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 Sandra Collins, Councillor Joan Davies, Councillor Sarah Kerrison, Councillor Colin McLaren, Councillor Kathleen Nickson, Councillor Linda Robinson, Councillor Stella Smith, Councillor Ann Stott, Councillor Roy Walker, Councillor John McCann and Councillor Beth Marshall

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:	Thursday, 17 November 2016
Place:	Council Chamber, Bury Town Hall, Knowsley Street, Bury BL9 0SW
Time:	9.15 am
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 APOLOGIES FOR ABSENCE

2 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.

3 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.

4 PENNINE ACUTE NHS TRUST CARE QUALITY COMMISSION ACTION PLAN *(Pages 1 - 26)*

Jude Adams the Operations Director and Jayne Downey, Director of Governance will be attendance. CQC action plan is attached.

5 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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The Pennine Acute Hospitals NHS Trust

Summary of the CQC and SRFT Diagnostic Improvement Plan

Key
Delivered
On track to deliver
Some issues – narrative disclosure (revised delivery date)
Not on track to deliver

Version	**Version 5.0**
Date	**30/9/16**

What and why we need to improve

During February 2016 the CQC inspected services at PAHT. On 1st March 2016 Ms Ann Ford, Head of Hospitals Inspection CQC, wrote to confirm immediate patient safety concerns that had been discovered as a result of the inspection. The concerns that ***required decisive immediate actions to stabilise services and assure patient safety*** were across 4 main service areas Maternity, Children, Urgent Care and Critical Care.

In April, following the interim appointment of Sir David Dalton as CEO, a team of senior health executives, supplemented by external support constructed and conducted a diagnostic review of the causes of risk to patient safety and care sustainability.

The diagnostic focus was to identify areas for improvement that impacted on patient safety. It was not a full investigation into all aspects of operations of the trust. Nor was it a full due diligence of the trust The diagnostic was informed by the immediate concerns raised by the CQC.

The key areas for improvement identified in addition to the fragile services were:

- Patient safety, harm and outcomes
- Systems of assurance and governance arrangements
- Operational management and data quality
- Workforce capacity and capability
- Leadership and external relations

The CQC report has now been published (August 2016). The CQC identified 77 'Must Dos' and 144 'Should Dos' to ensure sustainable improvement to care delivered across the Pennine Trust services. The full report corroborates the findings of SRFT's diagnostic.

The full CQC report has established evidence that PAHT, overall, is rated ***Inadequate***.

All of the CQC 'must dos' and 'should dos' have been mapped across to the themes for improvement identified in the SRFT Diagnostic.

This improvement plan sets out the immediate (first 9 months) improvement actions – this is to ensure we are getting the basics right, stabilising services and creating the right conditions upon which we can continue to improve and ultimately transform care delivery across Pennine.

Our quality improvement strategy '***Saving Lives, Improving Lives',*** aims to go beyond the immediate concerns raised by the CQC report, we will engage our staff in a quality improvement strategy that will result in our services to be rated good or outstanding by regulators, that our staff would rate as a good place to work and a good place for their relatives to be cared for.

Who is responsible?

NHS Improvement (NHSi), in conjunction with GM Health & Social Care Partnership (co-ordinating the response of Bury, Oldham, HMR and North Manchester CCGs), invited Salford Royal NHS Foundation Trust (SRFT), to provide interim leadership support to PAHT from 1st April 2016 the Chair, Mr Jim Potter and the CEO, Sir David Dalton, were appointed to interim positions of Chair and CEO of PAHT.

The Trust Chief Executive Sir David Dalton is ultimately responsible for implementing the actions in this document, the Trust executive team will provide the leadership to ensure we identify the right improvement actions that will tackle some of the long standing issues the Trust has faced and create the right conditions to deliver the changes required.

Our site leadership teams, divisional triumvirates and clinical leaders across the Trust will be key to delivering the actions that will ensure service sustainability and transformation. The high level deliverables articulated in this plan are underpinned by weekly improvement actions that clinical and management teams have developed and own. These weekly actions and evidence of delivery will be managed via an integration management office, teams will be supported to deliver changes at scale and pace with access to the SRFT standard operating model.

