# University Hospitals of Morecambe Bay Trust
# CQC Improvement Plan 2020/21

| | |
|---|---|
| Trust/Care Group: | *Trust Wide* |
| Status: | *Live* |
| Version: | *5.00* |
| Date: | *21/12/2020* |

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# 1: Foreword from the Chief Executive Officer

*Thank you for taking the time to read our CQC Improvement Plan which sets out how we will successfully address the 'must do' and 'should do' actions identified by the CQC following their recent inspection of our hospitals.*

*The plan reflects our continued partnership working across the system and aims to strengthen this further. Together with the support of our partners, clinical and non-clinical colleagues, we are committed to making sustainable improvements and for the benefit of everyone who uses or works across our services.*

*To support the plan, all actions are aligned to an Executive lead, and associated assurance committees, with clear accountability and sight through to the Trust Board.*

*It is important to me that we continue to engage with colleagues throughout and ensure that everyone remains updated on the progress we are making together. To support this, each month we will publish a copy of the action plan and a summary of the improvements on our website. Additionally, we will also write to all of our colleagues, partners, governors, volunteers and other stakeholders to ensure they also know where we are up to.*

*Thank you for your continued support; the Trust Board and I look forward to continuing to work with you in support of the delivery of the improvements identified.*

Aaron Cummings
**Chief Executive Officer**

University Hospitals of Morecambe Bay NHS Foundation Trust

# 2: CQC Trust Improvement Plan 2020/21

Improvement Plan Principles:

1) What is the Trust Doing?
2) Who in the Trust is Responsible?
3) The format and structure of this Improvement Plan
4) How will the Trust communicate progress on the Improvement Plan?

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# 2: Improvement Plan Principles

## What is the Trust Doing?

The Trust was rated as 'Requires Improvement' following an inspection by the Care Quality Commission (CQC) during November and December 2018 and a New Use of Resources Inspection.

The CQC made 111 recommendations in total, 35 Must Do, 66 Should Do and 10 areas for improvement from the Use of Resources) from the above two reports all recommendations area included in our improvement plan.

In addition, 29 recommendations (8 Must Do's and 21 Should Do's) have been added to the improvement plan from new services transferred into the Trust from Cumbria Partnership NHS Foundation Trust (CPFT) and Blackpool Teaching Hospitals NHS Foundation Trust (BTHT) along with any outstanding actions from the previous Inspection.

The Trust has also created 11 new Trust Wide Recommendations to address common theme or trends from the Core Service Recommendations this is to enable the implementation of improvements at a Trust Wide level and to ensure consistency of approach.

The plan is iterative and includes a governance review which is underway and due to report in June 2019 which will add to the improvement learning.

The Trust Board has approved the CQC Improvement Plan which has been designed to deliver the immediate actions required as well as the longer term improvements needed. Support and engagement of our staff and our stakeholders will be fundamental to making the sustainable changes that are required for the benefit of everyone who uses our services.

A robust system of governance has been established to track and deliver the progress against the plan. All the recommendations have been mapped against the following categories :-

- CQC Domain
- CQC Service
- New or Recurrent Recommendation
- Health and Social Care Act (HSCA) regulation that has been breached
- UMHB Care Group
- UHMB Executive Lead
- UHMB Action Owner
- UHMB Assurance Committee
- UHMB Assurance sub- committee/ Group
- UHMB Strategic Value (the 5 P's)

All actions are aligned to the Executive Portfolios and associated Assurance Committees, with clear accountability and sight through to the Board.

# 2: Improvement Plan Principles

## Who in the Trust is Responsible?

Our actions to address the recommendations identified in the CQC Inspection Reports have been agreed by the Trust Board.

Our Executive Chief Nurse and Deputy Chief Executive Officer, Sue Smith OBE, is the Executive lead with responsibility for implementing actions in this document. Other executive directors are responsible for ensuring the delivery of the areas in their portfolios.

Non-executive directors are responsible for testing and challenging the executive on the robustness of the plan, triangulating board reports with experience of front line staff and service users & carers, primarily through their roles as Chairs and Deputy Chairs of the Board Assurance Committees.

Ultimately, our success in implementing the recommendations of the CQC Improvement Plan will be assessed by the CQC when they re-inspect our Trust.

## Allocation of CQC Recommendations to Executive Directors and Board Assurance Committees

| Executive Director / Board Member Recommendations | | | | | |
|---|---|---|---|---|---|
| **Executive Director / Board Member** | **Trust Pre-Emptive Action** | **MUST DO** | **SHOULD DO** | **USE of RESOURCES** | **Total** |
| Chair | 0 | 0 | 0 | 0 | **0** |
| Chief Executive Officer | 0 | 0 | 0 | 0 | **0** |
| Executive Chief Nurse | 1 | 2 | 11 | 0 | **14** |
| Medical Director | 3 | 3 | 5 | 0 | **11** |
| Chief Operating Officer | 4 | 3 | 8 | 0 | **15** |
| Director of People & Organisational Development | 2 | 3 | 16 | 1 | **22** |
| Director of Finance | 1 | 0 | 0 | 2 | **3** |
| **Total** | **11** | **11** | **40** | **3** | **65** |

| Trust Board & Board Assurance Committees Recommendations | | | | | |
|---|---|---|---|---|---|
| **Trust Board / Board Assurance Committee** | **Trust Pre-Emptive Action** | **MUST DO** | **SHOULD DO** | **USE of RESOURCES** | **Total** |
| Trust Board | 0 | 0 | 0 | 0 | **0** |
| Audit Committee | 0 | 0 | 1 | 0 | **1** |
| Finance Committee | 2 | 2 | 2 | 2 | **8** |
| Quality Committee | 7 | 6 | 21 | 0 | **34** |
| Workforce Committee | 2 | 3 | 16 | 1 | **22** |
| **Total** | **11** | **11** | **40** | **3** | **5** |

# 2: Improvement Plan Principles

## The Format and Structure of this Improvement plan

The Improvement plan summarises all the recommendationsand findings of the following Inspection Reports :

- 2017 CQC Inspection Report - UHMBT (All CQC Core Services)
- 2018 CQC Inspection Report - BTHT (Paeditric Comminity Services)
- 2018 CQC Inspection Report - CPFT (Adult Community Services)
- 2019 CQC Inspection Report - UHMBT (Emergency, Medical and Surgical Services)
- 2019 NHSI Use of Resource Report - UHMBT
- 2020 2019 CQC Inspection Report - UHMBT (Materrnity and Paediatric Services)

The report is structured into :
- Trust wide actions
- Use of Resources
- UHMBT Care Groups

And then within the service the actions are ordered with Must Dos first and then the Should Dos, each Must Do and Should Do recommendations from all relevant CQC Inspection Reports and Areas of Improvement from NHS Improvement Use of Resources Reports, will have an individual action plan.

This result in a structure of:

1) Trust Improvement Plan, which contains;
2) All CQC Recommendations and NHSI Areas of Improvement, all of which have;
3) Individual Action Plans, which will normally contain multiple actions.

Where multiple Core Service recommendations have a common theme or have Trust wide implications, the Trust may create a 'duplicate' Trust Wide Recommendation to enable the implementation of improvement at a Trust Wide level to ensure consistency of approach. All the relevant Core Service recommendations will be clearly documented in the Trust Wide Recommendation Action Plan.

Where a Recommendation for a CQC Core Service is also being addressed at Trust Level, the Trust wide recommendation will be clearly documented in the Core Service Recommendation Action Plan.

The Improvement Plan is part of the Trust's continuous improvement approach and as such it will be an iterative working document that will evolve and develop during its lifetime.

# 2: Improvement Plan Principles

## How will the Trust communicate progress on the Improvement Plan?

We will provide a progress report every month, which will be monitored by Executive Directors Group, Assurance Committees and the Trust Board.

We will provide staff with ongoing regular updates through communication on specific improvements, monthly content in Trust publications and communication channels and quarterly face to face briefing sessions.

We will provide regular updates on the progress of the Improvement Plan to our Council of Governors.

We will provide monthly updates to our key stakeholders, the Care Quality Commission and Morecambe Bay CCG, through the monthly oversight and assurance meetings which we hold with them.

We will display the results of the Inspection report at the entrances of all sites operated by the Trust.

We will provide also provide our patients and the local population with updates via the Trust Website, social media channels, New releases and other work with local media outlets.

The Improvement Plan will be published on the Trust external website and internal intranet site to make it and on the progress we are making, available to our patients, the local population, our staff, governors, stakeholders and other interested parties..

# 3: Improvement Plan Legend

## Overview

The following section contains a summary of;
1) The 17 standard data items recorded for each Recommendation or Area for Improvement
2) The 14 standard data items recorded for each Action
3) The key to the 5 RAG ratings that are used to assess the progress status of each action and any associated KPI metric

## The Standard Data for each Recommendation or Area for Improvement

Each Recommendation has the following standard Data items recorded;
Ref. No., Must Do/Should Do/UoR Finding, Source Inspection Report, CQC Domain, CQC Service Type, CQC Core Service Name, UHMB Care Group, UHMB Site(s), UHMB Theme, CQC Recommendation, the story behind/reason for the CQC Recommendation, the 'Good' KLOE standard to be achieved, what the Trust can achieve in the financial year, relevant UHMB Strategic Value, relevant UHMB IPR Metrics, relevant UHMB BAF Risks and relevant UHMB operational risks.

## The Standard Data for each Action to address a Recommendation or Area for Improvement

Each Recommendation has the following standard Data items recorded;
Action Ref. No., Risk of Non-Delivery, Executive Lead, Action Owner, Assurance Committee, Action to be addressed, progress to date, Target Date, Target KPI, current KPI performance, Methodology/Evidence Base/Data Source, Action RAG Status and KPI RAG status.

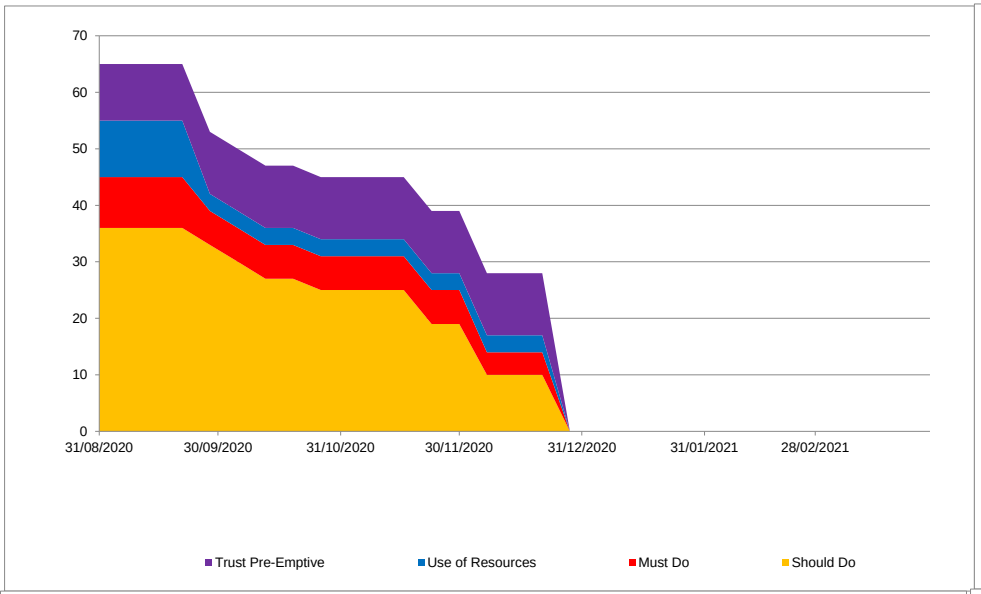
## Recommendation Action Plans: Overall Progress RAG Rating Matrix

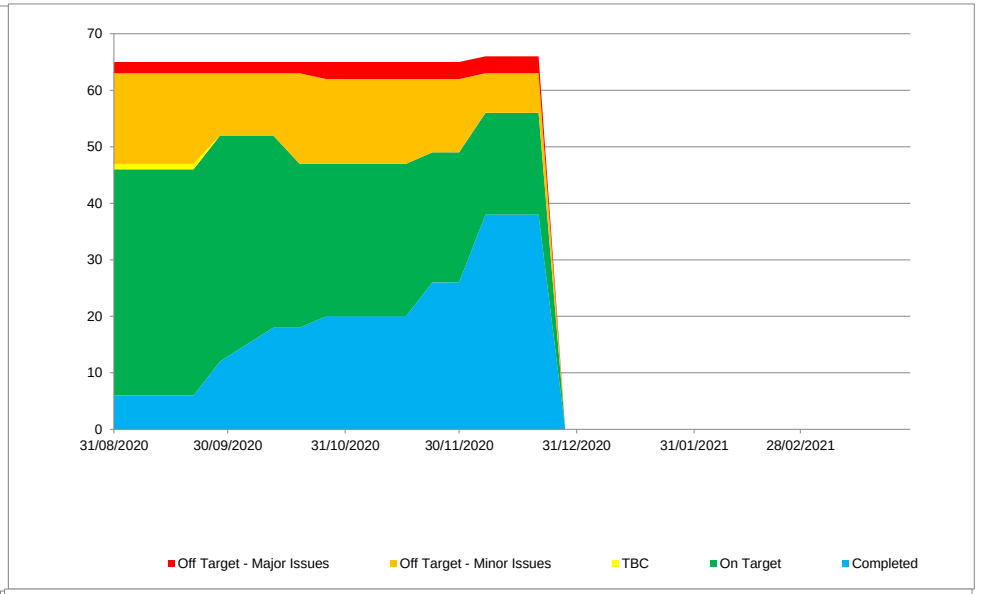
| Key | | Definition | |
|---|---|---|---|
| **On Track** | | **No Concerns** about the progress of the Action Plan or with the Action Plan delivering the required level of improvement. | |
| **Action Plan Off Track** | **Action Plan Off Track** | **Concerns** that there are issues with the development and implementation of the Action Plan, Inc. where there's no plan in place. | **ESCALATION to Red**: By agreement with the Relevant Care Group, Executive Lead or Assurance Committee |
| **Improvement(s) not yet being delivered** | **Improvement(s) not being delivered** | **Concerns** that although the Action Plan has been developed and implemented, this is not currently delivering the required level of improvement, Inc. where no target level has been recorded. | |
| **Completed** | | The Action Plan has been developed, implemented and has delivered the required level of improvement. | |
| **Superseded & Closed** | | The Action Plan has been superseded by another Action Plan. Normally where a Care Group Action Plan has been escalated to become a Trust Wide Action Plan. | |

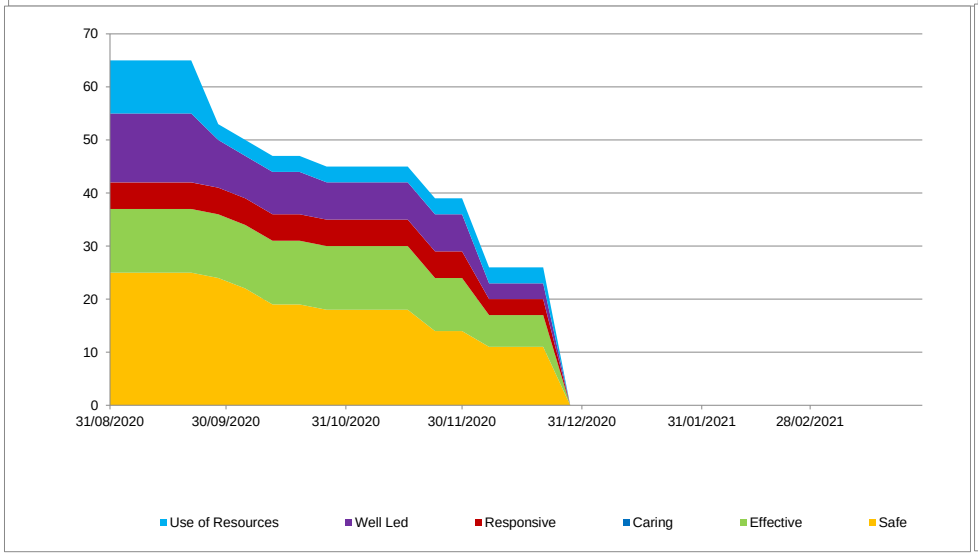
## Individual Actions: Action and KPI RAG Rating Matrix

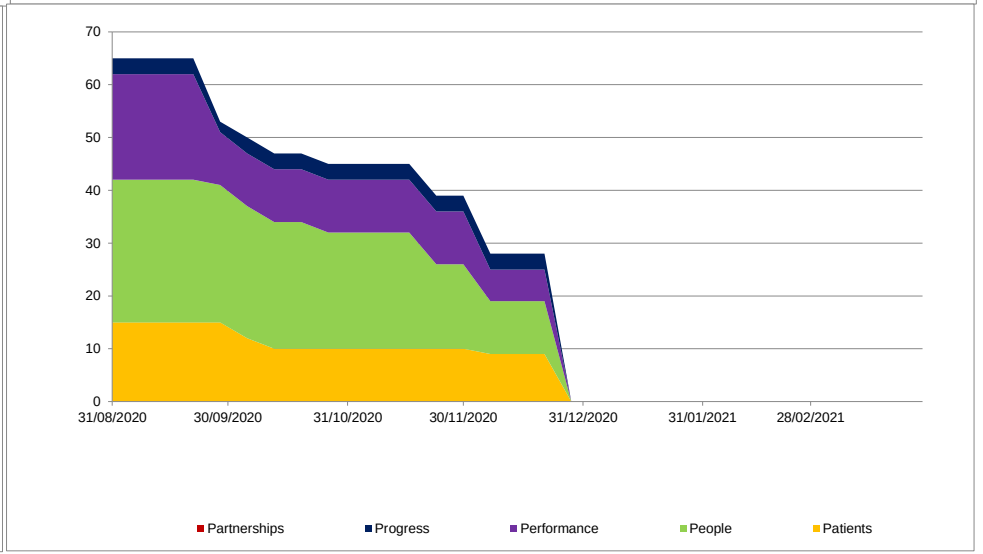
| Key | Status | Action Definition | KPI Definition |
|---|---|---|---|
| **OT** | On Track to be delivered. | The Action is expected to be delivered by the Target date. | The KPI has a 0 - 5% p.p adverse variance from Target. |
| **NTMI** | Not On Track to be delivered. (Minor issues to be addressed) | The Action at Minor risk; - Issue identified and target date has been slightly extended - Issue identified and target date will require a short extension | The KPI has a 5.1 - 10% p.p adverse variance from Target. |
| **NTMA** | Not On Track to be delivered. (Major issues to be addressed) | The Action at Major risk; - Issue identified and target date requires long extension - Issue identified with no resolution in yet identified/in place | The KPI has a > 10% p.p adverse variance from Target. |
| **D** | Delivered/Completed. | The Action has been completed. | Delivered with a subsequent six months of consistent KPI performance. (Integrated into BAU processes where applicable) |
| **NA** | An Indicator is not applicable/relevant. | An Indicator is not applicable/relevant. | An Indicator is not applicable/relevant. |

# 4: KPI Performance Graphs



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# 5: Recommendation Action Plan Index

| UHMB Ref. No. | CQC Report | CQC Domain | CQC Service | Must/ Should/ UoR Finding | HSCA Reg. Breached | UHMBT EXEC Lead | UHMBT Care Group Lead | UHMBT Specialist Function Lead | UHMBT Care Group / Directorate | Site | UHMBT Board Assurance Committee | UHMBT Strat. Obj. | UHMBT Theme | CQC Recommendation NHSI Finding | Action Plan Status | Target Completion Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TRUST01 | 2019 Inspection Report | Well Led | Trust | SHOULD DO | Not Listed by CQC | Sue Smith | Paul Jones | N/A | Corporate-CEO | Trust Wide | Audit Committee | Progress | Corporate Governance | The trust should consider reviewing the governance structure | On Target | 2020-21: Qtr4 |
| TRUST02 | 2019 Inspection Report | Effective | Trust | SHOULD DO | Not Listed by CQC | David Wilkinson | Ray Olive | N/A | Corporate-Workforce | Trust Wide | Workforce Committee | People | Staff Appraisal | The trust should ensure that all staff have received an annual appraisal and the overall rate of appraisals are brought in line with the trust target | On Target | 2020-21: Qtr4 |
| TRUST03 | 2019 Inspection Report | Safe | Trust | TRUST WIDE PRE-EMPTIVE ACTION | Not Listed by CQC | David Wilkinson | Ray Olive | N/A | Corporate-Workforce | Trust Wide | Workforce Committee | People | Staff Recruitment/Deployment | The Trust will take Action to help improve in the following Areas: Staffing levels and skill mix are planned, implemented and reviewed to keep people safe at all times. Any staff shortages are responded to quickly and adequately. Where relevant, there are effective handovers and shift changes to ensure that staff can manage risks to people who use services. | On Target | 2020-21: Qtr4 |
| TRUST04 | 2019 Inspection Report | Effective | Trust | TRUST WIDE PRE-EMPTIVE ACTION | Not Listed by CQC | David Wilkinson | Ray Olive | N/A | Corporate-Workforce | Trust Wide | Workforce Committee | People | Staff Development & Training | The Trust will take Action to help improve in the following Areas: All staff are qualified and have the skills they need to carry out their roles effectively and in line with best practice. The learning needs of staff are identified and training is provided to meet these needs. Staff are supported to maintain and further develop their professional skills and experience. | On Target | 2020-21: Qtr4 |
| TRUST05 | 2019 Inspection Report | Safe | Trust | TRUST WIDE PRE-EMPTIVE ACTION | Not Listed by CQC | Shahedal Bari | Kam Mom | N/A | Corporate-Medical Director | Trust Wide | Quality Committee | Patients | Medication Management & Storage | The Trust will take Action to, ensure that oxygen is always prescribed on the medication administration chart for patients requiring oxygen therapy, as per trust policy. | On Target | 2020-21: Qtr4 |
| TRUST06 | 2019 Inspection Report | Safe | Trust | TRUST WIDE PRE-EMPTIVE ACTION | Not Listed by CQC | Shahedal Bari | Kam Mom | N/A | Corporate-Medical Director | Trust Wide | Quality Committee | Patients | Medication Management & Storage | The Trust will take Action to, ensure that medicines reconciliations are completed within 24 hours. | On Target | 2021-22: Qtr1 |
| TRUST07 | 2019 Inspection Report | Safe | Trust | TRUST WIDE PRE-EMPTIVE ACTION | Not Listed by CQC | Shahedal Bari | Guatam Talawadaker | N/A | Corporate-Medical Director | Trust Wide | Quality Committee | Patients | Patient Care & Dignity | The Trust will take Action to, continue improving venous thromboembolism (VTE) assessments. | On Target | 2020-21: Qtr4 |
| TRUST08 | 2019 Inspection Report | Safe | Trust | TRUST WIDE PRE-EMPTIVE ACTION | Not Listed by CQC | Sue Smith | Lynne Wyre | N/A | Corporate-Chief Nurse | Trust Wide | Quality Committee | Patients | Patient Safety | The Trust will take Action to, ensure all risk assessments (e.g. National Early Warning Scores (NEWS), multifactorial falls risk assessments) are completed for all patients where appropriate and evidence of the same is documented consistently. | On Target | 2020-21: Qtr4 |
| TRUST09 | 2019 Inspection Report | Responsive | Trust | TRUST WIDE PRE-EMPTIVE ACTION | Not Listed by CQC | Kate Maynard | Carol Park, Dianne Smith | N/A | Corporate-COO | Trust Wide | Quality Committee | Performance | Operational Performance & Targets | The Trust will take Action to, ensure referral to treatment targets in outpatient clinics are met and backlogs are addressed in follow-up appointment waiting times. | Improvements Not Yet Being Delivered | 2020-21: Qtr4 |

| UHMB Ref. No. | CQC Report | CQC Domain | CQC Service | Must/ Should/ UoR Finding | HSCA Reg. Breached | UHMBT EXEC Lead | UHMBT Care Group Lead | UHMBT Specialist Function Lead | UHMBT Care Group / Directorate | Site | UHMBT Board Assurance Committee | UHMBT Strat. Obj. | UHMBT Theme | CQC Recommendation NHSI Finding | Action Plan Status | Target Completion Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TRUST10 | 2019 Inspection Report | Responsive | Trust | TRUST WIDE PRE-EMPTIVE ACTION | Not Listed by CQC | Kate Maynard | Mel Woolfall | N/A | Corporate-COO | Trust Wide | Quality Committee | Performance | Access & Flow | The Trust will take action to ensure that people attending Urgent and Emergency Services can access care and treatment in a timely way, that they have timely access to initial assessment, test results, diagnosis or treatment, that action is taken to minimise the length of time people have to wait for care, treatment or advice, that people with the most urgent needs have their care and treatment prioritised | On Target | 2020-21: Qtr4 |
| TRUST11 | 2019 Inspection Report | Safe | Trust | TRUST WIDE PRE-EMPTIVE ACTION | Not Listed by CQC | Kate Maynard | Tristram Reynolds | N/A | Corporate-COO | Trust Wide | Finance Committee | Progress | Patient Environment | The Trust will take Action to, ensure that Estate capital build requirements and Estate repairs requirements identified by the CQC are added to the Capital Plan and repairs schedules and appropriately prioritised within the prevailing Capital position. | Improvements Not Yet Being Delivered | 2020-21: Qtr4 |
| TRUST12 | 2019 Inspection Report | Safe | Trust | TRUST WIDE PRE-EMPTIVE ACTION | Not Listed by CQC | Keith Griffiths | Andy Wicks | Fiona Prestwood | Corporate-Finance | Trust Wide | Finance Committee | Patients | Information Governance | The Trust will take action to ensure that there are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. | Improvements Not Yet Being Delivered | 2020-21: Qtr4 |
| TRUST13 | 2019 Inspection Report | Effective | Trust | TRUST WIDE PRE-EMPTIVE ACTION | Not Listed by CQC | Kate Maynard | Carol Park | N/A | Corporate-COO | Trust Wide | Quality Committee | Performance | Operational Performance & Targets | The trust should continue to monitor and improve referral to treatment targets for all specialities | Improvements Not Being Delivered | 2020-21: Qtr4 |
| TRUST14 | 2020 Inspection Report | Effective | Trust | TRUST WIDE PRE-EMPTIVE ACTION | Reg. 18 | David Wilkinson | N/A | Tony Crick | Corporate-Workforce | Trust Wide | Workforce Committee | People | Staff Development & Training | The trust must ensure that it has appropriate arrangements in place to assure itself around staff competencies regarding equipment. | Improvements Not Yet Being Delivered | 2020-21: Qtr4 |
| UoR1 | 2019 Inspection Report | Use of Resources | Trust | UoR FINDING | N/A - NHSI Assessment not CQC | Keith Griffiths | N/A | N/A | Corporate-Finance | Trust Wide | Finance Committee | Performance | Finance | The Trust will take action to effectively manage its financial resources | Improvements Not Being Delivered | 2020-21: Qtr4 |
| UoR2 | 2019 Inspection Report | Use of Resources | Trust | UoR FINDING | N/A - NHSI Assessment not CQC | Keith Griffiths | N/A | N/A | Corporate-Finance | Trust Wide | Finance Committee | Performance | Finance | The Trust will take action use its resources to provide clinical services that operate as productively as possible | Improvements Not Being Delivered | 2020-21: Qtr4 |
| UoR3 | 2019 Inspection Report | Use of Resources | Trust | UoR FINDING | N/A - NHSI Assessment not CQC | David Wilkinson | Ray Olive | N/A | Corporate-Workforce | Trust Wide | Workforce Committee | People | Staff Sickness | The Trust will take action use its workforce to provide clinical services that operate as productively as possible. (Specific to Staff Sickness Rates) | On Target | 2020-21: Qtr4 |
| ED01 | 2019 Inspection Report | Safe | Urgent & Emergency Services | MUST DO | Not Listed by CQC | Shahedal Bari | Emma Fitton | Fiona Prestwood | Medicine - Emergency | RLI | Finance Committee | Patients | Information Governance | The service must ensure paper records are stored securely and computer screens are locked when not in use. | On Target | 2020-21: Qtr4 |
| ED02 | 2019 Inspection Report | Effective | Urgent & Emergency Services | MUST DO | Not Listed by CQC | Shahedal Bari | Andrew Higham | Stuart Bates | Medicine - Emergency | FGH | Quality Committee | Performance | Clinical Audit | Be able to demonstrate robust plans to address the department's failure to meet RCEM audit standards from 2016/17 and 2017/18 are in place, active and being monitored for progress with re-audit to provide assurance of improvement | Improvements Not Yet Being Delivered | 2020-21: Qtr4 |
| ED03 | 2019 Inspection Report | Safe | Urgent & Emergency Services | MUST DO | Not Listed by CQC | Kate Maynard | Diane Smith | Tristram Reynolds | Medicine - Emergency | WGH | Finance Committee | Patients | Patient Environment | Ensure there is a safe place at WGH UTC to support and treat patients who are living with a mental health condition which reduces the risk of them self-harming. | On Target | 2020-21: Qtr4 |

| UHMB Ref. No. | CQC Report | CQC Domain | CQC Service | Must/ Should/ UoR Finding | HSCA Reg. Breached | UHMBT EXEC Lead | UHMBT Care Group Lead | UHMBT Specialist Function Lead | UHMBT Care Group / Directorate | Site | UHMBT Board Assurance Committee | UHMBT Strat. Obj. | UHMBT Theme | CQC Recommendation NHSI Finding | Action Plan Status | Target Completion Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MED06 | 2019 Inspection Report | Safe | Medical Care | SHOULD DO | Not Listed by CQC | Sue Smith | Emily Henry | Anna Smith | Medicine | RLI | Quality Committee | Patients | Quality & Safety Assurance Checks | The trust should ensure that hazardous substances are stored safely at all times | On Target | 2020-21: Qtr4 |
| MED09 | 2019 Inspection Report | Effective | Medical Care | SHOULD DO | Not Listed by CQC | David Wilkinson | Diane Smith | N/A | Medicine | RLI | Workforce Committee | People | Staff Development & Training | Ensure there is a reasonable and proportionate induction process or access to relevant induction information for all locum medical staff attending the hospital on an ad-hoc or short term basis. | On Target | 2020-21: Qtr3 |
| SCC06 | 2017 Inspection Report | Responsive | Critical Care | SHOULD DO | Not Listed by CQC | Sue Smith | Jane Kenny | N/A | Surgery & Critical Care | FGH & RLI | Quality Committee | Patients | Patient Care & Dignity | 1) Patients discharged from critical care should receive a ward follow up visit by critical care nurses within 36 hours of discharge, planned as part of the appointment of a supernumerary coordinator and in accordance with the GPICS (2015) standard.<br>2) Critical Care Unit should continue to monitor discharges out of hours and develop actions with the Trust to improve the FGH critical care discharges out of hours. | On Target | 2020-21: Qtr4 |
| WACS09 | 2020 Inspection Report | Well Led | Children and Young People | SHOULD DO | Reg. 18 | David Wilkinson | Linda Womack | Matt France | Women & Children's | FGH | Workforce Committee | People | Staff Development & Training | The trust should ensure that medical and nursing staff receive appropriate supervision and support. | Improvements Not Yet Being Delivered | 2020-21: Qtr4 |
| WACS10 | 2020 Inspection Report | Safe | Maternity | SHOULD DO | Reg. 18 | Kate Maynard | Linda Womack | Dan Willis | Women & Children's | FGH | Quality Committee | People | Staff Development & Training | The service should ensure staff have access to child abduction and awareness training. | On Target | 2020-21: Qtr4 |
| WACS10A | 2020 Inspection Report | Safe | Maternity | SHOULD DO | Reg. 18 | Kate Maynard | Linda Womack | Dan Willis | Women & Children's | RLI | Quality Committee | People | Staff Development & Training | The trust should ensure staff have access to child abduction and awareness training. | On Target | 2020-21: Qtr4 |
| WACS12 | 2020 Inspection Report | Well Led | Children and Young People | SHOULD DO | Not Listed by CQC | David Wilkinson | Linda Womack | Matt France | Women & Children's | FGH | Workforce Committee | People | Culture & Leadership | The trust should take timely action to improve culture within the service and continue to monitor and sustain improvement | Improvements Not Yet Being Delivered | 2020-21: Qtr4 |
| ICS01 | 2017 CPFT Inspection Report | Safe | Community health services for In-patients | SHOULD DO | Not Listed by CQC | Shahedal Bari | Jane Dickinson | Stuart Bates | Integrated Community Services | Trust Wide | Quality Committee | Progress | Clinical Audit | The trust should audit implementation of their self-administration of medicines policy. | On Target | 2020-21: Qtr4 |

| UHMB Ref. No. | CQC Report | CQC Domain | CQC Service | Must/ Should/ UoR Finding | HSCA Reg. Breached | UHMBT EXEC Lead | UHMBT Care Group Lead | UHMBT Specialist Function Lead | UHMBT Care Group / Directorate | Site | UHMBT Board Assurance Committee | UHMBT Strat. Obj. | UHMBT Theme | CQC Recommendation NHSI Finding | Action Plan Status | Target Completion Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED04 | 2019 Inspection Report | Effective | Urgent & Emergency Services | SHOULD DO | Not Listed by CQC | Kate Maynard | Diane Smith | N/A | Medicine - Emergency | FGH | Quality Committee | Performance | Access & Flow | Continue to work towards meeting RCEM waiting time standards including the median time to treatment, four hour target and time patients wait for a bed after decision to admit has been made. | Completed | Completed Nov 2020 |
| ED05 | 2019 Inspection Report | Effective | Urgent & Emergency Services | SHOULD DO | Not Listed by CQC | David Wilkinson | Andrew Higham | N/A | Medicine - Emergency | FGH | Workforce Committee | People | Staff Recruitment/Deployment | Work towards recruiting substantive consultant level doctors for the FGH Emergency department | Completed | Completed Nov 2020 |
| MED01 | 2019 Inspection Report | Safe | Medical Care | SHOULD DO | Not Listed by CQC | David Wilkinson | Diane Smith | N/A | Medicine | RLI | Workforce Committee | People | Staff Recruitment/Deployment | The trust should continue to proactively recruit nursing and medical staff | Completed | Completed Nov 2020 |
| MED02 | 2019 Inspection Report | Safe | Medical Care | SHOULD DO | Not Listed by CQC | David Wilkinson | Diane Smith | N/A | Medicine | FGH & RLI | Workforce Committee | People | Staff Development & Training | RLI - The trust should ensure staff are given time to complete their mandatory training and that accurate compliance figures are maintained.<br>FGH - Continue to ensure that staff complete mandatory training in accordance with trust policy at FGH. | Completed | Completed Nov 2020 |
| MED03 | 2019 Inspection Report | Effective | Medical Care | SHOULD DO | Not Listed by CQC | David Wilkinson | Diane Smith | N/A | Medicine | FGH & RLI | Workforce Committee | People | Staff Appraisal | RLI - The trust should ensure that all staff benefit from the appraisal process and these are completed on an annual basis in accordance with local policy.<br>FGH - Improve compliance with staff appraisal by ensuring all staff receive an annual appraisal in line with trust policy. | Completed | Completed Nov 2020 |
| MED04 | 2019 Inspection Report | Well Led | Medical Care | SHOULD DO | Not Listed by CQC | Sue Smith | Emily Henry | Stuart Bates | Medicine | RLI | Quality Committee | Patients | Clinical Governance | The trust should continue to assess and measure the effectiveness of the WESEE governance framework and adapt practice accordingly | Completed | Completed Oct 2020 |
| MED05 | 2019 Inspection Report | Safe | Medical Care | SHOULD DO | Not Listed by CQC | Sue Smith | Emily Henry | Anna Smith | Medicine | RLI | Quality Committee | Patients | Quality & Safety Assurance Checks | The trust should ensure that bath and shower water temperatures are being accurately recorded and actioned in line with local policy | Completed | Completed Oct 2020 |
| MED07 | 2019 Inspection Report | Safe | Medical Care | SHOULD DO | Not Listed by CQC | David Wilkinson | Andrew Higham | N/A | Medicine | FGH | Workforce Committee | People | Staff Recruitment/Deployment | Review medical staffing cover at night and consider additional support to keep patients safe | Completed | Completed Nov 2020 |
| MED08 | 2019 Inspection Report | Well Led | Medical Care | SHOULD DO | Not Listed by CQC | Kate Maynard | Emily Henry | N/A | Medicine | FGH | Quality Committee | Performance | Clinical Governance | Ensure that staff on individual wards and clinical areas are clear of their local risks and have a plan to effectively minimise and manage their risks | Completed | Completed Sept 2020 |
| MED10 | 2017 Inspection Report | Safe | Medical Care | SHOULD DO | Not Listed by CQC | Sue Smith | Emily Henry | N/A | Medicine | FGH & RLI | Quality Committee | Patients | Patient Care & Dignity | Ensure all nursing and medical clinical documentation is completed in full and in accordance with recognised professional standards. | Completed | Completed Oct 2020 |
| SCC01 | 2019 Inspection Report | Effective | Surgical Care | SHOULD DO | Not Listed by CQC | Kate Maynard | Carol Park | N/A | Surgery & Critical Care | FGH, RLI & WGH | Finance Committee | Performance | Operational Performance & Targets | The trust should continue to monitor and improve referral to treatment targets for all specialities | Completed | Completed Sept 2020 |
| SCC02 | 2019 Inspection Report | Safe | Surgical Care | SHOULD DO | Not Listed by CQC | David Wilkinson | Carol Park | N/A | Surgery & Critical Care | FGH | Workforce Committee | People | Staff Recruitment/Deployment | The trust should continue with staff recruitment and retention for both nursing and medical staff to achieve planned fill rate establishment. | Completed | Completed Nov 2020 |
| SCC03 | 2019 Inspection Report | Effective | Surgical Care | SHOULD DO | Not Listed by CQC | Shahedal Bari | Carol Park | Claire Alexander | Surgery & Critical Care | FGH & RLI | Quality Committee | Performance | Operational Performance & Targets | The trust should prioritise hip fracture outcomes to meet national standards (National standard is treatment within 36 Hours). | Completed | Completed Nov 2020 |

