existing patients (pregnant women), their families, and the general public that the Trust's maternity services are safe.

If any expectant mother, partner or family member has a concern or any questions, they should contact their designated midwife in confidence to discuss further.

The Trust is planning to publish the final improvement plan in the coming weeks after input from the families involved, Trust medical and midwifery staff and partner agencies.

Information about this review and maternity services in general is available for patients and the general public on the Trust website at www.pat.nhs.uk .

Andrew Lynn
Head of Communication
22 May 2015

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The Pennine Acute Hospitals NHS Trust

If calling please ask for:
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Telephone: 0161 918 4491

Our ref: JOS/06151

Date: 22nd June 2015

Strictly Private & Confidential
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Dear Councillor McLaren,

I am writing in response to the recommendations outlined in the Joint Health Overview and Scrutiny Committee's '*Review of Elective Access within the Pennine Acute Hospitals NHS Trust*' that was prepared in March 2015.

The Joint Committee outlined 5 recommendations which have been discussed with relevant leads at The Pennine Acute Hospitals NHS Trust. The responses are noted as follows:

11.1 The Joint Committee would want to see test results being consistently notified to patients and their GPs within an agreed and publicised timescale, as with discharge letters

The Trust works collaboratively with GPs to improve clinical communications between hospital clinicians and GPs. A Clinical Communications Group has been established with representatives from all four localities to improve communication. The group has made significant progress to improve discharge letters, now known as Handover of Care Communication documents, and the remit of the group is to review other documentation including communication of test results. There are publicized timescales for all pathology investigations to be reported and electronic pathways are used to notify GPs of pathology results. The Clinical Communication Group will lead on reviewing test result reporting to GP practices with the involvement of secondary and primary care clinicians. To support the reporting of test results a significant IT project is in progress to improve reporting systems. This is an important foundation for improving reporting processes and communication with GPs and patients.

11.3 The Joint Committee would ask the Trust to take forward proposed work on scheduling of tests to avoid multiple visits to hospital.

The Elective Access team supports this recommendation and avoid multiple visits for patients to hospital. The Head of Elective Access is reviewing how this can be managed and delivered by the Elective Access team to improve patient experience.

11.4 The Joint Committee would ask the Trust to continue its work on communication with patients to ensure that timely, clear, appropriate letters are sent to patients from all departments delivering elective access care.

The Trust supports this recommendation. The Trust proactively monitors communication with patients and primary care for elective access care. Trust performance is monitored for Outpatient and Inpatient letters to ensure timely and appropriate letters. The Trust has robust monitoring processes and a number of work streams to continuously improve the quality and timeliness of letters.

The Trust has two key contractual measures for patient communication. Firstly, a local Key Performance Indicator for outpatient first attendance clinic letters that requires 95% of first attendance outpatient clinic letters to be sent to patients GP within 10 working days of the clinic date, and be compliant with timeliness, quality and completeness requirements. Secondly, a local Key Performance Indicator for inpatient Handovers of Care Communication documents whereby communication must be shared within 24 hours of discharge. There have been many improvements already implemented, such as; revised processes; clinical quality audits; re-training; and communication of best practice. In addition the digital dictation system is being proactively monitored to ensure a reliable system that supports timely clinic letters. The Trust successfully achieved the 95% compliance for Handovers of Care Communication in April 2015 and work continues to improve KPI compliance, with an action plan and continuous reinforcement and communication of best practice processes.

11.5 The Joint Committee would ask the CCGs to push forward with their work to ensure that patients fit for discharge can return home or to an appropriate care setting. This is not only an important area for hospitals trying to meet the increasing demand for their services but also a major factor in reducing the length of hospital stays and bringing care closer to home.

The Trust supports the CCGs and other partners to address the issues raised by the Joint Health Overview and Scrutiny Committee.

11.6 The JHOSC would ask the Trust to monitor cancellations of operations prior to the planned date and repeat cancellations prior to the planned date in the same way that they monitor cancellations on the date. The JHOSC would want the Trust to monitor the reasons for the cancellations and the areas where they occur.

The Trust supports this recommendation. The Trust has a policy for addressing these issues and have established processes to monitor and address any breaches. The policy does not allow for operating lists to be cancelled within 6 weeks of the booked date unless there are extenuating circumstances and these are authorised at Director level.

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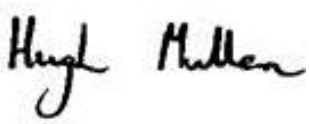
The Pennine Acute Hospitals NHS
NHS Trust

The Trust is taking these issues seriously and the work is ongoing, I would be happy for one of the team to attend a future Committee meeting to discuss further.

Yours sincerely



Hugh Mullen

Executive Director of Operations

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