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 Beth Marshall, Councillor John McCann, Councillor Colin McLaren, Councillor Kathleen Nickson, Councillor Linda Robinson, Councillor Stella Smith, Councillor Ann Stott and Councillor Roy 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, 6 December 2016
Place:	Peel Room, Bury Town Hall, Knowsley Street, Bury. BL9 0SW
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 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 MINUTES *(Pages 1 - 6)*

Minutes of the meeting held on the 13th September 2016 are attached.

4 MATTERS ARISING *(Pages 7 - 8)*

Report attached.

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 WORKFORCE UPDATE *(Pages 9 - 12)*

Report is attached.

7 HEALTHIER TOGETHER UPDATE *(Pages 13 - 16)*

Report is attached.

8 NURSING ASSESSMENT AND ACCREDITATION SYSTEM (NASS) *(Pages 17 - 22)*

Briefing Note attached.

9 URGENT BUSINESS

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

10 FOR INFORMATION **NOTES FROM THE CQC TASK AND FINISH MEETING *(Pages 23 - 50)*

CQC Action Plan attached.
Notes from the Task and Finish Group meeting held on the 17th November 2016 are attached.

Agenda Item 3

Meeting of:

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

Date: 13th September 2016

Present:

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

Alice Davies	Macmillan Associate Lead Cancer and Palliative Care
Professor Matt Makin	Executive Medical Director, Pennine Acute NHS Trust
Gavin Barclay	Assistant Chief Executive, Pennine Acute NHS Trust
Ms Julie Gallagher:	Joint Health Overview and Scrutiny Officer

PAT. 16/17-05 APPOINTMENT OF CHAIR AND VICE CHAIR

It was agreed:

1. That Councillor Colin McLaren (Oldham MBC) be appointed Chair of the Joint Health Overview and Scrutiny Committee for the Municipal year 2016/17.
2. That Councillor Stella Smith (Bury MBC) be appointed vice Chair of the Joint Health Overview and Scrutiny Committee for the Municipal year 2016/17.

PAT. 16/17-06 APOLOGIES

Apologies were received from Councillor Sandra Collins, Councillor Norman Briggs, Councillor Sarah Kerrison and Councillor Diane Williamson

PAT.16/17-07 DECLARATIONS OF INTERST

No declarations of interest were made.

PAT.16/17-08 PUBLIC QUESTIONS

There were no public questions.

PAT.16/17-09 MINUTES

It was agreed:

That the minutes of the meetings held on 22nd March 2016 and 7th September 2016 be approved as a correct record.

PAT.16/17-10 MATTER ARISING

Members of the Committee discussed the Attendance Management Report. The report contained the following updates;

- Sickness absence report
- Actions taken to reduce sickness absence and increase attendance

It was agreed:

1. A workforce themed item would be included on the agenda at the December meeting of the JHOSC.
2. A task and finish group will meet to discuss the Care Quality Commission Action Plan.

PAT.16/17-10 POLITICAL BALANCE REPORT

It was agreed:

That the necessity, that the Joint Health Overview and Scrutiny Committee for Pennine Acute NHS Trust be politically balanced, be waived for the municipal year 2016.2017.

Councillor Linda Robinson declared a prejudicial interest in item PAT.16/17-11and therefore left the meeting during consideration of this item.

PAT.16/17-11 PALLIATIVE AND END OF LIFE CARE (ELOC) UPDATE REPORT

Alice Davies, Macmillan Associate Lead Cancer and Palliative Care Nurse attended the meeting to update the Joint Committee on current palliative and EOLC initiatives across the Trust. The report contained the following information:

There are a number of palliative Care and EOLC initiatives within the PAHT, these include:

- Individual plan of care and support for the dying person plan and communication diary
- Palliative and EOLC (incorporating bereavement) Strategy
- PAHT palliative and EOLC Steering Group
- National Hospitals EOLC Audit
- National EOLC transformation programme
- Seven day week working
- Electronic palliative care co-ordination systems
- Personalised sympathy card

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

In response to a Member's question in respect of funding; the Macmillan Associate Lead Cancer and Palliative Care Nurse reported that funding for specialist palliative care is sufficient but EOLC is not always adequately resourced. PAHT are not the only providers of palliative care other services are provided by the Hospices and GPs. A review of palliative care services is ongoing which may result in some of the services being redesigned.

The Macmillan Associate Lead Cancer and Palliative Care Nurse reported that links have been established with representatives from the Muslim and Jewish communities to provide information, advice and assistance in respect of the support and services provided by the Trust.