The GM Improvement Board will bring together parts of the local health and care economies to ensure there is a shared understanding and collective commitment to the delivery of the improvement plan, including resources that need to be made available to enable the changes to happen.

It is evident that the Trust has many thousands of staff trying to deliver good standards of care to patients. However, we need to create a culture of continuous improvement supported by robust governance and accountability arrangements from Board to ward which ensures leaders are focused on the key risks to the delivery of excellent care.

How will we measure our improvement?

Measurement of our improvements will be fundamental to ensuring sustainability and the reliability of our care.
We will develop a high level assurance dashboard against our key themes that measures our progress. We need to ensure that our improvement actions and activities are translating to improvement in outcomes for patients using a small number of key performance indicators.

We will assure our improvement plan through our Trust board and Executive assurance committees

How will we communicate progress?

Internal Communication to staff within the Trust will utilise the full range of existing communication channels and our new leadership arrangements to listen, update and engage staff in the delivery of the improvement plan.

We will utilise a weekly message circulated to all staff, site notice boards; monthly face to face Team Talk sessions led by an Executive Director; regular briefings with the staff side representatives and direct engagement sessions between the Executive team and senior managers with a particular focus on meeting with the Clinical Directors.

Briefing of key issues through the line management structure; use of dedicated pages on the Trust intranet and articles on our improvement journey will feature in the monthly Pennine News magazine. Any matters which require immediate communication will be sent through an all user email.

There are multiple routes for staff to feed-back comments including the dedicated staff.views@pat.nhs.uk email address; raising issues at face to face sessions with their line managers or at Team Talk sessions; contributing through the staff engagement programme; if necessary using the Speak in Confidence system to raise matters anonymously directly with senior managers.

Working in partnership with the multi-agency communications group we will:

- Ensure the clear, consistent and integrated delivery of all internal and external communications including staff, patients, families and carers, commissioners, GPs;
- Ensure the public/patients are informed and reassured that services are safe;
- Ensure that all key partners and stakeholders are kept up to date and informed about developments, decisions and any service changes that are required and their impact;

- Ensure all related media enquiries are co-ordinated and managed effectively, to ensure clear and consistent messages and to ensure media coverage is accurate;
- Work together to manage and protect the reputation of the NHS and social care in Greater Manchester and the services provided across the local healthcare economy;
- Ensure any subsequent operational or service changes are communicated effectively across PAT and the local healthcare system to staff, GPs, the public and externally.

Improvement Theme	Summary of actions required	Agreed timescale	Assurance and external support	RAG Status	Executive and Operational Leadership	Revised deadline if required
Improving fragile services	***Urgent Care*** Establish clear leadership for the urgent care services and EDs in line with site based leadership model	1.12.16	External – GM Improvement Board CCGs GM providers Internal – Care Board and Quality Assurance Committee	On Target	Chris Brookes Executive Medical Director SRFT Steve Taylor Divisional Director	
	Ensure adequate stabilisation consultant and middle grade cover in ED at NMGH to meet the agreed service model requirements.	12.9.16		Consultant workforce stabilised. Middle grades revised date end Feb 2017		1.3.17
	Develop and deliver new service model for urgent care in North Manchester.	1.4 17		Dependent upon workforce recruitment.		
	Have in place a nursing, ENP, ANP workforce to meet the demand of patients across EDs	31.3.17		Delayed but pending successful recruitment and approval of nursing workforce model remains deliverable within due date.		
	Develop and deliver primary care offer within ED at NMGH	30.9.16		Completed		

	Develop integrated ambulatory pathways and frailty model at NMG	31.3.17		On Target clinical model – financial model TBA		
	Ensure best practice patient pathways within the ED and time to assessment, treatment and transfers are well understood and delivered in order to manage risks to patient safety and improve care	31.3.17		Likely to be delayed if workforce solution not in place		
	Ensure the assessment models for medical, surgical and paediatrics at NMGH and the speciality services capacity to respond to urgent and emergency care is developed in place.	31.3.17		Likely to be delayed if workforce solution not in place		
	Have in place an extended crisis response service for North Manchester, 8am – 10pm, over 7 days.	31.12.16		On Target, case agreed by CCG		
	Maternity Care Put in place the senior	30.9.16		Initially delayed CMFT additional support but	Matt Makin Executive	1.12.16

