Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

Salford I Oldham I Bury I Rochdale I North Manchester

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The Pennine Acute Hospitals NHS Trust

Quality Report

2018-19

Draft 19.03.2019

IMPORTANT NOTE FOR THE REVIEWER

This is an early-stage draft document. The document will be updated as we receive year end data and other information. Annotation has been added to all areas within this document requiring additions and/or extra content.

Contents

- Annex 1: Statement from local commissioners, local Healthwatch organisations and independent auditor's report to the Council of Governors of The Pennine Acute Hospitals NHS Trust on the annual quality report
- Annex 2: Statement of responsibilities for the quality report

Appendices

- Appendix A: Breakdown of CQUIN goals for 2018/19
- Appendix B: Glossary of definitions

If you require any further information about the 2018/19 Quality Report please contact: **The Quality Improvement Team** on **0161 918 4940** or email Daniel Rowbotham at **daniel.rowbotham@pat.nhs.uk**

Achievements in quality Displayed as Rosettes

In 2018/19 we have achieved:

- Stroke services at Fairfield are rated in the top 9 best performing units out of 209 hospitals nationwide according to Sentinel Stroke National Audit Programme (SSNAP) audit data.
- End PJ paralysis initiative launched across all Pennine sites in 2018, and the Wolstenholme intermediate care unit at RI won 'Best Event' in the national End PJ Paralysis Awards.
- Victoria breast care unit at Oldham was awarded the Christie Quality Mark for the second time
- Fairfield has become the first hospital in the UK to pledge to be part of the Homeless-Friendly programme – helping rough sleepers receive care before they fall dangerously ill.
- Ward J6 at North Manchester and Ward 2 at Fairfield are the first Pennine wards to attain SCAPE status for delivering 'safe, clean and personal care every time'.
- Pennine Acute hospitals achieved the top accreditation by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) for their endoscopy units.
- Rochdale Infirmary's Discharge to Assess: Home in a Day Team and Emergency Assessment and Treatment Team and North Manchester's Paediatric Emergency Department were shortlisted in the national HSJ Awards.
- Events for the public and staff were held at all Pennine sites to celebrate the 70th birthday of the NHS in July.
- The first ever national AHP (allied health professions) day was celebrated across the Trust with events for staff and the public to raise awareness of the roles of AHPs with patients and alongside other medical professionals
- Pennine's security team won a national award for 'Best Team,' at the British Security Industry Association (BSIA) awards proving they are a 'safe pair of hands' for staff, patients and visitors.
- Staff were celebrated at the NCA Staff awards, including Patients' Choice Awards voted and nominated by members of the public, which were awarded to John Mushing, Porter in the Pharmacy Department (Royal Oldham), Ward 8 at Fairfield General Hospital, and Louise McMahon, Sister in the Emergency Department (North Manchester)
- A CQC survey of new mums' experiences of maternity care at Royal Oldham and North Manchester hospitals showed significant improvement
- North Manchester Community Tissue Viability Service won the Person-Centred Care Champion Award at the NHS70 Parliamentary Awards for their wound clinics for the homeless

Statement on Quality by the CEO *Subject to slight amends*

Welcome to the Quality Report for Pennine Acute Hospitals NHS Trust for 2018/19.

This year has been an extremely busy, somewhat challenging year, but we have so much to be proud of.

We are now one of the largest organisations in the NHS and we bring together our staff, expertise and resources under the umbrella of the Northern Care Alliance NHS Group (NCA) enabling us to work together as one Group to share and spread best practice. We deliver care in many forms from our domiciliary, community and hospital services and all are working together to deliver our mission of 'Saving Lives, Improving Lives'.

This report provides us with an opportunity to highlight some of the main developments to our services and the improvements we have made to care over the past year across the Trust, whilst also reporting on how we have performed against key national and locally determined clinical standards, waiting times and our key quality improvement priorities.

Throughout 2018/19, we have continued to deliver our Quality Improvement Strategy, which aims to make us the safest organisation in the NHS. You can read about a number of key improvement projects and programmes of work which are currently underway in Section 2 of this Quality Account.

Over the coming year Pennine will partner with Salford to become Manchester's first Global Digital Exemplar (GDE) Fast Follower organisation. This is a national initiative which aims to improve digital maturity across the NHS. This is a fantastic opportunity to try, implement and, if necessary, modify and improve new technologies to support patient care following 'blue-print' principles and processes which have already been tested at Salford. Importantly the GDE Fast Follower programme runs alongside our infrastructure improvement and future Electronic Patient Record programmes which, as a whole, will enable us to achieve a digital future for healthcare.

In wider Northern Care Alliance news, we have been ranked number 25 in the Inclusive Top 50 UK Employers List in recognition of its continued dedication to workplace diversity. The List ranks UK based organisations that promote inclusion at every level of employment within an organisation. This is a fantastic achievement and I am incredibly proud of the organisation and our staff for making the Northern Care Alliance, our hospitals and community services in Salford, Oldham, Bury, Rochdale and North Manchester, truly equal, diverse and inclusive places to work.

In addition to this, in June 2018 the NCA joined with Greater Manchester's other public sector employers and signed up to a historic commitment to address race inequality at work. Other signatories included other NHS organisations, local

authorities, Greater Manchester Fire and Rescue Service and Greater Manchester Police. For years organisations have done their own work on this and made some good progress, but we haven't got it right. By coming together we can really make a difference to make sure everyone feels welcome in our public services and given the same opportunities to get on.

The Northern Care Alliance NHS Group has signed an Armed Forces Covenant promising that those who serve or who have served in the armed forces, and their families, are treated fairly by the organisation. By signing this document we are officially saying that we recognise the contributions that serving personnel in the regular and reservist Armed Forces, veterans and their families, all make to our businesses and country. We also promise to treat them fairly in our Organisation, including the injured and bereaved, so that they do not face any disadvantage.

In closing, I must pay tribute to all colleagues across the Northern Care Alliance who have risen to the challenge of coming together to create a Group that has the mission of improving and saving lives on a far greater scale than what the Trusts could achieve working on their own.

They have worked tirelessly to create better care for their patients with the results that a significant number of improvements have taken place at the Northeast Sector sites whilst Salford Royal has continued to retain its own high standards.

I am truly grateful for the support and contribution of staff at all grades and levels which have been crucial to our success.

What makes a real difference to our patients and service users is our people – our staff. It is the team spirit, shared values and 'can-do' attitude of staff across our Group that makes the real difference.

Finally, I am pleased to confirm that the Board of Directors has reviewed this 2018/19 Quality Account and confirm that it is an accurate and fair reflection of our performance.

I hope that this Quality Account provides you with a clear picture of how important quality improvement, safety and service user and carer experience are to us at Pennine Acute Hospitals NHS Trust and the Northern Care Alliance NHS Group.

Best wishes

Raj Jain

Chief Executive

Salford Royal NHS Foundation NHS Trust
Northern Care Alliance NHS Group
Comprising the Care Organisations of Salford, Bury & Rochdale, Oldham and North Manchester.

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Our Aims Potential QI image here

Since 2016, we have had in place a clear Quality Improvement Strategy which addresses the distinct quality challenges addressing the three Care Organisations that make up the North East Sector (NES).

The current version of our strategy details how we plan to accomplish this. A strategy which covers the whole Northern Care Alliance is currently in development.

No preventable deaths

Estimating preventable deaths is complex. However, we are certain through the mortality reviews we carry out on all patients who die whilst under our care, that not all patients receive all ideal aspects of care for their conditions in a timely manner. We use these mortality reviews to find defects in care that we can fix in service of pursuing our aim of having no preventable deaths.

In 2018/19 we have maintained our position for HSMR and SHMI. Both measures have now been 'as expected' for the past two consecutive years.

Continuously seek out and reduce patient harm

Harm is suboptimal care which reaches the patient either because of something we shouldn't have done, or something we didn't do that we should have done. As of February 2019, 94.22% of our patients receive harm free care, as measured by the safety thermometer.

Achieve the highest level of reliability for clinic care

At Pennine Acute we use the principles of reliability science to maintain high performance, and ensure that care is reliably high quality for every patient, every time. In the pages that follow, we detail several projects worked on over the past year in the pursuit of high reliability.

Deliver what matters most: work in partnership with patients, carers and families to meet all their needs and better their lives

The views of our patients and staff are very important to us and we receive feedback through a number of methods, including surveys and patient and staff stories, all of which provide us with vital information on how to improve. In 2018/19, XX.XX% of Pennine Acute's Patients rate their care as excellent or very good.

Deliver innovative and integrated care close to home which support and improve health, wellbeing and independent living

Caring for patients, their families and carers, is just as important out of hospital as it is when they're staying with us as an inpatient. Community based teams such as district nurses, community allied health professions, and intermediate care teams provide care closer to or in patients' homes.

A review of quality improvement projects 2018/19

NOTE TO DESIGN TEAM – PLEASE USE SYMBOLS USED IN LAST YEAR'S SALFORD ACCOUNT

Below is a list of quality initiatives in progress and their current status. These projects are explained in more detail in the following pages.

	Target achieved/On plan	Close to target	Behind plan
Improving Urgent care & Patient Flow	=		
Deteriorating Patients	=		
Infection Prevention	=		
Pressure Ulcer Reduction		*	
Nursing Assessment Accreditation Scheme	=		
Help Line	=		
Mortality Reduction	=		
End of Life/Bereavement Care	=		
End PJ Paralysis/Last 1000 Days	=		
Venous Thromboembolism	=		
Sepsis	=		
Theatres	=		
Maternal and Neonatal Health Safety Collaborative	=		
Elective Access	=		
Clinical Reliability Groups	=		
Paediatric and Neonatal Service			

Improving Urgent Care & Patient Flow

All North East Sector Care Organisations saw an improvement in 4 hour A&E performance in 2018-19.

The North East Sector Care Organisation, continues to face the ever-challenging demand of providing safe, effective, and efficient service to all patients.

To fulfil this vision, each of the three North East Sector Care Organisations have established a series of work programmes designed to improve patient flow and to reduce the number of 'Stranded' patients (A "Stranded Patient" is defined as a patient who has a hospital stay of seven days or more.)

These work programmes consist of a number of linked work streams focussing on improvements in Urgent Care systems, Inpatient Flow processes and pathways, and Stranded Patients reduction.

The improvement programmes are directed, monitored, and assured at each Care Organisation's established (Patient Flow/ Urgent Care) Improvement Board.

To successfully improve patient flow throughout the whole organisation to reach the national A&E targets			
April 2018 – Feb 2019	Bury & Rochdale	North Manchester	Royal Oldham
Goal	92%	90%	90%
Timescale	March 2019		
Outcome	**92.62% (↑)**	**77.60 % (↑)**	**75.33% (↑)**

To successfully improve patient flow throughout the whole organisation resulting in improvements towards reducing the number of 'stranded' patients.			
April 2018 – Feb 2019	Bury & Rochdale	North Manchester	Royal Oldham
Goal	>40 patients per week	15% reduction	10% reduction
Timescale	Apr-19	Mar-19	Mar-19
Outcome	**19.40% ↑**	**13.80% ↓**	**1.12% ↓**

Urgent Care

The aim of seeing patients presenting at A&E within the 4-hour allocated target remains challenging due to the increasing demand for the service. The Urgent Care improvement programme is working to meet that target through managing the high demand commanded of the service, as well as redesigning existing structures and processes to maximise efficiencies and productiveness.

Driver Diagrams have been developed by each Care Organisation to describe specific improvement projects best suited for the Organisation's needs to improve Patient Flow.

Improvements achieved

- Improvement Boards have been embedded at each Care Organisation. The Board consists of leaders (both clinical and non-clinical) of all levels to review and drive changes across the programmes
- The Same Day Care Centre was opened to the public in September 2018 at North Manchester General Hospital, further improving community accessibility to healthcare.

Further improvements identified

- Ensure all patients attending to A&E are having the best possible care and experience by 'streaming' to appropriate care pathways
- Continued investment to better manage patient demand, such as increasing the size of A&E estates in Oldham Care Organisation.

Inpatient Flow

Patients having the right care in the right place will reduce unwanted resulting in high patient care and experience, as well as ensuring maximum patient safety. Each Care Organisation dedicates improvement projects to develop effective and purposeful coordination across the system, making sure these aims are well met.

Improvements achieved

- Process mapping of assessment units and departments completed to understand improvement opportunities and identified system wastes such as delays and duplications.
- Relocation of the Ambulatory Care Unit (formerly known as the Treatment Centre) at North Manchester General Hospital now completed following feedback from CQC to maximise patient flow.

Further improvements identified

- Detailed diagnostic and process mapping exercises are currently being undertaken across each of the Care Organisations' assessment units to better understand capacity bottlenecks, and identify areas for improvements.
- The development and testing of Criteria Led Discharges to allow patients to be prepared for discharges at the earliest of opportunities as well as empowering other staff groups to discharge patients when medically ready.

Stranded Patients

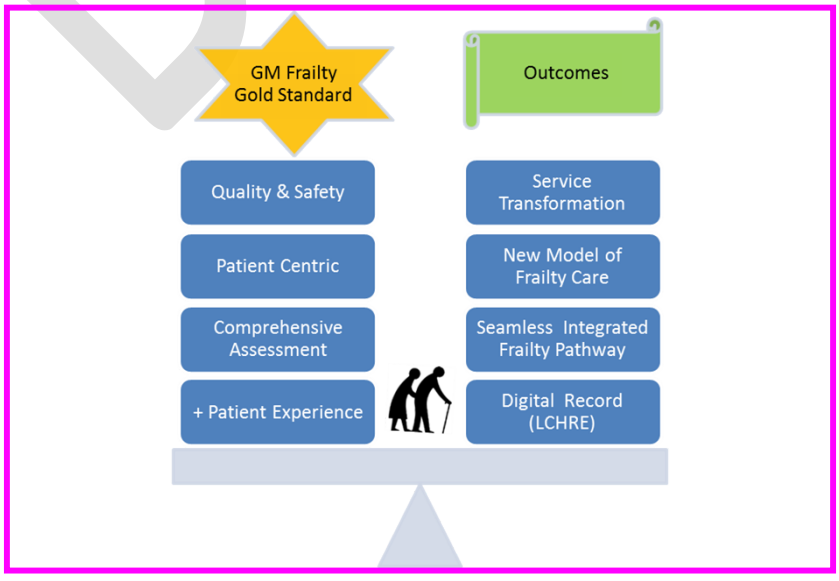
A "Stranded Patient" is defined as a patient who has a hospital stay of seven days or more. Improvement programmes and projects have been designed by each Care Organisations to make sure patients who do not need hospital interventions are safely and effectively returned back to their place of care in the community.

Improvements achieved

- A weekly Stranded Patient review is now in place for all Care Organisations, with the sole purpose of making sure all value added steps are taken to ensure patients are returned safely and timely to their chosen place of care.
- A dedicated Integrated Discharge Team has been **established in each Care Organisation** to aid safe discharge from the hospital. This specialist team works in collaboration with patients, staff, and external partners to make sure patients return to their place of care, at the earliest opportunity and when it is safe to do so.

Further improvements identified

- Oldham Frailty Network will be established imminently, bringing both internal and external (community) stakeholders together as a working group to tackle Oldham's frailty issues.



Oldham Frailty Network aims and outcomes

- The 'Trusted Assessor' model is now being trialled with a Manchester care home, Wellington Lodge. This scheme allows staff to assess patients on the behalf of their care home, effectively accelerating recovery and maximising resource. A Learning Package is currently being developed with the view of adopting the scheme across the locality.

Principles for D2A model	What does this mean?
Essential criteria	• Supporting people to go home should be the default pathway[2], with alternative pathways for people who cannot go straight home. • Free at the point of delivery, regardless of ongoing funding arrangements. • To be safe if the person is going home, the assessment should be done promptly (within 2 hours), with rapid (on the day) access to care and support if it is required. • Support services should be time limited - up to 6 weeks, in the best systems the average appears to be 2 weeks and can be longer than 6 weeks in exceptional cases. • Non selective, a service that tries to alway say 'yes' - to include support for end of life care.
User focus/patient centred care	• Put people and their families at the centre of decisions, respecting their knowledge and opinions and working alongside them to get the best possible outcome. • Take steps to understand both the perspectives of the patient and their carers and the communities they live in, their needs, aspirations, values and their definition of quality of life. • Ensure the person and their family receive clear information about their care within the acute setting including what will happen on discharge and who to contact if there are any problems after discharge. • Ensure continuity of communication so all members of the team are working to the agreed care plan, until discharge from the pathway. • Where the patient may not have capacity for a decision about discharge placement/assessment, apply the Mental Capacity Act 2005 (MCA), informed by the MCA Code of Practice and relevant case law.
Easy access to services	• Provide simple access to information, advice and services; including support and access to information to enable self-care and self-management. This will ideally be a one-stop shop, always available when needed, with the ability to provide a timely and responsive service for the people needing services and practitioners.

Some simple rules and principles for effective Discharge to Assess (D2A) ref: NHS Improvement

Deteriorating Patient Collaborative

42.34% reduction against baseline period in the cardiac arrest rate per 1000 admissions for North East Sector Innovation Wards

Across the North East Sector Care Organisations, we are committed to achieving no preventable deaths.

We have been working with a selection of innovation wards from across the Trust since November 2016 to design, test and reliably implement the improvement ideas of staff with the aim of positively impacting the care delivered to deteriorating patients.

What: Reduce the cardiac arrest rate (per 1000 admissions) in North East Sector Innovation Wards

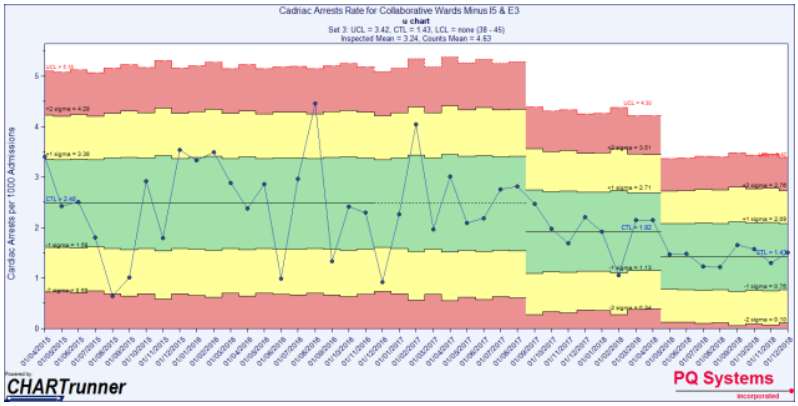
How much: 50% reduction

By when: December 2019

Outcome: During Phase 1 and 2 of the collaborative (since November 2016) we have achieved a 42.34% reduction in cardiac arrest rate in innovation wards

Progress: On plan

Data



In December 2018 the collaborative wards have achieved a 42.34% decrease in the cardiac arrest rate.

Improvements Achieved

A change package has been developed which details the six key improvements which can reduce cardiac arrests when applied reliable to patient care. The changes are:

1. Highlighting sick patients
2. Timely observations and appropriate escalation
3. Allocation of cardiac arrest roles
4. Manual observations
5. 'Stop the clock'
6. The weekend plan

As a collaborative, we have confidence in the changes which the wards have tested. Moving forward, the collaborative will spread to cover most inpatient wards across the North East Sector.

Further improvements achieved

- A video to support clinical staff with difficult conversations for treatment options has been recorded and is now being edited
- In November 2018, the NEWS2 observation chart was launched Trust-wide
- The Patientrack electronic observation system is now live across most North East Sector Care Organisations' wards
- The Patientrack system requires clinical staff to input physiological observations at the patient's bedside using a handheld iPad in order to provide an automated calculation of the early warning score (EWS) score which removes the risk of calculation error. The system will also alter the monitoring frequency and provide escalation prompts as required in line with the Trust's escalation protocol.

