AGENDA FOR

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR PENNINE ACUTE NHS TRUST

Contact:: Julie Gallagher
Direct Line: 01612536640
E-mail: julie.gallagher@bury.gov.uk
Web Site: www.bury.gov.uk

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

Councillors: N Briggs, R Dutton, L Hamblett, G McGill, Councillor Linda Robinson, S Smith, P Sullivan, R Surjan and R Walker

Dear Member/Colleague

Joint Health Overview and Scrutiny Committee for Pennine Acute NHS Trust

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

Date:	Tuesday, 8 October 2019
Place:	Council Chamber, Bury Town Hall, Knowsley Street, Bury BL9 0SW
Time:	10.30 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 MINUTES *(Pages 1 - 6)*

Minutes of the meeting held on 18th July 2019 are attached.

5 MATTERS ARISING *(Pages 7 - 10)*

- Cancer Access Targets
  Nicola Remmington, Lead Cancer Manager will report at the meeting. Presentation attached.

6 STANDING AGENDA ITEM - FINANCIAL UPDATE (INCLUDING OUTSOURCING UPDATE) *(Pages 11 - 22)*

Nicola Tamanis, Deputy Chief Finance Officer and Joe Lever, Director of Procurement and will report at the meeting. Presentation and report attached.

7 STANDING ITEM - RECRUITMENT AND RETENTION UPDATE *(Pages 23 - 30)*

Dean Hambleton Ayling, Associate Director of Workforce will report at the meeting. Reports attached.

8 UPDATES ON STATISTICS *(Pages 31 - 40)*

Linda Swanson, Group Associate Director Infection Control & Jayne Downey, Director of Corporate Nursing and Governance will report at the meeting. Report attached.

9 LEARNING FROM DEATHS QUARTERLY REPORT *(Pages 41 - 70)*

Alison Talbot, Head of Legal Services, & Paul Downes, Director of Patients Safety, reports attached.

10 NORTH MANCHESTER TRANSACTION UPDATE *(Pages 71 - 82)*

Steve Wilson, Executive Lead, Finance and Investment, GMHSC; Simon Neville, Director of Strategy & Development at Salford Royal Foundation Trust, and Peter Blythin, Executive Director of Workforce and Corporate Business will be in attendance.

11 URGENT BUSINESS

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

12 DATE OF NEXT MEETING

- Thursday 23rd January 2020 2pm – Bury Town Hall

This page is intentionally left blank

Agenda Item 4

Meeting of:

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

Date: 18th July 2019

Present:

Councillor R Walker (Bury Council)
Councillor S Smith (Bury Council)
Councillor G McGill (Bury Council)
Councillor L Hamblett (Oldham Council)
Councillor R Surjan (Oldham MBC)
Councillor N Briggs (Oldham Council)
Councillor R Dutton (Rochdale Council)
Councillor L Robinson (Rochdale Council)
Councillor P Sullivan (Rochdale Council)

Jon Rouse Chief Officer, Greater Manchester Health and Social Care Partnership
O Khan, Programme Director Salford Royal Foundation Trust
S Gardner, Deputy Programme Director, Single Hospital Services Programme, Manchester Foundation Trust
V Morris, Programme Manager
K Southern, Assistant Director – Quality, Productivity and Improvement Department - Northern Care Alliance NHS Group
Nicky Tamanis, Deputy Chief Finance Officer, Salford Royal and Pennine Acute
Jo Purcell, Deputy Director North East Sector
J Patel, Deputy Chief Information Officer - Northern Care Alliance NHS Group
S Lockett, HR Business Partner - Northern Care Alliance NHS Group
J Gallagher, Democratic Services Officer

Apologies:

There were no apologies for absence.

PAT.19/20-01 APPOINTMENT OF CHAIR AND VICE CHAIR

1. That Councillor Linda Robinson (Rochdale Council) be appointed Chair of the Joint Health Overview and Scrutiny Committee for the Municipal year 2019/20.
2. That Councillor Stella Smith (Bury MBC) be appointed vice Chair of the Joint Health Overview and Scrutiny Committee for the Municipal year 2019/20.

PAT.19/20- 02 APOLOGIES

Apologies were detailed above.

PAT.19/20-03 DECLARATIONS OF INTEREST

There were no declarations of interest.

PAT.19/20-04 PUBLIC QUESTIONS

There were no public questions.

PAT.19/20-05 MINUTES AND MATTERS ARISING

It was agreed:

That the minutes of the meetings held on 23rd April 2019 be approved as a correct record.

PAT 19/20-06 PENNINE ACUTE NHS TRANSACTIONS UPDATE

Jon Rouse, Chief Officer, Greater Manchester Health and Social Care Partnership, Oz Khan, Programme Director Salford Royal Foundation Trust and Stephen Gardner, Deputy Programme Director, Single Hospital Services Programme, Manchester Foundation Trust, attended the meeting to update members on the work being undertaken to progress the Pennine Acute NHS Transaction. The presentation contained the following information:

- Details of the proposed plans for the PAT
- PAT Transaction Board
- Benefits for patients
- Next steps
- Stakeholder engagement

This Transaction is essential to support the future clinical, financial and workforce sustainability of acute hospital services in the North East sector and across Greater Manchester. The Deputy Programme Director reported that this transaction is about re-modelling health care across Greater Manchester and is an opportunity to strengthen how acute and community based services across these hospitals are delivered for patients, service users and staff.

The proposed plans will support and complement local integrated healthcare plans to meet the population health needs of local communities and wider local health plans to strengthen community support, deliver more care closer to home and maximise the use of the estate on the PAT footprint.

A PAT Transaction Board, independently chaired by GM HSCP, is overseeing the formal transactions and proposed changes in ownership. The PAT Transaction Board aims to complete the transactions and to formally split PAT by 31 March 2020, subject to rigorous due diligence, agreement of financial plans and approval of business cases.

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

Councillor Walker raised concerns that the name Salford Royal will be lost with the establishment of the new Northern Care Alliance.

Members sought assurances with regards to the transaction, the Chief Officer confirmed that any costs associated with the transaction would be met from transformation monies and not from existing health care budgets. Capital works will still need to be undertaken regardless of the transaction.

Responding to a member's question, the Chief Officer reported that Greater Manchester no longer has a Level 1 centre to provide specialist surgery and care for congenital heart disease patients. The Chief Officer reported that this is the only service to be lost from Greater Manchester following devolution. The Deputy Programme Director reported that if the tertiary centres had been consolidated earlier the Trusts providing the care may have been in a stronger position to retain these services.

The Chief Officer reported that this transaction will not impact the development of the locality commissioning organisations/integrated commissioning arrangements.

The transaction will provide the workforce with opportunities including greater certainty, career development and better facilities. It is hoped for the patents too, the proposals will alleviate the variations in services, support and outcomes across Greater Manchester.

It was agreed:

The officers be thanked for their attendance.

PAT 19/20-07 OPERATIONAL PLANS UPDATE ON THE YEAR 2018/19

Vee Morris Programme Manager and K Southern, Assistant Director – Quality, Productivity and Improvement Department attended the meeting to provide members with an update in respect of the Trust's Operational Plan. The presentation, circulated in advance of the meeting provided information in respect of the Trust's performance in the following areas:

- Attendance and four hour target within Urgent Care
- Reducing the Length of stay
- Elective care – referral to treatment
- Cancer Access

The presentation also included information with regards to the elective access and theatre transformation programmes and the single oversight framework.

K Southern, Assistant Director – Quality, Productivity and Improvement Department reported that over the last year Pennine, like the rest of the NHS has experienced increasing pressure and demand on services. In 2018-19 the Trust saw the highest ever number of patients attending its emergency departments - There were 394,473 patient attendances; an average of 1,081 per day or one patient every 80 seconds.

Members discussed the Cancer access target and in particular the failure of the Trust in 2018/19 to reach the initial two week target or the 62 day standard for

treatment. The Programme Manager reported the Trust improved performance for the 2 week wait pathway passing the 93% national standard every month since February 2019, and has gradually improved against the 62 day standard during 2018-19. A Cancer Improvement Board is now in place at the Trust.

It was agreed:

The Pennine Acute NHS Trust will provide members with comparative data from the previous year in relation to the trust performance against the Cancer Access target.

PAT 19/20-08 BUDGET REPORT

Nicola Tamanis Deputy Chief Finance Officer attended the meeting to provide members with an updated financial plan, the presentation contained the following information:

- The provider sector deficit was £571m at year end
- 3.6% in year savings achieved
- £3.9bn capital invested - £400m more than allocated
- A&E Performance improved marginally despite increases in attendances – 4.3% increase at quarter 4
- 5.4% increase in emergency admissions
- 96,348 vacancies, a reduction overall but increases in nursing vacancies

The Deputy Chief Finance Officer reported that the financial requirements will include returning to financial balance; achieving cash-releasing productivity growth of at least 1.1%; reducing growth in demand for care through integration and prevention; reducing variation; and making better use of capital investment.

The Trust has a number of planned investments these will include, virtual outpatient appointments, digital first primary care innovations as well as improving the volume of elective treatment year on year.

The Trust still produces a statement of accounts separate to that of the SRFT. The required savings target is less for SRFT than it is for Pennine, this is in part due to a larger budget spend on drugs within this Trust.

It was agreed:

In light of the ongoing required budget pressures at the Pennine Acute NHS Trust, a financial update will be a standing agenda item.

PAT 19/20-09 RECRUITMENT AND RETENTION WORKFORCE UPDATE

S Lockett, HR Business Partner attended the meeting to provide and update in respect of recruitment, retention, agency spend and sickness rates across the Pennine Acute NHS Trust. The HR Business Partner reported that the workforce headcount is steadily growing but vacancy rates still remain problematic in some areas in particular women's and children's services and the division of medicine.

Agency spend continues to be a priority for the Trust and although still high, mechanisms have been put in place to address this.

The Trust has engaged in an international recruitment drive which has included approaching refugee charities and partnering with other Trusts to recruit internationally; this work has led to the successful recruitment of 27 FTE doctors. A similar approach has been taken to the recruitment of nurses. The Trust, like other Trusts in the country, continues to struggle to recruit to posts in A&E.

It was agreed:

As this continues to be an area of concern for members of the Committee, a workforce update will remain a standing agenda item.

PAT 19/20-10 NORTHERN CARE ALLIANCE IT STRATEGY

J Patel, Deputy Chief Information Officer – provided members with an overview of work currently being undertaken to address IT infrastructure concerns within the Trust. The Deputy Chief Information Officer reported that a new infrastructure programme will focus on new servers, increasing data storage and back up capabilities; moving the GM radiology from the N3 network to the Health and Social Care Network and a wifi, full equipment refresh.

Work will be undertaken to replace cabling, switching and cabinets as well as the installation of a new telephony system. There will also be an upgrade of the computer operating systems to improve cyber security.

The Deputy Chief Information Officer Reported that this planned worked will allow for improved system performance and productivity with a faster and more reliable network to support remote working. As well as increased wireless capability. Recruitment to IT remains problematic, it is hoped that the changes to the Trust's IT infrastructure as well as much needed investment will help colleagues to work more collaboratively across the Northern Care Alliance and provide staff with more opportunities to digitise workflows.

Members expressed concerns in relation to the poor state of some of the IT infrastructure. The Deputy Chief Information Officer Reported that the Trust had undergone a number of staffing changes and acknowledged that there has been a lack of focus in relation to this matter in recent years. This has now been addressed, a ten year plan has been adopted as well as an increase in investment. The focus has changed within the organisation with an acknowledgment that digitalisation should be seen as an enabler and a means of retaining staff.

PAT 19/20-11 A BRIEFING ON THE PENNINE CARE COMMUNITY SERVICES TRANSFER

Jo Purcell, Director of Strategy reported that the Pennine Care community services staff had successfully transferred to the Northern Care Alliance on 1st July. A

comprehensive welcome pack was shared with staff and a helpline was provided for any issues that emerge during the first weeks.

Service level agreements are still in place with PCFT for IMT and procurement and estates health informatics and bank arrangements. Risk share agreement and governance arrangements have been signed off.

The Director of Strategy reported that the local care organisation development will be primarily concerned with ensuring that the local systems to determine the right community service model is in place. The focus going forward will be less on transfer and more on transformation and delivering the locality plans.

Members discussed the future arrangements with regards to tendering and procurement of community services; the Director of Strategy reported that the Northern Care Alliance has been awarded the contract for two years, what will follow will be a further procurement exercise, the procurement process will be determined by the Commissioners.

It was agreed:

The Director of Strategy be thanked for her update.

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

PAHT Cancer Access Target July 2017 – July 2019

PAHT Joint Health Overview and Scrutiny Committee 8th October 2019

Comparative data from July 2017 to July 2019 in relation to the trust performance against the Cancer Access target.