Members of the Committee raised concerns with regards to the problems highlighted in respect of the inability to provide seven day working due to inadequate staffing. Dr. Patel reported that there are inconsistencies in care provided over the weekend.

In response to a Member's question, Dr Patel reported that there is some good palliative support and EOLC in primary care. Commissioners must ensure that this is provided consistently and good practice is embedded so that each person nearing the end of life receives an individualised care package.

The recent CQC inspection rated palliative care and EOLC as Good in the majority of areas but requires improvement in some areas. The Macmillan Associate Lead Cancer and Palliative Care Nurse reported that in response to the issues raised an action plan has been developed with the main focus on achieving consistency across the Trust footprint.

It was agreed:

A further palliative and end of life care update report will be considered at a future meeting of the Joint Health Overview and Scrutiny Committee.

Members agreed that items 12 and 14 would be considered together

PAT.16/17-12 SINGLE HOSPITAL SERVICE UPDATE REPORT AND HEALTHIER TOGETHER

Professor Matt Makin, Executive Medical Director, Pennine Acute NHS Trust attended the meeting to provide members of the committee with an update in respect of the Single Hospital Service. The presentation contained the following

Professor Makin, Executive Medical Director Pennine Acute NHS Trust, reported that Manchester City Council Health and Wellbeing Board (MCCHWB) had appointed Sir Jonathon Michael as an Independent Review Director with a commission to produce a report on the proposed SHS. The review was set out in two phases:-
Phase 1 – Benefits Assessment (completed April 2016)
Phase 2 – Governance and Organisational Arrangements (recommendations submitted to the Manchester City Council Health and Wellbeing Board on 8 June 2016. A copy of the report had been circulated.)

The review has recommended the creation of a new NHS Trust to encompass the three hospitals in Manchester (UHSM, CMFT and PAT). This would deliver a Local Care Organisation and enable a single commissioning function that would also support the Manchester Locality Plan. The MCCHWB agreed to request CMFT, UHSM and PAT to enter into discussions to consider the creation of a new single organisation and to provide an initial assessment on implementation requirements and timescale.

The outcome of the discussions would be reported back to the MCCHWB within 6 weeks. In addition, the review also highlighted that further discussions were required on the strategic alignment between the Manchester Single Hospital Service review and the North East sector review. This would include minimising any adverse impact from the realignment of North Manchester General Hospital on the sustainability of either the remaining clinical services provided by Pennine Acute Trust or the proposed new City wide Hospital Trust.

Members of the Committee discussed the implications for the three remaining hospital sites as well as issues with patient pathways and patient flows into NMGH. Members expressed their concern that uncertainty around the future of the Trust would not help alleviate the problems identified within the CQC report.

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

Members of the committee raised concerns about the proposals, the pace and amount of change ongoing with in the Greater Manchester area at the present time.

Members expressed concern that the proposals would not help services already identified as fragile within the Trust.

In response to a Member's question, the Executive Medical Director reported that money has previously been spent in the wrong places within the Trust, including £19 million on locum medical staff in the previous financial year. Money needs to be re-invested working in partnership with CCGs and the Local Authorities in the right places which may include public health and community based projects.

The Executive Medical Director reported that the Healthier Together reconfiguration will result in all high risk surgery being transferred to Oldham Royal Infirmary. These proposals will improve the outcomes of those suffering major trauma by combining expertise in designated centres. Dr Patel reported that there is too much duplication in the health service and Health service Leaders need to be brave about making future decisions in respect of health service reconfiguration.

The Executive Medical Director reported that there may be issues with the viability of low risk surgery at Fairfield Hospital, including concerns with regards to emergency services for children.

A new governance structure is being developed in respect of the north east sector, led by Martin Farrar.

The proposals will result in a whole system changes to how services are provided; this will include the ambulance service, to avoid un-necessary admittance and improve access to GP services.

Members of the Committee discussed the devolution monies available via the Transformation Fund, Dr Patel reported that each locality will bid for money from the fund. Salford Royal have also be awarded a £10 million additional funding for support IT project within the Trust and it is hoped some of that funding will be spent within the Pennine Acute NHS Trust.

It was agreed:

1. The Executive Medical Director, Pennine Acute NHS Trust be thanked for his attendance.
2. The update report being developed at part of the North east sector governance review will be shared with members of the Joint Health Overview and Scrutiny Committee.