Further improvements identified

We plan to now bring on board more innovation wards to spread the change package and reduce cardiac arrests further across the North East Sector.

Sepsis

In December 2018, 80% of patients in A&E with 'Red Flag Sepsis' received antibiotics within 1 hour of identification.

In December 2018, 92.1% of patients in in-patient ward areas with 'Red Flag Sepsis' received antibiotics within 1 hour of identification.

What: To treat patients who have Sepsis with antibiotics within 1 hour

How much: a minimum of 90% of patients with Red Flag Sepsis to be given antibiotics within 1 hour of identification

By when: September 2019

Outcome: In December 2018 80% of A&E patients and 92.1% of in-patients with red flag sepsis were given antibiotics within 1 hour of identification

Progress: On track

Sepsis is a highly complex disease process which is difficult to diagnose and complex to treat. Red flag sepsis is a time critical condition, in which immediate action is required due to severe sepsis being present.

The mortality rates associated with septic shock remain unacceptably high (up to 50%) with an estimated 37,500 deaths per year in the UK. Evidence has shown that early identification and treatment of these patients with antibiotics can lead to improved survival.

The early identification and timely treatment of sepsis remains an organisational priority for Care Organisations and is therefore a key component within The Quality Improvement Strategy.

Improvements achieved

- Governance for sepsis improvement established
- Fortnightly improvement meetings occurring in clinical areas

- The North East Sector Sepsis policy has been updated to align to national guidelines and to support Trust-level improvement work
- An improvement group was established which aims to improve the management of sepsis in community settings

Further improvements identified

- In Spring 2019, a Sepsis module will be added to the electronic observation system. This module will flag to clinical staff when a patient's observations trigger against any of the NICE Red Flag Sepsis parameters and will enable staff to complete the screening and action tool electronically.

Infection Prevention

Aim: To prevent, manage and minimise the risk of avoidable healthcare associated infections and achieve mandatory objectives set and monitored by our Clinical Commissioning Groups (CCG's) for reduction in clostridium difficile (no more than 54 cases) and MRSA bacteraemia (zero tolerance approach).

By when: April 2019

Outcome: The Trust is on target to report an achievement of its objectives to the CCG's, to reduce clostridium difficile infections with 34 cases to date against an annual objective of 54, with a 57% reduction of avoidable cases. The trust has had 2 cases of MRSA bacteraemia,

At The Pennine Acute Hospitals NHS Trust we are committed to ensuring we deliver safe care for all our patients.

In 2018/19 two of our Hospitals celebrated over 100 days of being C. difficile free.

The Trust considers Infection Prevention to be one of its most important organisational priorities. Over the past year, the organisation has undertaken extensive work to prevent patient harm from occurring as a result of infection. The improvement work has been structured under a number of work-streams and utilises the approach of testing ideas for improvement in pilot areas, and then spreading successful change across our organisation (wherever possible across both Acute and Community sectors).

Improvements achieved

Clostridium Difficile at Fairfield General Hospital

In August 2017, the senior management team at Fairfield General Hospital began a small scale improvement project to address the issue of Clostridium Difficile infection (CDI). The main themes identified as potential areas of improvement were as follows:

- Insufficient anti-microbial stewardship
- Outsourced cleaning
- Culture and Leadership

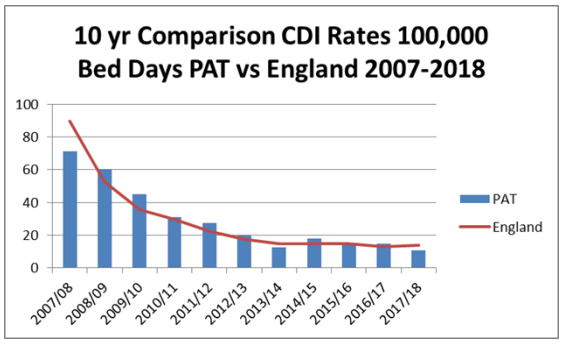
A selection of wards were chosen to participate in this improvement project and lead on the development and testing of change ideas.

Following a 90-day cycle of improvement, a selection of successful change ideas were identified as having a positive impact on reducing the number of hospital acquired CDI cases. These changes include:

- The Trust introduced a revised programme of cleaning on ward areas
- A new role of Antibiotic Pharmacist has been introduced across all 3 care organisations; Bury/Rochdale, Oldham and North Manchester.
- The impact of having the presence of the Antibiotic Pharmacist at ward level to provide the face-to-face training to the doctors and pharmacists to resolve antibiotic queries has had positive feedback from the wards.
- The role of the Antibiotic Pharmacist has been standardised across the three COs and extra role such as the HITT service has been taken on. An audit by The Mersey Internal Audit Agency (MIAA) has produced a very positive report, with some recommendations which have been actioned.
- The impact of the Antibiotic Pharmacist role can be demonstrated in the table below which shows that the number of C Diff cases per site has decreased year on year.

Sustaining Improvement

Over the last 10 years there has been sustained reduction in the number of health care acquired CDI infections within the Trust, the graph below demonstrates this.



The collaborative has been instrumental in identifying learning and allowing this to be shared across sites to reduce variance in practices. Some of the learning shared has included:

- greater clinical engagement in the monitoring of cleaning standards and in the inclusion of the cleaning staff as “in house” Trust staff and not as an out-sourced service.
- a Consultant hand hygiene ‘champion’ on each hospital site
- a “test of change” for the CDI risk assessment tool following staff feedback
- extra clinical hand wash basins installed at ward entrances on a rolling programme
- the infection prevention team have been undertaking ward rounds with the Consultant Microbiologist and Antimicrobial Pharmacist to promote greater MDT working and engagement with clinical teams

Further improvements achieved

- In addition to the C Diff improvement work at Fairfield General Hospital, The Royal Oldham Hospital also has a CDI collaborative
- The Trust is taking part in an initiative to reduce Urinary Tract Infections (UTI)
- The patient hand hygiene project is being rolled out across all hospitals within the Trust and will form part of the annual plan for infection prevention to ensure sustained delivery
- The Trust has been identified regionally as having a very low rate of MSSA infections

The Trust remains committed to a zero tolerance approach for MRSA bactereamias and has the following measures in place to support this:

Pressure Ulcers Collaborative

Background

A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear).The damage can be present as intact skin or an open ulcer and may be painful.

All patients are potentially at risk of developing a pressure ulcer. However, they are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition or poor posture or a deformity.

The Care Organisations have committed to reducing harm to patient through Pressure Ulcers by developing the 'Pressure Ulcer Collaborative' using the Breakthrough Series Model to structure the improvement work. A number of acute pilot wards areas are actively testing change ideas using the Model for Improvement to guide their tests. The community teams are testing and implementing the change ideas from the recently launched Pressure Ulcer Community Change Package.

What: Reduce the number of pressure ulcers acquired by patients whilst under our care

How much:

- A 20% reduction in hospital acquired Category 2 Pressure Ulcers in pilot areas
- Zero tolerance of hospital acquired Category 3&4 Pressure Ulcers in pilot areas
- A 20% reduction in avoidable Category 2 pressure ulcers in community areas

By when: 01 April 2019

Outcome: 2018/19 data outstanding

Progress: 2018/19 data outstanding

Improvements achieved

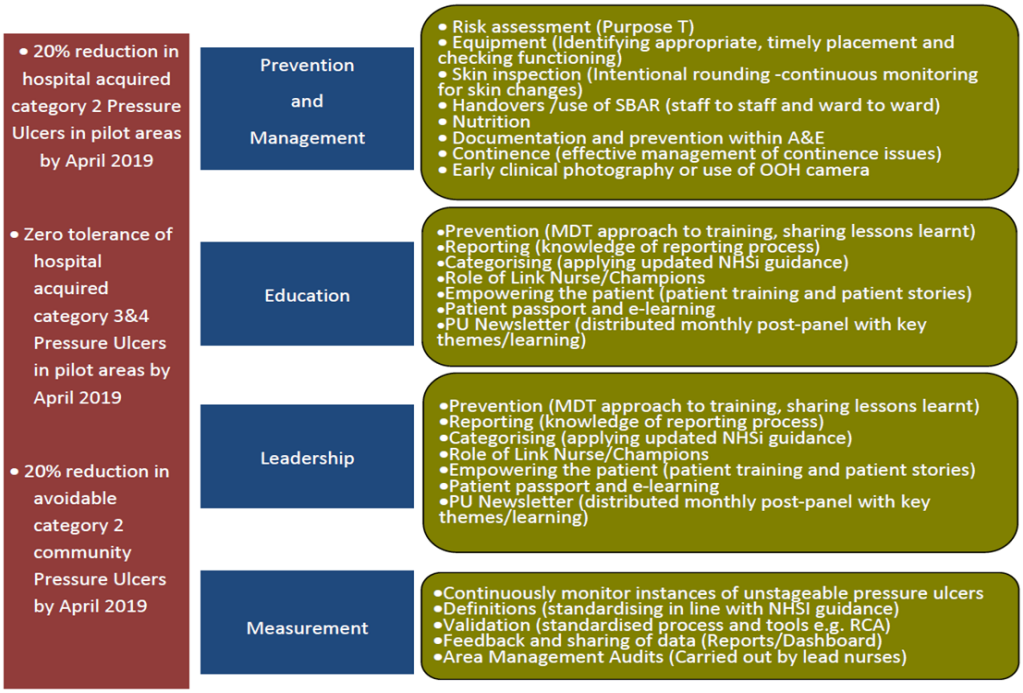
- The current tests of change from the collaborative pilot areas are:
  - Bed board visual prompt to highlight at risk patients
  - 'Time to turn' prompt to empower patients
  - Alert sticker in the patients notes for either 'At Risk' or 'Has Pressure Damage'
  - 'When pressure is found' process map to support ward staff
  - Reliable bedside handover to identify gaps in documentation before shifts end
  - Prevention and management pathway
- Critical Care Units have been working together to develop tests of change specific to their environment, including an innovative approach to securing feeding tubes.
- A Top Tips Guide to support healthcare assistants to deliver pressure care has been developed and is currently being piloted.
- Two collaborative learning sessions held in Oct '18 and Jan '19. The most recent event focussed on the Science of Reliability and how teams can apply reliable design concepts to embed their successful tests of change as 'business as usual'.
- Community Change Package Launch held February 2019

Potential image here

Further improvements identified

- Community teams will be supported to spread the Community Change Package and to make the tests of change 'business as usual'
- The Acute Change Package is currently in development and will be launched in May 2019.

A Driver Diagram was designed within a Pressure Ulcer Steering Group to capture all activity identified to help us achieve our aim and provides direction for the improvement work.


• 20% reduction in hospital acquired category 2 Pressure Ulcers in pilot areas by April 2019
• Zero tolerance of hospital acquired category 3&4 Pressure Ulcers in pilot areas by April 2019
• 20% reduction in avoidable category 2 community Pressure Ulcers by April 2019
Prevention and Management
• Risk assessment (Purpose T)
• Equipment (Identifying appropriate, timely placement and checking functioning)
• Skin inspection (Intentional rounding -continuous monitoring for skin changes)
• Handovers /use of SBAR (staff to staff and ward to ward)
• Nutrition
• Documentation and prevention within A&E
• Continence (effective management of continence issues)
• Early clinical photography or use of OOH camera
Education
•Prevention (MDT approach to training, sharing lessons learnt)
•Reporting (knowledge of reporting process)
•Categorising (applying updated NHSi guidance)
•Role of Link Nurse/Champions
•Empowering the patient (patient training and patient stories)
•Patient passport and e-learning
•PU Newsletter (distributed monthly post-panel with key themes/learning)
Leadership
•Prevention (MDT approach to training, sharing lessons learnt)
•Reporting (knowledge of reporting process)
•Categorising (applying updated NHSi guidance)
•Role of Link Nurse/Champions
•Empowering the patient (patient training and patient stories)
•Patient passport and e-learning
•PU Newsletter (distributed monthly post-panel with key themes/learning)
Measurement
•Continuously monitor instances of unstageable pressure ulcers
•Definitions (standardising in line with NHSI guidance)
•Validation (standardised process and tools e.g. RCA)
•Feedback and sharing of data (Reports/Dashboard)
•Area Management Audits (Carried out by lead nurses)

Nursing Assessment and Accreditation System (NAAS)

The Nursing Assessment and Accreditation System (NAAS) is designed to support nurses in practice to understand how they deliver care, identify what works well and advise and support where further improvements are required.

NAAS was introduced at the Pennine hospital sites in September 2016 and is now well embedded in practice with all adult and children's inpatient wards assessed on a regular basis using a 'traffic light' scoring system of red, amber or green to identify how well a ward team is performing.

What: To ensure at least 50% of wards that are assessed are rated as green by the end of 2018

Outcome:

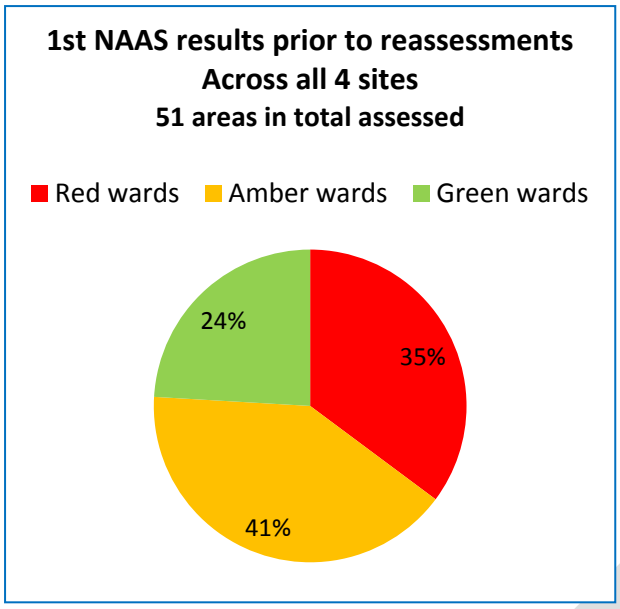
- All but 2 of the adult and children's inpatient wards/departments had been assessed at least twice at the **end of December 2018.**

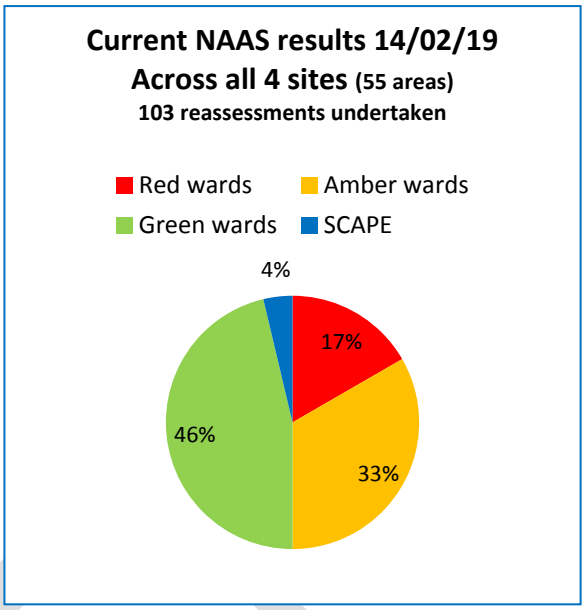
Progress: Aim achieved

As of Feb 2019 50% of wards were rated as green and two wards included in that figure were classed as 'SCAPE' blue wards.

The SCAPE status is awarded when wards have demonstrated consistently high standards of care and as a result, they are invited to apply to the Trust Board to achieve this accolade.

These wards; Ward J6 at NMGH and Ward 2 at FGH were awarded this status in November 2018.





The aim for the next 12 months is to ensure all adult and children's inpatient ward areas have ongoing assessments and that wards are showing improvements.

Where progress is not seen additional focus is given to these areas to understand the problems and provide appropriate support.

The NAAS tool has been amended and agreed for Community Nursing Teams and is also being developed for maternity services.

Three Corporate Quality NAAS matrons are in post and are assigned to specific Care Organisations. They provide support to the ward teams with their action plans to ensure safe, effective care is being delivered.

Venous Thromboembolism

Background

Venous thromboembolism (VTE) is a condition where a blood clot forms in a vein. This is most common in a leg vein, where it is known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE). 1 VTE includes both DVT and PE.

VTE is a major contributor to the global burden of non-infectious diseases. Almost anyone can be affected by VTE, and England sees around 64,000 cases of VTE a year, with a 10% mortality rate.

In 2017 Pennine Care and Salford Royal agreed to join under the umbrella of the Northern Care Alliance (NCA). In 2018 Salford Royal became a VTE Exemplar Centre, now the North East Sector sites (previously Pennine) aim to achieve the same status.

What: for the NES COs to meet the exemplar criteria for VTE by September 2019.

How much: All criteria must be met

By when: 30th September 2019

Outcome: Improved care across the NES in regards to VTE prevention and more robust process around incidents where they occur to better improve learning and care

Progress: On track

Outcome so far

1. **Number of avoidable hospital acquired VTE across the NES**

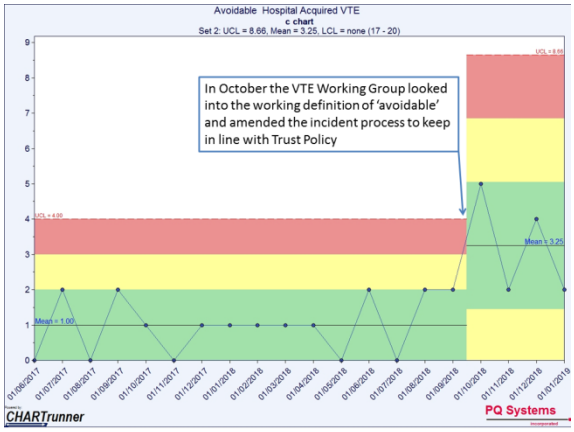


Figure 1: A chart to show the number of avoidable hospital acquired VTE per month across the NES

Current performance reflects an accurate picture of the NES avoidable hospital acquired VTE incidents.

2. Progress against criteria

The table below shows a high level update of each theme within the criteria.

"Ongoing" refers to areas where the group is still working to meet the criteria, and "improvement" refers to areas where the requirements are met, yet improvements are underway.

Theme	Current stage
1. VTE Strategy	Improvement
2. Compliance and Processes	Ongoing
3. Training and Education	Improvement
4. Communications	Ongoing
5. Implementation	Ongoing
6. Patient and Community	Improvement

Further improvements identified and next steps

1. Agree a trust wide incident process
2. Care Organisation based VTE Leads
3. Updated education packages

Theatres Transformation Programme

What: To support and facilitate the transformation (standardisation) of theatres across the NCA to improve productivity, efficiency and patient experience.

Progress: On Track

To provide sustainable clinical services we must meet our financial targets in a very difficult economic context. We do believe that high quality care often costs less because it is well organised, carried out with minimal waste and meets the needs of patients the first time around.