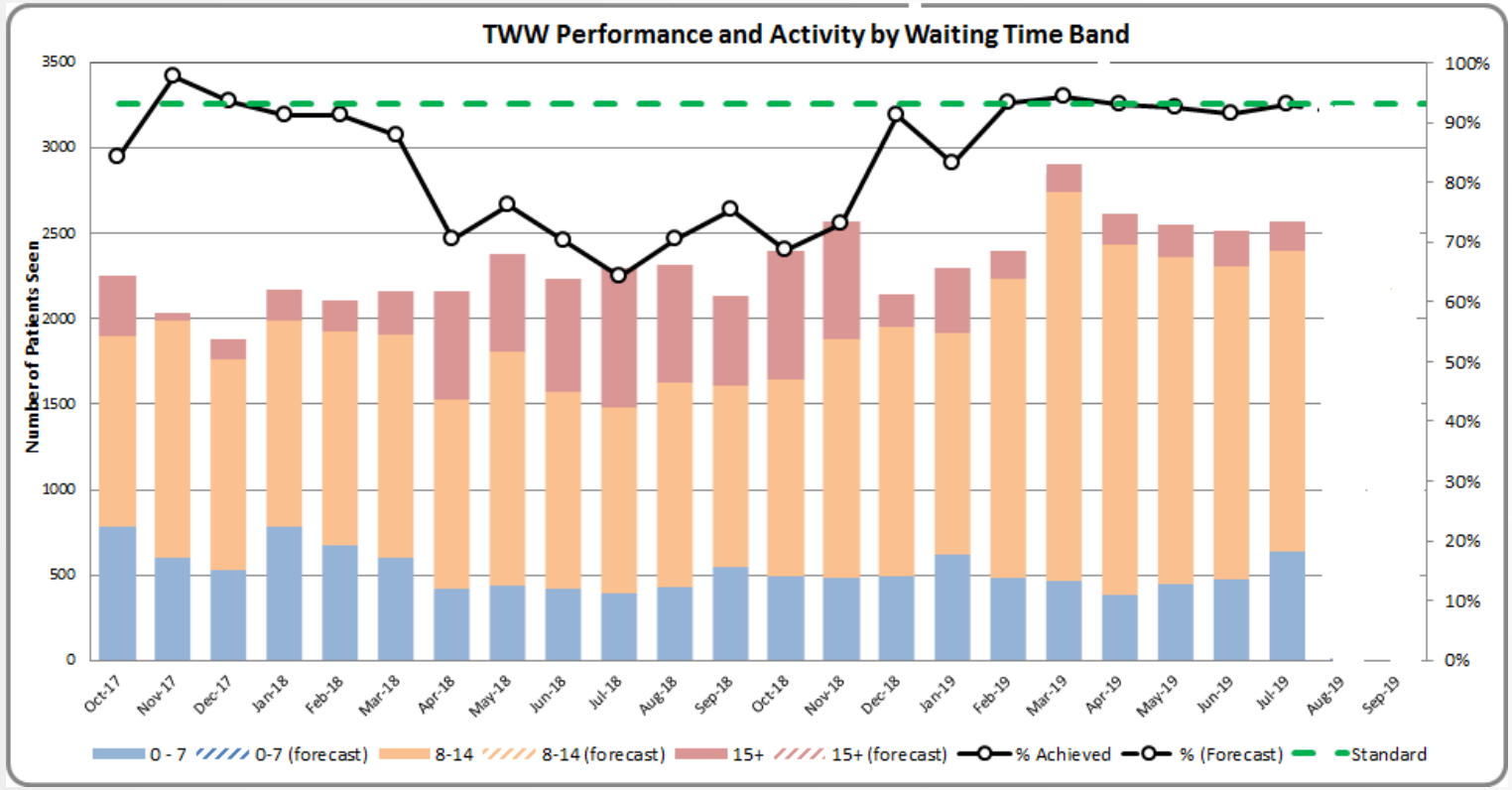
Nicola Remmington, Lead Cancer Manager

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

PAHT Cancer Access Target

Two Week Wait Performance

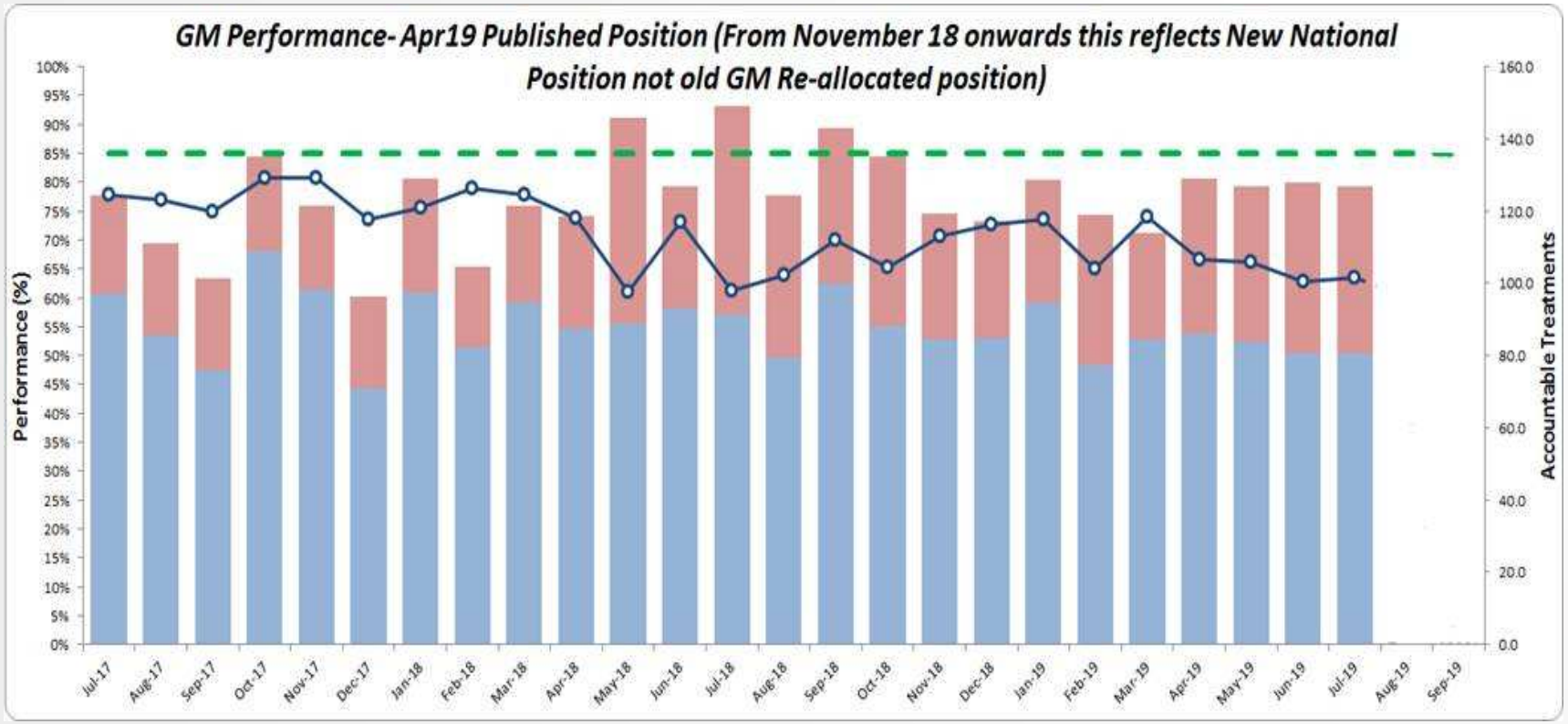


PAHT achieved the target with performance at 93.0% for Jul19. Gynaecology & H&N (ENT) were the only breaching specialties (79.2% & 83.1% respectively). Gynaecology is the main contributor towards failing performance at both OCO and Trust level for this target since Apr19. Unprecedented increase in referral rates in Gynae have resulted in a capacity shortfall (increase rate as high as 44% compared to previous twelve months since Mar19).

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

Cancer Access Target
62 Days Position



PAHT has continued to fail the 62D standard during 17/18, 18/19 and for 1920 to date. July performance was below target at 63.4%, the majority of breaches occurred in OCO but were widespread across all significant (in terms of activity) tumour groups with the exception of Breast (94.9%).

This page is intentionally left blank

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

2019/20 – 2023/24
Long Term Plan

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

NHS LTP Implementation Framework

Clinically-led: identify and support senior clinicians to lead on the development of implementation proposals for all LTP commitments

Locally owned: Local government will be key partners. Similarly, the voluntary sector and other local partners will also be asked to be involved

Realistic workforce planning: The interim NHS People Plan sets out the national context. System plans should be realistic and matched to activity. Include steps locally to improve retention and recruitment.

Saving lives, Improving lives

Northern Care Alliance NHS Group

NHS LTP Implementation Framework

Financially balanced: Systems need to show how they will deliver the commitments in the plans within the resources available to meet the five tests:

Test 1: plans will need to include financial recovery plans for individual organisations in deficit against specified deficit recovery trajectories

Test 2: actions to achieve cash releasing savings

Test 3: reduction of unwarranted variation

Test 4: moderate growth demand

Test 5: set out capital investment priorities for capital budgets being agreed through the forthcoming Spending Review

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

Key Planning Milestones

27 September 2019: Systems to share a draft of their plans, including detail on clinical priorities and trajectories. Regions, working with central teams, will use this information to build a national picture against our overall outcome goals, feeding back where adjustments are needed.

By 15 November 2019: System plans should be agreed with system leads and regional teams, in consultation with National Programme Directors. Packages of future support from central teams to support delivery will also be agreed.

By the end of March 2020: Provider and CCG plans for 2020/21, which are fully aligned with the system-level plans, to be submitted, along with agreed contracts between providers and commissioners. A further submission to demonstrate that plans and contracts are aligned between commissioners and providers will also be required.

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

Long Term Plan - Timetable

Milestone	Date
Interim People Plan published	3 June 2019
Long Term Plan Implementation Framework published	27 June 2019
Main technical and supporting guidance issued	July 2019
High Level "do nothing" plan submission to GM to size potential gap	2 August 2019
Initial Submission from Providers & Commissioners for aggregation & triangulation by GM	16 September 2019
Initial system planning submission	27 September 2019
System plans agreed with system leads and regional teams	15 November 2019
Operational and technical guidance issued	December 2019
Publication of the national implementation programme for the Long Term Plan	December 2019
First submission of draft operational plans	Early February 2020
Final submission of operational plans	By end March 2020

This page is intentionally left blank

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

Overview of Outsourced Contracts at Pennine Acute

Joe Lever, Group Procurement Director

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

Overview

Pennine Acute Joint Health Overview and Scrutiny Committee meeting requested details of services/contracts which had been outsourced to other organisations

This presentation sets out a number of contracts The Pennine Acute NHS Trust have outsourced to private providers

Details will be provided on what the service is and the supplier selection process

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

Legal Services

This agreement gives the Trust access to specialist legal support providing advice and assistance on legal matters, drafting/ review of both legal and commercial documents, advising on or engaging in negotiations of contracts and licenses, undertaking legal research or analysis.

As a result of a further competitive exercise undertaken under a SBS Framework Agreement, Hill Dickinson LLP was appointed as the provider of legal services to Pennine with preferential than framework rates being obtained.

Hill Dickinson has also agreed to continue with the agreed value added services already provided such as mock inquests, witness support sessions as part of the contract along with secondment arrangements and the provision of a volume discount rebate.

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

Interpretation and British sign Language (BSL)

Pennine Acute utilises the specialist support of Interpretation, Translation and Non-spoken word providers to supplement the availability and resource of its existing interpreter staff.

This service also provides a useful route to source niche or uncommon languages and dialects that are not available within the current in-house team of interpreters.

Services taken include face to face, telephone and British Sign Language (include Lip speaking and Deaf-blind interpretation).

The various services have been either put out to procurement or mini-competitions to ensure value for money against the contracted rates.

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

MRI Scanning

MRI scanning is partially outsourced across Pennine Acute as demand continues to increase at an unprecedented rate year on year.

To adhere to the 6 week waiting times for MRI scanning, a private company provides a staffed scanner at off site locations that are accessible to our patients.

A further competition under a framework was conducted to award this contract to one provider. Services were previously provided by a number of suppliers so by rationalising this contract, financial efficiencies were realised.

The framework also offers the flexibility to direct award to other providers when additional capacity is required.

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

Conclusions

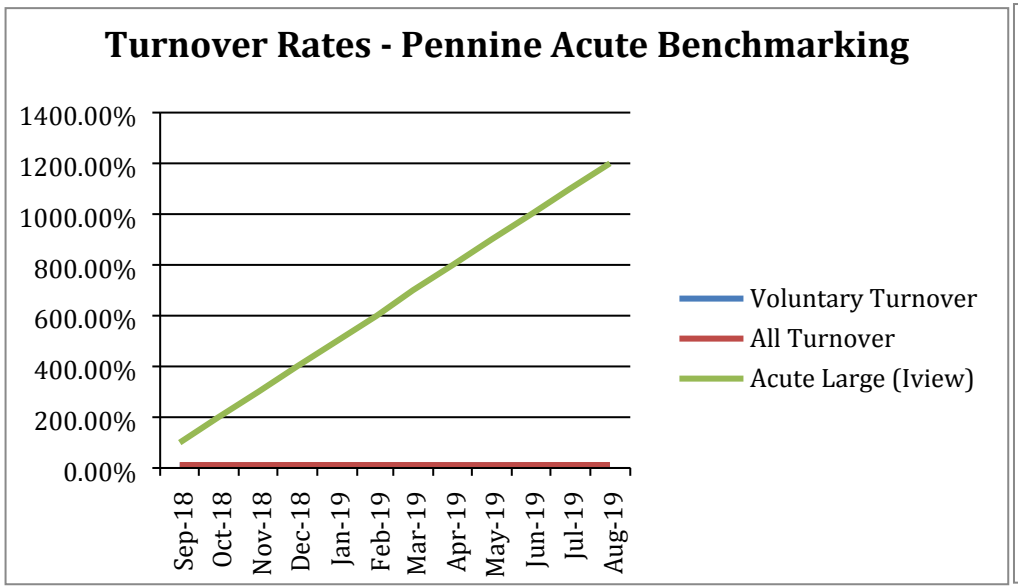
The driver for outsourcing is through demand, lack of capacity, skills, expertise or better value for money can be achieved.

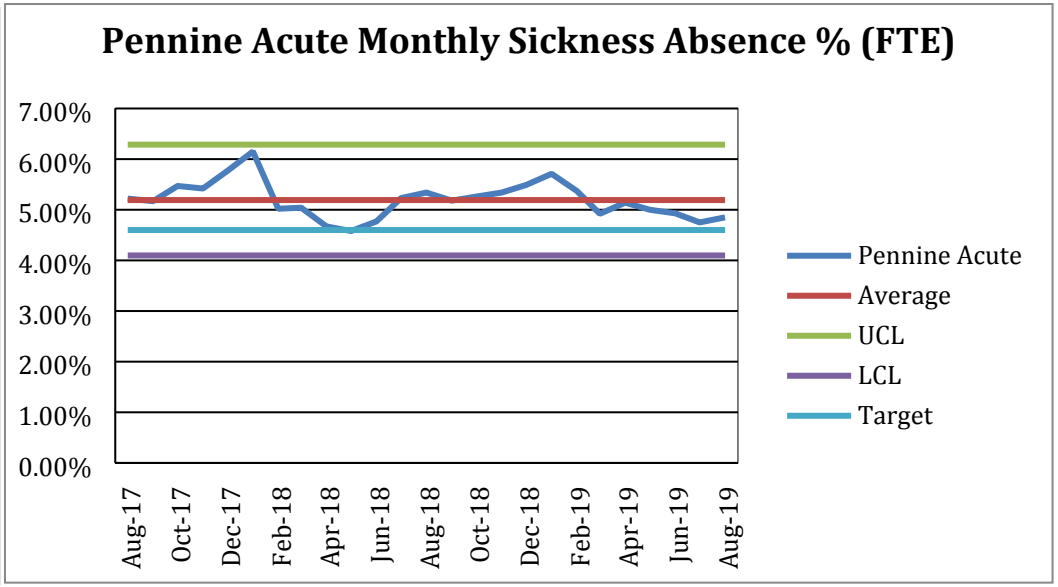
The decision making process around this is rigorous and review through the appropriate Northern Care Alliance governance committees.

Outsourced contracts are reviewed on a on-going basis to ensure value for money or whether a different model being more effective to support better patient care

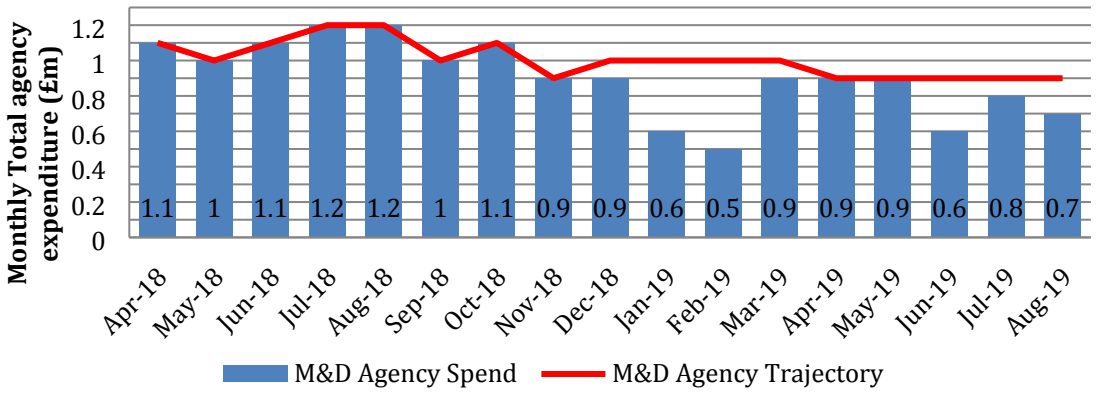
This is evidenced through recent decisions where historical outsourced contracts are now being brought back in house due to changes in the market place and new skills being available to recruit the essential staff required

Trust Wide – Month 5 (August 19)
Sickness and Turnover

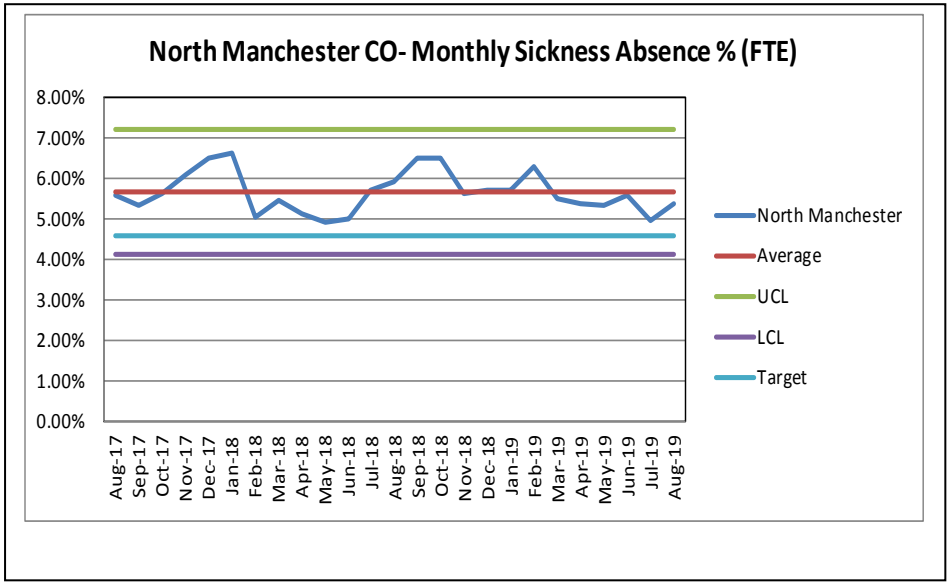


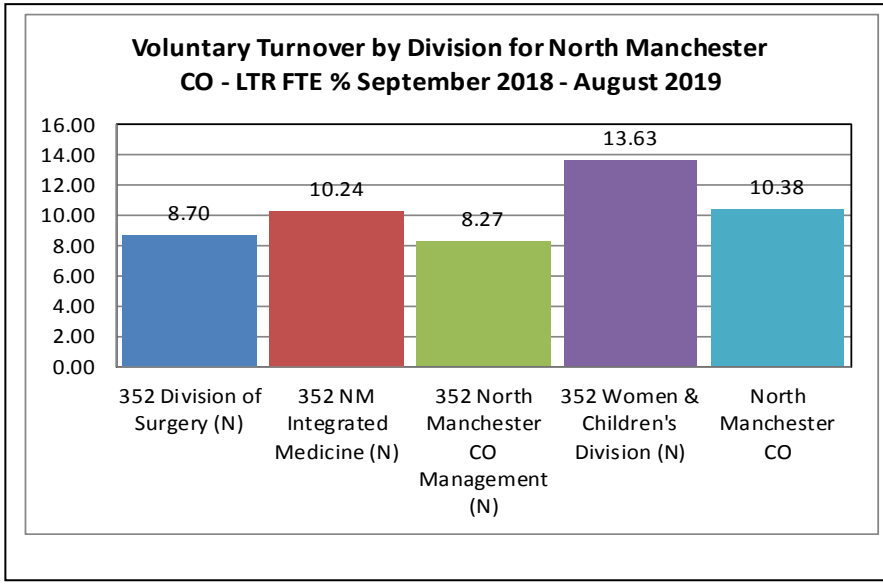


North Manchester Care Organisation – Month 8 (August 2019)
Staff In Post, Agency, Sickness and Turnover