| UHMB Ref. No. | CQC Report | CQC Domain | CQC Service | Must/ Should/ UoR Finding | HSCA Reg. Breached | UHMBT EXEC Lead | UHMBT Care Group Lead | UHMBT Specialist Function Lead | UHMBT Care Group / Directorate | Site | UHMBT Board Assurance Committee | UHMBT Strat. Obj. | UHMBT Theme | CQC Recommendation NHSI Finding | Action Plan Status | Target Completion Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SCC04 | 2019 Inspection Report | Responsive | Surgical Care | SHOULD DO | Not Listed by CQC | Kate Maynard | Carol Park | N/A | Surgery & Critical Care | FGH & RLI | Quality Committee | Performance | Operational Performance & Targets | The trust should continue to monitor the average length of stay for elective and non-elective patients to improve performance standards measured against the England national average. | Completed | Completed Nov 2020 |
| SCC05 | 2019 Inspection Report | Effective | Surgical Care | SHOULD DO | Not Listed by CQC | David Wilkinson | Carol Park | N/A | Surgery & Critical Care | FGH & RLI | Workforce Committee | People | Staff Recruitment/Deployment | Increase Orthogeriatrician input on surgical wards | Completed | Completed Nov 2020 |
| WACS01 | 2020 Inspection Report | Safe | Children and Young People | MUST DO | Reg. 12 | Shahedal Bari | Sanjay Sinha | Heather Pratt | Women & Children's | FGH | Quality Committee | Patients | Patient Care & Dignity | The trust must ensure that there is a clear pathway for 16 and 17 year old patients that all staff are aware of. | Completed | Completed Nov 2020 |
| WACS02 | 2020 Inspection Report | Well Led | Children and Young People | MUST DO | Reg. 17 | Sue Smith | Linda Womack | Anna Smith | Women & Children's | FGH | Quality Committee | Performance | Clinical Governance | The trust must ensure all risks are assessed, monitored and actions taken to mitigate them are effective and timely. | Completed | Completed Jan 2020 |
| WACS02A | 2020 Inspection Report | Well Led | Maternity | MUST DO | Reg. 17 | Sue Smith | Linda Womack | Anna Smith | Women & Children's | RLI | Quality Committee | Performance | Clinical Governance | The trust must ensure all risks are assessed, monitored and actions taken to mitigate them are effective and timely. | Completed | Completed Jan 2020 |
| WACS03 | 2020 Inspection Report | Well Led | Children and Young People | MUST DO | Reg. 17 | Kate Maynard | Carol Carlile | Rob O'Neill | Women & Children's | FGH & RLI | Quality Committee | Performance | Data Quality and Systems | The trust must ensure that systems to collect and analyse data are effective. Such as the maternity dashboard accurately reflects current data or performance . That validated data is easily accessible to staff to allow them to understand performance, make decisions and improvements. | Completed | Completed Sept 2020 |
| WACS03A | 2020 Inspection Report | Well Led | Maternity | MUST DO | Reg. 17 | Kate Maynard | Carol Carlile | Rob O'Neill | Women & Children's | FGH & RLI | Quality Committee | Performance | Data Quality and Systems | The trust must ensure that systems to collect and analyse data are effective. Such as the maternity dashboard accurately reflects current data or performance. That validated data is easily accessible to staff to allow them to understand performance, make decisions and improvements. | Completed | Completed Sept 2020 |
| WACS04 | 2020 Inspection Report | Safe | Children and Young People | MUST DO | Reg. 18 | David Wilkinson | Sanjay Sinha | N/A | Women & Children's | FGH | Workforce Committee | People | Staff Recruitment/Deployment | The trust must ensure that there are sufficient numbers of suitably qualified medical staff on the rota | Completed | Completed Sept 2020 |
| WACS05 | 2020 Inspection Report | Effective | Maternity | MUST DO | Reg. 18 | David Wilkinson | Linda Womack | Tony Crick | Women & Children's | FGH | Workforce Committee | People | Staff Development & Training | The trust must ensure that it has appropriate arrangements in place to assure itself around staff competencies regarding equipment | Completed | Completed Dec 2020 |
| WACS05A | 2020 Inspection Report | Effective | Maternity | MUST DO | Reg. 18 | David Wilkinson | Linda Womack | Tony Crick | Women & Children's | RLI | Workforce Committee | People | Staff Development & Training | The trust must ensure that it has appropriate arrangements in place to assure itself around staff competencies regarding equipment. | Completed | Completed Dec 2020 |
| WACS06 | 2020 Inspection Report | Safe | Children and Young People | SHOULD DO | Reg. 20 | Sue Smith | Linda Womack | Nicky Edmondson | Women & Children's | FGH | Quality Committee | Patients | Clinical Governance | The service should ensure that incident records clearly evidence duty of candour has been completed. | Completed | Completed Oct 2020 |
| WACS06A | 2020 Inspection Report | Safe | Children and Young People | SHOULD DO | Reg. 20 | Sue Smith | Linda Womack | Nicky Edmondson | Women & Children's | RLI | Quality Committee | Patients | Clinical Governance | The trust should ensure that incident records clearly evidence that duty of candour has been completed. | Completed | Completed Oct 2020 |

| UHMB Ref. No. | CQC Report | CQC Domain | CQC Service | Must/ Should/ UoR Finding | HSCA Reg. Breached | UHMBT EXEC Lead | UHMBT Care Group Lead | UHMBT Specialist Function Lead | UHMBT Care Group / Directorate | Site | UHMBT Board Assurance Committee | UHMBT Strat. Obj. | UHMBT Theme | CQC Recommendation NHSI Finding | Action Plan Status | Target Completion Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WACS07 | 2020 Inspection Report | Well Led | Children and Young People | SHOULD DO | Reg. 17 | Shahedal Bari | Sanjay Sinha | Robin Proctor | Women & Children's | FGH | Quality Committee | People | Patient Safety | The trust should ensure leads for **mortality** and safeguarding are in place within the service. | Completed | Completed Dec 2020 |
| WACS07A | 2020 Inspection Report | Well Led | Children and Young People | SHOULD DO | Reg. 17 | Shahedal Bari | Sanjay Sinha | Robin Proctor | Women & Children's | FGH | Quality Committee | People | Patient Safety | The trust should ensure **morbidity and mortality processes** are consistent across both sites. | Completed | Completed Dec 2020 |
| WACS07B | 2020 Inspection Report | Well Led | Children and Young People | SHOULD DO | Reg. 18 | Sue Smith | Linda Womack | Mark Lippett | Women & Children's | FGH | Quality Committee | People | Patient Safety | The trust should ensure leads for mortality and **safeguarding** are in place within the service. | Completed | Completed Dec 2019 |
| WACS08 | 2020 Inspection Report | Safe | Not Listed by CQC | SHOULD DO | Reg. 12 | Sue Smith | N/A | Nicky Edmondson | Women & Children's | FGH | Quality Committee | Patients | Clinical Governance | The trust should ensure that all appropriate incidents go to the serious incidents requiring investigation (SIRI) panel. | Completed | Completed Dec 2019 |
| WACS11 | 2020 Inspection Report | Well Led | Children and Young People | SHOULD DO | Not Listed by CQC | David Wilkinson | Linda Womack | N/A | Women & Children's | FGH | Workforce Committee | People | Culture & Leadership | The trust should consider increasing the visibility of senior leaders across maternity and the children and young people's service areas. | Completed | Completed Dec 2020 |
| WACS11A | 2020 Inspection Report | Well Led | Maternity | SHOULD DO | Not Listed by CQC | David Wilkinson | Linda Womack | N/A | Women & Children's | RLI | Workforce Committee | People | Culture & Leadership | The trust should consider increasing the visibility of senior leaders across maternity and children and young person services. | Completed | Completed Dec 2020 |
| WACS13 | 2020 Inspection Report | Safe | Maternity | SHOULD DO | Not Listed by CQC | Sue Smith | Carol Carlile | N/A | Women & Children's | FGH | Quality Committee | Patients | Quality & Safety Assurance Checks | The trust should consider auditing in line with the WHO maternity safety checklist procedures carried out in birthing rooms. | Completed | Completed Dec 2019 |
| WACS14 | 2020 Inspection Report | Well Led | Children and Young People | SHOULD DO | Not Listed by CQC | Shahedal Bari | Sanjay Sinha | Heather Pratt | Women & Children's | FGH | Quality Committee | Progress | Clinical Audit | The service should continue to audit care plans to ensure they are not changed unless there is a clinical reason. | Completed | Completed Sept 2020 |
| WACS15 | 2020 Inspection Report | Safe | Maternity | SHOULD DO | Not Listed by CQC | David Wilkinson | Linda Womack | Kate Casey | Women & Children's | FGH | Workforce Committee | People | Staff Development & Training | The trust should consider ensuring data to monitor training compliance can be viewed at service level. | Completed | Completed Oct 2020 |
| WACS16 | 2020 Inspection Report | Safe | Maternity | SHOULD DO | Reg. 15 | Kate Maynard | Carol Carlile | Tristram Reynolds | Women & Children's | RLI | Finance Committee | Performance | Patient Environment | The trust should ensure all equipment is appropriately located for the purpose for which they are being used. | Completed | Completed Jun 2020 |
| WACS17 | 2017 BTHT Inspection Report | Responsive | Community health services for children, young people and families | SHOULD DO | Not Listed by CQC | Kate Maynard | Linda Womack | N/A | Women & Children's | Community - North Lancashire | Quality Committee | Performance | Operational Performance & Targets | The trust should ensure waiting times in community [Paediatric] therapy services are addressed as planned | Completed | Completed Dec 2020 |
| CCS01 | 2018 Inspection Report | Well Led | Diagnostic Imaging | SHOULD DO | Not Listed by CQC | David Wilkinson | Russell Norman | Matt France | Core Clinical Services | RLI | Workforce Committee | People | Culture & Leadership | Continue to build relationships and develop closer team working for medical staff in radiology and breast services across all locations to develop a one trust culture. | Completed | Completed Oct 2020 |
| CCS02 | 2019 Inspection Report | Safe | Medical Care | SHOULD DO | Not Listed by CQC | David Wilkinson | N/A | Tony Crick | Core Clinical Services | FGH | Workforce Committee | People | Staff Recruitment/Deployment | Continue to work on strategies to improve the recruitment and retention of therapy staff in medical care services | Completed | Completed Oct 2020 |

# 6: Overall Update on the Improvement Plan

**Summary of the Key Issues that are relevant to the progress of Improvement Plan**

In October and November 2020 a total of 19 Recommendations on the Trust Improvement Plan were completed; 1 Must Do, 18 Should Do's.

In October and November 2020 a total of 4 Recommendations from the WACs Inspection Report were completed; 1 Must Do, 3 Should Do's.
(For avoidance of doubt ,these recommendations are also included in the Trust Total)

In October and November 2020 Medicine Care Group completed 9 Should Do recommendations and Surgery Care Group completed 4 Should Do recommendations.
(For avoidance of doubt ,these recommendations are also included in the Trust Total)

There are a further 28 Recommendations that continue to be progressed, 1 is scheduled for completion in December 2020, 26 are scheduled for completion in March 2021, 1 are scheduled for completion in April 2021.

The 28 Recommendations are distributed as follows:
- Corp. Functions: 17 Recommendations (12 Trust Action, 3 Use of Resorces, 2 Should Do)
- Medicine Care Group: 5 Recommendations (3 Must Do, 2 Should Do)
- WACS Care Group: 4 Should Do Recommendations
- Surgery Care Group: 1 Should Do Recommendation
- Community Care Group: 1 Should Do Recommendation

Corporate Functions are now responsible for 61% of the remaining Recommendations.

# 6: Overall Progress of the Improvement Plan

## Completion of Recommendation Action Plans from Jan 2020 to present

| Period | Trust Pre-Emptive Actions | Use of Resources | MUST DO Recommendations | SHOULD DO Recommendations | TOTAL |
|---|---|---|---|---|---|
| 2019/20: Qtr4 | 0 | 0 | 2 | 3 | **5** |
| 2020/21: Qtr1 | 0 | 0 | 0 | 1 | **1** |
| 2020/21: Qtr2 | 0 | 0 | 3 | 3 | **6** |
| 2020/21: Qtr3 | 0 | 0 | 3 | 23 | **26** |
| TOTAL COMPLETED | 0 | 0 | 8 | 30 | **38** |
| 2020/21: Qtr3 | 0 | 0 | 0 | 1 | **1** |
| 2020/21: Qtr4 | 10 | 3 | 4 | 9 | **26** |
| 2021/22: Qtr1 | 1 | 0 | 0 | 0 | **1** |
| TOTAL REMAINING | 11 | 3 | 4 | 10 | **28** |
| TOTAL | 11 | 3 | 12 | 40 | **66** |
| % TOTAL COMPLETED | **0.00%** | **0.00%** | **66.67%** | **75.00%** | **57.58%** |

| | |
|---|---|
| **Recommendation Ref. No.:** | **TRUST01** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **WELI LED** |
| **CQC Service Name:** | **Corporate Services** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **Sue Smith** |
| **UHMBT Care Group:** | **Corporate Services** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Audit Committee** |
| **UHMBT Strategic Objective:** | **Progress** |
| **UHMB Theme:** | **Corporate Governance** |
| **CQC Recommendation:** | The trust should consider reviewing the governance structure |
| **Story behind the Recommendation:** | The arrangements for quality governance were extensive and there were a significant number of committees, sub-committees and meetings which fed into the main committees. This presented a risk of duplication of work and areas being missed. It was acknowledged these arrangements were put in place to address the trust's historic quality and patient safety concerns. However, they consumed a large management resource There was scope for the trust to review streamlining these arrangements going forward and potentially enable greater self-sufficiency within the care groups. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | The board and other levels of governance in the organisation function effectively and interact with each other appropriately.<br>Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.<br>Staff are clear about their roles and accountabilities. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Complete and implement actions from Governance Review by March 2021 |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TRUST01.1 | Sue Smith | Paul Jones | Undertake External Governance Review to investigate/review findings and recommendations identified by the CQC (in Trust Wide Well Led Domain) and current UHMBT processes/practices and to compare with prevailing best practice and regulatory requirements to identify areas for improvement. | External Governance review by Deloittes has been completed and the Trust response will be signed off at Public meeting of the Board. Work streams have been identified which will address CQC areas of concern. | Deloittes Governance Review Report | Deloittes External Governance Review<br>Trust Board minutes | 30/06/2019 | N/A | N/A | D | NA | Low |
| TRUST01.2 | Sue Smith | Paul Jones | Review the findings and recommendations of the Deloittes Governance Review and agree next steps. | As per Action Trust 2.1 | Deloittes External Governance Review<br>Trust Board minutes | Deloittes External Governance Review<br>Trust Board minutes | 31/07/2019 | N/A | N/A | D | NA | Low |
| TRUST01.3 | Sue Smith | Paul Jones | Undertake review and refresh of the Trust Integrated Performance Report to improve the Board's oversight and review of key performance issues and to reduce duplication of reporting at Board, Assurance Committee and Care Group levels. | Initial Meeting Held on 21/05/2019.<br>Agreed that full review and refresh will take time and that 2019/20 will require a transitional IPR process and reports with an aim of delivering the new IPR in financial year 2020/21.<br>December 2019: Revised IPR approved by the Board in November 2019.<br>January 2020: New IPR is now in use. Action complete.<br>Revised approach to quarterly performance reviews also approved. | IPR report to Board | Revised IPR Format and Process | 31/03/2020 | N/A | N/A | D | NA | Low |
| TRUST01.4 | Sue Smith | Paul Jones | Consider undertaking a secondary external review of the new/updated Governance framework to establish if the required changes have been implemented and have been effective | External Governance review by Deloittes was signed off at Public meeting of the Board. Work streams have been identified which will address CQC areas of concern. Audit committee will have oversight of the key areas of focus and a review will be undertaken in May 2020.<br>July 2020: Following on from the development work with Deliottes, the Board of Directors has agreed to commission further external support to undertake additional work regarding updating the purpose, values and operating models at UHMBT. Action closed. | External Review | External Review | 31/05/2020 | N/A | N/A | D | NA | Low |
| TRUST01.5 | David Wilkinson | Paul Jones | Full review of Fit & Proper Person policy underway in the light of the Kark Report. | Review of the policy will address some of the issues highlighted by the MIAA report. Fit and Proper Persons SOP is being prepared. Findings from the MIAA and CQC have been merged and will be addressed by the policy and the new SOP. Revised SOP agreed. Testing of new system to be undertaken following Medical Director recruitment process. Action now complete. | Revised FPPR Policy | Review of FPPR Policy | 31/07/2019 | N/A | N/A | D | NA | Low |
| TRUST01.6 | David Wilkinson | Paul Jones | MIAA Internal Audit Report of Fit and Proper Persons Requirement. | As per Action Trust 2.5 | MIAA Internal Audit Report of Fit and Proper Persons Requirement. | Revised FPPR process | 31/07/2019 | N/A | N/A | D | NA | Low |
| TRUST01.7 | David Wilkinson | Paul Jones | Implementation of Kark Report and MIAA Auditor Recommendations | As per Action Trust 2.5 | MIAA Internal Audit Report of Fit and Proper Persons Requirement. | Revised FPPR process | 31/07/2019 | N/A | N/A | D | NA | Low |
| TRUST01.8 | Ian Johnson | Paul Jones | Undertake Review of Best Practice for recording of Board Minutes, using and assessment against Cambridge University Hospital Trust (rated as 'Outstanding for 'Well Led' by CQC in April 2019). | Board Minutes format was updated in April 2019 to reflect identified best practice and is now in use. | Trust Board Minutes Format | Updated Trust Board Minutes Format/Process | 20/04/2019 | N/A | N/A | D | NA | Low |
| TRUST01.9 | Ian Johnson | Paul Jones | Include revised format for recording board minutes as part wider Governance review | Completed | Deloittes Governance Review Report | Updated Trust Board Minutes Format/Process | 30/06/2019 | N/A | N/A | D | NA | Low |

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| TRUST01.10 | Ian Johnson | Paul Jones | Chair undertook work with Non-Executive Directors and Council of Governors in 2018 to review the effectiveness and efficiency of current working arrangements. | The Governance Review by Deloitte has made recommendations in respect of the role of Governors and these will be addressed through a development programme for Governors commencing in Autumn 2019. | Governors Development Programme | Development Programme | 01/10/2019 | N/A | N/A | D | NA | Low |
| TRUST01.11 | Ian Johnson | Paul Jones | Chair to consider the scope of additional work with Non-Executive Directors in 2019 to further review the effectiveness and efficiency of current working arrangements. | The Chairman, supported by the Company Secretary has established a meeting of the chair's of the assurance committees. This group will consider how NEDs support the governor framework.<br>December 2019: Review of Terms of Reference of the Assurance Committees is underway.<br>January 2020: New Chairman is working with the Company Secretary to review Assurance Committee structure for 2020/21.<br>july 2020: New structure for Board approval in July 2020. Action complete. | Minutes of Meeting of Assurance Chairs | Minutes from Chair's meeting | 31/05/2020 | N/A | N/A | D | NA | Low |
| TRUST01.12 | Ian Johnson | Paul Jones | Discussion with external provider regarding training and development of Council of Governors, which may also include a review of the effectiveness of the Council of Governors | A workshop facilitated by an external provider has been undertaken and will help take forward the findings of the Governance Review. No further progress has been made as yet due to Governor elections. Further work will be undertaken when the new Chairman is appointed.<br>December 2019: Through NHS Providers joint work with Neighbouring Trusts is being investigated. Ongoing as at March 2020.<br>July 2020: New joint working arrangements with neigbouring Trusts now established. Complete. | Workshop records. | Development Programme | 31/05/2020 | N/A | N/A | D | NA | Low |
| TRUST01.13 | Ian Johnson | Paul Jones | Revised Governor to Non-Exec Director scrutiny process to be reviewed as part of wider Governance review. | January 2020: New Chairman has requested a review of the working arrangements for the Council of Governors including processes for Governors holding Non-executive Directors to account.<br>July 2020: Following review of working arrangements, increased attendance of NEDs at Governor working groups to report on progress within the Trust. Action complete. | Deloittes Governance Review Report | Deloittes External Governance Review | 31/05/2020 | N/A | N/A | D | NA | Low |
| TRUST01.14 | Sue Smith | Paul Jones | Undertake a review of BAF and Corporate Risk Register | Review Underway to be completed end of Q1 2019/20. Feedback from Q1 review and the External Governance Review will be used to make further revisions for Q2 review . A Risk Development Session has been held with TMB. | Review Document | | 31/07/2019 | N/A | N/A | D | NA | Low |
| TRUST01.15 | Mike Thomas | Paul Jones | Record of decisions taken by Chair and CEO | Record of decisions taken by Chair and CEO added to Trust Public Board Minutes. | Public Board Minutes | Record of decisions taken by Chair and CEO included in Public Board Minutes | 30/06/2020 | N/A | N/A | D | NA | Low |
| TRUST01.16 | Mike Thomas | Paul Jones | BAF, Corporate Risk Register and Risk Management Strategy to be reviewed as part of Wider Governance review. | A revised BAF has been approved by Board and a new Risk Management Strategy is being prepared. This is scheduled for the Board in January 2020.<br>January 2020: a report was submitted to the Audit Committee on a revised approach to Risk Management which was endorsed and will form the basis of the revised strategy to be approved and implemented by the end of March 2020.<br>This has been delayed until July 2020 due to COVID.<br>July 2020: Review of Risk Management Strategy underway.<br>December 2020: The Trust has established an executive Risk Oversight Group and the Good Governance Institute diagnostic will help shape the Trusts approach to risk. Revise date for completion is March 2021 | Deloittes Governance Review Report | Revised BAF<br>Trust Board minutes | 31/03/2021 | N/A | N/A | OT | NA | Low |
| TRUST01.17 | Mike Thomas | Paul Jones | Review the Trust Committee structure (inc. Board Assurance Committee and Care Group Committees) and ensure alignment of structure and of Terms of Refernce to ensure greater assurance to Assurance Committees and Trust Board and to prevent/reduce overlap of responsibilities and reporting. | Review underway led by Trust Board Administrator and Quality and Service Development Manager.<br>September 2020: Initial review, delayed by COVID, now completed, outline Committee Structure established for; Trust Board, Audit Committee, Finance Committee, Quality Committee, Workforce Committee, Medicine Care Group, Surgery Care Group, WACs Care Group, Community Care Group, Core Clinical Services Care Group.<br><br>26 Sub-Committee / Meetings to be added to Structure.<br>54 Terms of Reference still to be reviewed/aligned - Trust Board Administrator working with Trust Procedural Document Team to ensure ToR's are fast tracked through Trust document approval process | Trust Procedural Document Library | Trust Committee Structure in Trust Procedural Document CORP/TOR/001 | 31/03/2021 | N/A | N/A | OT | NA | Low |

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| TRUST01.18 | Mike Thomas | Paul Jones | Appoint Good Governance Instustute to undertake Review of Governance issues identified in Initial report/Feedback from Niche Consulting investigation into Urology Services | Good Governance Instustute appointed, initial meetings being scheduled. The GGI will undertake a review of our governance structures and processes across the Trust, alongside delivery of a supported improvement programme.The purpose of the review is for GGI to provide a clear, independent and unbiased view of how our governance system is adding value to the Trust, and to support us to identify any gaps and inform practical solutions as to how these can be addressed. There will be two overlapping phases to this work, which will take place over a period of six months. The first phase is comprehensive governance review to be completed in Q3; and the second, a targeted development programme to secure better governance and assurance, to be completed in Q4. The scope of work will include a series of interviews, meeting observations, documentation collection and focus groups, which will therefore inform areas for improvement<br>November 2020: Phase 1 now completed and Phase 2 underway. This will involve a review of the evidence collection and outcomes of the Phase 1 activities and associated KLOEs. Initial feedback has been positive. | Good Governance Instustute Review | Good Governance Instustute Review documents | 31/03/2021 | N/A | N/A | OT | NA | Low |

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| **Recommendation Ref. No.:** | **TRUST02** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **EFFECTIVE** |
| **CQC Service Name:** | **Corporate Services** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Workforce** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMB Theme:** | **Staff Appraisal** |
| **CQC Recommendation:** | The trust should ensure that all staff have received an annual appraisal and the overall rate of appraisals are brought in line with the trust target |
| **Story behind the Recommendation:** | Appraisal rates were reported and monitored at the workforce assurance committee and each care group had responsibility for addressing gaps in their appraisal rates with action plans being discussed monthly at performance review meetings and senior operational meetings. The people information report, July 2018, presented to the trust board, identified that only 76% of staff were up to date with their annual appraisal, which was much lower than the trust target of 95%. This equated to 1261 staff being non-compliant with their annual appraisal. The workforce assurance committee had prioritised improving appraisal completion rates for managers of staff at band 8a and above as well as staff who had never received an appraisal. This had resulted in no staff employed at the trust who had never had an appraisal and a 91% of management appraisal rate, which remained under the trust target. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | Staff are supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal.<br>Where relevant, staff are supported through the process of revalidation.<br>There is a clear and appropriate approach for supporting and managing staff when their performance is poor or variable. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Achive Appraisal Target by March 2021 |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust02.01 | David Wilkinson | Matthew France | Staff Appraisal Timetable Developed and Implemented: Leadership (Band 8A and above) - April to June<br>Band 1 to 7 - on Anniversary of staff members start date | 98% Leadership appraisals (8a & above) were completed by 30th June 2019. This means that all future appraisals will fall in Q1 2020/21.<br>Action complete | TMS | | 01/04/2019 | | | D | NA | Low |
| Trust02.02 | David Wilkinson | Matthew France | Achieving Trust Wide Staff Appraisal rates of 95%.<br><br>'Live' Performance Data is reported on the Workforce Dashboard.<br><br>Performance is reported monthly in the People Information report, which is reported as part of the monthly Integrated Performance Report and is also reported to the Workforce Assurance Committee. | Appraisal rates are split by Leadership appraisal and Band 1-7. This is reported through the two actions below. | TMS | Achieving Trust Wide Staff Appraisal rates of 95%. | 31/03/2020 | 95% | | NA | NA | Medium |
| Trust02.03 | David Wilkinson | Matthew France | 2019/20 Achieving Trust Wide Staff Appraisal rates of 95% - Bands 1-7 & Bands 8a+ (No line management responsibility) | July 2019 - 85%<br>August 2019 - 84%<br>September 2019 - 87%<br>October 2019 - 86%<br>November 2019 - 86%<br>December 2019 - 85%<br>January 2020 - 85%<br>February 2020 - 84%<br>March 2020 - 83%<br><br>Target remains at 95% average across care groups. Range is currently 80% to 99% | TMS | Achieving Trust Wide Staff Appraisal rates of 95%. | 31/03/2020 | 95% | 83% | D | NTMA | Medium |
| Trust02.04 | David Wilkinson | Matthew France | 2019/20 Achieving Trust Wide Staff Appraisal rates of 95% - Bands 8a+ (With line management responsibility) | Achieved- this metric will remain compliant until June 31st 2020 | TMS | Achieving Trust Wide Staff Appraisal rates of 95%. | 31/03/2020 | 95% | 98% | D | OT | Low |
| Trust02.05 | David Wilkinson | Matthew France | 2019/20 Achieving Trust Wide Staff Appraisal rates of 95% - Medical Staff | Apr 2019 - 91%<br>May 2019 - 91%<br>June 2019 - 88%<br>July 2019 - 88%<br>August 2019 - 90%<br>September 2019 - 89%<br>October 2019 - 90%<br>November 2019 - 90%<br>December 2019 - 84%<br>January 2020 - 84%<br>February 2020 - 82%<br>March 2020 | TMS | Achieving Trust Wide Staff Appraisal rates of 95%. | 31/03/2020 | 95% | 82% | D | NTMA | Medium |
| Trust02.06 | David Wilkinson | I3 | Develop and Implement a 'Managers Portal' on TMS (Training Management System) to enable managers to see an overview of all their staff providing information on training and appraisal goal compliance, to help early identification of potential non compliance. | Portal completed and made operational on 15/10/2019. Additional functionality also includes a 'meeting log' tab for documenting details of one-to-one meetings held throughout the year around feedback, issues raised and actions identified. | TMS | Manager Portal Operational | 31/10/2019 | N/A | N/A | D | NA | Low |

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| Trust02.07 | David Wilkinson | I3 | I3 to develop an automated link from ESR to TMS to ensure staff records (starters, leavers, maternity etc.) in TMS are accurate and up to date to reduce the level of 'false negative' appraisal records in TMS | Draft Trust Leadership Competency Framework presented at Workforce Committee.<br>September 2020: This is not happening at the moment as this also affects the finance ledger and how things are coded in ESR. MF linking with LH - ask MF for update once back from leave. | | ESR-TMS Link | 31/07/2020 | N/A | N/A | OT | NA | Low |
| Trust02.08 | David Wilkinson | Andrea Willimott | Governance Team to undertake a Review of Trust Recommendations and Use of Resource findings to identify Action plans that can be integrated into the existing Work plans of the Workforce Committee or one of its sub Committees for ongoing monitoring and reporting to aviod unecessary duplication of monitoring and reporting. | Trust Recommendation Trust 7 identified for potential closure. To be monitored/reported at Care Group Performance Reviews and at Workforce Committee.<br>Closure request submitted to July Workforce meeting | CQC Improvement Plan Paper to Workforce Committee | Review Completed | 31/07/2020 | N/A | N/A | D | NA | Low |
| Trust02.09 | David Wilkinson | Matthew France | 2020/21 Achieving Trust Wide Staff Appraisal rates of 80% - Bands 1-7 & Bands 8a+ (No line management responsibility) | All Appraisal activity suspended during Apr-Jun due to COVID This metric will remain compliant until June 2020.<br>2020/21 Post COVID plan to complete all Band 8 appraisal by 30th September<br>Anyone who wants a full appraisal can, however the requirement is for a COVID appraisal. These are to be completed by the end of March 2021.<br>September 2020: COVID check-in appraisal introduced. All appraisals are due to be completed by the end of March 2021. This is being reported via WAC.<br>October 2020: 71%<br><br>October 2020: COVID-19 Check-in Appraisal introduced, to be complete by end March 2021.<br>Delivery is on target to meet this trajectory, with 2818 completed and 1412 started. There is always a reporting lag as "completion"requires electronic sign-off by the appraiser and appraise. The Feedack is now being analysed.<br>Most positive response has been from colleagues in Integrated Community Services (67%). Estates and Facilities having the lowest (51%).<br>Most positive comments were about the way the organisation communicated with staff and, in particular, the daily e-mails.<br>Negative responses were low (12% overall) with Surgery & Critical Care having the most negative responses (17%) and Core Clinical the lowest (5%). Communication and the perceived lack of PPE were raised as the issues of concern. | TMS | Achieving Trust Wide Staff Appraisal rate | 31/03/2021 | | | OT | | Medium |
| Trust02.10 | David Wilkinson | Matthew France | 2020/21 Achieving Trust Wide Staff Appraisal rates of 95% - Bands 8a+ (With line management responsibility) | All Appraisal activity suspended during Apr-Jun due to COVID. Medics can have a full appraisal if they wish, however for the time being, they only need to have a 'wellbeing conversation' which can be recorded on TMS and used as evidence in their full appraisal at a later date.<br><br>September 2020: COVID check-in appraisal introduced. All appraisals are due to be completed by the end of March 2021. This is being reported via WAC.<br>October 2020: 45%<br><br>October 2020: COVID-19 Check-in Appraisal introduced, to be complete by end March 2021.<br>Delivery is on target to meet this trajectory, with 2818 completed and 1412 started. There is always a reporting lag as "completion"requires electronic sign-off by the appraiser and appraise. The Feedack is now being analysed.<br>Most positive response has been from colleagues in Integrated Community Services (67%). Estates and Facilities having the lowest (51%).<br>Most positive comments were about the way the organisation communicated with staff and, in particular, the daily e-mails.<br>Negative responses were low (12% overall) with Surgery & Critical Care having the most negative responses (17%) and Core Clinical the lowest (5%). Communication and the perceived lack of PPE were raised as the issues of concern. | TMS | Achieving Trust Wide Staff Appraisal rate | 30/09/2020 | | | OT | OT | Low |

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| Trust02.11 | David Wilkinson | Matthew France | 2020/21 Achieving Trust Wide Staff Appraisal rates of 95% - Medical Staff | All Appraisal activity suspended during Apr-Jun due to COVID. Medics can have a full appraisal if they wish, however for the time being, they only need to have a 'wellbeing conversation' which can be recorded on TMS and used as evidence in their full appraisal at a later date.<br><br>September 2020: COVID check-in appraisal introduced. All appraisals are due to be completed by the end of March 2021. This is being reported via WAC.<br>October 2020: 60%<br><br>October 2020: COVID-19 Check-in Appraisal introduced, to be complete by end March 2021.<br>Delivery is on target to meet this trajectory, with 2818 completed and 1412 started. There is always a reporting lag as "completion"requires electronic sign-off by the appraiser and appraise. The Feedack is now being analysed.<br>Most positive response has been from colleagues in Integrated Community Services (67%). Estates and Facilities having the lowest (51%).<br>Most positive comments were about the way the organisation communicated with staff and, in particular, the daily e-mails. Negative responses were low (12% overall) with Surgery & Critical Care having the most negative responses (17%) and Core Clinical the lowest (5%). Communication and the perceived lack of PPE were raised as the issues of concern. | TMS | Achieving Trust Wide Staff Appraisal rate | 31/03/2021 | | | OT | | Medium |

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| **Recommendation Ref. No.:** | **TRUST03** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **SAFE** |
| **CQC Service Name:** | **Corporate Services** |
| **Must or Should Action / UoR Finding:** | **TRUST WIDE PRE-EMPTIVE ACTION** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Trust Wide** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMB Theme:** | **Staff Recruitment/Deployment** |
| **CQC Recommendation:** | The Trust will take Action to help improve in the following Areas:<br>Staffing levels and skill mix are planned, implemented and reviewed to keep people safe at all times.<br>Any staff shortages are responded to quickly and adequately.<br>Where relevant, there are effective handovers and shift changes to ensure that staff can manage risks to people who use services. |
| **Story behind the Recommendation:** | This Recommendation has been created to enable a Trust Wide response to the issues identified in a number of Care Group Recommendations related to Staff Recruitment and Deployment. |
| **What the CQC expect 'Good' to look like:<br>(Taken from relevant KLOE definition)** | Staffing levels and skill mix are planned, implemented and reviewed to keep people safe at all times.<br>Any staff shortages are responded to quickly and adequately.<br>Where relevant, there are effective handovers and shift changes to ensure that staff can manage risks to people who use services.<br>Staff recognise and respond appropriately to changes in the risks to people who use services.<br>Risks to safety from changes or developments to services are assessed, planned for and managed effectively. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Achieve Staff Recruitment/Rentention Target by March 2021 |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| Trust03.01 | David Wilkinson | Lynn Hadwin | Recruitment is managed through Profession based Work streams (Medical, Nursing, AHP Etc.) by a member of the relevant Clinical Leadership Team. | Live' Performance Data is reported on the Workforce Dashboard.<br><br>Performance is reported monthly in the People Information report, which is reported as part of the monthly Integrated Performance Report and is also reported to the Workforce Assurance Committee on a bi-monthly Basis. | N/A | N/A | | N/A | N/A | NA | NA | Medium |
| Trust03.02 | David Wilkinson | Lynn Hadwin | Achieve Target Vacancy for Consultant Medical Staff | Monthly Vacancy Rate Performance:<br>Jan 2019: 12.30%<br>Feb 2019: 11.70%<br>Mar 2019: 10.20%<br>April 2019: 10.27%<br>May 2019: 11.73%<br>June 2019: 11.93%<br>July 2019: 12.90%<br>August 2019: 11.70%<br>September 2019: 12.90%<br>October 2019: 12.70%<br>November: 2019: 11.2%<br>December 2019: 10.8%<br>January 2020: 12.7%<br>February 2020: 11.1%<br>March 2020: 10.74% | ESR | Reduction in Vacancy rate | 31/03/2020 | 5% | 10.74% | NTMI | NTMI | Medium |
| Trust03.03 | David Wilkinson | Lynn Hadwin | Achieve Target Vacancy for Registered Nurses | Monthly Vacancy Rate Performance:<br>Jan 2019: 7.90%<br>Feb 2019: 7.90%<br>Mar 2019: 8.20%<br>April 2019: 8.19%<br>May 2019: 8.02%<br>June 2019: 8.90%<br>July 2019: 8.63%<br>August 2019: 8.60%<br>September 2019: 7.30%<br>October 2019: 7.0%<br>November 2019: 6.0%<br>December 2019: 5.4%<br>January 2020: 5.5%<br>February 2020: 4.9%<br>March 2020: 4.64% | ESR | Reduction in Vacancy rate | 31/03/2020 | 5% | 5% | D | D | Medium |
| Trust03.04 | David Wilkinson | Lynn Hadwin | Achieve Target Vacancy for Registered Midwives | Monthly Vacancy Rate Performance:<br>Jan 2019: 10.10%<br>Feb 2019: 9.70%<br>Mar 2019: 12.20%<br>April 2019: 11.71%<br>May 2019: 11.95%<br>June 2019: 10.90%<br>July 2019: 10.85%<br>August 2019: 11.30%<br>September 2019: 11.70%<br>October 2019: 6.1%<br>November 2019: 5.7%<br>December 2019: 5.1%<br>January 2020: 4.2%<br>February 2020: 5.2%<br>March 2020: 5.33% | ESR | Reduction in Vacancy rate | 31/03/2020 | 5% | 5% | OT | OT | Medium |
| Trust03.05 | Shahedal Bari | Shahedal Bari | Medical Director to undertake Deep Dive Analysis of Medical Staffing Expenditure to identify potential cross cutting opportunities to improve productivity where a standardisation of practices across the organisation could have an impact on improved productivity within medical staffing as part of an organisational wide approach. | Paper presented to Executive Director Group and Cost Control Board on 11/06/2019. | Paper presented to Executive Director Group and Cost Control Board on 11/06/2019 | | 11/06/2019 | N/A | N/A | D | NA | Low |