	management and clinical leadership to develop and drive forward the maternity improvement plan Have in place robust workforce plans and available staff to deliver maternity services, including medical, nursing and support posts. Establish comprehensive risk and governance arrangements which includes learning from incidents, complaints, auditing practice and improving incident and risk management systems and processes. Ensure all staff are trained and developed specific to their job roles Ensure the engagement of all staff in the improvement plan, developing a culture of continuous quality improvement	1.1.17 19.12.16 31.3.17 31.3.17	External – GM Improvement Board CCGs CMFT/RBH Internal – Care Board and Quality Assurance Committee	revised delivery date agreed. Midwifery plan on track, obstetricians delayed due to consultation with locums. On Target On Target On Target	Medical Director PAHT Deborah Carter Divisional Director	

	Paediatric Care Ensure adequate numbers of trained paediatric nurses are in place to meet the demand and ensure safe care Develop and deliver on the new model to stabilise paediatric urgent care for FGH Ensure all staff are trained and competent to manage the critically ill child and have in place a 24hr/7 day rota for APLS trained staff. Ensure the capacity to treat and care for children requiring elective treatment is in place sustainably Develop and deliver on the new models of care to receive, assess and treat paediatrics at all sites	 31.3.17 30.9.16 1.12.16 1.3.17 30.6.17	External – GM Improvement Board CCGs CMFT/RBH Internal – Care Board and Quality Assurance Committee	 Currently limited response to recruitment activities and beds remain closed Completed On Target Delayed may require revised date due to recruitment of RSCN On Target. Test of change at NMGH	Matt Makin Executive Medical Director PAHT Deborah Carter Divisional Director	
			External – GM			

	Critical Care Ensure sufficient consultant and middle grade cover to the HDU at ROH Ensure that the required nursing/AHP workforce across the critical care units is determined and in place Determine the requirements for critical care outreach and safe response at night and weekends	30.9.16 1.6.17 1.6.17	Improvement Board CCGs CMFT/RBH Internal – Care Board and Quality Assurance Committee	Interim locum solution in place, revised date for sustainable solution On track for nursing, AHP requires review Review post QI collaborative	Chris Brookes Executive Medical Director SRFT Deborah Ashton Divisional Director	31.1.17
Improving Quality	***Develop and Ignite our QI Strategy*** Develop PAHT QI strategy ***Improving Safety*** • QI Collaborative on deteriorating patients and managing sepsis Engagement of staff Development of QI faculty	1.9.16 30.9.16 21.10.16	External – GM Improvement Board CCGs Internal – Care Board and Quality Assurance Committee	Early version drafted, requires finalisation by Haelo Completed Completed	Elaine Inglesby-Burke Site Nurse Directors and Medical Directors	14.11.16

	Commence collaborative • 90 day improvement cycles Have in place reliable data for pressure ulcers, falls, CAUTI Develop ward improvement goals and plans • 90 day improvement cycle reducing hospital acquired CDiff Have in place reliable data Develop ward improvement goals and plans • Implement NASS System to ensure core nursing standards are met Mobilise team and engage senior nurse leaders in NASS model	18.11.17 (March-June 17) 1.3.17 1.6.17 (Oct-Dec) 1.10.16 1.1.17 9.9.16		On track Project not yet started Delayed – revised delivery date Completed Completed		Nov-Jan

	Undertake desktop assessment Identify data collections methods and priority areas (pilot wards) Baseline assessment of all priority wards and improvement plans developed Completion of all wards • Implement patient support system Deploy a support system to support vulnerable patients and families	30.9.16 14.10.16 31.3.17 30.6.17 Commence 1.10.16 Complete 31.12.16		Completed On Target Revised start date 31.10.16		28.10.16 31.10.16
	Improving Effectiveness • Reducing mortality Outline methodology Undertake mortality review	 1.9.16 1.3.17	External – GM Improvement Board CCGs Internal – Care Board and Quality Assurance Committee	Completed High level complete, first detailed review by Dec	Matt Makin Site Nurse Directors and Medical Directors	31.12.16