Division	Position FTE	Actual FTE	Variance	% Vacant
352 Division of Surgery (N)	748.08	664.40	83.68	11.19%
352 NM Integrated Medicine (N)	787.33	723.16	64.17	8.15%
352 North Manchester CO Management (N)	9.89	11.80	-1.91	-19.31%
352 Women & Children's Division (N)	435.80	378.76	57.04	13.09%
352 North Manchester CO	1981.10	1778.12	202.98	10.25%
Pennine Acute	9890.67	9108.85	781.82	7.90%



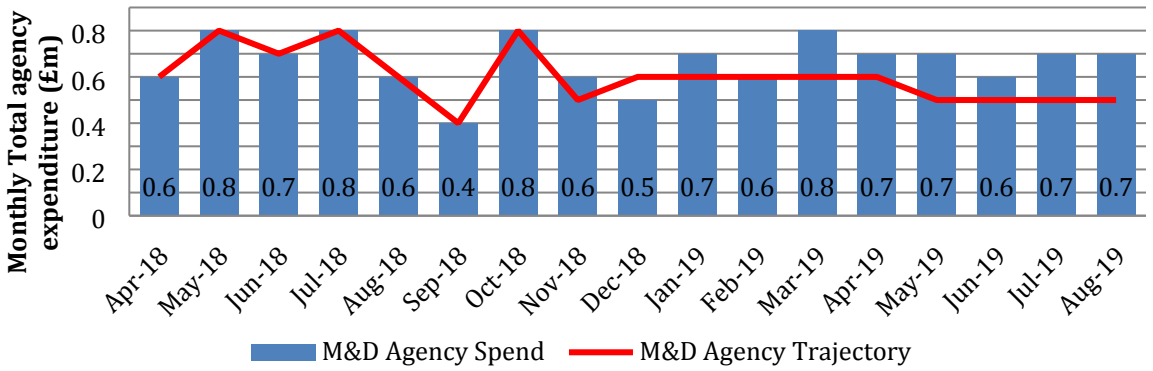


Saving lives, Improving lives

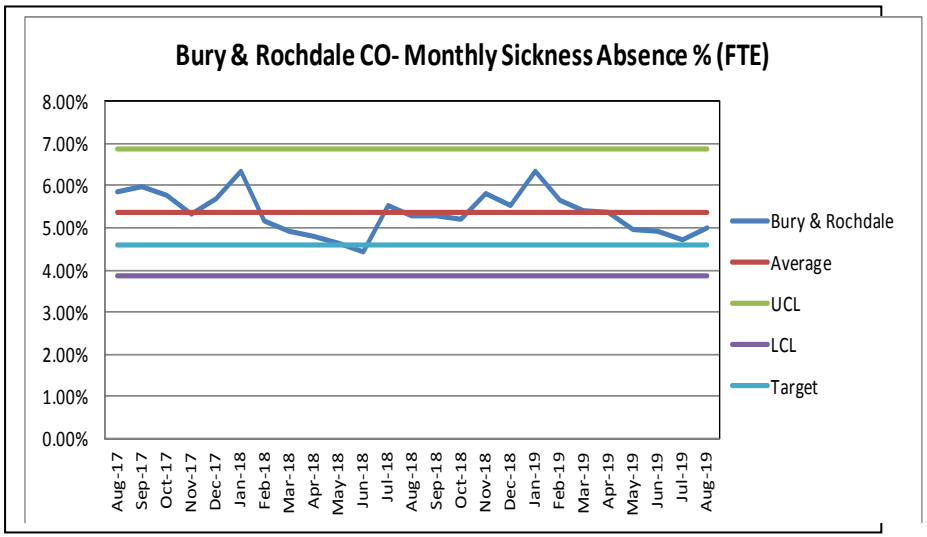
NHS
Northern Care Alliance
NHS Group

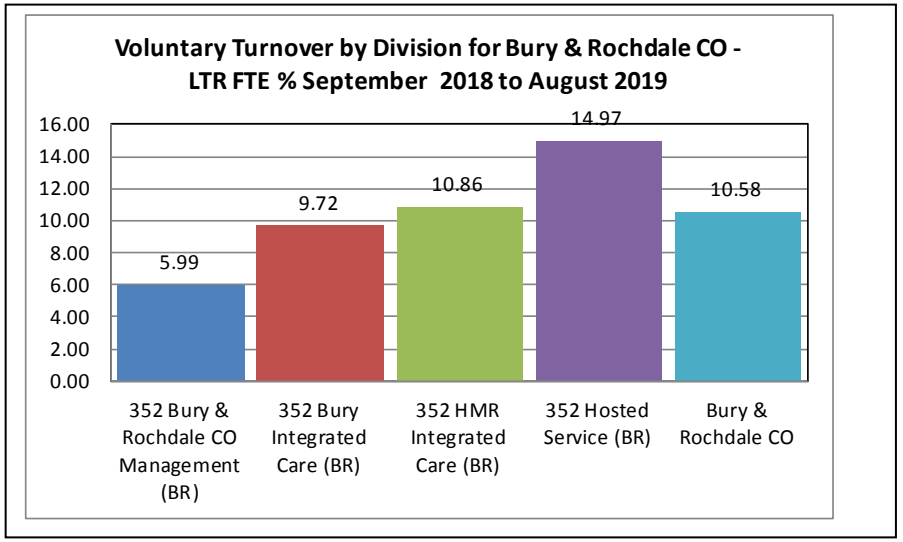
Salford | Oldham | Bury | Rochdale | North Manchester

Bury and Rochdale Care Organisation – Month 8 (August 2019)
Staff In Post, Agency, Sickness and Turnover



Staff Group	Position FTE	Actual FTE	Variance	% Vacant
Add Prof Scientific and Technic	33.33	35.68	-2.35	-7.05%
Additional Clinical Services	476.35	446.07	30.28	6.36%
Administrative and Clerical	152.06	148.42	3.64	2.39%
Allied Health Professionals	27.03	24.63	2.40	8.89%
Estates and Ancillary	17.40	17.85	-0.45	-2.61%
Healthcare Scientists	28.56	23.92	4.64	16.25%
Medical and Dental	261.64	191.64	70.00	26.75%
Nursing and Midwifery Registered	947.98	834.37	113.61	11.98%
Students	1.00	1.00	0.00	0.00%
352 North Manchester CO	1945.35	1723.59	221.76	11.40%
Pennine Acute	9745.49	8971.41	774.08	7.94%



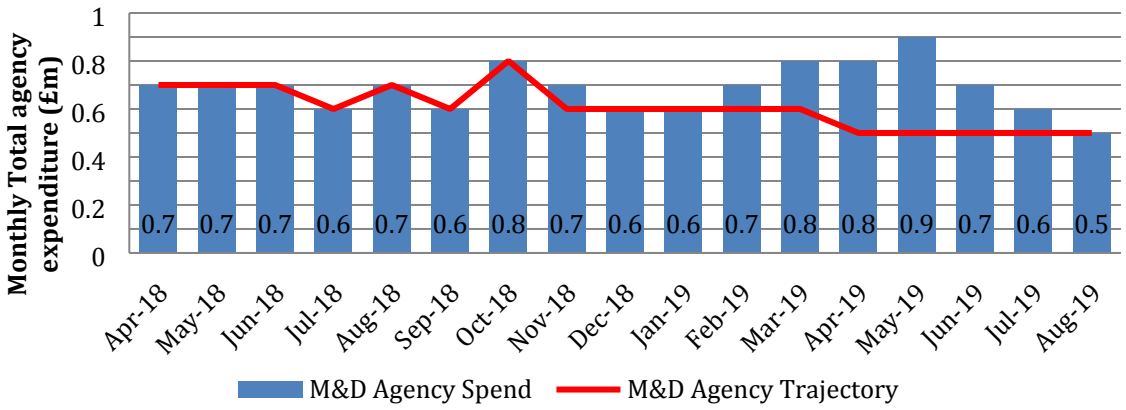


Saving lives, Improving lives

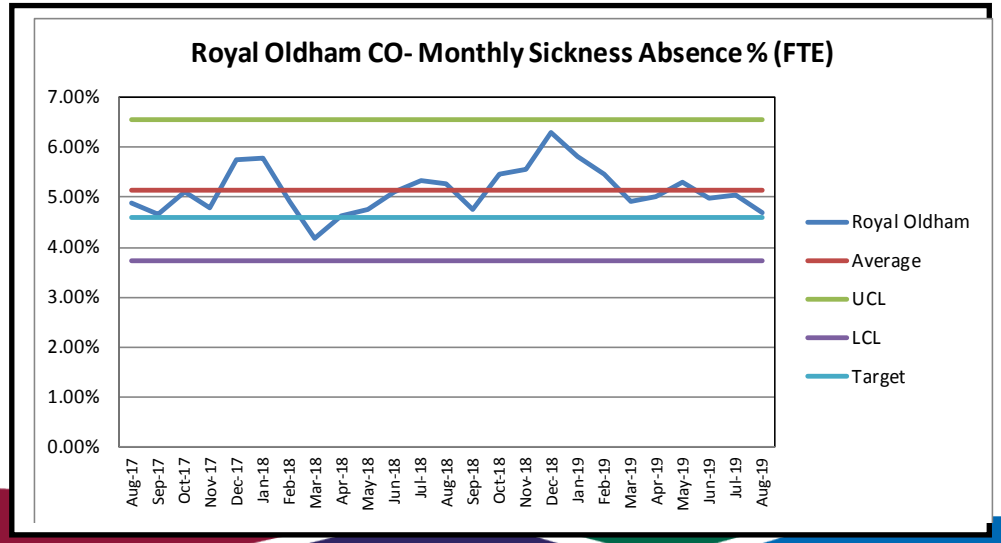
NHS
Northern Care Alliance
NHS Group

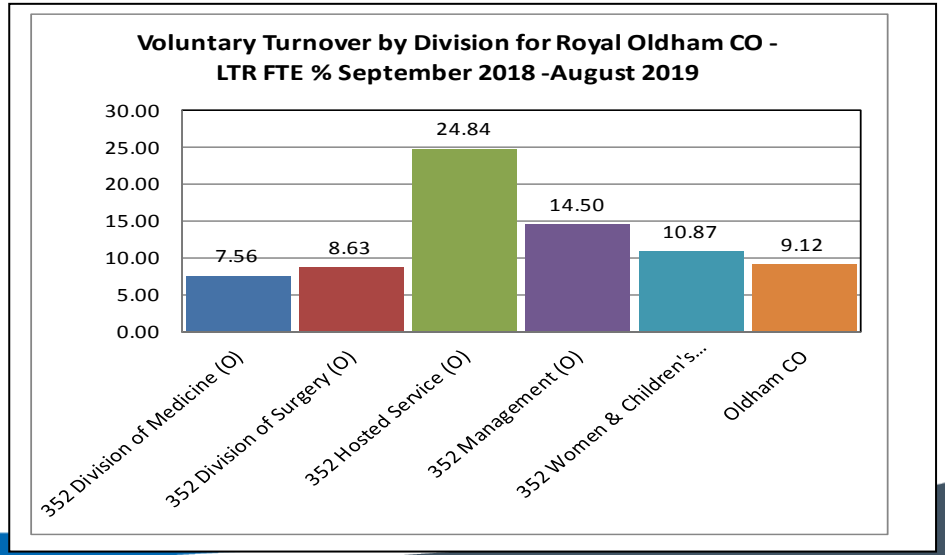
Salford | Oldham | Bury | Rochdale | North Manchester

Royal Oldham Care Organisation – Month 8 (August 2019)
Staff In Post, Agency, Sickness and Turnover



Division	Position FTE	Actual FTE	Variance	% Vacant
352 Division of Medicine (O)	684.29	668.22	16.07	2.35%
352 Division of Surgery (O)	915.85	902.31	13.54	1.48%
352 Hosted Service (O)	20.10	22.64	-2.54	-12.64%
352 Management (O)	15.74	14.49	1.25	7.92%
352 Women & Children's Division (O)	638.89	585.18	53.71	8.41%
352 Royal Oldham CO	2274.87	2192.84	82.03	3.61%
Pennine Acute	9890.67	9108.85	781.82	7.90%





Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

Salford | Oldham | Bury | Rochdale | North Manchester

Northern Care Alliance

Briefing Paper
Health and Wellbeing September 2019

Health and Wellbeing Update: September 2019

Background

Over the summer we have been developing our Strategy and delivery plan to improve the Health and Wellbeing of staff. This work started with a Health and Wellbeing Survey which closed in July. The survey was used to identify those areas of improvement that staff identified as being important to them. It was also used to develop the delivery plan.

Health and Wellbeing Survey Results

1136 employees completed the survey from across all Care Organisations.
The main factors affecting the health and wellbeing of staff were identified as:

- Staffing levels
- The behaviour of colleagues and managers
- Car parking
- Management decisions
- Inability to switch off outside work

Staff also told us the things that had the greatest positive impact on their health and wellbeing are:

- Colleagues
- Flexible working
- Teamwork
- Work-life balance

Included within the survey were 5 questions, known as the World Health Organisation 5 Wellbeing index. These questions showed in the last 2 weeks that:

- Most staff said they have felt in good cheer more than half the time (or more frequently)
- Half felt calm and relaxed more than half the time (or more frequently)
- Most said their life was filled with things that interested them
- However, a minority of staff (46%) said they felt active.
- Only 31 % of staff said that woke up feeling fresh and rested more than half the time (or more frequently).

Health and Wellbeing Strategy

To address these concerns, a Health and Wellbeing Strategy has been developed (see attached), based on the feedback from the survey and has been developed in conjunction with Care Organisations and trade unions.

The Strategy is formed of four pillars:

- To create a Safe, Healthy & Inclusive Work Environment
- Active Involvement
- Tailored Support
- A culture that enables physical and emotional wellbeing

Aligned to the Patient Experience Strategy, each of these pillars is made up of 'I' statements and 'We' statements. The 'I' statements reflect how we would like staff to feel when they come to work. The 'We' statements reflect what management will put in place to enable this to happen.

It is anticipated that the Strategy will be signed off at September's Board.

Health and Wellbeing Delivery Plan

The Delivery Plan is structured using the same four pillars as the Strategy. Each of the 'We' statements have been mapped to specific work activities. The Delivery Plan is currently in a draft format, awaiting consultation with those functions who will be responsible for delivering the activities.

Current Health and Wellbeing Activities

While we wait for Delivery Plan to be signed off we have been implementing the following activities:

- We have introduced a training course for staff newly diagnosed with Cancer (in conjunction with Macmillan Nurses)
- We have introduced free Relki and Indian head massage sessions across all sites
- We are developing a programme for Health and Wellbeing Champions, which we will have on each shift
- We are aiming to train 500 Mental Health First Aiders across all sites by April 2020
- In October we are launching a new platform to promote all staff benefits in a single location with an extended range of benefits on offer
- Also in October we are launching a new Employee Assistance Programme across all sites, including offering access to 24 hour support and counselling to in addition to the service currently provided by Occupational Health.
- We are working with Simply Health to help staff look after their health and wellbeing which offers money back on some of your healthcare expenses.

Recommendation

It is recommended that this item is to note.

Dean Hambleton-Ayling
Associate Director Of Workforce

This page is intentionally left blank

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

Salford | Oldham | Bury | Rochdale | North Manchester

Northern Care Alliance

PAT Healthcare Acquired Infection Report

For

Pennine Acute Joint Health & Overview Scrutiny Committee

Linda Swanson
Group Associate Director Infection Control

PENNINE ACUTE TRUST HEALTHCARE ACQUIRED INFECTION (HCAI) REPORT.

1ST APRIL-31ST AUGUST 2019

EXECUTIVE SUMMARY

1.1 The externally set objective for reduction for *Clostridium difficile* infections (CDI) cases across Pennine Acute Trust (PAT) for 2019/20 is no more than 103 reportable cases

1.2 The CDI attribution process has changed and cases will be assigned to the acute trust if Healthcare Onset Healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA).

1.3 The externally set objective for MRSA bacteraemia remains as a zero tolerance objective.

1.4 In addition to external infection objectives the Trust continues to support the reduction of other alert organisms with internal improvement and reduction objectives for MSSA, E.coli, CPE, and VRE.

1.5 To date there have been 53 cases of CDI, 30 HOHA and 23 COHA. To date 37 of these cases have been reviewed by the MDT RCA panel and 6 of these cases have been deemed avoidable, with learning identified.

1.6 To date there have been 0 cases of MRSA Bacteraemia.

1.7 QI methodology is used to identify improvements required, perform tests of change and implement successful initiatives

2.0 CHANGES TO *CLOSTRIDIUM DIFFICILE* ATTRIBUTION

CDI remains an unpleasant, and potentially severe or even fatal infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. Although nationally we have made great strides in reducing the number of CDIs the rate of improvement has slowed over recent years, and some infections are a consequence of factors outside the control of the NHS organisation that detected the infection. Further improvement on the current position requires a greater understanding of individual causes across the healthcare system to ensure all potential learning is identified and avoid a culture of apportioning blame through the lapses in care process.

