NHS
Bury Clinical Commissioning Group

Governing Body

22 March 2017

Details	Part 1	**X**	Part 2		Agenda Item No.	**10**
Title of Paper:	PAHT Quality Improvement Plan					
Board Member:	Catherine Jackson, Executive Nurse					
Author:	Catherine Jackson, Executive Nurse					
Presenter:	Catherine Jackson, Executive Nurse					
Please indicate:	For Decision		For Information		For Discussion	**X**

Executive Summary

Summary	The CQC report was published in August 2016. The CQC identified 77 'Must Dos' and 144 'Should Dos' to ensure sustainable improvement to care delivered across the Pennine Trust services. The full CQC report has established evidence that PAHT, overall, is rated ***Inadequate***. PAHT developed an initial Trust wide Improvement Plan. This improvement plan sets out the immediate (first 9 months) improvement actions - to ensure they are getting the basics right, stabilising services and creating the right conditions upon which the Trust can continue to improve and ultimately transform care delivery across Pennine. This paper provides the background to the development of the Trust's Quality Improvement Plan, describes the progress to date whilst recognising the current issues and risks.					
Risk	**High**		**Medium**	**X**	**Low**	
	The risks are articulated in the Report in Appendix 1					
Recommendations	The Governing Body is asked to: • Note the contents of the report • Identify any gaps in assurance that they wish the Quality Team to discuss with the Trust and the Improvement Board • Support the Quality Improvement Programme of work					

Strategic themes

To deliver improved outcomes and reduce health inequalities for patients through better preventative strategies			
To deliver service re-design in priority areas through innovation			**x**
To develop primary care to become excellent and high performing commissioners			
To develop the CCG leadership to work with the Local Authority to be excellent integrated commissioners			
To develop robust and effective working relationships will all stakeholders and partners to drive integrated commissioning			**x**
To deliver long term financial sustainability through effective commissioning and innovative investment across the wider system			**x**
To develop and influence the provider landscape through development of a Locality Care Organisation (LCO)			
Equality Analysis Assessed?		Supports NHS Bury CCG Governance arrangements	**X**

Introduction

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

- Maternity
- Children
- Urgent Care
- Critical Care.

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

1.3 The diagnostic focus was to identify areas for improvement that impacted on patient safety was inform the new team of the immediate concerns raised by the CQC.

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

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

1.5 The CQC report was published in August 2016. The CQC identified 77 'Must Dos' and 144 'Should Dos' to ensure sustainable improvement to care delivered across the Pennine Trust services.

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

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

1.8 PAHT developed an initial Trust wide Improvement Plan. This plan sets out the immediate (first 9 months) improvement actions - to ensure they are getting the basics right, stabilising services and creating the right conditions upon which the Trust can continue to improve and ultimately transform care delivery across Pennine.

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

Structure and Scrutiny

2.0 NHS Improvement (NHSi), in conjunction with GM Health & Social Care Partnership (co-ordinating the response of Bury, Oldham, HMR and North Manchester CCGs), invited Salford Royal NHS Foundation Trust (SRFT), to provide interim leadership support to PAHT from 1st April 2016.

2.1 The GM Improvement Board chaired by The GM Health and Social Care Partnership (GMHSCP) have brought together parts of the local health and care economies including Bury CCG to ensure there is a shared understanding and collective commitment to the delivery of the improvement plan, including resources that need to be made available to enable the changes to happen.

2.2 A new structure of site level leadership teams, to include a Medical Director, Director of Nursing and Managing Director in addition to divisional triumvirates and clinical leaders across the Trust will be key to delivering the actions that will ensure service sustainability and transformation.

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

2.4 Measurement of improvements will be fundamental to ensuring sustainability and the reliability of patient care. The Trust has developed a high level assurance dashboard against their key themes that measures progress.

2.5 Scrutiny of the Improvement Plan and the key performance indicators captured in the high level assurance dashboard lies with the GMHSCP Improvement Board, CQC and locally the CCG Executive Nurses and Quality Leads.