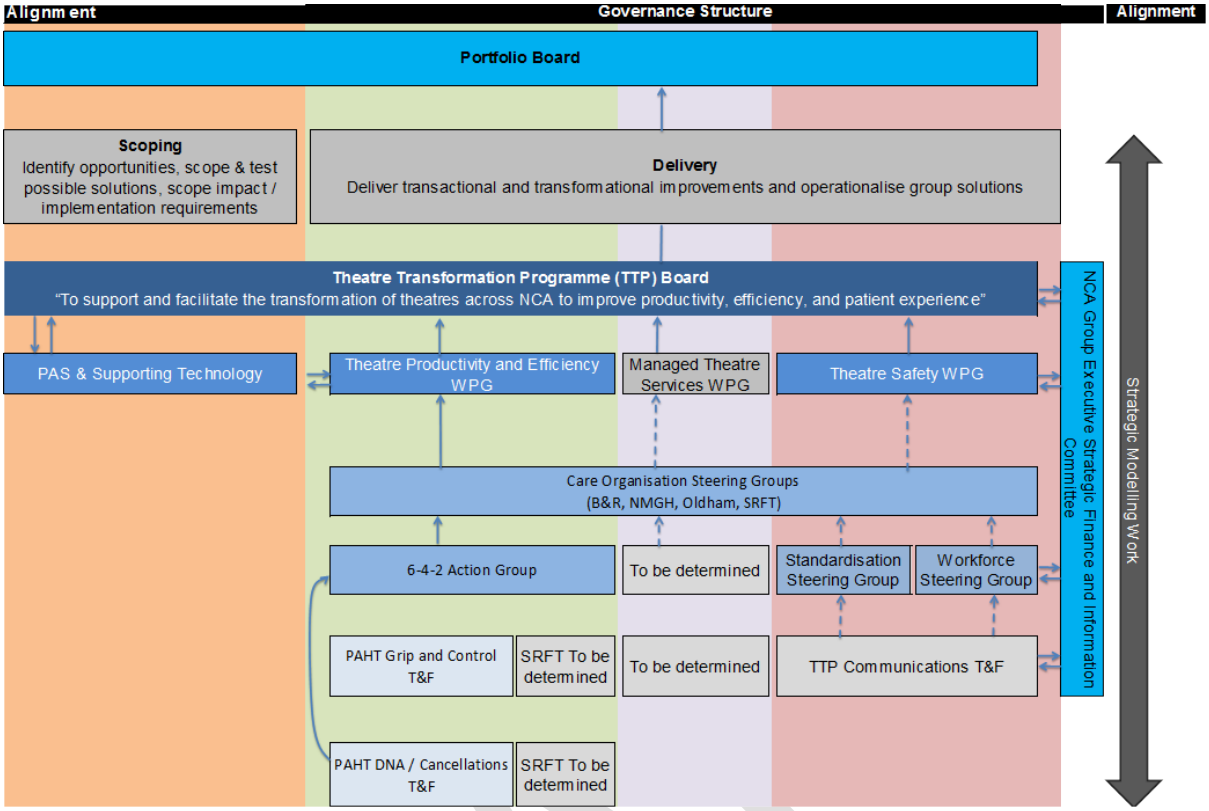
We know that to successfully do this, we must take the learning from our improvement programmes that have reduced harm across the organisation over the last ten years. The Quality and Productivity Improvement Directorate (QPID) formed approximately 12 months ago which brought together QI (Quality Improvement) and productivity delivery (Operational Experience). This has brought together a wealth of experience and expertise, which has proven to be effective in allowing us to develop new methodologies and innovative working.

This approach to working has been applied to the NCA Transformation Programmes; Theatre Transformation, Elective Access Transformation (read more on page __) and Diagnostics & Pharmacy Transformation.

Potential image here

Improvements Achieved:

A governance structure has been formed for the programme as shown in the diagram below, providing a clear escalation process and information flow between groups.



- Improvements in processes for booking and scheduling surgery including theatre resource meetings, 6-4-2, and Grip & Control.
- Implementation of a golden patient process to improve theatre start times.
- Task and Finish group established to reduce DNAs & OTD cancellations. This group has analysed data to identify key issues and focus specialties, and work is now progressing at a specialty level to address the issues identified, including review of communications with patients at pre-op, in letters and on the day.
- A Theatre Assessment and Accreditation System is in development to identify a set of standards and indicators providing assurance that patients receive the highest standards of care within all our NCA theatres.
- An NCA wide survey of staff working in theatres is being undertaken to identify and understand areas of good practice, as well as areas requiring improvements, which will direct some of the work programme.

Further Improvements identified:

- Standardisation of policies, standard operating procedures and working practices across NCA theatres
- Piloting and roll out of Theatre Assessment and Accreditation System across NCA Theatres
- Regular staff survey to ascertain progress on Safety Culture and continue to drive improvement.
- Increased utilisation of 23 hour unit at Rochdale Infirmary

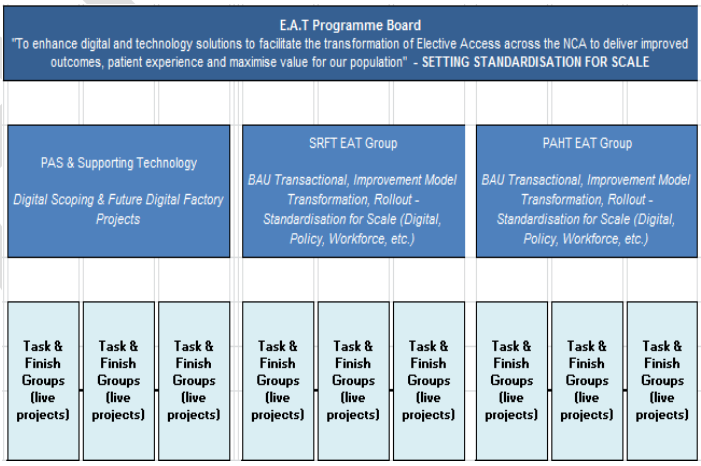
Elective Access Transformation Programme

What: To enhance digital and technology solutions to facilitate the transformation of elective access across the Northern Care Alliance to deliver improved outcomes, patient experience and maximise value for our population

Progress: On Track

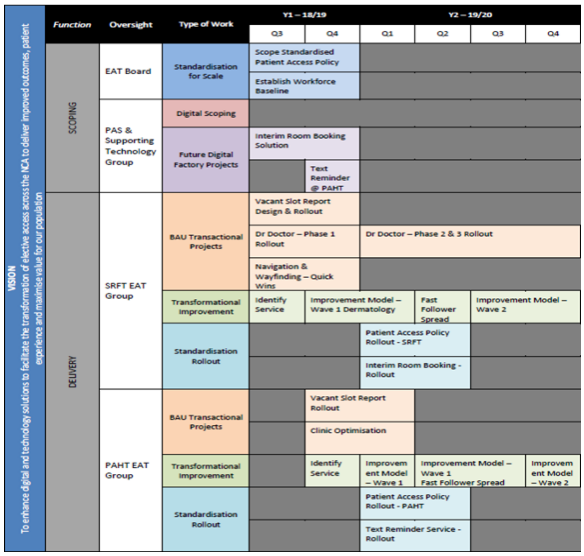
Improvements achieved:

- Governance arrangements established for the programme
- Stakeholder engagement with CCGs and Patients
- Focused task and finish groups established
- Identified, analysed key issues across Elective Access and categorised these into key themes which are now directing the programmes work
- Improvement Model designed to support bottom up transformation within focused services



Projects underway:

- Develoment and rollout of Vacant slot report to support full utilisation of available clinic slots
- Clinic Optimisation. Working in collaboration with services across the Pennine sites to find ways of increasing clinic utilisation across Elective Access.
- Image to the right shows the programme on a page document which includes live and pipeline projects across the Northern Care Alliance



Further Improvements identified:

- Cardiology Improvement Model designed to support bottom up approach to support transformation
- Room Booking utilisation- scoping of a process to support the full usage of clinic rooms
- Patient Access Policy rollout
- Text Message reminder service
- Further development of the patient communication system –including patient led booking and digital correspondence.
- Further design, development and delivery of tailored digital solutions to support and enhance key processes across elective access.

Clinical Reliability Groups

Clinical Reliability Groups are an improvement approach which is used by hospitals which operate as a group (where individual hospitals come together to work under a common structure). The approach brings together doctors, nurses and other health professionals to develop common standards across pathways of care. We, as a newly established group of hospitals are trialling this approach in a small number of areas of care, starting with end of life care

Trialling Clinical Reliability Groups is an important piece of work for us as we have a good opportunity to learn from the way care is delivered across the individual hospitals in our group (the Northern Care Alliance). We can then take the elements of care which we view to be the most effective and replicate them in each of the hospitals of the group.

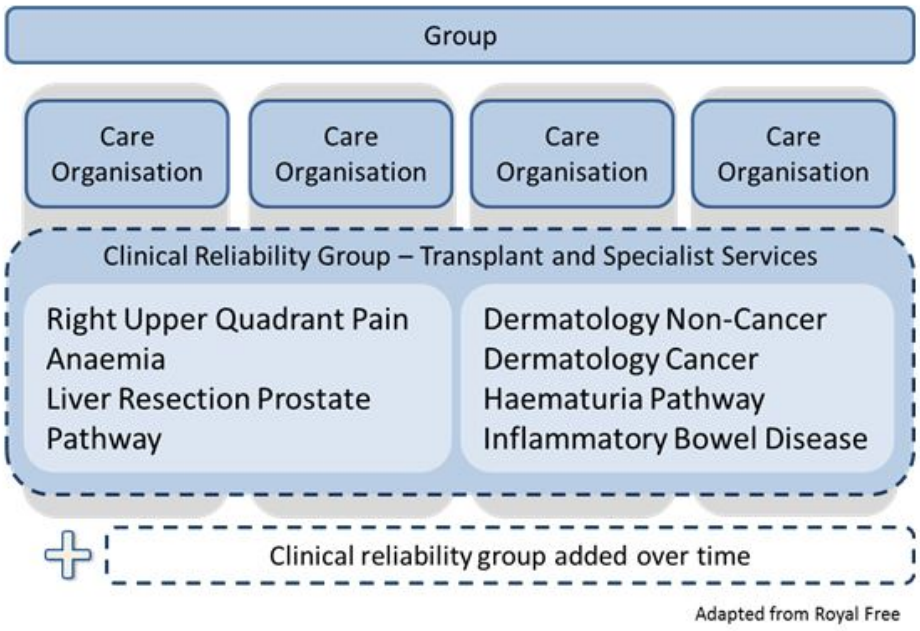
What: To trial the Clinical Reliability Group improvement approach

How much: We will trial with two pathways of care

By when: March 2020

Outcome: We have started working with the end of life pathway

Progress: On track



- *Structure of a Clinical Reliability Group approach*

At the end of 2018 we started working with clinicians from all of our hospitals across the end of life pathway to start to develop a Clinical Reliability Group. So far, we have:

- Appointed a clinical chair to deliver the work
- Had an initial meeting with clinicians to describe the purpose and ambition of the work
- Started to draft a series of standards which describe what any patient coming into any of our hospitals should expect in relation to end of life care

Next Steps

- Establish monthly improvement team meetings
- Continue to develop our end of life care standards
- Develop pieces of work which will help us deliver those standards reliably

Implementing the 'Helpline Scheme'

What: For Helpline to be available 24/7 at each of our hospitals

Progress: On Track

Work-stream

The Helpline scheme provides a mechanism for patients or their families to contact a senior member of staff if they have concerns about care or feel there is a risk of preventable harm. This scheme has been available since early 2017 at each of our Care Organisations.

The Helpline scheme is advertised by displaying posters in each of the bed/bay areas. In addition, each ward & department entrance has a larger A3 sized multi-lingual version of the poster.

Improvements Achieved

- Promotion of the Helpline to ensure that posters are displayed and staff are aware of Helpline
- Senior managers started checks to ensure the Helpline scheme was advertised appropriately and incorporated this as part of their senior nurse walk rounds, safety huddles, and ward and patient safety meetings
- Each of our hospitals was provided with templates to produce small Helpline cards to display on wards and departments, that could be taken off site by patients or their families and used to contact the Helpline
- On call managers were provided with updated mobile phone handsets
- A method to log Helpline calls was introduced on 23rd May 2018 using our existing risk management system (Datix). This allows calls to be logged easily by managers and for managers to be notified of calls entered onto the system to raise awareness and share learning

Impact

Information from the calls placed to the Helpline contributes to identifying areas for safety or patient experience improvement within the Care Organisation.

Since the implementation of using Datix to record calls, there have been 29 calls made to the Helpline scheme that have all been successfully managed and resolved. Some calls were escalated for senior management information or input.

Calls taken by subject type since Datix Helpline launch 23/05/18

The type of calls taken has varied by subject type but include:

- Admission, transfer and discharge procedure
- Equipment
- Staff attitude, behaviour and communication
- Treatment

Calls taken by Divisional breakdown since Datix Helpline launch 23/05/18

	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Total
Bury Division of Integrated Care	1	2	0	1	2	3	1	2	1	13
North Manchester Division of Acute Medicine	3	0	1	1	0	1	0	0	0	6
North Manchester Division of Surgery	1	3	2	0	0	0	1	0	0	7
ROH Division of Surgery	1	1	1	0	0	0	0	0	0	3
Total	6	6	4	2	2	4	2	2	1	29

The 29 calls represent 29 separate contacts; however there was one patient family that used the Helpline twice during their stay at North Manchester, so there were 28 unique calls.

Calls taken by subject type since Datix Helpline launch 23/05/18

	Admissions / transfers / discharge procedure	Aids / appliances / equipment	Attitude and behaviour	Clinical treatment	Communication (oral)	Patient privacy / dignity	Patient status	Policy & commercial decisions of NHS board	Shortage / availability	Total
Bury Division of Integrated Care	2	1	1	4	3	0	1	1	0	13
North Manchester Division of Acute Medicine	2	0	1	2	0	0	0	0	1	6
North Manchester Division of Surgery	0	0	2	2	2	1	0	0	0	7
ROH Division of Surgery	2	1	0	0	0	0	0	0	0	3
Total	6	2	4	8	5	1	1	1	1	29

Mortality review

Placeholder – addition might be required

Palliative, End of Life, Chaplaincy and Bereavement Care

Potential image here

Swan Model of End of Life Care and Bereavement

Pennine Acute Hospitals NHS Trust is committed to providing equitable care irrespective of place of dying, for every patient, every family, and every time. We are privileged to deliver this care with dignity, honesty and compassion; we only have one chance to get it right, and to fail is unacceptable. We must create treasured memories of dying and death, to become that memory living on for each and every family.

There is no 'end' date for this fundamental part of care that is the responsibility of everyone. End of life and bereavement care are ongoing and constant, at any time, in any setting, if we are to achieve an improved grief journey for the bereaved.

At end of life, at death and after death, we aim to ensure that families feel at that moment they are the only people who matter. Their experience is unique and they are cared for with compassion and sensitivity, and given the time they need.

The Swan Bereavement Nurses support families at the time of death in any place by being there; listening, diffusing, calming, offering mementos, providing care, compassion and helping to turn each and every situation they're involved in, into a moment that becomes a memory. They also provide education, training and real time coaching to enable all staff to provide this care, wherever they are, whatever their role. They collect data, complete audits and are involved in supporting families before, during and after Inquest and Complaints. They support all families and visit the deceased of any age and Faith.

Specialist Palliative Care/EOLC Practice Development Team

The Specialist Palliative Care Service helps patients and families live as well as possible by providing high quality pain and symptom control, in addition to Specialist psychological, emotional, social, spiritual and input as appropriate.

The Service supports patients with life- limiting illnesses and is based on a multi-disciplinary model of care, with excellent relationships with many disciplines and specialties within the Trust and in the local community.

Patients receiving input from the Service are usually within the last 12 months of their lives. However, in some cases, patients and their carers may require input at the time of diagnosis and intermittently on an ongoing basis when in hospital or outpatient clinic. The Service will be involved, as appropriate, at any point in the patient's illness journey.

The EOLC Practice Development Team lead and facilitate quality improvements in the provision of End of Life Care by providing ongoing education and support for local, regional and National End of Life Care agendas.

Chaplaincy Service
The Service offers emotional, spiritual, pastoral or religious support to patients, their family and loved ones, and also to Trust staff. Spiritual Care is person centred care which seeks to help people (re)discover hope, resilience and inner strength in times of illness, injury, transition and loss.

Spiritual Care is person centred care which, through affirmation, enables a person to make the best use of their personal and spiritual resources in facing and coping with the doubts, anxieties and questions which arise in a healthcare setting, and often accompany ill health and suffering.

Healthcare Chaplaincy is a service provided to patients, their carers and staff within the healthcare setting which involves haring and meeting their existential, spiritual, religious and pastoral needs.

Chaplains are trained to serve appropriately the needs of those of different faiths, denomination and backgrounds as well as those of no particular faith.

Improvements achieved

In 2018/19 the Trust has introduced the following:

- Development of Bereavement Support Groups
- Quarterly service reports for end of life care, bereavement and specialist palliative care including patient stories, data, complaints, good news
- Continued improvement of mortuary environment and facilities
- Staff trained and empowered to offer mementos every time to every family – already offering locks of hair and personal message cards, now training to take handprints, footprints, lip ‘kisses’.
- Development of Faith Death Procedure
- SWAN bereavement Nurse role pilot for 12 months based at HMR coroners
- Development of service level agreement for Shabbos room
- Bereavement & loss module accredited for delivery at Bolton University
- Long stay policy for the mortuary
- Development of guidance following the death of a patient in an operating theatre setting
- Development of an EOLC newsletter
- Revised uDNACPR policy
- Chaplaincy service now under new line management as part of Palliative, EOLC & Bereavement services
- Assess to clinical supervision for teams

- Revision of rapid Discharge checklist
- Development of electronic coroner reporting form, tool kit & take 5 presentation
- Development of Swan Implementation package
- Development of verification of death policy & training
- Production of quarterly service team reports
- Development of bereavement operational policy
- Audits:
    - Coroner referrals
    - National EOLC audit Opioid Transdermal Patch monitoring audit & Implementation of monitoring charts
- Training Needs Analysis for knowledge, skills & confidence around EOLC
- Development of deteriorating patient video
- Attendance/involvement at mortality & morbidity meetings
- Implementation of Swan car park vouchers for families visiting loved ones at EOL
- Development of funeral specification for those patients who die with no next of kin
- Seven day week working for the Bereavement Service
- Appointment of Mental Health bereavement liaison worker

Further improvements identified

The Northern Care alliance remains committed to providing the highest standard of End of Life and Bereavement Care. Therefore, moving into 2019/20 we aim to prioritise the following improvements:

- Seven day week working for Specialist Palliative Care & Chaplaincy services
- Hosting of EOLC community services for Oldham & Bury
- Further integration/standardisation of services across the NCA
- Evaluation of the Swan bereavement nurse role based at the coroner's office
- Development of the Clinical Reporting Group for Palliative Care
- Development of EOLC committees within each care organisation

Patient Story: Ralph Williamson

The story below was submitted by Mrs Williamson, wife of patient Ralph Williamson, who was treated at the Royal Oldham Hospital.

A year ago today you did an incredible act of kindness for me and my family but most of all for my husband, Ralph Williamson.

Ralph had been a patient on your ward, and others, many times due to his COPD and other illnesses which had rendered him virtually housebound and dependent on 24 hour oxygen in his last few years. He was always shown fantastic care and his adamant wish for a window open or at least a jar!! Was met with humour and a willingness to oblige where possible. We thank you for all the care he received.

On the 11th January 2018, Ralph was once again rushed by ambulance to A&E and put on the dreaded C-pap machine. We knew though although Ralph had beaten the odds on more than one occasion that this was to be his last day. Having called all his family we were told that although Ralph was dying there wasn't a bed to be had anywhere. Ralph had told us that under no circumstances did he wish to ever spend his last hours in ICU with all its manic bleeping, scary machines and frightening atmosphere that he so dreaded.

My daughters were able to speak to someone who incredibly found somewhere for us all to spend those last few precious hours. It was you.

I cannot convey to you how special that time was to us. In Oak Room, that you had prepared, even though your ward was overwhelmed you gave us sanctuary. Everything possible was done for Ralph to make his end so peaceful and dignified and with all his family around him. You gave him the best possible care and compassion and for us, his family, we will always be so very grateful.

When we talk of Ralph passing it is with one of peace. Our memories are good ones and you made that happen. We will never forget how peaceful he looked and we thank you from the bottom of our hearts for your compassion, thoughtfulness and care – not just for Ralph but for us all.