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| Trust03.06 | Shahedal Bari | Shahedal Bari | Medical Director's Deep Dive Analysis of Medical Staffing Expenditure identified a number of 'Hot Spots' of Medical Locum Use within the Care Groups.<br>The Medical Directors and Deputy Medical Directors will now undertake scoping exercises with Care Group Clinical Directors and Clinical Leads to:<br>- Identify areas where locum use and spend can decreased<br>- Identify where additional recruitment can be undertaken<br>- Undertake audit of job plans to better utilise PA's<br>- Review of SLA's with wider system partners in support of aligning the agreed staffing resources and activity match<br>- Review sickness absence reporting across all care groups with a focus on short term, short notice absences to ensure accurate reflection of staff absences and reasons | All actions are underway and ongoing, Progress will be reported through Trust Recommendation UoR5. | Trust Recommendation UoR5 | Deep Dive completed | 31/03/2020 | N/A | N/A | D | NA | Medium |
| Trust03.07 | Shahedal Bari | Shahedal Bari | Medical Recruitment strategy to recruit an additional 211 RN during 2019/20 to reduce residual RN vacancy rate to 5%. | 2018/19 Recruited - 161.87 WTE<br><br>2019/20 Target - 14 WTE<br>2019/20 Recruited: 14 WTE<br>2019/20 Firm Forecast: 6WTE<br>2019/20 Firm Forecast Year End: 20 WTE<br><br>Final Recruitment Position on 31/03/2020: 212.42 WTE | ESR | Recruit 20 WTE | 31/03/2020 | 20 | 14 | OT | OT | Medium |
| Trust03.08 | Sue Smith | Joann Morse | Nurse Recruitment strategy to recruit an additional 211 RN during 2019/20 to reduce residual RN vacancy rate to 5%. | 2018/19 Recruited - 161.87 WTE<br><br>2019/20 Target - 211 WTE<br>2019/20 Recruited: 150.21 WTE<br>2019/20 Firm Forecast: 52.67WTE<br>2019/20 Firm Forecast Year End: 202.88 WTE<br><br>Recruitment on going current figures as of 20/11/19 are:<br>160.41 wte in post<br>42.83 wte with booked start dates<br>7.27 wte awaiting checks<br>Total = 210.57 (99.7% of target) | ESR | Recruit 211 WTE RN's | 31/03/2020 | 211 | 212.42 | D | D | Medium |
| Trust03.09 | Sue Smith | Joann Morse | Continue to utilise a 'hotspot' and the workforce heat map report which aggregates vacancies, long term sickness and maternity leave for any department, to target these areas with the additional RN staff recruited, whilst taking into consideration candidates preferences for placement.<br><br>This is reviewed by the senior nursing leadership team at the Executive Chief Nurse (ECN) forum monthly. | Ongoing Review Process, no specific target date.<br><br>Areas with less than 85% staff availability:<br>Apr 2019 - 48 Areas<br>Oct 2019 - 23 Areas<br>Nov 2019 - 14 areas (under 90%)<br>Dec 2019 - 12 areas<br>Feb 2020 - 9 areas<br>March 2020 16 Areas (partial Impact from COVID)<br><br>67% reduction during 2019/20. | Workforce Committee People Information Report | Ongoing monitoring of Hot Spots | 31/03/2020 | N/A | N/A | D | NA | Low |
| Trust03.10 | Sue Smith | Joann Morse | Continue to develop our 'Grow our Own' policy working collaboratively with the HEI who have established a number of Apprentice programmes for HCSW, Trainee Nursing Associates and RN. | Nursing Associate Apprenticeship scheme launched.<br><br>June 2020: This has been paused due to COVID, Waiting for univerisities to return to their 'new normal' and looking how to reduce cost pressure. | Workforce Committee People Information Report | | 31/03/2020 | N/A | N/A | D | NA | Low |
| Trust03.11 | Sue Smith | Joann Morse | Continue to develop our 'Return to Practice' for RN's, across the organisation in hospital community and primary care | There are not any specific targets for recruitment via 'Return to Practice', so no KPI to monitor. Ongoing. | | | 31/03/2020 | N/A | N/A | D | NA | Low |
| Trust03.12 | Sue Smith | Tony Crick | AHP Professional Lead to scope a Deep Dive Analysis of AHP Staffing Expenditure to identify potential cross cutting opportunities to improve productivity where a standardisation of practices across the organisation could have an impact on improved productivity within medical staffing as part of an organisational wide approach. | The deep dive is currently ongoing and has identified a number of areas of potential improvement, progress will be reported through Trust Recommendation UoR4 | Trust Recommendation UoR4 | Deep Dive completed | 31/03/2020 | N/A | N/A | D | NA | Medium |
| Trust03.13 | David Wilkinson | Andrea Willimott | Governance Team to undertake a Review of Trust Recommendations and Use of Resource findings to identify Action plans that can be integrated into the existing Work plans of the Workforce Committee or one of its sub Committees for ongoing monitoring and reporting to aviod unecessary duplication of monitoring and reporting. | Trust Recommendation Trust 10 identified for potential closure.<br>To be monitored/reported at Care Group Performance Reviews and at Workforce Committee.<br>Closure request submitted to July Workforce meeting | CQC Improvement Plan Paper to Workforce Committee | Review Completed | 31/07/2020 | N/A | N/A | D | NA | Low |
| Trust03.14 | David Wilkinson | Lynn Hadwin | Achieve 2020/21 Target Vacancy for Consultant Medical Staff | Monthly Vacancy Rate Performance:<br>August 2020: 13.0%<br>September 2020: 12.8%<br>October 2020: 11.8%<br>November 2020: 11.6%<br>December 2020: %<br>January 2021: %<br>February 2021: %<br>March 2021: %<br><br>December 2020: Consultant vacancy levels are now 11.6% (down from 0.2% last month) with the SAS Doctor vacancy levels at 7.9% (down from 0.1% last month). | ESR | Reduction in Vacancy rate | 31/03/2021 | 5% | 13.0% | OT | NTMA | Medium |

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| Trust03.15 | David Wilkinson | Lynn Hadwin | Achieve 2020/21 Target Vacancy for Non-Consultant Medical Staff<br>Higher Grades, Junior Grades, SAS Grades | Monthly Vacancy Rate Performance:<br>August 2020: 5.3%<br>September 2020: 6.0%<br>October 2020: 4.4%<br>November 2020: 5.1%<br>December 2020: %<br>January 2021: %<br>February 2021: %<br>March 2021: % | ESR | Reduction in Vacancy rate | 31/03/2021 | 5% | 0.3% | OT | OT | Low |
| Trust03.16 | David Wilkinson | Lynn Hadwin | Achieve 2020/21 Target Vacancy for Registered Nurses | Monthly Vacancy Rate Performance:<br>August 2020: 5.8%<br>September 2020: 4.8%<br>October 2020: 4.3%<br>November 2020: 3.1%<br>December 2020: %<br>January 2021: %<br>February 2021: %<br>March 2021: %<br><br>October 2020: Recruitment has remained strong this month in all areas of clinical recruitment, with the end-of-year target for nurse recruitment surpassed and further appointments to longstanding Consultant vacancies.<br><br>The Trust has now recruited 197.6 WTE registered nurses this year against a target of 188 WTE (based on vacancies, turnover and predicted absence in March).<br>Of these:<br>• 118.7 WTE have started in post<br>• 63.8 WTE have a start date booked (including 56 international nurses)<br>• 15.0 WTE are progressing through pre-employment checks and clearances<br><br>The latest projection, based on agreed/expected start dates, projects that 180 WTE nurses will have commenced by the end of January<br>2021.<br><br>International nurse recruitment remains a key area of focus, with the figures set out above including 2 further cohorts set to join before Christmas, with 14 arriving on 12 November and 22 on 30th November, with a further cohort of 20 nurses planned for January 2021.<br>The Trust has been successful in obtaining funding support through NHSEi for international nurses. An allocation of £90k has been received to enable wrap-around care & infrastructure support (pastoral, technical IT for remote working through quarantining and educational). The outcome of a second bid is awaited.<br>The impact of the recruitment success is an overall nurse vacancy rate of 4.4%, an improvement from 4.9% last month. This continued downward trend will enable additional support during winter and COVID wave 2. | ESR | Reduction in Vacancy rate | 31/03/2021 | 5% | 5.8% | OT | OT | Medium |
| Trust03.17 | David Wilkinson | Lynn Hadwin | Achieve 2020/21 Target Vacancy for Registered Midwives | Monthly Vacancy Rate Performance:<br>August 2020: 5.2%<br>September 2020: 6.2%<br>October 2020: 5.2%<br>November 2020: 5.4%<br>December 2020: %<br>January 2021: %<br>February 2021: %<br>March 2021: % | ESR | Reduction in Vacancy rate | 31/03/2021 | 5% | 5.2% | OT | OT | Medium |
| Trust03.18 | David Wilkinson | Lynn Hadwin | Achieve 2020/21 Target Vacancy for AHP's | Monthly Vacancy Rate Performance:<br>August 2020: 1.5%<br>September 2020:.2.1%<br>October 2020: 1.6%<br>November 2020: -0.8%<br>December 2020: %<br>January 2021: %<br>February 2021: %<br>March 2021: % | ESR | Reduction in Vacancy rate | 31/03/2021 | 5% | -0.8% | OT | OT | Low |

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| **Recommendation Ref. No.:** | **TRUST04** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **EFFECTIVE** |
| **CQC Service Name:** | **Corporate Services** |
| **Must or Should Action / UoR Finding:** | **TRUST WIDE PRE-EMPTIVE ACTION** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Trust Wide** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMB Theme:** | **Staff Training** |
| **CQC Recommendation:** | The Trust will take Action to help improve in the following Areas:<br>All staff are qualified and have the skills they need to carry out their roles effectively and in line with best practice.<br>The learning needs of staff are identified and training is provided to meet these needs.<br>Staff are supported to maintain and further develop their professional skills and experience. |
| **Story behind the Recommendation:** | This Recommendation has been created to enable a Trust Wide response to the issues identified in a number of Care Group Recommendations related to Staff Development & Training. |
| **What the CQC expect 'Good' to look like:<br>(Taken from relevant KLOE definition)** | All staff, including volunteers, are qualified and have the skills they need to carry out their roles effectively and in line with best practice.<br>The learning needs of staff are identified and training is provided to meet these needs.<br>Staff are supported to maintain and further develop their professional skills and experience. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Achieve Staff Core Skill Framework (Mandatory Training) Target by March 2021 |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust04.01 | David Wilkinson | Matthew France | Achievement of Trust Target of 95% compliance in the 8 NHS Core Skills Framework (Mandatory Training):<br>- Equality, Diversity & Inclusion<br>- Fire Safety (General and Departmental)<br>- Information Governance<br>- Infection Prevention and Control<br>- Health & Safety<br>- Manual Handling (Module A & B)<br>- Safeguarding Adults (Level 1)<br>- Safeguarding Children (Level 1) | Live' Performance Data is reported on the Workforce Dashboard.<br><br>Performance is reported monthly in the People Information report, which is reported as part of the monthly Integrated Performance Report and is also reported to the Workforce Assurance Committee.<br><br>July 2020: a 6 month CSF extension was implemented in March due to COVID. This is likely to be extended. At the end of June 2020, 90% of colleagues were 100% compliant with their CSF training. However, it is acknowledged that this is likely due to the extension to compliance rates.<br><br>For October, using the previous metric, compliance is at 96% or higher for all topics with the exception of:<br>Fire Safety (General and Departmental): 93%<br>Safeguarding Adults Level 2: 91%<br>Safeguarding Children Level 3: 82%<br><br>CSF compliance levels remain high at both an individual course element level and against the percentage of colleagues 100% compliant.<br>There has been a slight deterioration in month with the principal reason non-compliance with Departmental Fire Training.<br>A review of the course requirements with the Subject Matter Expert has identified that colleagues wholly working from home falls outside of the scope of the programme so can be removed until they return to the workplace. This is being worked through any individual identified will have a replacement learning based on fire safety in the home.<br><br>Compliance with Safeguarding level 1 & 2 and MCA/DoLS is largely positive and shows an improved picture from last month – however,<br>Safeguarding Level 3 remains a cause of concern.<br>The compliance levels will be escalated through the Workforce Assurance and Quality Committees in November – whilst COVID is a factor, preventing face-to-face training, Care Groups will need to provide assurance to the Committees that associated risks are | TMS | Achieve 95% Compliance | 31/03/2020 | 95% | N/A | OT | NA | Medium |
| Trust04.02 | David Wilkinson | Matthew France | Achieving Trust Wide NHS Core Skills training compliance rates of 95% - Equality, Diversity & Inclusion | June 2020: 99%<br>Compliance rates have been consistently over the 95%. Action closed. | TMS | Achieve 95% Compliance | 31/03/2020 | 95% | 98.00% | D | D | Medium |
| Trust04.03 | David Wilkinson | Matthew France | Achieving Trust Wide NHS Core Skills training compliance rates of 95% - Fire Safety (General and Departmental) | June 2020: 96% | TMS | Achieve 95% Compliance | 31/03/2020 | 95% | 93% | D | D | Medium |
| Trust04.04 | David Wilkinson | Matthew France | Achieving Trust Wide NHS Core Skills training compliance rates of 95% - Information Governance | June 2020: 98% | TMS | Achieve 95% Compliance | 31/03/2020 | 95% | 95% | D | D | Medium |
| Trust04.05 | David Wilkinson | Matthew France | Achieving Trust Wide NHS Core Skills training compliance rates of 95% - Infection Prevention and Control | June 2020: 99% | TMS | Achieve 95% Compliance | 31/03/2020 | 95% | 97% | D | D | Medium |
| Trust04.06 | David Wilkinson | Matthew France | Achieving Trust Wide NHS Core Skills training compliance rates of 95% - Health & Safety | June 2020: 96% | TMS | Achieve 95% Compliance | 31/03/2020 | 95% | 94% | D | D | Medium |
| Trust04.07 | David Wilkinson | Matthew France | Achieving Trust Wide NHS Core Skills training compliance rates of 95% - Manual Handling (Module A & B) | June 2020: 99% | TMS | Achieve 95% Compliance | 31/03/2020 | 95% | 96% | D | D | Medium |
| Trust04.08 | David Wilkinson | Matthew France | Achieving Trust Wide NHS Core Skills training compliance rates of 95% - Safeguarding Adults (Level 1) | June 2020: 99% | TMS | Achieve 95% Compliance | 31/03/2020 | 95% | 97% | D | D | Medium |
| Trust04.09 | David Wilkinson | Matthew France | Achieving Trust Wide NHS Core Skills training compliance rates of 95% - Safeguarding Children (Level 1) | June 2020: 99% | TMS | Achieve 95% Compliance | 31/03/2020 | 95% | 96% | D | D | Medium |

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| Trust04.10 | David Wilkinson | Kate Casey | The Trust Mandatory Training (NHS Core Skills) Training Policy (CORP-POL-10) defines how the Trust delivers training that is compliant with NHS Core Skills Framework and resolves areas of Non-compliance.<br><br>The Policy is recorded on the Trust Procedural Document Library and is due for review and re-approval no later than 01/04/2020.<br><br>The Trust Policy CORP-POL-10 does not encompass 'Job Essential Training' such as; Basic Life Support, Deprivation of Liberty Safeguards, Mental Capacity Act, Mental Health Act, Safeguarding Level 2 and Level 3.<br><br>The Trust Policy CORP-POL-10 does not encompass 'Clinical Skills Training' such as; acute non-invasive ventilation (NIV), or Emergency Paediatric Nursing | Initial review of Policy to commence in Quarter 3 2019/20<br><br>December 2019: Review of Essential Skills training is now complete. Review of the policy will begin in Q4.<br><br>May 2020: Action owner changed to Kate Casey - MF to pick up with Kate<br><br>KC to send LR update of action wording and progress update | Trust Procedural Document Library | Updated Trust Policy | 30/06/2020 | N/A | N/A | OT | NA | Medium |
| Trust04.11 | David Wilkinson | Matthew France | Work with the relevant Specialist Teams to develop a training matrix that encompasses the Trust requirements to; set standards for, define record keeping requirements, and deliver and monitor compliance with the 'Job Essential Training' that is required for Trust Staff. | The action has been re-worded to implement a training matrix - MF to update once back from leave. Work is underway with the clinical care groups. | Trust Procedural Document Library | Implement a Trust Policy | 01/04/2020 | N/A | N/A | OT | NA | Medium |
| Trust04.13 | David Wilkinson | Matthew France | Work with the TMS Coordinators / Practice Educators to cleanse the Trust Training Management System (TMS) of staff who have been incorrectly recorded as requiring 'Job Essential Training/Clinical Skills' that is not directly relevant to their Role. | September 2020: Delayed due to difficulty in establishing TMS / ESR link | TMS | | 31/03/2020 | N/A | N/A | OT | NA | Medium |
| Trust04.15 | David Wilkinson | Matthew France | Work with the relevant Care Groups (to identify which 'Job Essential Training/Clinical Skills' is of 'Trust level relevance' and as such should be included in the Trust People Information Report. | Contingent on results of 'job essential' training review. - still in progress - require update from MF. Delayed due to difficulty in establishing TMS / ESR link | | Revised Trust People Information Report. | 31/03/2020 | N/A | N/A | OT | NA | Medium |
| Trust04.17 | David Wilkinson | Andrea Willimott | Governance Team to undertake a Review of Trust Recommendations and Use of Resource findings to identify Action plans that can be integrated into the existing Work plans of the Workforce Committee or one of its sub Committees for ongoing monitoring and reporting to aviod unecessary duplication of monitoring and reporting. | Trust Recommendation Trust 11 identified for potential closure.<br>To be monitored/reported at Care Group Performance Reviews and at Workforce Committee.<br>Closure request submitted to July Workforce meeting | CQC Improvement Plan Paper to Workforce Committee | Review Completed | 31/07/2020 | N/A | N/A | OT | NA | Low |

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| **Recommendation Ref. No.:** | **TRUST05** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **SAFE** |
| **CQC Service Name:** | **Corporate Services** |
| **Must or Should Action / UoR Finding:** | **TRUST WIDE PRE-EMPTIVE ACTION** |
| **UHMBT Exec Lead:** | **Shahedal Bari** |
| **UHMBT Care Group:** | **Trust Wide** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Patients** |
| **UHMB Theme:** | **Medication Management & Storage** |
| **CQC Recommendation:** | The Trust will take Action to, ensure that oxygen is always prescribed on the medication administration chart for patients requiring oxygen therapy, as per trust policy. |
| **Story behind the Recommendation:** | This Recommendation has been created to enable a Trust Wide response to the issues identified in a Care Group Recommendation related to Oxygen prescribing and administration. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | Staff meet good practice standards described in relevant national guidance, including in relation to non-prescribed medicines.<br>People receive their medicines as prescribed. The service involves them in regular medicines reviews.<br>Staff manage medicines consistently and safely. Medicines are stored correctly, and disposed of safely. Staff keep accurate records of medicines. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Substantial Improvement in Oxygen Prescribing and Administration rates from Baseline performance established by Audit 2113 |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| Trust05.01 | Shahedal Bari | Mel Waszkiel | Confirm that Oxygen is included in EPMA module of Lorenzo, to enable the electronic tracking of:<br>- Oxygen Prescribing<br>- Oxygen Administration<br><br>And that Oxygen Prescribing and administration is included in Lorenzo EPMA Training | Confirmed with EPR Clinical Lead Mel Waszkiel, Oxygen Prescribing and Administration is included in Lorenzo EPMA Module and Training. | Lorenzo | Confirmation that Oxygen is included in EPMA module of Lorenzo | 15/06/2019 | N/A | N/A | D | NA | Low |
| Trust05.02 | Shahedal Bari | Alison Calvert / Tim Gatherall | Undertake exploratory discussions with relevant Medics to identify best process for ensuring that oxygen is always prescribed for patients requiring oxygen therapy, as per trust policy. | Progress to date:<br>- the FYI has done a spot audit on Ward 37 as part of a QUIP,<br>- devised some O2 alert cards to be displayed on the O2 ports of patients on O2<br>- discuss the possibility of it being introduced to the ward note. Recent discussions at UHMB ePrescribing and Medication Steering Group (5.2.19) to include pharmacists to include O2 in their medicine reconciliation.<br>30th January update on 3rd PDSA cycle: Cycle 3- Intervention- visual alert on front of all patient observation charts<br>7/27 patients on oxygen, all have prescription<br>20/27 patients not on oxygen but 15 of these patients have a prescription. Data shows that nursing colleagues are very good at maintaining target O2 sats when they are prescribed. Results are preliminary but shows that a simple intervention can be effective<br>June 2020: O2 is now being prescribed more regularly. The importance of prescribing 02 continues to be raised with any new doctors and nursing staff. Unclear as to whether the idea of having this as part of the ward note has been taken any further. The visual cues as part of cycle 3 have shown to be an effective method in increasing O2 px. The team are looking at ways to disseminate this information and raise awareness. | | | 31/03/2020 | N/A | N/A | D | NTMI | Low |
| Trust05.03 | Shahedal Bari | Lynne Wyre | Undertake exploratory discussions with relevant Nurses to identify best process for ensuring that oxygen is always Administered for patients requiring oxygen therapy, as per trust policy. | Raised at ECN, picked up on matron's audit and the QAAS visits where this will be monitored. LW suggested that there needs to be a separate audit from QAAS - discuss with SY and pharmacy. | | | 01/12/2019 | N/A | N/A | D | NA | Low |
| Trust05.04 | Shahedal Bari | Carrie Eddy | Pharmacy to add Oxygen prescribing as one of the medicines to clinically verify on review of prescriptions. Training to be provided to Pharmacists to increase skills in this area. | Agree strategy with KM. CE to link with respiratory nurses / physio to arrange pharmacist training.<br><br>August 2020: The respiratory team have done a presentation to do some additional training for ward staff - pharmacy to receive the training also. Waiting to hear back from the resp team. Target date moved to end of September. | | | 30/09/2020 | N/A | N/A | OT | NA | Low |

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| Trust05.05 | Shahedal Bari | Carrie Eddy | Consider undertaking an Audit of Oxygen Prescribing and Oxygen Administration. | Audit 1853 "Oxygen Prescribing Quality Improvement Project 2019-20" registered on Ulysses<br>November 2019: Initial audit has been carried out on Ward 37 at RLI. This has flagged issues that Oxygen is not being prescribed the majority of the time. To be discussed with ES in the Clinical Audit department about adding this to the audit plan. CE to forward results of audit to SBari. December 2019: CE discussed with ES who has agreed to provide ongoing support around this.<br>February 2020: This action is being managed by the respiratory team, outcomes:<br>- Assess the effectiveness of simple measures (visual cues) that were initiated on the respiratory ward to improve the rate of oxygen prescription on Lorenzo<br>- Increase awareness and application of the Guidelines<br>- Produce statistical data for reflection and improvement<br>- The outcome of this project was significant improvement across 3 PDSA cycles for the prescribing of oxygen<br>- A second phase of audits is about to commence, to ensure sustained improvement in this area | | | 31/12/2019 | | | NA | NA | Low |
| Trust05.06 | Shahedal Bari | Lynne Wyre, Robin Proctor | Lynne Wyre and Robin Proctor to implement and oversee an Audit of oxygen prescribing in all areas - Audit to be undertaken by Junior Doctors | Audit 2113 "Corporate Oxygen Prescribing Audit 2020-21" registered on Ulysses.<br>Audit 2113 being managed by Janet Manning - Patient Safety Matron.<br>Data collection now in progress, via My Assure.<br>Junior Doctors yet to be allocated.<br>Trust O2 Champion to be identified and appointed. | Ulysses | Audit Completed | 31/12/2020 | 100% of oxygen Prescriptions and Administrations recorded in Lorenzo | TBC | OT | | Low |
| Trust05.07 | Shahedal Bari | Janet Manning | O2 Prescribing and Administration checklist to be added to MY Assure to enable data collection for Audit 2113 and to provide pro forma checklist for future Assurance checks and/or Audits | O2 Prescribing and Administration checklist added to MY Assure.<br>Can be used to collect data for statistical assessment of performance | My Assure | O2 Prescribing and Administration checklist | 30/09/2020 | N/A | N/A | D | NA | Low |
| Trust05.08 | Shahedal Bari | TBC | Audit 2113 Results and Action Plan to presented to Trust Clinical Audit & Effectiveness Group meeting. | Requires completion of Audit 2113, then scheduling in to Trust Clinical Audit & Effectiveness Group meeting Agenda for January 2020 or March 2020.<br>Presenter also needs to be confirmed. | Trust Clinical Audit & Effectiveness Group meeting Agenda, Papers and Minutes | Audit 2113 Results and Action Plan to presented | 31/03/2021 | N/A | N/A | OT | NA | Low |
| Trust05.09 | Shahedal Bari | Paul Grout/Robin Proctor | The Medical Director and Deputy Medical Director(s) to ensure that all consultants are checking that oxygen has been prescribed. | Progress reported to the Quality Committee in September 2020. DMD advised a cultural change of medics to ensure that oxygen was prescribed is required. | Quality Committee Agenda, Papers and minutes | Assurance that Consultants are encouraging and checking their Juniors are prescribing Oxygen | 31/03/2021 | N/A | N/A | OT | NA | Low |
| Trust05.10 | Shahedal Bari | Paul Grout/Robin Proctor | Include Article on Oxygen Prescribing in Trust Weekly News to help increase awareness of Aoxygen presecribing and administration | Article on Oxygen Prescribing in Trust Weekly News Issue 706 October 2020 | Weekly News Issue 706 Octobert 2020 | Article on Oxygen Prescribing in Trust Weekly News | 31/10/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **TRUST06** |
| **CQC Report:** | **2019 Inspection Report, 2017 Inspection Report** |
| **CQC Domain:** | **SAFE** |
| **CQC Service Name:** | **Corporate Services** |
| **Must or Should Action / UoR Finding:** | **TRUST WIDE PRE-EMPTIVE ACTION** |
| **UHMBT Exec Lead:** | **Shahedal Bari** |
| **UHMBT Care Group:** | **Trust Wide** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Patients** |
| **UHMB Theme:** | **Medication Management & Storage** |
| **CQC Recommendation:** | The Trust will take Action to, ensure that medicines reconciliations are completed within 24 hours. |
| **Story behind the Recommendation:** | This Recommendation has been created to enable a Trust Wide response to the issues identified in a number Care Group Recommendation related to medicines reconciliations . |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | Staff meet good practice standards described in relevant national guidance, including in relation to non-prescribed medicines.<br>People receive their medicines as prescribed. The service involves them in regular medicines reviews.<br>Staff manage medicines consistently and safely. Medicines are stored correctly, and disposed of safely. Staff keep accurate records of medicines. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Achieve and maintain Medcines Reconcilliation with 24 Hrs of Admission rates of 80% |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| Trust06.01 | Shahedal Bari | Kam Mom | Review Pharmacy staffing structure to ensure sufficient staff to provide a meds reconciliation service 7 days a week. To review pharmacy staffing to extend medicine reconciliation services to wards and departments that cannot currently be covered by the service. | Review of staffing started, full costings awaited.<br>Costing completed.<br>Option proposed for 7 day services.<br>Formal Business case to be drafted and submitted - meeting to be arranged between AS, JB and VR to take this forward.<br>August 2020: KM attended exec meeting last week to highlight the staff requirements in order to provide a level 2 medicine reconciliation to the NICE standards. Meds rec has been running at level 1 during COVID. Execs have asked for benchmarking work to be done but there was an agreement for pharmacy to go back onto the wards with the knowledge that the compliance level will drop. The review section of this action is complete. If finance is agreed to recruit extra staff, the implemtentation of this action would take a number of months. Target date for implementation set for end of April 2021.<br>October 2020: Finalised structure and process for implementation is ongoing. | | | 30/04/2021 | N/A | N/A | OT | NA | Medium |
| Trust06.02 | Shahedal Bari | Jenny Bowler / Andrea Scott | Review pathway of Pharmacy and Technician job plans to see if any more time can be allocated to medicines reconciliation. | January 2020: Review of job plans has been completed. Band 4 techinician job description revised to include this role. A new role of Lead Technician responsible for medicine reconciliation at ward level seconded. | | | 31/01/2020 | | | D | | Low |
| Trust06.03 | Shahedal Bari | Clinical Directors & Nursing Leads | Review training and competences of healthcare professionals admitting patients to ensure full clerking of medications on admission. | October 2019: Pharmacy has a supportive role in this and it links to what is being reported around medicines reconciliation too. There is now a report created by Pharmacy which pulls what % of patients are clerked in in the proscribed way. There is still some refinement of the report to be done but it shows that the majority are not clerked in that way.<br><br>There are still issues with regards to no clerking which means poor quality TTOs so pharmacists pulled from wards to service that which means no meds rec and opportunity to sort out the drugs while the patient is in which means poor TTOs, etc.<br>December 2019: LR discussed with SB who has asked for Pharmacy to email the issues to the CD's and nursing leads and cc SB in to move this on and ensure these issues are being addressed.<br><br>August 2020: Action is linked to business case for meds rec (15.1) - cannot be taken further until this progresses. There is a still a requirement to train doctors & CD's aware. The business case includes how pharmacy will do the data entry.<br>October 2020: Ongoing. Taking part in frailty pathway 'Perfect Month'. Putting a meds management technician who will be doing data entry onto the frailty unit to see what difference this makes to the process of meds management on the ward. | TMS | | 30/04/2021 | | | OT | | Medium |
| Trust06.04 | Shahedal Bari | Jenny Bowler | Review as an interim measure the rotas of current staff to maximise medicines reconciliation provision. | Completed<br>Rotas reviewed and a small number of additional sessions of Medicines reconciliation being provided on ad hoc basis as soon as possible.<br>Additional investing in staffing required to provide sufficient medicines reconciliation cover. | E-Roster | | 30/04/2019 | | | D | | Low |

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| Trust06.05 | Shahedal Bari | Jenny Bowler | Provide training to pharmacy technicians to increase number of staff members competent to perform medicines reconciliation. | Completed<br>Programme of training of pharmacy technicians ongoing.<br>Band 4 job description reviewed and to be approved by matching panel (VR) | TMS | | 31/10/2019 | | | D | | Low |
| Trust06.06 | Shahedal Bari | Jenny Bowler | Pro-actively review the methodology and tools for measuring Medicines Reconciliation Compliance. | New report available to monitor clerking of medicines onto Lorenzo confirmed, still a gap for it to meet required standards (see action 15.2 - escalated to SB and PG) | | | 31/10/2019 | N/A | N/A | D | NA | Low |
| Trust06.07 | Shahedal Bari | Jenny Bowler | Consider project to undertake mapping of impact of Medicines reconciliation non compliance on; subsequent patient care and treatment whilst in Hospital, at discharge and information supplied to Primary Care Providers. | January 2020: Letter to be sent to SB and PG detailing support required from<br>March 2020: Deep dive into med recs has been done. Further discussion around this action and incorporating into Business Case. Once this has been done this action could be closed. Discuss next time.<br>August 2020: This project has been done which has led to the business case. The new way of working will be implemented in September after staff training completed. The discharge to primary care providers has been taken on by a different workstream led by I3 with pharmacy input. Action complete. | | | 30/06/2020 | N/A | N/A | D | NA | Medium |
| Trust06.08 | Shahedal Bari | | Monitoring of Medicine Reconcilliation performance | March 2020: 36.7%<br>April 2020: 66.14%<br>May 2020: 85.9%<br>June 2020: 85.10%<br>July 2020: 77.30%<br>August 2020: 69.80%<br>September 2020: 62.40%<br><br>Significant improvement in performance due to Remote working on EPMA and reducued patient numbers.<br>Will require further monitoring as patient attendances beging to recovery to prior levels. The current performance is not sustainable unless there is significant investment in workforce, now that beds are being occupied, other services are resuming e.g. surgery, oncology, opd etc, turnaround of patients is increasing, at present we are maintaining service as is it part of the Covid 19 response and funding is still available.<br>Unfortunately as this has improved, tto turnaround performance has decreased.<br>A business case/Strategic Assurance Group paper is in production. This will reflect experience gained over the last few months, current review of next steps to start to introduce the step of talking to patients, reviewing of patients own medicines and clinical actions<br>August 2020: Monitoring of meds rec is being done through the dashboard. This action is tied in with 15.1 - see comments. | Lorenzo | | 30/04/2021 | 95% | 8519% | OT | NTMI | Low |

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| **Recommendation Ref. No.:** | **TRUST07** |
| **CQC Report:** | **2017 Inspection Report** |
| **CQC Domain:** | **SAFE** |
| **CQC Service Name:** | **Corporate Services** |
| **Must or Should Action / UoR Finding:** | **TRUST WIDE PRE-EMPTIVE ACTION** |
| **UHMBT Exec Lead:** | **Shahedal Bari** |
| **UHMBT Care Group:** | **Trust Wide** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Patients** |
| **UHMB Theme:** | **Patient Care & Dignity** |
| **CQC Recommendation:** | The Trust will take Action to, continue improving venous thromboembolism (VTE) assessments. |
| **Story behind the Recommendation:** | An audit sample of 116 surgical patients completed in April 2016 showed 110 patients had venous thromboembolism (VTE) and bleeding risk recorded within 24 hour of admission (95%), 34 patients had VTE risk and bleeding risk reassessed 24 hour after admission (29%) . As a result of poor audit results, the trust established as VTE Lead, VTE Policy now rewritten to comply with NICE guidance, a steering group established, standalone bridging guidelines developed, VTE training package now available on the training management system and there was a new VTE algorithm in the clerking documentation. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | Staff recognise and respond appropriately to changes in the risks to people who use services.<br>Risks to safety from changes or developments to services are assessed, planned for and managed effectively.<br>Risks to people who use services are assessed, monitored and managed on a day-to-day basis. These include signs of deteriorating health, medical emergencies or behaviour that challenges.<br>People are involved in managing risks and risk assessments are person-centred, proportionate and reviewed regularly. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Achieve and maintain VTE Risk Assessment completion levels of 95% |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| Trust07.01 | Shahedal Bari | Gautam Talawadekar | Fully Implement the remaining elements of the VTE Action Plan developed in December 2018 | September 2020: action plan delivered. Action closed. | VTE Action Plan | Full Implementation of the VTE Action Plan | 31/08/2020 | N/A | N/A | D | NA | Medium |
| Trust07.02 | Shahedal Bari | Gautam Talawadekar | 2019/20 Financial Year:<br>Improve VTE Assessment compliance to achieve target rate of 95% of Patients. | January 2019 - 93.99%<br>February 2019 - 91.59%<br>March 2019 - 92.88%<br>April 2019 - 93.06%<br>May 2019 - 95.48%<br>June 2019 - 91.12%<br>July 2019 - 94.64%<br>August 2019 - 95.59%<br>September 2019 - 94.78%<br>October 2019 - 93.98%<br>November 2019 - 91.96%<br>December 2019 - 94.21%<br>January 2020: 93.44%<br>February 2020: 94.66%<br>March 2020: 94.52% | NHSI - VTE Assessment Transparency Data | Achieve 95% Compliance | 31/03/2020 | 95% | 94.52% | D | OT | Medium |
| Trust07.03 | Shahedal Bari | Gautam Talawadekar | Implement Trust Wide VTE Steering Group | Group Implemented and estabished, meets on Monthly Basis | VTE Steering Group ToR | Group Implemented and estabished | N/A | N/A | N/A | D | NA | Low |
| Trust07.04 | Shahedal Bari | Gautam Talawadekar | Implement Annual Clinical Audit to assess Trut compliance with prevailing NICE Guidance and National Standards | Audit 1660 on 2019/20 Audit Forward Plan<br>Data colllection in progress, awaiting collation and assessment of 2019/20 Qtr4 performance data.<br>Post Audit Presentation and Action Plan will be developed following data collection/assessment.<br>Request for Audit results and action plan to be presented by Mr Talawadker at the Trust Clinical Audit Steering Group - this will be presented 17th September 2020. Audit has been completed. | Ulysses | Audit completed | 30/09/2020 | Compliance with NICE Guidance and National Standards | TBC | D | | Low |
| Trust07.05 | Shahedal Bari | Gautam Talawadekar | Implement the mandatory VTE Assessment on Admission | This has now been actioned | Lorenzo | | 30/06/2019 | N/A | N/A | D | NA | Medium |
| Trust07.06 | Shahedal Bari | Cathy Hay<br>William Lumb | Review VTE Assessments in Community Inpatient Wards which do not use Lorenzo, e.g. Abbey View, Langdale & Millom | January 2020: GM to contact community colleagues.<br>February 2020: Gill Speight (ADoN of Community) has confirmed Abbey View transferred to Lorenzo in Jan 2020.<br>Langdale Unit scheduled transfer to Lorenzo in March 2020 - delayed due to COVID 19 - target date TBC<br>Millom will remain on EMIS as Medical support is provided by Millom GP practice, Millom has a maximumof 8 beds (normally 6 beds) so not being on Lorenzo will have limited impact on VTE compliance monitoring.<br>June 2020: Langdale Unit transferred to Lorenzo on 01/06/2020, Lorenzo VTE assessment now in use. | Lorenzo | Community Inpatient Wards using Trust standard VTE form | 30/06/2020 | N/A | N/A | D | NA | Medium |