2.1 KEY CHANGES FOR 2019/2020

CDI ATTRIBUTION

From April 2019 cases reported to the HCAI data capture system (DCS) will be assigned by DCS as follows:

a) **HOHA** - Healthcare onset healthcare associated: cases detected in the hospital ≥2 days after admission

b) **COHA** - Community onset healthcare associated: cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks

c) **COIA** - Community onset indeterminate association: cases that occur in the community (or within2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks

d) **COCA** - Community onset community associated: cases that occur in the community (or within 2 days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks

HOHA + COHA = TOTAL HEALTHCARE ASSOCIATED

COIA + COCA = TOTAL COMMUNITY ASSOCIATED

Objectives for each CCG and NHS acute provider have been set using extrapolated data from 1 April - 31 December 2018, using the new case assignment definitions (please see below for case and rate assignment for each Care Organisation).

ACUTE PROVIDERS

- Acute provider objectives for 2019/20 will be set using categories a) and b) above.
- This will mean a shift in numbers of cases that are trust assigned, as healthcare associated cases will include those with recent (last 4 weeks) hospitalisation.
- Based on PHE data, estimates are that the proportion of healthcare associated cases will increase to around 65% of the total number of cases.

2.2 RCA PROCESS AND ATTRIBUTION PANEL

NHSI continue to encourage organisations across the health and social care system to carry out clinical case reviews for each CDI case to determine whether it was linked to any lapses in care related to the care and treatment of the patients, in or out of the hospital setting and identify any patient safety issues or learning. The co-ordinating commissioner under each commissioning contract will continue to be able to consider the results of these assessments to seek assurance that robust systems are in place to prevent, diagnose and treat CDI infections.

The North East Sector (NES) RCA panel meet monthly to discuss cases of healthcare acquired infection such as CDI and MRSA. Cases are reviewed by the multi-disciplinary team to determine avoidability and any learning identified. Learning is shared via infection prevention and control committees, clinical effectiveness committees and governance boards. 7 minute briefings are used to inform staff of learning themes and these are also discussed as part of ward safety huddles.

From 1st April 2019 the NCA have implemented a standardised RCA tool which allows for identification of organisational control for the management of CDI and opportunities for shared learning. This tool is also encouraged for the use of community associated infections.

3.0 CDI OBJECTIVES

NHSI ACUTE AND CCG CDI CASE AND RATE OBJECTIVE 2019/2020

	CASE OBJECTIVE	RATE OBJECTIVE
PAT	103	27.3
SRFT	39	15.4
BURY CCG	47	24.7
OLDHAM CCG	79	33.6
HMR CCG	59	26.9
SALFORD CCG	65	26.5
MANCHESTER CCG	166	30.5

ADDITIONAL KEY POINTS

- Guidance for testing and reporting CDI cases remains unchanged. Financial sanctions will continue to be applied at the discretion of the commissioner; the key change is shifting the culture from the application of sanctions to learning and improving patient safety.
- A review of financial sanctions and the current lapses in care process will be undertaken ahead of 2020-2021.
- Faecal sampling and CDI testing rates for all providers will be reviewed in the next year. PHE already collects this data on a quarterly basis; providers will need to ensure that the data is accurate

3.1 NORTHERN CARE ALLIANCE INFECTION OBJECTIVES 2019/2020

The aggregate CDI objective for the Royal Oldham, North Manchester and Bury and Rochdale Care Organisations (no more than 103 cases) has been further divided based upon the average of the previous 3 years performance and taking into account the number of additional cases that would have been attributed using the new criteria set by NHSI (see table below). The acuity and specialities of each site has also been taken into consideration when dividing the objective, however it must be noted that it is the aggregate CDI objective that is reported to NHSI.

NORTHERN CARE ALLIANCE HCAI COMBINED EXTERNAL AND INTERNAL INFECTION OBJECTIVES

Whilst CDI objectives are set externally, there are other infections which impact on patient experience and outcome but are not currently included within mandatory objectives. In an effort to drive improvement in these The Northern Care Alliance (NCA) sets internal improvement objectives for all Care Organisations within the alliance. These have been instrumental in helping to focus attention on key infections, target resources, identify and share learning, and drive improvement initiatives and programmes. These reduction targets are based where possible on the previous year's performance, and where possible aim for reductions of between 3 - 6%. It is important to remember that these are internally set reduction targets, and as such do not carry

financial sanctions. However they aim to drive improvement, inform prevention strategies, identify best practice and reduce avoidable harm. The NCA remains committed to a zero tolerance approach to MRSA bacteraemia.

CARE ORGANISATIONS HCAI OBJECTIVES 2019/20

CARE ORGANISATION	CDI	MRSA BSI	MRSA COLONISATION	MSSA BSI	E COLI BSI	CPE	VRE BSI
ROYAL OLDHAM	41	0	37	13	29	6	4
NORTH MANCHESTER	35	0	37	13	26	6	13
FAIRFIELD & ROCHDALE	27	0	27	5	12	6	6

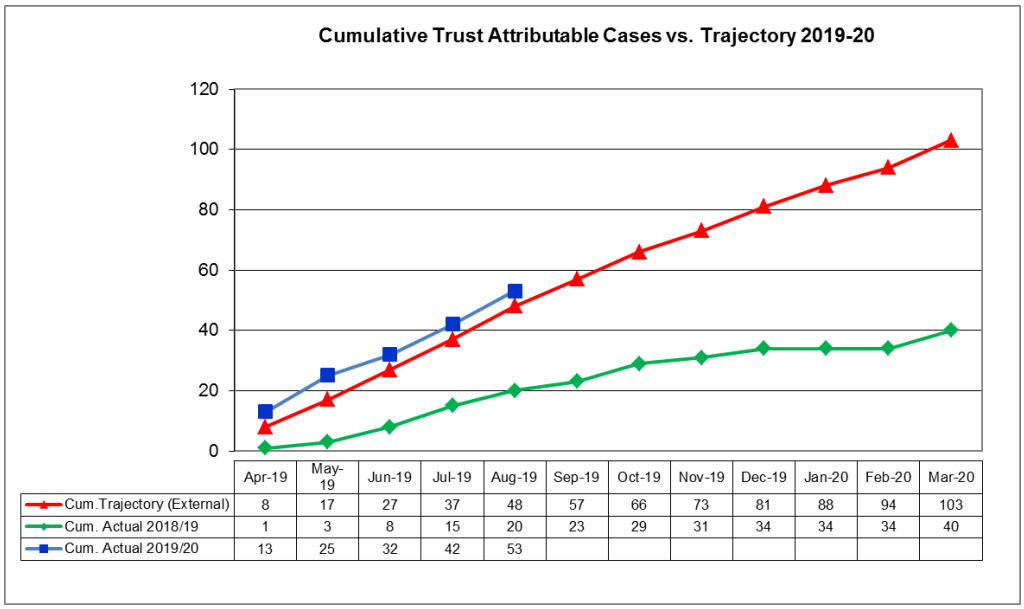
3.2 CARE ORGANISATIONS PERFORMANCE vs OBJECTIVES APR 2019 – 31st AUG 2019

CARE ORGANISATION	CDI	MRSA BSI	MRSA COLONISATION	MSSA BSI	E COLI BSI	CPE	VRE BSI
ROYAL OLDHAM	20/41	0	7/37	5/13	12/29	3/6	2/4
NORTH MANCHESTER	14/35	0	7/37	5/13	12/26	3/6	2/13
FAIRFIELD & ROCHDALE	15/27	0	4/27	1/5	8/12	1/6	0/6

3.3 MONTHLY CARE ORGANISATION CDI (HOHA AND COHA)

	ROH		NMGH		BARCO	
	HOHA	COHA	HOHA	COHA	HOHA	COHA
Apr-19	5	0	2	4	0	3
May-19	3	2	2	2	1	1
Jun-19	2	1	0	1	2	1
Jul-19	2	2	3	0	1	2
Aug-19	2	1	3	1	2	2
Sep-19						
Oct-19						
Nov-19						
Dec-19						
Jan-20						
Feb-20						
Mar-20						
TOTAL	20		18		15	

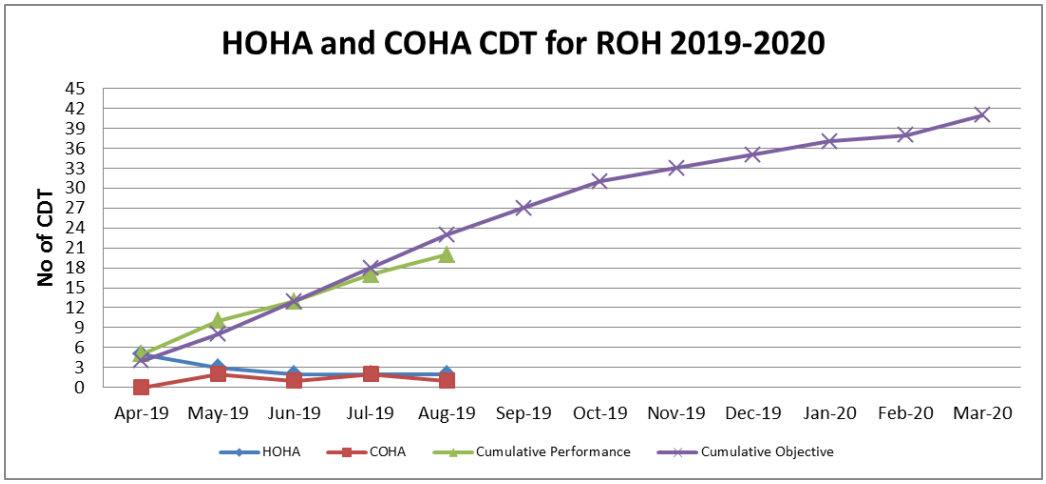
PAT OVERALL CDI PERFORMANCE vs OBJECTIVE 2019-2020



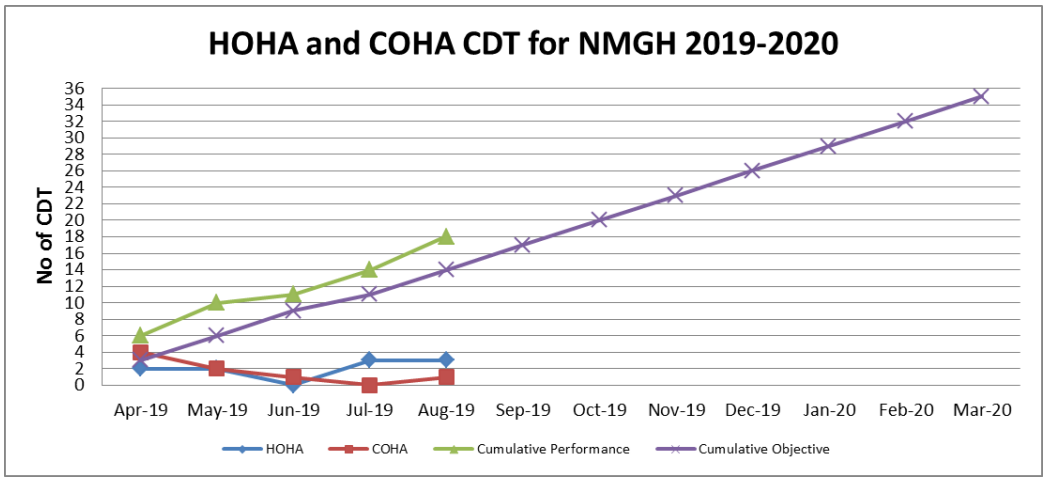
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Cum.Trajectory (External)	8	17	27	37	48	57	66	73	81	88	94	103
Cum. Actual 2018/19	1	3	8	15	20	23	29	31	34	34	34	40
Cum. Actual 2019/20	13	25	32	42	53							

CARE ORGANISATIONS CDI PERFORMANCE vs OBJECTIVE

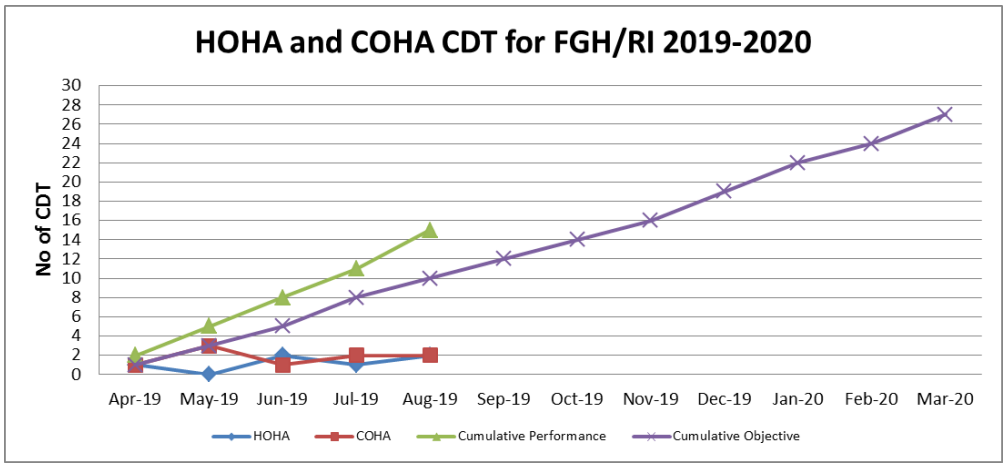
ROYAL OLDHAM



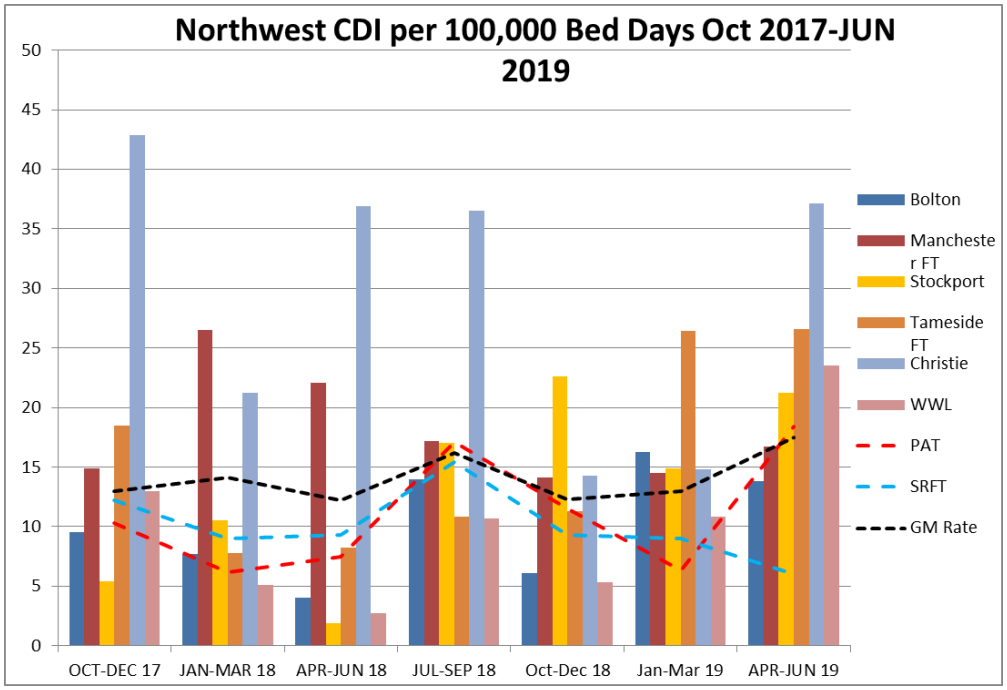
NORTH MANCHESTER



BURY AND ROCHDALE



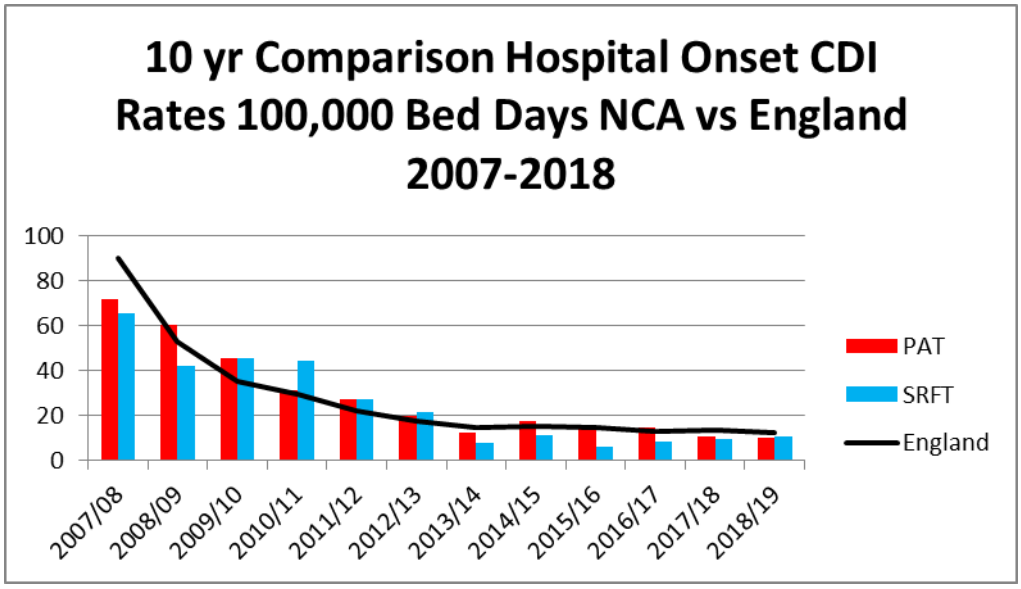
3.4 GRAPH 1. NORTHWEST CDI RATES PER 100,000 BED DAYS



PRIOR CDI PERFORMANCE 2018/19 PHE 2019

Area	Count	Value	95% Lower CI	95% Upper CI
England	4,201	12.2*	-	-
Greater Manchester NHS region	288	13.7*	-	-
The Christie	14	25.2	-	-
Manchester University NHS Foundation Trust	125	18.2	-	-
Stockport	30	13.8	-	-
Tameside Hospital	20	13.7	-	-
Salford Royal	28	10.6	-	-
Pennine Acute Hospitals	40	10.5	-	-
Royal Bolton Hospital	20	9.9	-	-
Wrightington, Wigan and Leigh	11	7.3	-	-