This letter has taken me a year to write though you have been thought and spoken of between ourselves many times. We would like especially to thank one nurse in particular although we are sorry that we cannot recall her name. She encouraged us to take some time hair each and this year we all had a glass locket and we put a bit of him on all our Christmas trees. You truly deserve every accolade. Thank you for everything you did for Ralph. We will never forget you.

#End PJ Paralysis / Last 1000 Days

Making people more active whilst staying in hospital can reduce the amount of time they spend as an inpatient

What: To rollout the End PJ Paralysis Change Package across our Care Organisations

By when: December 2018

Outcome: Change Package successfully rolled out

Progress: Target achieved

Throughout 2018/19 the End PJ Paralysis / Last 1000 Days project has grown from a campaign to a full improvement project. By implementing the change package throughout the Northern Care Alliance, we can demonstrate that the most engaged wards have seen a reduction in harm to patients that can occur if patients are bed bound for longer than is necessary. We have measured this by looking at our falls, pressure ulcer and length of stay data.

In June we held the first national End PJ Paralysis conference attended by colleagues from across the country. The event hosted by Professor Brian Dolan took place at Salford Royal Hospital. The event was well attended and highlighted the importance of keeping up the hard work that has been undertaken and building upon further improvements in the future.

Improvements achieved

- 100% of wards engaged in the End PJ Paralysis campaign
- 23% reduction in falls in the 'Top 5 wards' engaged in the campaign
- 17% reduction in the length of stay for the 'Top 5 wards' engaged in the campaign
- Winner of two awards at the National End PJ Paralysis Awards

Further improvements identified

- The launch of phase 2 of the project targeting areas with potential to achieve further improvements, with a focus on preventing what is known as ‘deconditioning’ (a decline in patients’ physical abilities due to being bed bound)
- Focusing on spreading the initiative into community services, ensuring that patients are out of bed and dressed if possible
- The launch of the ‘Dining Champions’ scheme enabling volunteers to spend mealtimes with inpatients.

Case study by Lynette Cook (PAT) to follow the project page.

Potential image here

National Maternal and Neonatal Health Safety Collaborative

Pennine Acute was successful in its application to join the first phase of this national safety collaborative.

The Maternal and Neonatal Health Safety Collaborative is a three-year programme which launched in February 2017. The collaborative is led by the Patient Safety team at NHS Improvement and covers all maternity and neonatal services across England.

The aim is to:

- Support maternal and neonatal care services to provide a safe, reliable and quality healthcare experience to all women, babies and families across maternity care settings in England.
- Create the conditions for continuous improvement, a safety culture and a national maternal and neonatal learning system.
- Contribute to the national ambition of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020.

What: Reduce rates of maternal and neonatal deaths

How much: 20%

By when: 2020

Outcome: Benchmarking and foundation work undertaken. Visible reduction anticipated in 2018/19

Progress: On track

Improvements achieved

- Agreed Memorandum of Understanding with Greater Manchester and East Cheshire Strategic Clinical network for a midwife from North Manchester and a midwife from Oldham to work with the Specialist Midwife in Public Health Surveillance and support the implementation of the Saving Babies Lives Care Bundle. This funding was until the end of March 2019.
- Quarterly data reports are available to monitor progress of the four elements of the care bundle: smoking, detection of small for gestational age babies (SGA), fetal movements and fetal monitoring.

- Carbon Monoxide monitoring at booking is over 90%.

- Information from the perinatal institute places Pennine in the top 10 trusts in the UK for detection of small gestational age babies.
- We have reached the target of 95% for the generation of birth centile charts and for the last three months have achieved over this target.
- We are achieving over 85% of 'fresh eyes' review every hour of cardiotocograph traces for women in labour.
- We are actively involved in the development of a regional fetal monitoring assessment tool.
- The identification of small babies alongside the implementation of the Saving Babies Lives Care Bundle has seen a 44 % reduction in our still birth rates since 2013.

Other current work streams

- ***Improve the identification and management of sepsis in babies.***
  Across the NCA we are working with the neonatal teams to have set times for neonatal antibiotics on the postnatal ward and have implemented the red hats for babies who are assessed as high risk at birth. Along with the implementation of the neonatal observation charts which support early detection of concerns ensuring appropriate escalation.

- ***Improve the optimisation and stabilisation of the very pre term infant***.
  Across the NCA we are working as part of the The PReCePT initiative. This is an evidence based project designed to help reduce cerebral palsy in babies with the administration of magnesium sulphate to mothers in preterm labour. The aim is to achieve 85% administration of magnesium sulphate in all maternity units in England with a stretch target of 95% by 2020 (at the outset the data demonstrated an uptake of 43.9% for eligible babies). We are currently collecting data across the NCA and have identified champions to lead the work.

Further improvements identified

- Increase Carbon Monoxide monitoring at 36 weeks of pregnancy
- Reduce smoking in pregnancy – this would be improved with consistency in access to support services across the NCA
- Improving the detection and management of diabetes
- A sustained reduction in the separation of mums and babies following birth in line with the ATAIN programme (a national programme working at **A**voiding **T**erm **A**dmissions **I**nto **N**eonatal units). In conjunction with this working with

our neonatal teams to implement transitional care to further reduce unnecessary separation of mother and baby.

Paediatric and Neonatal service page to be added when received

2.

Our plans for the future Potential image here

Priorities for Improvement

Progress made since 2017/18 Quality Accounts

[To be updated with more information in next draft]

On 01 March 2018, the Care Quality Commission (CQC) awarded Pennine Acute Hospitals NHS Trust a rating of Requires Improvement against the Safe domain. This rating is an improvement on 2016's inspection result of Inadequate and reflects the dedication of our staff to improve the safety of patients by adapting their working practices and embracing quality improvement initiatives.

For 18/19 we continued this trend of working with our staff to continuously improve care for our patients. Below is a table of the aims we set a year ago and our progress towards achieving these aims.

2018/19 Priority	Measured by	Outcomes	2018/19	2017/18
Pursue quality improvement to assure safe, reliable and compassionate care	HSMR	As expected	96	98.3
	SHMI	As expected	97	1.01
	Cardiac arrest rate (per 1000 admissions)	The cardiac arrest rate for the all the North East Sector Care Organisations has been reduced by 24.58% as of December 2018*		
	Patient safety thermometer	94.22% of patients reporting harm-free care as of February 2019	94.22%	98.60%
	Pressure ulcers	To be added	To be added	
	Infection Control	To be added	To be added	
	Inpatient flow and stranded patients workstream metrics	Measures of improvement dependent on specific areas of improvement chosen- please see [number of project page(s)] for more detail		
Deliver Operational Excellence		Performance against national targets and locally selected indictors (please see sections 2 and 3)		

Support our staff to deliver high performance and continuous improvement	Staff survey scores	Please see section 2 for performance against core indicators
	Associated improvements outlined in previous project pages as an indication of staff engagement in Quality Improvement principles and projects	

*compared with baseline data for the North East Sector – please see the Deteriorating Patient Collaborative project page for more information.

The project pages found in Part 1 (pages [# to #]) provide more detail regarding the improvement programmes undertaken over 2018/19 to achieve the above priorities and the appropriate measure of progress.

Further information regarding PAHT's progress against locally-selected and national metrics can be found in Part 3 (page #).

Pursue quality improvement to assure safe, reliable and compassionate care

OBJECTIVE: We will demonstrate continuous improvement towards our goal of being the safest health and social care organizations in England.

Improve care and services through integration, collaboration and growth

OBJECTIVE: We will improve patient and care pathways to deliver improved prevention, earlier diagnoses, earlier treatment and earlier discharge across the system (including care at home or in a supportive environment)

Deliver Operational Excellence

OBJECTIVE: We will ensure good operational planning and execution to:

- Deliver on our urgent care, cancer and elective plans and trajectories
- Deploy relevant standard operating models

Support our staff to deliver high performance and continuous improvement

OBJECTIVE: We will support staff to have rewarding, productive and fulfilling careers, enabling us to recruit and retain talented people.

Ideas for improvement are also generated by staff across the COs through their participation in Quality Improvement initiatives. These ideas are taken forward as tests of change in specific project workstreams, to support the delivery of our improvement priorities in 2019/20.

The progress of these priorities and the associated improvement initiatives will be monitored and reported on through the CO's assurance committees over the 2019/20 reporting period.

Statement of assurance from the board

Review of services
*To be added when reviewed

Participation in clinical audit ('TBC' elements to be added)

National clinical audit

During 2018/19, 52 national clinical audits and three national confidential enquiries covered NHS services that the Pennine Acute Hospitals NHS Trust provides.

During that period, the trust participated in 50 (96%) of the national clinical audits, and ?? (??%) of the national confidential enquiries, of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the PAHT was eligible to and did participate in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The table below shows:

- The national clinical audits and national confidential enquiries that Pennine Acute Hospitals NHS Trust was eligible to participate in during 2018/19.
- The national clinical audits and the national confidential enquiries that Pennine Acute Hospitals NHS Trust participating 2018/19.
- The national clinical audits and the national confidential enquiries that Pennine Acute Hospitals NHS Trust participated in. and for which data collection was completed during 2018/19, are listed below alongside the number of cases to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Project Name	Provider Organisation	Eligible	Participated	% Submitted
National Neonatal Audit Programme (NNAP)	Royal College of Paediatrics and Child Health	Yes	Yes	100
Maternal, New-born and Infant Clinical Outcome Review Programme	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Yes	Yes	100
National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetricians and	Yes	Yes	100

	Gynaecologists			
National Audit of Seizures and Epilepsies in Children and Young People	Royal College of Paediatrics and Child Health	Yes	Yes	100
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	Yes	Yes	100
ICNARC (Case Mix Programme)	Intensive Care National Audit and Research Centre	Yes	Yes	100
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	Yes	Yes	100
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership	Yes	Yes	TBC
National Diabetes Audit – Adults*	NHS Digital	Yes	Yes	100
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	Yes	Yes	100
Inflammatory Bowel Disease programme / IBD Registry	Inflammatory Bowel Disease Registry	Yes	No	N/A
National Asthma and COPD Audit Programme*	TBC	YES	YES	100
Adult Community Acquired Pneumonia	British Thoracic Society	Yes	Yes	100
Non-Invasive Ventilation - Adults	British Thoracic Society	Yes	Yes	TBC
Elective Surgery (National PROMs Programme)	NHS Digital	Yes	Yes	TBC
National Ophthalmology Audit	Royal College of Ophthalmologists	No	No	N/A
National Bowel Cancer Audit (NBOCA)	NHS Digital	Yes	Yes	110
National Lung Cancer Audit (NLCA)	Royal College of Physicians	Yes	Yes	100
National Oesophago-gastric Cancer (NAOGC)	NHS Digital	Yes	Yes	90
National Prostate Cancer Audit	Royal College of Surgeons of England	Yes	Yes	100
National Audit of Breast Cancer in Older People	Royal College of Surgeons	Yes	Yes	100
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	British Society for Rheumatology	Yes	No	100
National Audit of Dementia	Royal College of Psychiatrists	Yes	Yes	100
Myocardial Ischaemia National Audit Project (MINAP)	National Institute for Cardiovascular	Yes	Yes	100

	Outcomes Research			
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research	Yes	Yes	100
National Audit of Percutaneous Coronary Interventions (PCI)	National Institute for Cardiovascular Outcomes Research	Yes	Yes	100
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre		Yes	100
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research	Yes	Yes	100
National Vascular Registry	Royal College of Surgeons of England	Yes	Yes	100
National Comparative Audit of Blood Transfusion programme*	NHS Blood and Transplant	Yes	Yes	100
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Serious Hazards of Transfusion	Yes	Yes	100
Falls and Fragility Fractures Audit Programme (FFFAP)*	Royal College of Physicians of London	Yes	Yes	TBC
Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians	Yes	Yes	100
National Audit of Intermediate Care	NHS Benchmarking Network	Yes	Yes	100
Major Trauma Audit	The Trauma Audit and Research Network	Yes	Yes	100
Feverish Children (care in emergency departments)	Royal College of Emergency Medicine	Yes	Yes	100
Vital Signs in Adults (care in emergency departments)	Royal College of Emergency Medicine	Yes	Yes	100
VTE risk in lower limb immobilisation (care in emergency departments)	Royal College of Emergency Medicine	Yes	Yes	100
Seven Day Hospital Services	NHS England	Yes	Yes	100
Surgical Site Infection Surveillance Service	Public Health England	Yes	Yes	100
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Public Health England	Yes	Yes	100
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*	Public Health England	Yes	Yes	TBC
National Mortality Case Record Review Programme	Royal College of Physicians	Yes	Yes	75
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol's Norah Fry Centre for Disability Studies	Yes	Yes	100

National Audit Care at End of Life (NACEL)	NHS Benchmarking Network	Yes	Yes	100
BAUS Urology Audit - Cystectomy	British Association of Urological Surgeons	Yes	Yes	100
BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	British Association of Urological Surgeons	Yes	Yes	100
BAUS Urology Audit - Nephrectomy	British Association of Urological Surgeons	Yes	Yes	100
BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)	British Association of Urological Surgeons	Yes	Yes	100
BAUS Urology Audit – Radical Prostatectomy	British Association of Urological Surgeons	Yes	Yes	100

Note: For Information on non-participation please see the Pennine Acute Hospital NHS Trust's Clinical Audit 2018/2019 Annual Report.

NCEPOD confidential enquiries

Title	Eligible	Participated	% of cases submitted	% questionnaire submitted
Pulmonary Embolism Study	Yes	Yes	100%	31%
Acute Bowel Obstruction	Yes	Yes	100%	TBC
Long Term Ventilation	Yes	TBC	TBC	TBC

The reports of 30 national clinical audits (including two NCEPOD reports) were reviewed by the provider in 2018/19 and Pennine Acute Hospitals NHS Trust has taken or intends to take the following actions to improve the quality of healthcare provided.

Title	Outcome
National Dementia Audit	The Trust participated in the 2018 National Dementia Audit achieving case ascertainment at each Organisation. The report will be published in 2019. Throughout the national data collection, evidence for local learning was simultaneously collated. The findings were delivered to the relevant divisional nursing leads thus eliminating the delay in addressing issues whilst awaiting publication of the national report. These will be discussed at relevant divisional meetings and will form a preliminary base for action planning.
National Audit of Inpatient Falls	The audit report was published in early 2018, each Organisation achieved case ascertainment. The report was discussed within the directorate and an action plan

	created. This included such items as: • Process mapping lying and standing blood pressures • Education • Test of change All actions have been successfully completed. In 2019 the audit moved to continuous data collection with close links to the National Hip Fracture Audit. The Organisational questionnaire was completed in January 2019 and data collection commenced in February 2019.
National Heart Failure Audit	The Trust continued to participate in the national audit throughout 2018 working closely with clinical teams to ensure efficient data collection and submission. In 2018 the national reporting methodology switched to a combined National Cardiac Audit Programme (NCAP). This brought together six major cardiac audits for patients treated in the UK for heart disease. Heart Failure is within the six. The latest report was published in November 2018 and presents aggregate data from 2016/2017; 16 key national recommendations were made. The report was shared widely within the directorate however due to the methodology change; local level data was not contained within the national report. Local data has been collated and shared with the directorate to assist action planning in 2019. The 2019 NCAP report is awaiting publication containing data for the 2017/2018 period.
Sentinel Stroke National Audit Programme (SSNAP)	The Organisations continued to participate in SSNAP throughout 2018 with quarterly data submissions. The fourth annual report was published in 2018 and details results from 2016/2017. Positive results were identified; the directorate are responsible, in collaboration with community staff, to complete an action plan around areas of concern during 2019.
National Hip Fracture Database	The latest report, published November 2018 (2017 data) identifies good practice across both participating hospital sites. Areas of good practice evidenced around assessment criteria, especially physiotherapy assessment and post op bed mobilisation. This can be coupled with findings of the outcomes data, where very low numbers of patients

	developing a pressure ulcer are reported. The findings have been shared with the division and trauma and orthopaedic directorate. Action plans are requested for areas of failing / concerning performance, these actions will be monitored in monthly directorate meetings throughout 2019.
National Joint Registry	The Trust continues to submit data to the audit during 2018 and 2019 with combined current completeness rates at: • 2018- 100% and 96% 2019 to date. • 571 hip procedures and 671 knee procedures were performed on 2018. • At the Royal Oldham hospital consent rates dipped in August and February 2018. A 2018 annual report is awaited however the clinical audit department are in the process of compiling reports based on local available data.
National Bowel Cancer Audit	The 2018 report details patients accessing services between April 2016 and March 2017; it reviews the quality of bowel cancer services by monitoring against set measures. Case ascertainment exceeded 100%, improvements are observed in the proportion of patients having major surgery with no ASA recorded. Length of hospital stay has also reported improvements along with adjusted 18 month stoma rates. The report will be presented at the directorates Audit and Governance meeting on 26th February 2019 following which a comprehensive action plan will be created. Additional work has been undertaken by the lead clinician around the 90 day and 2 year mortality and length of stay data. This exercise involves a review of the last two years data, the findings will be presented in the same forum.
National Oesophageal Cancer Audit	The 2018 report was published in September 2018. Case ascertainment reached above 90% and some positive improvements were noted. The Trust does not treat non palliative patients therefore only holds responsibility for the referral and diagnostic proportion of this national audit with responsibility shared between Salford Royal and The Christie. The report and key findings were shared with the

	directorate; the lead clinician will be working directly with the clinical audit manager to produce an action plan.
National Prostate Cancer Audit	The latest annual report was published in February 2019; it contained very positive findings with the Trust reporting above national and regional benchmarks. Some slight reductions in the recording of TNM & Gleason score were noted. The report has been shared with the directorate and findings will be discussed at their audit and governance meeting in March 2019. An action plan may be pulled together however the results are very positive and consistently above national levels.
National Lung Cancer Audit	The Trust submitted a total of 625 lung cancer cases to the audit. 96.5% of cases had a complete pre-treatment staging and 91% had a performance status documented, both figures are higher than national findings however both are a decrease in comparison to the previous years published results. One year survival rate is observed as 38.2%, compared to 38% nationally. The report was widely discussed within directorate and divisional meetings. An action plan was compiled by the audit lead and deadlines assigned to all items; these included the review of the medical oncology pathway and an audit of NOS cases.
National Breast Cancer in Old People	The 2018 national report details data on patients diagnosed between 2014 and 2016 and contains data for 739 Trust patients. The national reports contain aggregate data however local data is currently being reviewed and an action plan collated by the directorate with assistance from the clinical audit department.
National 4th Emergency Laparotomy Audit	The national report along with the key findings have been presented to the respective Care Organisations requesting review and provision of action plans on the areas identified for improvement. North Manchester achieved 91.3% case ascertainment, Oldham 100% both figures higher in comparison to to other hospitals. The report was presented at the directorate Audit and Governance meeting on 20 November 2018. Areas requiring improvement will be highlighted on a regular

	basis through newly implemented monthly dashboard reporting.
National Paediatric Diabetes Audit	Full participation in 2018 with data collection ongoing and the report expected in June 2019. The 2018 (2017 data) report has been presented at internal divisional meetings and an action plan was created in June 2018. The action plans look to deliver against the Trust being an outlier for HbA1c in comparison to national averages. The action plan is closely monitored within the division and is to be reviewed in March 2019.
National Neonatal Audit Programme (NNAP)	The Trust continues to participate annually in this audit programme. The 2018 report (2017 data) was published in October 2018 and shared widely throughout the division. Both North Manchester and Oldham hospitals have created comprehensive action plans to be monitored throughout 2019. The action plans are individual and look to address different areas reflecting the variance in practice across sites. A schedule of small audits combined with QI projects is planned.
National Diabetes Audit	The Trust continued to participate during 2018 with a methodology switch implemented to continuous data collection. The 2017 reports were presented at Clinical Effectiveness meetings during 2018. This informed on required actions for: • A reduction in the number of prescription errors • Improvements to foot inspections and MDT meetings • Overall patient satisfaction. An update on all actions is scheduled for June 2019.
7 Day Services	The Trust met submission in April 2018 achieving above recommended case ascertainment. 79% compliance to clinical standard 2 (CS2) Time to first Consultant review, (target within 14 hours) with all data validated by Consultant leads. Week day compliance to CS2 reached 85% with weekend dipping to 71%.