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| Trust07.07 | Shahedal Bari | Gautam Talawadekar | The New/Revised VTE assessment form in Lorenzo needs to be launched to ensure practice remains in line with NICE guidance. | Discussed with GT 17/12/19 - will provide update early January 2020.<br>Discused with I3 EPR team, no further development on New VTE form since September 2019, further discussions with Mr Talawadekar in Feb/Mar 2020 to address some User error issues.<br>September 2020: This has been completed and ready to be used including the new lower limb mobilisation form. The medicine care group have raised a query re an aspect of the form - awaiting further discussion around this.<br>October 2020: No further input from Medicine. Discussed at the VTE Steering Group meeting and it was decided to assume they have no further issues with the form. | Lorenzo | New/Revised VTE assessment form in Lorenzo | 31/03/2020 | N/A | N/A | OT | NA | Medium |
| Trust07.08 | Shahedal Bari | Gautam Talawadekar | Paper forms need to be withdrawn from all clinical areas once this has been agreed by Clinical Directors | This has now been actioned | N/A | Withdrawal of Paper VTE Assessment forms | 30/06/2019 | N/A | N/A | D | NA | Medium |
| Trust07.09 | Shahedal Bari | Gautam Talawadekar | The Post Take Ward Round (PTWR) elements of the December action plan are being built into the EPR (but were not active during this quarter). | This has now been actioned | Lorenzo | PTWR active in Lorenzo | 30/06/2019 | N/A | N/A | D | NA | Medium |
| Trust07.10 | Shahedal Bari | Gautam Talawadekar | 2020/21 Financial Year:<br>Improve VTE Assessment compliance to achieve target rate of 95% of Patients. | Performance data from 2020/21 Qtr1 has been impacted by reduced clinical activity from COVID, further monitoring required to confirm if improvements can be sustained<br><br>August 2020: 94.05%<br>September 2020: 93.55%<br>October 2020: 93.86%<br>November 2020: 93.98%<br><br>September 2020: VTE compliance now consistently over 95%. Action complete.<br><br>October 2020: There has been a drop in VTE compliance at RLI AMU and ASU. The following actions are being taken to address this:<br>1) VTE champions will be to keep reminding doctors on the ward | NHSI - VTE Assessment Transparency Data | Achieve 95% Compliance | 31/03/2021 | 95% | 96.17% | D | OT | Medium |
| Trust07.11 | Shahedal Bari | Gautam Talawadekar, Ash Kale | NICE guidance indicates that patients over 16 should have a VTE assessment completed, this includes Paeditric-Adult transition patients aged 16-17 years.<br>Lorenzo is currently configured in way that does not allow Paediatric staff to acess the Adult VTE Asssessment forms.<br>The Trust is current not compliant with this element of the NICE Guidance, Technical fix required in Lorenzo. | Issue raised with I3 EPR team: VTE Assessment form can be added to the added to the Paediatric Inpatient Charts in Lorenzo, but will require agreement from Trust VTE Lead and from Paediatrics for change to be implemented.<br><br>October 2020: To be discussed by Dr Ash Kale in the CBU meeting. Awaiting feedback. | Lorenzo | Adult VTE assessment form available for Paediatric transition patients | 31/12/2020 | N/A | N/A | OT | NA | Medium |

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| **Recommendation Ref. No.:** | **TRUST08** |
| **CQC Report:** | **2017 Inspection Report** |
| **CQC Domain:** | **SAFE** |
| **CQC Service Name:** | **Corporate Services** |
| **Must or Should Action / UoR Finding:** | **TRUST WIDE PRE-EMPTIVE ACTION** |
| **UHMBT Exec Lead:** | **Sue Smith** |
| **UHMBT Care Group:** | **Trust Wide** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Patients** |
| **UHMB Theme:** | **Patient Safety** |
| **CQC Recommendation:** | The Trust will take Action to, ensure all risk assessments (e.g. National Early Warning Scores (NEWS), multifactorial falls risk assessments) are completed for all patients where appropriate and evidence of the same is documented consistently. |
| **Story behind the Recommendation:** | This Recommendation has been created to enable a Trust Wide response to the issues identified in Care Group Recommendations related to the completion of Patient documentation. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | Staff recognise and respond appropriately to changes in the risks to people who use services.<br>Risks to safety from changes or developments to services are assessed, planned for and managed effectively.<br>Risks to people who use services are assessed, monitored and managed on a day-to-day basis. These include signs of deteriorating health, medical emergencies or behaviour that challenges.<br>People are involved in managing risks and risk assessments are person-centred, proportionate and reviewed regularly. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Complete the NEWS2 implementation in Lorenzo |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| Trust08.01 | Sue Smith | Lynne Wyre, Joann Morse | NEWS2 assessments are completed for patients and compliance is monitored through Matron Audits and the Quality Assurance and Accreditation Scheme (QAAS) process. | Ongoing Process, no obvious target date.<br>The Trust moved to the national NEWS2 in 2018/19.<br>Spot-checks for quality of recording are carried out during matrons monthly audits and additional spot-checks are carried out when the departments undergo a QAAS inspection.<br>When any concerns are identified the matron does audits weekly until compliance improves.<br><br>This is now embedded onto the quality assurance process on My Assurance. Action is complete. | My Assurance | Improvement in NEWS2 Compliance | 31/10/2019 | | | D | | Low |
| Trust08.02 | Sue Smith | Fiona Ryder | As part of the deteriorating patient CQUIN in 2018/19 regular audits of NEWS2 charts were carried out. | As part of the deteriorating patient CQUIN in 2018/19 regular audits of NEWS2 charts were carried out and the Trust saw a significant increase in earlier call for support for deteriorating patient (Peri-Arrest Call) being identified sooner in their stay as a direct result of improved NEWS2 monitoring.<br><br>Peri-Arrest Calls made in 2018/19:<br>Qtr1 = 29<br>Qtr2 = 38 - NEWS2 E-Learning introduced in August 2018<br>Qtr3 = 56 - NEWS 2 introduced in October 2018<br>Qtr4 = 53 | CQUINN | Increase in Peri-Arrest Calls | 31/03/2019 | Qtr 1 = 100% | Qtr 2 - 31% Increase on Qtr 1<br>Qtr 3 - 93% Increase on Qtr 1<br>Qtr 4 - 82% Increase on Qtr 1 | D | NA | Low |
| Trust08.03 | Sue Smith | Laura Neal/Lynne Wyre | Complete the NEWS2 implementation in Lorenzo | October 2020: NEWS2 is now live in Lorenzo in all areas except Endoscopy at RLI. This remains ongoing. | Lorenzo | | 31/03/2020 | N/A | N/A | NTMI | NA | Low |
| Trust08.04 | Sue Smith | Kim Wilson | Falls Risk assessment process has been reviewed and updated with the multi-factor falls risk assessment being automatically generated as a mandatory part of the Patients E-care plan within Lorenzo, with an extended assessment in place for all patients over the age of 65years. | Ongoing Process, no obvious target date.<br>The Completion of assessments is audited during QAAS inspections and matrons monthly audits.<br>This is part of the ePR and monitored through QAAS and My Assurance. Action complete. | My Assurance | | 31/10/2019 | | | D | NA | Low |
| Trust08.05 | Sue Smith | Laura Neal | 2019/20 CQUIN CCG7: Three high impact actions to prevent Hospital Falls; Checking for the presence of 3 key high impact actions to prevent falls (including the assessment) has begun which has led to further adjustment of the assessment in the care plan.<br><br>Three High Impact Actions for patients over 65 Years and Hospital Stay of 48+ Hours:<br>- Lying and standing blood pressure recorded at least once<br>- No hypnotics or antipsychotics or anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented<br>- Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatient unit | Quarterly submission via National CQUIN collection<br>Year End position March 2020 - 82% oof Patients receiving all three high impact actions | CQUINN | 80% of older inpatients receiving key falls prevention actions. | 31/03/2020 | 80% | 82% | D | D | Low |

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| Trust08.06 | Sue Smith | Ward Managers | Continue to report all patients who fall, or are suspected to have fallen, as a Patient Safety Incident for investigation by the Care Groups | Ongoing Process, no obvious target date.<br>All patients who fall, or are suspected to have fallen, are reported as a Patient Safety Incident for investigation by the Care Groups<br>- When a rapid review is undertaken, the care groups check for the completion of the falls risk assessment, and check that the weekly update is also completed<br>- The lead nurse for falls reviews and validates all Patient Falls on a monthly basis<br><br>Action embedded and complete | Ulysses | | 31/10/2019 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **TRUST09** |
| **CQC Report:** | **2017 Inspection Report** |
| **CQC Domain:** | **RESPONSIVE** |
| **CQC Service Name:** | **Corporate Services** |
| **Must or Should Action / UoR Finding:** | **TRUST WIDE PRE-EMPTIVE ACTION** |
| **UHMBT Exec Lead:** | **Kate Maynard** |
| **UHMBT Care Group:** | **Trust Wide** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Performance** |
| **UHMB Theme:** | **Operational Performance & Targets** |
| **CQC Recommendation:** | The Trust will take Action to, ensure referral to treatment targets in outpatient clinics are met and backlogs are addressed in follow-up appointment waiting times. |
| **Story behind the Recommendation:** | This Recommendation has been created to enable a Trust Wide response to the issues identified in Care Group Recommendations related to RTT. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies.<br>This is monitored to ensure consistency of practice. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | TBC - Target for 2020/21 to be reconfirmed following national increase in COVID Cases and Admissions, impact of Level 3 restrictions in Lancaster region and Level 2 restrictions in Barrow region |
| **The key actions to achieve this Recommendation will be:** | |

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| Trust09.01 | Kate Maynard | Kate Maynard | The CQC's recommendation is not fully consistent with the current commissioning arrangements for Outpatient services and backlog (IRD) management.<br>UHMBT Chief Operating Officer (or Deputy) to raise the CQC's recommendation and the issues it raises with the relevant Commissioners. | See progress below. | | | 30/09/2019 | N/A | N/A | D | NA | Medium |
| Trust09.02 | Kate Maynard | Kate Maynard | UHMBT Chief Operating Officer (or Deputy) to raise the CQC's recommendation and the issues it raises within the Bay Health and Care Partners to see if there is scope for better alignment around the provision of outpatient services across the partner organisations to improve Outpatient performance. | See progress below. | | | 30/09/2019 | N/A | N/A | D | NA | Medium |
| Trust09.03 | Kate Maynard | Kate Maynard | RTT Recovery plan to be developed and presented at Trust Board Meeting in July 2020 | Update from July's Finance Committee: There was a decline in RTT performance due to postponement of elective activity and an<br>increase in waiting list size with a 70% reduction in routine referrals received in<br>May only partially offsetting the patients that were postponed due to COVID19. The increase in diagnostic waits of over 6 weeks attributed to the closure of endoscopy services<br>KM arranging a deep dive session for NEDs on the recovery plan to restore operational performance; to gain assurance on assumptions, dependencies and critical path. | RTT Recovery plan | RTT Recovery plan | 31/07/2020 | N/A | N/A | D | NA | Medium |
| Trust09.04 | Kate Maynard | Julian Grieves | Review of Outpatient delivery channels due to impact of COVID.<br>Development of Outpatient Transfeormation Programme | During the period of the emergency response we have continued to accept outpatient referrals<br>We have rapidly rolled out technology to support non face to face consultations<br>We have developed and implemented a clinical validation tool for outpatient wait lists, ensuring review and triage of new referrals; review of those waiting test results and those who are delayed past their review date.<br><br>Move to virtual Outpatient processes as a result of COVID has been well received by Patients.<br><br>Expansion of virtual models, including 'Attend Anywhere' being progressed by Outpatient Transformation programme<br><br>December 2020: Good progress maintained. Roll out plans being developed for all services:<br>E-letters, E-booking, Attend Anywhere.<br>Maintaining a high proportion of non-face to face appointments.<br>PIFU numbers are increasing but still significantly off the 10% target. DNA rates have increased which is understood to be linked to the increased prevalance pf Covid19. | Outpatient Review | Review of Outpatient delivery channels | 31/03/2021 | N/A | N/A | OT | NA | Medium |

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| Kate Maynard | Leanne Cooper | Trust Restoratrion and Recovery Plan as part of COVID phase 3<br>OP Target: Restoration to 100% of last year's activity for first outpatient attendances andfollow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).<br>Where an outpatient appointment is clinically necessary, the national benchmark is that at least 25% could be conducted by telephone or video including 60% of all follow-up appointments | Monthly Vacancy Rate Performance:<br>August 2020: 76.23%<br>September 2020: %<br>October 2020: %<br>November 2020: %<br>December 2020: %<br>January 2021: %<br>February 2021: %<br>March 2021: % | Outpatient Review | Review of Outpatient delivery channels | 31/03/2021 | 90% | 76% | OT | NTMA | Medium |

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| **Recommendation Ref. No.:** | **TRUST10** |
| **CQC Report:** | **2019 Inspection Report, 2017 Inspection Report** |
| **CQC Domain:** | **RESPONSIVE** |
| **CQC Service Name:** | **Corporate Services** |
| **Must or Should Action / UoR Finding:** | **TRUST WIDE PRE-EMPTIVE ACTION** |
| **UHMBT Exec Lead:** | **Kate Maynard** |
| **UHMBT Care Group:** | **Trust Wide** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Performance** |
| **UHMB Theme:** | **Access & Flow** |
| **CQC Recommendation:** | The Trust will take action to ensure that people attending Urgent and Emergency Services can access care and treatment in a timely way, that they have timely access to initial assessment, test results, diagnosis or treatment, that action is taken to minimise the length of time people have to wait for care, treatment or advice, that people with the most urgent needs have their care and treatment prioritised. |
| **Story behind the Recommendation:** | This Recommendation has been created to enable a Trust Wide response to the issues identified in Care Group Recommendations related to Access and Flow in Urgent and Emergency Services. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies.<br>This is monitored to ensure consistency of practice. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | TBC - Target for 2020/21 to be reconfirmed following national increase in COVID Cases and Admissions, |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| Trust10.01 | Kate Maynard | Kate Maynard | Develop and then implement a new System Wide Urgent Care Recovery Plan on behalf of the Morecambe Bay A&E Delivery Board | New draft urgent Care Recovery Plan has been drafted and will be considered by Morecambe Bay A&E Delivery Board on 13 June 2019.<br>Foluke Ajayi will be the UHMBT Executive Lead and Action Owner for a significant proportion of the Actions in the plan. | Urgent Care Recovery Plan | | | N/A | N/A | | NA | Medium |
| Trust10.02 | Kate Maynard | Diane Smith | Trust Wide PMO Work Book 'FLOW Improvement Programme - ED / SAFER RLI' established.<br>In progress since June 2018, with the aim of improving ED patient flow and performance, through the following objectives:<br>• ED: Co-ordination & Escalation<br>• ED: Non-Admitted Pathway<br>• ED: Improve Triage<br>• ED: Embed an ED safety checklist<br>• ED: STAFFING ROTAS - Nursing<br>• ED: Complete an Achievement Report<br>• ACU: Development & launch of Ambulatory care pathways<br>• ACU: Extend direct access to ACU (NWAS role)<br>• ACU: ACU opening Hours - to align capacity & demand<br>• ACU: Review pull of patients to ACU<br>• Patient Flow: SAFER<br>• Patient Flow: Transfer patients from AMU to base wards by 12 noon.<br>• Patient Flow: GOLDEN PATIENT - RLI<br>• Patient Flow: Wave 1 - WARD 37 Roll out of SAFER<br>• Patient Flow: SAFER EDD SOP<br>• Patient Flow: SITE MANAGEMENT & CSM - Review CSM team process across RLI<br>• Patient Flow: CONTROL CENTRE & SITE ESC<br>• Red to Green Dashboard: REVIEW / FLOW DASHBOARD | Progress already achieved:<br>• 50% reduction in patients medically fit for discharge waiting in acute hospital beds, releasing 50 beds across bay;<br>• Cumbria Care Reablement development including a new shift based commissioning service for domiciliary care supporting patients to be at home;<br>• Integration of health and social care discharge teams – developing further into the Lancashire ICAT and Cumbria ICAT in development – expediting integrated care and reductions in delays;<br>• Commissioning of additional EMI Nursing beds to support the south Cumbria population and reducing DTOC at FGH;<br>• Expansion of Mears Crisis domiciliary care supporting more people to be at home;<br>• Development of the Hospital Home Care team originally designed to bridge the gap between assessment and provision of an agency package of care but now providing short health package bridging and discharge to assess support out of hospital<br>• Implementation of the Discharge to Assess model – releasing over 70 beds across bay;<br>• Mental health??<br>• Triage – now at a near 99% performance against the national target of all patients being triaged within 15 minutes of arrival<br>• Use of Patient Safety Checklists in ED supporting the reduction of clinical risk within busy ED departments<br>• SAFER Care Bundle weekly "Move Me" length of stay reviews and regular MADE Events reducing long lengths of stay and helping to improve bed occupancy<br>• 100% Challenge Events which led to the establishment of an acute-based Control Room function linked to two-hourly safety flow meetings and OPEL system escalation and improved site | PMO Workbook | | 31/03/2020 | N/A | N/A | OT | NTMI | Medium |

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| Trust10.03 | Kate Maynard | Diane Smith | Trust Wide PMO Work Book 'FLOW Improvement Programme - ED / SAFER FGH' established.<br>In progress since June 2018, with the aim of improving ED patient flow and performance, through the following objectives:<br>• ED: Demand and Capacity review<br>• ED: Implement Senior rota<br>• ED: Create Second ED Triage Stream for peak times<br>• ED: Estates Improvement Plan<br>• ED: Review of Escalation Triggers<br>• ED: review of Ambulance Handovers<br>• ACU/AMU: Development of Emergency Care Floor - Relocation of ACU to old Labour Ward to expand AEC pathways<br>• ACU/AMU: Extend direct access to ACU (NWAS role)<br>• ACU/AMU: Development of Frailty Model<br>• ACU/AMU: ACU DATA COLLECTION<br>• ACU/AMU: Good practice review and development of SOP<br>• ACU/AMU: AMU Improvement Plan<br>• SAFER (ECIST): SAFER EDD SOP<br>• SAFER (ECIST): SAFER Training<br>• SAFER (ECIST): WARD ORGANISATION<br>• SAFER (ECIST): WARD INDUCTION<br>• SAFER (ECIST): GOLDEN PATIENT - FGH<br>• SAFER (ECIST): Transfer patients from AMU to base wards by 12 noon | Progress already achieved:<br>• 50% reduction in patients medically fit for discharge waiting in acute hospital beds, releasing 50 beds across bay;<br>• Cumbria Care Reablement development including a new shift based commissioning service for domiciliary care supporting patients to be at home;<br>• Integration of health and social care discharge teams – developing further into the Lancashire ICAT and Cumbria ICAT in development – expediting integrated care and reductions in delays;<br>• Commissioning of additional EMI Nursing beds to support the south Cumbria population and reducing DTOC at FGH;<br>• Expansion of Mears Crisis domiciliary care supporting more people to be at home;<br>• Development of the Hospital Home Care team originally designed to bridge the gap between assessment and provision of an agency package of care but now providing short health package bridging and discharge to assess support out of hospital<br>• Implementation of the Discharge to Assess model – releasing over 70 beds across bay;<br>• Mental health??<br>• Triage – now at a near 99% performance against the national target of all patients being triaged within 15 minutes of arrival<br>• Use of Patient Safety Checklists in ED supporting the reduction of clinical risk within busy ED departments<br>• SAFER Care Bundle weekly "Move Me" length of stay reviews and regular MADE Events reducing long lengths of stay and helping to improve bed occupancy<br>• 100% Challenge Events which led to the establishment of an acute-based Control Room function linked to two-hourly safety flow meetings and OPEL system escalation and improved site | PMO Workbook | | 31/03/2020 | N/A | N/A | OT | NTMI | Medium |
| Trust10.04 | Kate Maynard | Diane Smith | Monitoring of ED performance during COVID | December 2020: Deterioration against the 4 hour target during the pilot:<br>the pilot was a different model to that implemented in phase 1 of COVID19 in that the model was not a pull into AFU, it was based on an in-reach into ED.<br>• Bed pressures meant that the flow overall of patients was significantly reduced and overall 4 hour performance reduced significantly<br>• On arriving into ED each day the FIT team worked though patients in arrival time order. There were often a backlog of patients who had already breached waiting to be seen.<br>• There were issues with consultant cover over the trial leading to ED & AFU being covered by a single consultant some days resulting in less timely patient reviews.<br>• A number of breaches can be directly attributed to the FIT model. On average the team saw patients 1hr30 into their attendance, leaving at best 2hr30 for assessment – assessing; arranging appropriate packages of<br>care in the community and transport does inevitably take time but the benefit of avoiding an admission was seen to outweigh breaching the 4 hour target. There was opportunity to use ACU for patients awaiting<br>commissioning service and transport but this would have split the team between two clinical areas and impacted on the number of patients the team were able to see | ED Performance data | Continued monotoring of performance | 30/09/2020 | 95% | 92% | OT | OT | Low |
| Trust10.05 | Kate Maynard | Rhiannon Tinson | Monitor and Report Overall Trust ED 4 Hour Wait performance to Trust Board via Integrated Performance Report (IPR). | 2020/21 Trust ED 4 Hour Performance:<br>Apr: 89.7%<br>May: 92.4%<br>June: 92.3%<br>July: 93.5%<br>Aug: 91.1%<br>Sep: 89.2%<br>Oct: 80.4%<br>Nov: 80.2%<br>Dec:<br>Jan:<br>Feb:<br>Mar: | IPR Report | Reporting of Performance | 31/03/2021 | 95% | 91% | OT | NTMI | Low |

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| **Recommendation Ref. No.:** | **TRUST11** |
| **CQC Report:** | **2019 Inspection Report, 2017 Inspection Report** |
| **CQC Domain:** | **RESPONSIVE** |
| **CQC Service Name:** | **Corporate Services** |
| **Must or Should Action / UoR Finding:** | **TRUST WIDE PRE-EMPTIVE ACTION** |
| **UHMBT Exec Lead:** | **Kate Maynard** |
| **UHMBT Care Group:** | **Estates & Facilities** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Finance Committee** |
| **UHMBT Strategic Objective:** | **Progress** |
| **UHMB Theme:** | **Patient Environment** |
| **CQC Recommendation:** | The Trust will take Action to, ensure that Estate capital build requirements and Estate repairs requirements identified by the CQC are added to the Capital Plan and repairs schedules and appropriately prioritised within the prevailing Capital position. |
| **Story behind the Recommendation:** | This Recommendation has been created to enable a Trust Wide response to the issues identified in Care Group Recommendations related to Capital Build requirements. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies. This is monitored to ensure consistency of practice. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Completion of PLAN compliant Cubicles at FGH ED and WGH UTC, review and re-design of RLI Emergency Department central nursing station. |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| Trust11.01 | Foluke Ajayi | Tristram Reynolds | Apply for Hospital Improvement Plan (HIP) Seed funding to enable the development of plans to Improve the Trust Estates | Hip Funding granted to UHMBT | HIP Funding Statement | HIP funding granted | 31/08/2019 | N/A | N/A | D | NA | Medium |
| Trust11.02 | Kate Maynard | Tristram Reynolds | Develop an estate strategy for the ED at RLI which will require c. £45m of additional capital. | Currently ED at RLI is undersized by c 50% compared to the activity volumes being experienced so with 8% growth in ED attendances over the last 12 months a structural solution that will improve patient safety and flow/ productivity/VFM is now high on our agenda and we are influencing the ICS accordingly at all levels.<br><br>July 2020: ED RLI - Working group was set up to look at the existing ED layout and identify short falls in efficiency (Autumn 2019). High level design exercise was undertaken using the current footprint, the fracture clinic and a number of extensions to provide a functional layout. The group, chaired by Kate Maynard, received a proposal it in December 2019 and a high level cost of circa £15m. The design was to be presented to the execs but due to COVID and a competing proposal of demolishing the education centre and building ED on its footprint this did not go ahead. Awaiting strategic direction on how to proceed. £100K is proposed within the clinical bids for 20/21 to progress design - awaiting approval. | Estates Strategy | Estates strategy in place that addresses RLI ED Capacity issues | 31/03/2020 | N/A | N/A | NTMA | NA | High |
| Trust11.03 | Foluke Ajayi | Mark Hampton | Specification, Instruction and Capital in place to deliver two additional bays that meet relevant building standards for Mental Health Patients at RLI ED. | Complete-handed to user 12/08/2019 | | Specification, Instruction and Capital in place | 31/03/2019 | N/A | N/A | D | NA | Low |
| Trust11.04 | Foluke Ajayi | Mark Hampton | Construction Project to deliver two additional bays that meet relevant building standards for Mental Health Patients at RLI ED. | Complete-handed to user 12/08/2019 | | Two additional bays that meet relevant building standards for Mental Health Patients at RLI ED. | 31/07/2019 | N/A | N/A | D | NA | Low |
| Trust11.05 | Kate Maynard | Mark Hampton | Upgrade of the RLI Intensive Care Unit to meet the relevant Building Standards. | Requires Capital Funding to be in place. There is no available finance to implement any scheme during 2019-20. Scheme would require significant re-design of buildings at the RLI Site<br><br>July 2020: £50K has been highlighted within the capital bids for 20/21 to develop a proposal - awaiting approval. | Capital plan group minutes. | Estates strategy in place that addresses RLI ED Capacity issues | 31/03/2020 | N/A | N/A | NTMA | NA | High |
| Trust11.06 | Foluke Ajayi | Mark Hampton | Undertake Feasibility Study to identify potential locations for an additional bay/room that meets relevant building standards for Mental Health Patients at FGH ED. | Completed | | Feasibility Study completed | 31/08/2019 | N/A | N/A | D | NA | Low |
| Trust11.07 | Foluke Ajayi | Mark Hampton | Request Capital Works for the additional bay/room that meets relevant building standards for Mental Health Patients at FGH ED. | This project was noted in the Capital Plan Group minutes of the 17th September (item 5.3) to proceed this financial year; Requires final approval by DoF; Received email approval on the 1st October to proceed with the FGH Mental Health Scheme.<br><br>Update 09/12/2019 - Capital has been identified and construction to begin 03.02.20. | Capital plan group minutes. External capital provided by DoH. | Capital funding in Place | 30/12/2019 | N/A | N/A | D | NA | High |

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| Trust11.08 | Kate Maynard | Mark Hampton | Undertake Construction Project to deliver additional bay/room that meets relevant building standards for Mental Health Patients at FGH ED. | Construction has been postponed due to the high cost following the feasibility study. Joint business case required for FGH and KUTC<br>Update 09/12/2019 - Construction for the additional Mental Health bay at FGH Emergency Department has a start date for construction of 03.02.20. Capital has been identified for construction and completion by end of 19/20 financial year. Construction work began 03 Feb 2020, Work delayed due to COVID 19, Work recommenced in May 2020, Revised Target Completion date is 30/06/2020<br>July 2020: Project was paused due to COVID. Work has now recommenced and is due to be complete on the 28th August 2020<br>Constructin Work C0ompleted in September 2020 | Capital plan group minutes. External capital provided by DoH. | Construction Project completed | 31/08/2020 | N/A | N/A | D | NA | High |
| Trust11.09 | Foluke Ajayi | Mark Hampton | Estate Capital Services to undertake Feasibility Study to identify potential locations for an additional bay/room that meets relevant building standards for Mental Health Patients at Kendal UTC | Feasibility study ongoing | Capital plan group minutes. | Feasibility study complete | 30/09/2019 | N/A | N/A | D | NA | Medium |
| Trust11.10 | Kate Maynard | Mark Hampton | Undertake Construction Project to deliver additional bay/room that meets relevant building standards for Mental Health Patients at Kendal UTC. | The Trust has begun examining design options to create this facility within the Urgent Treatment Centre. No finance has been provided by DH and no internally-generated capital monies are available this financial year. Construction has been postponed, Joint business case required for FGH and KUTC.<br><br>Update 09/12/2019 - WGH are to benefit from a full design, it is currently 95% complete and at the preparing project cost stage this is hoping to be presented at December 2019 Capital Plan Group meeting for a decision to proceed and for the Capital funding to be confirmed.<br><br>July 2020: Initial feasibility design has been produced - cost circa £65K (2019). DoF asked us not to proceed at the time due to insufficient capital funding. This project does not appear on the care group's high priorities for 20/21.<br>December 2020: No further progress has been made. | Capital plan group minutes. | Works complete | 30/09/2020 | N/A | N/A | NTMA | NA | High |
| Trust11.11 | Foluke Ajayi | Glyn Davies | Undertake Repair Works for Kendal UTC. | Requires Funding to be in place and request to be made, Clinical areas are being prioritised for plaster repair.<br>Funding supplied by Medicine Care Group | Capital plan group minutes. | Works completed | 01/04/2020 | N/A | N/A | D | NA | Medium |
| Trust11.12 | Foluke Ajayi | Mark Hampton | Undertake Feasibility Study to identify building works required to improve the line of sight for Children's waiting area at Kendal UTC | Feasibility study ongoing, needs more exploration due to costing-plan to complete 30/09/2019 | Capital plan group minutes. | Feasibility Study completed | 30/09/2019 | N/A | N/A | D | NA | Medium |
| Trust11.13 | Foluke Ajayi | Mark Hampton | Undertake Construction Project to deliver building works required to improve the line of sight for Children's waiting area at Kendal UTC | Requires Capital Funding to be in place; Emergency capital bid has been made, the board are fully aware of the risks and are doing all they can to escalate; Reviewed and included within a redesign feasibility study however no funding has been identified; we have asked for a cost for this area to be covered with CCTV (action Facilities dept.);<br><br>Update 09/12/2019 -Continue to explore the use of CCTV for children's waiting area at Kendal UTC. Looking for clarity from the department to confirm CCTV will be ok from the user perspective and then to consider an update from the CCTV provider.<br><br>CCTV now installed. | Capital plan group minutes. | Works Completed | 01/04/2020 | N/A | N/A | D | NA | High |
| Trust11.14 | Kate Maynard | Mark Hampton | Estates Feasibility review and re-design of RLI Emergency Department central nursing station to facilitate confidentiality and improved Information Governance, as per Recommendation UES9. | Sketch plan meetings are underway (every second Friday) with key stakeholders lead by Kate Maynard.<br>Capital Services has commissioned the support of an Architect to progress the ideas onto plan.<br>Planned signed off Friday 25th October by senior managers to allow us to progress to outline design/cost stage.<br><br>Update 09.12.19 - As part of full grand build scheme at RLI Emergency Department the incorporation of confidentiality within the department will be taken into account.<br><br>Work delayed due to COVID 19, Revised Target Completion date is 30/09/2020 | Capital plan group minutes. | Works Completed | 30/09/2020 | N/A | N/A | OT | NA | Medium |
| Trust11.15 | Foluke Ajayi | Mark Hampton | RLI Ward 37: Conversion of 9 Bed bay (Level 1 beds) to 6 Bed bay (Level 2 Beds) required to improve care and treatment of patient required Non-Invasive Ventilation and High Dependency Care | Need to confirm details with Medicine ADOP.<br>Ward37 has been re-configured as part of COVID Response. Conversion project will need to be reviewed following COVID. No Target Date can be confirmed at present. | Capital plan group minutes. | Works Completed | | N/A | N/A | D | NA | Medium |

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| Trust11.16 | Keith Griffiths | Andrea Willimott | Governance Team to undertake a Review of Trust Recommendations and Use of Resource findings to identify Action plans that can be integrated into the existing Work plans of the Finance Committee or one of its sub Committees for ongoing monitoring and reporting to avoid unnecessary duplication of monitoring and reporting. | Trust Recommendation Trust 19 identified for potential closure. To be monitored/reported at Estates Capital Building Meeting. Closure request submitted to June Finance & Performance meeting | CQC Improvement Plan Paper to Finance Committee | Review Completed | 30/06/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **TRUST12** |
| **CQC Report:** | **2019 Inspection Report, 2017 Inspection Report** |
| **CQC Domain:** | **SAFE** |
| **CQC Service Name:** | **Corporate Services** |
| **Must or Should Action / UoR Finding:** | **TRUST WIDE PRE-EMPTIVE ACTION** |
| **UHMBT Exec Lead:** | **Keith Griffiths** |
| **UHMBT Care Group:** | **I3** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Finance Committee** |
| **UHMBT Strategic Objective:** | **Patients** |
| **UHMB Theme:** | **Information Governance** |
| **CQC Recommendation:** | The Trust will take action to ensure that there are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. |
| **Story behind the Recommendation:** | This Recommendation has been created to enable a Trust Wide response to the issues identified in Care Group Recommendations related to Information Governance and Information Governance issues identified through Quality Inspections. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.<br>When there are different systems to store or manage care records, these are coordinated. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | TBC - Target for improvement to be confirmed with Information Governance Team |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| Trust12.01 | Shahedal Bari | Andy Wicks, Fiona Prestwood | I3 to undertake review of the technology used with the Emergency Department(s) to identify areas of possible improvements in Information Governance and Data Security | Replacement/Upgrade of Computers in ED at FGH and RLI underway<br>Feedback from ED staff is that smartcard only VDI login can take 'minutes', unclear if this a hardware/software issues or a staff awareness/training issue.<br>Progress delayed due to COVID restricting non-essential access to RLI ED | IG Review | Review completed | 31/03/2021 | N/A | N/A | OT | NA | Low |
| Trust12.02 | Shahedal Bari | Andy Wicks, Fiona Prestwood | Implement a Trust Wide IG Campaign with the same 4 key messages (in line with NHS Digital) being delivered across the Trust in the form of a digital poster (Paper Posters to be printed by i3 from April 2020):<br>1) Lock and Remove - lock computers when not in use (incl. showing 'quick lock' keys) and remove smartcard<br>2) Fishy emails - contact I3 if suspicious email received<br>3) Swiping people in - don't!<br>4) Passwords - ensure strong mixed case used. | In Progress, scheduled for the following:<br>w/c 27.01.20: Weekly News every other week until end of February 2020 (with a view to refresh in April)<br>10.02.20: Desk Top Message (when next item it programmed to start)<br>22.01.20: Screen Savers of all Trust computers for one month<br>Date tbc: Friday Message<br>Date tbc: Team Talk/Brief<br>Date tbc: CEO's Blog<br>ASAP: i3 Champions to disseminate<br><br>Delayed due to COVID, timescale to be revised | IG Campaign | IG Campaign completed | 30/09/2020 | N/A | N/A | OT | NA | Low |