3.5 GRAPH 2. 10 YEAR COMPARISON HOSPITAL ONSET CDI RATE PER 100,000 BED DAYS NCA vs ENGLAND



QUARTERLY RATES OF INFECTION (INCLUDING CDI) PER 100,000 BED DAYS IN COMPARISON TO THE NORTH WEST RATE (PHE REPORT AUGUST 2019)

RATES OF INFECTION PER 100,000 BED DAYS APR-JUN 2019		
ORGANISM	**PAT RATE**	**GM RATE**
MRSA Bactereamia	0.0	0.2
CDI	18.4	17.5
E.coli	14.3	19.0
P.aeruginosa	1.0	2.7
Klebsiella species	11.2	10.6
MSSA Bactereamia	4.1	8.2

3.6 ORGANISATIONAL ACTIONS TO SUPPORT CDI REDUCTION STRATEGY

- All hospital attributed cases receive a root cause analysis (RCA). The RCA's for each case are completed and discussed at the review panel monthly, and presented at the care organisations Infection Prevention and Control Committee (CO IPCC). The review panel consists of multi-disciplinary members who review each case, identify whether the case was avoidable or unavoidable, and identify lessons learned. Any themes/learning are then shared with clinicians and trust staff through training and educational sessions, link nurse

sessions, ward safety huddles, monthly reports, divisional governance boards and the clinical effectiveness committee. The setting up of a *C. difficile* action group (CDAG) is currently under discussion with the CCG's. It is anticipated that this group will be a combined group with membership across the health economy. It is proposed that this group meets bi-monthly to discuss themes, share patient stories and identify learning for the health economy. Driver diagrams will be used to set objectives and map progress. The CDAG group will be monitored by the Care Organisations Infection Prevention and Control Committees.

- There is a CDI QI Collaborative currently underway on the Royal Oldham site.
- All patients are required to have bowel movements recorded on a Bristol stool chart. The Infection Prevention Team undertake diarrhoea ward rounds, where medical and surgical wards are visited weekly to assess compliance with care pathways for diarrhoea and to support ward teams with assessing patients with diarrhoea for risk of CDI.
- Senior Infection Prevention Nurse spot-checks of standards of cleaning take place on each Care Organisation monthly in partnership with facilities teams.
- Monthly cleaning meetings are held on each Care Organisation.
- During December 2018 cleaning was brought "in house".
- Additional educational drop-in sessions regarding *Clostridium difficile* are provided weekly at all sites for any staff to attend.
- All wards where CDI cases have been identified, have undergone a deep clean and disinfection using hydrogen peroxide vapour where possible.
- Where 2 or more cases have an epidemiological link a Period of Increased Incidence (PII) is instigated and incident meetings are held to ensure that all aspects of CDI management are robust. Ribotyping of the isolates is undertaken and if cross transmission is confirmed the incident is declared as an outbreak.
- Rates of CDI are monitored using SPC charts and these are reviewed monthly at the Care Organisations Infection Prevention and Control Committee (IPCC). Where any increase/clusters of CDI are identified management meetings are led by the Medical Director/Director of Infection Prevention and Control, the Chief Operating Officer/Director of Nursing, and Group Associate Director Infection Control. Clinical engagement at a senior level is required, and learning from RCA's is presented at the monthly IPCC . During this time 7 minute briefings are issued and are communicated on the organisations intranet and shared at each ward daily safety huddle.
- An infection control self – assessment of practice document has been implemented across all care organisations to aid staff to ensure infection prevention strategies are part of the daily ward culture.
- There is currently a patient hand hygiene test of change underway within some of our wards on the Royal Oldham site.

4.0 MRSA

There have been 0 MRSA bacteraemias to date.

The Northern Care Alliance remains committed to the zero tolerance objective for MRSA bacteraemia.

MRSA acquisition (carriage not bacteraemia) remains a focus for reduction objectives as it is recognised that those who are colonised are at increased risk of MRSA bacteraemia.

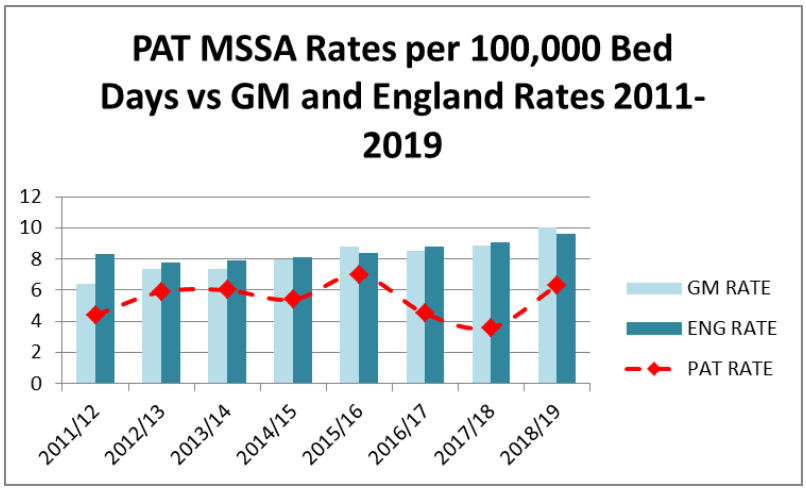
5.0 MSSA

Mandatory reporting to the National DCS includes MSSA (Meticillin sensitive *staphylococcus aureus)* and E.Coli blood stream infections. Whilst there are currently no external objectives set for

these infections, they are monitored and reported to commissioners and as of April 2018 internal improvement objectives have been set by the Northern Care Alliance.

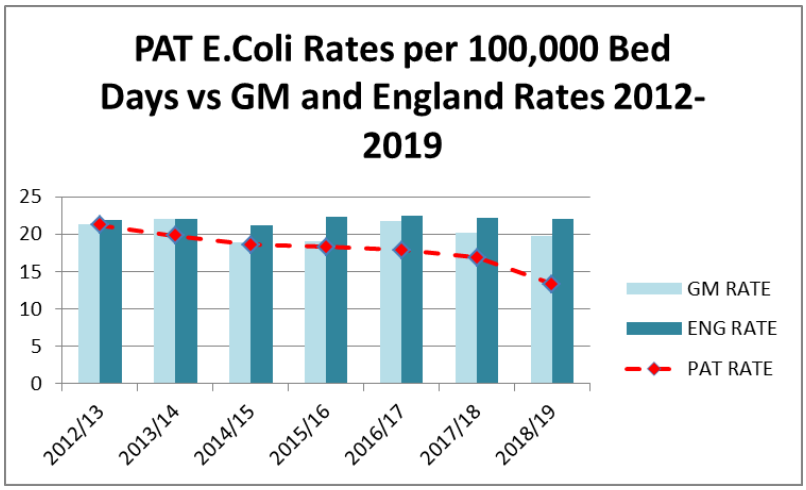
7.1. MSSA PERFORMANCE

The tables below demonstrate PAT's apportioned rate per 100,000 bed days for MSSA bacteraemias when benchmarked with England and Greater Manchester from 2011-2019. PAT's performance has remained below both England and GM rates, and PAT has been identified as a low statistical outlier for these infections. The root cause of the bacteraemias are predominantly community associated skin and soft tissue infections rather than IV device related.



8.0 E COLI BACTERAEMIA

E.coli bacteraemias are commonly associated with Urinary tract; Hepatobiliary and wound/ulcer infections, but are not significantly related to urinary catheters within PAT. The table below demonstrates PAT's apportioned rate per 100,000 bed days for *E.Coli* bacteraemias when benchmarked with both England and Greater Manchester for 2012/19



Northern Care Alliance NHS Group
Salford Royal NHS Foundation Trust (SRFT) & the Pennine Acute Hospitals NHS Trust (PAT)

Title of Report	**Group Learning from Deaths Report**

Meeting	**Group Risk Assurance Committee**
Authors	Roger Prudham, Director of Professional Standards and Mortality Lead for the Northern Care Alliance NHS Group Rheanne Laybourn, Mortality Improvement Project Lead, Northern Care Alliance NHS Group Alison Talbot, Head of Legal Services, Northercare Care Alliance NHS Group
Presented by	Roger Prudham, Director of Professional Standards and Mortality Lead for the Northern Care Alliance NHS Group
Date	**July 2019**

Executive Summary	This paper represents the Northern Care Alliance (NCA) scheduled Group 'Learning from Deaths' report in compliance with National Guidance requirements. This report provides: • The Q4 report for 2018/19; • Provides a dashboard report for awareness and scrutiny in line with National Guidance and the required National Reporting Criteria; and • Sets out how Salford Care Organisation and the North East Sector (NES) Care Organisations systematically review and learns from deaths. **Key points:** • In Q4 85% of SJR have been completed across the NCA. The focus for Q4 2018/19 for the NES Care Organisations was; (1) improve learning outputs by using data and business intelligence , and; (2) switching to the Datix Mortality Module to streamline current systems. • Business intelligence from Dr Foster, CHKS and NHS Digital has been shared with the NES Care Organisation Mortality Oversight

Groups to assist with the development of a bespoke mortality Learning from Deaths Agenda and mortality improvement strategy.

- SJRs have been completed electronically in Q4 2018/19 using the Datix Mortality Module.

  The Module has assisted with quality improvement controls on the quality of SJRs and will assist with audits of the governance models at each Care Organisation with evidence of the process from Structured Judgement Review; Mortality and Morbidity Meetings, and; Care Organisation Mortality Overview Groups.

  The roll out of the Datix mortality module has caused a delay to completion of the SJR's as additional training and demos were required for staff trained in Structured Judgement Review methodology across the NES Care Organisations. As a result of the delay in completion, the embedded evidence of the governance model and embedded learning for Q4 2018/19 will be available in Q1 2019/20.

- The NCA continues to increase the uptake of trained SJR reviewers across the multi-disciplinary team by offering training sessions across all sites. The number of Consultants, Nurses and Allied Health Professional trained in SJR case records review methodology has increased at the NCA to 133.

Mortality Alerts

- Salford Care Organisation is in the **below expected range** on the HSMR and SMR rolling 12 month period March 2018 – February 2019 Dr Foster Scorecard.

- HSMR across the NES Care Organisations remains within the **as expected range** for HSMR and SMR on the rolling 12 month period March 2018 – February 2019 Dr Foster Scorecard.

Oldham Care Organisation

- **HSMR** at the Oldham Care Organisation has increased since the last quarterly report. The HSMR is above the peer group average, at 107. Whilst the HSMR confidence interval remains in the as expected range; the increase is being closely monitored by Oldham Care Organisation's Oversight Mortality Group and a focus group convened by the Medical Director,

with the aim to improve HSMR to within acceptable variation limits (below 100).

Clinical reviews of targeted CCS Diagnostic Basket Groups and Patient Safety Indicators using Structured Judgement Review Methodology continue to be completed alongside coding and standards assurance audits performed by NHS Digital approved clinical coding auditors from Salford Care Organisation. Corrections addressing data quality and coding have been submitted to SUS, however, the effect on HSMR will not be processed by Dr Foster intelligence until August 2019.

Clinical improvements in service delivery will not have an immediate effect on HSMR due to the reporting process used by Dr Foster. Dr Foster uses a rolling 12 month trend relative risk methodology, published 5 months in arears. Improvement work in clinical service delivery may not have an effect on HSMR for at least 6 months.

- **SHMI** for the Oldham Care Organisation, available from NHS Digital on a rolling 12 month period February 2018 to January 2019 and published 5 months in arears, is at 1.02.

- Whilst it is recognised that there are issues with Oldham Care Organisations relative risk HSMR profile on the Dr Foster Scorecard, specifically the use of palliative care coding. It is recognised by Oldham Care Organisation that there is an upward trend in relative risk and an outlier present on both HSRM and SHMI mortality indices.

  SHMI differs from HSMR in that it includes deaths within 30 days of discharge and no adjustment is made for palliative care. The data is produced by NHS Digital and is calculated using Hospital Episode Statistics (HES) data linked to Office for National Statistics (ONS) death registrations data.

Bury and Rochdale Care Organisation

- **HSMR** at Fairfield General Hospital has continued to increase and is now at 97. Whilst the HSMR confidence interval remains in the as expected range; the increase is being closely monitored.

- **SHMI** for Fairfield General Hospital, available from NHS Digital on a rolling 12 month period February 2018 to January 2019 and published 5 months in arears, is at 1.08.

	• This has been discussed at the Bury and Rochdale Mortality Oversight Group and a focus group convened by the Medical Director will be addressing HSMR and SHMI and an action plan will be implemented for Q1 2019/20. • The learning from deaths event has been confirmed for 21st September 2019 with key note speakers including the National Medical Examiner (provisional) and a former National Mortality Case Record Review Manager & Patient Safety Programme Manager at The Royal College of Physicians.
Annual Plan Objective	**Corporate Priorities supported by this paper:** 1. To pursue quality improvements, to assure safe, reliable and compassionate care. 3. To support our staff to deliver high performance and improvement. 4. To improve care and services through integration and collaboration. 5. To demonstrate compliance with mandatory standards.
Associated Risks	Lack of embedded learning from patient safety incidents, inquests and mortality will increase risk to patient safety and impact negatively on the reputation of the Northern Care Alliance NHS Group. Non-compliance in reporting and learning from deaths as per the National Guidance may result in additional performance monitoring being implemented, and the organisations ability to identify and address themes to improve patient safety.
Recommendations	The committee is asked to note and approve the content for submission to Committees in Common (Board) and subsequent dissemination throughout the Northern Care Alliance NHS Group, commissioning organisations and the general public. The committee is asked to note progress on the action plan devised by Oldham Care Organisation to support with HMSR.
Public and/or Patient Involvement (including equality related impact) None	

Communication: The report should be shared internally with the Care Organisations, and following approval at Group Executive Assurance and Risk Committee, submitted to Committees in Common, and subsequently shared with external partners and the public.
Freedom of Information Please 'cross' one of the boxes below: a) This document does not contain confidential information and Can be made available to the public. [x] b) This document contains some confidential information that would Need to be redacted before the document was made available to the public. [ ] c) This document is entirely confidential, as the redaction of confidential Information would render the document meaningless. [ ]

1. Introduction

The NCA is committed to learning from both positive and negative aspects of patient's care, with a clear process for completing mortality reviews and providing a clinical judgement on areas of preventability. Learning identified during mortality reviews allows specialities to review and improve their processes, with collated learning providing corporate themes for larger quality improvement projects. The NCA is committed to systematically investigating, reporting and learning from deaths and delivering a clinical quality improvement agenda.

2. Scope

The purpose of this report is to inform the Board and the general public of the progress of, and findings from, mortality reviews for Q4 2018/19 data and learning.

3. Mortality Review Process

Each reported death is reviewed in line with three levels the NCA has adopted in line with the National Quality Board guidance:

1. Death certification.
2. Case record review, through SJR methodology or other nationally indicated reviews LeDer, MBRRACE or Child Death Review.
3. Investigation – service level, serious incident (SI) reported on StEIS or safeguarding.

The three levels of review are not systematic and any deaths identified at Stage 1 or 2 will be immediately escalated to Stage 3 investigations if they are identified as meeting the StEIS or safeguarding criteria.

The Care Organisations report quarterly on the number of deaths that are considered to have been "preventable". A Hogan score of 4+ will trigger a more detailed review by the Clinical Division to determine if the declaration to an SI is required.

If a cause for concern is identified about the care provided this must be escalated for discussion at the Mortality & Morbidity Meetings (M&M) and/or reported as a clinical incident.