PAT.16/17-13 CORPORATE PRIORITIES

Gavin Barclay, Assistant Chief Executive, Pennine Acute NHS Trust attended the meeting to update members of the Joint Committee on the Trust's Corporate Priorities. The update contained the following information:
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.

Corporate Priorities include:
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

The Assistant Chief Executive reported that the corporate priorities will provide a clearer focus for staff.

The Executive Medical Director responded to members concerns in respect of the information that had been presented to members in previous years. He understands that members may feel sceptical in respect of this information and more reliable data will be presented in the future which will provide a more honest and transparent account of what is going on at the Trust.

It was agreed:

The Assistant Chief Executive, Pennine Acute NHS Trust be thanked for his attendance.

Joint Health Overview and Scrutiny Committee
Briefing on the NES work
November 2016

1. Introduction

Work to develop a strategy for the North East Sector (NES) is currently being managed across through the Oversight Group being independently chaired by Mike Farrar. The intention is that this work should drive commissioning of one acute service contract across the sector, three locality care contracts and support the development of an agreed Clinical Services Strategy across the NES.

The Chief Executives of Bury, Rochdale and Oldham Local Authorities(LAs), the Chief Officers of the Clinical Care Groups (CCGs) which initially included North Manchester CCG and Pennine Acute Hospitals Trust/Salford Royal Foundation Trust have been engaged and involved in this work across the NES.

This report provides an update on the draft independent report that has been produced by Mike Farrar which was submitted for discussion and comment on 16th November 2016 to the Oversight Group.

2. Background

The Oversight Group includes all the LA and CCG Chief Executives and Chief Officers across the NES. In March, they agreed to review together their plans for sustainable high quality acute services for their population.

The Group have supported work at NES to better align the plans of all CCGs and PAHT in terms of finance and activity, although this is not yet fully concluded.

The Group also received in October, a NES Transformation Fund proposal which was due to be agreed at the meeting on 16th November.

3. Current position

The Oversight Group received Mike Farrar's draft independent report. The key points are noted below and the report was taken back for redrafting:

- The report outlines a recommendation around the development of an integrated single commissioning function to produce a single specification/contract for acute care across Bury, HMR and Oldham. It would also produce a single specification for specialised and out of sector services. This was the subject of discussion for the vast proportion of the meeting, but was agreed in principle.
- At locality level, commissioning would be integrated between LAs and CCGs for out of hospital care in the first instance, with a suggestion that this might move to a sector approach over time.
- The meeting discussed the need for this work to actively link into the Single Hospital Service work streams with regard to North Manchester General Hospital.
- Locality services must work to consistent service specifications and standards based on best evidence or practice.
- It was acknowledged that current LCO models were at different stages of development but should aim to have a commonality of approach.

- In terms of acute services, support was given by the sector to the continued arrangement with SRFT and LA's were keen to support and be involved in discussions around the long term management contract for PAHT with NHS Improvement.

4. Actions agreed at the meeting

The Oversight Group debated the report at length, especially with regard to commissioning. They agreed to the formation of a NES wide group which would include Council Leaders and clinical leaders to be in place in shadow form by January 2017. An Executive Group would undertake the work programme to support this Board. The group members agreed to produce a nomination process and suggested membership of the group to the next meeting. This would be formally established in April 2017.

The Group agreed that a programme resource and infrastructure would be required to support this work and that the existing NES bid should be reshaped to request that.

The Group requested engagement in discussions related to the current planning round and the development of a shared NES plan which would be in detail for 12 months, but include a further 2 years. This would be based on the current work being undertaken on the Annual Plan, but would also formally include plans within the LAs.

The Group agreed to begin construction of a narrative that can be used with local politicians, councillors and in all organisations about the NES work.

5. Next steps and recommendations

The JHOSC is asked to note this report.

The draft report is currently being reshaped by Mike Farrar, with the intention that this will be agreed in December 2017. The CCGs, Local Authorities and PAHT will draft formal responses to the draft report to feed into this process.

The JHOSC may wish to request a full briefing when the report is agreed in December after it has been agreed at the GM Health and Social Care Partnership Board.

