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, Collins, Councillor Joan Davies, Kerrison, McClaren, Councillor Kathleen Nickson, Councillor Linda Robinson, S Smith, Councillor Ann Stott, R Walker and Williamson

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, 13 September 2016
Place:	Meeting Rooms A&B, Bury Town Hall, Kowsley Street Bury BL9 OSW
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:	**Light refreshments will be available from 1.30pm**

AGENDA

1 APPOINTMENT OF CHAIR AND VICE CHAIR

2 APOLOGIES FOR ABSENCE

3 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.

4 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.

5 MINUTES *(Pages 1 - 4)*

The minutes of the meeting held on the 22nd March 2016 are attached.
The minutes of the meeting held on the 7th September 2016 will be sent to follow.

6 MATTERS ARISING *(Pages 5 - 10)*

Sickness Absence Report.

7 POLITICAL BALANCE REPORT *(Pages 11 - 12)*

A report from the Joint Health Overview and Scrutiny officer is attached.

8 PALLIATIVE AND END OF LIFE CARE UPDATE REPORT *(Pages 13 - 22)*

Alice Davies, Macmillan Associate Lead Cancer and Palliative Care Nurse, will be in attendance. Report attached.

9 SINGLE HOSPITAL SERVICE UPDATE REPORT

Professor Matt Makin, Medical Director, Pennine Acute NHS Trust, will report at the meeting. Report attached.

10 CORPORATE PRIORITIES *(Pages 23 - 26)*

Gavin Barclay, Assistant Chief Executive, Pennine Acute NHS Trust will be report at the meeting. Report attached.

11 HEALTHIER TOGETHER UPDATE

Gavin Barclay, Assistant Chief Executive, Pennine Acute NHS Trust will be report at the meeting.

12 URGENT BUSINESS

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

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Agenda Item 5

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

Date: 22nd March 2016

Present:

Councillor Roy Walker (Bury Council)
Councillor Sarah Kerrison (Bury Council)
Councillor Stella Smith (Bury Council)
Councillor Colin McLaren (Oldham Council)
Councillor Joan Davies (Manchester City Council)
Councillor Sandra Collins (Manchester City Council)
Councillor Kathleen Nickson (Rochdale MBC)
Councillor Linda Robinson (Rochdale MBC)
Councillor Ann Stott (Rochdale MBC)

Stuart North	- Chief Operating Officer, Bury Clinical Commissioning Group
Nadine Armitage	- Head of Partnerships, Pennine Acute NHS Trust
Sandra Good	-Director of Strategy and Commercial Development, Pennine Acute NHS Trust.
Joanne Moore	- Divisional Director Medicine Pennine Acute NHS Trust.
Ms Julie Gallagher:	- Joint Health Overview and Scrutiny Officer, Bury MBC

No members of the public were present at the meeting.

PAT. 15/16-28 APOLOGIES

Councillor Mark Hackett (Manchester City Council)
Councillor Norman Briggs (Oldham Council)
Councillor Derek Heffernan (Oldham Council)

PAT. 15/16-29 DECLARATIONS OF INTEREST

No declarations of interest were made.

PAT. 15/16-30 PUBLIC QUESTIONS

There were no public questions.

PAT. 15/16- 31 MINUTES

It was agreed:

That the minutes of the meetings held on 5th January 2016 be approved as a correct record.

PAT. 15/16-32 MATTERS ARISING

Following the departure of Dr Fairfield to take up a new role of Chief Executive of Brighton and Sussex University Hospitals Trust the Chair and Chief Executive, Jim Potter and Sir David Dalton, of Salford Royal Hospital NHS Foundation Trust are to provide leadership and support to Pennine Acute Hospitals NHS Trust from 1 April 2016.

Both Jim Potter and Sir David Dalton have agreed to take on the chair and chief executive responsibilities respectively for Pennine Acute on an interim basis. The move follows the departure of Pennine Acute's Chief Executive for a role in the south and the completion of the term of office of the former Board chair.

NHS Improvement is working with the Pennine Acute Trust and Salford Royal to complete an initial review of development work needed. An immediate priority will be to review the outcome of the CQC's inspection that took place in February, to assure patient safety and clinical effectiveness. Any changes to arrangements at Pennine Acute will need to be consistent with the locality plans for health and social care devolution in Greater Manchester.

The clinical commissioning groups (CCGs) and local authorities from Bury, Rochdale, Manchester and Oldham - the areas Pennine Acute covers - have welcomed the move and have offered their full support to Salford Royal and the Trust in the coming period.

Members of the Joint Committee expressed concern that the Trust representatives could not confirm the timescale for Dr Fairfield's secondment or the period of time Salford Royal would be providing support to the Pennine Acute Trust.

PAT. 15/16-33 DELAYED DISCHARGE

Joanne Moore, Divisional Director Medicine attended the meeting to provide members of the Joint Committee with an update in respect of delayed discharge within the Pennine Acute NHS Trust footprint. The presentation contained the following information:

The Divisional Director Medicine reported that the Trust Development Authority facilitated a Rapid Process Improvement 4-day Event (RPIE) in January 2016; 10 partner organisations took part; over 40 members of staff involved, the event was supported at Executive Level.

Following the event new terminology was agreed patients will now be identified as "Medically optimised awaiting transfer" rather than "medically fit for discharge".