	The model for reporting switched to a Board Assurance Framework (BAF) in 2019 and the Trust will participate in the Pilot of this reporting method in February 2019.
National Audit Care at End of Life (NACEL)	The Trust participated fully in this audit in 2018. Data was submitted by all Care Organisations with clinical leadership from Bereavement Nurses. The results are yet to be published but key themes / lessons identified locally were collated alongside the national data collection allowing for action plans to commence in the interim before national publication.
National Mortality Case Record Review Programme	During 2018 the Trust has worked to standardise the mortality review process across each Care Organisation. Collaboration between management, QI and clinicians has seen an increase in reviews to 80%. Work is underway to build upon this and ensure the 100% target by 2020. Stage 1 reviews are currently being developed within directorates across each Organisation and the Trust continues to increase the number of staff qualified as Structured Judgement Reviewers (SJR).
National Vascular Registry	The Trust continues to submit and report on data from the National Vascular Registry. The latest report was published in 2018 and covers data from 2015-2017. **Carotid Endarterectomy:** Pennine Acute Hospitals Trust is one the highest performing Carotid Endarterectomy (CEA) Vascular Centre in the Northwest of England. • During 2017 the median delay, for a carotid endarterectomy from symptom to surgery, was 8 days, compared to 12 days across the UK. • Our in-hospital survival rate for CEA's, during 2017 was 99.2%. The national in-hospital survival rate was 98.0%. **Elective Infra-renal AAA repairs:** During 2015 - 2017 the vascular team performed a total of 176 abdominal aortic aneurysm (AAA) repairs. In-hospital survival rate for elective AAA repairs (Open and EVAR) is 99.0%. The national in-hospital survival rate was 98%. Our process of care for elective AAA patients shows: • 100.0% of patient had a formal anaesthetic review • 98.0% of patient had their fitness measured • 100% of patients were discussed at the weekly vascular MDT.

	Lower Limb Amputations NCA in-hospital survival rate for major lower limb amputations, over a three-year time period 2015–2017, was 95.6% compared to the national in-hospital survival rate of 94.5%. The results show that the Organisations are delivering safe surgical care with the results and practice being discussed at weekly MDT and directorate meetings.
National COPD Audit Programme	Participation continued throughout 2018 with all sites barring Rochdale Infirmary eligible. Data is available for the first two quarters of the 2018/19 period and reports: • BPT at <25% • Case ascertainment 99% The latter quarters will be populated in due course. Compliance reports are distributed throughout divisions and directorates ensuring early identification of performance / trends and allowing for adequate action planning. 2017 results were shared widely within the divisions resulting in the creation of a regularly meeting project group to monitor compliance and actions. The Trust results identified room for improvement in all areas ranging from provision of timely care, recording key clinical information, and smoking cessation.
ICNARC (Case Mix Programme)	The Trust continues to fully participate in the Case Mix Programme and has done so since its conception in 2011.The 2017/2018 annual report identified: • 100% data completeness • 319 high risk sepsis admissions • 1 unit acquired blood infection • Between 5-10% of admissions were out of hours • Between 0-4% direct admissions to home • Between 0-3% of non-clinical transfers to another unit and unplanned readmissions The results are widely shared throughout the Critical Care directorate who hold overall responsibility for this audit. The results are positive but should any actions be required these would be addressed and monitored through Clinical Effectiveness Committees.
National Intermediate Care Audit	There was full participation to both the Organisational and Service User audit during 2017/2018. The audit identified reductions in all three branches of categorising the effectiveness of intermediate care.

	Service user experience was generally positive with 99% of people feeling they were treated with dignity and respect. Waiting times post referral have increased in both home and re-ablement services. 71-81% of patients are successfully discharged to home. The Chief Executive received the latest report and has tasked the Trusts intermediate care leads to report on progress of the development and implementation of an action plan.
RCEM – Fractured Neck of Femur	The results of the audit were published in June 2018 and have been presented at the three Emergency Departmental Audit meetings. Localised action plans have been developed to include: • Education all triage staff importance of pain score • New fracture neck of femur pathway has in cooperated assessment on arrival pain score assessment • Posters developed highlighting the targets / standards. Snapshot reviews to be undertaken during 2019/20 to monitor compliance of the action plan.
RCEM – Procedural Sedation in adults	The results of the audit were published in June 2018 and have been presented at the three Emergency Departmental Audit meetings. Localised action plans have been developed to include: • New assessment form is being used to assess and document pre procedure assessment. • Further education has been delivered to staff • Poster encouraging use of pro forma to be put up in doctors' office Snapshot reviews to be undertaken during 2019/20 to monitor compliance of the action plan.
RCEM – Pain in Children	The results of the audit were published in June 2018 and have been presented at the three Emergency Departmental Audit meetings. Localised action plans have been developed to include: • Educate all triage staff that pre-hospital analgesia should be documented as part of triage text. • Quality Improvement Project identified and is underway. • Poster displayed to assist with initial scoring and instructing triage staff to complete and hand out pain

	assessment sheets. Snapshot reviews to be undertaken during 2019/20 to monitor compliance of the action plan.
BTS - National Adult Bronchiectasis Audit	Both the organisation and audit finding reports have been distributed to the care organisation respiratory teams. Actions plan templates have been distributed to the respiratory leads and the paediatric leads across the care organisations. They have been generated to include the national improvement plan.
UK TARN	The Trust continues to participate in this annual national audit. The latest available data covers the first two quarters of 18/19 and reports on evidence based measures and system indicators. These reports are provided for each Care Organisation. The reported quality of the data for the quarter one and quarter two are: • North Manchester 94.7% • Bury 92.4% • Rochdale 89.8% • Oldham 96.9% Actions are devised between the Lead Clinician and the Trusts UK TARN user Coordinator who monitor progress closely. Presently the team are concentrating on reducing times to CT and the grade of Doctor reviewing the applicable patients.
NCEPOD - Acute Heart Failure (Failure to Function)	The national report was received by the Trust in November 2018. The Cardiology teams across the Trust are in the process of reviewing the study results and are linking relevant areas identified for improvement from this study to the findings of the National Heart Failure audit.
NCEPOD - Peri-operatives Diabetes Patient Management (Highs & Lows)	The national report was received by the Trust in November 2018. The clinical teams across the Trust are in the process of reviewing the study results and will then develop action plans linked to their services to address any areas requiring improvement

Local Clinical Audit

The reports of 79 local clinical audits were reviewed by the provider in 2018/19.

The table below includes examples of local audits reported in 2018/19. Further actions planned and undertaken in response to the audit findings will be detailed in Trusts 2018/19 Clinical Audit Annual Report.

Bury & Rochdale Care Organisation	
Audit	**Actions taken / planned**
GP Summary Letters after Attendance in the Emergency Department	The aim of the audit was to assess the quality of discharge letters completed by Doctors from the Emergency department at Bury Hospital. Variance in results was identified with positive findings around the documentation of diagnosis, treatment, medication and additional comments to the GP. Improvements required in the documentation of status (ward admitted to) and imaging. As a result of this audit the following recommendation was created: Staff should be made aware of the importance of accurate coding and using added explanatory text to clarify diagnoses, management, and follow up that may be appropriate. This should be discussed at induction training. Compliance to this is monitored departmentally with a re-audit required to assess improvements.
Audit of Expectations of Patients in a Secondary Care Pain Clinic	An audit conducted with the aim of exploring the reasons why new patients attend pain clinic and to ascertain their expectations with regards to further management of their pain. A patient survey was completed and the findings suggested that patients are keen that their pain problem is recognised as a health problem affecting their life. A high proportion of patients are seeking medication changes or procedural interventions rather than psychological therapies and support and a significant number would like their pain to be further investigated. There is also an interest in

	exploring alternative therapies. This suggests either that patients are referred before they have reached the endpoint in their medical/surgical investigations or interventions. The findings were disseminated throughout all pain and anaesthesia colleagues and were presented at the audit and governance meeting in January 2019. Actions were compiled and will be monitored throughout 2019.
HMR Pressure Area Management Documentation re-audit	A re-audit undertaken in June 2018 with the aim to assess if standards of documentation and care in relation to Pressure Area Management delivered by the HMR Integrated Neighbour-hood teams had improved. 100% compliance was only achieved in two key areas, staging and incident reporting, however the results show vast improvements in documentation of pressure area management. The majority of teams are now achieving 100% compliance in many of the areas audited. Where improvement isn't evidenced the results have remained static with no deterioration in the standard of documentation. The results were presented within the division and the following actions will be monitored. Ongoing provision of wound management training, pressure area management and documentation training alongside an annual audit.
North Manchester Care Organisation	
Audit	**Actions taken / planned**
An assessment on appropriateness of listings and DNA for flexible cystoscopy	The main aim of the audit was to identify patterns in non-attendance rates (DNA) and cancellations in flexible cystoscopy clinics across the trust and to monitor appropriate indications for booking the procedure. The results of the audit highlighted that

	there is obvious variation in bookings across all three PAT sites where flexible cystoscopy is performed. There also appears to be a pattern of at least one DNA and one cancellation per list. The most common cause for last minute cancellation was found to be UTI identified on the day by urine dipstick. All procedures were requested for correct indications. The results of the audit have been discussed within a Urology audit and governance meeting in October 2018 from which a robust action plan has been developed. The division has been asked to monitor the implementation of the actions identified and a re-audit is planned for 2019.
Compliance with general surgery hot clinic standards and criteria	The aim of the audit was to perform a prospective baseline audit to assess on average how many patients are seen in the General Surgery Hot Clinic and what proportion of Hot Clinic patients meet the criteria for ambulatory care. The second objective was to implement a specific criteria-based guideline and monitoring programme to improve compliance with the ambulatory care criteria. The results of the baseline audit showed that the compliance with Hot Clinic criteria was very poor; however, the implementation of a specific criteria-based guideline for Hot Clinic significantly decreased the number of patients attending and improved the compliance with ambulatory care criteria. The findings from this audit were presented within a divisional governance meeting and a robust action plan was developed and successfully implemented including a specific criteria-based guideline for identifying eligible patients for ambulatory care.
Re-audit of needle stick injuries	A re-audit undertaken to determine if doctors are adhering to Trust protocols on dealing with needle stick injuries in order to ensure patients are provided with correct assessments and drugs and that follow ups are arranged for patients

	discharged from the department. Compliance was positive and the following actions have been taken. Creation of a single flowchart to include both staff and members of the public. Flow chart to be displayed in all ED's and all clinicians to ensure that all needle stick patients are appropriately discharged and follow ups arranged.
Intravenous Fluid Therapy	The aim of the audit was to assess the knowledge of junior doctors working in AMU and covering on call in IV fluid management, and their level of adherence to the NICE guidance. The results of the audit highlighted: A good level of knowledge of the type, rate and volume of fluid used, although reduced knowledge when to seek senior help and the role of human albumin solution in severe sepsis. Following the audit, teaching is being delivered to junior doctors in AMU during weekly teaching and planned to deliver teaching to foundation year doctors in December. To introduce information on IV fluid therapy into the junior doctor induction pack. - Weekly training for junior doctors in AMU - Teaching for foundation year doctors - Introduce IV fluid information into junior doctor induction pack.
Patient discharges from Koala Admission Unit	The Paediatric Admission Unit or Koala Unit at North Manchester General Hospital has six beds and one back room for short stays unwell patients. Due to the high rates of referrals and admissions from either General Practice or Accident & Emergency department, delays to triage and assessment to patients occur during peak hours. An audit undertaken to identify the common medications that are dispensed to allow pharmacy to be aware of the high demand on certain medications, i.e. inhalers during winter seasons. Thus,

	this will ensure steps can be taken to ensure adequate medications are available and easily dispensed during peak hours. Secondly, potential causes can be identified, and measures implemented to assist delay reduction. The findings highlighted delays in completion of discharge summaries by the clinical team. Delays in medication request received by the pharmacist, inadequate staffing (pharmacist, technician, and dispenser) and multiple medication requests at one time for multiple patients. A comprehensive action plan was compiled c by the directorate including the creation of a referral flow pathway and education of doctors on discharge summaries. These actions will be monitored throughout 2019.
Shoulder Dystocia Re-audit	Shoulder dystocia has significant association with maternal and neonatal morbidity. The aim of the audit was to review current compliance of shoulder dystocia management against standards of documentation, communications and both maternal and neonatal care. The results of the audit highlighted: • 0.9% incidence rate of shoulder dystocia • 71% of women were **not** debriefed following delivery, this is an area for concern • The fetal anterior shoulder was only documented in 66% of cases • The Shoulder Dystocia Proforma was completed in only 69% of cases. The actions are currently under creation by the division.
Oldham Care Organisation	
Audit	**Actions taken / planned**
Re-Audit Loss of Productivity due to IT delays	This audit / QI looked at the loss of productivity due to IM&T delays. It was

	conducted on a surgical ward at the Oldham Care Organisation over two separate time periods. The findings were very interesting resulting in evidence of potential delays of up to 7.5 hours in a week period. The re-audit was presented at the Trauma and Orthopaedic audit and governance meeting on 24th January 2019 where the findings and actions were widely appreciated. The clinician leading has devised solutions to overcome these time delays and has created an information tool for staff to follow. This will be shared at all Junior Doctor inductions / staff rotations across the Trust.
Skin closure technique in stoma reversal: Are we doing the best practice	An audit conducted with the aim to identify a multi-centre retrospective baseline to assess the most common skin closure technique used during stoma closure at the Trust. Stoma closure is associated with a high risk of Surgical Site Infection which can cause increased morbidity and poor quality of life. The audit identified that the Trust is not compliant to the recommended closure technique and practice varied between centres. This was raised within the surgical directorates and an action plan was successfully created. This included discussions between colorectal surgeons to consider PSC as the skin closure of choice. These discussions have been held in December and a re-audit planned for 2019.
Lymphoma Audit: concordance of departmental diagnosis and referral diagnosis	All suspected lymphoma cases at Oldham Care Organisation are sent to HMDS for an expert opinion with minimal tests completed locally, in accordance with local protocol. An audit conducted to evidence if some histopathology expertise has been lost with the advent of HDMS.

	The audit identified that 73% concordance locally with HMDS diagnosis and 100% compliance to the adequacy of core biopsy. There was clear evidence of an impressive reduction in inadequacy rates both locally and at HMDS. The findings were discussed at the Trust Lymphoma MDT meeting in July 2018. Positive findings resulted in a singular action of a combined senior decision as to the level of detail required locally prior to expedition to HMDS.
Follow up of hepatitis C positive serology	National recommendation is that all patients with a positive or indeterminate hepatitis C serology should have a confirmatory serology test and an RNA PCR test within 12 months of the first positive serological rest. As a consequence of this recommendation the audit aimed to establish how many patients across the Trust have a serological and molecular test for the hepatitis C virus within 12 months of a positive hepatitis C virus serology. The audit identified none compliance with just 17% receiving both tests. There was variance seen in compliance to the tests individually. The results of the audit were presented on 11th July 2018 departmentally, it was recommended that the trusts Microbiology Laboratory fall In line with the new UK SM and move towards reflex NAAT testing of first positive HCV serology samples. Currently the audit findings are under review with the management team. The audit findings and minutes of the meeting have been shared with clinicians, GPs and other clinics dealing with high risk patients for HCV in order to highlight the need for improvement of patient follow.
Re-audit Paediatric Escalation and Care	The MANCHEWS (Manchester

Quality (MANCHEWS)	Children's Early Warning System) is a track and trigger traffic light system used to record and score the patient observations using age specific parameters for six physiological recordings. A second round re-audit to ensure the action plan put in place previously has been successfully implement and improvements have been made. The results of the audit highlighted that the actions from the previous re-audit have not shown a high level of improved compliance, with the exception of patient's observations being documented in 25.82%more cases. Actions have been created and are monitored within directorate meetings. These include the medical team reminded at each morning handover to ensure Consultants see every new patient on their ward round. Medical staff reminded of the importance to use labels for patients scoring amber and red and the importance of documenting observation in the patient's notes.
Re audit of the use of Vancomycin on the Neonatal Unit	The original audit showed babies less than 29 weeks gestation were not achieving therapeutic levels with the existing Vancomycin schedule, as per the recommendation the schedule was changed. The aim of this re-audit was to assess whether the amended schedule was appropriate in achieving therapeutic concentrations. Findings were positive with significantly more patients achieving therapeutic range sooner and 100% of patients were treated as per the guideline. The findings were discussed within the division and further amendments were made to the schedule to assist continued improvements.

Participation in clinical research

The Trust is committed to research and transformation as a driver for improving the quality of care we provide to our patients. It enables our staff and the wider NHS, regionally and nationally, to improve the current and future health outcomes of the people we serve. Only by carrying out research into "what works" can we continually improve treatment for patients, and understand how to focus NHS resources where they will be most effective.
We currently support 497 research studies, of which 159 are clinical trials involving medicinal products. Our engagement with clinical research demonstrates the Trust's commitment to testing and offering the latest medical treatments and techniques. During 2018-19, we recruited patients to 111 National Institute for Health Research Clinical Research Network (NIHR CRN) clinical research studies. The number of patients receiving NHS services
provided or sub-contracted by the Trust in 2018-19 that were recruited during that period to participate in research approved by a research ethics committee was 31,500. This year, more patients from across our Trust have participated in high quality NIHR research studies than in any other previous year. Furthermore, the Trust was the top recruiting NHS organisation to NIHR CRN studies in England, which is a fantastic achievement and demonstrates our commitment to high quality research.

The Trust's reputation for attracting, initiating and delivering high quality industry trials has continued to grow this year, with the Trust currently supporting 118 industry sponsored trials. Our extensive collaborations with industry provide our patients with the very latest access to state of the art treatments and interventions.

Goals agreed with commissioners: use of the CQUIN payment framework

A proportion of Pennine Acute NHS Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Pennine Acute NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

For 2018/19 the baseline value of the CQUIN for Acute clinical contracts was 2.5% of the contract value, the national CQUIN schemes attracted 1.25% of the available 2.5%. The remaining 1.25% is linked to local Sustainability & Transformation plans. For NHS England specialised services the CQUIN value equates to 2.8% of the contract value – this is because NHS England are using the CQUIN framework to incentivise those Trusts that lead one or more operational delivery networks. Pass through costs such as high cost drugs and devices do not attract CQUIN payments. The value of the schemes for the acute clinical contracts is £5m with a further £5m associated with STF. The value of NHS England CQUIN schemes is £1.27m. There is a further £80k related to community services contracts.

For year to date performance 2018/19 (Q1 to Q3 inclusive) Commissioners for the NHS England contract have indicated that the majority of milestones have been met satisfactorily. Final performance for Q4 has yet to be appraised; for the indicators not currently performing, there is an opportunity to rectify by year end. For the community contract CQUIN schemes Q1 – 3 performance has been judged as achieving the required milestones. For the acute activity contracts commissioners have indicated that some milestones have not been satisfactorily met for some discrete areas of specific schemes. It has been agreed that where milestones have not been met but there is an opportunity to address in the final quarter that these milestones will be judged in Q4. Q4 data will be shared with commissioners at the end of April 2019; and a final response is usually to be expected for the end of the following month.