The Pennine Acute Hospitals NHS Trust

Attendance Management Report

Attendance Management Report
November 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. However, the Trust will be restructuring itself in 2017 to manage services on a site basis. At this point site data will be available. 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	
	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	Mar-2016	Apr-2016	May-2016	Jun-2016	Jul-2016	Aug-2016	Sep-2016	Oct-2016
352 B - Integrated & Community Services	4.72%	4.26%	4.68%	5.33%	5.57%	4.90%	**5.14%**	**4.46%**	3.99%	4.35%	3.85%	3.65%	3.88%
352 C - Medicine	6.86%	6.05%	6.61%	6.89%	6.18%	6.68%	**7.08%**	**6.91%**	**6.84%**	**7.07%**	**6.35%**	**6.00%**	6.21%
352 D - Surgery & Anaesthesia	5.87%	6.56%	6.66%	6.79%	6.42%	6.40%	5.18%	4.57%	4.67%	5.02%	4.83%	4.90%	5.20%
352 E - Women & Children	6.56%	7.08%	7.64%	7.29%	7.08%	6.33%	**6.27%**	5.17%	4.75%	5.62%	**5.97%**	**5.65%**	5.56%
352 G - Division of Support Services	5.70%	5.48%	5.81%	6.16%	5.93%	6.18%	5.49%	5.34%	**4.99%**	**5.34%**	**4.86%**	4.31%	4.80%
352 J - Elective Access	5.98%	5.95%	5.00%	4.50%	4.88%	4.68%	4.50%	4.09%	4.16%	4.57%	3.97%	4.32%	5.76%
352 K - Corporate Services Other	5.28%	5.15%	4.96%	4.38%	4.35%	3.86%	2.98%	2.51%	3.13%	3.46%	3.26%	3.22%	3.30%
TRUST TOTAL	5.92%	5.83%	6.07%	6.19%	5.95%	5.87%	**5.50%**	5.04%	4.89%	**5.28%**	4.91%	4.69%	5.02%

The figures for Sept and October 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. Since then we have seen a steady decrease until October which is indicative at 5.02%. Benchmarking over the last 7 years 5.02% is the lowest ever October figure since 2009.

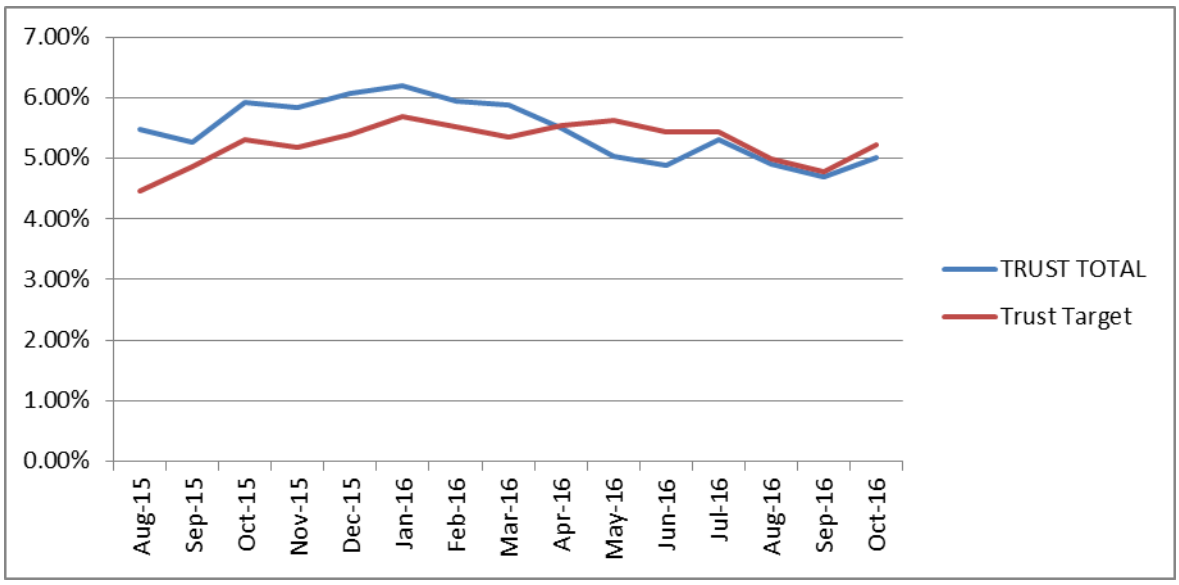

Chart (1)*Trust overall sickness absence rates*

The above table and the chart below show that the trend since August 2015 to October 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 112 days which is a 24% decrease.

3.3 The Trust has also seen a shift in long/short term absence. The Trust has 207 staff on long term sickness and currently as at 31st October 604 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.