A 30-day follow up event has been arranged and the key achievements thus far:

- Agreed standard definition for patients Medically Optimised awaiting transfer
- Working more closely with colleagues - better engagement and barriers broken down
- Creation/development of an MDT discharge document for ward staff
- A new board round structure adopted – piloted on 2 wards, being rolled out
- Agreement for the Trusted Assessor model to be adopted
- Reduced nursing time spent completing referrals
- New processes for assessing out of borough patients for social workers
- Better presence/input into information sharing to get a more accurate picture
- Stopped charging for reportable DToC
- Integrated single point of access with health and social care staff
- Daily operational meetings improved

Current work-streams have all developed project plans with actions to be delivered as soon as possible. Progress will be monitored through twice-weekly numbers reporting. Issues/barriers will be addressed through Gold operational assurance and Urgent Care Improvement Steering Groups. 60 and 90 day follow up events planned to maintain momentum.

Those present were given the opportunity to ask questions and make comments and the following issues were raised:

With regards to the Social Worker pilot, the Divisional Director reported that all partner organisations have signed up to the pilot, organisational development work has been undertaken to ensure that all staff work is of the same standard and the management structure has been reviewed to support single site discharge. Pilot work has now been completed and single site discharge will be rolled out across Pennine Acute Trust in June 2016.

Members of the Joint Committee expressed concerns with regards to the inconsistency in residential care provision. Families can be reluctant in some instances to discharge their family member into the care of particular residential homes which may then result in a patient remaining in an Acute setting for longer than necessary.

It was agreed

Members will continue to monitor and receive regular update reports in respect of Delayed Discharge across the Pennine Acute NHS Trust footprint.

PAT. 15/16-34 SERVICE TRANSFORMATION UPDATE

Sandra Good, Director of Strategy and Commercial Development, Pennine Acute NHS Trust attended the meeting to provide members of the Joint Committee with an update in respect of the Trust's Service Transformation Strategy. The presentation contained the following information:

There are a number of different strands to service transformation within Pennine Acute which include: Devolution Manchester, healthier together, clinical transformation and the different locality plans.

The Greater Manchester Strategic plan was launched in December 2015, devolution will go live in April 2016. The Greater Manchester transformation programmes in development and the governance arrangements are currently being established.

The North east sector transformation oversight review will continue, a commissioner led review, which brings together the elements of transformation work across GM including healthier together, single hospital service for the city, local care organisation.

In respect of City of Manchester Single Hospital Service, the project has been initiated by Manchester Health and Wellbeing Board to scope a single hospital service for the city. Phase one of the review included:

- Analysis of the existing service portfolios of all three trusts
- Consider eight exemplar services including cardiac, respiratory, secondary paediatrics, obstetrics, radiology, infectious diseases, critical care and rheumatology
- Determine the potential benefits for a fully-aligned single hospital service for Manchester

Phase two:

- Consider potential options for governance and organisational arrangements
- Appraise options and identify preferred options
- Report June 2016

The Manchester provider group has been tasked with the delivery of the one team model and development of a Local Care Organisation (LCO). A requirement of the LCO is to enable a single contact to be held for all community provision.

It was agreed

Members will consider the outcome of the City of Manchester Single Hospital site review at the next meeting of the Joint Committee.

PAT. 15/16-35 QUALITY ACCOUNT

It was agreed

Members agreed that once published the Quality Account will be circulated to members of the Joint Committee for comment. Once received, the Chair in consultation with the Joint Health Overview and Scrutiny Officer will formulate a response and submit it to the Pennine Acute NHS Trust.

Attendance Management Report
September 2016

1. Background

1.1 Following the JHOSC meeting on 6th January 2016 the committee asked for a further report on:

- Sickness absence since our last report
- What actions have been taken to reduce sickness absence and increase attendance?

2. Sickness absence by site and division

2.1 The trust operates a single service model and therefore uses the Divisional management structures as the basis for collecting and presenting sickness absence data. As such the Trust is unable to give the committee a 'hospital by hospital' comparison as data is not collected on a site basis. In table (1) below the committee can see the break down by the Trust's divisional structure.

Table (1) *Sickness Absence Rates by Division*

	Confirmed Sickness Levels									Indicative Levels		
	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
352 B - Integrated & Community Services	5.31%	4.25%	4.72%	4.26%	4.68%	5.33%	5.57%	4.90%	5.14%	4.46%	4.11%	4.55%
352 C - Medicine	6.27%	6.16%	6.86%	6.05%	6.61%	6.89%	6.18%	6.68%	7.08%	6.91%	6.74%	7.09%
352 D - Surgery & Anaesthesia	6.10%	5.79%	5.87%	6.56%	6.66%	6.79%	6.42%	6.40%	5.18%	4.57%	4.68%	4.92%
352 E - Women & Children	5.48%	5.56%	6.56%	7.08%	7.64%	7.29%	7.08%	6.33%	6.27%	5.17%	4.73%	5.63%
352 G - Division of Support Services	5.02%	4.91%	5.70%	5.48%	5.81%	6.16%	5.93%	6.18%	5.49%	5.34%	5.08%	5.40%
352 J - Elective Access	4.64%	5.17%	5.98%	5.95%	5.00%	4.50%	4.88%	4.68%	4.50%	4.09%	4.23%	4.66%
352 K - Corporate Services Other	4.29%	4.23%	5.28%	5.15%	4.96%	4.38%	4.35%	3.86%	2.98%	2.51%	2.88%	3.47%
TRUST TOTAL	5.48%	5.27%	5.92%	5.83%	6.07%	6.19%	5.95%	5.87%	5.50%	5.04%	4.89%	5.31%

The figures for June and July are provisional as the data input by managers needs to be verified by payroll before being confirmed. As the committee can see the rate peaked in January 2016 at 6.19%. This peak was a combination of winter colds and flu along with the impact of organisational change and impact of the publishing of the maternity review which particularly impacted on the Women's and Children's division.