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| **Recommendation Ref. No.:** | **TRUST13** |
| **CQC Report:** | **2019 Inspection Report, 2017 Inspection Reports** |
| **CQC Domain:** | **EFFECTIVE** |
| **CQC Service Name:** | **Surgical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **Kate Maynard** |
| **UHMBT Care Group:** | **Corporate Services** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Finance Committee** |
| **UHMBT Strategic Objective:** | **Performance** |
| **UHMB Theme:** | **Operational Performance & Targets** |
| **CQC Recommendation:** | The trust should continue to monitor and improve referral to treatment targets for all specialities. |
| **Story behind the Recommendation:** | This Recommendation has been created to enable a Trust Wide response to the issues identified in Care Group Recommendations related to RTT.<br><br>**FGH:** From August 2017 to July 2018, the trust's referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average. In the most recent month, July 2018, the number of admitted pathways at the trust that were completed within 18 weeks was 49.9%, which was worse than the England average of 67.0%. We discussed the RTT's with the senior management team. Improving RTT's had been set as a priority within the care group. From August 2017 to July 2018 the trusts performance for RTT in general surgery had declined compared to the last inspection figures in 2016 which showed an improvement against the England average of 75%.<br><br>**RLI:** The highest risks identified were meeting referral to treatment targets<br>We discussed the RTT's with the senior management team. Improving RTT's had been set as a priority within the care group. From August 2017 to July 2018 the trusts performance for RTT in general surgery had declined compared to the last inspection figures in 2016 which showed an improvement against the England average of 75%.<br>At the time of the inspection the trust gave assurance that they continued to review ongoing validation, new ways of working, pathway development and partnership working with stakeholders to improve RTT. Work was ongoing to improve waiting list size and RTT waits. Senior management explained that bed pressures, nurse and theatre staffing had impacted on RTT waiting times.<br><br>**WGH:** From August 2017 to July 2018, the trust's referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average. In the most recent month, July 2018, the number of admitted pathways at the trust that were completed within 18 weeks was 49.9%, which is worse than the England average of 67.0%.<br>We discussed the RTT's with the senior management team. Improving RTT's had been set as a priority within the care group. From August 2017 to July 2018 the trusts performance for RTT in general surgery had declined compared to the last inspection figures in 2016 which showed an improvement against the England average of 75%.<br>At the time of the inspection the trust gave assurance that they continued to review ongoing validation, new ways of working, pathway development and partnership working with stakeholders to improve RTT. Work was ongoing to improve waiting list size and RTT waits. Senior management explained that bed pressures, nurse and theatre staffing had impacted on RTT waiting times. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies.<br>This is monitored to ensure consistency of practice. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | TBC - Target for 2020/21 to be reconfirmed following national increase in COVID Cases and Admissions, impact of Level 3 restrictions in Lancaster region and Level 2 restrictions in Barrow region |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| TRUST13.01 | Kate Maynard | Carol Park | Four Eyes Consultancy have been engaged to work with the Trust on backlog clearance | This work is in progress and is due to complete towards the end of August 2020 | TBC | Backlog cleared | 31/08/2020 | N/A | N/A | OT | NA | Low |
| TRUST13.02 | Kate Maynard | Carol Park | Four Eyes Consultancy have been engaged to work with the Trust on establishing sustainable Outpatient clinic capacity going forward | This work is in progress and is due to complete towards the end of August 2020 | TBC | Sustainable OP Clinics | 31/08/2020 | N/A | N/A | OT | NA | Low |
| TRUST13.03 | Kate Maynard | Carol Park | Comply with National Planning request to recommence routine treatment activity following COVID. | Routine activity recommenced.<br>Evidence over the last 12 weeks has demonstrated that we don't need to see all our patients face to face.<br>We have a unique opportunity to rebase and reset performance.<br>To support this we are going to end date all pre-existing clinics, therefore any requests for routine clinic capacity are being made from a zero base.<br>Virtual clinics introduced e.g. fracture clinic, with further virtual ophthalmic clinics planned for Q2.<br>Completed revised theatre scheduling in conjunction with Cancer alliance surgical prioritisation guidelines<br>Completed forecast for forthcoming surgery plans<br>Working alongside "four eyes" to map out Patient activity and align<br>[capacity and demand]<br>Confirmed CLW and Medic rota – rollout process to support efficient management to support clinician leave and 42 productive week<br>Theatre transformation at WGH including estates planning | TBC | TBC | 31/03/2021 | N/A | N/A | OT | NA | Medium |
| TRUST13.04 | Kate Maynard | Leanne Cooper | Development and Implementation of Trust Wide RTT recovery plan for financial Year 2020/21, as part of a wider ICS process to improve RTT Performance. | Restoration and Recovery Plan prsented to Public Board on September 2020. | RTT Performance data | Improvement in RTT Performance | 31/03/2021 | TBC | TBC | OT | | Medium |
| TRUST13.05 | Kate Maynard | Rhiannon Tinson | Monitor and Report Overall Trust RTT performance to Trust Board via Integrated Performance Report (IPR). | 2020/21 Trust Overall RTT Performance:<br>Apr: 70%<br>May: 61%<br>June: 50%<br>July: 43%<br>Aug: 48%<br>Sep: 53.4%<br>Oct: 57.3%<br>Nov: 59.1%<br>Dec:<br>Jan:<br>Feb:<br>Mar: | IPR Report | Reporting of Performance | 31/03/2021 | 91% | 48% | OT | NTMA | Low |

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| **Recommendation Ref. No.:** | **TRUST14** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Effective** |
| **CQC Service Name:** | **Maternity** |
| **Must or Should Action / UoR Finding:** | **Must Do** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Corporate** |
| **UHMBT Site(s):** | **Trust Wide Medical Device training compliance and issues reported to Health and Safety Committee by the Chair of the Medical Devices Management Group (Sub Group of the Health and Safety Committee).** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMBT Theme:** | **Staff Development & Training** |
| **CQC Recommendation:** | The trust must ensure that it has appropriate arrangements in place to assure itself around staff competencies regarding equipment. |
| **Story behind the Recommendation:** | We were not assured that the overarching trust governance processes were robust as there were discrepancies in information that was held locally with centrally held trust data (see information section for more detail). This included the system regarding staff competencies relating to equipment, which highlighted a 35% compliance rate with competencies that was inaccurate. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | *All staff are qualified and have the skills they need to carry out their roles effectively and in line with best practice. The learning needs of staff are identified and training is provided to meet these needs. Staff are supported to maintain and further develop their professional skills and experience.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| TRUST14.1 | Sue Smith | Anna Smith | Trust Wide Medical Device training compliance and issues reported to Health and Safety Committee by the Chair of the Medical Devices Management Group (Sub Group of the Health and Safety Committee). | Training Compliance reported to Committee on regular ongoing basis. | Papers and Minutes of Health and Safety Committee | Regular Monitoring Report to Committee/Group | Completed | N/A | N/A | D | N/A | Low |
| TRUST14.2 | David Wilkinson | Kate Casey | Care Group level Medical Device training compliance and issues reported to Education Governance Group (Sub Group of Workforce Assurance Committee) by Care Groups. | Training Compliance reported to Group on regular ongoing basis. | Papers and Minutes of Education Governance Group | Regular Monitoring Report to Committee/Group | Completed | N/A | N/A | D | N/A | Low |
| TRUST14.3 | Sue Smith | Tony Crick | Following discussion at Care Group Performance reviews, Task and Finish group established, chaired by Tony Crick to review and address issues regarding medical Device Training records | Task and Finish group to improve training for Practice Educator Facilities and to clarify their role in Medical Device TMS and TNA | Task and Finish group | Task and Finish group Review | Completed | N/A | N/A | D | N/A | Low |
| TRUST14.4 | Sue Smith | Tony Crick | Task and Finish Group to arrange additional training Medical Device TMS and TNA for Practice Educator Facilitors | Completed | Task and Finish group | Additional Training | Completed | N/A | N/A | D | N/A | Low |
| TRUST14.5 | Sue Smith | Tony Crick | Task and Finish Group to provide clarity regarding the role of Practice Educator Facilities in updating the Medical Device TMS and TNA | Completed | Task and Finish group | Revised Role | Completed | N/A | N/A | D | N/A | Low |
| TRUST14.6 | Mike Thomas | Paul Jones | Confirm if the reporting and escalation of Medical Device training compliance and issues to ensure appropriate oversight at Trust Board Assurance Committee/Sub-Committee, was included/identified as an issue in Corporate Governance review. | Not identified as an issue within the Corporate Governance Review | Governance Review | Confirmation if identified as issue | 31/05/2020 | N/A | N/A | D | N/A | Low |
| TRUST14.7 | David Wilkinson | Kate Casey | Review of remit and processes of the Educational Governance Group (EGG) reports to Workforce Assurance Committee, is currently in Progress.<br>Review will involve integration of Medical Education and Clinical Skills.<br>Medical Device Training will be included within the Clinical Skills element of this review.<br>This will deliver ensure appropriate oversight, with Assurance and Escalation to the Workforce Assurance Committee. | Review in Progress, but currently delayed by COVID.<br>Confirmed that the Remit of EEG will not include Medical Device training<br>This will require a Trust wide decision on which Committee/Sub-Committee/Group will have responsibility for Resolving the issues related to Medical Device Training and Medical Device Training records | Procedural Document Library | Review Completed. Revised TOR and Procedural Documents completed | 31/12/2021 | N/A | N/A | D | N/A | Low |
| TRUST14.8 | Andrea Willimott | Andrea Willimott | Escalation required to obtain a Trust wide decision on which Committee/Sub-Committee/Group will have responsibility for Resolving the issues related to Medical Device Training and Medical Device Training records | Learning and Orgnisational Development Team confirmed that Educational Governance Group (EGG) do not have remit to resolve these issues.<br>Medical Engineering are responsible for maintaining an up to date inventory of Medical Devices in use in the Trust,<br>Learning and Organisational development are responsible for the TMS system , but are not responsible for the content of 'Non-Mandatory Training' Courses.<br>Clinical Skills Team have genera, responsibility for clinical training but this does not seem to encompass all medical device training, especially training on specialist devices.<br>Training on 'Specialist Devices' often can only be delivered by accredited trainers, these accredited trainers are often employed directly by the manufacturer of the devices, as such training is outside of the Trusts direct control to deliver and Assure.<br><br>Review of Educational Governance Group (EGG) Terms of Reference confirms EGG are/should be responsible for the oversight of 'Non-Mandatory Training' Courses - issue to be raised with Chair of EGG.<br>Educational Governance Group is a sub-committee of the Workforce Assurance Committee - Issue to be raised with Chair of WAC and Exec Director of Workforce | TBC | Clarity of responsibility for Medical Device Training Records | 31/12/2020 | N/A | N/A | NTMI | N/A | Medium |

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| TRUST14.9 | Andrea Willimott | Andrea Willimott | Escalation of concerns regarding overall responsibility for Medical Device Training and Medical Device Training Records to Workforce Assurance Committee. | Concerns reporting in CQC Engagement/Improvement Report to Workforce Assurance Committee neeting on 16th November.<br>Advised that Tony Crick is still leading on this Issue. | Agenda and Papers of Workforce Committee | Escalation to Workforce Committee | 30/11/2020 | N/A | N/A | D | N/A | Low |
| TRUST14.10 | Sue Smith | Tony Crick | Establish Task and Finish Group to review current TNA and TMS process and system related to Medical Devices to deliver a functional Medical Devices Module in TMS that provides accurate Medical Device Training Records. | Group established, Reps from I3, Medical Engineering and Governance - requires Rep from Practice Education.<br>Review meeting to held fortnighly from 19/11 onwards.<br>Tony Crick to take issues to ENACT meeting to raise awareness and engagement from Senior Nursing Team.<br>I3 to review current system and confirm scale and scope of change that is required. | TMS | Functional Medical Devices Module in TMS that provides accurate Medical Device Training Records | 31/03/2021 | N/A | N/A | OT | N/A | Medium |

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| **Recommendation Ref. No.:** | **UOR01** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **USE OF RESOURCES** |
| **CQC Service Name:** | **Corporate Services** |
| **Must or Should Action / UoR Finding:** | **USE OF RESOURCES** |
| **UHMBT Exec Lead:** | **Keith Griffiths** |
| **UHMBT Care Group:** | **Trust Wide** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Finance Committee** |
| **UHMBT Strategic Objective:** | **Performance** |
| **UHMB Theme:** | **Finance** |
| **CQC Recommendation:** | The Trust will take action to effectively manage its financial resources |
| **Story behind the Recommendation:** | The trust is in deficit and does not have a track record of managing spending within available resources and in line with plans<br>The trust failed to balance its budget in 2017/18 and 2018/19.<br>The trust is reliant on external loans to meet its financial obligations and deliver its services.<br>The level of non-recurrent CIP delivered in the current and previous year is above 50%.<br>The trust needs to urgently start to reduce the deficit and deliver a high proportion of CIPs recurrently. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | TBC - Copy from NHSI Guidance Document |
| **What the Trust believes is achievable in Financial Year 2020/21:** | TBC - need to confirm current/revised financial targets for 2020/21 |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| UoR01.01 | Keith Griffiths | Janet Higgs | Care Group & Corporate Team CIP Schemes for 2018/19 | The Schemes delivered total savings of £14.65m, of which £6.05m was recurrent. | 2018/19 CIP Programme | Completion of 2018/19 CIP Programme | 01/04/2019 | N/A | N/A | D | NA | Low |
| UoR01.02 | Keith Griffiths | Keith Griffiths | Agree Control total and CIP target with NHS England. | The Trust has accepted its control total and is planning a deficit of £60.1m (before Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF), meaning a requirement to deliver a Cost Improvement Programme of £22 million for 2019/20, agreed in March 2019 | Agreement of Cost Control Total | Acceptance of Trust Cost control total | 01/04/2019 | N/A | N/A | D | NA | Low |
| UoR01.03 | Keith Griffiths | Keith Griffiths | Develop and agree a 2019/20 CIP to deliver £22m savings, Care Groups CIPs of £8.846m and Corporate CIPs of £13.154m.<br><br>Achievement of this CIP target would allow access to PSF & FRF of £21.5m recusing the Trust deficit for 19/20 to £38.6m. | To achieve the CIP target, there is an agenda for organisational development to drive efficiencies in the organisation. A piece of work done by Four Eyes high lights efficiency opportunities not only for the trust, but also across the health economy.<br><br>2019/20 CIP Agreed at Trust Finance Committee April 2019 meeting.<br>Performance will monitored at the Trust Finance Committee and at Cost Control Board on a monthly basis. | 2019/20 CIP Programme | 2019/20 CIP Programme agreed | 30/04/2019 | N/A | N/A | D | NA | Low |
| UoR01.04 | Keith Griffiths | Keith Griffiths | Cost Control Board established which comprises of the Executive Team, the PMO and invited others as required | Cost control Board accountable for the overall programme, monitoring and reporting of work programmes. | Cost Control Board ToR, Agendas, Papers and minutes | Cost Control Board established | 01/04/2019 | N/A | N/A | D | NA | Low |
| UoR01.05 | Keith Griffiths | Keith Griffiths | Develop and implement an ongoing 'War on waste' campaign to mobilise all our colleagues on the finance agenda and in so demonstrating that out standing care means reduced variation and lower cost. | Project Launched,<br>Dedicated website, email address and phone number | 'War on waste' campaign | | 31/03/2020 | N/A | N/A | D | NA | Low |
| UoR01.06 | Keith Griffiths | Keith Griffiths | The finance and informatics teams are investigating innovative ways of reporting the financial and performance message, so that front line colleagues can identify how they personally can contribute to making the necessary savings. | | | | 31/03/2020 | N/A | N/A | D | NA | Low |
| UoR01.07 | Keith Griffiths | As per PMO CIP workbooks | The Care Group CIPS have identified £8.846m in potential savings.<br><br>The Care Groups CIPs have been graded by the PMO as follows:<br>Low Risk - £3.361m<br>Medium Risk - £1.214m<br>High Risk - £3.412m | Progress against CIP is reported fortnightly to NHSE/I - awaiting latest figures from Janet Higgs | 2019/20 CIP Programme | Savings of £8.846m | 31/03/2020 | £8.846m | £1,324m | D | NTMA | Medium |

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| UoR01.08 | Keith Griffiths | As per PMO CIP workbooks | The Corporate Cross Cutting CIP Programme has identified 10 CIPS with £13.154m in potential savings, each with an Executive Lead:<br>£5.800m - Effective Use of People (David Wilkinson)<br>£2.000m - Outpatient Pathway (Foluke Ajayi)<br>£2.000m - Procurement (Keith Griffiths)<br>£0.900m - Theatres & Endoscopy (Keith Griffiths)<br>£0.530m - Prescribing & Medicines (Shahedal Bari)<br>£0.470m - Diagnostics (Shahedal Bari)<br>£0.400m - Service Sustainability (Shahedal Bari)<br>£0.400m - Space Utilisation (Foluke Ajayi)<br>£0.400m - Ward Standardisation (Sue Smith)<br>£0.254m - Commercial Strategy (Keith Griffiths)<br><br>All of Cross Cutting CIPs have been risk graded by the PMO as follows:<br>Low Risk - £0m<br>Medium Risk - £0m<br>High Risk - £13.154m | Corporate Cross Cutting CIP Programme is being tracked monthly with the significant CIP cross cutting schemes scheduled to release savings from July 2019. | 2019/20 CIP Programme | Savings of £13.154m | 31/03/2020 | £13.154m | £0.000m | D | NTMA | High |
| UoR01.09 | Kate Maynard | Tristram Reynolds | Prepare a business case for the introduction of Automated Number Plate Recognition (ANPR) across Trust car parks to enable the potential introduction of penalty charging scheme. | Need to confirm timescale for business case development<br>Suspended Due to COVID | Business Case | Business Case developed and presented | 31/03/2021 | N/A | N/A | OT | NA | Medium |
| UoR01.10 | Keith Griffiths | Andrea Willimott | Governance Team to undertake a Review of Trust Recommendations and Use of Resource findings to identify Action plans that can be integrated into the existing Work plans of the Finance Committee or one of its sub Committees for ongoing monitoring and reporting to avoid unnecessary duplication of monitoring and reporting. | Use of Resources UoR1 identified for potential closure.<br>Trust Financial position to be monitored/reported at Finance & Performance Committee<br>Closure request submitted to June Finance & Performance meeting | CQC Improvement Plan Paper to Finance Committee | Review Completed | 30/06/2020 | N/A | N/A | D | NA | Low |
| UoR01.11 | Keith Griffiths | Tim Povall | Work towards financial Breakeven position in fionancial year 2020/21 | At the end of September the Trust is reporting a breakeven position after receiving top up<br>income of £58.6m<br>Excluding Covid, the Trust has an underlying deficit worse than planned, trading £3.4m<br>above the planned deficit position of £38.8m. The trading position has continued todeteriorate for the third month in a row and needs management response<br>Capital spend to the half year position is £12.4m, 25% of the annual plan of £48.6m. The second half of the year has its risks and challenges. Of the current total spend, £6.4m relates to COVID. A financial envelope for the second half of the year has been allocated to the ICS, however discussions continue with the ICS Directors of Finance to understand the impact for the<br>individual organisations. Monthly block payments based on activity levels delivered in line with the phase 3 letter will continue. These block payments will flex, dependant on the<br>delivery of activity against the phase 3 targets | | Financial Performance Report to Board | 31/03/2021 | | | OT | | Medium |
| UoR01.12 | Keith Griffiths | Keith Griffiths | Devcelop and Implment Trust Financial Recovery Plan | Trust Board Workshop on Financial recovery on 26 August 2020<br>Oppurtunites totalling £44.7m identified<br>Paper presented to Public Board Meeting in September. | Financial recovery Plan | Financial Performance Report to Board | 31/03/2021 | | | | | Medium |
| UoR01.12 | Keith Griffiths | Tim Povall | Confirm Financial Envelope for 2020/21. | Financial Envelope for September 2020 to March 2021 to be confirmed.<br>October 2020: The financial envelope for months 7-12 remains under negotiation with the ICS. The forecast<br>spend for the remaining months' amounts to £76m. This is £18m higher than that incurred in months 1-6 and reflects the additional costs for stepping up activity in a Covid secure environment and dealing with the anticipated winter pressures. The total year end forecast is £135m a slight improvement on the previous month but still outside of the envelope range for the remaining six months. | | | 31/03/2021 | | | OT | | Medium |

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| **Recommendation Ref. No.:** | **UOR02** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **USE OF RESOURCES** |
| **CQC Service Name:** | **Corporate Services** |
| **Must or Should Action / UoR Finding:** | **USE OF RESOURCES** |
| **UHMBT Exec Lead:** | **Kate Maynard** |
| **UHMBT Care Group:** | **Trust Wide** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Finance Committee** |
| **UHMBT Strategic Objective:** | **Performance** |
| **UHMB Theme:** | **Finance** |
| **CQC Recommendation:** | The Trust will take action use its resources to provide clinical services that operate as productively as possible |
| **Story behind the Recommendation:** | The trust benchmarks above the national median for per WAU for; Overall costs, Medical costs, Nursing costs, AHP costs and Agency spend<br>The trust benchmarks in the highest (worst) quartile for estates and facilities, hard and soft FM costs and backlog maintenance.<br>The trust benchmarks above the national average for the majority of corporate services, including HR, Finance and Payroll function cost per £100m turnover.<br>The trust's DNA rate is increasing and is higher than the national average. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | TBC - Copy from NHSI Guidance Document |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Improvement in Operational Efficiency from implementation of Inpatient , Outpatients and Theatre Workstreams |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| UoR02.01 | Foluke Ajayi | Kate Maynard | Maintain and build on the existing rigour around the Board, Finance and performance, Sustainability Board; Cost Control Board, monthly meetings with the Finance Director (FD)/Chief Operating Officer (COO) and care group triumvirate to manage immediate challenges and maintain a focus on the future. | Ongoing Process, no obvious target date | N/A | | | N/A | N/A | D | NA | Low |
| UoR02.02 | Foluke Ajayi | Kate Maynard | Implement the Five year recovery plans with detailed, integrated financial planning. The detailed plan is driven by activity, capacity, workforce and illustrates the action being taken to reduce our deficit by over 50% over five years, whilst also meeting the demands of an ageing workforce and local demographic changes. | Ongoing Process, no obvious target date | Five year recovery plans | Implement the Five year recovery plans | | N/A | N/A | D | NA | Medium |
| UoR02.03 | Keith Griffiths | Suzanne Hargreaves | Model Hospital and GiRFT Steering Group established and Chaired by the Finance Director to drive the reduction of unwarranted variation in clinical practice and holding clinical leaders to account for the stewardship and behaviours that can affect both income and cost. | Ongoing Process, no obvious target date | Model Hospital and GiRFT Steering Group ToR, Papers & Minutes | Model Hospital and GiRFT Steering Group | | N/A | N/A | D | NA | Medium |
| UoR02.04 | Keith Griffiths | Janet Higgs | Implementation of a new PLIC (Patient Level Patient Level Information and Costing) System linked to our data warehouse which will enable a connected quality, performance and financial reporting tool. | | PLIC System | Implementation of a new PLIC System | 31/08/2019 | N/A | N/A | D | NA | Medium |
| UoR02.05 | Keith Griffiths | | Bay wide working on the triple aim (Quality, Performance, Sustainability) with costs consciously sponsored by the Trust, CCG, primary care, social care and third sector partners and a system understanding of our cost base.<br><br>This project has ongoing timeline and performance will be reviewed on a quarterly basis. | Ongoing Process, no obvious target date.<br>Action still in development, Exec Lead and Actions Owners not yet agreed | | | | N/A | N/A | D | NA | Medium |
| UoR02.06 | Keith Griffiths | | Undertake an analytic deep dive into Overall WAU along with benchmarked data to explore potential additional solutions- September 2019 to complete initial analytics. | Action still in development, Exec Lead and Actions Owners not yet agreed | | | 30/09/2019 | N/A | N/A | D | NA | Low |
| UoR02.07 | Keith Griffiths | I3 Business Intelligence Team | Investigate the scope to develop internal 'run rate' monitoring for WAU, to help the early identification of improvements or reductions in WAU. | Existing NHSI Methodology for WAU is a once per annum calculation, which uses annualised performance data and annual cost data, amongst other data sources.<br>Internal Assessment is that an internally produced WAU run rate would be extremely difficult to administer and is almost certain to produce inaccurate/misleading data.<br>Decision taken not to proceed with further development.<br>Monitoring/Assessment of WAU will take place when Model Hospital is updated by NHS Improvement in December 2019. | N/A | Investigation completed | 30/09/2019 | N/A | N/A | D | NA | Low |
| UoR02.08 | Keith Griffiths | N/A | Work with NHS Improvement to assess and interrogate Model Hospital Data as it is updated and published to identify potential areas of opportunity and to investigate the feasibility of delivering these opportunities. | The trust has agreed to revisit the WAU/ model hospital in October's Finance & Performance Committee and will take any further analysis and action. | | | 31/03/2020 | N/A | N/A | D | NA | Low |
| UoR02.09 | Keith Griffiths | N/A | Focus upon the delivery of the Trusts Control Target in financial year 2019/20.<br>Delivery of the Control Target will, by default, lead to reduction in the cost base which should then lead to increased productivity/efficiency. | Cost reductions reported in the Sustainable Financial Recovery Plan of October 2018.<br>Developing actions to increase cost reductions in Qtr3 & Qtr4 of 2019/20. | | | 31/03/2020 | N/A | N/A | D | NA | Low |
| UoR02.10 | Keith Griffiths | N/A | Review the 2018/19 WAU data to be published by NHS Improvement in December 2019 to assess if improvements have been made in the areas identified by NHS Improvement: Overall WAU | 2017/18 - £4095/WAU<br>2018/19 - Equivalent data not produced due to change in NHSI methodology, comparison not possible/meaningful | NHSI Model Hospital | Review completed | 31/03/2020 | N/A | N/A | D | NA | Low |

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| UoR02.11 | Keith Griffiths | N/A | Review the 2018/19 WAU data to be published by NHS Improvement in December 2019 to assess if improvements have been made in the areas identified by NHS Improvement: Medical WAU | 2017/18 - £544/WAU<br>2018/19 - Equivalent data not produced due to change in NHSI methodology, comparison not possible/meaningful | NHSI Model Hospital | Review completed | 31/03/2020 | N/A | N/A | D | NA | Low |
| UoR02.12 | Keith Griffiths | N/A | Review the 2018/19 WAU data to be published by NHS Improvement in December 2019 to assess if improvements have been made in the areas identified by NHS Improvement: Nursing WAU | 2017/18 - £877/WAU<br>2018/19 - Equivalent data not produced due to change in NHSI methodology, comparison not possible/meaningful | NHSI Model Hospital | Review completed | 31/03/2020 | N/A | N/A | D | NA | Low |
| UoR02.13 | Keith Griffiths | N/A | Review the 2018/19 WAU data to be published by NHS Improvement in December 2019 to assess if improvements have been made in the areas identified by NHS Improvement: AHP WAU | 2017/18 - £144/WAU<br>2018/19 - Equivalent data not produced due to change in NHSI methodology, comparison not possible/meaningful | NHSI Model Hospital | Review completed | 31/03/2020 | N/A | N/A | D | NA | Low |
| UoR02.14 | Keith Griffiths | N/A | Review the 2018/19 WAU data to be published by NHS Improvement in December 2019 to assess if improvements have been made in the areas identified by NHS Improvement: Agency Spend WAU | 2017/18 - £195/WAU<br>2018/19 - Equivalent data not produced due to change in NHSI methodology, comparison not possible/meaningful | NHSI Model Hospital | Review completed | 31/03/2020 | N/A | N/A | D | NA | Low |
| UoR02.15 | Foluke Ajayi | Claire Alexander | Identify a solution to the Day Case Theatres at the Royal Lancaster Infirmary (concern identified regarding air quality and safety standards), to enable Surgical Day Case output to be maintained. | The two Day Case Theatres at the Royal Lancaster Infirmary will be closed by the end of October 2019.<br>Ophthalmology day case surgery will be undertaken at Westmorland General Hospital.<br>The work of other Surgical Specialties currently undertaken at RLI will be transferred to other sites, predominately WGH. | Trust Management Board minutes (02/10/2019) | Solution identified and implemented | 02/10/2019 | N/A | N/A | D | NA | Low |
| UoR02.16 | Foluke Ajayi | Claire Alexander | Identify a solution that will increase throughput through our theatres and reduce waiting times for Surgical patients, in particular for Trauma and Orthopaedics. | Trauma and Orthopaedics will implement all day theatre lists at Royal Lancaster Infirmary, Furness General Hospital and Westmorland General Hospital.<br>Extend all day theatre lists for other appropriate Surgical specialties once implementation of Trauma and Orthopaedics lists has been completed. | Trust Management Board minutes (02/10/2019) | Solution identified and implemented | 02/10/2019 | N/A | N/A | D | NA | Low |
| UoR02.17 | Keith Griffiths | Shahedal Bari | Identify a solution that will increase the time that our senior medical staff to maximise their front line clinical patient contact, to help address waiting times and improve patient flow. | Senior medical staff will be asked to minimise clinical audit and administration time from October 2019 to March 2020. | Trust Management Board minutes (02/10/2019) | Solution identified and implemented | 02/10/2019 | N/A | N/A | D | NA | Low |
| UoR02.18 | Keith Griffiths | Sue Smith | Identify a solution that will enable our senior nurse leadership to move away from coordination roles to maximise their front line clinical patient contact, to ensure that the needs of the patient come first. | Senior nurse leadership staff will move away from coordination roles as much as practically possible from October 2019 to March 2020. | Trust Management Board minutes (02/10/2019) | Solution identified and implemented | 02/10/2019 | N/A | N/A | D | NA | Low |
| UoR02.19 | Keith Griffiths | David Wilkinson | Implement a freeze on the recruitment of Admin and Clerical staff | Freeze Implemented | Trust Management Board minutes (02/10/2019) | Freeze Implemented | 02/10/2019 | N/A | N/A | D | NA | Low |
| UoR02.20 | Keith Griffiths | David Wilkinson | Implement a freeze on administration related overtime. | Freeze Implemented | Trust Management Board minutes (02/10/2019) | Freeze Implemented | 02/10/2019 | N/A | N/A | D | NA | Low |
| UoR02.21 | Keith Griffiths | David Wilkinson | Implement a freeze on the review of the salary banding of current job roles. | Freeze Implemented | Trust Management Board minutes (02/10/2019) | Freeze Implemented | 02/10/2019 | N/A | N/A | D | NA | Low |
| UoR02.22 | Keith Griffiths | Andrea Willimott | Governance Team to undertake a Review of Trust Recommendations and Use of Resource findings to identify Action plans that can be integrated into the existing Work plans of the Finance Committee or one of its sub Committees for ongoing monitoring and reporting to avoid unnecessary duplication of monitoring and reporting. | Use of Resources UoR identified for potential closure.<br>WAU performance metrics are only updated once per year by NHS Improvement.<br>WAU metrics for 2019/20 and 2020/21 will be impacted by COVID.<br>Trust will measure efficiency improvements by use PLICs data.<br>PLICS data to be included in Performance report to F & P , EDG and Board<br>Closure request submitted to June Finance & Performance meeting.<br>Closure request agreed - Action Plan closed | CQC Improvement Plan Paper to Finance Committee | Review Completed | 30/06/2020 | N/A | N/A | D | NA | Low |
| UoR02.23 | Keith Griffiths | Andrea Willimott | Request from Chief Executive that WAU Related Recommendation Action Plans (UoR2 - UoR6) are re-opened and new actions initiated | Action Plans (UoR2 - UoR6) re-opened<br>Awaiting confirmation of new actions to enable update of new action plan | CQC Improvement Plan | CQC Improvement Plan | 30/09/2020 | N/A | N/A | D | NA | Low |
| UoR02.24 | Foluke Ajayi | Tristram Reynolds | In partnership with NHSI/E build a strong case to DHSC for capital investment to address ageing estate and lack of available funding over a number of years which has resulted in major operational, reputational and financial challenges. | Application submitted to NHSI.<br>Copy of paper submitted to May Finance committee Meeting. | Business case for Capital Investment | Application submitted to NHSI. | 01/04/2020 | N/A | N/A | D | NA | Low |
| UoR02.25 | Foluke Ajayi | Tristram Reynolds | Submit Emergency Capital Financing Application to NHS Improvement for £34m to address:<br>- Refurbishment of RLI Centenary Building Theatres<br>- Replacement of RLI Day Case Theatres<br>- Refurbishment of WGH Theatres<br>- Improvement Radiology Capacity at FGH and RLI<br>- Asbestos removal at RLI<br>- Rebuild the RLI Energy Centre | Application submitted to NHSI.<br>Copy of paper submitted to May Finance committee Meeting.<br>Monthly progress reports/updates to be reported to Finance Committee and Trust Board. | Application for Capital Investment | Emergency Capital Financing Application submitted to NHSI | 31/10/2019 | N/A | N/A | D | NA | Medium |
| UoR02.26 | Foluke Ajayi | Tristram Reynolds | 2019/20 Capital Plan agreed and includes £5.3m of work to address maintenance Backlog.<br>There is a further £10.5m of maintenance Backlog. | | 2019/20 Capital Plan | | 31/03/2020 | N/A | N/A | D | NA | Low |
| UoR02.27 | Foluke Ajayi | Tristram Reynolds | Check comparative status again once Model Hospital is revised upon the 2019 ERIC return. | Data on income from car parking will be correctly submitted to ERIC this year, reducing total E&F costs recorded in NHSI Model Hospital by ~£2m.<br>A data entry error in the 2018 ERIC data submission to NHSE Estates team, resulted in £1m income from car parking being incorrectly added to, not subtracted from, the net cost of E&F services. | Model Hospital and ERIC Returns | Hard FM and overall Estates & Facilities costs will be within second best quartile when Model Hospital re-issued in late 2019. | 30/06/2019 | | | D | NA | Low |
| UoR02.28 | Foluke Ajayi | Tristram Reynolds | Identify a solution to help reduce maintenance costs. | Out Of Hours maintenance will be significantly limited as from October 2019. | Trust Management Board minutes (02/10/2019) | Solution identified and implemented | 02/10/2019 | N/A | N/A | D | NA | Low |

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| UoR02.29 | Foluke Ajayi | Tristram Reynolds | Review of NHSI Improvement Model Hospital data for 2018/19, when published on Model Hospital, to assess the Overall Estates & Facilities Costs to confirm if there has been any year on Year improvement from 2017/18 to 2018/19 and to review those area identified by NHS Improvement as having largest potential scope for significant improvement opportunities and align with CIP plans where practical. | 2016/17: £396/m<br>2017/18: £402/m<br>2018/19: £309/m<br><br>2018/19 National Median is £366/m | NHSI Improvement Model Hospital data for 2018/19 for the Estates and Facilities Corporate function | Review completed | 30/11/2019 | N/A | N/A | D | D | Low |
| UoR02.30 | Foluke Ajayi | Tristram Reynolds | Review of NHSI Improvement Model Hospital data for 2018/19, when published on Model Hospital, to assess the Hard FM Costs to confirm if there has been any year on Year improvement from 2017/18 to 2018/19 and to review those area identified by NHS Improvement as having largest potential scope for significant improvement opportunities and align with CIP plans where practical. | 2016/17: £94/m<br>2017/18: £120/m<br>2018/19: £ 102/m<br><br>2018/19 National Median is: £86/m<br>2018/19 Peer Median is: £99/m | NHSI Improvement Model Hospital data for 2018/19 for the Estates and Facilities Corporate function | Review completed | 30/11/2019 | N/A | N/A | D | D | Low |
| UoR02.31 | Foluke Ajayi | Tristram Reynolds | Review of NHSI Improvement Model Hospital data for 2018/19, when published on Model Hospital, to assess the Soft FM Costs to confirm if there has been any year on Year improvement from 2017/18 to 2018/19 and to review those area identified by NHS Improvement as having largest potential scope for significant improvement opportunities and align with CIP plans where practical. | 2016/17: £168/m<br>2017/18: £161/m<br>2018/19: £111/m<br><br>2018/19 National Median is: £122/m<br>2018/19 Peer Median is: £142/m | NHSI Improvement Model Hospital data for 2018/19 for the Estates and Facilities Corporate function | Review completed | 30/11/2019 | N/A | N/A | D | NTMA | Low |
| UoR02.32 | Foluke Ajayi | Tristram Reynolds | Review of NHSI Improvement Model Hospital data for 2018/19, when published on Model Hospital, to assess the Backlog Maintenance to confirm if there has been any year on Year improvement from 2017/18 to 2018/19 and to review those area identified by NHS Improvement as having largest potential scope for significant improvement opportunities and align with CIP plans where practical. | 2016/17: £569/m<br>2017/18: £596/m<br>2018/19: £513/m<br><br>2018/19 National Median is: £200/m<br>2018/19 Peer Median is: £225/m | NHSI Improvement Model Hospital data for 2018/19 for the Estates and Facilities Corporate function | Review completed | 30/11/2019 | N/A | N/A | D | NTMA | Low |
| UoR02.33 | Foluke Ajayi | Tristram Reynolds | Estates and Facilities 2019/20 CIP has identified £1.08m of potential savings. | CIP Position as of; August 2019<br>Plan: £466k<br>Achieved: £312k<br>67% of Plan | 2019/20 CIP Programme | CIP savings delivered | 31/03/2020 | 100% of Planned CIP | 67% | D | NTMA | Medium |
| UoR02.34 | Foluke Ajayi | Tristram Reynolds | Identify a solution to standardised the approach to maintenance across the Trust's sites. | In progress.<br>Need to confirm target date. | | Standardised approach implemented | | N/A | N/A | D | NA | Low |
| UoR02.35 | Foluke Ajayi | Tristram Reynolds | Determine which Building and Infrastructure projects will receive capital funding from the £34 million two year loan from DHSC will be allocated to. | £18 million loan in 2019/20, £14 million loan in 2020/21<br>Initial announcement that funning will be allocated to:<br>Upgrade of Operating Theatres<br>Upgrade to Radiology Facilities<br>Upgrade to Heating Systems | Capital plan group minutes. | Funding allocated | | N/A | N/A | D | NA | Medium |
| UoR02.36 | Keith Griffiths | Andrea Willimott | Governance Team to undertake a Review of Trust Recommendations and Use of Resource findings to identify Action plans that can be integrated into the existing Work plans of the Finance Committee or one of its sub Committees for ongoing monitoring and reporting to avoid unnecessary duplication of monitoring and reporting. | Use of Resources UoR identified for potential closure.<br>Estates Costs to be monitored at Estate Performance Review Meetings and at Finance Committee<br>Closure request submitted to June Finance & Performance meeting | CQC Improvement Plan Paper to Finance Committee | Review Completed | 30/06/2020 | N/A | N/A | D | NA | Low |
| UoR02.37 | Keith Griffiths | Relevant Corporate Service | Review of NHSI Improvement Corporate services costs overview 2018/19, when published on Model Hospital, to assess the Corporate Services that NHS Improvement have identified as having potential scope for significant improvement opportunities. | Review of NHSI Improvement Corporate services costs overview 2018/19 published In September 2019.<br>Corporate Service Costs per £100m of Trust turnover reduced from £7.04m in 2017/18 to £6.9m in 2018/19, 2% reduction.<br><br>Service Assessment, in terms of cost per £100m of Trust turnover, UHMBT compated to National Lower Quartile:<br>- All Corporate Services, UHMBT £6.9m, LQ £5.15m, 34% variance<br>- Finance, UHBMT £0.61m, LQ £0.60m, 2% variance<br>- Governance, UHMBT, £1.11m, LQ £0.62m, 78% variance<br>- HR, UHMBT £1.16m, LQ £0.86m, 34% variance<br>- IMT (Transactional), UHMBT £2.01m, LQ £1.46m, 38%variance<br>- Legal, UHMBT £0.17m, LQ £0.09m, 93%variance<br>- Payroll, UHMBT £0.12m, LQ £0.08m, 45%variance<br>- Procurement, UHMBT £0.22m, LQ £0.14m, 53%variance<br><br>Largest potential improvement opportunities, by value, are in Governance, HR and IMT | NHSI Improvement Corporate services costs overview 2018/19 | Services with largest potential improvement opportunities identified | 31/10/2019 | N/A | N/A | D | NA | Low |
| UoR02.38 | David Wilkinson | Gertie nic Philib | Trust to tender for a new payroll supplier through the LPP Framework Procurement Process- Feb 19 | Bidder presentations took place in March/ April 19.<br>Preferred supplier is East Lancashire Financial Shared Services.<br>Contract Awarded, planned go Live on 01/10/2019 | N/A | New Payroll supplier appointed | 01/04/2019 | N/A | N/A | D | NA | Medium |
| UoR02.39 | David Wilkinson | Gertie nic Philib | Programme Board management of the transition Chaired by the Director of People and OD and supported by a Programme Director with a planned exit of supplier by October 2019. | New supplier is East Lancashire Financial Shared Services, contract awarded, planned go Live on 01/10/2019.<br>Contract with SBS terminated with effect from 30/09/2019. | New Supplier | Transition between suppliers | 31/10/2019 | N/A | N/A | D | NA | Medium |
| UoR02.40 | Sue Smith | Andrea Willimott | Undertake a review of the Clinical and Corporate Governance Structure to reduce the total headcount, the alignment of band 8 level posts in line with that of comparable services, to address banding differences and to bring the Trust back in alignment with other NHS Trust Governance services. | Review underway, Review completed, new structure in place | ESR | Review completed and change implemented | 31/03/2020 | N/A | N/A | D | NA | Medium |