	Determine and deliver improvement actions using review data and Dr Foster intelligence Ensure reliable system for M&M reviews and learning from avoidable factors	1.11.16 30.4.17		To be finalised following Dec review On Target		30.4.16
	Improving patient experience • Improving End of Life Care Undertake a baseline assessment of bereavement care Work with wards and departments to agree the plan Roll out the Royals Alliance bereavement model • Implement 'what matters most to me'	30.9.16 1.12.16 31.3.17 Commence 1.4.17 Complete 1.9.17	External – GM Improvement Board CCGs Internal – Care Board and Quality Assurance Committee	Completed On Target Project not yet started	Elaine Inglesby-Burke Site Nurse Directors and Medical Directors	

	Ensure safe medicines management Develop and deliver on audit plans derived from core standards	31.10.16		On Target for Duthie Audits. Additional MIAA audit potentially requires additional actions and revised date	Jayne Downey Director of Governance Philippa Jones Chief Pharmacist	30.4.17
Improving Risk and Governance	***Implement new risks and governance arrangement across the Trust*** Undertake comprehensive assessment of governance arrangements and develop workplan focussing initially on 4 priority areas: complaints, claims, serious incidents and coroners inquests Implement new risk and governance framework Put in place new Board Assurance Framework Roll out risk training for all staff	31.11.16 31.12.16 31.10.16 31.3.17	External – GM Improvement Board CCGs Internal – Care Board Executive Risk Assurance Committee	On Target On Target Completed On Target	Jayne Downey Director of Governance Paul Downes Director Patient Safety	

	Implement new datix system	31.4.17		On Target		
	Review all safeguarding Deliver on level 3 children's safeguarding training to agreed standard Undertake gap analysis for MCA DOLs and deliver on agreed action plan	 31.11.16 31.2.17	External – GM Improvement Board CCGs Local Authorities Internal – Care Board and Executive Quality Assurance Committee	 On Target On Target	Jayne Downey Director of Governance Sue Smith Head of Safeguarding	
Improving Operations and Performance	***Ensure improvement to patient flow*** Implement SAFER model across all wards Ensure flow/bed requirements are driven by agreed clinical pathways of care, are modelled and delivered Have in place robust systems and	 16.12.16 1.4.17 1.4.17	External – GM Improvement Board CCGs Local Authorities Community providers Internal – Care Board and Executive	 On Target On Target On Target	Jude Adams Interim Director Michelle Morgan, Senior Nurse Divisional Triumvirates	

	processes for the management and escalation of patient flow across the acute sites to ensure patients are care for in the right place Put in place and deliver against agreed standards which ensure medically optimised patients are transferred safely and appropriately	 1.6.17	Operations and Performance Committee	 Work to be supported by ECIP		

	Ensure data quality systems and processes are robust to deliver on operational performance		External – GM Improvement Board CCGs		Jude Adams Interim Director	14.11.16
	Reduce PAS open registrations by completing data cleanse exercise and put in place systems and process for access control	28.10.16	Internal – Care Board and Executive Operations and Performance Committee	Completion of full PAS cleanse delayed by 2 weeks due to tender award	Divisional Triumvirates Head of Informatics	
	Create business intelligent patient tracking list and tools to support operational staff in managing stages of treatment for patients	1.1.17		On Target subject to above		
	Ensure all identified staff groups have access to and are trained and assessed on referral to treatment rules and PAS functionality	1.1.17		On Target, training underway		
	Ensure booking and scheduling functions and resources are in place to meet the standards required and are structured to support operational delivery and the best patient experience.	31.3.17		Delayed start but may not require revised date		
	Put in place systems and	1.10.16		Requires additional ED		14.11.16

	processes to ensure clinical input into validation of ED breaches and non breaches Ensure ED symphony system is utilised and optimised in patient tracking and clinical pathway management. Ensure ED patient tracker roles are developed and supported across all EDs Undertake self-assessment against audit commission standards on DQ, develop action plans to address gaps.	1.12.16 31.12.16 1.12.17		consultant input May require revised date due to system functionality On Target Not yet commenced		
Workforce and safe staffing	***Undertake baseline safe staffing review of nursing*** Assess all wards and departments against Salford Nursing Standards commencing with high risks areas	30.9.16	External – GM Improvement Board CCGs Internal – Care Board and Executive Quality	Completed for all surgical and medical wards, ED Revised date for paeds and maternity	Elaine Inglesby-Burke, Chief Nurse Site Nurse Directors	14.11.16