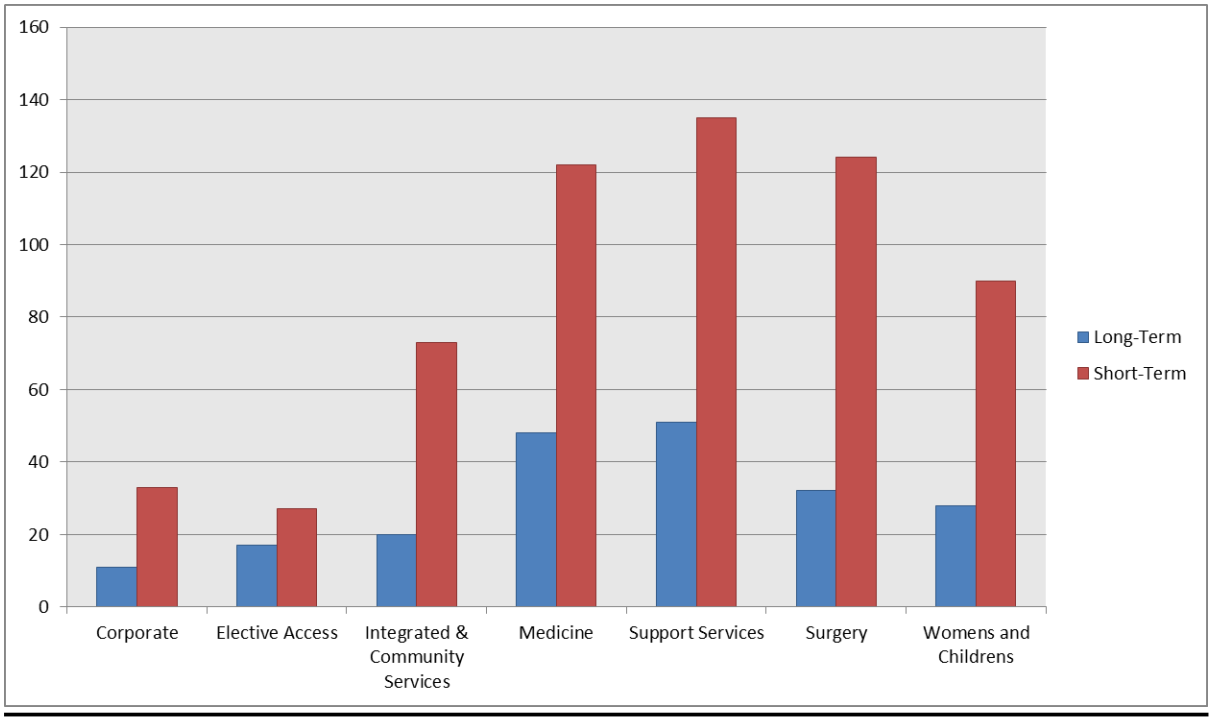

Chart (2)Trust long term/short term absence cases by division.

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

4. Conclusion

4.1 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
November 2016

Joint Health Overview and Scrutiny Committee

Healthier Together Briefing
November 2016

1. Background

As the Joint Health Overview and Scrutiny Committee are aware, work has been progressing to implement Healthier Together (HT) since July 2015. In strategic terms, this sees the Royal Oldham Hospital become a high acuity site for general surgery for the North East Sector (Bury, Rochdale, Oldham and North Manchester).

2. Developing the Business Case

Originally, the NE sector was required to complete an outline business case by December 2016 and a final business case for the implementation of the Healthier Together changes by March 2017. This business case, along with the other three sectors would then be amalgamated into one by HT and one GM funding bid submitted.

The start of this process was the creation by HT of a Greater Manchester position statement which was to be submitted to the Theme 3 Delivery Board. However, it became apparent that there were issues with the HT GM position statement. This has resulted in the position statement being reworked in November/December which has in turn impacted on the business case timetable. A new timetable has yet to be communicated by HT.

The NES is actively involved in the reworking of the position statement data. Stuart North from Bury CCG is the Senior Responsible Officer for the NES work at GM level.

3. Implementation timelines

No implementation date has been agreed. HT originally suggested April 2017 as the date when the first moves of high-risk elective GS could take place with emergency GS to move later. However, the risks listed below around a phased implementation and surgical independencies are still to be worked through. HT is comfortable with this. However, a number of points that other sectors are being asked to get in place by April 2017 are already in situ in the NES, namely; sector wide colorectal MDTs, a single GS lead, a single GS consultant team.