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| UoR02.41 | Keith Griffiths | Andrea Willimott | Governance Team to undertake a Review of Trust Recommendations and Use of Resource findings to identify Action plans that can be integrated into the existing Work plans of the Finance Committee or one of its sub Committees for ongoing monitoring and reporting to avoid unnecessary duplication of monitoring and reporting. | Use of Resources UoR identified for potential closure.<br>Corporate Services Costs to be monitored at Finance Committee<br>Closure request submitted to June Finance & Performance meeting | CQC Improvement Plan Paper to Finance Committee | Review Completed | 30/06/2020 | N/A | N/A | D | NA | Low |
| UoR02.42 | Kate Maynard | Russell Norman | Monitoring of UHMBT performance against NHS National Benchmarking data | The NHS National Benchmarking data collection report states that nationally the average DNA rate for all specialities in 2018 was 8.4%.<br>UHMB outpatient dashboard shows DNA rate across all specialities for 18/19 was 8.11%<br>UHMB outpatient dashboard shows DNA rate across all specialities for 19/20, to date, is currently 8.09%. | NHS National Benchmarking data and UHMBT Outpatient Dashboard | Monitoring of UHMBT performance against NHS National Benchmarking data | 31/03/2020 | 8% | 8.09% | D | OT | Low |
| UoR02.43 | Kate Maynard | Russell Norman | Monitoring of UHMBT performance against NHS Improvement Model Hospital data | Model Hospital Data:<br>Period: 2019/20 Qtr 3<br>UHMB Performance: 7.50%<br>National Average: 7.11% | NHSI Model Hospital | Match or beat the National Average | 31/03/2020 | 7% | 7.50% | D | NTMI | Low |
| UoR02.44 | Kate Maynard | Russell Norman | Achieve Target DNA Rate of 5% | Apr 2019 - 8.04%<br>May 2019 - 7.398%<br>June 2019 - 8.067%<br>July 2019 - 8.518%<br>August 2019 - 8.730%<br>September 2019 - 7.544%<br>October 2019 - 8.442%<br>November 2019<br>December 2019<br>January 2020<br>February 2020<br>March 2020 - 7.9% | Quality Committee Dashboards | Achieve Target DNA Rate of 5% | 31/03/2020 | 5.00% | 7.90% | D | NTMI | Low |
| UoR02.45 | Foluke Ajayi | Russell Norman | Establish an Outpatient Steering Group to oversee the delivery of savings on the efficiencies and improvements for Years 1 and 2, and the significant changes to episodic care and long-term conditions for years 3 to 5 | Group established, first meeting held on 09/01/2019.<br>ToR Agreed on 30/04/2019.<br>Three Task and Finish Groups established:<br>- Digital Task and Finish Group<br>- Hospital Outpatient Efficiency Task and Finish Group<br>- Clinical Pathways Task and Finish Group | ToR of Outpatients Steering Group | Outpatient Steering Group established | 31/03/2019 | N/A | N/A | D | NA | Low |
| UoR02.46 | Foluke Ajayi | Russell Norman | Work with Bay Health and Care Partners to establish a 5 year project with significant cross provider work stream to review Outpatient pathways. | Review identified three areas to improve outpatient performance:<br>1) Clinical pathways, from primary care referral and care planning, to care and intervention in the acute setting<br>2) Development of digital enabling tools and mechanisms to support the patient journey and improve flow<br>3) Ensuring that acute processes and services are efficient and fit for purpose. | Review Completed | Review Completed | 31/05/2019 | N/A | N/A | D | NA | Medium |
| UoR02.47 | Foluke Ajayi | Russell Norman | Element 3 of Action Uor10.4 relates to UHMBT.<br>Review of element 3 to determine process for ensuring that acute processes and services are efficient and fit for purpose. | An internal steering group has been established with clear governance and Executive oversight.<br>The steering group has identified 19 areas of work to deliver a reduction of outpatient appointments within the current year (minimum 13500) and cash releasing efficiencies of £2m. | ToR, Agenda, Papers and Minutes of Outpatients Steering Group | Action Plan developed and implemented | 30/06/2019 | N/A | N/A | D | NA | Medium |
| UoR02.48 | Foluke Ajayi | Russell Norman | Set stretching 5 year target for reduction in outpatient appointments | Outpatients Steering Group agreed the following five year targets on 09/01/2019<br>• 30% reduction in re-imagining outpatients by Year 5.<br>• 25% reduction in episodic care by Year 5.<br>• 66% reduction in appointments for patients with long-term conditions by Year 5. | ToR, Agenda, Papers and Minutes of Outpatients Steering Group | Targets agreed | 31/03/2020 | N/A | N/A | D | NA | Medium |
| UoR02.49 | Aaron Cummins | Paul Jones | Establish a Strategy and Transformation Group to lead on delivery in operational effecicieny using; COVID remodelling, Model Hospital, PLICs etc | Group established<br>Is not a Board Assurance Committee<br>Reports to Finance Committee and Board on Bi-weekly Basis | ToR of Strategy and Transformation Group | Strategy and Transformation Group established | 30/06/2020 | N/A | N/A | D | NA | Low |
| UoR02.50 | Kate Maynard | Chair of S&T Group | Strategy and Transformation Group to identify Key Workstreams to improve operational efficiency during 2020/21 | Key Workstreams confirmed as:<br>- Inpatients (RTT Backlog, Ward modelling and utilisation, LoS, Delayed Discharge etc)<br>- Outpatients (RTT Backlog, Clinic Utilisation DNA etc)<br>- Theatres (Theatre modelling, capacity and utilisation) | ToR, Agenda, Papers and Minutes of Strategy and Transformation Group | Key Workstreams identified and initiated | 30/07/2020 | N/A | N/A | D | NA | Low |
| UoR02.51 | Keith Griffiths | Keith Griffiths | Establish Process for ongoing review of Effficiency programmes at Finance Committtee during financial year 2020/21. | Process established<br>October 2020 - Request from Finance Committee for Recommendation UoR2 to be at status of 'Improvement not being Delivered'. | Papers and minutes of the Finance Committee | Review of Effficiency programmes at Finance Committtee | 31/03/2021 | N/A | N/A | OT | NA | Low |
| UoR02.52 | Kate Maynard | TBC | Implementation of Inpatients Workstream<br>(RTT Backlog, Ward modelling and utilisation, LoS, Delayed Discharge etc) | Arrange meeting with Suzanne Hargreaves to agree process for receiving progress updates from S&T Group | Papers and Minutes of Strategy and Transformation Group | Workstream implemented, improved efficiency | 31/03/2021 | N/A | N/A | OT | NA | Medium |
| UoR02.53 | Kate Maynard | TBC | Implementation of Outpatients Workstream<br>(RTT Backlog, Clinic Utilisation DNA etc) | Arrange meeting with Suzanne Hargreaves to agree process for receiving progress updates from S&T Group | Papers and Minutes of Strategy and Transformation Group | Workstream implemented, improved efficiency | 31/03/2021 | N/A | N/A | OT | NA | Medium |
| UoR02.54 | Kate Maynard | TBC | Implementation of Theatres Workstream (Theatre modelling, capacity and utilisation) | Arrange meeting with Suzanne Hargreaves to agree process for receiving progress updates from S&T Group | Papers and Minutes of Strategy and Transformation Group | Workstream implemented, improved efficiency | 31/03/2021 | N/A | N/A | OT | NA | Medium |

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| **Recommendation Ref. No.:** | **UOR03** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **USE OF RESOURCES** |
| **CQC Service Name:** | **Corporate Services** |
| **Must or Should Action / UoR Finding:** | **USE OF RESOURCES** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Workforce** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMB Theme:** | **Staff Sickness** |
| **CQC Recommendation:** | **The Trust will take action use its workforce to provide clinical services that operate as productively as possible.**<br>**(Specific to Staff Sickness rates only)** |
| **Story behind the Recommendation:** | Sickness absence rates are above the national average and the trust should focus on how the wellbeing and occupational support offered to staff can support a reduction on sickness absence. |
| **What the CQC expect 'Good' to look like:**<br>**(Taken from relevant KLOE definition)** | TBC - Copy from NHSI Guidance Document |
| **What the Trust believes is achievable in Financial Year 2020/21:** | TBC - Need to confirm if current Target, in light of increased cases of COVID and new Restrictions in Barrow and Lancaster regions |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| UoR03.01 | David Wilkinson | Ray Olive | Continue to build and strengthen existing work programme that identifies key areas for concern and hotspot area of high absence and support specific interventions in these areas. | | | | 31/03/2020 | N/A | N/A | | NA | Low |
| UoR03.02 | David Wilkinson | Ray Olive | Continue programme of preventative measures and campaigns to develop staff resilience providing staff with advice, guidance and tips on how they can stay healthy and well – including a focus on mental health, flu vaccination and physical wellbeing. | delivery of preventative measures and campaigns is dependant upon the level of staff engagement and involvement. | | | 31/03/2020 | N/A | N/A | | NA | Medium |
| UoR03.03 | David Wilkinson | Ray Olive | Monitoring of UHMBT 2019/20 performance against NHS Improvement Model Hospital data | Model Hospital Data:<br>Period: Dec 2019<br>National Average: 4.77%<br>Apr 2019 - 4.83%<br>May 2019 - 4.97%<br>June 2019 - 4.64%<br>July 2019 - 4.99%<br>August 2019 - 5.07%<br>September 2019 - 5.03%<br>October 2019 - 5.12%<br>November 2019 - 5.31%<br>December 2019 - 5.49%<br>January 2020 -<br>February 2020 -<br>March 2020 -<br><br>Since Jan 2018, UHMBT has never performed better than the NHSI National Average<br><br>October 2020: Attendance levels in October have seen a declining picture, largely driven through a rise in COVID-related sickness absence, although it remains significantly below the peak of 16% seen in April/May 2020.<br><br>During wave 1, COVID related absence peaked at 11% (April 2020) with a low of 1.5% (August). Pre-August figures included any extremely clinically vulnerable colleagues required to shield during the first national lockdown period. At the end of October 2020 the level reached 3.6% and this has continued to rise through early November, with a number of outbreaks across many services (including detection of asymptomatic colleagues), self-isolation and COVID positive colleagues. The biggest impact is on colleagues in nursing (including Healthcare Support Workers) and Estates & Facilities.<br><br>Non-COVID absences have fluctuated and remain at an elevated level, which is largely driven by absences due to anxiety, stress and depression (most time lost) and gastrointestinal problems | NHSI Model Hospital | Match or beat the National Average | 31/03/2020 | 4.77% | 4.95% | OT | NTMI | Low |
| UoR03.04 | David Wilkinson | Gertie Nic Philib | Monthly Monitoring of Trust Wide 2019/20 Attendance rate performance at Workforce Assurance Committee | Apr 2019 - 95.3%<br>May 2019 - 95.25%<br>June 2019 - 95.19%<br>July 2019 - 95.16%<br>August 2019 - 95.3%<br>September 2019 - 95.0%<br>October 2019 - 94.5%<br>November 2019 - 94.4%<br>December 2019 - 94.2%<br>January 2020 - 94%<br>February 2020 - 94.7%<br>March 2020 - 94.8% | ESR | Achieve Target rate of 95.6% | 31/03/2020 | 95.60% | 94.80% | D | OT | Low |
| UoR03.05 | David Wilkinson | Gertie Nic Philib | Develop a Trust Wide Sickness/Absence management and reduction Plan.<br>The key challenges evidenced from the data were:<br>• Increases in absence across all Care Groups<br>• Big increases in medical and allied health professional absence<br>• Increase in ratio of short-term absence<br>• 3 main causes (Anxiety/depression, musculoskeletal, injury/fracture)<br>• Nursing (registered and support staff) accounted for greatest loss of days | A number of interventions have been put in place to support Care Groups but this has not yet result in improvements in the attendance rate, in part due to the Impact ov COVID in teh latter half of Qtr4 2019/20.<br>• Re-introduction of Care Group Check & Challenge Sessions<br>• Focus on Managing Long-Term Cases (those approaching, or in, nil pay)<br>• Focus on Managing Short-Term Cases (ensuring appropriate escalation through the check and challenge sessions)<br>• Promotion of Flourish – nutrition, hydration, rest, exercise, healthy minds<br>• Introduction of the Disability Leave Policy and Health Passport | Trust Procedural Document Library | Trust Wide Sickness/Absence management and reduction Plan | 31/03/2020 | N/A | N/A | D | NA | Low |
| UoR03.06 | David Wilkinson | Gertie Nic Philib | Undertake a review and re-design of the Trust 'Flourish' Staff health and Well Being programme. | Flourish Health and Wellbeing Strategy approved at Trust Board meeting on 30th September 2019. | Trust Procedural Document Library | Revised Trust 'Flourish' Staff health and Well Being programme | 31/12/2019 | N/A | N/A | D | NA | Low |

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| UoR03.07 | David Wilkinson | Karmini McCann | Review/Develop a Trust Wide Bullying and Harassment Reduction Plan | There is already a work programme developed by the Bullying and Harassment Working Party and a clear action plan is in place | Trust Procedural Document Library | Revised Trust Wide Bullying and Harassment Reduction Plan | | N/A | N/A | OT | NA | Low |
| UoR03.08 | David Wilkinson | Clare Hill | Undertake Flu Vaccination programme to vaccinate as maby staff as possible and to achieve the national target of 80% of frontline Health Care Workers | Vaccination Programme commenced on 01/10/2019 with Drop in Clinics, Site Walkabouts and appointments, campaign continuing over Winter.<br>10/12/2019: 80% HCW Target achieved<br>Perfomance at 28/02/2020:<br>All Staff: 80.86%<br>HCW: 83.46% | Occupational Health Flu Vaccination data | Flu Vaccination target of 80% of frontline Health Care Workers | 28/02/2020 | 80% | 83.46% | D | D | Low |
| UoR03.09 | David Wilkinson | Clare Hill | Develop and implement 12 week a 'Winter Wellness' communication campaign to make staff more aware of simple preparation and remedies to help reduce sickness and improve well being | Campaign commenced on 01/11/2019:<br>06/11: Flu Vaccine<br>13/11: Check you Home Medication cabinet<br>19/11: Beating Winter Tiredness<br>29/11: Catch it, bin it, kill it<br>03/12: Managing Anxiety<br>10/12: Skin Care<br>20/12: Keep Warm and Layer Up<br>31/12: Healthy Breakfast Discount<br>17/01: Keep Hydrated<br>24/01: Keeping Active<br><br>From the end of January 2020 the winter wellness articles changed the focus to communicating about COVID-19 (Coronavirus) awareness and articles 11 and 12 were not completed/published. | Weekly News and Intranet Articles | 12 Articles published | 31/01/2020 | 12 | 10 | D | D | Low |
| UoR03.10 | Keith Griffiths | Andrea Willimott | Governance Team to undertake a Review of Trust Recommendationsand Use of Resource findings to identify Action plans that can be integrated into the existing Work plans of the Finance Committee or one of its sub Committees for ongoing monitoring and reporting to aviod unecessary duplication of monitoring and reporting. | Use of Resources UoR identified for potential closure.<br>Sickness absence rates to be monitored at Care Group Performance Reviews and at Workforce Committee<br>Closure request submitted to June Finance & Performance meeting | CQC Improvement Plan Paper to Finance Committee | Review Completed | 30/06/2020 | N/A | N/A | D | NA | Low |
| UoR03.11 | David Wilkinson | Ray Olive | Monitoring of UHMBT 2020/21 performance against NHS Improvement Model Hospital data | Model Hospital Data:<br>National Average: %<br>Apr 2020 - 9.03%<br>May 2020 - 5.47%<br>June 2020 - 4.75%<br>July 2020 - 4.40%<br>August 2020 - %<br>September 2020 - %<br>October 2020 - %<br>November 2020 - %<br>December 2020 - %<br>January 2021 - %<br>February 2021 - %<br>March 2021 - % | NHSI Model Hospital | Match or beat the National Average | 31/03/2021 | 3.93% | 4.40% | OT | OT | Medium |
| UoR03.12 | David Wilkinson | Ray Olive | Monthly Monitoring of Trust Wide 2019/20 Attendance rate performance at Workforce Assurance Committee | Apr 2020 - %<br>May 2020 - %<br>June 2020 - %<br>July 2020 - %<br>August 2020 - %<br>September 2020 - %<br>October 2020 - %<br>November 2020 - %<br>December 2020 - %<br>January 2021 - %<br>February 2021 - %<br>March 2021 - % | ESR | Achieve Target rate of 95.6% | 31/03/2021 | 95.60% | TBC | OT | | Medium |

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| **Recommendation Ref. No.:** | **ED01** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **SAFE** |
| **CQC Service Name:** | **Urgent & Emergency Care** |
| **Must or Should Action / UoR Finding:** | **MUST DO** |
| **UHMBT Exec Lead:** | **Shahedal Bari** |
| **UHMBT Care Group:** | **Medicine Care Group** |
| **UHMBT Site(s):** | **RLI** |
| **UHMBT Board Assurance Committee** | **Finance Committee** |
| **UHMBT Strategic Objective:** | **Patients** |
| **UHMB Theme:** | **Information Governance** |
| **CQC Recommendation:** | The service (RLI ED) must ensure paper records are stored securely and computer screens are locked when not in use. |
| **Story behind the Recommendation:** | Paper and electronic records were used in the department. We noted that paper records were not stored securely. Within the major's area paper records for each patient were stored on work top at a central desk. There was not always a member of staff present so these records could be accessed by anyone in the department. For patients in holding areas such as corridors, loose sheets of patient records were stored in an open file.<br>We also observed in each of the areas, minors, majors and resus, computer screens were left unlocked with access cards left in situ. The computer screens had confidential patient information displayed. We asked a staff member to assist us in viewing the electronic records of patients and they could not locate their access card. It was found a few minutes later by another member of staff. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.<br>When there are different systems to store or manage care records, these are coordinated. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Improved Information Governance Compliance inn RLI ED |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| ED01.1 | N/A | N/A | Trust Wide Action on Information Governance being undertaken under Trust Recommendation 12. | This Recommendation will only report on actions undertaken in RLI ED. | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| ED01.2 | Shahedal Bari | Vicky Squires, Jen Molloy | Review system for safe storage of paper records | New Records trolleys ordered,<br>Arrived on 26/07/2019 | N/A | New Trolleys in Use | 19/07/2019 | N/A | N/A | D | NA | Low |
| ED01.3 | Shahedal Bari | Colin Read, Andy Crundell | Educate staff in relation to SMART cards | Department to introduce a zero tolerance approach on SMART cards in computers commencing 09/08/2019<br>Further work to be undertaken re education and awareness of smartcard vigilance:<br>Messages - leaving patient data unattended, particularly in public/patient areas the potential risk to both staff and patient data and consequences to the Trust and themselves. We will develop some communications materials including weekly news articles, posters etc. - draft materials by end of August 2019<br>Review policy and training - Double check to make sure the message that is being delivered is consistent and clear | N/A | Improved Staff understanding | 31/08/2019 | N/A | N/A | D | NA | Low |
| ED01.4 | Shahedal Bari | Andy Crundell | Work with IT to introduce new computers into the department which allow quicker access | Replacement/Upgrade of Computers in ED at FGH and RLI underway<br>All new computers now in place | N/A | Replacement/Upgrade of Computers | 26/07/2019 | N/A | N/A | D | NA | Low |
| ED01.5 | Shahedal Bari | Vicky Squires, Jen Molloy | Establish monitoring process to track information governance training for ED >95% | Process established | N/A | Process established | 26/07/2019 | N/A | N/A | D | NA | Low |
| ED01.6 | Shahedal Bari | Vicky Squires, Jen Molloy | Ensure all staff have completed information governance training | Nursing staff at 95.0%<br>Medical staff at 95.2% | TMS | 95% Compliance | 31/03/2020 | 95% | | D | D | Medium |
| ED01.7 | Shahedal Bari | Vicky Squires, Jen Molloy | Review of central nursing station to facilitate confidentiality | Completed | N/A | Review completed | 28/06/2019 | N/A | N/A | D | NA | Medium |
| ED01.8 | Foluke Ajayi | Andy Waddington | request Estates Feasibility review and re-design of central nursing station to facilitate confidentiality | Progress will be reported through Trust Recommendation 11 | N/A | Feasibility review and re-design of central nursing station | 29/11/2019 | N/A | N/A | D | NA | Medium |
| ED01.9 | Shahedal Bari | Emma Fitton | Fitting of 'privacy' filters to computer screens in RLI ED to reduce scope for accidental disclosure of patient information | In Progress<br>On Order, confirm if delivered | Oracle | privacy' filters fitted | 31/12/2020 | N/A | N/A | OT | NA | Low |
| ED01.10 | Shahedal Bari | Emma Fitton | RLI ED Matron to develop and implement ongoing Awareness and check and challenge for Information Governance in the RLI ED | Implemented.<br>Process for ongoing random checks and challenge by ED Matron In place | N/A | Process established | 31/10/2020 | N/A | N/A | D | NA | Low |
| ED01.11 | Shahedal Bari | Emily Henry | Medicine Governance Team to establish process for issuing monthly Care Group IG bulletin to help improve IG awareness and performance | Completed. Monthly Bulletin now being issued | Monthly IG Bulletin | Monthly IG Bulletin | 31/08/2020 | N/A | N/A | D | NA | Low |
| ED01.12 | Sue Smith | Andrea Willimott | Governance to escalate concerns raised by ED staff regarding the performance of Computeres in RLI ED to IG&DQ Meeting, Digital and FAC | | | | | | | | | |

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| **Recommendation Ref. No.:** | **ED02** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **EFFECTIVE** |
| **CQC Service Name:** | **Urgent & Emergency Care** |
| **Must or Should Action / UoR Finding:** | **MUST DO** |
| **UHMBT Exec Lead:** | **Shahedal Bari** |
| **UHMBT Care Group:** | **Medicine Care Group** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Quality Committeee** |
| **UHMBT Strategic Objective:** | **Performance** |
| **UHMB Theme:** | **Clinical Audit** |
| **CQC Recommendation:** | Be able to demonstrate robust plans to address the FGH Emergency Department's failure to meet RCEM audit standards from 2016/17 and 2017/18 are in place, active and being monitored for progress with re-audit to provide assurance of improvement |
| **Story behind the Recommendation:** | In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, the emergency department at Furness General Hospital failed to meet any of the national standards.<br>In the 2016/17 Consultant sign-off audit, the emergency department at Furness General Hospital failed to meet any of the national standards.<br>In the 2016/17 Severe sepsis and septic shock audit, the emergency department at Furness General Hospital failed to meet any of the national standards.<br>The department had poor results in the RCEM audits overall. Not only did the department fail to meet standards, for national audits such as the severe sepsis audit, moderate to severe asthma audit or consultant sign off audit, they were in the lower quartile of hospitals nationally.<br>The trust provided us with evidence it had taken part in two RCEM audits in 2017/18, procedural sedation and pain in children. The reports showed the department had not met any of the standards in either.<br>We requested information from the trust about clinical audit within ED. The trust provided us with evidence that the department was taking part in this year's RCEM audits. The audit plan also showed two re audits were planned in 2018/19. However, the trust did not provide us with evidence of actions taken to ensure staff met RCEM standards for audits they undertook in 2016/17. |
| **What the CQC expect 'Good' to look like:**<br>**(Taken from relevant KLOE definition)** | People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies. This is monitored to ensure consistency of practice.<br>There is participation (that includes all relevant staff) in relevant local and national clinical audits and other monitoring activities such as reviews of services, benchmarking and peer review and approved service accreditation schemes.<br>Accurate and up-to-date information about effectiveness is shared internally and externally and is understood by staff.<br>It is used to improve care and treatment and people's outcomes and this improvement is checked and monitored. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Completion of all revelant 2020/21 RCEM Audits, review and completion of outstanding actions from previous years RCEM Audits |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED02.1 | Shahedal Bari | Stuart Bates | Governance Division (Clinical Audit) to undertake review of Trust Wide Clinical Audit management processes and procedures to identify possible improvements and then develop actions to implement them. | Review to include:<br>a) Review of the Audit nomenclature in Ulysses system to make Audits easier and quicker to identify and monitor<br>b) Ensure the linking of Audits and any subsequent Re-Audits to make the complete audit chain easier and quicker to identify and monitor<br>c) Deliver standardised minimum content and format for all internal Audit presentations; Overview, methodology, findings/performance, recommendations, high level action plan<br>d) Examples of Supporting Evidence that should be attached to the Audit in the Ulysses System; Original Audit document from issuing Agency, Presentation to local Clinical Meeting(s), Minutes of the relevant local Clinical Meeting(s), Minutes of the relevant Trust CEASG meeting(s), any Communications (Weekly News articles, Poster etc.), any Trust or Care Group Learning to Improve Bulletins | Clinical Audit and Effectiveness Sterring Group | Revised Clinical Audit process in place | 30/09/2019 | N/A | N/A | D | NA | Low |
| ED02.2 | Shahedal Bari | Andrew Higham | Establish a Medicine Care Group Clinical Audit and Effectives (NICE) Group, which will monitor the Clinical Audit process and ensure that Recommendations and actions are acted upon. | Medicine audit and NICE working has been established | Medicine Care Group Clinical Audit and Effectives (NICE) Group | Group Established | 30/04/2019 | N/A | N/A | D | NA | Low |
| ED02.3 | Shahedal Bari | Emily Henry | Request Clinical Audit Team (Governance) send a representative to the Medicine Care Group Clinical Audit and Effectives (NICE) Group, to provide advice and guidance on compliance with relevant Trust processes and procedures. | Clinical Audit Team have advised they are willing to support this Group and are now attending the meetings. | Medicine Care Group Clinical Audit and Effectives (NICE) Group | Attendance by Clinical Audit Representative | 31/05/2019 | N/A | N/A | D | NA | Low |
| ED02.4 | Shahedal Bari | Raj Kondragunta | To Review Emergency Medicine Forward Audit Plan to ensure that all relevant RCEM Audits are jointly undertaken at RLI ED and FGH ED, and where appropriate also at Kendal UTC | Clinical Audit Team to review RCEM Audits on forward Audit Plan and ensure the clinical teams are aware of requirements. | Ulysses | Appropriate Forward Audit Plan for RCEM Standards | 31/07/2019 | N/A | N/A | D | NA | Medium |
| ED02.5 | Shahedal Bari | Stuart Bates | Clinical Audit Team to deliver training to FGH ED Medical Staff on how to register, manage and update a clinical audit in the Audit Module of Ulysses system. | Clinical Audit Team liaising with Medicine Care group to agree target dates for training completion.<br>The audit lead for FGH ED has received training and support in the use of the Ulysses System Audit Module.<br>The Clinical Audit Team also offer ongoing support for any staff member who needs it. | Training Records | Training Delivered | 31/10/2019 | N/A | N/A | D | NA | Low |
| ED02.6 | Shahedal Bari | Carol Park, Raj Kondragunta | In conjunction with Clinical Audit Team, undertake a Deep Dive into Clinical Audits, to identify relevant actions plans and actions that still need to be addressed/implemented | departmental Deep Dive meeting completed in June | Action Plans | Deep Dive completed | 28/06/2019 | N/A | N/A | D | NA | Low |
| ED02.7 | Shahedal Bari | Carol Park | Attend Care Group Clinical Audit meeting to identify requirements | Completed | N/A | Attendance at Meeting | 24/05/2019 | N/A | N/A | D | NA | Low |
| ED02.8 | Shahedal Bari | Carol Park | Work with the Clinical Audit team to identify the outstanding actions from Audits | Outstanding actions from Audits identified and collated | Ulysses | Outstanding actions from Audits identified | 28/06/2019 | N/A | N/A | D | NA | Low |

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| ED02.9 | Shahedal Bari | Raj Kondragunta | Complete outstanding actions from Clinical Audits | Some issues around accessing the RCEM audit datbase, now resolved.<br>Focussed meeting took place w/c 23rd September with audit dept.<br>Robust processes in for tracking, monitoring ane completing outstanding actions from Clinical Audits.<br>Presentations for 2 RCEM audits to take place in March - cancelled due to COVID.<br>Re-Scheduled for presentation at Medicine Audit Group on 23/07/2020<br>Nov 2020 - COVID impact on Medical engagement in Clinical Audit programme in Medicine Care Group, escalated to Trust Clinical Audit and Effectiveness Group | Ulysses | Outstanding Actions completed | 31/07/2020 | N/A | N/A | NTMI | NA | Medium |
| ED02.10 | Shahedal Bari | Raj Kondragunta | Complete forward audit plan | Forward plan for 2019/210 completed.<br>Forward Plan for 2020/21 Agreed. | Ulysses | Forward Audit Plan updated and compliant with RCEM requirements | 30/09/2019 | N/A | N/A | D | NA | Medium |
| ED02.11 | Shahedal Bari | Stuart Bates | Clinical Audit to review Ulysses Systema nd provide a List of outstanding all RCEM Audits and associated actions, to identify and remainaing Audits/Action Medicine had not yet addressed. | review completed, List provided to Medicine Care Group Audit Meeting | Ulysses | List of outstanding all RCEM Audits and associated actions | 31/082020 | N/A | N/A | D | NA | Low |
| ED02.12 | Shahedal Bari | Emily Henry | Care Group to schedule RCEM Audit Review Meeting to review all outstanding actions from RCEM Audits | Care Group level RCEM Audit Review Meeting scheduled for 17/09/2020<br>Nov 2020 - COVID impact on Medical engagement in Clinical Audit programme in Medicine Care Group, escalated to Trust Clinical Audit and Effectiveness Group | Medicine Care Group Audit Meeting | Outstanding all RCEM Audits and associated actions completed | 30/09/2020 | N/A | N/A | NTMI | NA | Low |

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| **Recommendation Ref. No.:** | **ED03** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **SAFE** |
| **CQC Service Name:** | **Urgent & Emergency Care** |
| **Must or Should Action / UoR Finding:** | **MUST DO** |
| **UHMBT Exec Lead:** | **Kate Maynard** |
| **UHMBT Care Group:** | **Medicine Care Group** |
| **UHMBT Site(s):** | **WGH** |
| **UHMBT Board Assurance Committee** | **Finance Committee** |
| **UHMBT Strategic Objective:** | **Patients** |
| **UHMB Theme:** | **Patient Environment** |
| **CQC Recommendation:** | Ensure there is a safe place to support and treat patients who are living with a mental health condition which reduces the risk of them self-harming. |
| **Story behind the Recommendation:** | The department had no specific room suitable for adult and paediatric patients with mental health conditions. The department currently used a cubicle. These were not suitable rooms because they were not ligature point free, had standard furniture that could be used as a weapon, did not have two exits and did not meet PLAN (psychiatric liaison accreditation network) standards.<br>When we asked staff, they told us that patients living with a mental health condition did occasionally present to the department. Staff had access to the crisis team to come and see them however until the crisis team arrived, mental health patients were not supported in an appropriate environment. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | The design, maintenance and use of facilities and premises should meet relevant building and clinical standards and keeps people safe.<br>The design, maintenance and use of facilities and premises should keep people safe.<br>The cleaning of facilities and premises should appropriate to the clinical risk/activity and keep people safe. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Completion of PLAN compliant Cubicle at WGH UTC |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| ED03.1 | Sue Smith | Andrea Willimott | Undertake Review of PLAN standards to ascertain applicability to Urgent Treatment Centres | The Royal College of Psychiatrists Quality Standards for Liaison Psychiatry Services, Fifth Edition 2017, only make reference to Emergency Departments, there is no reference to Urgent Treatment Centres.<br>With reference to facilities for Providing urgent and emergency mental health care, the standards state the following; "The liaison team has access to appropriate facilities for conducting high risk assessments within the emergency department"<br><br>PLAN Standards do not seem to be Fully applicable to Urgent Care Centres | Royal College of Psychiatrists Quality Standards for Liaison Psychiatry Services, Fifth Edition 2017 | Review of PLAN standards | 30/09/2019 | N/A | N/A | D | NA | Low |
| ED03.2 | Sue Smith | Diane Graham, Jackie Pennington | Identify safe area for mental health patients | Room 6 will be used as interim solution.<br>Area identified, with full involvement and advice from mental health and crisis team. | N/A | Interim Safe Area identified | 05/07/2019 | N/A | N/A | D | NA | Medium |
| ED03.3 | Sue Smith | Diane Graham, Jackie Pennington | Review the SOP for mental health patients | SOP drafted, to go to Care Group Procedural Documents group, then Trust Procedural Documents group | Trust Procedural Document Library | SOP in place | 04/10/2019 | N/A | N/A | D | NA | Low |
| ED03.4 | Sue Smith | Diane Graham, Jackie Pennington | Ensure the [Risk Assessment] algorithm is sent to Policy and procedure group for sign off | To be approved at Proc/Docs, awaiting scheduling and feedback | Trust Procedural Document Library | SOP in place | 04/10/2019 | N/A | N/A | D | NA | Low |
| ED03.5 | Sue Smith | Diane Graham, Jackie Pennington | Undertake full risk assessment of designated area | Ligature Risk assessment completed | Risk Assessment | Risk Assessment completed | 05/07/2019 | N/A | N/A | D | NA | Low |
| ED03.6 | Sue Smith | Diane Graham, Jackie Pennington | Request that Health and Safety Undertake full risk assessment of department | Health and Safety have completed the Review. | Risk Assessment | Risk Assessment completed | 24/05/2019 | N/A | N/A | D | NA | Low |
| ED03.7 | Sue Smith | Diane Graham, Jackie Pennington | Identify key priorities for capital investment | 1) Short Term Modifications to improve safety of MH Patients<br>2) Long Term Capital Build to ensure safety of MH Patients | N/A | Priorities confirmed | 14/06/2019 | N/A | N/A | D | NA | Medium |
| ED03.8 | Sue Smith | Diane Graham, Jackie Pennington | Identify area where patients with mental health issues will be cared for | Room 6 identified | N/A | Area Identified | 28/06/2019 | N/A | N/A | D | NA | Low |
| ED03.9 | Sue Smith | Jackie Pennington | Inform Care group leaders of requirements for mental health facilities | Review by Mental Health Team has advised the following changes to Room 6<br>- Remove Window Locks<br>- Remove Overhead Ceiling Light<br>- Board off the Radiator<br><br>Radiator work costed and awaiting work to be completed. Still outstanding as of 07/08/2019. Work should be completed by 15/08/19 | N/A | Requirements confirmed | 13/09/2019 | N/A | N/A | D | NA | Low |
| ED03.10 | Sue Smith | Leanne Cooper, Carol Park | Care group managers to prioritise capital finance | Limited Capital Availability in 2019/20<br>On Capital Plan<br>Capital identified for interim mitigation measures | Capital Plan Meeting minutes | Capital Allocated | 28/06/2019 | N/A | N/A | D | NA | Medium |
| ED03.11 | Sue Smith | Leanne Cooper, Carol Park | Contact estates staff to assess the area for improvement | Estates Dept. have been to "measure up" the area | N/A | Estates Work confirmed | 28/06/2019 | N/A | N/A | D | NA | Low |
| ED03.12 | Sue Smith | Jackie Pennington | Mental Health Team to visit UTC to undertake a risk assessment of suitability | Completed | N/A | Visit completed with recommendations | 28/06/2019 | N/A | N/A | D | NA | Low |
| ED03.13 | Sue Smith | Jackie Pennington | Undertake 15 steps review for Adult mental health patients | Completed on Monday 15/07/2019. Feedback positive, awaiting written report | Report on 15 Steps Assessment | Written 15 Steps Report [with recommendations] | 26/07/2019 | N/A | N/A | D | NA | Low |

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| ED03.14 | Sue Smith | Jackie Pennington | Undertake 15 steps review for Child and Adolescent mental health patients | Matron for Paediatrics visited UTC, suggested that school children undertake a 15 step assessment of the Department.<br>Posters for signposting to CAMHS services to be obtained for adolescent patients.<br>To invite reps from "looked after" children school to undertake assessment of Department.<br>Target date moved, awaiting feedback form School | Report on 15 Steps Assessment | Written 15 Steps Report [with recommendations] | 29/11/2019 | N/A | N/A | D | NA | Low |
| ED03.15 | Kaye Maynard | Mark Hampton | Capital Build project requested under Action Trust 19.11 | Capital available and planning work completed.<br>Need confirmation of Funding and implementation of construction project.<br>Furniture Ordered but not available, awaiting confirmation of delivery date/schedule from manufacturers<br>Target date not yet confirmed, delayed due to large number of projects at WGH - to be confirmed with Mark Hampton | Capital plan group minutes. | Construction Project completed | 31/03/2021 | N/A | N/A | OT | NA | Medium |