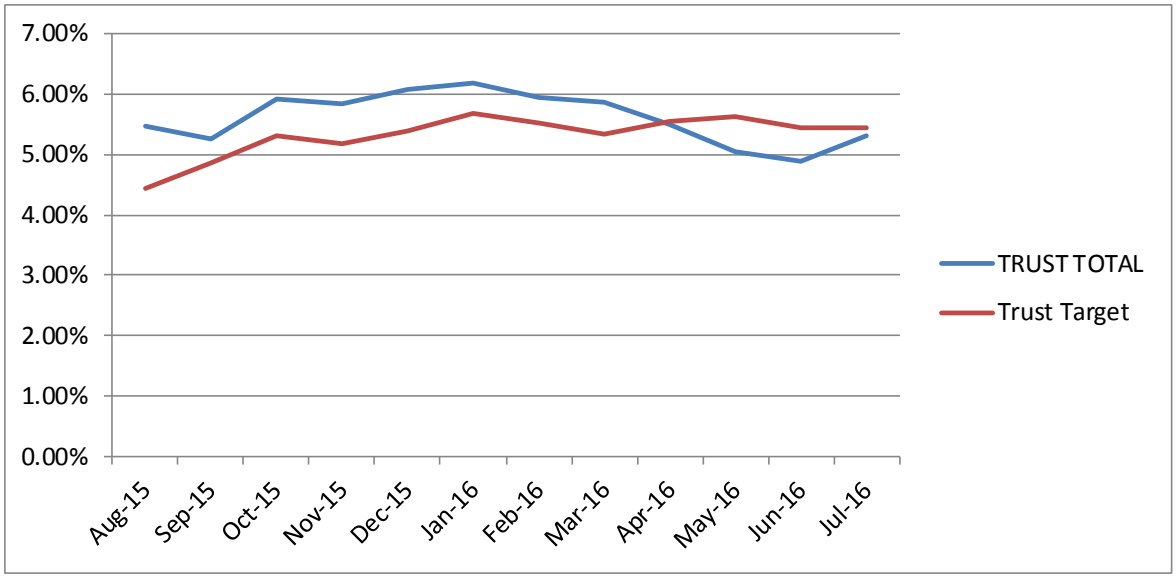

Chart (1)*Trust overall sickness absence rates*

The above table and the chart below show that the trend since August 2015 to July 2016 has been gradually downwards, which is positive and reflects the increased focus being given to health and well-being programmes and attendance management.

3. Management of Sickness Absence during the last 12 months

3.1 Actions taken since January 2016 include the introduction of a new attendance policy with a new trigger for management action of no more than 14 days in a 12 month period. The policy is seen as more supportive as the emphasis is on the health interview and what support can be given to staff by managers.

3.2 A focused case management HR support introduced in November 2015 has seen the average length of long term sickness fall from 149 days to 115 days which is a 23% decrease.

3.3 The Trust has also seen a shift in long/short term absence and apart from the Medical division the gap in the other divisions is growing between long and short term sickness absence. The Trust has 205 staff on long term sickness and currently as at 31st July 437 staff who have open absence cases because they have hit a trust trigger for management action. The chart below shows the number of open cases by division.

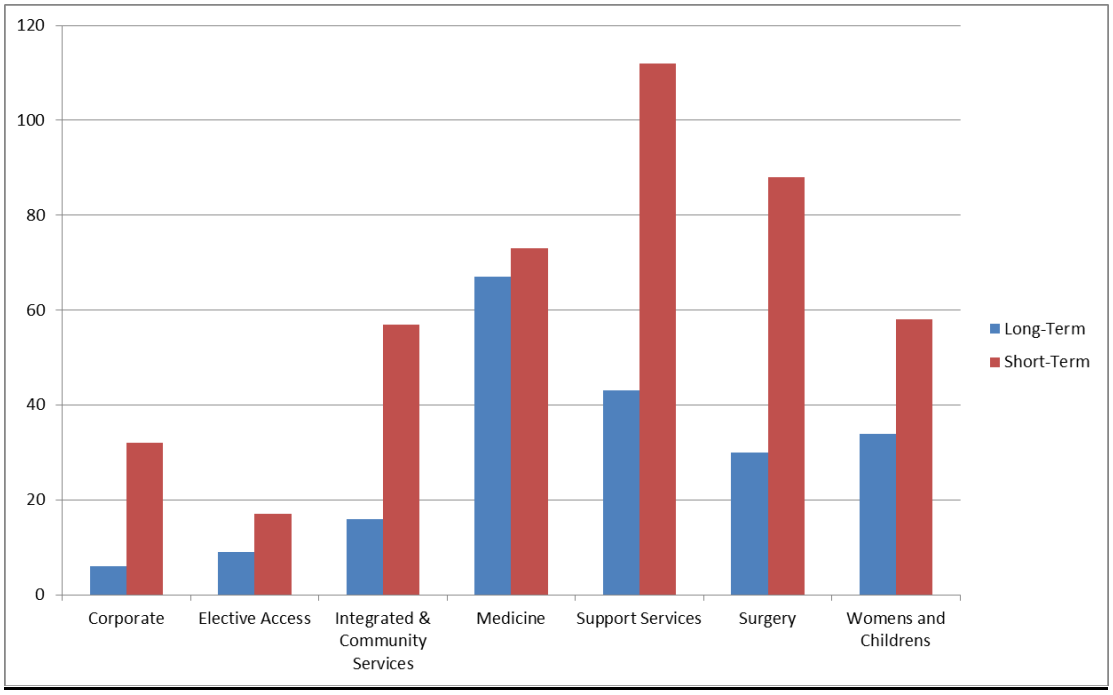

Chart (2)Trust long term/short term absence cases by division.