Appendix A provides a breakdown of CQUIN goals for 2018/19.

Statements from Care Quality Commission

The Pennine Acute Hospitals NHS Trust is required to register with the Care Quality Commission (CQC) and is fully registered for the services it provides. Its current registration status is 'registered without conditions'. The Pennine Acute Hospitals NHS Trust has the following conditions on registration- 'none'.

The CQC has not taken enforcement action against The Pennine Acute Hospitals NHS Trust during 2018/19.

The Pennine Acute Hospitals NHS Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2018/19:

1. **Reviewing of Safeguarding in the Emergency Department at Fairfield Hospital as part of the CQC health economy wide '*Children looked after and safeguarding reviews*'**

The CQC visited the Emergency Department at Fairfield General Hospital on the 7th September 2018 and undertook a review of safeguarding systems and processes as part of their health economy wide '*Children looked after and safeguarding reviews*'.

The identified issues have required a health-economy approach to address; the ones with a specific impact at the Bury & Rochdale Care Organisation are as follows

I. **Capacity of the Safeguarding team** across the Pennine Acute Trust footprint; a business case was developed for an additional two nurse posts, one for children's and one for adults. These posts have been advertised.
II. **Effective communication** to ensure community health practitioners are promptly informed about children and young people presenting at ED; the Health visitor is now informed when a child between the ages of 0-5 years

attends ED and the school nurse notified of all attendees of age 6-16 years. There are now procedures in place to follow up any concerns.

III. **System wide quality of information and communications technology** (ICT) to enable well-co-ordinated, streamlined and efficient transfer of information about children and young people who move between health and care services; Children safeguarding referrals are now submitted online as opposed to faxing; the pathway for routine information sharing between the ED and community services, such as health visiting and school nursing is being reviewed. A proforma has been developed for all clinicians to receive feedback on actions identified at safeguarding reviews and a secure email system is being set up to facilitate the transfer of information electronically.

IV. **'Think Family' approach** has been strengthened to ensure regular and effective communication between midwives, health visitors, adult health practitioners and GPs by joint awareness raising of the need to escalate concerns. 'Think Family' has been discussed with all ED staff at FGH as part of the training to recognise safeguarding issues, including those patient attendances where there may be high risk mental health or domestic violence situations and the patient attends without their children who may be at home and may have witnessed inappropriate situations. The effectiveness of both the training and the 'Think Family' approach is monitored by the CCG led Safeguarding Governance and Assurance Group.

V. **Raised Awareness of Professional Curiosity** of frontline clinicians was a key aspect for FGH. Specifically, this related to clinicians checking, following up and recording actions to safeguard children and young people. This has been strengthened by implementation of the Child Protection Information System (CP-IS) , an electronic database that enables staff to review whether a child or young person is already known to social services. Additionally, a daily retrospective audit is in place which reviews all admissions against a standardised safeguarding checklist to ensure all appropriate referrals have been made.

VI. **Appropriate levels of paediatric doctor and nurse expertise** within the ED at FGH has been reviewed and additional recruitment has been successful and further is planned.

CQC Inspection October/November 2017

Between 17th October and 16th November 2017 the Care Quality Commission inspected services at North Manchester General Hospital, The Royal Oldham Hospital and Fairfield General Hospital.

Oldham Care Organisation

At Oldham Hospital the CQC inspected: urgent and emergency services, medical care, surgery, critical care and service for children and young people. End of life care

and outpatient and diagnostic imaging were not assessed and outcomes relate to the most recent inspection in 2016.

Ratings for Royal Oldham Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Requires improvement →← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Medical care (including older people's care)	Requires improvement →← Feb 2018	Requires improvement →← Feb 2018	Good →← Feb 2018	Requires improvement →← Feb 2018	Requires improvement ↓ Feb 2018	Requires improvement →← Feb 2018
Surgery	Requires improvement →← Feb 2018	Requires improvement →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Good →← Feb 2018	Requires improvement →← Feb 2018
Critical care	Requires improvement ↑ Feb 2018	Requires improvement →← Feb 2018	Good →← Feb 2018	Requires improvement →← Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ↑ Feb 2018
Maternity	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Services for children and young people	Requires improvement ↑ Feb 2018	Requires improvement →← Feb 2018	Good ↑ Feb 2018	Requires improvement →← Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ↑ Feb 2018
End of life care	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Requires improvement Aug 2016
Outpatient and Diagnostic Imaging	Requires improvement Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall*	Requires improvement ↑ Feb 2018	Requires improvement →← Feb 2018	Good →← Feb 2018	Requires improvement →← Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ↑ Feb 2018

Following the inspection a full action plan was developed and continues to be monitored via the Oldham Care Organisation Assurance Committees. Action plans have been developed at divisional and directorate level and these are reviewed regularly to ensure appropriate progress is being made.

Key successes of the Improvement Plan

- Strengthening of response to workforce challenges with on-going recruitment events and improved recruitment proecsses, development of additional roles such as the trainee nurse associate, and improved nursing retention rates at Oldham Hospital.
- Improvement in paediatric pathways within the Emergency Department.
- A working group focusing upon the WHO (World Health Organisation) checklist within theatres, led by theatre staff to improve compliance and processes related to the checklist
- Development of risk processes around incident management, risk registers and complaints

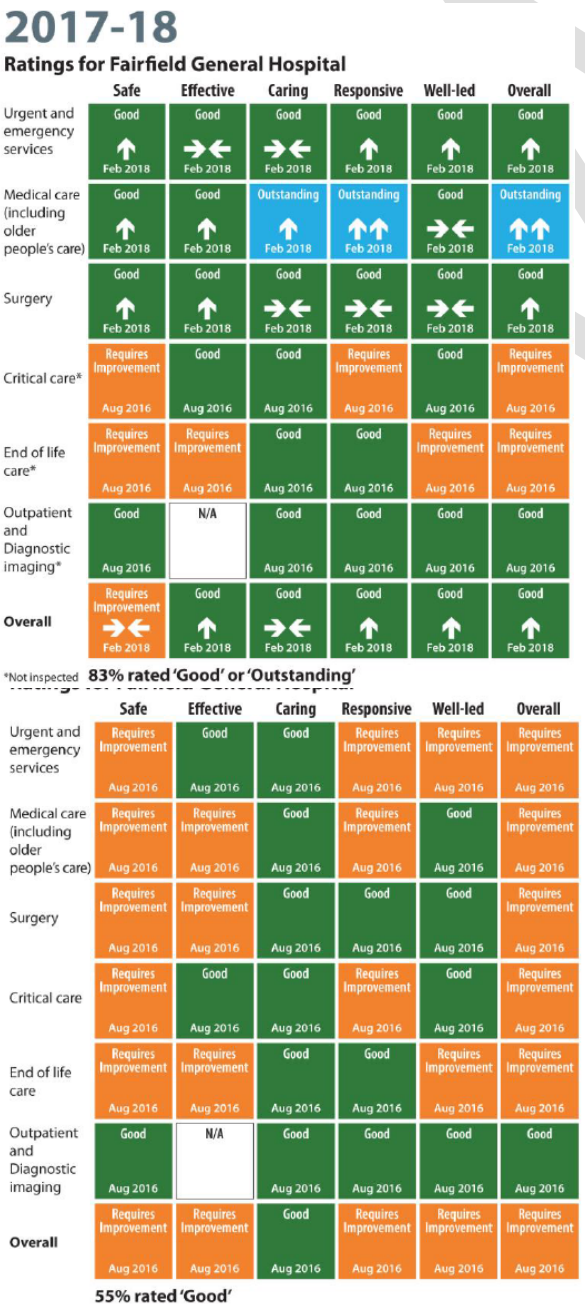
- Engagement of staff in quality improvement projects across the organisation including deteriorating patients, pressure ulcer reduction and ending PJ paralysis

Key challenges within the Improvement Plan

- Risks associated with IM&T including old unsupported IM&T systems
- Continued focus required on recruitment particularly of nursing and medical staff and the impact this has upon reductions in usage of bank and agency
- Management of capacity and demand and the operational pressures within services across the organisation; including urgent and emergecny care and services for patients with cancer

Bury and Rochdale Care Organisation

At Fairfield General Hospital the CQC inspected urgent and emergency care, medical services and surgery. The CQC did no inspect Rochdale Infirmary or Community Services which were rated as good overall at the last inspection.



A full action plan was developed and is monitored at Assurance Committee and divisional level via a dashboard & visual checking by all senior staff

Key successes of the Improvement Plan

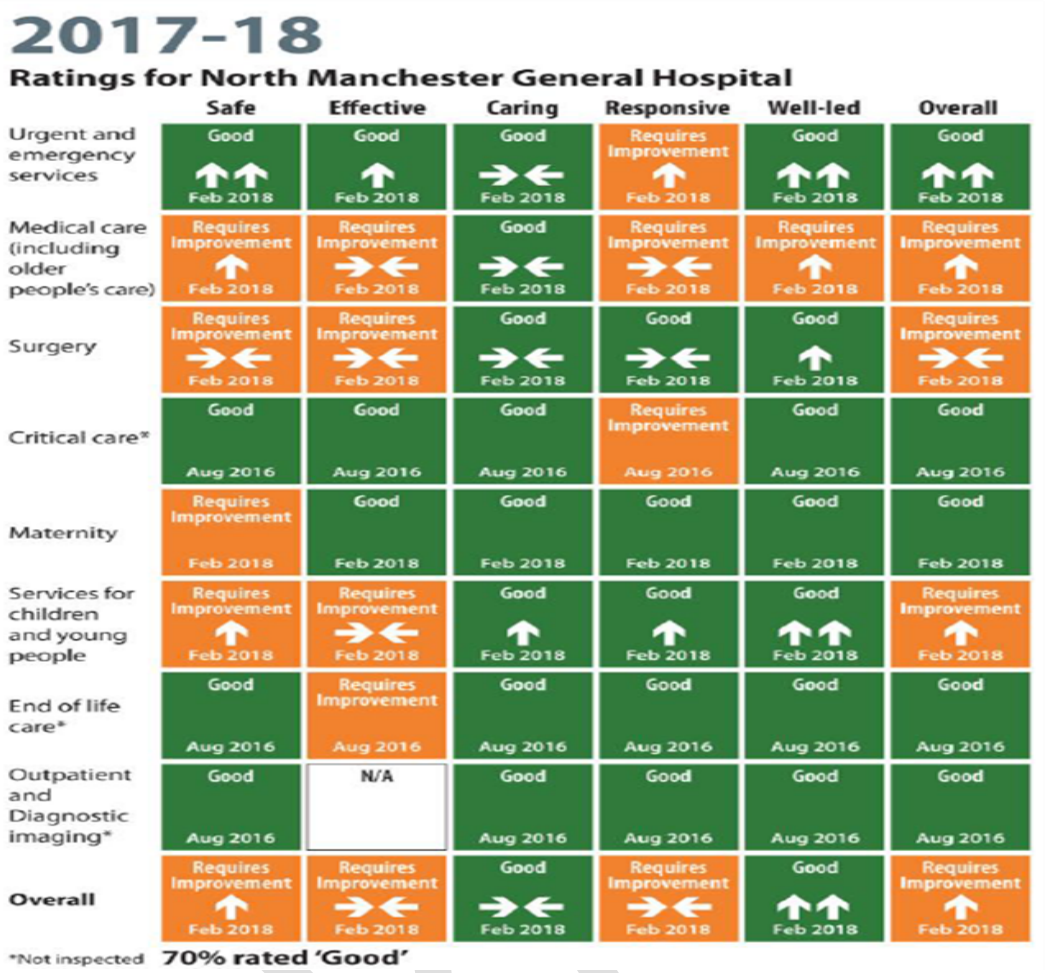
- Quality Improvement project on deteriorating patients
- Safeguarding Improvement Board – evidence based improvements focussed A&E
- Implementation of revised paediatric assessment documentation in ED
- Bespoke system of local nurse assurance audits
- Statistically significant reduction in avoidable falls
- Robust risk management system underpinned by Datix (risk management and incident reporting) database
- Storage and documentation of medicines
- Improvements to Registered Nurse staffing levels overall
- Viewing room for recently deceased patients at FGH
- Enhanced privacy in ED triage at FGH

Key challenges within the Improvement Plan

- Safeguarding; continuing to evidence sustained reliability in response to September 2018 visit
- Medical staffing; continuing to respond to challenges and ensuring reliable, consistent cover
- Reducing reliance on temporary medical workforce
- Ensuring reliable application and understanding of the Mental Capacity Act and Deprivation of Liberty legislation

North Manchester Care Organisation

At North Manchester General Hospital the CQC inspected urgent and emergency care, medical services, maternity and children and young people because these services were rated as inadequate at the last inspection. The CQC also inspected surgical services which were rated as requires improvement.



Following the inspection a full action plan was developed and continues to be monitored via the North Manchester Organisation Assurance Committees. Action plans have been developed at divisional and directorate level and these are reviewed regularly to ensure appropriate progress is being made.

Key successes of the Improvement Plan

- A strengthened response to workforce challenges with innovative approaches to recrutiment including; overseas recruitment events and joint appointments in hard to recruit specialties.
- A reduction in agency spend
- Achievement of trajectories for key areas of Harm
    - Infection Control Trajectories
    - Pressure Ulcers
    - Falls
- Successful implementation of E-Obs
- Embedded Governance Structures
- Improvements in Governance Processes

- Successful implementation of NAAS with 60% of wards either Green or SCAPE status
- A working group focusing upon the WHO (World Health Organisation) checklist within theatres, led by theatre staff to improve compliance and processes related to the checklist
- Engagement of staff in quality improvement projects across the organisation including deteriorating patients, pressure ulcer reduction and ending PJ paralysis
- Mortality Reduction continuing to reduce

Key challenges within the Improvement Plan

- Risks associated with IM&T including old unsupported IM&T systems
- Continued focus on embedding support functions and training to consolidate application of the Mental Capacity Act
- Continued focus required on recruitment particularly of nursing and medical staff and the impact this has upon reductions in usage of bank and agency
- Management of capacity and demand and the operational pressures within services across the organisation; including urgent and emergecny care and services for patients with cancer

NHS number of GMP code validity

- PLACEHOLDER – SECTION TO BE ADDED

Information Governance and Information Security Assurance

The Information Governance Toolkit is no longer used nationally and has been replaced by the Data Security Protection Toolkit (DSPT). DSPT is an online self-assessment, which allows the Trust and partners to assess themselves against the National Data Guardian review's 10 data security standards and key requirements of the General Data Protection Regulation (GDPR). Pennine Acute NHS Hospitals Trust has additionally achieved the Cyber Essentials PLUS. Attainment of the new standards remain fundamental to accessing the NHS N3 secure network and to promote safe data sharing both key in supporting delivery of effective clinical care.

Clinical Coding Error Rate

The Pennine Acute Hospitals NHS Trust was not subjected to the 'Payment by Results Clinical Coding Audit' during 2018/19.

During the course of 2018/19 a number of internal audits took place as part of our overall Clinical Coding Assurance programme, the below accuracy rates were

submitted as evidence for the DSP Toolkit Standard 1 requirement. The Trust achieved the mandatory standard based on the below audit results.

The audit programme includes random samples of activity from the three care organisations, mortality indicators and data quality metrics.

The results should not be extrapolated further than the actual sample audited.

Primary Diagnosis	94.22%
Secondary Diagnosis	96.66%
Primary Procedure	95.51%
Secondary Procedure	96.42%

Data quality: relevance of data quality and action to improve data quality

- SECTION TO BE ADDED

Learning from deaths

In March 2017, the National Quality Board introduced new guidance for NHS providers on how they should learn from the deaths of people in their care. The Learning from Deaths framework is designed to help NHS providers identify where improvements in the quality of the care they provide to patients and their families can be made.

The Northern Care Alliance values prompt learning from experience from all aspects of patient care. As a Trust we are committed to learn from both positive and negative aspects of patient's care, with a clear process for completing mortality reviews to help identify where changes should be made to improve patient experience and safety for the future. The learning from Deaths framework has been implemented to learn and continually improve the quality of care provided to all patients.

A care quality mortality review is carried out by named clinicians on patients who have died to determine whether there were any problems in the care provided. This is undertaken routinely to reflect, learn and improve in the absence of any particular concerns about care. By 03/2020 the Trust aims to have completed care quality mortality reviews on 100% of all in patient deaths.

Following a care mortality review a more in depth review may be undertaken called a structured judgement review (SJR). An independent clinician will conduct the SJR using a review methodology that has been validated by the Royal College of Physicians. It is based upon a clinician using explicit statements and care scoring to comment on the quality of healthcare in five specific phases of a patient's journey. This is undertaken routinely for patients with learning disabilities, severe mental illness and unexpected deaths to ensure opportunities for learning and improving the care provided to these particular patients is not missed. It is also done where concerns exist, such as when bereaved families or staff raising concerns about care.

Following the publication of the guidance for learning from deaths The National Health Service (Quality Accounts) (Amendment) Regulations 2017 was introduced to require NHS providers to share the following data below:

During 2018/19 (between 1st April 2018 and 31st March 2019) 2385 of The Pennine Acute Hospitals NHS Trust patients sadly died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- **669** in the first quarter;
- **612** in the second quarter;
- **763** in the third quarter; and
- **341** in the fourth quarter (*January only).

By 28th February 2019, 722 deaths have received a mortality care quality review and 49 investigations have been carried out in relation to 2385 of the deaths included above.

The following reporting is based on number of deaths from April – December 2018 as deaths in the fourth quarter are still subject to the mortality review process. These will be reported on separately in the Quality Accounts for 2019/20.

By 28th February 2019, 97 SJR methodology have been undertaken, and 41 investigations have been carried out in relation to 2044 of the deaths included above. In 13 cases a death was subjected to both a case record review using SJR methodology and an investigation.

The number of deaths in each quarter for which a mortality care quality review, case record review using SJR methodology or an investigation was carried out was:

Mortality Care Quality Review	Structured Judgement Review	Investigation	Total
252 in the first quarter	**42**	**3**	**259**
246 in the second quarter	**21**	**18**	**249**
159 in the third quarter	**33**	**20**	**162**

An estimate of the number of deaths during the reporting period included above for which a case record review or investigation has been carried out which the Trust judges as a result of the review or investigation, were more likely to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the method used to assess this:

1 case record review using SJR methodology, representing 0.04% of the patient deaths during the reporting period, was judged to be having been more likely due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- **0** representing **0%** for the first quarter;
- **1** representing **0.1%** for the second quarter; and
- **0** representing **0%** for the third quarter;

These numbers have been estimated using the Hogan et al scoring system, as follows

- Reviews scoring 1 (definitely not preventable), 2 (Slight Evidence of Preventability) and 3 (Possibly preventable) are allocated **<50% preventability i.e. not preventable**

- Reviews scoring 4 (Probably Preventable) 5 (Strong Evidence of Preventability) and 6 (Definitely Preventable) are allocated **>50% preventability i.e. preventable**

A summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the death identified above:

The predominant themes from learning have been: improvement around delays in escalation of deteriorating patient and quality improvement work around poor documentation and improved clerking and handover information.

A description of the actions which the Trust has taken in the reporting period, and proposes to take following the reporting period, in consequence of what has been learnt in relation the death identified above:

The Trust has introduced a deteriorating patient collaborative and a North East Sector Sepsis collaborative to drive improvement.

In the following reporting period SMART learning (specific, measurable, achievable, realistic, timed) will be introduced to support follow up quality improvement action where learning has been identified.

The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in the relevant documentation:

3 case record reviews and 2 investigations completed after 1st April 2018 related to deaths which took place before the start of the reporting period.

An estimate of the number of deaths included above which the Trust judges as a result of the review or investigation were more likely to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this:

0 representing 0% of the patient deaths before the reporting period are judged to be having been more likely due to problems in the care provided to the patient.