3.2 Developments in the Mortality Review Process

The NES Care Organisations are working towards implementing a revised mortality process that aligns with Salford Care Organisation. Each death will be reviewed using a four step process:

1. Death Certification, GP Summary and Clinical Coding.
2. Care Quality Review.
3. Case record review, through SJR methodology by an independent Consultant or other nationally indicated reviews LeDer, MBRRACE or Child Death Review.

4. Investigation – service level, serious incident (SI) reported on StEIS or safeguarding.

The NES Care Organisations face unique structural challenges in comparison to Salford Care Organisation who benefits from an electronic patient system (EPR) and health information system (HIS) with systems interoperability. Oldham Care Organisation has been piloting the revised mortality process on wards F7 (Respiratory), F9 (Medical) and AMU with plans to expand into the other NES Care Organisations in Q4 2018/19.

An electronic Deceased Handover of Care that includes a care quality review has been developed by Oldham Care Organisation in Q4 2018/19 and the form is expected to go live for Q2 2019/20.

The delay in the launch of the electronic form is due to unexpected user surface technicalities with Healthviews that are expected to be resolved by the IM&T Department within the next quarter. In the interim, a paper death summary and screening tool will be rolled out across the NES Care Organisations. This should assist with the total number of deaths being reviewed and put the NES Care Organisations on an improved trajectory towards the aim of 100% of deaths being reviewed by March 2020 pending the launch of the electronic form.

4. SJR Methodology

The NCA will continue to review all deaths using case record review methodology that are triggered in line with the National Guidance on Learning from Deaths:

- Learning Disability (SJR & LeDer);
- Serious Mental Illness (SJR);
- Perinatal and maternal deaths (MBRRACE);
- Child Deaths (Child Death Overview Process);
- Unexpected deaths; elective admissions and certain cardiac arrests (SJR);
- Care concern and/or complaint and/or ‘alarm’ (SJR);
- Planned improvement work (SJR);
- Regulation 28 Report on Action to Prevent Future Deaths (SJR); and
- Random selections of deaths.

4.2 Developments in the SJR Methodology

The criteria for SJR methodology for Q4 2018/19 included additional triggers:

- All care organisations within the NCA reviewed deaths where an SI was being undertaken to triangulate all elements of learning from deaths;

- In Q4 2018/19 Oldham Care Organisation reviewed a random selection of deaths aligned with mortality alerts from Dr Foster and CHKS intelligence as part of the HSMR mortality improvement action plan.

Each Care Organisation within the NCA will continue to develop bespoke triggers that are individual to the patient population and services to understand prime mortality factors and help plan improvement work. This will be in addition to the minimum requirements of the National Guidance on Learning from Deaths and will be led by the Clinical Mortality Lead and overseen by the Care Organisation Mortality Oversight Group/Committee.

4.3 Challenges to completing SJR's and Learning from Deaths

A key focus for Q4 2018/19 was to enhance opportunities for learning across the NCA and improve the quality of SJR's complete. The roll out of the Datix mortality module has caused a delay to completion of the SJR's as additional training and demos were required for staff trained in Structured Judgement Review methodology. As a result of the delay in completion, the embedded evidence of the governance model and embedded learning for Q4 2018/19 will be available in Q1 2019/20.

Whilst these delays have caused the compliance to decrease it is important ot note the Datix mortality module has allowed:

- Joint Nursing and Medical Reviews;
- Learning Disability Deaths being reviewed by the Medical and Learning Disability and Autism Team;
- Quality improvement audits regarding the quality of the Structured Judgement Reviews completed with an attached record of the documentation and records used and internal communications;
- Quality improvement audits of the governance model with evidence of the process from Structured Judgement Review; Mortality and Morbidity Meetings; Care Organisation Mortality Overview Group; and
- Embedded evidence of key themes and learning using SMART (specific, measurable, achievable, realistic, and timed) actions.

5. Mortality Review Data Q4 2018/19

The below data (**Figure 1**) shows the total number of deaths with number and percentage of mortality reviews completed for each Care Organisation and preventability scoring allocated.
Key points:

- In Q4 2018/19 1296 deaths were recorded of which 11 patients were known to have Learning Disabilities.

- 16 of the 1296 deaths were investigated as Serious Incidents (SIs).

- 64 of 75 **(85%)** of deaths triggering an SJR mortality review methodology have been completed across the NCA.

- Salford Care Organisation continues to review 100% of all cases that are indicated within the National Guidance minimum requirements.

Preventability scoring:

- In Q4 2018/19 mortality reviews were undertaken for 426 cases with 425 confirmed as non-preventable deaths. There was 1 possibly preventable death identified.

  A further possible preventable death was identified during Q4 2018/19 from reviews pending in Q3 2018/19 at the time of publication of the quarterly Learning from Death Report from Salford Care Organisation.

- **The current total number of potentially preventable deaths due to problems in care identified across the NCA to date for 2018/19 is 8 (0.4% of all reviewed deaths n= 1952).**

Fig. 1 Q4 2018/19 Mortality Review Data for the Northern Care Alliance NHS Group

CO	Total	Total LD Deaths	Total Deaths SI	SJR	Number of SJR Reviews		Total Deaths Reviewed including those reviewed by SJR		Preventability scoring
North Manchester Care Organisation	240	2	3	**14**	Q3 18 (100%)	**Q4 12 (85%)**	Q3 62 (30%)	**Q3 44 (18%)**	44 Non-preventable deaths 0 Possibly preventable death
Oldham Care Organisation	356	3	2	**24**	Q3 18 (81%)	**Q4 16 (66%)**	Q3 59 (19%)	**Q4 63 (17%)**	63 Non-preventable deaths 0 Possibly preventable death
Bury & Rochdale Care Organisation	338	1	1	**6**	Q3 7 (70%)	**Q4 5 (83%)**	Q3 61 (23.7%)	**Q4 48 (14%)**	48 Non-preventable deaths 0 Possibly preventable death

Salford Care Organisation	362	5	10	**31**	Q3 35 (81%) **100% of national min. requirement*	**Q4 31 (100%)**	Q3 273 (75%)	**Q4 283 (74%)**	271 Non-preventable deaths 1 Possibly preventable death in review **6 in review*
NCA	1296	11	16	75	Q3 78 (83%)	**Q4 64 (85%)**	Q3 455 (40%)	**Q4 426 (32%)**	425 Non-preventable deaths 1 Possibly preventable death **6 in review*

*** Outstanding cases at the NES Care Organisations that are within the minimum requirements of the National Guidance on Learning from Deaths from Q3 & Q4 2018/19 have been allocated and are awaiting completion. It is anticipated these will be completed by publication of the Q1 2019/20 Learning from Death Paper***

Phase of care scoring:

Fig. 2a North Manchester Care Organisation
Of the 8 independent SJR reviews performed (72% of cases flagged) during Q4, care was rated as:

Phase of care *	Very poor	Poor	Adequate	Good	Excellent
First 24hours/ admission	1	1	5	3	2
Ongoing care	1	6	2	1	2
Care during procedure	-	-	3	-	-
Peri-operative care	-	-	2	2	-
End of life Care	3	2	3	2	2
Overall care	1	5	3	2	1

- 2 elective admissions triggered for Structured Judgement Review were not completed due to the deaths being reviewed under the formal complaints process.
- 2 Learning Disability Deaths: 1 case where overall care was judged to be poor and 1 case where overall care was judged to be adequate.
- 4 cases where overall care was judged to be poor, death was judged to be non-preventable.

Fig. 2b Oldham Care Organisation
Of the 8 independent SJR reviews performed (47% of cases flagged) during Q4, care was rated as:

Phase of care *	Very poor	Poor	Adequate	Good	Excellent
First 24hours/ admission	-	1	5	4	4
Ongoing care	-	1	2	8	2
Care during procedure	-	-	-	-	-
Peri-operative care	-	-	-	-	-
End of life Care	-	1	3	9	-
Overall care	**-**	1	5	8	**-**

- 1 SI triggered for Structured Judgement Review was not completed due to the death being reviewed under the formal complaints process.
- 3 Learning Disability Deaths; overall care was judged to be good in 2 cases and adequate in 1 case.
- 1 case where poor care was identified, death was judged to be non-preventable.
- 2 cases from the CCS Group 'Peri- *endo- and myocarditis cardiomyopathy*' have been forwarded to the Coding Team for coding and standards assurance following a front line review, an SJR has not been completed.

Fig. 2c Bury and Rochdale Care Organisations
Of the 5 independent SJR reviews performed (83% of cases flagged) during Q4, care was rated as:

Phase of care	Very poor	Poor	Adequate	Good	Excellent
First 24hours/ admission	-	-	1	2	2
Ongoing care	-	-	2	2	1
Care during procedure	-	-	-	2	-
Peri-operative care	-	-	-	1	-
End of life Care	-	-	3	1	1
Overall care	-	-	-	4	1

- 1 Learning Disability Death; overall care was judged to be good.

Fig. 2d Salford Care Organisation
Of the 31 independent SJR reviews performed (100% of cases flagged) during Q4, care was rated as:

Phase of care	Very poor	Poor	Adequate	Good	Excellent
First 24hours/ admission	1	5	1	12	12
Ongoing care	-	8	4	7	6
Care during procedure	-	-	1	-	-
Peri-operative care	-	1	1	-	2
End of life Care	-	3	10	6	12
Overall care	-	9	6	6	10

- 1 case death was judged to be possibly preventable and 6 are still in review.

6. Learning from Deaths

The below describes the learning taken following recent deaths. In addition, the NCA has a planned learning from deaths event will take place on 21st September 2019 with key note speakers including the National Medical Examiner (provisional) and a former National Mortality Case Record Review Manager & Patient Safety Programme Manager at The Royal College of Physicians.

A key focus for Q1 2019/20 will be translating learning from Mortality and Morbidity Meetings into SMART actions. A training session from the Quality Improvement Division will be showcased at the 'Learning from Death' event and support will be provided to Mortality and Mortbidity Leads.

North Manchester Care Organisation

Learning from Structured Judgment Reviews

SJR 1554 highlighted a late delay in the diagnosis of HIV. Incident and Inquest Data have identified the same theme and a NICE CG 60 Implementation Task and Finish group has been established to ensure that HIV screening practices are reflective of the needs of the local population and commissioned appropriately.

SJR 1282 highlighted poor care for patients with Learning Disabilities who transition into adult services. The SJR was discussed at the Bury and Rochdale Care Organisation and a Focus Group led by the Assistant Director of Quality Improvement has been established to investigate this further.

SJR 1512 & 1558 identified poor documentation and late referral to specialist multidisciplinary mental health teams. Both cases have been shared with the relevant Clinical Directorates to raise awareness and ensure cross speciality learning can be

facilitated and shared amongst colleagues.

SJR 1348, SJR 1511, SJR 1470 and **SJR 1771** highlighted poor end of life and/or specialist palliative care by the parent medical team. Cases have been shared with the relevant Clinical Directorates to raise awareness of specialist palliative care input and ensure cross speciality learning can be facilitated and shared amongst colleagues.

SJR 1348 and following investigation **R48395** a Patient Care Alert has been circulated that Oxygen cylinders valve will be checked to be in the full open position manually by the administering clinician.

SJR 3201 and following investigation **R39619** a Patient Care Alert has been reminding staff about handovers and making sure there is ownership of this in radiology so that referring teams have a point of contact. A Standard Operating Procedure for on-call referrals to the General Surgery Team has been developed by the Clinical Lead for Surgery.

Good practice themes identified from SJR	The following good practice has been identified from SJR during Q4: 1st 24hr of care: • Excellent teamwork with speciality teams; • Evidence of early senior Consultant review. Ongoing care: • Prompt multi-disciplinary involvement for patient with severe mental illness. Peri-operative care • Evidence of thorough work-up and multi-disciplinary involvement in optimising patient for surgery; • Evidence of good medical and nursing team-work and communication; • Pathways completed. End of life care: • Good recognition of end-of-life and family discussions with use of care plans to support holistic management.

Bury and Rochdale Care Organisation

SJR 1282 highlighted poor care for patients with Learning Disabilities who transition into adult services. The SJR was discussed at the Bury and Rochdale Care Organisation and a Focus Group led by the Assistant Director of Quality Improvement has been established to investigate this further.

Good practice themes identified from SJR	The following good practice has been identified from SJR during Q4: 1st 24hr of care • Prompt triaging; • Excellent teamwork with speciality teams; • Evidence of early senior Consultant review; • Prompt antibiotic administration. • DNACPR completed with patient and family for acutely unwell and high mortality risk presentations. Ongoing care: • Prompt multi-disciplinary involvement; • Prompt escalation of patients with elevated NEWS scores for assessment; • Evidence of regular senior medical review; Peri-operative care • Evidence of thorough work-up and multi-disciplinary involvement in optimising patient for surgery; • Evidence of good medical and nursing team-work and communication; • Pathways completed; • Clear instructions for post-op fluids, antibiotics and analgaesia. • Excellent documentation. End of life care: • Good recognition of end-of-life and family discussions with use of care plans to support holistic management.

Oldham Care Organisation

Learning from Structured Judgment Reviews

Following **R38962** a Patient Care Alert has been circulated reminding staff of the Policy for the Prescription and Administration of Oxygen in Adults in the Acute Setting, compliance with the Observation Policy/NEWS, recording of blood gases for patients with oxygen requirements and compliance with the clinical record keeping policy. A formal complaint from the family was partially upheld and assurances have been given to prevent reoccurrence.

HSMR CCS Diagnostic Group *'Septicaemia (except in labour)'*
SJR 1665, SJR 1666, SJR 1667, SJR 1668 and **SJR 1671** evidenced prompt antibiotic administration supported by microbiology advice. Improvements in care around end of life and specialist palliative care input were indicated.

HSMR CCS Diagnostic Group *' Peri- endo- and myocarditis cardiomyopathy'*
SJR 1685, SJR 1684 and **SJR 1680** evidenced early recognition of clinical symptoms and markers of infection. On call Cardiology opinions were appropriately sought. Two cases have been escalated to the Coding Team for coding and standards assurance.

SJR 1698 highlighted incomplete nursing documentation. This has been shared with the relevant Clinical Directorates to raise awareness and ensure learning can be facilitated and shared amongst colleagues.

SJR 1573 identified the need for staff to document care after death in detail in relation to family needs.

SJR 1473 identified clinical decision making out of hours was complicated by working culture and highlighted the importance of good communication and teamwork with NCA clinical colleagues. This has been shared with the relevant Clinical Directorates for cross organisational learning.

SJR 1474 identified unnecessary transfers for a patient who had been identified for palliative care. Clinical staff should be mindful of liaising with the specialist palliative care service for guidance on clinical management. This has been shared with the relevant Clinical Directorates to raise awareness of specialist palliative care input and ensure cross speciality learning can be facilitated and shared amongst colleagues.

Good practice themes identified from SJR	The following good practice has been identified from SJR during Q4: 1st 24hr of care: • Excellent teamwork with speciality teams; • Evidence of early senior Consultant review; • Evidence of prompt antibiotic administration supported by microbiology advice; • Good recognition of end-of-life and family discussions with use of care plans to support holistic management. Ongoing care: • Multi-disciplinary involvement in optimising high-risk patients; • Evidence of prompt antibiotic administration supported by microbiology advice; Peri-operative care • Evidence of thorough work-up and multi-disciplinary involvement in optimising patient for surgery; • Pathways completed.

	End of life care: • Good recognition of end-of-life and family discussions with use of care plans to support holistic management.

Salford Care Organisation
Co-ordinating patient care between the inpatient specialty area and community Salford Care Organisation is working collaboratively with catchment CCG partners to explore the possibility of a wider GM solution for the long-term management of this patient group. **Optimising use of acute non-invasive ventilation (NIV)** There has been a submission to EPR for a series of digital tools to be installed as a long term adjunct to caring for patients requiring NIV. There is ongoing educational work being undertaken to develop the skillset of the hospital at night team to potentially deliver temporary acute NIV at the ward bedside when needed to minimise delay to initiation. The necessary scoping is being undertaken to ensure that the necessary supports are in place for this to be conducted with an emphasis on patient safety. **Meeting infection control standards in a time-critical emergency** Following investigation **R129690** a “Take 5” bulletin has been circulated to re-emphasise that urgent/emergency situations may mean that there has to be compromise of infection control policy. **Learning from Structured Judgment Review** **SJR M3307** was associated with investigation **41435** led by group diagnostics and radiology with specialist input from the MCCN division. This case highlights the importance of considering blunt/ligamentous spinal injury where initial CT imaging may not show any initial gross traumatic injury. Clinical staff should be particularly mindful where the picture maybe confounded by: • **CT with a large degree of degenerative changes** which may make detection of subtle changes such as disc space widening more difficult to identify. Where there is sufficient doubt, this may benefit from maintenance of spinal precautions until expert interpretation by a neuroradiologist can be obtained. • **Patient confusion/agitation or potential other distracting injuries** that may cloud the clinical assessment of the neck. Any unexplained focal change in neurology in the context of ongoing neck pain despite previous normal CT imaging

should warrant urgent reassessment of the patient and consideration given to re-instituting spinal precautions and obtaining further investigations.