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| **Recommendation Ref. No.:** | **MED06** |
| **CQC Report:** | **2019 Inspection Report, 2017 Inspection Report** |
| **CQC Domain:** | **SAFE** |
| **CQC Service Name:** | **Medical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **Sue Smith** |
| **UHMBT Care Group:** | **Medicine Care Group** |
| **UHMBT Site(s):** | **RLI** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Patients** |
| **UHMB Theme:** | **Quality & Safety Assurance Checks** |
| **CQC Recommendation:** | The trust should ensure that hazardous substances are stored safely at all times. |
| **Story behind the Recommendation:** | Sluice rooms were found to be unlocked. Products such as bleach were safely stored away in a locked cupboard marked Control of Substances Hazardous to Health (COSHH) within the sluice. In the Cardiac Care Unit, the COSHH cupboard was left unlocked with the key in the lock. The room was unattended which could pose a risk to vulnerable patients. We brought this to the attention of the ward manager who promptly found the padlock and secured the cupboard. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | There are clearly defined and embedded systems, processes and standard operating procedures to keep people safe.<br>Standard operating or safety procedures are completed to the appropriate standard and frequency. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Complete COSHH Audit Cycle and implement Action Plan if required |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| MED06.01 | Sue Smith | Anna Smith | COSHH checks will be discussed at the Trust Wide Health and Safety Representatives meeting on 22/05/2019, with the aim of identifying any possible improvements to correct processes and procedures. | Feedback/outcome from meeting:<br>- Is there a 'formal' requirement to keep Sluice doors locked?<br>- Need to increase COSHH awareness and need for vigilance and compliance amongst Ward Managers | Minutes of Health and Safety Representatives meeting on 22/05/2019 | Feedback from the Trust Wide Health and Safety Representatives meeting | 24/05/2019 | N/A | N/A | D | NA | Low |
| MED06.02 | Sue Smith | Anna Smith | To investigate the suggested requirement for Sluice Room Doors to be locked.<br>Is this some kind of 'formal' standard, or is a personal opinion/belief of the Inspector?<br>If it is a 'formal' standard, investigate how the Trust can comply with this standard. | July 2019<br>Infection Prevention, Health & Safety and Waste management have confirmed they are not aware of any standard that require Sluice doors to be locked.<br>This has been queried with the CQC by the Governance Team. CQC are investigating and will respond in due course.<br><br>Sept 2019<br>No response from CQC, will request this is an agenda item at a forthcomining CQC engagement meeting.<br><br>Oct 2019<br>Response from CQC; Doors should be locked to comply with 2002 COSHH regs section 7.3 potential exposure to Chemical COSSH as to why Doors should be locked.<br>Health & Safety team assessment is that locking doors may breach 2002 COSHH regs section 7.6 potential exposure to Biological COSSH.<br>Queried back to CQC<br><br>No further feedback from CQC - Action closed | Copy of Document that contains requirement for Sluice Doors to be locked | Confirmation if this is formal standard | 30/11/2019 | N/A | N/A | D | NA | Low |
| MED06.03 | Sue Smith | Anna Smith | Request that the Executive Nurse Group instruct that within the next 12 months all Departments and Wards must request and undertake a COSHH specific Health and Safety Managerial Support visit, from the Health and Safety Team. | Request sent to Kim Wilson on 23/05/209 | Copy of Email from Executive Nursing Group | Instruction issued to all Department/ Ward Managers | 31/05/2019 | N/A | N/A | D | NA | Low |
| MED06.04 | Sue Smith | Anna Smith | Health and Safety Team to undertake a COSHH specific Health and Safety Managerial Support visit to all Departments and Wards that request a COSHH specific Health and Safety Managerial Support visit.<br>Report on findings to be presented to Matrons meeting in April 2020. | First visits commence in July 2019.<br><br>Progress being reported to Health & Safety Committee on monthly basis:<br>Sept 2019 - 20.6% completed<br>Oct 2019 - 27% completed<br>Nov 2019 - 35% Completed, 62% scheduled, 3% to be scheduled<br>Mar 2020 - Visits suspended due to COVID | Progress to be reported to the Health and Safety Committee on a monthly basis. | COSHH specific Health and Safety Managerial Support visit to all Departments/ Wards | 31/05/2020 | 100% of Wards | 35% of Wards | D | NA | Medium |
| MED06.05 | Sue Smith | Anna Smith | Any urgent findings or lessons learned from COSHH specific Health and Safety Managerial Support visits to be shared with:<br>- Medicine Care Group Associate Director of Nursing, Matrons & Governance Business Partner for immediate remedial action or monitoring<br>- Learning to Improve Group for wider learning/dissemination | Important Issues to be shared as they occur.<br>Review of Initial findings to be completed in October 2019.<br>Presentation to Matrons meeting in Nov 2019, will be cascaded to Ward Managers<br>Findings; Sluice Doors unlocked, Some COSHH not in COSHH cupboard, Some COSHH without Risk assessment in place | Learning to Improve Meeting Minutes | Learning to Improve Bulletin | 31/05/2020 | N/A | N/A | D | NA | Low |
| MED06.06 | Sue Smith | Anna Smith | Health and Safety Team to complete Audit 1058 'Annual COSHH Checklist' in June 2019, to establish Baseline COSHH compliance. | Audit has been stopped due to significant issues with the quality of data that is currently available. This was approved by the Director of Goverenance. | Audit Report and Action Plan | Audit Completed | 31/08/2019 | N/A | N/A | D | NA | Low |
| MED06.07 | Sue Smith | Anna Smith | Any urgent findings or lessons learned from Audit 1058 to be shared with:<br>- Medicine Care Group Associate Director of Nursing, Matrons & Governance Business Partner for immediate remedial action or monitoring<br>- Learning to Improve Group for wider learning/dissemination | Audit has been stopped due to significant issues with the quality of data that is currently available. This was approved by the Director of Goverenance. | Learning to Improve Meeting Minutes | Audit Findings | 30/09/2019 | N/A | N/A | D | NA | Low |

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| MED06.08 | Sue Smith | Anna Smith | Health and Safety Team to complete Audit 1278 'Annual COSHH Checklist' in June 2020 to identify any improvements in COSHH Compliance. | Audit on Forward Plan due to commence in June 2020<br>Audit suspended due to COVID | Audit Report and Action Plan | Audit Completed | 31/08/2020 | N/A | N/A | D | NA | Low |
| MED06.09 | Sue Smith | Anna Smith | Any urgent findings or lessons learned from Audit 1278 to be shared with:<br>- Medicine Care Group Associate Director of Nursing, Matrons & Governance Business Partner for immediate remedial action or monitoring<br>- Learning to Improve Group for wider learning/dissemination | Awaiting outcomes from Audit 1278 in August 2020<br>Audit suspended due to COVID | Learning to Improve Meeting Minutes | Audit Findings | 30/09/2020 | N/A | N/A | D | NA | Low |
| MED06.10 | Sue Smith | Anna Smith | Health and Safety Team to produce pro-forma COSHH Risk assessment regarding the relative risks of 2002 COSHH regs section 7.3 potential exposure to Chemical COSSH and section 7.6 potential exposure to Biological COSSH, in respect of the requirmennt to state that it is required that all COSHH cupboards are locked, but that it is not required that Sluice Room Doors are locked. | Risk Assesment drafted.<br>Reviewed by Quality Matron and IPC Matron<br>Reviewed and approved by Director of Nursing. | COSHH Risk Assesment Repository | Risk Assessment completed and distributed | 31/12/2019 | N/A | N/A | D | NA | Low |
| MED06.11 | Sue Smith | Anna Smith | H&S Team to develop and issue a COSHH Mini Questionnaire via MS teams to undertake COSHH Compliance checks Questionnaire include similar questions to COSHH Support visits and Audit 1278, excluding the requirements to undertake physical review of Departments/Wards | Questinnaire developed and issued.<br>Responses completed/returned from 64 Departments/Wards<br>Preliminary Results suggest positive performance improvement<br>Full Report to be presented to H&S Committee meeting in November 2020<br>Lessons learned to be communicated following prestation of Report. | H&S Committee Papers | COSHH Survey completed | 30/11/2020 | N/A | N/A | OT | NA | Low |
| MED06.12 | Sue Smith | Anna Smith | Communication of Lesssons Learned and implementation of any Actions arrising from the Mini Questionnaire | Awaiting prsentation of final report at H&S Committee | H&S Committee Papers | Communication and Action Plan | 31/03/2020 | N/A | N/A | | NA | Low |

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| **Recommendation Ref. No.:** | **MED09** |
| **CQC Report:** | **2019 Inspection Report, 2017 Inspection Report** |
| **CQC Domain:** | **EFFECTIVE** |
| **CQC Service Name:** | **Medical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Medicine Care Group** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMB Theme:** | **Staff Development & Training** |
| **CQC Recommendation:** | Ensure there is a reasonable and proportionate induction process or access to relevant induction information for all locum medical staff attending the hospital on an ad-hoc or short term basis. |
| **Story behind the Recommendation:** | Ward staff completed induction checklists with agency staff and ensured they were familiar with ward protocols before delivering any patient care however, there was no evidence of any induction or on-line resource for ad-hoc locum medical staff that had little or no knowledge of the hospital. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | All staff, including volunteers, are qualified and have the skills they need to carry out their roles effectively and in line with best practice.<br>The learning needs of staff are identified and training is provided to meet these needs.<br>Staff are supported to maintain and further develop their professional skills and experience. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Completion and implementation of Locum Induction Document |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| MED09.01 | David Wilkinson | Pam Calder, Clinical Service Managers | Deputy ADOP to work with Clinical Service Managers to undertake review of existing Medical Locum Induction documentation to identify best practice across the Care Group and to identify scope for the standardisation of induction process across the Care Group. | | | Review completed | 31/12/2019 | N/A | N/A | D | NA | Low |
| MED09.02 | David Wilkinson | Pam Calder, Clinical Service Managers | Deputy ADOP to work with Clinical Service Managers to update/develop induction documentation for ad-hoc or short term Medical Locums. | Delayed and impacted by COVID - need updated position | Trust Procedural Document Library | Induction documentation updated | 30/06/2020 | N/A | N/A | D | NA | Low |
| MED09.03 | David Wilkinson | Pam Calder, Clinical Service Managers | Deputy ADOP to work with Clinical Service Managers to update/develop induction documentation for ad-hoc or short term Medical Locums. | Delayed and impacted by COVID - need updated position | Trust Procedural Document Library | Induction documentation updated | 30/06/2020 | N/A | N/A | D | NA | Low |
| MED09.04 | David Wilkinson | Neil Smith | Medicine Care Group Deputy Associate Director of Operations, to review Induction process/documentation for Locum Doctors at FGH | New Action created in Nov 2020<br>Query formal process, weekly handover.<br>Lorenzo training to be completed in advance. | | Induction documentation updated | 31/12/2020 | N/A | N/A | OT | NA | Low |

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| **Recommendation Ref. No.:** | **SCC06** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **Responsive** |
| **CQC Service Name:** | **Critcal Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **Sue Smith** |
| **UHMBT Care Group:** | **Surgery & Critical Care Group** |
| **UHMBT Site(s):** | **FGH & RLI** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Patients** |
| **UHMB Theme:** | **Patient Care & Dignity** |
| **CQC Recommendation:** | 1) Patients discharged from critical care should receive a ward follow up visit by critical care nurses within 36 hours of discharge, planned as part of the appointment of a supernumerary coordinator and in accordance with the GPICS (2015) standard.<br>2) Critical Care Unit should continue to monitor discharges out of hours and develop actions with the Trust to improve the FGH critical care discharges out of hours. |
| **Story behind the Recommendation:** | Patients discharged from critical care should receive a ward follow up visit by critical care nurses within 36 hours of discharge, it was reported that this had not be provided consistently by staff in the unit and was affected by activity and staffing resources. Staff we spoke with were planning improvement as part of the appointment of a supernumerary coordinator.<br><br>**Surgery and Critical Care requested that the two outstanding Recommendations from the 2017 UHMBT CQC Inspection Report related to discharge from Intensive Care are combined to enable an integrated response to be implemented.** |
| **What the CQC expect 'Good' to look like:<br>(Taken from relevant KLOE definition)** | People can access the right care at the right time.<br>Access to care is managed to take account of people's needs, including those with urgent needs.<br>People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies.<br>This is monitored to ensure consistency of practice. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | TBC - Need to confirm how 2020/21 target has been impact by COVID |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| SCC06.01 | Sue Smith | Jane Kenny | Monitor 2019/20 compliance with the 36 hour Target at FGH. | FGH Performance:<br>Dec-19: 73.68%<br>Jan-20: 70.58%<br>Feb-20: 100.00%<br>Mar-20: 70.58% | Lorenzo | Improved Performance | 31/03/2020 | 100% | 70.58% | D | NTMA | Medium |
| SCC06.02 | Sue Smith | Jane Kenny | Monitor 2019/20 compliance with the 36 hour Target at RLI. | RLI Performance:<br>Dec-19: 21.42%<br>Jan-20: 48.50%<br>Feb-20: 45.45%<br>Mar-20: 4.16% | Lorenzo | Improved Performance | 31/03/2020 | 100% | 4.16% | D | NTMA | High |
| SCC06.03 | Sue Smith | Jane Kenny | Review of the roles and responsibilities of supernumerary co-ordinator | Progress update (10.7.19)<br>Tracking is through the critical care group and reports through to Quality Committee. The minutes are going to be sent quarterly to Quarterly Committee Claire to add some more information<br>Update 09.10.2019 - No movement of the current data (evidence available) organisational awareness and bed flow will help address inappropriate inpatients on critical care resulting in 'patients in harm'<br><br>Update 12.11.19<br><br>This KPI is dependent upon business of ICU, nurse staffing has now stabilised cross bay in order to provide SNC on daytime shifts. Follow up is an expectation of this role and performance has standardised and improved.<br><br>AUG : FGH (87%) RLI (72.7%)<br>SEP : FGH (100%) RLI (80.85%)<br>OCT : FGH (100%) RLI (80.55%<br>15/01/2019- KPI from ICNARC, for review of Q3 data and closure Feb'20 | Reports through Critical Care group with report to Quality Committee if applicable for any outlying status. | | 28/02/2020 | N/A | N/A | NTMI | NA | Low |

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| SCC06.04 | Sue Smith | Jane Kenny | Explore PDSA of an unfunded link between ICU and Ward support trial | Progress update (10.7.19)<br>Tracking is through the critical care group and reports through to Quality Committee. The minutes are going to be sent quarterly to Quarterly Committee Claire to add some more information<br>Update 09.10.2019 - No movement of the current data (evidence available) organisational awareness and bed flow will help address inappropriate inpatients on critical care resulting in 'patients in harm'<br><br>Update 12.11.19<br>Point 2<br>OOH discharges are monitored through CCDG.<br>Delays and MSO are raised at daily bed meetings.<br>OOH d/c are reported as CIR.<br>OOH discharges are only pursued where there is a clinical need to admit a patient to the unit. The risks of OOH discharge in other circumstances are balanced on a case by case basis dependent upon the clinical needs of the patient lead by Consultant in charge of care and Senior nursing staff. Outreach dervice has been Three month pilot in place to pilot ICU outreach and build wider clinical expertise withthe wider ward staff. | | | 29/02/2020 | N/A | N/A | NTMI | NA | Low |
| SCC06.05 | Sue Smith | Jane Kenny | Implement Fit2Sit – Cross Bay any patient who is being discharged in the next 4 hours will be sat out, unless medically this is not safe, so that we create capacity at a ward level, | This is a PDSA project<br>15/01/2020 -Project complete | Fit 2 Sit | | 29/02/2020 | N/A | N/A | D | NA | High |
| SCC06.06 | Sue Smith | Jane Kenny | Continue to Monitor TTO performance to identify any areas of potential improvement | We have now mapped every process step in the TTO journey the data will ensure we have visibility of delays in the process, and areas to target<br>15/01/20 - All TTO's monitored electronically | TTO Data | | 29/02/2020 | N/A | N/A | D | NA | High |
| SCC06.07 | Sue Smith | Jane Kenny | Medical Director meeting to discuss the medical input required to move the discharge curve 4 hours earlier in the day | Complete. This continues to be tracked by the SAFER work | SAFER work | | 29/02/2020 | N/A | N/A | D | NA | High |
| SCC06.08 | Sue Smith | Jane Kenny | Daily focus on the "Golden patients" for the next day (Patient Flow Matron) reviewing any failed to understand why and what steps need to be taken to prevent future occurrences | Complete. Matron identifies golden patient. This continues to be tracked by the SAFER work | SAFER work | | 29/02/2020 | N/A | N/A | D | NA | High |
| SCC06.09 | Sue Smith | Jane Kenny | Monthly tri-partite meetings with NWAS PTS to reduce discharge booking cancellations, alongside patient eligibility for transport and online booking to understand capacity and demand | Daily monitoring of patient flow system. Track and action accordingly | Daily monitoring of patient flow system. Track and action accordingly | | 29/02/2020 | N/A | N/A | D | NA | High |
| SCC06.10 | Sue Smith | Jane Kenny | Monitor 2020/21 compliance with the 36 hour Target at FGH. | FGH Performance:<br>Apr-20: 15.38%<br>May -20: 62.28%<br>Jun-20: %<br><br>Performance has been impacted due to the ongoing COVID-19 situation, wherever possible nursing staff have made telephone contact or undertaken a visit to these patients. | Lorenzo | Improved Performance | 31/03/2021 | 100% | 62.28% | OT | NTMA | Medium |
| SCC06.11 | Sue Smith | Jane Kenny | Monitor 2020/21 compliance with the 36 hour Target at RLI. | RLI Performance:<br>Apr-20: 0.00%<br>May -20: 12.50%<br>Jun-20: %<br><br>Performance has been impacted due to the ongoing COVID-19 situation, wherever possible nursing staff have made telephone contact or undertaken a visit to these patients.<br>To be added to the hand over for the night shift to pickup any patients that haven't been completed during the day.<br>Ward managers we will be checking performance each day. | Lorenzo | Improved Performance | 31/03/2021 | 100% | 12.50% | OT | NTMA | High |
| SCC06.12 | Sue Smith | Jane Kenny | Monitor 2020/21 'out of hours discharges' at FGH. | Need to confirm current performance with ICNARC Co-ordinator | ICNARC? | Reduction in Out of Hours Discharges | 31/03/2021 | TBC | TBC | OT | | Low |
| SCC06.13 | Sue Smith | Jane Kenny | Monitor 2020/21 'out of hours discharges' at RLI. | Need to confirm current performance with ICNARC Co-ordinator | ICNARC? | Reduction in Out of Hours Discharges | 31/03/2021 | TBC | TBC | OT | | Low |

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| **Recommendation Ref. No.:** | **WACS07** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Well Led** |
| **CQC Service Name:** | **Children and Young People** |
| **Must or Should Action / UoR Finding:** | **Should Do** |
| **UHMBT Exec Lead:** | **Shahedal Bari / Sue Smith** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **FGH & RLI** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMBT Theme:** | **Culture & Leadership** |
| **CQC Recommendation:** | The trust should ensure leads for **mortality** and safeguarding are in place within the service.<br>The trust should ensure **morbidity** and **mortality** processes are consistent across both sites. |
| **Story behind the Recommendation:** | At inspection we established that within the trust the mortality leads were no longer in post. The medical director was covering these roles and was reviewing approximately 35% of deaths trust wide. We also noted that different mortality review processes were being undertaken in the trust's two main hospitals. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | *There is participation (that includes all relevant staff) in relevant local and national clinical audits and other monitoring activities such as reviews of services, benchmarking and peer review and approved service accreditation schemes. Accurate and up-to-date information about effectiveness is shared internally and externally and is understood by staff. It is used to improve care and treatment and people's outcomes and this improvement is checked and monitored.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Mortality Lead in place for FGH by 31/12/2020 |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| WACS7.1 | Shahedal Bari | Paul Grout | Undertake Review of Paediatric Mortality Process | Review undertaken in 2019.<br>The number of paediatric deaths in our Trust is very low and sporadic, which makes standardised regular review process difficult to implement.<br>Paediatric mortality cases are now reviewed during Annual KIDS day (cross-bay day that focuses on audits and service development projects taking place within the department on both sites and is usually face-to-face).<br>Paediatric mortality review process is consistent across both sites. | Agenda, Papers and Minutes of KIDS day | Review Completed | Completed | N/A | N/A | D | NA | Low |
| WACS7.2 | Shahedal Bari | Robin Proctor | Undertake Review of Perinatal Mortality Process | Perinatal mortality cases are discussed during the quarterly cross-bay Perinatal Mortality & Morbidity meetings, held via videoconferencing attendance by Obstetricians, Midwives and other staff if involved in the case. The purpose of the meeting is to review all cases of stillbirth, early neonatal deaths, neonatal deaths and other cases of interest which are admitted to the neonatal unit. This is regularly attended by Paediatric/Neonatologist from neighbouring trust in cases when there has been a transfer of care. | Agenda, Papers and Minutes of Perinatal Mortality & Morbidity meetings | Review of Perinatal Mortality Process | Completed | N/A | N/A | D | NA | Low |
| WACS7.3 | Sue Smith | Nicola Askew | Cumbria & Lancashire Local Authorities, Child Death Over Panel in place, where every child death is reviewed and discussed. | These panels are attended by our Named Nurse for Safeguarding Children and our Named Midwife for Safeguarding.<br>Lessons learned are discussed at Trust Safeguarding Operational Performance Group that is attended by Care Groups members. | Agenda, Papers and Minutes of Cumbria & Lancashire Local Authorities, Child Death Over Panel | Child Death Over Panel in place | Completed | N/A | N/A | D | NA | Low |
| WACS7.4 | Sue Smith | Carol Carlile | Review compliance with the national standardised Perinatal Mortality Review Tool (PMRT) and Maternity Safety action 1. | Trust is are compliant with the national standardised Perinatal Mortality Review Tool (PMRT) and Maternity Safety action 1.<br>Trust undertakes a Monthly Perinatal Mortality Review Tool as outlined PMRT Panel. The UHMBT panels have representation from Obstetricians, Neonatologists, Neo-natal nurses and Midwives. We also ensure that our staff regularly attended external panels within the Local Maternity System. The cases reviewed are:<br>- All neonatal deaths from birth at 22+0 to 28 days after birth;<br>- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 days the following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die. | national standardised Perinatal Mortality Review Tool (PMRT) | Review Completed | Completed | N/A | N/A | D | NA | Low |

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| WACS7.5 | Shahedal Bari | Robin Proctor | Deputy Medical Director currently undertaking a review of Trust Wide Mortality Review Process and Systems to include:<br>- Integration with the recently established New Medical Examiner processes<br>- Alignment of the reporting of all mortality reviews through/into the Trust Mortality Review Meetings<br>- Improvement in the oversight and assurance of the Trusts Mortality Review processes | Initial Assessment identified the following Key Issues:<br>- Vacancy for Mortality Lead at FGH<br>- a number of minor technical issues with the 'standard' adult mortality review software<br>- which resulted in issues with how some patients are identified and reported within the with the 'standard' adult mortality review software<br>- parts of the Trust (Inc. Paediatrics and Maternity) undertake mortality reviews, with a different format from the 'standard' Adult Mortality - this due to differing reporting requirements with external agencies for these types of deaths<br>- lack of clarity in the Terms of Reference and procedural documents on how these reviews undertaken in different formats are then included in / integrated with the 'standard' mortality reviews into the trust-wide mortality reports<br><br>Trust Wide Mortality Review ongoing.<br>COVID has currently curtailed further assessment/review work for the time being.<br>Subject Judgement reviews trialled in UHMBT Urology Reviews, to be considered across other Specialities in UHMBT, and if successful implemented Trust Wide | Updated Mortality Review Process documents | Review Completed | 31/12/2020 | N/A | N/A | D | NA | Low |
| WACS7.6 | Shahedal Bari | Robin Proctor | Appoint a Mortality Lead for FGH | Trust Wide Mortality Review ongoing.<br>COVID has currently curtailed further assessment/review work for the time being.<br>Sept 2020 - review of other Trusts has shown that site based Mortality Lead is not a requirement, if a Trust Wide Mortality Lead is established and appropriately supported with Adminstration. | Mortality Review Group Meeting ToR | Mortality Lead Appointed | 31/12/2020 | N/A | N/A | D | NA | Medium |
| WACS7.7 | Shahedal Bari | Robin Proctor | Review of the software used for 'standard' adult mortality review | The 'standard' adult mortality review software is not used for Maternal, Perinatal or Paediatric Mortality Reviews.<br>This due to differing review and reporting requirements with external agencies for these types of deaths.<br>Review of Software is not currently relevant to this CQC recommendation. | N/A | Review Completed | 01/01/2021 | N/A | N/A | D | NA | Low |
| WACS7.8 | Shahedal Bari | Robin Proctor | Complete review of ToR of Paediatric Audit meeting and add requirement for Paediatric and Perinatal Mortality Reviews to be formally reported to the Site Mortality Lead and the Trust Mortality Leads | Trust Wide Mortality Review ongoing.<br>COVID has currently curtailed further assessment/review work for the time being. | ToR of Paediatric Audit meeting | Review Completed | 31/12/2020 | N/A | N/A | D | NA | Low |
| WACS7.9 | Shahedal Bari | Robin Proctor | Complete review of ToR of Trust Mortality Review Meetings and add requirement for all and Perinatal Mortality Reviews to be formally reported to the Site Mortality Lead and the Trust Mortality Leads | Trust Wide Mortality Review ongoing.<br>COVID has currently curtailed further assessment/review work for the time being. | ToR of Trust Mortality Review Meeting | Review Completed | 31/12/2020 | N/A | N/A | D | NA | Low |
| WACS7.10 | Shahedal Bari | Robin Proctor | Complete review of Trust Mortality Procedural documents to review and update content related to Paediatric and Perinatal Mortality reviews, to make it clear how and where these take place and how they are reported | Trust Wide Mortality Review ongoing.<br>COVID has currently curtailed further assessment/review work for the time being. | Trust Mortality Procedural document | Review Completed | 31/12/2020 | N/A | N/A | D | NA | Low |
| WACS7.11 | Shahedal Bari | Sanjay Sinha | Clinical Director of WACS to undertake a review/check that all Paediatric and Perinatal Mortality reviews in a six month period (01/01/2021 to 30/06/2021) had been reported into the Trust Mortality Review Processes accordance with the revised ToR. | Action to commence on 01/01/2021 | Report to Trust Mortality Meeting | Review Completed | 31/07/2021 | 100% | TBC - Future action | D | NA | Low |
| WACS7.12 | Shahedal Bari | Robin Proctor | DMD for Mortality to review Role of Trust Wide Mortality Lead to establish common practice with regional and peer group Trusts. | Review of other Trusts has shown that site based Mortality Lead is not a formal requirement, if a Trust Wide Mortality Lead is established and appropriately supported with Adminstration, as perprocess at similar Trusts | TBC | Review Completed | TBC | N/A | N/A | D | NA | Low |
| WACS7.13 | Shahedal Bari | Robin Proctor | Implement Subject Judgement Reviews in Urology as a trial for wider implememation acrosss UHMBT | Urology Subject Judgement Reviews in Progress | TBC | Review Completed | TBC | N/A | N/A | D | NA | Low |
| WACS7.14 | Shahedal Bari | Robin Proctor | UHMBT to Review and Relaunch Patinet Safety Unit, to consist of PA's from Deputy Medical Director and work from the Patient Safety Matron | Patinet Safety Unit relaunched in Oct 2020 | TBC | TBC | TBC | N/A | N/A | D | NA | Low |
| WACS7.15 | Sue Smith | Andrea Willimott | Review of WACS Improvement Actions with Trust Wide Elements to determine if WACS ReCccomendation has been completed and whetehr Trust Wide elements can continue through other Reporting Mechanisms | Review of Reccommendation WACS7 (inc WACS7A)<br>Maternal, Perinatal and Paediatric Mortality process are compliant with Legislation, regulation and pervailig best practice.<br>The Trust does not hold specific Maternal, Perinatal and Paediatric Mortality meetings - due moartlity rates being low and infrequent - Cases are reviewed on an individual basis, normally through Audit or Case review meetings<br>All Trust Actions on this recommendation to be closed. | Review by Director of Governance | Decisions made | 31/12/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **WACS9** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Well Led** |
| **CQC Service Name:** | **Children and Young People** |
| **Must or Should Action / UoR Finding:** | **Should Do** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMBT Theme:** | **Staff Development & Training** |
| **CQC Recommendation:** | The trust should ensure that medical and nursing staff receive appropriate supervision and support. |
| **Story behind the Recommendation:** | Staff told us they witnessed bullying and harassment of other staff and raised concerns with senior staff. Medical staff told us they did not feel supported or had not had enough supervision depending on which paediatric consultant was working on the ward or on call. We escalated this to the trust and requested assurance that nursing and medical staff would be supported and supervised going forward. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | *Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed.*<br>*The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and acts to address them.*<br>*Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. There are processes to support staff and promote their positive wellbeing. Leaders at every level live the vision and embody shared values, prioritise high-quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services.*<br>*All staff, including volunteers, are qualified and have the skills they need to carry out their roles effectively and in line with best practice. The learning needs of staff are identified and training is provided to meet these needs. Staff are supported to maintain and further develop their professional skills and experience.*<br>*Staff are supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal. Where relevant, staff are supported through the process of revalidation. There is a clear and appropriate approach for supporting and managing staff when their performance is poor or variable.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Delivery of Paediatrics Organisational Development Plan<br>Plan will address Recommendations WACS09 & WACS12 |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WACS9.1 | David Wilkinson | Matt France | Organisational Development Team to undertake review of workplace culture issues within Paediatrics at FGH and to identify potential areas for action | FGH Paediatrics Organisational Development Report completed by Matt France | FGH Paediatrics Organisational Development Report | FGH Paediatrics Organisational Development Report | 30/04/2020 | N/A | N/A | D | NA | Low |
| WACS9.2 | David Wilkinson | Lynne Wyre | Director of Nursing to review Action Plan to confirm Nursing issues and concerns are included and addressed | Review completed | Feedback from Director of Nursing | Review Completed | 31/07/2020 | N/A | N/A | D | NA | Low |
| WACS9.3 | David Wilkinson | Matt France | 15 Point Action Plan developed to address issues identified from review; including Behavioural Aspects, Policies and Procedures, and Environmental Factors<br>Action Plan to be led by Matt France and Linda Womack | Draft Copy received<br>Action owners and target dates now being agreed<br>Action plan in progress<br>Oct 2020: Personal support in progresssing the Action Plan from Trust Medical Director and Chief Operating Officer | Action Plan | Action Plan | 31/03/2021 | N/A | N/A | NTMI | NA | Medium |
| WACS9.4 | David Wilkinson | Linda Womack/Matt France | Delivery of 15 Actions within Action Plan | Nov 2020 Update: 7 Actions completed, 3 Actions Ongoing, 5 Actions Delayed | Action Plan | Action Plan | 31/03/2021 | 15 | 7 | NA | NTMI | Medium |
| WACS9.5 | David Wilkinson | Linda Womack/Matt France | Progress report on Action Plan to be reported to WACS Management Board and Workforce Committee | Quarterly Progress Updates to be provided Quarterly Progress Updates to be provided to Workforce Committee.<br>Nov 2020: Report to Workforce Committee by Matt France and Linda Womack | Agenda, Minutes | Progress Reports | 31/03/2021 | N/A | N/A | OT | NA | Low |
| WACS9.6 | David Wilkinson | Andrea Willimott | Governance Team to schedule and complete a Corporate Quality Review of Paediatrics at FGH to assess improvement in Culture and Leadership | Scheduling delayed due ongoing COVID Restrictions.<br>Target date extended from Dec 2020 to Mar 2021 | Corporate Quality Review Records | Corporate Quality Review completed | 31/03/2021 | N/A | N/A | OT | NA | Low |

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| **Recommendation Ref. No.:** | **WACS10** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Safe** |
| **CQC Service Name:** | **Maternity** |
| **Must or Should Action / UoR Finding:** | **Should Do** |
| **UHMBT Exec Lead:** | **Kate Maynard** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **FGH & RLI** |
| **UHMBT Board Assurance Committee** | **Quality Committee / Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMBT Theme:** | **Staff Development & Training** |
| **CQC Recommendation:** | The service should ensure staff have access to child abduction and awareness training. |
| **Story behind the Recommendation:** | Following our inspection, we also requested staff compliance in abduction training, but the trust did not provide this data and confirmed it was not delivered as part of the 'skills and drills' training for maternity services. We did, however, note that staff needing to familiarise themselves with the baby abduction policy was an agenda item in the October and November 2019 monthly governance meeting minutes. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | *There are clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse, using local safeguarding procedures whenever necessary.*<br>*Staff have received up-to-date training in all safety systems, processes and practices.*<br>*All staff, including volunteers, are qualified and have the skills they need to carry out their roles effectively and in line with best practice. The learning needs of staff are identified and training is provided to meet these needs. Staff are supported to maintain and further develop their professional skills and experience.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | TBC - Need to review target with WACS Senior Management team in light iof changes to planned traing process. |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WACS10.1 | Kate Maynard | Dan Willis<br>Roz McMeeking | Trust LSMS (Local Security Management Specialist) and Care Group Governance Business Partner issued Request in October 2019 to all Team Leaders in Care Group to confirm that all areas had tested the Child Abduction policy locally. | Completed | Training Package | Training Package | 31/10/2020 | N/A | N/A | D | NA | Low |
| WACS10.2 | Kate Maynard | Nicola Askew | WACS Care Group to implement interim Child Abduction Awareness and Training, pending the implementation of Trust Wide Child Abduction Awareness and Training | Each ward & department have ensured that staff have updated themselves with the current Child Abduction policy.<br>Regular reminders to staff are issued through team meetings agendas.<br>Awareness of Child Abduction policy is also part of staff induction process. | Interim Child Abduction Awareness and Training | Interim Child Abduction Awareness and Training | 31/03/2020 | N/A | N/A | D | NA | Low |
| WACS10.3 | Kate Maynard | Dan Willis | Trust LSMS to develop training session/package on child abduction policy and procedures to help increase staff awareness of the basic principles in reducing the likelihood of a Child Abduction, and what response is required of them in the case of a child abduction. | Completed | Training Package | Training Package | 31/07/2020 | N/A | N/A | D | NA | Low |
| WACS10.4 | Kate Maynard | Dan Willis | Trust LSMS to update content of child abduction policy to say that where an insufficient response to testing of Child Abduction has been identified that the members of staff involved will be asked to re attend the training session. | Completed | Trust Procedural Document Library | Revised Child Abduction Policy | 31/08/2020 | N/A | N/A | D | NA | Low |
| WACS10.5 | Kate Maynard | Dan Willis / WACS Education Teams | Schedule of Skills and Drills training for WACS areas to be established. | Review of Skills and drills completed Abductiopn Awareness added.<br>Trust LSMS to work with WACS Education Teams and WACs Governance Business Partner to establish Training schedule.<br>Development of Classroom Training schedule put on hiatus due to COVID, LSMS to develop video based traing course as COVID safe alternative - see action WACS10.13 | Training Schedule | Schedule of Skills and Drills training for WACS | 31/08/2020 | N/A | N/A | D | NA | Low |
| WACS10.6 | Kate Maynard | Nicola Askew | Develop regular ward/unit abduction simulation to ensure the staff have understood the processes involved. | Development and Implementation of the simulations have been delayed by COVID, target date extended | abduction simulation | ward/unit abduction simulation | 31/03/2021 | N/A | N/A | OT | NA | Low |
| WACS10.7 | Kate Maynard | Dan Willis / WACS Education Teams | Schedule of Skills and Drills training for WACS areas to be delivered to at least 50% of WACS Staff | Dates have been circulated<br>Development of Classroom Training schedule put on hiatus due to COVID, LSMS to develop video based traing course as COVID safe alternative - see action WACS10.13 | TMS | Training delivered | 31/03/2020 | 50% | N/A | D | NA | Low |
| WACS10.8 | Kate Maynard | Dan Willis | Learning from WACs Skills and Drills training to be reviewed for inclusion in any Trust Wide training | Development of Classroom Training schedule put on hiatus due to COVID, LSMS to develop video based traing course as COVID safe alternative - see action WACS10.13 | Review Documents | Review of Training | N/A | N/A | N/A | D | NA | Low |
| WACS10.9 | Kate Maynard | Dan Willis | Trust Wide communication through Learning to Improve and/or Weekly News etc. to increase general awareness of child abduction issues | Dan Willis to work with Care Group Team to develop awareness material that can be shared through different media for staff awareness. | Learning to Improve and/or Weekly News | Lessons Learned published | 31/03/2021 | N/A | N/A | NTMI | NA | Low |
| WACS10.10 | Kate Maynard | Dan Willis | Child Abduction trainingh to be added to TMS to enable more accurate monitoring of Training compliance | Completed | TMS | Training Course listed | 30/09/2020 | N/A | N/A | D | NA | Low |
| WACS10.11 | David Wilkinson | Linda Womack | WACS to identify all WACS staff who should have Child Abduction Training listed as 'Job Essential' for their Role and update TMS Records accordingly | LSMS to develop video based traing course as COVID safe alternative - see action WACS10.13 | TMS | Job Essential listing in place | 30/11/2020 | N/A | N/A | OT | NA | Low |
| WACS10.12 | David Wilkinson | Linda Womack | Establish process for Job Essential Child Abduction Training compliance rates to be reported to WACs Triumvirate on regular and ongoing basis | LSMS to develop video based traing course as COVID safe alternative - see action WACS10.13 | Report WACS TMB and DGAG meetings? | reporting process in place | 30/12/2020 | N/A | N/A | OT | NA | Low |