Seven Day Hospital Services

Pennine Acute NHS Trust has committed to implementing the NHS Improvement standards for seven day hospital services. The sections below describe the progress that has been made against the four priority standards:

Standard 2- Time to first consultant review

- The April 2018 audit showed that the trust overall compliance with standard 2 was 91% at North Manchester, 78% at Oldham and 66% at Bury
- All sites have increased the presence of acute / general medical consultants on site to a minimum of 12 hours per day at weekends and 14 hours per day presence of Emergency Medicine consultants.
- The Trust has expanded the paediatric consultant base to improve evening cover. Areas where the standard is difficult to achieve are the smaller surgical specialties such as Ear, Nose and Throat, Head and Neck, and Urology).
- A consultant for general surgery is on-site at the weekend to review admissions and operate 8am – 8pm.
- There is 7 day consultant presence for obstetrics and gynaecology, including overnight shifts (but not on all nights). The Trust is working to recruiting more consultants.
- **Potential image here**

Standard 5- Access to diagnostic tests

- Radiology services are provided 24/7 for all core procedures for urgent and emergency patients. Seven day services are offered for scans (computerised tomography, magnetic resonance imaging and ultrasound) and plain x-ray examinations for routine inpatients wherever possible. The hours for ultrasound (9am – 12pm) and magnetic resonance imaging (8am – 8pm) are limited due to availability of radiographers & funding.
- Echocardiography for critically ill patients can be accessed via the on call cardiology consultant if needed.

Standard 6- Access to consultant-directed interventions

- Consultant delivered interventional radiology service is available 24 hours per day (one of the few in the region).
- Consultants review emergencies (and sick inpatients) daily including each weekend day in urology, obstetrics gynaecology and orthopaedics.
- We have a 24/7 gastrointestinal bleed service from our gastroenterologists

Standard 8- On-going review by consultant twice daily of high dependency patients, daily for others

- We have completely revised the working practices in medicine at the weekend. There are three consultant physicians (including acute physicians and general physicians) working each weekend. This facilitates consultant review of medical patients referred to medicine in accident and emergency, continuous post take ward rounds 8am-8pm and consultant review of the most unwell ward patients.
- On-call physicians visit all post-acute medical wards at weekends
- Increased establishment of acute physicians has enabled seven-day working on the acute medical unit (AMU) with acute physicians and/or general physician present and working in AMU from 8am to 8pm, seven days per week. This has also led to a daily consultant ward reviews of new AMU medical admissions seven days a week, until 8pm.

Business cases are being developed for further expansion of acute and general medical consultant numbers to further develop improved consultant presence.

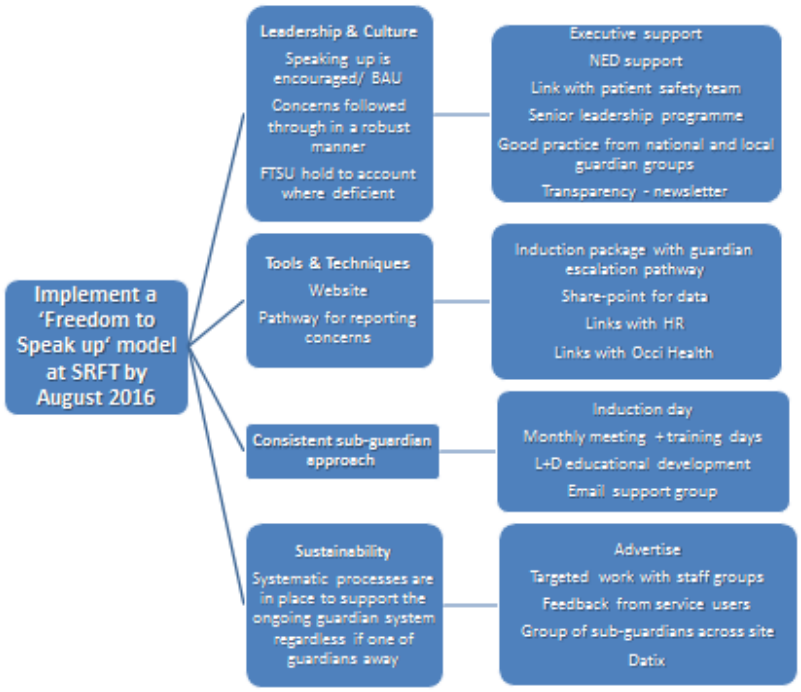
Raising concerns at Pennine Acute Trust 2019

The Whistleblowing / Concerns Reporting Policy is a comprehensive document which outlines and provides guidance to staff about how to speak up. This policy provides support, reassurance and signposting for staff who may wish to report a concern.

In the first instance staff are encouraged to raise concerns via their line manager / HR or using the DATIX system. However, it is recognised that staff may feel it is challenging to report a concern and the Freedom to Speak Up Team (FTSU) have been established to provide confidential support to staff, particularly with regards to concerns which are related to patient safety. Staff are also informed about Safecall which is another independent means for staff to raise concerns.

The FTSU Team consists of a lead Guardian and a team of sub-guardians independent of existing divisions and representing various staff groups and disciplines. The FTSU model was launched at Salford Care Organisation in August 2016, and the programme has been gradually rolled out to Pennine Acute Trust, with Royal Oldham Hospital first having a FTSU in place in September 2018, and Bury and Rochdale in November 2018. Interviews for the NMGH CO FTSU lead will take place on 29th March 2019

Driver diagram representing implementation of FTSU at SRFT



The FTSU Team is responsible for supporting a culture where staff can feel confident to raise concerns. The service does this through increasing awareness of how to raise concerns, supporting individuals who wish to speak up and making sure that individuals who raise concerns receive feedback and outcomes related to their issues. The service works proactively to tackle barriers to speaking up.

The FTSU team do not get directly involved in investigations, but remain independent and impartial to this process. The FTSU Guardian ensures regular contact is maintained with the individual who has raised the concern. This enables the FTSU team to hold the investigating team to account. Feedback is specifically requested on whether individuals suffer any detriment as a consequence of speaking up and the FTSU team provide support to the individual concerned and escalate to the executive governance and safety lead if any detriment occurs.

Updates and outcomes from any investigations are sought from the investigating team and are shared with the individual wherever possible in terms of how the issue was investigated and the conclusion of any investigation. If all outcomes cannot be disclosed (e.g. if it infringes the right to confidentiality of others) the guardian will explain this to the individual.

FTSU also ask for feedback from individuals who have approached the service. Anonymised example below:

1). Given your experience would you speak up again?	Yes
2). Please explain your response to given your experience would you speak up again.	I raised my concerns and they were dealt with and escalated in a promptly and adequate manner
3). Were you satisfied with the service from the Freedom to Speak up team.	Yes
4). Please explain your response to were you satisfied with the service from the Freedom to Speak up team	It was taken seriously and escalated appropriately
5). Would you use the Freedom to Speak up Team again? (Please tick the box for Yes)	Yes

Other comment: ‘’***I cannot praise higher your help with this matter. Thank you for raising this for me. Now it seems that common sense has prevailed. Now we will start conversations to streamline the service and measure its effectiveness, which was the right thing to do from the beginning.***

Thank you again for your help.’’

The FTSU guardian is responsible for ensuring all concerns are appropriately and correctly logged, including confidentiality preferences and details of themes are reported.

The FTSU send out quarterly newsletters providing updates on the service and a synopsis of cases seen (when permission has been secured, with anonymised data) to ensure transparency of the FTSU service. The first Northern Care Alliance newsletter was sent out in October 2018 to coincide with FTSU month.

The Northern Care Alliance FTSU lead has support from a non- executive director.

FTSU at Salford Care Organisation also report to the National Guardian’s office on a quarterly basis.

Since the team has been established at Pennine Acute Trust, 2 concerns have been raised to ROH, and 2 at Bury and Rochdale.

Reporting against core indicators

TO BE UPDATED WITH NEW DATA BEFORE PUBLICATION. We are expecting rows with yellow highlighted text to be updated when data is available. Some others may also change but difficult to confirm at this stage.

Since 2012/13 NHS foundation trust have been required to report performance against a core set of indicators using data made available to the trust by NHS Digital.

The core indicators are listed in the table below;

Domain	Indicator	2018/ 2019	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2017/ 2018	2016/ 2017	2015/ 2016
Preventing people from dying prematurely Enhancing quality of life for people with long-term conditions	SHMI value and banding (most recent: January 2018 to December 2018)	97.0	100	N/A	N/A	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reason: mortality reduction has been a focus for the Trust since publication of the Quality Improvement Strategy in 2017. The actions which the Trust has taken to achieve this score is detailed on the Mortality project page and throughout this Quality Account.	101	107	111

Domain	Indicator	2018/ 2019	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2017/ 2018	2016/ 2017	2015/ 2016
	% patients deaths with palliative care coded at either diagnosis or speciality level (most recent: October 2017 to September 2018)	1.2% (data taken from SHMI data – provided by NHS Digital)	1.8%	N/A	N/A	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust now has an established palliative care team who provide in reach across the hospital. The Pennine Acute Hospitals NHS Trust continues to take the actions highlighted in this Quality Account to improve this percentage and so the quality of its services, by continuing to place the upmost importance on high quality palliative care for our patients.	21.3 %	20.0%	21.7 %

Domain	Indicator	2018/ 2019	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2017/ 2018	2016/ 2017	2015/ 2016
Helping people recover from episodes of ill health or following injury	Patient reported outcome scores for groin hernia surgery (1st April to 30th September 2017 – most recent data release published in June 2018)	N/A	N/A	N/A	N/A	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. Following a review of the data submitted in previous years it was identified for 2017/18 the adjusted health gain was 0.04 compared to improvement in general health of 39.8% by comparing pre- and post-operative 'EQ-5D Index' scores (a combination of five key criteria concerning patients' self-reported general health). National data collection ceased for this cohort of patients on 30th September 2017. Patients are encouraged to participate in the Friends and Family Test.	39.8 %	53.3%	59.4 %

Domain	Indicator	2018/ 2019	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2017/ 2018	2016/ 2017	2015/ 2016
	Patient reported outcome scores for varicose vein surgery 1st April to 30th September 2017 – most recent data release published in June 2018)	N/A	N/A	N/A	N/A	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. Following a review of the data submitted in previous years it was identified for 2017/18 the adjusted health gain was 0.9 compared to improvement in general health of 49.2% by comparing pre- and post-operative 'EQ-5D Index' scores (a combination of five key criteria concerning patients' self-reported general health). Nationally data collection ceased for this cohort of patients on 30th September 2017. Patients are encouraged to participate in the Friends and Family Test.	49.2 %	47.4%	50.0 %

Domain	Indicator	2018/ 2019	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2017/ 2018	2016/ 2017	2015/ 2016
	Patient reported outcome scores for hip replacement surgery (1st April to 30th September 2018 – most recent data release)	Less than 30 modelled responses	91.1% April 18 – September 2018 is provisional data provided by NHS Digital)	N/A	N/A	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. Following a review of the data submitted in previous years it has was identified for 2017/18 the adjusted health gain was 0.44 compared to improvement in general health of 90.5% by comparing pre- and post-operative 'EQ-5D Index' scores (a combination of five key criteria concerning patients' self-reported general health). The Trust pre-operative assessment clinics for hip replacement are based on the site where the surgery is to take place and this has seen an improvement in patient compliance and expectation following surgery. The Trust	90.5 %	87.1%	88.0 %

Domain	Indicator	2018/ 2019	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2017/ 2018	2016/ 2017	2015/ 2016
	Patient reported outcome scores for knee replacement surgery (1st April to 30th September 2018 – most recent data release)	Less than 30 modelled responses	82.9% April 18 – September 2018 is provisional data provided by NHS Digital)	N/A	N/A	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. Following a review of the data submitted in previous years it has was identified for 2017/18 the adjusted health gain was 0.32 compared to improvement in general health of 77.4% by comparing pre- and post-operative 'EQ-5D Index' scores (a combination of five key criteria concerning patients' self-reported general health). The Trust pre-operative assessment clinics for hip replacement are based on the site where the surgery is to take place and this has seen an improvement in patient compliance and expectation	77.4 %	79.6%	84.6 %

Domain	Indicator	2018/ 2019	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2017/ 2018	2016/ 2017	2015/ 2016
Helping people to recover from episodes of ill health or following injury	28 day readmission rate for patients aged 0 – 15					The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons: [*insert reasons*] The Trust [*intends to take / has taken*] the following actions to improve this [*indicator/percentage/score/data/rate/number*], and so the quality of services, by [*insert description of actions*]			

Domain	Indicator	2018/ 2019	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2017/ 2018	2016/ 2017	2015/ 2016
	28 day readmission rate for patients aged 16 or over					The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons: [*insert reasons*] The Trust [*intends to take / has taken*] the following actions to improve this [*indicator/percentage/score/data/rate/number*], and so the quality of services, by [*insert description of actions*]			

Domain	Indicator	2018/ 2019	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2017/ 2018	2016/ 2017	2015/ 2016
Ensuring that people have a positive experience of care	Responsiveness to inpatients' personal needs: CQC national inpatient survey score (care & treatment section score)	Not available	n/a	9.0	7.5	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons: Improving the experience of the people that access our services, carers and families is one of the key priorities for the northern care alliance which Pennine Hospitals are part of. Significant work is in progress to support the development of corporate led programmes of improvement work and locally focused responsive systems. A variety of feedback systems are used and in development to improve real-time and near real time feedback including NHS Choices, patient stories and Observe & Act. The NCA approach is focused on developing user led driven improvements working with key stakeholders	7.8 About the same	7.5	7.7

Domain	Indicator	2018/ 2019	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2017/ 2018	2016/ 2017	2015/ 2016
dsds dsdd	Percentage of staff who would recommend the provider to friends or family needing care 2018 Staff Survey	60.1 %	69.9%	90.3%	49.2%	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust has implemented a number of actions from April 2016 onwards, such as the Pioneers' programme, 1000 voices and open surgeries with directors. These were aimed at further improving staff engagement and we can see from the 2018 survey that these have had a positive impact on staff which in turn benefits patients and patient care. The Pennine Acute Hospitals NHS Trust continues to take further actions to improve these outcomes and so the quality of its services, by continuing to deliver against any actions following the 2018 results and throughout 2019.	56.4 %	51.8%	55.4 %

Domain	Indicator	2018/ 2019	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2017/ 2018	2016/ 2017	2015/ 2016
Treating and caring for people in a safe environment and protecting them from avoidable harm	% of admitted patients risk-assessed for Venous Thromboembolism (Q3 2018/19)	95.64 % (data published by NHS Improvement)	95.65%	100.00 %	54.86%	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons: the Trust has an ongoing VTE project covering the entire North East Sector Care Organisations. Part of this project concerns increasing the completion of VTE risk assessments through improving compliance processes. The actions the Trust is taking to improve this percentage is detailed on the VTE project page in this Quality Account.	95.61 %	96.30 %	96.72 &

Domain	Indicator	2018/ 2019	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2017/ 2018	2016/ 2017	2015/ 2016
	Rate of C.Difficile per 100,000 bed days ([*insert time period*], is the most recent data release, please see Trust reported data pages for more current data))					The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons: [*insert reasons*] The Trust [*intends to take / has taken*] the following actions to improve this [*indicator/percentage/score/data/rate/number*], and so the quality of services, by [*insert description of actions*]	14.7	58	56

Domain	Indicator	2018/ 2019	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2017/ 2018	2016/ 2017	2015/ 2016
Treating and caring for people in a safe environment and protecting them from avoidable harm	Rate of patient safety incidents per 1000 bed days Prior to 2014/15 rate was based on 100 admissions					The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons: [*insert reasons*] The Trust [*intends to take / has taken*] the following actions to improve this [*indicator/percentage/score/data/rate/number*], and so the quality of services, by [*insert description of actions*]			

Domain	Indicator	2018/ 2019	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2017/ 2018	2016/ 2017	2015/ 2016
	Rate of patient safety incidents that resulted in severe harm or death per 1000 bed Prior to 2014/15 rate was based on 100 admissions					The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons: [*insert reasons*] The Trust [*intends to take / has taken*] the following actions to improve this [*indicator/percentage/score/data/rate/number*], and so the quality of services, by [*insert description of actions*]			

Domain	Indicator	2018/ 2019	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2017/ 2018	2016/ 2017	2015/ 2016
Ensuring that people have a positive experience of care	Inpatient Friends and Family Test	90.9 % (Jan 19)	95%	100%	81%	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust continues to promote the FFT survey to patients on their discharge. The Trust utilises this data to ensure a culture of open and honest reporting and encourages as many patients to participate as possible. The Pennine Acute Hospitals NHS Trust continues to take actions to improve these outcomes and so the quality of its services, by prioritising patient experience and engagement.	90%	91%	93%

Domain	Indicator	2018/ 2019	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement	2017/ 2018	2016/ 2017	2015/ 2016
Ensuring that people have a positive experience of care	Accident and Emergency Friends and Family Test	83.7 % (Jan 19)	86%	100%	43%	The Pennine Acute Hospitals NHS Trust considers that this data is as described for the following reasons. The Trust continues to promote the FFT survey to all patients who have attended accident & emergency. Feedback demonstrates transparency of our organisation. The Pennine Acute Hospitals NHS Trust continues to take actions to improve these outcomes and so the quality of its services, by prioritising patient experience and engagement.	82%	81%	92%

3

Other Information

Performance against locally selected indicators

TO BE UPDATED WITH NEW DATA BEFORE PUBLICATION. We are expecting rows with yellow highlighted text to be updated when data is available. Some others may also change but difficult to confirm at this stage.