3.4 New health and well being initiatives include, zumba & yoga, choir taster sessions and lunchtime walking groups, which are all well supported.

4. Bank and agency spend

4.1 The Tables below show expenditure on temporary staffing for the month of July 2016. The Trust works estimates that 37% of this spend is due to sickness absence. This estimate is derived from data reported by the nurse rostering system. Therefore 1.8m is due to the cost of covering staff due to sickness absence.

Division	£000
Corporate	201
Medicine	2,055
Elective Access	152
Surgery	999
Womens	652
Integrated & Community	419
Support Services	405
Total Temp Staff	**4,883**

Corporate	Jul-16 £000
Agency	180
Locum Medics	(1)
Nurse Bank	1
Clerical Bank	22
Total Temp Staff	**202**

Medicine	Jul-16 £000
Agency	1,610
Locum Medics	213
Nurse Bank	225
Clerical Bank	8
Total Temp Staff	**2,056**

Elective Access	Jul-16 £000
Agency	84
Locum Medics	0
Nurse Bank	0
Clerical Bank	68
Total Temp Staff	**152**

Surgery	Jul-16 £000
Agency	662
Locum Medics	202
Nurse Bank	133
Clerical Bank	1
Total Temp Staff	**998**

Womens	Jul-16 £000
Agency	403
Locum Medics	197
Nurse Bank	51
Clerical Bank	1
Total Temp Staff	**652**

Integrated & Community	Jul-16 £000
Agency	296
Locum Medics	91
Nurse Bank	25
Clerical Bank	7
Total Temp Staff	**419**

Support Services	Jul-16 £000
Agency	297
Locum Medics	100
Nurse Bank	3
Clerical Bank	6
Total Temp Staff	**406**

The negative value in the corporate table reflects a refund on invoices

5. Conclusion

5.1 The Trust recognises that it has a significant sickness absence challenge. However, we are confident that the on-going implementation of our 'Healthy, Happy Here' Plan supported by efforts and further ideas of our managers, staff and their representatives will help us to successfully address this challenge over the next 6 months and achieve our target to reduce our cumulative absence levels to below 4.6% by March 2017.

J Lenney
Executive Director of Workforce & OD
1st September 2016

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Agenda item

POLITICAL BALANCE – PENNINE ACUTE JOSC 2016/17

Under the Local Government Act 2000 provisions, overview and scrutiny must generally reflect the political nature of the full council. Where a Joint Committee is established, the political balance requirements apply for each participating local authority, unless Members of all authorities agree otherwise.

In the report that went to each authority to establish the Joint committees, the following was included:

- The rules concerning proportional political representation apply to the establishment of such Joint committees, unless members of all authorities agree that they need not apply.

- The two committees will need to be politically balanced reflecting the overall political balance of the appointing authorities.

This municipal year, the Political Balance rules require:

Across the whole Pennine Acute footprint, there are 267 seats. When taken together and the proportions worked out, it equates to:

With 219 of the 267, 82% of seats go to Labour
With 28 of the 267, 10% of seats go to Conservatives
With 15 of the 267, 6% of seats go to the Liberal Democrats
With 5 of the 267, 2% of seats go to others.

Therefore for the Joint Committee to be politically balanced the membership would have to be constituted as follows:

Labour – 10 members
Liberal Democrats – 1 member
Conservatives – 1 member
Independents/Others – 0 members

The proposed membership of the Joint Committee is as follows:
Labour – 8 members
Liberal Democrats – 1 member
Conservatives – 2 members
1 vacancy

In previous municipal years the Joint Committee **has resolved to waiver the right** for the Joint Committee to be politically balanced.

Julie Gallagher: Joint Health Overview and Scrutiny Officer
July 2016

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The Pennine Acute Hospitals NHS Trust

Title of Report	Palliative & End of Life Care (EOLC) highlight report
Executive Summary	This paper will provide an update of the current Palliative & EOLC initiatives across the organisation
Actions requested	Update for Joint Health Overview and scrutiny Meeting – August 2016

Corporate Objectives supported by this paper:

1. To provide high quality, evidence based, safe services delivered in a personal and compassionate way
2. To modernise, transform & integrate services across our sites
3. To improve productivity & reduce variation
4. To engage & support patients, carers, volunteers, staff, public & communities in our work
5. To create an environment so staff choose to work with us, sickness absence is reduced/morale increased
6. To be an influential organisation working in partnership with others across the health & social care system to improve the health of the population.

Risks:

- Inability for sole delivery of the EOLC agenda and to meet the educational requirements of all health care professionals working across Pennine Acute Hospitals Trust (PAHT) by the EOLC/Specialist Palliative Care team due to small workforce.
- Inability to provide seven day week working, due to inadequate staffing establishments, for Specialist Palliative Care across the hospital sites. This is a national requirement. This risk has been placed on the Divisional risk register for Integrated and Community Services and was discussed at the Divisional Quality & performance committee.
- Carers not appropriately supported through the bereavement phase due to no dedicated service, therefore a business case has been developed and submitted to the Deputy Chief Nurse. Following this more detailed work is taking place around service modelling/re-design. Visits now undertaken with the patient experience lead to look at other organisations bereavement service models. Following this a paper outlining the preferred model is to be submitted.