SJR M3393 reviewed the acute care provided to a patient with learning difficulty. This case identified the need for staff to help support patient decision-making specifically where declining a recommended treatment even where the patient may appear to have capacity by attempting to identify:

- What the patient's specific concerns and reasons are to decline advice given?
- Have these concerns been addressed sufficiently?
- Are there significant others that may help the patient understand and weigh-up the advice being presented?

SJR M3735 and M3783 highlighted the need for medical staff to be mindful of the potential for serious underlying pathology where patients develop newly emergent severe pain disproportionate to clinical findings such that it requires strong opiate pain relief.

SJR M3735 highlighted the value of being vigilant and taking a full drug history including OTC medication and considering key risk groups where relevant such as analgesics (NSAIDS), anticoagulants and immunosuppression.

Good practice themes identified from SJR	The following good practice has been identified from SJR during Q4: 1st 24hr of care • Excellent teamwork demonstrated during difficult resuscitation effort following the sudden unexpected death of a child presenting to ED. There was excellent bereavement support provided including arranging an appointment for parents to attend the mortuary over the weekend. Ongoing care: • Several instances of prompt antibiotic administration supported by excellent and timely microbiology advice; • Prompt escalation of patients with elevated NEWS scores for assessment; • Good clear language being entered into patient discharge summaries to support better user experience; • Excellent support and follow-up provided by specialist nurses including Epilepsy and Diabetes nurse specialists; • Evidence of regular senior medical review and senior specialty review on-call over weekends. Peri-operative care • Many examples of thorough work-up and multi-

	disciplinary involvement in optimising high-risk patients for surgery (surgical/anaesthetic/renal); • Evidence of good team-work and communication during unexpected operative deterioration that required necessary discontinuation; • Excellent duration and frequency of assessment of high-risk patients post-operatively in recovery. End of life care: • Good recognition of end-of-life phase supported by timely referral to palliative care and use of care plan to support holistic management; Excellent family discussions by surgical consultant following an unexpected death.

7. NHS priorities for improvement in care for patients with Learning Disabilities

The following conditions have been highlighted as a focus for future improvement to close the gap in reduced life expectancy for patients with Learning Disabilities and will be considered in the ongoing review of patient deaths within the NCA as part of our commitment to the LeDer review process:

- Sepsis: timely identification and treatment;
- Respiratory conditions;
- Pneumonia including uptake of the flu vaccine;
- Constipation and bowel management;
- Uptake of cancer services.

8. Mortality Indicators – Dr Foster Data Source

The HSMR is calculated each month for each hospital in England. It includes deaths of patients with the most common conditions in hospital which account for around of 80% of deaths in hospital. HSMR is the ratio of observed to expected deaths, multiplied by a 100, from 56 baskets of the 80% most common diagnoses. If the HSMR is above 100 then there are more observed deaths than expected deaths. Upper and lower confidence intervals are applied to HSMR. HSMRs with values between the confidence intervals are consistent with random or chance variation. To have a red flag means the HSMR is above 100 and the lower confidence interval is above 100 which signifies the variation is unlikely to be due to random or chance variation and other issues may be causing the variation.

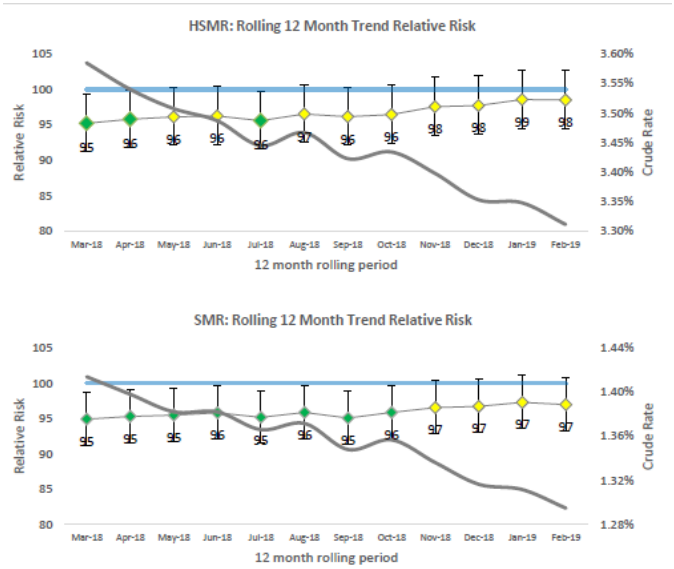
It is important to note that while the mortality indices from the Dr Foster data source are important, the frequency of risk groups (both in the treatments and operations that each hospital offers and the make-up of its local population) vary widely between Trusts. Whilst the HSMR scoring system works by taking a hospital's crude mortality rate and adjusting it for a variety of factors such as frequency of risk groups; local weightings such as lack of community-based hospice services and clinical coding errors may have an impact on HSMR as well as the quality of clinical services.

HSMR should be closely monitored alongside SHMI and RAMI mortality indices with intelligence from Dr Foster, CHKS and NHS Digital and internal intelligence from risks, incidents and complaints data forming part of the mortality strategy.

8.2 The NES Care Organisations

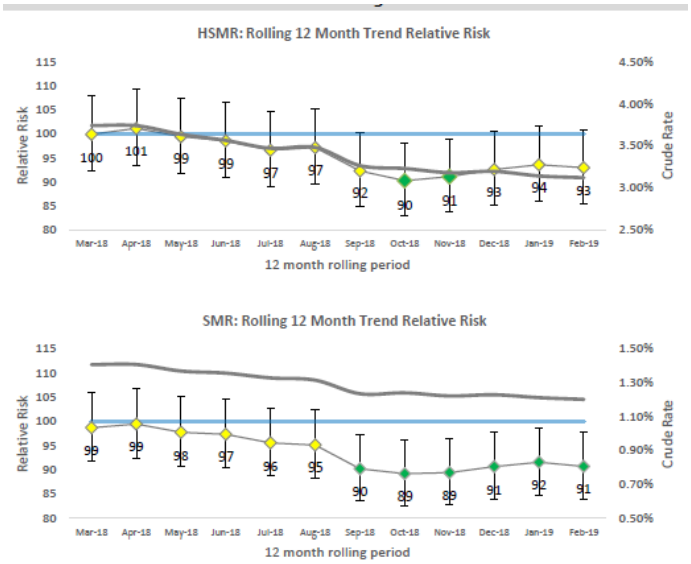
The confidence interval is in the **as expected range on the HSMR** and **SMR** on the rolling 12 month period March 2018 – February 2019 Dr Foster Scorecard. HSMR data has slightly increased from 97 to 98 and is now above peer group average, **RR 98:94**.

The peer group average in the most recent Dr Foster scorecard since the last quarterly report has moved from 98 to 94 and this may be due to improvements in other Trusts relative risk profiles and/or a national benchmark change incorporated into the latest data update.



8.2.1 North Manchester Care Organisation

The confidence interval is in the **as expected range** on the HSMR and **the below expected range** on SMR rolling 12 month period March 2018 – February 2019 Dr Foster Scorecard. HSMR data remains lower than the peer group average, **RR 93.**



4 CUSUM alerts were noted on the Dr Foster Scorecard. A clinical coding and standard data assurance exercise was completed for 2 of the 4 CUSUM alerts and no coding errors were reported. A low threshold for expected deaths was noted on all of the CUSUM alerts with no significant variation from the expected number. However, the Clinical Mortality Lead will be performing a front line review to assess whether the deaths should be escalated for further review using Structured Judgement Methodology in Q1 2019/20.

3 CCS Diagnostic Baskets were noted as possible mortality outliers with significant variation when reviewed further using CHKS Intelligence. A clinical coding and standard data assurance exercise was completed for 2 of the 3 CCS Diagnostic Baskets. The 1st CCS Diagnostic Basket 'Cancer of liver and intrahepatic bile duct' was found to have a significant amount of coding errors and it was determined no further action was indicated. A partial review of the 2nd CCS Diagnostic Basket 'Cancer of the Colon' found no coding errors and this alert will be escalated to NCA cancer quality improvement groups.

The 3rd CCS Diagnostic Basket 'Liver Disease – Alcohol Related' has been selected for further clinical review using Structured Judgement Review methodology as part of the Learning from Deaths agenda. The data will be available in Q1 2018/19.

No patient safety indicator was noted on the Dr Foster Scorecard.

8.2.2 Bury and Rochdale Care Organisation

The confidence interval for Fairfield General Hospital and Rochdale Infirmary is in the **as expected range on the HSMR** and **SMR** rolling 12 month period March 2018 – February 2019 Dr Foster Scorecard. HSMR data remains lower than the peer group average, **RR 97** and **RR 82**.

The HSMR has slightly increased at both the Fairfield General Hospital and Rochdale Infirmary.

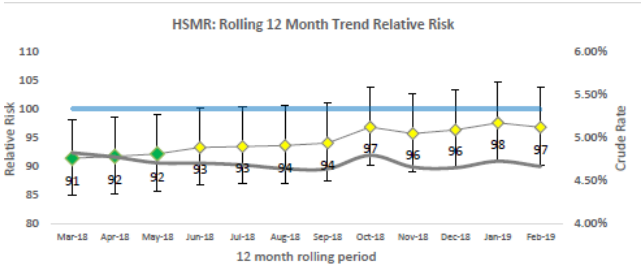
There is an upward trend in relative risk at Fairfield General Hospital on the Dr Foster Scorecard.

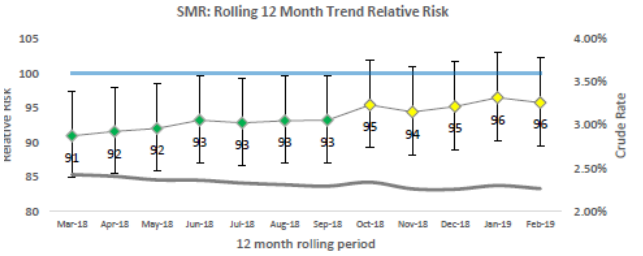
No CUSUM alerts or Patient Safety Indicators are noted.

CCS Diagnostic Basket '*Coma stupor and brain damage'* has been noted as a potential mortality outlier. This basket has been data assured and no coding errors were found. A random selection of deaths falling into this basket will be reviewed using SJR methodology as part of the Bury and Rochdale Care Organisation 'Learning from Deaths' agenda.

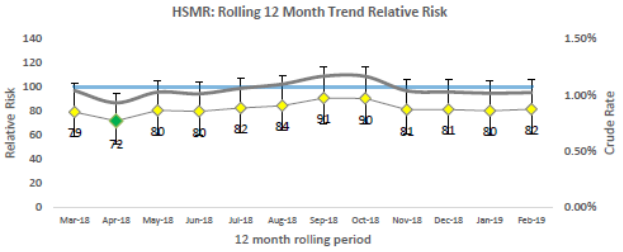
A focus group convened by the Medical Director will be addressing HSMR and SHMI and an action plan will be implemented for Q1 2019/20 and will be published in the next quarterly Learning from Death Report.

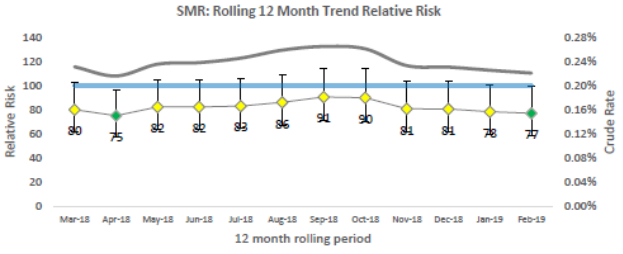
8.2.2.1 Fairfield General Hospital





8.2.2.2 Rochdale Infirmary

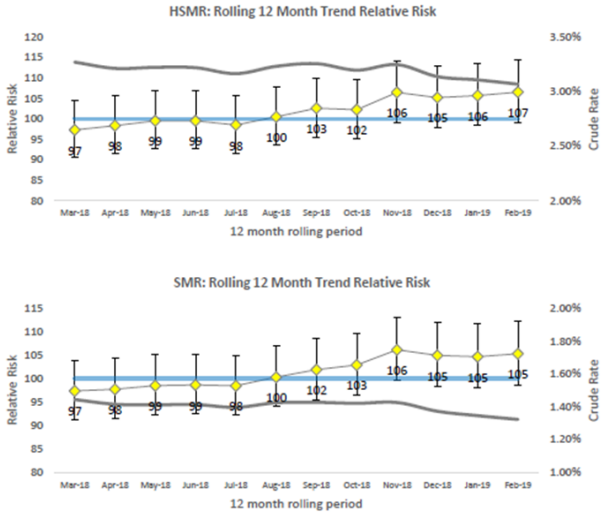




8.2.3 Oldham Care Organisation

The confidence interval is in the **as expected range on the HSMR** and **the SMR** on the rolling 12 month period March 2018 – February 2019 Dr Foster Scorecard. HSMR data remains significantly above the peer group average, **RR107.**

As part of the HSMR action plan HSMR influencers from the Dr Foster Scorecard were investigated to understand the impact on Oldham Care Organisations relative risk profile.



8.2.4 Oldham Care Organisation - HSMR Action Plan

HSMR Influencer – Palliative Care Coding
It is noted that the palliative coding HSMR influence is significantly below the national average for both non-elective spells and non-elective deaths with specialist palliative care involvement (SPC). Oldham Care Organisation is performing at 1.71% for non-elective spells and 13.7%; the national average is 4.07% and 31.97%. Compared to other sites within the Northern Care Alliance using data from CHKS intelligence, Oldham Care Organisation is significantly underperforming and this will be contributing towards an increased relative risk profile for HSMR as the expected death denominator will be under estimated. Finished Consultant Episode (FCEs) deaths with palliative care code Z515 at Salford Care Organisation for March 2018 to February 2019 is 44.5%.

Finished Consultant Episode (FCEs) deaths with palliative care code Z515 at Fairfield General Hospital and Rochdale Infirmary for March 2018 to February 2019 is 32.8% and 8.3%, respectively. Finished Consultant Episode (FCEs) deaths with palliative care code Z515 at North Manchester Care Organisation for March 2018 to February 2019 is 31.9%. Finished Consultant Episode (FCEs) deaths with palliative care code Z515 at Oldham Care Organisation for March 2018 to February 2019 is 15.6%.	
Action	A focus group was convened by the Medical Director to investigated specialist palliative care services at the Oldham Care Organisation. It was noted that telephone consultations with the specialist palliative care team had not been allocated with a Z515 code. The clinical coding team have completed a further review of the deaths and allocated a Z515 code where this is documented in the clinical notes. Corrections addressing data quality and coding have been submitted to SUS, however, the effect on HSMR will not be processed by Dr Foster intelligence until August 2019. It is recognised that there is not a standard definition of what constitutes as 'specialised palliative care', and each Trust's palliative care team will differ, it strongly recommended that the clinical coding department works closely with the Trust's specialist palliative care team to identify when palliative care/specialised palliative care has been administered. The Clinical Coding team will continue to work with the specialist palliative care team to standardise the documentation and coding of palliative care and publish a policy on palliative care coding by September 2019. The focus group will continue to convene to discuss whether improvements are indicated in clinical service delivery with a business plan for a 7 day service at the Oldham Care Organisation scheduled for presentation in September 2019.

HSMR Influencer – Charlson Comorbidity Scoring	
The Charlson Index scores on the Dr Foster HSMR scorecard is above the national average for % of spells with a comorbidity score of 0 at 52.1%; the national average is 47.9%. The Charlson index scores on the Dr Foster HSMR scorecard is below the national average for % of spells with a comorbidity score of 20+ at 8.5%; the national average is 9.1%. Coding feedback has indicated that there is a potential weakness in clinical documentation. Coding relies upon explicit documentation of each individual condition that informs the Charlson Index. The Charlson Index will be underscored if the comorbidities are not listed. Although, only marginal differences are observed, this will be contributing towards an increased relative risk profile for HSMR as this will reduce the likelihood of expected death and therefore increase mortality for the site.	
Action:	A focus group was convened by the Medical Director and a revised Clerking Proforma has been designed by the Clinical Mortality Lead. The document has been circulated at the Medicine Mortality and Morbidity Meeting for review and feedback and will be presented at the July Mortality Oversight Group. It is anticipated that the document will be live by August 2019. Clinical Coding will be attending educational seminars to share best practice around documentation of comorbidities and performing ward walk rounds to raise the profile of the importance of recording comorbidities in clinical documentation.

HSMR Influencer – Weekend Admissions
It is noted that weekend admissions at the Oldham Care Organisation on the January 2018 – December 2019 Dr Foster Scorecard was an outlier. Site performance for Saturday was below the national average at 99.3; the national average was 101.6. However, site performance for Sunday was above the national average at 110; the national average was 101.

Intelligence from CHKS would indicate that the weekend admissions is an amber mortality alert, albeit, caution is advised as the trend is unpredictable.	
Action	A selection of weekend deaths have been randomly selected for review by the Mortality Lead for the Northern Care Alliance to understand any mortality trends and assess whether there are a patient safety concerns in service delivery. This review will be completed by September 2019 and findings will be available for the Q1 2019/20 quarterly report.