4. Brief description of what Healthier Together implementation means for NES

Under HT the following procedures will move from non-hub sites to specialist hospitals;

- All high risk elective General Surgery (GS). GS being defined as activity codes 100-General surgery (minus breast and vascular), 104 colorectal and 106 upper GI surgery. High risk being defined as a high risk procedure on any patient or a low risk procedure on a high risk patient
- All emergency GS

Since the Decision Making Business case was agreed, HT have decided that the difficulty in identifying relevant patients for ambulance crews means that no urgent, emergency or acute medicine (UEAM) will transfer under HT however UEAM still have a number of HT standards they will be expected to meet.

4.1 Activity shifts

Under HT the Royal Oldham Hospital becomes a specialist hospital. Modelling work indicates the following activity numbers will move;

	NMGH	ROH	FGH
High risk elective General Surgery	254 →		
Emergency General Surgery	1974 →		

4.2 General Surgery Model

This model is still in development and is being designed with the full engagement of GS consultants. This model is fully compliant with HT;

	Patient Cohort	ROH (hub)	NMGH (non Hub)	FGH (non hub)	RI (non hub
GS	High Risk Elective Surgery	✓	X	X	X
	Low Risk elective Surgery	✓	✓	✓	X
	Daycase	✓	✓	✓	✓
	Outpatient Clinics	✓	✓	✓	✓
	Emergency General Surgery	✓	X	X	X
	Ambulatory general Surgery Care	Delivered by a shared pathway across the sites			

4.3 Resource requirements

Modelling undertaken by HT and NES (using actual patient spell data) indicates that to accommodate the GS activity moving from NMGH the following additional resource will be required at ROH;

- 43 beds
- 4 Critical Care Beds
- 2 theatres

- Additional diagnostic and endoscopy resource requirement for GS is still being calculated
- Supporting infrastructure

The workforce requirements to deliver the GS model are currently being worked through.

This is still work in progress and will continue to be refined as part of the business case.

5. Main issues and risks

The main issues and risks are noted below for the Board's attention:

- It is still unclear as to where additional resources noted for both revenue and capital in the original HT work are going to be secured from.
- There remains a risk that required workforce may not be available or be able to be put in place, particularly around critical care, radiology and the requirement to deliver consultant led care 16 hours a day minimum at the specialist Emergency Department and 12 hours a day minimum at the non-hub Emergency Department
- Moving high risk activity to ROH will put additional strain on critical care which is currently being managed as a fragile service within the Pennine Acute Improvement Plan.
- There remains a view from Surgery is that moving high risk elective GS and emergency GS separately will present a number of issues around continuity of care for patients and the best approach will be to move both elements at the same time. As the emergency GS activity will require capital build to accommodate this will lead to a longer anticipated timeline for implementation
- There are a number of interdependencies between GS and other services which mean that moving GS will increase risk in other specialities. These are still to be worked through and include;
    - GS surgeons are often required to assist with fractured neck of femur patients on an emergency basis
    - The same cohort of junior staff the rotas for both GS and urology at NMGH. Moving the juniors to ROH with GS with destabilise the urology service.

6. Recommendations

The JHOSC is asked to note the progress being made with Healthier Together implementation. Further updates can be provided as the Business Case is nearing completion.

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Pride in Pennine | Quality-Driven Responsible Compassionate

Title of Paper	**Nursing Assessment and Accreditation System (NAAS): a summary**
Executive Summary	This paper provides an overview of the Nursing Assessment and Accreditation System (NAAS), which has been introduced at Pennine Acute Hospitals NHS Trust (PAHT) as one of the key projects to help deliver the CQC and SRFT Diagnostic Improvement Plan. During February 2016 the CQC inspected services at PAHT and rated them as "inadequate" overall. Several key areas for improvement were identified by both the CQC and the findings of SRFT's diagnostic review, these included; patient safety, systems of assurance and governance arrangements, leadership and quality of care. The introduction of NAAS will support the Trust's aim of creating 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. NAAS is designed to measure the quality of nursing care delivered by individuals and teams. It supports nurses in practice to understand how they deliver care, identify what works well and where further improvements are needed. The Joint Health Overview and Scrutiny Committee wished to explore in more detail one of the Trust's improvement projects – NAAS was identified as this is relevant to all of the localities and a good reflection of a system at Trust level and the care delivery and leadership at ward level.