Public and/or patient involvement:

- User representation on the Trust palliative & EOLC Steering Group
- Patient/carer focus groups to inform the development of the strategy
- Bereavement survey feedback
- Links with the Pennine Patient Partnership Group
- Patient stories
- Carer involvement at previous EOLC showcase events

Title of Report	Palliative & End of Life Care (EOLC) highlight report

Resource implications:

- Resource required to fund seven day week working for Specialist Palliative Care which is being considered at Divisional level, this will be dependent upon the outcomes following the piloting of this.
- Potential resource required from staffing & estates perspective for the development of a trust bereavement service. This is currently under review with a business case being developed as above.
- Initial funding for EOLC resources including canvas property bags, jewellery pouches, hair lock pouches, comfort packs has initially been secured via the Specialist Palliative Care endowment fund. All items have now arrived and the packs are being put together by Newbridge student future finder's volunteers. These have now been distributed to ward areas with guidance for use. Permanent funding for this will be required.

Communication:

- Via Chief/Deputy Chief Nurse supporting EOLC agenda
- Quarterly EOLC report now to be submitted via the Safety Committee
- Feedback via Divisional Q&P Committees and Divisional structures
- Via Patient Experience Committee

Have all implications been considered?	**YES**	**NO**	**N/A**
Assurance	✔		
Contract			✔
Equality and Diversity	✔		
Financial / Efficiency	✔		
HR			✔
Information Governance Assurance	✔		
IM&T	✔		
Local Delivery Plan / Trust Objectives	✔		
National policy / legislation	✔		
Sustainability	✔		

Name	Alice Davies
Job Title	Macmillan Associate Lead Cancer & Palliative Care Nurse
Date	30/8/16
Email	Alice.davies@pat.nhs.uk

Palliative & End of Life Care (EOLC) highlight report

1. Introduction

- The EOLC phase as in accordance with the North West EOLC model includes the period from advancing disease (pre-dicted12mths to live) through to time of death & into bereavement.
- There are currently a variety of national recommendation's and guidance in relation to palliative & EOLC. Significant improvements are required here at PAHT to optimise the patient/care experience at the End of Life.
- This report will provide an overview of the current Palliative and EOLC initiatives and the progress to date.

2. Strategic Context

Detailed below are recent palliative and EoLC publications. The initiatives described throughout this report will significantly contribute towards achievement of these recommendations and guidance.

Title	Overview
Care of dying adults in the last days of life (December 2015 NICE)	This guidance provides recommendations to help healthcare professionals to recognise when a person is entering the last days of life or may have stabilised or be improving even temporarily; to communicate and share decisions respectfully with the dying person and people important to them; and to manage hydration and commonly experienced symptoms to maintain the persons comfort and dignity without causing unacceptable side effects.
Ambitions for palliative and end of life care (September 2015, Department of Health)	This publication details an overarching vision and six ambitions that health professionals should endeavour to achieve. Each of the six ambitions includes a statement to describe the ambition in practice, primarily from the point of view of a person nearing the end of life. The initiatives detailed in the main body of the report would further progress achievement of these ambitions.
Dying without Dignity (May 2015, Parliamentary and Health Service Ombudsman)	This report identifies key themes. These themes enable area's that require further improvement in relation to the quality of EOLC provided. The themes include not recognising that people are dying, poor symptom control, poor communication, inadequate out-of –hours services, poor care planning and delays in diagnosis and referrals for

Title	Overview
	treatment. Again all current work involves addressing all of these areas.
One Chance to Get it Right: how health and care organisations should care for people in the last days of life (June 2014, Department of Health)	The alliance has developed five Priorities for Care, which set out the standards of care that dying people and their families should expect to receive. Across the organisation we are implementing the five principles as part of the individualised plan of care and alongside educational initiatives.

3. PAHT Palliative & End of Life Care Update

3.1 Individual plan of Care and Support For the Dying Person plan and Communication Diary

Following the national review and withdrawal of the Liverpool Care Pathway the Leadership Alliance for the Care of Dying People established key Priorities For Care when it is thought that a person may die within the next few days or hours. It was recommended that organisations adopt these principles in the form of an individual care plans.

As an organisation we worked in partnership with the Strategic Clinical Network to develop documentation to support implication of these principles of care. This document has been piloted across the transform wards and is now fully implemented across the trust including the use of the communication diary.

The use of the priorities of care within this plan will provide assurance that every patient who is in the last days of life across the organisation with receive the best possible quality of EOLC and that the carers of these patients will be appropriately supported.

Monthly monitoring of the use of the individual plan of care for the dying person is taking place and reported via the Trust EOLC steering group. The EOLC team have recently undertaken an audit of all the adult deaths that have taken place in the last week of June, in relation to the application of the principles of care. Results will be available within the next three weeks.

3.2 Palliative & EOLC (incorporating Bereavement) Strategy

This has now been fully ratified at Trust Board. Engagement and input has now been obtained from:

Nursing & Midwifery Committee
Pennine Patient User Partnership group
PAHT palliative & EOLC steering group
End of life Care CCG leads across localities of PAHT
Specialist Palliative Care service & Governance group

Three focus groups for wider community engagement from a variety of support groups took place October 2015. The issues raised from these groups have been incorporated into a patient feedback action plan as part of the strategy and monitoring of this progress towards this will take place via the Palliative and EOLC Steering Group.

Following Board of Director approval, the Palliative and EOLC strategy and a variety of current EOLC initiative across the Trust have been now launched at EOLC showcase events.

3.3 PAHT Palliative & EOLC Steering Group

This is fully established with agreed Terms of Reference & reporting arrangements. This Meeting is being chaired by Deputy Chief Nurse/Lead Clinician (Dr Iain Lawrie, Consultant in Palliative Medicine). This group oversees the implementation of the Trust Palliative & EOLC (incorporating Bereavement) Strategy.