CCS Diagnostic Basket Groups	
Aspiration pneumonitis/food/vomitus A review of this diagnostic group was completed by a member of the Oldham Clinical Coding Team and a Consultant Physician. It was determined that there were errors with coding. ***Peri- endo- and myocarditis cardiomyopathy*** A selection of 6 cases was reviewed. No care concerns were noted following the review. ***Septicaemia (except in labour)*** A selection of 5 cases was reviewed by the Clinical Lead for Sepsis using Structured Judgement Review Methodology. No care concerns were noted following the review. It was noted that all of the patients had presented with a high risk of mortality. Although there were some minor delays it was concluded that this did not have an effect on the outcome for the patient. It was noted that there was no palliative care involvement in all 5 cases selected for review.	
Action:	***Aspiration pneumonitis/food/vomitus*** No further clinical action was indicated. The observed to expect deaths was no longer an outlier following identification of the coding errors. It was noted that impressions were being used instead of The Triangle Sign so that information cannot be coded. This was shared with relevant clinical teams and the Oversight

Mortality Group.

Peri- endo- and myocarditis cardiomyopathy
2 cases have been escalated to the Coding Team for coding and standards assurance.

Septicaemia (except in labour)
Dr Foster Intelligence has published a briefing on sepsis. One of the recommendations is that the Trusts' coding departments should work with their clinical teams to agree a clear internal process to identify which patients have sepsis. Part of this collaborative effort should include a clear agreement on how to distinguish between an identified local infection, such as a chest infection or urinary infection. A guidance document has been developed and shared with the clinical coding team.

The Clinical Lead for Sepsis has been leading improvement work on sepsis identification and management in the care organisation. Due to the reporting process used by Dr Foster (Dr Foster uses a rolling 12 month trend relative risk methodology, published 5 months in arears) this may not be reflected in the most recent HSMR scorecard.

Oldham Care Organisation is working towards a target of a minimum of 90% patients with red flag sepsis to be given antibiotics within 1 hour of identification by September 2019. Highlight reports on improvement work are forwarded to the Clinical Effectiveness Committee. The outlier will continue to be monitored by the COMOG with input from the Clinical Lead for sepsis.

The Clinical Sepsis Policy is being reviewed and an updated version is estimated to be completed by the end of July 2019.

The sepsis microsystem model is ongoing and this consists of a core group of the medical and nursing sepsis leads, QI representatives, nursing representatives from ED (inc paeds), and audit representatives along with other stakeholders when required who meet two weekly to drive changes and improvement in sepsis care. This group reports back

	to the sepsis steering group.

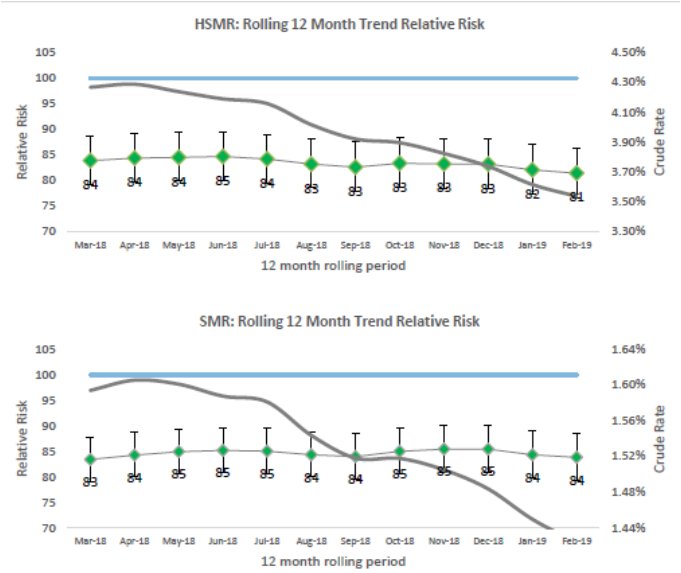
Patient Safety Indicators on Dr Foster and Incident and Risk Data	
Data from incidents and risks has been reviewed in line with Patient Safety Indicators from Dr Foster. A deep dive exercise is being undertaken led by the Northern Care Alliance Mortality Improvement Lead.	
Action	Deaths after surgery and deaths in low diagnostic groups were selected for a deep dive exercise. 20 cases have been selected from Gastroenterology, General and Colorectal Surgery for review by the Northern Care Alliance Clinical Lead for Mortality. A working task group is being convened led by the Clinical Lead for Mortality and surgeons trained in Structured Judgement Review methodology to complete the reviews by September 2019. The Northern Care Alliance Clinical Lead for Mortality has been providing support to the Gastroenterology team. The Gastroenterology Directorate has committed to providing a seven day service at the earliest opportunity. An outline business case is in development lead by the Clinical Director and the Directorate Manager. As mortality work has identified that there have been greater than expected numbers of deaths in HRGs within Gastroenterology and that HSMR by day of admission has been greater than expected for patients admitted on a weekend on the Oldham Care Organisation site to which Acute Gastroenterology cases are admitted, then the expectation is that the development of a seven day Gastroenterology service will contribute to improving patient experience, outcomes and ultimately mortality. A selection of deaths occurring on the discharge ward have also been selected for review by the Clinical Mortality Lead for Oldham Care Organisation using structure Judgement Review methodology to complete the reviews by September 2019.

	The Medical Director has been trained in Structured Judgement Review methodology and will be reviewing a random selection of Haematology deaths. Support will be provided to the Haematology Mortality & Morbidity Meeting by the Medical Director and Northern Care Alliance Mortality Lead in next quarter.

8.2.5 Salford Care Organisation

The confidence interval is in the **below expected range** on the HSMR and SMR rolling 12 month period January 2018 – December 2018.

HSMR data remains significantly lower than the national average, **RR 81: 98**.



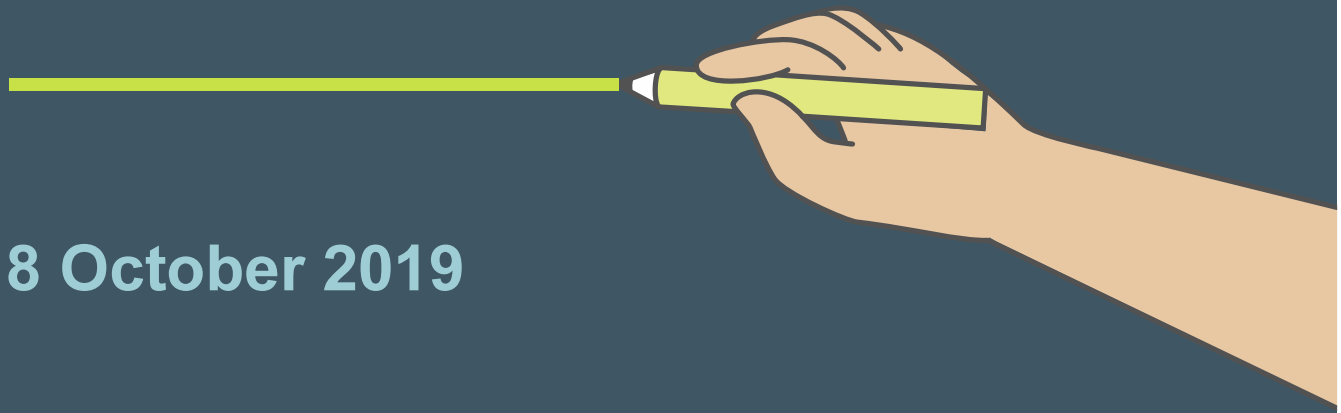
Appendix 1: Oldham Care Organisation - HSMR Action Plan

Actions	Owner	Due by / Update
Review of harm allocated to incidents reported at Oldham CO. Exercise to be undertaken to provide assurance regarding ratios of harm reported within Datix. (Increases in harm levels would provide an initial indication of concerns regarding practices).	Medical Director, Head of Legal Services, Associate Director of Governance	COMPLETED
To quality assure the diagnosed outliers in the HSMR basket to determine if there are any coding errors.	Clinical Coding	COMPLETED
To measure staff mix on acute medical wards to determine mix between substantive and locum medical staff and triangulate against mortality – disparities to be escalated by medical division.	Re-allocated to Divisional Managing Director for Medicine and Urgent Care	OUTSTANDING 30 April 2019 Revised completion deadline of 12 July 2019
A sample audit of the diagnosis group (*within the HSMR basket) 'septicaemia (except in labour)' to be reviewed using SJR case record review methodology to determine quality improvement areas and opportunities for learning.	Clinical Mortality leads for medicine	COMPLETED
A sample audit of the diagnosis group (*within the HSMR basket) 'aspiration pneumonitis/food/vomitus' to be reviewed using SJR case record review Methodology to determine quality improvement areas and opportunities for learning.	Consultant Physician	COMPLETED
A sample audit of the diagnosis group (*within the HSMR basket) 'Peri- endo- and myocarditis cardiomyopathy' to be reviewed using SJR case record review methodology to determine quality improvement areas and opportunities for learning.	Consultant Cardiology	COMPLETED
Patient Safety Indicators on Dr Foster Dashboard to be data assured and reviewed using SJR case record review methodology to determine quality improvement areas and opportunities for learning.	Clinical Mortality Lead for the Northern Care Alliance	30 June 2019 Frontline review completed and working task group created to complete the clinical review by 30 September 2019.
Coding process will be reviewed with input from the North East Sector Clinical Palliative Lead to improve the current under coding of specialist palliative care	Clinical Palliative Lead and Coding	30 June 2019 Frontline review

patients.		completed and working task group created to complete by 30 September 2019.
Develop guidance for coding on specialist palliative care.	Clinical Palliative Lead and Coding	30 June 19 Frontline review completed and working task group created to complete by 30 September 2019.
To develop a business case to enable 7 day services for specialist palliative care patients.	TBC	30 September 2019
Scope changing the ward clerking Proforma to include the Charlson index; explicitly discourage recording of 'complex frailty' as a diagnostic term.	Clinical Mortality Lead	30 September 2019
To develop a business case to enable 7 day service on Gastroenterology.	CD Gastroenterology Medical Director/Associate Director of Governance	30 September 2019
Right patient right ward walk round to be included in the SJR reviews to determine if there is learning around patient transfers.	SJR reviewers	30 September 2019
To review volume and acuity trends for Oldham Care Organisation admissions.	Associate Director of Governance	30 June 2019
Coding ward walk rounds to educate Consultants on FCE1 and FCE2 and the importance of correct documentation.	Clinical Coding	On- going
A sample audit of weekend mortality to be reviewed using Structured Judgement Review Methodology	Clinical Mortality Lead	30 September 2019

Greater Manchester Health and Social Care Partnership

PENNINE ACUTE HOSPITALS NHS TRUST (PAT) TRANSACTIONS PROGRAMME UPDATE



8 October 2019

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

OVERVIEW

- NHS England and NHS Improvement (NHSE/I) and Greater Manchester-wide system stakeholders and partners continue to work together to develop a long term solution for the Pennine Acute Hospitals NHS Trust (PAT)
- Agreement that a new ownership and long-term management arrangement is essential to support the future clinical, financial and workforce sustainability of the hospitals and services currently run by PAT
- Future arrangements are an opportunity to strengthen how acute and community based services in these areas are delivered for patients and service users
- Optimise the use of the hospital estate on the PAT footprint – The Royal Oldham, Fairfield General Hospital in Bury, Rochdale Infirmary, and North Manchester General Hospital (NMGH)
- Once in a lifetime opportunity to secure the long-term future of each of the PAT hospital sites, partners are committed to ensuring we get this right
- Complex process that includes the need for a solution to secure the required capital investment, and will therefore take some time to complete

BENEFITS TO PATIENTS AND STAFF

Quality of Care - Reduce variation in the effectiveness and safety of care, improve access to specialist care

Patient Experience - Reduce fragmentation, reduce duplication. Transfer care closer to home

Workforce - Improve the recruitment and retention of appropriately skilled workforce. Access to strong organisational development programmes.

Financial / Operational - Improve operational performance. Ensure resource is focussed appropriately

Enhance Research and Innovation

Enhance Education and Training

Sharing Best Practice across Group

PM VISIT AND NMGH ANNOUNCEMENT

- On Sunday 29 September, staff at North Manchester General Hospital welcomed a visit by the Prime Minister, Boris Johnson, and Health Secretary, Matt Hancock.

- The visit coincided with the announcement that the North Manchester site is one of a number of hospitals that is earmarked to receive additional capital funding over the coming years as part of the Government's Health Infrastructure Plan.

- The funding will be at the cornerstone of the ambitious plans to redevelop the hospital and care facilities on the NMGH site

- There was an acknowledgement and recognition that our staff continue to provide high quality care with pride and compassion, despite the challenges of working in some of the oldest and most challenged hospital estate in the NHS.

- Staff have worked incredibly hard and made significant improvements in quality and safety outcomes over the past few years across all PAT sites and this provides a really positive context when the case for investment is being put forward.

DEVELOPING THE PENNINE ESTATE

- Work is continuing with regulators to secure capital that has been committed for The Royal Oldham as part of the GM Healthier Together Programme and the phase 4B capital bid for backlog maintenance, bed and critical care capacity.

- Capital investment is required to upgrade parts of the Royal Oldham site and IT infrastructure across all PAT sites. There is a real need to:

  - Improve and modernise facilities to 21st century standards across the North East Sector and in particular in Oldham
  - Increase the bed and critical care capacity necessary to enable us to realise the changing acuity of patients and to meet the needs of those high risk patients designated for the Oldham site

- All partners all committed to securing capital investment required for NMGH, The Royal Oldham site and to upgrade IT infrastructure across PAT.

SECURING CAPITAL FUNDING

- Discussions are on-going with national bodies with the aim of securing ~~a~~ significant investment. This is being considered by NHSE/I and the Government subject to rigorous due diligence, agreement of financial plans and approval of business cases.

- However, any long term capital settlement for the NHS will need to be agreed as part of the multi-year Government spending review now expected in 2020. The progress of these discussions will influence how the transaction processes develop.

PROGRESS AND TIMEFRAME

- A strategic case outlines the reasons, benefits and strategic plans for a formal acquisition. Strategic cases for the proposed acquisitions were submitted to NHSE/I by Salford Royal (SRFT) and Manchester University NHS Foundation Trust (MFT) in March 2019.

- NHSE/I currently reviewing both strategic cases as the decision-making authority. This is a complex process that includes the need for a solution to secure the required capital investment, and will therefore take some time to complete.

- Following strategic case review NHSE/I will then decide if SRFT and MFT can proceed to full business case development.

- If approved, there will be significant further work for SRFT and MFT to do on the development of business cases.

PROGRESS AND TIMEFRAME

- Post transaction implementation plans will also need to be developed alongside the business cases, including service continuity arrangements and transfer of employment for staff (under TUPE).

- All partners are committed to confirming future arrangements for the running of PAT sites and services by 31 March 2020, but it is looking unlikely that a formal legal transaction and the transfer of staff to SRFT and MFT can now be completed by this time. This is in part due to the challenges outlined in relation to capital funding.

- The need to secure the required capital investment does not mean progress will be halted on aligning service and management arrangements for sites with the long term plans.

PROGRESS AND TIMEFRAME

- Options are currently being considered for how this split and reorganisation can be put in place ahead of the transactions.

- MFT and SRFT are now working with NHSE/I to identify alternative arrangements that could be agreed by April 2020, so that NMGH can effectively be managed as part of the MFT Group, with the Oldham, Bury and Rochdale sites continuing to be managed by SRFT as part of the Northern Care Alliance NHS Group (NCA).

- Formal transactions would then be completed at a later date.

KEEPING SERVICES SAFE

- Whilst there is a process to support the proposed legal transactions, and possible interim arrangements, MFT and SRFT are continuing to work together, engaging with senior clinicians and managers across PAT to understand and prepare for how services will be provided safely and effectively in the future.

- Both SRFT and MFT have made clear that no material changes will be made to services on Day 1 following implementation of either a formal transaction or an alternative arrangement.

- The future arrangement and reorganisation of PAT will ensure the long term clinical, financial and workforce sustainability of these hospitals and services across the north part of GM.

KEEPING STAFF INFORMED AND ENGAGED

- Regular communications and on-going engagement with clinical and non-clinical staff across PAT remain a key priority for PAT (and the acquiring Trusts SRFT and MFT)

- Joint internal comms and staff engagement sessions involving MFT directors attending the NMGH site continue, and equal emphasis on staff engagement and briefings given to staff on the other PAT sites

- Local Healthwatch partners continue to be updated and involved in the process, through briefings by SRFT and MFT directors

- Appropriate public and patient communication and engagement around future plans for PAT hospitals and services will increase where required during 2019/20 as part of the Business Case stage

- This will ensure the public are informed and reassured about access to their hospital services as no major services changes are expected from Day 1 post-transaction i.e. no changes to A&E or Maternity services.

- Engagement and regular updates on the PAT Transactions are being given to Local Authority Cllr members of local HOSCs by GM HSCP and SRFT and MFT, and at quarterly meetings of the Pennine Acute Joint HOSC.

QUESTIONS AND DISCUSSION