2.6 A recent review of the Improvement Board recognised their key role to date. The Trust, with its key stakeholders have made significant progress since April with improved recruitment in a number of areas, refreshed leadership and a comprehensive Quality Improvement Plan. Financial contributions have been secured from local commissioners, GMHSCP and NHSI for 15-16 and details for 16-17 and beyond are being finalised as part of a 5 year management contract.

2.7 Moving forward the Improvement Board has proposed the following next steps:
Formalising a governance structure underneath the Improvement Board to have the following sub-committees reporting in:

- Quality Review Group (previously Clinical Quality Leads Committee)
- Maternity and Paediatric Improvement Board (previously Maternity only)
- Urgent and Emergency Care Board (previously Systems Resilience Group)

2.7.1 Senior NHSI and GMHSCP attendance at all sub committees to spread learning from other Trusts.

2.7.2 A review of the Improvement Plan by an Independent Improvement Director from another Trust in partnership with PAHT to support further refinement in the plan and to identify further expert resource needed to support the Trust.

2.7.3 NHSI with the Trust to coordinate a clinical review to validate the Improvement Boards assessment of progress made against the plan and identify any further critical issues.

2.7.4 NHSI to request improvement monies to support any identified gaps where the Trust may benefit from additional improvement support.

Progress and Risks

3.1 Workforce remains the main barrier to delivering improvement at pace. PAHT are subject to the same recruitment and retention pressures as all Trusts across the UK and continue to supplement their workforce with first line Bank and Agency staff. Additionally PAHT use their own staff to provide overtime to cover gaps in staffing.

3.2 Staffing in the NHS currently is at a crisis with the Greater Manchester picture being described across the nation; however the Trust has clear tactics about how they can recruit and retain staff and use the workforce differently.

3.3 PAHT has a programme in place 'Healthy Happy Here' to help improve people's working lives to tackle sickness and absence and improve staff retention.

3.4 Site level leadership is evident on the wards and positive feedback from the staff that this is impacting on the Improvement Plan.

3.5 104 new registered nurses and midwives recruited, 14 doctors (consultants and middle grades) recruited, 69 Health care support workers recruited, 34 midwives started in October and a further 90 newly qualified registered nurses start 2nd October.

3.6 The staff survey (Sept 2016, published March 2017) however remains poor in parts with lower scores than in 2015.

Quality on the Wards

4.1 Nursing care on the wards has been energised with the role out of the Nursing Assessment and Accreditation System (NAAS) which has been used successfully at SRFT to bring all wards up to the required standards, reduce variability, and improve patient care, safety and experience.

4.2 The NAAS programme helps support ward managers providing them with a clear framework for managing their environments and delivering excellence. The NAAS programme will have all the wards assessed by June 2017 and action plans developed where required. NAAS is a rolling programme to ensure standards are maintained in the long term.

Current issues

5.1 The following bullet points identify the current most pressing issues that have the focus of the Trust, GMHSCP Improvement Board, CCGs and current stakeholders.

- A&E performance and flow through the hospital
- 12 hour wait in the A&E department
- Ambulance handover delays
- Complaints management
- Serious incidents management
- Progress regarding the Diagnostics Improvement Plan
- Patient care planning, management and escalation
- JAG accreditation for endoscopy
- Care of the deteriorating patient; recent Prevention of Future Deaths report issued by the coroner

5.2 The CQC will visit one of the Trust's fragile services in Q1 of 2016/17,

5.3 On-going scrutiny of progress towards the Trusts strategic goal of being a good or outstanding Trust will continue to be led by the GMHSCP Improvement Board reporting nationally to the DH.

Recommendations

6.0 The Governing Body is asked to:

- Note the contents of the report
- Identify any gaps in assurance that they wish the Quality Team to discuss with the Trust and the Improvement Board
- Support the Quality Improvement Programme of work

Catherine Jackson
Executive Nurse