3.4 National Hospitals EOLC Audit

The data collection has now taken place and the national report has recently been published. Some of the key findings from the clinical patient case note review are as follows:

Recognition of dying

- 93% of patients whose death was predictable had documentation that they would probably die. In 76% of cases, a senior doctor was involved in the recognition of dying. For half the patients, recognition of dying occurred within 5 days after admission and for half the patients this occurred less than 34 hours before death.

Communication and treatment decisions

- Only 4% (415/9302) of patients had documented evidence of an advance care plan made prior to admission to hospital
- UDNACPR order in place for 94% of patients notes at the time of death. Where sudden death excluded, discussion about CPR by a senior doctor with the patient was recorded in 36%. Overall, for 16% there was no reason recorded why a discussion did not take place.

Communication with people important to patient

- In 38% of cases, there was documented evidence in the last episode of care that the patients' needs had been discussed with the people important to them.
- There was documented evidence of care and support of the patient's family at the time of and immediately after death, in 65% of cases with wide variation between different sites.

Individual plan of care- symptom control

- 83% of patients had had a holistic assessment with a view to making an individual plan of care
- There was documented evidence that pain was controlled in 79% cases, agitation in 72%, noisy breathing/death rattle in 62% and nausea/vomiting in 55%

Drinking and eating

- In the last 24hrs of life there was documented evidence that: in two- thirds of cases the patient's ability to drink had been assessed. 39% of patients were documented as drinking and in 45% of cases that the patient had been supported to drink.
- 18% of patients had a nil by mouth order in their last 24hrs
- 71% of cases, there was documented evidence that the patient had an assessment regarding the need for clinically assisted (artificial) hydration (CAH) at any time between the final admission and death.
- CAH was in place during the last 24hours before death in 43% of patients.

Spiritual care

- There was documented evidence of discussion regarding the patient's spiritual/cultural/religious/practical needs with 15% of patients who were capable of participating in such discussions.

The national results have only been provided collectively across all the hospital sites of PAHT; however a breakdown of this per site has been requested from the national team. To date this has not yet been received. The findings from this will be presented and disseminated widely during the next couple of months. Following detailed analysis of the results an action plan has been drafted and will be presented and monitored via the EOLC steering group.

We are also in the process of engaging with IM&T in relation to some prognostic guidance around EOLC that can be available on the intranet. We have now producing some small pocket cards for clinical staff detailing the Priorities for Care and Support for the Dying person. Laminated A4 sheets detailing the priorities for care are now placed within agreed clinical areas. EOLC resource folders are now in place on all relevant clinical areas.

3.5 National EOLC Transformation Programme

As an organisation we registered at National level to take part in the National EOLC Transformation Programme. This entails transforming end of life care services and working to 'The route to success - improving quality end of life care in acute hospitals' (2010) - based on the National End of Life Care Strategy (2008). The aim of this is to provide excellent end of life care to all patients and carers, using a structured approach, with set standards and outcomes. Two wards on each hospital site have now undertaken the full programme. All base line data was previously collected and includes audits around case notes, staff skills and knowledge, mortuary transfer times and a bereavement survey. Post programme data is now available and the post programme report and action plan are in place. The implementation of these will be monitored by the Palliative & EOLC Steering Group. The rollout of the second cohort is now underway. Base line audit has now taken place.

3.6 Policies/guidelines/leaflets

Development of a variety of palliative and EOLC policies/guidelines has taken place. We currently have seven Palliative and EOLC policies/guidelines available across the trust. The Pain and Symptom control guidelines have now been reviewed as the Strategic Clinical Network have just reviewed and revised these, which we have adopted. The Rapid Transfer Pathway Policy is now finalised. These documents have all been fully ratified and uploaded onto the trust intranet. There is also availability of ten EOLC patient/carer leaflet. We have also developing a rapid Transfer Leaflet for patients going home to die which is available on the intranet.

Work has been undertaken with North Manchester community colleagues to ensure all acute end of life care policies include relevant community information as one joint policy. All updated policies now have appropriate community additions.

3.7 EOLC volunteers

SevenTrust volunteers have been trained to work as EOLC volunteers on the transform wards. The volunteers have identified key roles and responsibilities, which primarily are supporting the patients and carer with basic care such as assisting with drinking following advice from Nursing staff, washing face / hands and combing hair, sitting with the dying patient to allow carers a comfort break if required, explaining the facilities available for carers and where refreshments cab be obtained. The EOLC team are currently in the process with the volunteer's manager to further progress this initiative.

Further recruitment is to take place within the next six months, to further expand this provision to enable further role out across the Trust.

3.8 SPC seven day week working

North Manchester community palliative and supportive care service currently provide this provision. All hospital sites of PAHT are non-compliant with this at present. There is a small pot of funding to pilot this. Currently no permanent funding secured for the provision of seven day week working for Specialist Palliative Care teams across the hospital sites. This risk has been placed on the Division of Integrated and Community Services risk register and was discussed at the Divisional Quality & performance committee. The plan is to pilot seven day week working at NMGH, aiming to commence October/November 2016.

3.9 Electronic Palliative Care Co-ordination Systems (EPaCCS)

The data field requirements for EPaCCS have been incorporated within SPC data base. The clinical portal will have a platform for EPaCCS. Further role out of EPaCCS is dependent on commissioning via local CCGs to enable transfer of information between key stakeholders. North Manchester CCGs have funded the development of EPaCCS and are working towards implementation this co -ordination system. A North East Sector project has now been commissioned, (PAHT leading this work) to implement a Medical Interoperability Gateway (MIG), this will be a platform for EPaCCS implementation.