	Agree and develop workforce plan to address shortfalls Have in place systems and processes to report and close workforce gaps to achieve safe reliable staffing (90% standard)	31.10.16 30.6.17	Assurance Committee	Approval given for 50wte Band 6 posts to rebalance skill mix. Full business case to be completed by 31.11.16 Current processes to ensure reliable data under review. Workforce gap remains greater than plan		31.11.16
	Undertake baseline safe staffing assessment for medical staff Understand vacancies against funded establishment Assess fragile services against national standards and clinical service need. Develop plans for resolution of gaps Close medical workforce gaps on sustainable basis ***Implement new model for recruitment*** Identify hard to recruit groups	 31.8.16 31.12.16 31.6.17 30.9.16	External – GM Improvement Board CCGs, GMTU Internal – Care Board and Executive Workforce Assurance Committee	 Completed On Target Progress on stabilisation but sustainable solution timescale poses risk to urgent care interim solution Completed	Jon Lenney Executive Director of HR &OD Susan Hunt Head of Workforce	

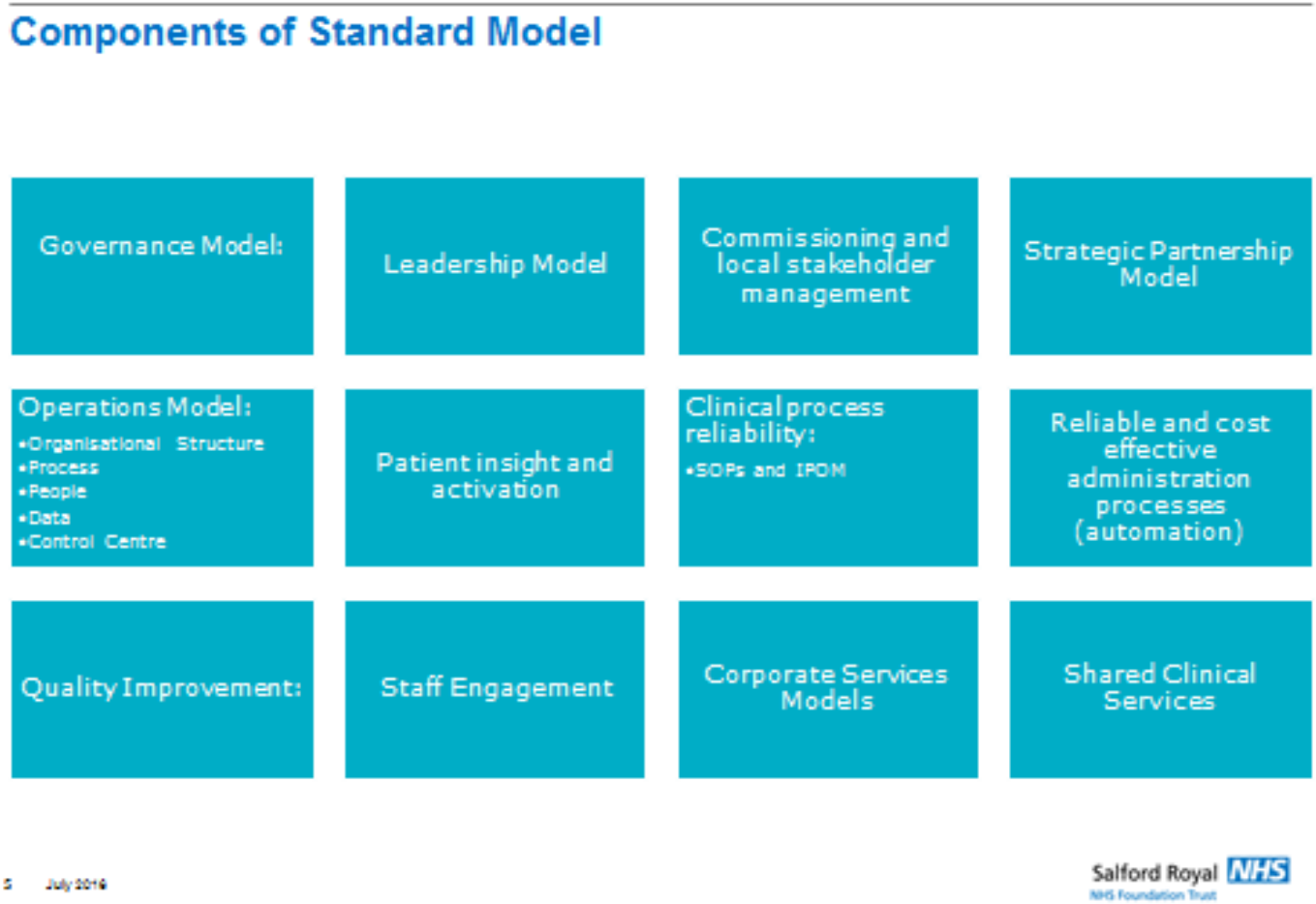
	Outline model and strategy for recruitment for fragile services	30.9.16		Completed		
	Deliver on staff 'Happy Health Here' programme Promote and improve the health and wellbeing of the workforce Improve availability of the workforce and reduce reliance on temporary staffing Develop new PDR offer and ensure staff have opportunity to engage in performance development discussions. Meet 90% PDR standard Ensure all staff have access to and complete mandatory training Meet 90% standard	 31.3.17 31.3.17 31.3.17 31.3.17	External – GM Improvement Board CCGs Internal – Care Board and Executive Workforce Assurance Committee	 On Target Temporary staffing spend reduced. Workforce R&R plan developed but delivery date may be at risk New offer developed. Current performance below target Current performance below target	Jon Lenney Executive Director of HR &OD Vicky Cooney HR Improvement manager	