	Metric	Target	Performance 2018/19	Performance 2017/18	Comments
Patient safety outcomes	Hospital standardised mortality rate (calculated using annual benchmark)		96.0	98.3	
	Standard Hospital Mortality Indicator (SHMI)		97.0	1.01	
	Hip Replacement SSI				
	Knee Replacement SSI				
	Reduction of Long Bone SSI				
	Repair of Neck of Femur SSI				
	Safety thermometer acute - % of patients safe from new harm	95%		98.60%	
	Safety thermometer community - number of patients safe from new harm				
	Pressure Ulcers acute				
	MRSA		2	2	
	Cdiff - All cases (including unavoidable)		34	43	
	28 Day Readmission - overall (Ytd)		9.60%	7.90%	
	0-15			8.59%	
	16+			7.75%	
Clinical effectiveness	Advancing quality - Composite Qualtiy score for Alcohol Related Liver Disease	70.7%	58.2%	51.5%	Please note the data provided is from 1st Jan 18 to 30th Nov 18. The data collection period is 1st Jan 18 to 31st Dec 18.
	Advancing quality - Appropriate Qualtiy score for Alcohol Related Liver Disease	50.0%	15.4%	1.9%	
	Advancing quality - Composite Quality Care score for AKI	55.3%	62.2%	35.3%	
	Advancing quality - Appropriate Quality care score for AKI	50.0%	21.6%	5.4%	
	Advancing quality - Composite Quality Care score for Diabetes	66.0%	69.6%	53.4%	
	Advancing quality - Appropriate Quality care score for Diabetes	50.0%	29.2%	9.9%	
	Advancing quality - Composite Care score for Pneumonia	89.2%	86.9%	82.1%	

	Advancing quality - Appropriate Care Score for Pneumonia	66.0%	65.3%	50.8%	
	Advancing quality - Composite Care score for SepsisNEWS	75.0%	74.7%	82.9%	
	Advancing quality - Appropriate Care Score for SepsisNEWS	50.0%	49.5%	50.1%	
	Advancing quality - Composite Care score for Sepsis	82.7%	86.9%	82.9%	
	Advancing quality - Appropriate Care Score for Sepsis	54.8%	61.6%	50.1%	
	VTE Risk assessment	95.0%	95.9%	95.3%	Please note the date for 18/19 is from 1st Apr 18 to 31st Dec 18
Patient Experience	% of adult in-patients who felt they were treated with respect and dignity		Data embargoed until August 2019	77.0%	
	% of adult in-patients who had confidence in the trust doctors treating them	National Picker score average	Data embargoed until August 2019	78.0%	
	Count of patients who waited more than 52 weeks for treatment	Local target: 0	Data embargoed until August 2019		
	GP Out of Hours - Time from case active to definitive telephone clinical assessment. Urgent calls within 20 minutes		Data embargoed until August 2019		
	GP Out of Hours - Time from case active to definitive telephone clinical assessment. Non-gent calls within 60 minutes		Data embargoed until August 2019		

Performance against nationally selected indicators

	Metric	Target	2018/19	2017/18	Comments
Infection control	Number of Cdiff cases		34	43	
	Number of MRSA Acquisition		2	2	
	Number of MRSA Bacteremia		2	2	
Access to cancer services	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96%	97.47%	98.22%	
	% of cancer patients waiting a maximum of 31 days for subsequent treatment(anti cancer drugs)	98%	100.00%	98.50%	
	% of Cancer patients waiting a maximum of 31 days for subsequent	94%	88.16%	93.91%	

	treatment (surgery)				
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (radiotherapy)	-	-	-	
	% of cancer patients waiting a maximum of 62 days from urgent GP referral to treatment	85%	73.39%	82.02%	
	% of cancer patients waiting a maximum of 62 days from the consultant screening service referral to treatment	90%	81.48%	71.43%	
	% of cancer patients waiting a maximum of two weeks from urgent GP referral to date first seen	93%	73.13%	89.07%	
	% of symptomatic breast patients (cancer not initially suspected) waiting a maximum of two weeks from urgent GP referral to date first seen	93%	64.13%	96.17%	
Access to treatment	18 weeks RTT - patients on incomplete pathway (Non Breached)		33601	32447	
	18 weeks RTT - patients on incomplete pathway (Breached 18 weeks)		6072	5009	
	Maximum 6-week wait for diagnostic procedures		23 wks		Note: measurement displays the longest waiting time experienced by a patient during 2018/19.
	Total patients on incomplete Pathway		39673	37456	
	% Incomplete pathways <92%	92%	85%	86.6%	
Access to A&E	% of patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or discharge	95%	85.47%	83.56%	Prior to July 2015 A&E was reported weekly
Cancelled operations	% of patients whose operations were cancelled by the hospital for non clinical reasons on the day of or after admission to hospital	0%	1.56%	1.66%	
Cancelled operations not treated within 28 days	% of those patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not treated within 28 days	0%	15.58%	9.32%	

NHS England patient safety alerts information 2018/19

Patient safety alerts are issued by NHS England (NHSE) to warn the healthcare system of risks and provide guidance on preventing incidents that may lead to harm or death.

The table below details the alerts issued by NHSE during 2018/19 and the Trust's response to each alert.

Reference	Alert Title	Issue date	Response	Deadline
NHS/PSA/W/2018/001	Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders	09.01.18	The alert has been discussed at Pharmacy meetings and the Pennine Medication Safety Committee, liaised with colleagues at SRFT and a bulletin produced for issue to staff , A poster on safe use of cylinder produced by Head of Pharmacy and Medical devise Governance Manager. Estates also produced additional information regarding the use of the cylinders	20.02.18
NHS/PSA/W/2018/002	Risk Of Death Or Severe Harm From Inadvertent Intravenous Administration Of Solid Organ Perfusion Fluids	20.04.18	These products are not on our pharmacy system and the product is not ordered by pharmacy. The fluid is provided by the transplant teams and theatres have confirmed they do have any of this fluid in stock	31.5.18
NHS/PSA/RE/2018/003	Resources to support the safe adoption of the revised National Early Warning Score (NEWS2)	25.04.18	NEWS2 Champions identified. Documentation reviewed, new NEWS 2 Chart produced Adult Observation Policy now updated to include documentation required as described in Alert	21.06.18
NHS/PSA/RE/2018/004	Resources to support safer modification of food and drink	27.04.18	Associate Directors AHPS for Speech and Language Therapy (SALT) are leading on a actions identified in alert. Implementation plan adopted in SRFT being shared to introduce	01.04.19

			at Care Organisations.	
NHS/PSA/RE/2018/005	Resources to support safer bowel care for patients at risk of autonomic dysreflexia	25.07.18	Leads identified and specialist nurses involved in ensuring information disseminated and actions in the alert completed.	25.01.19
NHS/PSA/RE/2018/006	Resources to support safe and timely management of hyperkalaemia (high level of potassium in the blood)	08.08.18	Medical Directors provided leads to implement actions required in Alert. Progress to be monitored by care Organisations Clinical Effectiveness Committees	08.05.19
NHS/PSA/RE/2018/007	Management Of Life Threatening Bleeds From Arteriovenous Fistulae And Grafts	12.11.18	Liaised with Medical Directors, leads identified for this alert to implement actions required . Quality & Patient Experience/Clinical Effectiveness Committees to monitor progress and agree to sign off when actions are complete.	13.05.19
NHS/PSA/RE/2018/008	Safer temporary identification criteria for unknown or unidentified patients	05.12.18	Alert Distributed to all Care Org Medical Directors, Dir Nursing, EP Lead to identify lead for combined approach across all care organisations.	05.06.19
NHS/PSA/RE/2018/009	Risk of harm from inappropriate placement of pulse oximeter probes	05.12.18	Medical Devices Governance Manager completed initial scoping exercise to identify where we have ordered which type of probe across all Care Orgs. Further work with practice educators to carryout actions. To be monitored by Clinical effectiveness committee prior to	05.06.19

			sign off.	

Never Events Reported During 2018/19

Never events are serious incidents that have occurred despite the presence of national guidelines or safety recommendations that should have prevented them from happening. Never events provide important insights into safety processes and highlight potential areas for improvement across the Trust.

During 2018/19, two never events were reported by the Trust. The details of what happened and the actions we have taken to prevent them from happening again are provided in the table below.

Never event	Location Incident Occurred	Description	Key findings from root cause analysis	Actions to prevent recurrence
Unintentional connection of a patient requiring oxygen to an air flowmeter	North Manchester A&E	A patient who required oxygen was connected to an air flowmeter when the intention was to connect them to an oxygen flowmeter, this was a near miss incident that did not cause any harm to the patient.	Despite using black meters with black worded covering caps, the air tubing was attached.	All air flowmeters were removed from the Accident and Emergency Department (and all other clinical areas). This was following a discussion with the Consultant Clinical Lead who agreed that the need for piped air was not required in the department. Staff in ED will now be unable to connect any tubing to an air flowmeter as they are no longer available anywhere in the ED. Sufficient replacement nebuliser machines have been purchased.

				Incident now impossible to replicate.
Wrong site surgery	Rochdale Theatres	Wrong sided interscalene brachial plexus block administered.	Investigation ongoing	Action plan in development

Annex 1:

Statement from local commissioners, local Healthwatch organisations and overview and scrutiny committees

To be added:

- **CCG statement for The Pennine Acute Hospitals NHS Trust Quality Accounts 2017/18**
- **MHCC Response to Pennine Acute Hospital NHS Trust (PAHT) 2017/18 Services at North Manchester General Hospital and Community Services**
- **Response of North East Sector Healthwatch organisations (Healthwatch Bury, Healthwatch Rochdale and Healthwatch Oldham) to the Pennine Acute Hospitals NHS Trust Quality Account 2017/18**

Annex 2:

Statement of responsibilities for the quality report

To be added

Independent Practitioner's Limited Assurance Report to the Group Committees in Common of The Northern Care Alliance NHS Group on the Quality Report

Grant Thornton UK LLP
Chartered Accountants
4 Hardman Square
Spinningfields
Manchester
M3 3EB
Date: May 2018

To be added

Appendix A: Breakdown of CQUIN goals for 2018/19

Applicable To	Name	Indicative Value Year Two	Indicative Value Year Two
		Community	Acute
Acute and Community	NHS staff and wellbeing.		
	Part 1 – Staff Survey	£2,172	£337,870
	Part 2 – Healthy foods	£2,172	£337,870
	Part 3 – Flu vaccinations for staff	£2,172	£337,870
Acute	Reducing the impact of serious infections		
	Scheme 1 Part a – timely identification of sepsis – ED and Inpatient settings		£253,403
	Scheme 1 Part b – timely treatment of sepsis ED and Inpatient settings		£253,403
	Part c – Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.		£253,403
	Part d - Reduction in antibiotic consumption per 1,000 admissions		£253,403
Acute	Improving services for people with mental health needs who present in A&E		£627,919
Acute	Improving services for people with mental health needs who present in A&E - implementation of ECDS and quality of coding		£338,110
Acute	Offering advice and guidance		£1,013,611
Acute - 2018/19	Preventing ill health by risky behaviours		
	Part 1		£50,681
	Part 2		£202,722
	Part 3		£253,403
	Part 4		£253,403
	Part 5		£253,403
Community - 2017-19	Preventing ill health by risky behaviours		

Applicable To	Name	Indicative Value Year Two	Indicative Value Year Two
		Community	Acute
	Part 1	£326	
	Part 2	£1,303	
	Part 3	£1,629	
	Part 4	£1,629	
	Part 5	£1,629	
Community	Wound Care	£6,517	
Community	Personalised care and support planning	£6,517	
NHS England	Improving HCV treatment pathways through ODNs **(Y2)**		£672,499
NHS England	Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT) **(Y2)**		£59,071
NHS England	Activation System for Patients with Long Term Conditions **(Y2)**		£68,159
NHS England	Medicines Optimisation **(Y1)**		£245,371
NHS England	Neonatal Community Outreach **(Y1)**		£227,196
Oldham CCG Community - Diabetes	Practice support clinic.	£6,536	
Oldham CCG Community - Respiratory	Structured review and Education re: improving asthma care / scope and present options for setting up a transition clinic.	£9,886	
Oldham CCG Community - Ophthalmology	Demand management / review of pathways	£24,564	
HMR Community - anticoagulant therapy	No CQUIN proposed by commissioners / agreed in 18/19	£11,131	
HMR IECP Local (Acute)	Local indicator re developing Outcome Measures ((all other CQUINs assessed as part of Acute Schemes		£47,583
		£78,186	**£6,340,352**

Appendix B: Glossary of definitions

To be updated if any of the 'to be added' content contains abbreviations

Term	Explanation
Acute medical unit (AMU)	AMU is a short-stay department which acts as the first point of entry for patients who are either referred to hospitals as emergencies by their GP or who require admission from the emergency department.
Advancing Quality	Is a regional quality improvement programme facilitated by AQuA. Its stated aim is to improve standards of healthcare provided in NHS hospitals across the North West of England and to reduce variation in clinical practice. There are 2 scores provided in the quality accounts: Appropriate Care Score (ACS) shows the percentage of the AQ population receiving the whole bundle of AQ defined best practice measures Composite Process Score (CPS) shows the percentage of AQ measures met across the whole AQ population
ADNS	Assistant Director of Nursing Services. A job role in the hospital relating to nursing management.
ADT	Admission, discharge and transfer system.
AKI	Acute kidney injury, previously known as acute renal failure is damage to kidneys which prevents them from functioning properly.
Allied Health Professionals (AHPs)	AHPs provide treatment and help to rehabilitate patients and work across a wide range of different settings. They frequently work alongside doctors, nurses and other healthcare professionals. Examples of AHPs include Dietitians, Occupational Therapists and Physiotherapists.
ATAIN	Avoiding Term Admissions Into Neonatal Units
Bed days	A bed-day is a day during which a person if confined to a bed and in which the patient stay overnight in a hospital.
Breakthrough Series Collaborative (BTS)	A Quality Improvement methodology undertaken at Pennine Acute.
BSIA	British Security Industry Associated
Care bundle	A group of interventions which are proven to treat a particular condition.
Catheter	Catheters are medical devices that are inserted into the body to treat diseases or perform a surgical procedure. Catheters are used for many reasons for example, draining urine and in the process of haemodialysis.
Catheter associated urinary tract infection (CaUTI)	An infection which is believed to have been caused by a urinary catheter.
CCG	Clinical Commissioning Group responsible for most healthcare services available within a specific geographical area.
CDI	Clostridium difficile infection
Change package	A group of changes or interventions developed to help tackle a particular problem or make an improvement.
Clostridium difficilie (C Diff)	A type of infection.
Collaborative	Working together towards a shared purpose.
Control chart/SPC chart	Control charts, also known as Shewhart charts or process control charts (SPC charts), are graphs used to determine whether or not a process is stable. This is helpful in monitoring performance and monitoring improvement work. If there is an active improvement effort going on, these tools can also be used to determine if an improvement has been made.

COPD	Chronic obstructive pulmonary disease. The name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease.
CQC	Care Quality Commission- the independent regulator of all health and social care services in England.
CQUIN	Commissioning for quality and innovation. This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.
Deep vein thrombosis (DVT)	A blood clot occurring in the deep veins of the leg.
Dementia	Condition includes symptoms such as memory loss and confusion.
Department of Health	Ministerial department responsible for government policy for health care in England.
Driver diagram	A Quality Improvement tool which helps to visualise the aims, drivers and change ideas for a particular improvement project.
E-observations	Patient observations which have been recorded electronically within our e-observation system, Patientrack.
EOLC	End of life care
EWS	Early Warning Score
Executive Team	The most senior managers in the Trust consisting of the Group Chief Executive Officer, the Group Chief Nursing Officer, the Group Chief Medical Officer, the Group Chief Finance Officer, the Group Chief Strategy and Organisational Development Officer and the Group Chief Delivery Officer.
GDE	Global Digital Exemplar
General Medical Practice Code	Organisation code of the GP Practice that a patient is registered with.
GP	General Practitioner.
Harm	An unwanted outcome of care intended to treat a patient.
Hospital Episode Statistics	A data warehouse containing details of all admitted patient care, outpatient attendances and A&E attendances in England.
Hospital Standard Mortality Ratio (HSMR)	A system which compares expected mortality of patients to actual mortality based on a patients' risk of dying.
HSJ	Health Service Journal
Huddle/Safety huddle	A brief meeting which often occurs at the start or finish of shifts in care areas.
Human Factors	Study of human behaviour and the influence that this has on an environment.
IG toolkit	Information Governance Toolkit is a performance tool produced by the Department of Health.
Intervention	A treatment which is intended to improve a patient's condition.
Intermediate care units	Units which patients go to when they no longer require the acute care of the hospital but are not yet ready to go home.
JAG	Joint Advisory Group
Mersey Internal Audit Agency (MIAA)	Provide external audits and diagnostics for the Trust.
Maternity Early Warning Score (MEWS)	Early warning tool which aims to improve maternal morbidity through the recording of physiological observations to identify deterioration.
Morbidity	Morbidity comes from the word morbid, which means "of or relating to disease".
Mortality	Mortality relates to death. In health care mortality rates means death rate.
MRSA	Methicillin-resistant staphylococcus aureus (MRSA) is a type of infection.
MSSA	Methicillin-susceptible Staphylococcus aureus (MSSA) is a type of infection
Multi-disciplinary Team (MDT)	A team consisting of members of staff from different professional groups, for example doctors, nurses, physiotherapists and pharmacists.
NAAS	Nursing Accreditation and Assessment System

NCA	Northern Care Alliance
NCEPOD	The National Confidential Enquiry into Patient Outcome and Death reviews clinical practice following a patient death.
North East Sector Care Organisations	The Bury and Rochdale, North Manchester and Oldham Care Organisations (otherwise referred to as Pennine Acute) are together referred to as the North East Sector Care Organisation.
Never event	Never events are patient safety incidents that are preventable and should not occur because: - there is guidance that explains what the care or treatment should be; -there is guidance to explain how risks and harm can be prevented; - there has been adequate notice and support to put systems in place to prevent harm from happening.
NEWS/EWS	National Early Warning Score- the NEWS is a scoring system in which a score is allocated to six physiological measurements in order to detect and respond to clinical deterioration. The NEWS was developed by the Royal College of Physicians to provide system-wide standardisation in the measurement and documentation of physiological observations.
NHS England	Executive non-departmental public body, sponsored by the Department of Health.
NHS Improvement	Responsible for overseeing Foundation Trusts and NHS Trusts, as well as independent providers that provide NHS-funded care.
NHS Quest	NHS Quest is a network for Foundation Trusts who wish to focus relentlessly on improving quality and safety.
NICE	National Institute of Clinical Excellence- an independent organisation that provides national guidance and standards on the promotion of good health and the prevention and treatment of ill health.
Nursing Assessment and Accreditation System (NAAS)	The NAAS is designed to support nurses and the wider ward teams to understand how they deliver care and where further improvements are needed. The NAAS measures specific aspects of safety, cleanliness, nursing care and multi-disciplinary working. Wards are then allocated a rating of red, amber or green.
Oesophago-gastric cancer	Refers to cancer of the oesophagus (gullet).
PDSA	The 'Plan, Do, Study, Act' cycle is a Quality Improvement methodology which provides a framework for developing, testing and implementing changes leading to improvement. Using PDSA cycles enables teams to test out changes on a small scale, building on the learning from these test cycles before wide scale implementation.
PReCePT	Preventing celebral palsy in preterm labour
Process mapping	Process mapping is a tool through which a system/process is visually mapped out in order to identify opportunities for improvement to improve patient experience of make efficiencies.
Prophylaxis	Preventative medicine or care.
Quality Improvement	Quality Improvement is a systematic approach which uses specific techniques and methodologies to improve quality.
Quality Improvement strategy	A document which outlines the aims and objectives of the Trust relating to patient safety and improving quality.
Rapid assessment and treatment model (RAT)	Is a model used within emergency departments to provide early senior assessment of patients in order to improve patient safety and flow within the department.
Red flag sepsis	Is a definition from the national Sepsis Trust which identifies a set clinical parameters. The presence of one of these parameters in the context of infection define sepsis as high risk of death with a requirement for urgent treatment.
Reliability science	The science relating to ensuring that all processes and procedures perform their intended function.
Root cause analysis (RCA)	A method of problem solving that tries to identify the root causes of issues and why they are happening.
Run charts	Run charts are graphs used to display data for quality improvement purposes. Run charts are easier for teams to work with than control charts, although they may be less statistically sensitive. Run charts are helpful for monitoring performance and improvement work. If there is an active improvement effort going on, these tools can be used to determine if an improvement has been made.

SAFER	The SAFER patient flow bundle is made up of five elements of best practice which, when implemented, helps to reduce delays for patients in adult inpatient wards.
Safety thermometer	A point of care survey which is used to record the occurrence of four types of harm (pressure ulcers, falls, catheter associated urinary tract infection and venous thromboembolism).
SCAPE	Safe clean and personal care everytime
Secondary uses service	Is a single comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.
Sepsis	A life-threatening condition caused when the body is overcome by infection.
SGA	Small for gestational age
SHMI	The Summary Hospital-level Mortality Indicator reports on mortality at trust level across the NHS in England.
SSNAP	Sentinel Stroke National Audit Programme
SSI (surgical site infection)	A healthcare-associated infection in which a wound infection occurs after an invasive (surgical) procedure.
Steering group	A group of people who are involved in the management of a piece of work or a project.
Thrombosis	Formation of blood clots within a vessel.
uDNACPR	Unified do not attempt cardiopulmonary resuscitation
Urinary catheter	A device which is placed into a patient's bladder for the purpose of draining urine.
Venous Thromboembolism (VTE)	A blood clot forming within a vein.
WHO	World Health Organisation.