3.10 Education & Training

Previous palliative and EOLC rolling education programme revised and updated which includes identifying patients approaching end of life and planning of their care, priorities for care and support for the dying person including emotional, spiritual and religious needs, care at time of death and into early bereavement, communication in Palliative Care incorporating: unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR) and rapid transfer, palliative care emergencies, nutrition & hydration in palliative patients and pain and symptom control at end of life. The topics are delivered within a modular basis over two days, three times a year rotating over sites. The revised programme started in November 2015. Attendance for training is recorded via the training and development department and the use of the standard trust evaluation forms.

Previous programmes have evaluated well within the last year 310 nursing staff, 42 medical staff, 16 Allied Health Care professional have undertaken formal training in EOLC. This only captures the training accessed via the education centres. We are working with the Learning and Development departments to capture the ad hoc EOLC education that is delivered within the clinical areas. We also adopted a national EOLC e-learning programme across the organisation; figures can now be accessed for those who have undertaken the modules.
There is a Palliative and EOLC link member's one day programme across the trust which is held three times a year. Communication skills' training is provided across the Trust in the form of Sage and Thyme training. The End of Life Care Team also have a session on the Care Certification training once a month, an annual session on the Cadets training and the Specialist Palliative Care Team support the Consultants in Palliative Medicine to provide training to the FY1 and FY2's on an annual basis. The End of Life Care Team has recently piloted training for ancillary staff. The evaluation demonstrated the sessions required need to be tailored to each individual staff group in

which the End of Life Care Team will be revisiting. We have a national EOLC programme available via e-learning within the organisation called e-ELCA (EOLC for adults). There now also an e-learning package developed, for clinical staff to undertake training around the EOLC priorities of care and the individualised EOLC plan.

3.11 EOLC Standards for Clinical Areas

Developed as part of a 'listening into action event', patient/carer feedback and national guidance. Some of these include: Utilise butterfly symbol for patients at end of life, open visiting time for loved ones, relatives area available and each ward has access to quiet area. Every patient at end of life is offered emotional support and spiritual care, patients who are on an Individual Plan of Care and Support for the dying person will be automatically referred to the Spiritual Care team.
Process for monitoring of these will be linked into the nursing accreditation process.

3.12 Bereavement survey

An organisation bereavement survey was undertaken in 2013 by the EOLC Team/Clinical Audit. Action plans developed and taken forward. Some issues included lack of dignity and respect for relatives and poor communication skills, lack of spiritual care support. We have introduced the use of the butterfly across the trust and pursued the delivery of communications skills training for all levels of staff and the spiritual care team automatically offer their support to any every patient who is on an EOLC Individual Plan of Care and Support for the Dying person. The survey was repeated in May 2015. Results now available with an action plan developed. Work has now been undertaken to review the survey and the plan is that this will be available for all bereaved relatives/significant others to receive within the bereavement pack they take on collection of the death certificate. The updated surveys have now been printed and roll out to commence, September 2016.

3.13 Personalised sympathy card

This has now been drafted and ratified via the NMB and the patient experience committee and is to be piloted on wards across sites. This will be sent to all bereaved relatives/significant others expressing sympathy but also giving them the opportunity to meet with any of the clinical team to discuss any issues/concerns they may have. Pilot to commence September 2016.

3.14 Bereavement service developments

A preferred service outline is to be developed jointly between Palliative Care Lead Nurse and General Office/Bereavement Office Manager and the patient experience lead, proposing a model for delivery of bereavement services across the trust. Visits have taken place to other organisations to observe other models.
We have now secured temporary funding for the implementation of property bags, jewellery / hair pouches, personal message card, comfort packs and sympathy cards for relatives across clinical areas. All items have now arrived and the packs are being put together by Newbridge student future finder's volunteers. These have now been disturbed to ward areas for use.
Walk rounds of the bereavement/general offices where relatives/significant others collect death certificates, have taken place and suggestions made in relation to environmental improvements made. Many of these recommendations have now been actioned. This is being monitored via the EOLC steering group.

3.15 uDNACPR

uDNACPR educator now appointed for twelve months. Actions to date include:

- Development of project/action plan to address gaps from previous audit findings
- Undertaken Training Needs Analysis
- Education strategy now drafted to be finalised by September/October
- Lessons learnt taken place from incident reporting and appropriate teaching within clinical area's taking place
- Priority area's for support agreed with EOLC/CCG leads within localities

3.16 KPIs for EOLC

Have now been drafted, to be circulated for wider comments before final ratification via the next EOLC steering group in September 2016

3.17 Hospital Statement of Intent for discharge of EOLC patients from hospital out of hours/over a weekend period.

For the unlikely event that a patient dies following rapid discharge from hospital and before their own GP has had the opportunity to review them, it would help if the hospital medical team could provide a Statement of Intent to avoid unnecessary and distressing police attendance. This will remain valid until 1800 hours on the next working weekday after discharge. As soon as possible, the patient's own GP will review the patient and issue a Statement of Intent that will supersede the one from the hospital.

This is now drafted with guidance notes by Dr Iain Lawrie, currently with the coroners awaiting final agreement prior to coming via the safety committee.

3.18 Prognostic indication guide to identify those patients who are within the EOLC phase

This guide would provide staff with indicators to help identify EOLC patients and then the prompts to consider certain actions e.g. advance care planning, uDNACPR.

The EOLC team are in the process of developing a prognostic indication guidance tool for staff to access on the trust intranet. We are currently working with IT regarding the development of this. This has now been agreed by IT and will be developed and piloted within the next six months on the FGH site.

3.19 Rapid Transfer Pathway

This is fully implemented on the ROH and the NMGH sites. Further roll out has now taken place on the RI & FGH site. From the areas where this is fully embedded into practice of these patients being discharged on this, they are all achieving their preferred place of death, with no further hospital admissions. From the patient stating their preferred place of death is at home and they are in the last days of life, all have achieved discharge within twenty four hours. Patients are discharged in a co-ordinated manner with all anticipatory EOLC drugs.