Corporate objectives supported by this paper:

- Pursue Quality Improvement to assure safe, reliable and compassionate care
- Support our staff to deliver high performance and improvement
- Improve care and services through integration and collaboration
- Demonstrate compliance with mandatory standards

Risks:

1. Failure to deliver on the corporate objectives
2. Failure to meet 2016/17 CQUIN performance targets for the implementation of a ward accreditation system; of note – from Q2 2016/17, the associated CQUIN has already been amended to reflect NAAS

Public and/or patient involvement: Will be incorporated via the Patient Experience Team.

Resource implications: Senior Project Manager from the Transformation Team and the NAAS Team (Lead Nurse and Senior Sister).

Communication:
Through Corporate Nursing, Divisional Management Structures and the Communications Department.

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

Name	**Helen Carter, Jane Garforth and Hayley Mannin**
Job Title	**Lead Nurse and Senior Sister (NAAS Team), Senior Project Manager NAAS**
Date	23.11.16
Email	helen.carter@pat.nhs.uk jane.garforth@pat.nhs.uk Hayley.mannin@pat.nhs.uk

1. Introduction

The Nursing Assessment and Accreditation System (NAAS) has been operational at Salford Royal Foundation Trust (SRFT) for 8 years. Prior to 2008 there were inconsistencies and gaps in assurance and quality of nursing care was measured mainly through IT systems rather than by a systematic approach where care delivery was observed. There was no real recognition for best practice, good leadership or for the patient's voice and frontline staff at ward level to be heard and acted upon. SRFT Board at this time had publicly stated an ambition to become the safest hospital in the NHS and the introduction of NAAS formed a significant part of the nursing strategy at SRFT to help deliver this.

Since the implementation of NAAS at SRFT there has been a considerable improvement in culture, reduction in harms, improved patient satisfaction resulting in the CQC rating the SRFT as "Outstanding" following their inspection in January 2015. The NAAS system was highlighted as an example of outstanding practice by delivering a high level of transparency to the Trust Board and patients in relation to performance indicators and measures.

A NAAS team at Pennine has been created to develop and implement the Salford Royal NAAS model at Pennine and consists of 2 WTE members of staff; Helen Carter, Lead Nurse (seconded from SRFT in August 2016) and Jane Garforth, Senior Sister, who has worked at Pennine for 18 years. An introduction pilot covering 9 wards was developed and supported by the Transformation Team through the allocation of Hayley Mannin, Senior Project Manager, to provide the necessary project support.

A project plan was created detailing which Ward/Specialty was to be assessed with allocated dates and targets for completion. Weekly updates in relation to the projects' performance are presented to the Quality Improvement Delivery Meeting and the Care Board.

The Salford NAAS documentation was used for the pilot with modification to ensure it was suitable for PAHT.

During the pilot, 3 different versions of the document were used;

- the current 2016 SRFT version
- the original 2008 SRFT version
- an amended current SRFT version.

The pilot assessments were conducted across three sites, NMGH, FGH and TROH between 3rd October 2016 and 2nd November 2016.

The pilot was evaluated by the Executive Team, and the final assessment document has been agreed by the Directors of Nursing and senior nursing team. The full roll out across all sites will commence the week beginning 21st November 2016. The aim of the NAAS team is to have conducted an assessment of all 59 wards by week commencing 12th June 2017; this will include a re-assessment of the pilot wards using the final NAAS documentation.

When this phase has been completed, consideration will be given to expand to cover all specialties including Maternity with a total of 93 clinical areas.

2. Assessment & development

NAAS measures the quality of nursing care delivered by individuals and teams, it incorporates Essence of Care standards, key clinical indicators and each question is linked to Compassionate Care - The 6cs of: care, compassion, competence, communication, courage and commitment, whilst providing evidence for the Care Quality Commission's Fundamental standards.

The framework is designed around 13 standards with each standard subdivided into Environment, Care and Leadership. The 13 standards are: Organisation and Management of the Clinical Area, Safeguarding Patients, Pain Management, Patient Safety (1), Environmental Safety (2), Nutrition and Hydration, End of Life Care, Medicines Management, Person Centred Care, Pressure Ulcers, Elimination, Communication and Infection Control.

The NAAS is designed to support nurses in practice to understand how they deliver care, identify what works well and where further improvements are needed.