Improving Leadership and strategic relations	***Development of Group*** Transition from interim executive Chair and CEO arrangement to permanent solution Finalise group structure and governance arrangements	1.8.16 31.3.17	External – NHSi, NHSE, GM Improvement Board CCGs Internal - BOD	Awaiting finalisation of management contract Engagement and consultation across organisation commenced	David Dalton	
	Implement Site Leadership model Agree model and for site leadership and management of services Recruit to site leadership teams Develop site improvement plans and accountability framework	31.10.16 Commence 1.9.16 Conclude 1.4.17 1.12.16	External – GM Improvement Board CCGs Internal – Care Board and Executive Workforce Assurance Committee	Completed On Target On Target	Jon Lenney Executive Director of HR &OD	

	Develop and deliver on clinical leadership programmes Design, commission and deliver joint clinical leadership programmes with Chief Nurse, PAHT MD and Salford Head of Leadership (post TFL programme) Develop and deliver a range of leadership workshops for non-clinical leaders with SRFT Head of Leadership and Executive Sponsor(s)	Design 1.10.16 Delivery commence 1.12.16 Develop 31.10.16 Delivery commence 1.11.17		Worked commenced on nursing. Review medical leadership offer, requires revised date Work commenced may require revised date	Jon Lenney Executive Director of HR &OD Diana Finlayson Head of OD	

Requirements to support improvement action	Timescale for implementation	Owner	Progress against timescale	Revised deadline if required
Agreement of management contract with SRFT	31.10.16	Raj Jain		
Financial settlement agreed to support improvement plans and delivery on LTFM in 16/17 and projections for 17/18	30.9.16	Damien Finn/CCGs	In year settlement agreed. Business case for transformation to be drafted by 31.10 16	
Agreed specification and plans from commissioners on model of care for 'primary care front end'	1.12.16	CCGs		
Engagement with and support from CCGs and LA to deliver on site and locality clinical service strategies	31.3.17	CCG/LAs		
Engagement and contribution to system wide UC improvement & safety workshop led respectively by ECIP and Charles Vincent	31.1.17	CCG/LAs and PAHT		
Review of clinical quality and performance arrangements with commissioners to ensure robust assurance and safety systems in place	1.12.16	CCGs and PAHT		
Establishment of IMO to manage integration and co-ordinate improvement activities/synergies with SRFT	31.9.16	Jude Adams	In place	
Support from GM transformation unit and GM providers to develop and contribute where appropriate to new models of care for frail services	30.9.16	GMTU	In place	

SALFORD STANDARD OPERATING MODEL



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