Conclusion

To conclude this paper provides an update and over view of current Palliative and EOLC initiative's across the trust.

Recommendations

The Committee are asked to:

.
Note, review, consider and endorse the initiatives going forward within the report.

Title: Macmillan Associate Lead Cancer & Palliative Care Nurse
Date of joint Overview and scrutiny Meeting: September 2016

Pride in Pennine | Quality-Driven Responsible Compassionate

The Pennine Acute Hospitals NHS
NHS Trust

Title of Report	Trust Priorities 2016 / 2017

Submitted to	Joint Health Overview and Scrutiny Committee
Date	15 September 2016

Executive Summary	The Trust Priorities for 2016 / 2017 were approved by the Trust Board at its meeting on 30 June 2016. The Corporate Priorities for 2016/17 flow on from the key issues identified in previous years and also reflect the main issues identified in the CQC Report and in the Salford Diagnostic of the Trust. Copies are being made widely available across the Trust. Performance against the priorities is monitored through the line management structure and assured through the Executive Governance Committee process, to the Trust Board.
Actions requested	The Committee is requested to note the final version of the Trust Priorities for 2016/17.

Corporate Priorities supported by this paper:
1. Pursue Quality Improvement to assure Safe, Reliable and Compassionate Care
2. Deliver Financial Plans to assure sustainability
3. Support High Performance and Improvement
4. Improve Care and Services through Integration and Collaboration
5. Demonstrate Compliance with Mandatory Standards

Risks:
All strategic risks are relevant

Development and Assurance
This paper has been prepared by the Assistant Chief Executive / Board Secretary.

Public and/or patient involvement:
None

Resource implications:
The Trust Priorities will address issues facing the Trust.

Communication:
Full communication to all staff, stakeholders and the general public

Have all implications been considered?	**YES**	**NO**	**N/A**
Alignment to Trust Vision, Values and Priorities	✓		
Assurance through the Committee structure	✓		
Consultation (internal or external)	✓		
Contract Implications	✓		
Equality and Diversity	✓		
Financial / Efficiency Implications	✓		
Information Governance Assurance	✓		
IM&T Requirements	✓		

National policy / legislation	✓		
Patient Experience	✓		
Partnerships	✓		
Sustainability and Carbon Reduction	✓		
Workforce Implications	✓		

Name	Gavin Barclay
Job Title	Assistant Chief Executive / Board Secretary
Email	gavin.barclay@pat.nhs.uk
Date	6 September 2016

Our Trust's Priorities 2016/2017

The Pennine Acute Hospitals NHS
NHS Trust

Our **strategic goals:**

- To provide excellent care to our patients in our hospitals and community services.
- To work with our partners and local people to build resilient and sustainable local services for the communities we serve.
- To support our staff to provide the best care by developing their skills and nurturing their talent.
- To support 'values-based' leadership which role models the behaviours we expect from everyone.
- To achieve high reliability and high performance across all of our services.
- To deliver strong productivity which will assure financial sustainability.

Priorities | **2016/17 Targets**

Pride in Pennine | Quality-Driven Responsible Compassionate

Saving lives, Improving lives

Improving the health and wellbeing of the people and communities that we serve.

1. Pursue quality improvement to assure safe, reliable and compassionate care

Save lives
Assure a year on year reduction in standardised mortality rate to within the top 10% of acute Trusts nationally

Meet Care Quality Commission (CQC) requirements
Deliver improvements within time scales

Reduce harm
Assure safety thermometer target so that at least 95% of patients receive harm free care

Improve patient experience
Demonstrate improvements so that patients "would recommend as a place for treatment" on NHS patient survey

2. Deliver financial plan to assure sustainability

Drive efficiency & productivity to deliver substantial financial improvement including cost improvements of at least £25m

Reduce spend on agency staff

3. Support our staff to deliver high performance & improvement

Improve staff engagement score
Use NHS staff survey staff engagement score and Friends and Family test to demonstrate improvement, so that the Trust is recommended as a place to work

Improve staff contribution to goals & values
Implement the new staff contribution assessment framework to ensure that staff receive an effective and quality appraisal

Reduce staff sickness absence to 4.6%
Implement Healthy, Happy, Here workforce plan

4. Improve care and services through integration and collaboration

Support development of Local Care Organisations in Oldham, Bury, Rochdale and Manchester
Describe the Trust's contribution to improvements in locality plans. Agree at least one key aim per locality with stakeholders

Progress Single Hospital Service in Manchester
Develop and implement an action plan for North Manchester General Hospital to form part of a Single Hospital Service for the City of Manchester and assure safe and effective services are supported at Oldham, Bury and Rochdale

Improve the Urgent Care Service at North Manchester in line with Care Quality Commission (CQC) and NHS Improvement requirements
Implement urgent care improvement plan. Deliver on A&E 4 hour standard in line with stretch trajectory

Assure developments of high acuity services at The Royal Oldham as part of Healthier Together
Implement Healthier Together standards for general surgery by April 2017

Improve services through 'standardisation at scale' in association with Salford Royal NHS Foundation Trust

5. Demonstrate compliance with mandatory standards

Infections
C.Diff = <55 cases
MRSA = 0 cases
Set targets for each site to achieve above

Achieve Access standards:
- A&E 4 hour standard
- Referral To Treatment (RTT) 18 week standard
- Cancer 62 day standard
- Diagnostics 6 week standard
- Deliver endoscopy improvement plan

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