2.1 Proposed Assessment Awards:

Below are the assessment awards used in the pilot and proposed for the full rollout. Each ward will have an assessment completed and will be accredited with a level 0 to 3. Reassessment will take place at a time interval dependent upon the results:

Red	**5 red standards or more in total**	**Level 0**	**Reassess in 2 months**
Amber	**3 - 4 red standards in total / or less than 7 green standards**	**Level 1**	**Reassess in 4 months**
Green	**1- 2 red standards in total and a minimum of 7 green standards**	**Level 2**	**Reassess in 8 months**
Blue	**3 consecutive green NAAS assessments (Accredited wards)**	**Level 3**	**Reassess in 12 months**

2.2 Accreditation

1. Following the assessment the Ward Manager and Matron will be required to formulate an action plan. The action plan will be prepared on a standard template used throughout the organisation.

2. The Ward Manager and the Matron will be given 2 weeks to complete their action plan. The date for completion will be noted on the front sheet of the Assessment.

3. A copy of each assessment and action plan will be sent to the Lead Nurse and Divisional Nurse Director responsible for that area to approve and endorse in practice.

4. Action plans must then form part of every ward/unit team meeting and Ward Manager to track progress.

5. If the ward achieves red status then the Ward Manager will have an appraisal completed by the Lead Nurse, with clear objectives set.

6. Progress reports will be received by the Trust Board and the Trust Governors.

7. The NAAS results must also be included in Service Reviews and in Executive Ward Rounds.

Level 0 (Red) Wards

- Wards that achieve Level 0 (Red) concurrently will be given an appropriate level of support to improve their status. These wards will be reviewed by the Chief Nurse, the Divisional Director of Nursing for that area and other relevant members of staff.

- Staff will be managed according to the Trust's Capability Policy.

Level 1(Amber) Wards

- Wards that fail to achieve above Level 1 (Amber) on two concurrent assessments, unless there are extenuating circumstances, will be reviewed by the Matron, Lead Nurse and the Divisional Nurse Director for that area.

- The Ward Manager will have an appraisal completed by the Lead Nurse and clear objectives will be set.

4. Appendices

Appendix 1 – Current 2016 NAAS assessment tool

NAAS 2016 - Pennine (10) FINAL.doc

Pride in Pennine

Quality-Driven
Responsible
Compassionate

Pride in Pennine | Quality-Driven Responsible Compassionate

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 Ensure adequate stabilisation consultant and middle grade cover in ED at NMGH to meet the agreed service model requirements. Develop and deliver new service model for urgent care in North Manchester. Have in place a nursing, ENP, ANP workforce to meet the demand of patients across EDs Develop and deliver primary care offer within ED at NMGH	1.12.16 12.9.16 1.4 17 31.3.17 30.9.16	External – GM Improvement Board CCGs GM providers Internal – Care Board and Quality Assurance Committee	On Target Consultant workforce stabilised. Middle grades revised date end Feb 2017 Dependent upon workforce recruitment. Delayed but pending successful recruitment and approval of nursing workforce model remains deliverable within due date. Completed	Chris Brookes Executive Medical Director SRFT Steve Taylor Divisional Director	1.3.17

	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

Components of Standard Model

5 July 2016

Salford Royal NHS
NHS Foundation Trust

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Meeting of: JHSOC for Pennine Acute - Task and Finish Group to review the PAT CQC Action Plan

Date: 17th November 2016 – Bury Council Chamber, Bury Town Hall

Present: Councillors; Briggs, McLaren and Smith and Jude Adams Interim Operations Director, Pennine Acute NHS Trust

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Members discussed and reviewed the summary of the CQC and SRFT Diagnostic Improvement Plan.

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.

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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 published (August 2016) 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.

Members present reviewed the high level assurance dashboard – The Dashboard identifies key themes that measure the Trust's progress. The Dashboard will provide an evidence base to will ensure that the improvement actions and activities are translating to improvement in outcomes for patients using a small number of key performance indicators.

The Trust will assure the improvement plan through the Trust Board and Executive assurance committees

Members discussed the workforce proposals in respect of the new site management structure, problems with recruiting staff and achieving consistency in treatment and care across all sites and wards within the Trust.

It was agreed:

- Following consideration in the first instance at the Trust's Board, the high level assurance dashboard (considered at the meeting) would be shared with JG for wider circulation with other members of the Committee.
- A training session for Elected members would be arranged by the Trust in respect of the NASS model. The Chair has proposed two dates : Thursday 19th January at 2pm or Tuesday 24th January at 2pm
- In advance of the training session in January a briefing/narrative report will be produced by the Trust for circulation with the December JHOSC papers.