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| WACS10.13 | Kate Maynard | Dan Willis | LSMS to create Video training course for Child Abduction Training to be made available via TMS to enable eaiser access to training course for Trust Staff | Action added Nov 2020<br>Training course in development, target date set at 31/01/2021, due other higher priority security related projects | TMS | Video Training Course in place | 31/01/2021 | N/A | N/A | OT | NA | Low |
| WACS10.14 | Kate Maynard | Linda Womack | WACS Senior management Team to ensure that all relevant staff have undertaken and completed Video Based training course for Child Abduction. | Action added Nov 2020<br>Need update from Linda on Target dates, Target KPIs and progress | TMS | Compliance with training target | 31/03/2021 | TBC | TBC | TBC | TBC | Medium |
| WACS10.14 | Sue Smith | Linda Womack, Nicola Askew, Carol Carlile | Request from Chief Nurse that WACS develop and implement local regime of testing staff knowlegdge and skils | Action added Nov 2020<br>Need update from Linda on Target dates, Target KPIs and progress | | | TBC | TBC | TBC | TBC | TBC | |

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| **Recommendation Ref. No.:** | **WACS12** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Well Led** |
| **CQC Service Name:** | **Children and Young People** |
| **Must or Should Action / UoR Finding:** | **Should Do** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMBT Theme:** | **Culture & Leardership** |
| **CQC Recommendation:** | The trust should take timely action to improve culture within the service and continue to monitor and sustain improvement. |
| **Story behind the Recommendation:** | There had been a deterioration in culture since our last inspection. Staff morale was low and there were strained relationships between clinicians and nursing staff. Staff raised concerns to us about the culture. Most staff were focused on the needs of patients receiving care. Staff told us the culture had not supported openness and honesty at all levels within the organisation. Medical staff told us they were not confident in raising incidents for fear of repercussions. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | *Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed.*<br>*Leaders at every level are visible and approachable. Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, deployment and support processes and succession planning.*<br>*The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and acts to address them.*<br>*Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. There are processes to support staff and promote their positive wellbeing. Leaders at every level live the vision and embody shared values, prioritise high-quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Delivery of Paediatrics Organisational Development Plan<br>Plan will address Recommendations WACS09 & WACS12 |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WACS12.1 | David Wilkinson | Matt France | Organisational Development Team to undertake review of workplace culture issues within Paediatrics at FGH and to identify potential areas for action | FGH Paediatrics Organisational Development Report completed by Matt France | FGH Paediatrics Organisational Development Report | FGH Paediatrics Organisational Development Report | 30/04/2020 | N/A | N/A | D | NA | Low |
| WACS12.2 | David Wilkinson | Lynne Wyre | Director of Nursing to review Action Plan to confirm Nursing issues and concerns are included and addressed | Review completed | Feedback from Director of Nursing | Review Completed | 31/07/2020 | N/A | N/A | D | NA | Low |
| WACS12.3 | David Wilkinson | Matt France | 15 Point Action Plan developed to address issues identified from review; including Behavioural Aspects, Policies and Procedures, and Environmental Factors<br>Action Plan to be led by Matt France and Linda Womack | Draft Copy received<br>Action owners and target dates now being agreed<br>Action plan in progress<br>Oct 2020: Personal support in progresssing the Action Plan from Trust Medical Director and Chief Operating Officer | Action Plan | Action Plan | 31/03/2021 | N/A | N/A | NTMI | NA | Medium |
| WACS12.4 | David Wilkinson | Linda Womack/Matt France | Delivery of 15 Actions within Action Plan | Nov 2020 Update: 7 Actions completed, 3 Actions Ongoing, 5 Actions Delayed | Action Plan | Action Plan | 31/03/2021 | 15 | 7 | NA | NTMI | Medium |
| WACS12.5 | David Wilkinson | Linda Womack/Matt France | Progress report on Action Plan to be reported to WACS Management Board and Workforce Committee | Quarterly Progress Updates to be provided Quarterly Progress Updates to be provided to Workforce Committee.<br>Nov 2020: Report to Workforce Committee by Matt France and Linda Womack | Agenda, Minutes | Progress Reports | 31/03/2021 | N/A | N/A | OT | NA | Low |
| WACS12.6 | David Wilkinson | Andrea Willimott | Governance Team to schedule and complete a Corporate Quality Review of Paediatrics at FGH to assess improvement in Culture and Leadership | Scheduling delayed due ongoing COVID Restrictions.<br>Target date extended from Dec 2020 to Mar 2021 | Corporate Quality Review Records | Corporate Quality Review completed | 31/03/2021 | N/A | N/A | OT | NA | Low |

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| **Recommendation Ref. No.:** | **ICS1** |
| **CQC Report:** | **2017 CPFT Inspection Report** |
| **CQC Domain:** | **SAFE** |
| **CQC Service Name:** | **Community Services fro Adults** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **Shahedal Bari** |
| **UHMBT Care Group:** | **Integrated Community Services** |
| **UHMBT Site(s):** | **Trust Wide** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Progress** |
| **UHMB Theme:** | **Clinical Audit** |
| **CQC Recommendation:** | The trust should audit implementation of their self-administration of medicines policy. |
| **Story behind the Recommendation:** | We also found that although the trust medicines policy encouraged the support of safe medicines self-administration this was not adopted in practice.<br>One nurse told us that self-administration on discharge had been raised as a concern by one of the rehabilitation teams. |
| **What the CQC expect 'Good' to look like:**<br>**(Taken from relevant KLOE definition)** | People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies. This is monitored to ensure consistency of practice.<br>There is participation (that includes all relevant staff) in relevant local and national clinical audits and other monitoring activities such as reviews of services, benchmarking and peer review and approved service accreditation schemes.<br>Accurate and up-to-date information about effectiveness is shared internally and externally and is understood by staff.<br>It is used to improve care and treatment and people's outcomes and this improvement is checked and monitored. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Complete Audit of Self Administration Policy |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ICS1.01 | Shahedal Bari | Stuart Bates | Governance Division (Clinical Audit) to undertake review of Trust Wide Clinical Audit management processes and procedures to identify possible improvements and then develop actions to implement them. | Review to include:<br>a) Review of the Audit nomenclature in Ulysses system to make Audits easier and quicker to identify and monitor<br>b) Ensure the linking of Audits and any subsequent Re-Audits to make the complete audit chain easier and quicker to identify and monitor<br>c) Deliver standardised minimum content and format for all internal Audit presentations; Overview, methodology, findings/performance, recommendations, high level action plan<br>d) Examples of Supporting Evidence that should be attached to the Audit in the Ulysses System; Original Audit document from issuing Agency, Presentation to local Clinical Meeting(s), Minutes of the relevant local Clinical Meeting(s), Minutes of the relevant Trust CEASG meeting(s), any Communications (Weekly News articles, Poster etc.), any Trust or Care Group Learning to Improve Bulletins | Clinical Audit and Effectiveness Meeting | Revised Clinical Audit process in place | 30/09/2019 | N/A | N/A | D | NA | Low |
| ICS1.02 | Shahedal Bari | Jane Dickinson | Review of Care Group Self Administration Policy to consolidate those inherited from BTHT and CPFT and to align with UHMBT Pharmacy principles/requirements. | Policies have been reviewed with regards to the section on self-administration. Excepted by CHSI care group, and a larger piece of work with pharmacy taking place. Will be harmonised as part of the Procedural documents group. Re viewed policies for medicine management, community care group has agreed that the section reffering to self managemnt of medicines will be adopted from UHMBT policy. Further work required before full policy can go for ratification. | Procedural documents Meeting | Revised Self Administration Policy in place | 30/10/2019 | N/A | N/A | D | NA | Low |
| ICS1.03 | Shahedal Bari | Jane Dickinson | Implement UHMBT Self Administration Policy | Reviewed policies for medicine management, community care group has agreed that the section reffering to self managemnt of medicines will be adopted from UHMBT policy. Further work required before full policy can go for ratification. Agreed a way forward with regards to the management of control drugs in the community setting, Policy can be sent for ratification during the month of January. | Procedural documents Meeting | Revised Self Administration Policy in place | 30/01/2020 | N/A | N/A | OT | NA | Low |
| ICS1.04 | Shahedal Bari | Carrie Eddy | Trust Medication Safety Officer to ensure that an Audit of Self Administration of Medicine is added to the Forward Audit Plan for 2020/21 | Awaiting update from Medication Safety Officer | Forward Audit Plan for 2020/21 | Audit of Self Administration on Forward Audit Plan for 2020/21 | 31/03/2020 | N/A | N/A | OT | NA | Low |

# CQC Trust Improvement Plan 2019/20

## Completed Recommendation Action Plans

bettercare together

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

The BayWay

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| **Recommendation Ref. No.:** | **ED04** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **EFFECTIVE** |
| **CQC Service Name:** | **Urgent & Emergency Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **Kate Maynard** |
| **UHMBT Care Group:** | **Medicine Care Group** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Finance Committee** |
| **UHMBT Strategic Objective:** | **Performance** |
| **UHMB Theme:** | **Access & Flow** |
| **CQC Recommendation:** | Continue to work towards meeting RCEM waiting time standards including the median time to treatment, four hour target and time patients wait for a bed after decision to admit has been made. |
| **Story behind the Recommendation:** | The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust met the standard for five months over the 12-month period from September 2017 to August 2018. The standard had not been met since January 2018. At the trust, the median time from arrival to treatment has also been greater than the England average since February 2018.<br>In the most recent month of available data, August 2018, the median time to treatment at the trust was 64 minutes compared to the England average of 56 minutes<br>When looking at four-hour target performance, the trust consistently breached the 95% standard from September 2017 to August 2018. Furthermore, the trust's four-hour target performance was worse than the England average in 10 of the last 12 months. A large improvement in the trust's performance can be seen between March 2018 and May 2018 where the percentage of patients seen within 4 hours increased from 76.3% in March 2018 to 90.6% in May 2018, however, performance has declined since this point.<br>We requested information from the trust about the four hour performance target for individual sites. The data provided by the trust also includes attendances to the Ophthalmic CAS clinic which does not fall under the scope of the inspection.<br>The performance data provided ranged between 76.24% in January 2018 and 93.10% in November 2017. The data shows the Furness General Hospital site consistently did not meet the national four hour performance target of 95% in any month. It is unclear what the impact of the inclusion of the ophthalmology CAS clinic data has had on performance.<br>Over the 12 months from September 2017 to August 2018, 214 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in March 2018 (78 patients), January 2018 (37 patients) and February 2018 (25 patients).<br>We requested information from the trust about 12 hour waits from decision to admit.<br>The data showed Furness General Hospital site had patients breaching 12 hours 9 months of the 12 month period. Staff we spoke with gave an example of patients living with a mental health condition, waiting more than 80 hours for a bed in a mental health trust. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies.<br>This is monitored to ensure consistency of practice. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Implement the revised ED SOP. |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED04.1 | Foluke Ajayi | Leanne Cooper | Support from Ernst & Young on ED Improvement Work | Completed in January 2019 | N/A | Support from Ernst & Young | 31/01/2019 | N/A | N/A | D | NA | Low |
| ED04.2 | Foluke Ajayi | Leanne Cooper | Re-emphasise the procedures for re-utilisation of cubicles to prioritise patients with the highest clinical needs to staff to ensure awareness of procedures | Clinical prioritisation of patients is standard practice within the Department, need to ensure that standards are maintained during very busy and extremely busy periods. | N/A | Appropriate Clinical Prioritisation | | N/A | N/A | D | NA | Low |
| ED04.3 | Foluke Ajayi | Leanne Cooper | Review and update the Escalation flow charts / trigger charts for the Emergency Departments | Completed | Escalation flow charts / trigger charts | Revised Escalation flow charts / trigger charts in use | 28/02/2020 | N/A | N/A | D | NA | Low |
| ED04.4 | Foluke Ajayi | Neil Smith | Introduce seen on green process | Issues around cubicle space due to ongoing refurbishment works in dept.<br>Process now Implemented | Seen on Green Process | Seen on Green established and embedded | 21/06/2019 | N/A | N/A | D | NA | Medium |
| ED04.5 | Foluke Ajayi | Neil Smith | Implement "Decision made within 120 minutes" | Implemented | | | 30/08/2019 | N/A | N/A | D | NA | Medium |
| ED04.6 | Foluke Ajayi | Shahedal Bari | Relaunch the Emergency Dept. SOP | SOP Awaiting confirmation of Watershed rulesby Medicine and SCC CD's<br>Emergency Department SOP - Approved at November Trust Procedural Document Library | Emergency Dept. SOP | Emergency Dept SOP in place | 30/11/2020 | N/A | N/A | D | NA | Low |
| ED04.7 | Foluke Ajayi | Neil Smith | Establish process to Monitor the 30 mins response from Specialities | Process established, identified that ED Medics do not implement 30 min rule.<br>Requires change in understanding between ED Medics and Surgery Medics | Process | July 2019 Audit Completed | 28/06/2019 | N/A | N/A | D | NA | Medium |
| ED04.8 | Foluke Ajayi | Neil Smith | Review and Implement daily monitoring of four hour target | Completed | N/A | Daily monitoring of 4Hr target | 17/05/2019 | N/A | N/A | D | NA | Low |
| ED04.9 | Foluke Ajayi | Neil Smith | Ensure a Robust triage system is in place | Triage system in place, Clinical leaders hours adjusted in order to improve compliance | Triage System | Triage system established and embedded | 17/05/2019 | N/A | N/A | D | NA | Low |
| ED04.10 | Shahedal Bari | Ash Chatterjee | Monitor the "Decision made within 120 Minutes' delays by Speciality and send report to Dr Bari for review. | Need to input from Trust Medical Director and Care Group Clinical Directors regarding the implementation of the 30 min rule.<br>Monitoring of 30 minute rule included in the revised ED Emergency Care Admisssion SOP. | | Report completed and sent to Dr. Bari | 31/03/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **ED05** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **EFFECTIVE** |
| **CQC Service Name:** | **Urgent & Emergency Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Medicine Care Group** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMB Theme:** | **Staff Recruitment/Deployment** |
| **CQC Recommendation:** | Work towards recruiting substantive consultant level doctors for the department |
| **Story behind the Recommendation:** | From October 2017 to September 2018, the trust reported a vacancy rate of 6.3% for medical staff working in urgent and emergency care.<br>We discussed staffing and vacancies whilst in the department. The department was funded for three WTE (whole time equivalent) consultants however at the time of the inspection, there were no substantive consultants employed in the department. There was some occasional consultant cover from a recently retired consultant although this was minimal.<br>The department was not meeting the RCEM (Royal College of Emergency Medicine) standards which state an ED should have 16 hours of consultant cover each day. The department was overseen by an associate specialist (one grade lower than a consultant). We had some concerns about there being no consultant oversight of the department. Staff told us the trust was looking at providing consultant support from Royal Lancaster Hospital (RLI) however this was not in place at the time of the inspection. |
| **What the CQC expect 'Good' to look like:<br>(Taken from relevant KLOE definition)** | Staffing levels and skill mix are planned, implemented and reviewed to keep people safe at all times.<br>Any staff shortages are responded to quickly and adequately.<br>Where relevant, there are effective handovers and shift changes to ensure that staff can manage risks to people who use services.<br>Staff recognise and respond appropriately to changes in the risks to people who use services.<br>Risks to safety from changes or developments to services are assessed, planned for and managed effectively. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Maintain ED Consultant and Junior Grade staffing levels at a level that ensures an appropriate level of patient safety and treatment. |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED05.1 | David Wilkinson | Ash Chatterjee | Implement recruitment strategy to recruit to required RCEM WTE standard | Continuous Recruitment Strategy implemented<br>Weekly review of Medical staffing levels in place.<br>Weekly review of possible candidates with subsequent initial Skype interviews where appropriate.<br>Limited success in candidates willing to move to formal interview. | ESR | Recruit to required RCEM WTE standard | 31/03/2021 | N/A | N/A | NTMA | NA | High |
| ED05.2 | David Wilkinson | Ash Chatterjee | Arrange meeting with Clinical Director of Medicine Care Group to devises a plan going forward to resolve recruitment and deployment issues at FGH | Meeting planned with NS, AC and PG for the 03/09<br>Meeting held | N/A | Meeting Scheduled | 13/09/2019 | N/A | N/A | D | NA | Low |
| ED05.3 | David Wilkinson | Katy Stretch | Schedule meeting with Workforce Business Partner to investigate bespoke recruitment strategy/process for FGH ED. | Emailed KS from HR, had no response<br>Meeting Held December 2019 | N/A | Decision on bespoke recruitment strategy/process | 30/09/2019 | N/A | N/A | D | NA | Low |
| ED05.4 | Foluke Ajayi | Leanne Cooper | Chief Operating Officer to work with Medicine Care Group ADOP to review potental alternatives to recruitment which could increass Consultant cover at FGH ED | Alternative Recruitment via CESR, Work with Bespoke Agencies | Review Report | Review completed | 31/12/2019 | N/A | N/A | D | NA | Low |
| ED05.5 | David Wilkinson | Carol Park | set up recruitment focus group | meeting planned with Neil Smith , Ash Chatterjee and Paul Grout 03/09. this has been superceeded by the recruitment which attracts ass specialist t othen progess with consultant training. Consultant post to be advertised | recruitment focus group | recruitment focus group | 27/09/2019 | N/A | N/A | D | NA | Low |
| ED05.6 | David Wilkinson | Neil Smith | Implement ongoing advertisement for ED Consultant roles at FGH | Continuous advert now in place until recruitment completed | Advertisement for ED Consultant roles at FGH | ongoing advertisement for ED Consultant roles at FGH | 25/10/2019 | N/A | N/A | D | NA | Low |
| ED05.7 | David Wilkinson | Neil Smith, Ash Chatterjee | Ongoing recruitment of associate specialists to provide further Non-Consultant medical cover | 2 ASS specialist recruited, one has commenced employment and further to start in January. 3 vacancy at the present time. Further interviews planned for October. 10/10 further recruitment of two ass specialist, | ESR | Increasse in number of associate specialists | 27/09/2019 | TBC | TBC | D | NA | Medium |
| ED05.8 | David Wilkinson | Neil Smith, Ash Chatterjee | Recruit Associate Specialists roles which will undertake in house CESR training which will lead to Consultant posts | Projected that three will complete training 2020. | TBC | Increasse in number of Consultants | 24/04/2020 | 3 | 3 | D | NA | Medium |
| ED05.9 | David Wilkinson | Ash Chatterjee, Jeremy Harrison | Need to identify scope for cross bay cover for consultant | CP to discuss with Jeremy Harrison. Discussion has taken place with JH, no cover available from RLI. | Review Report | review completed | 18/10/2019 | N/A | N/A | D | NA | Medium |
| ED05.10 | David Wilkinson | Neil Smith, Ash Chatterjee | Develop Associate Specialists roles which will undertake in house CESR training which will lead to Consultant posts | 2 Associate Specialists roles now in CESR programme, results expected in November 2020 | ESR | Associate specialists qualified as Consultants | 31/03/2021 | TBC | TBC | D | NA | Medium |
| ED05.11 | David Wilkinson | TBC | Medicine Care Group to undertake risk assesment to review current mitigations and to establish the level of potential risk to Patients | In Progress | Risk Assessment | Risk Assessment completed | 30/09/2020 | N/A | N/A | D | NA | Low |
| ED05.12 | David Wilkinson | Mel Woolfall, Diane Smith | Review with Care Group to detrmine if this recommendation is encapsulated within Trust Wide Action TRUST03 and whether this recommendation can be closed and progress monitored through processes detailed in TRUST03. This will avoid duplication of reporting. | Discussed with Care Group at CQC review meeting on 26 November.<br>Confirmation that this recommenation can now be closed. | CQC Improvement Plan | Recommendation Action Plan closed | 30/11/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **MED01** |
| **CQC Report:** | **2019 Inspection Report, 2017 Inspection Report** |
| **CQC Domain:** | **SAFE** |
| **CQC Service Name:** | **Medical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Medicine Care Group** |
| **UHMBT Site(s):** | **RLI** |
| **UHMBT Board Assurance Committee** | **Workforce Commiteee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMB Theme:** | **Staff Recruitment/Deployment** |
| **CQC Recommendation:** | The trust should continue to proactively recruit nursing and medical staff. |
| **Story behind the Recommendation:** | The trust commissioned a nurse staffing levels review for 2018/19, undertaken by an external provider. The biggest identified risk was that the trust did not have a safe nurse staffing policy in place, nor a staff rostering policy. As a result, it was not clear how or when to escalate risk caused by low nurse staffing levels, however we were informed that action had already been taken to address this.<br>As at September 2018, 87.6% of qualified nursing shifts were filled across the whole trust. Nursing fill rates were low at the Royal Lancaster Infirmary with fill rates of 87.1%. However, we saw evidence that the trust had made significant improvements in their nurse fill rates since our last inspection and although there is further work to be done, good progress had been made in recruiting and retaining nursing staff.<br>We had concerns about the levels of stroke consultants during the week and at weekends.<br>Consultants reviewed stroke patients on the Huggett Suite every day, Monday to Friday. Stroke nurses provided cover at weekends, and deteriorating patients could be reviewed by the medical consultant on call at weekends or evenings. There was no stroke specific medical cover at weekends. This did not meet recommendations set out by the Royal College of Physicians, and was on the divisional risk register.<br>On ward 23, we had concerns about the levels of doctor cover as at times there was only one doctor on duty with periods of no overlap with colleagues. We heard that this situation was in part due to long term leave within the team.<br>We were advised that a junior doctor led ward rounds on a Tuesday. The stroke consultant told us that they were available to contact should the junior doctor need support. However, day to day elements, such as ECGs and phlebotomy had to be completed solely by the junior doctor.<br>Out of hours medical cover consisted of twilight cover from a registrar and Senior House Officer (SHO), plus a junior doctor, until 12.30am. After this time until 9am there was one night registrar and a SHO based in AMU covering all the hospital's medical wards. There was a hospital at night team, consisting of two nurses, one based in the main building, and one in Medical Unit 2. There was no critical care outreach team.<br>We were told that there was junior doctor and consultant cover for AMU seven days a week. However, an average of only 75.9% of patients were reviewed by a consultant within 14 hours of arrival.<br>The Elderly Assessment Unit (EAU) hosted a junior doctor and a GP on rotation but as the GP was also on call there was often only one doctor present. We heard on inspection that some junior doctors were working long hours. The guardian for safer working's last report to trust board showed 65 incidents reported from junior doctors over the previous three months, relating to long hours. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | Staffing levels and skill mix are planned, implemented and reviewed to keep people safe at all times.<br>Any staff shortages are responded to quickly and adequately.<br>Where relevant, there are effective handovers and shift changes to ensure that staff can manage risks to people who use services.<br>Staff recognise and respond appropriately to changes in the risks to people who use services. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Achive target Recruitment levels for Medical and Nursing staff by March 2021 |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MED01.01 | David Wilkinson | Mel Woolfall | Achieve target vacancy rate for Registered Nurses | Need to confirm progress in Care Group | ESR | Achieve target vacancy rate | 31/03/2021 | 5% | | NA | D | Medium |
| MED01.02 | David Wilkinson | Andrew Higham | Achieve target vacancy rate for Consultant Medical Grades | Need to confirm progress in Care Group | ESR | Achieve target vacancy rate | 31/03/2021 | 5% | | NA | D | Medium |
| MED01.03 | David Wilkinson | Andrew Higham | Achieve target vacancy rate for other Medical Grades | Need to confirm progress in Care Group | ESR | Achieve target vacancy rate | 31/03/2021 | 5% | | NA | D | Medium |
| MED01.04 | David Wilkinson | Mel Woolfall | Deliver the Care Group Nursing Recruitment Plan for 2019/20 | Ongoing process.<br>Increasing numbers of international recruits arriving during 2019/20<br>2019/20 Plan Completed/Closed | ESR | Care Group Nursing Recruitment Plan for 2019/20 delivered | 31/03/2020 | | | D | NA | Medium |
| MED01.05 | David Wilkinson | Andrew Higham | Deliver the Care Group Medical Recruitment Plan for 2019/20 | Ongoing process.<br>2019/20 Plan Completed/Closed | ESR | Care Group Medical Recruitment Plan for 2019/20 delivered | 31/03/2020 | | | D | NA | Medium |
| MED01.06 | David Wilkinson | Matrons | Review of all recruitment adverts | Completed | TRAC | Review completed | 02/08/2019 | N/A | N/A | D | NA | Low |
| MED01.07 | David Wilkinson | Emma Fitton | Contact all local universities | Completed | N/A | Universities contacted | 28/06/2019 | N/A | N/A | D | NA | Low |
| MED01.08 | David Wilkinson | Matrons | Establish proces for Monthly review of all staffing | Staff in Post Reviewed | Staffing Review | Reviews completed | 26/07/2019 | N/A | N/A | D | NA | Low |
| MED01.09 | Sue Smith | Mel Woolfall | Review the current preceptorship | T&F group for revising the preceptorship pack. 23/9 - first meeting cross care group involvement<br>Review completed 20/09/2019 | Review completed | Review completed | 20/09/2019 | N/A | N/A | D | NA | Low |
| MED01.10 | Sue Smith | Mel Woolfall | Establish what Percetorship programmes are already available / used in other organisations, to identify any best practice or innovation that can be used | Review completed 04/10/2019 | N/A | Review completed | 04/10/2019 | N/A | N/A | D | NA | Low |
| MED01.11 | Sue Smith | Mel Woolfall | Schedule Fortnightly meetings to review & agree percetorship package | Meeting established and scheduled | Meeting Schedule | Meeting Schedule | 15/11/2019 | N/A | N/A | D | NA | Low |
| MED01.12 | Sue Smith | Mel Woolfall | Develop a revised preceptorship package. | In Progress<br>Update from Helen Thompson in Sept 2020<br>Half day session on teams<br>Full day classroom sessions | Revised Perceptorship | Revised Perceptorship | 30/09/2020 | N/A | N/A | D | NA | Low |
| MED01.13 | David Wilkinson | Nicole Dixon/Simon Glover | Develop package for Band 6's | Need to confirm Action Owner<br>08/08 initial pack developed and shared with ward managers at RLI. To be shared with FGH.<br>Package Agreed | Package for Band 6's | Package for Band 6's | 26/07/2019 | N/A | N/A | D | NA | Low |
| MED01.14 | David Wilkinson | Nicole Dixon/Simon Glover | Agree the agenda/programme for the Band 6 package | 8/8/19 To share with FGH<br>Agend/Programme now agreed | Package for Band 6's | Package for Band 6's | 23/08/2019 | N/A | N/A | D | NA | Low |
| MED01.15 | David Wilkinson | Nicole Dixon/Simon Glover | Send out for & Collate expressions of interest for the Band 6 package | Completed | Package for Band 6's | Package for Band 6's | 01/11/2019 | N/A | N/A | D | NA | Low |
| MED01.16 | David Wilkinson | Nicole Dixon/Simon Glover | Set dates to commence the Band 6 package | To commence on W/C 29/11/2019 | Package for Band 6's | Package for Band 6's | 01/11/2019 | N/A | N/A | D | NA | Low |
| MED01.17 | David Wilkinson | Nicole Dixon/Simon Glover | Commence the Band 6 package | Commenced | Package for Band 6's | Package for Band 6's | 29/11/2019 | N/A | N/A | D | NA | Low |
| MED01.18 | David Wilkinson | Nicole Dixon/Simon Glover | Evalute the effectiveness of the Band 6 package | Programme commenced W/C 29/11/2019<br>Half day session on teams<br>Full day classroom sessions | Review Document | Review completed | 31/12/2019 | N/A | N/A | D | NA | Low |
| MED01.19 | David Wilkinson | Mel Woolfall | Learn from staff exit interviews | Exit Interviews now in place<br>Feedback at MCGAG meeting on quarterly basis | Findings from Exit Interviews | Implementation of findings from Exit Interviews | 02/08/2019 | N/A | N/A | D | NA | Low |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MED01.20 | David Wilkinson | Mel Woolfall, Katy Stretch | Involvement in NHSI recruitment and retention for ED work stream | Action completed | | Involvement in NHSI Workstreams | 21/06/2019 | N/A | N/A | D | NA | Low |
| MED01.21 | David Wilkinson | Mel Woolfall, Diane Smith | Review with Care Group to detrmine if this recommendation is encapsulated within Trust Wide Action TRUST03 and whether this recommendation can be closed and progress monitored through processes detailed in TRUST03. This will avoid duplication of reporting. | Discussed with Care Group at CQC review meeting on 26 November.<br>Confirmation that this recommenation can now be closed. | CQC Improvement Plan | Recommendation Action Plan closed | 30/11/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **MED02** |
| **CQC Report:** | **2019 Inspection Report, 2017 Inspection Report** |
| **CQC Domain:** | **SAFE** |
| **CQC Service Name:** | **Medical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Medicine Care Group** |
| **UHMBT Site(s):** | **FGH & RLI** |
| **UHMBT Board Assurance Committee** | **Workforce Commiteee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMB Theme:** | **Staff Development & Training** |
| **CQC Recommendation:** | **RLI -** The trust should ensure staff are given time to complete their mandatory training and that accurate compliance figures are maintained.<br>**FGH -** Continue to ensure that staff complete mandatory training in accordance with trust policy at FGH. |
| **Story behind the Recommendation:** | **RLI**<br>The trust set a target of 95% for completion of mandatory training. This was delivered either by eLearning or face to face. Staff we spoke to said that they did find time to complete their mandatory training. However, on viewing WESEE reports (ward level bulletins), we saw that divisional compliance with Basic Life Support (BLS) training was below target and falling (80.6% in June 2018 and 79.9% in October 2018). The governance team were aware of this issue and were using messages in these reports to encourage greater compliance. Practice educators had been asked to provide more sessions to increase training capacity. We heard on inspection that some nurses and doctors did not maintain their protected learning time due to time pressures.<br><br>**FGH**<br>Mandatory training figures at FGH varied considerably from ward to ward and from topic to topic.<br>Ward managers also showed us mandatory training figures for their respective wards, which showed a slight variance from division figures. Generally, ward based capture of mandatory training was higher than reported. |
| **What the CQC expect 'Good' to look like:**<br>**(Taken from relevant KLOE definition)** | All staff, including volunteers, are qualified and have the skills they need to carry out their roles effectively and in line with best practice.<br>The learning needs of staff are identified and training is provided to meet these needs.<br>Staff are supported to maintain and further develop their professional skills and experience. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Achieve Target Core Skill Framework Training levels by March 2021 |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MED02.01 | David Wilkinson | Mel Woolfall | Identify training demand | TNA Completed | Training Needs Analysis | Training demand confirmed | 14/06/2019 | N/A | N/A | D | NA | Low |
| MED02.02 | David Wilkinson | Mel Woolfall | Map out training for 12 months | Training plan in place | TMS | 12 month training plan established | 26/07/2019 | N/A | N/A | D | NA | Medium |
| MED02.03 | David Wilkinson | Mel Woolfall, Diane Smith, Andrew Higham | Achieving Trust Wide NHS Core Skills training compliance rates of 95% - Equality, Diversity & Inclusion | Need confirm current performance with Care Group | TMS | Achieve 95% Compliance | 31/03/2021 | 95% | | D | NA | Medium |
| MED02.04 | David Wilkinson | Mel Woolfall, Diane Smith, Andrew Higham | Achieving Trust Wide NHS Core Skills training compliance rates of 95% - Fire Safety (General and Departmental) | Need confirm current performance with Care Group | TMS | Achieve 95% Compliance | 31/03/2021 | 95% | | D | NA | Medium |
| MED02.05 | David Wilkinson | Mel Woolfall, Diane Smith, Andrew Higham | Achieving Trust Wide NHS Core Skills training compliance rates of 95% - Information Governance | Need confirm current performance with Care Group | TMS | Achieve 95% Compliance | 31/03/2021 | 95% | | D | NA | Medium |
| MED02.06 | David Wilkinson | Mel Woolfall, Diane Smith, Andrew Higham | Achieving Trust Wide NHS Core Skills training compliance rates of 95% - Infection Prevention and Control | Need confirm current performance with Care Group | TMS | Achieve 95% Compliance | 31/03/2021 | 95% | | D | NA | Medium |
| MED02.07 | David Wilkinson | Mel Woolfall, Diane Smith, Andrew Higham | Achieving Trust Wide NHS Core Skills training compliance rates of 95% - Health & Safety | Need confirm current performance with Care Group | TMS | Achieve 95% Compliance | 31/03/2021 | 95% | | D | NA | Medium |
| MED02.08 | David Wilkinson | Mel Woolfall, Diane Smith, Andrew Higham | Achieving Trust Wide NHS Core Skills training compliance rates of 95% - Manual Handling (Module A & B) | Need confirm current performance with Care Group | TMS | Achieve 95% Compliance | 31/03/2021 | 95% | | D | NA | Medium |
| MED02.09 | David Wilkinson | Mel Woolfall, Diane Smith, Andrew Higham | Achieving Trust Wide NHS Core Skills training compliance rates of 95% - Safeguarding Adults (Level 1) | Need confirm current performance with Care Group | TMS | Achieve 95% Compliance | 31/03/2021 | 95% | | D | NA | Medium |
| MED02.10 | David Wilkinson | Mel Woolfall, Diane Smith, Andrew Higham | Achieving Trust Wide NHS Core Skills training compliance rates of 95% - Safeguarding Children (Level 1) | Need confirm current performance with Care Group | TMS | Achieve 95% Compliance | 31/03/2021 | 95% | | D | NA | Medium |
| MED02.11 | David Wilkinson | Mel Woolfall, Diane Smith | Review with Care Group to detrmine if this recommendation is encapsulated within Trust Wide Action TRUST04 and whether this recommendation can be closed and progress monitored through processes detailed in TRUST04. This will avoid duplication of reporting. | Discussed with Care Group at CQC review meeting on 26 November.<br>Confirmation that this recommenation can now be closed. | CQC Improvement Plan | Recommendation Action Plan closed | 30/11/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **MED03** |
| **CQC Report:** | **2019 Inspection Report, 2017 Inspection Report** |
| **CQC Domain:** | **EFFECTIVE** |
| **CQC Service Name:** | **Medical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Medicine Care Group** |
| **UHMBT Site(s):** | **FGH & RLI** |
| **UHMBT Board Assurance Committee** | **Workforce Commiteee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMB Theme:** | **Staff Appraisal** |
| **CQC Recommendation:** | **RLI** - The trust should ensure that all staff benefit from the appraisal process and these are completed on an annual basis in accordance with local policy.<br>**FGH** - Improve compliance with staff appraisal by ensuring all staff receive an annual appraisal in line with trust policy. |
| **Story behind the Recommendation:** | **RLI**<br>Most staff we spoke to said they had received an appraisal. However, appraisal rates were low and below the 95% target. For example, on ward 37 only 60% of staff had a current appraisal. Appraisal rates were monitored at ward level but were not monitored using the divisional WESEE report. Appraisal rates were something we had asked the Trust to improve following our previous inspection.<br>It was not clear whether bank staff had appraisals and access to a supervision framework. One bank staff member we spoke with could not remember completing an appraisal and felt it would be helpful.<br><br>**FGH**<br>Staff we spoke with during the inspection said they had received their appraisal with their line manager. Despite this, information provided by the trust (see below) showed that compliance was below the trust target of 95%. As at September 2018, 73.3% of staff within medicine at the trust received an appraisal compared to a trust target of 100% for leadership staff and 95% for all other staff.<br>It was unclear as to the arrangements for training and supervision for bank staff as some told us they were not included in any appraisal system. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | Staff are supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal.<br>Where relevant, staff are supported through the process of revalidation.<br>There is a clear and appropriate approach for supporting and managing staff when their performance is poor or variable. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Achieve Target Appraisal levels by March 2021 |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MED03.01 | David Wilkinson | Mel Woolfall | Identify Appraisal demand/requirements for next 12 months | Completed | TMS | Training demand confirmed | 14/06/2019 | N/A | N/A | D | NA | Low |
| MED03.02 | David Wilkinson | Mel Woolfall | Map out appraisals for next 12 months | Completed | TMS | 12 month training plan established | 26/07/2019 | N/A | N/A | D | NA | Medium |
| MED03.03 | David Wilkinson | Mel Woolfall | Establish Process to review compliance with appraisals at weekly sickness meeting | Process established. Individual reminders sent to staff. Discussed weekly on sickness call | TMS | Review Completed | 28/06/2019 | N/A | N/A | D | NA | Medium |
| MED03.04 | David Wilkinson | Mel Woolfall | identify areas of low / no compliance | Areas of low compliance identified | Process in place | Review Completed | 05/07/2019 | N/A | N/A | D | NA | Medium |
| MED03.05 | David Wilkinson | Mel Woolfall | Develop actions to address low compliance | Action Plan in place | N/A | Actions in Place | 26/07/2019 | N/A | N/A | D | NA | Medium |
| MED03.06 | David Wilkinson | Andrew Higham | 2019/20: Achieve 95% Compliance with staff appraisal - Medical Appraisal | 100% compliance achieved in March 2020 | Action Plan | Achieve 95% compliance | 31/03/2020 | 95% | 100% | D | D | Medium |
| MED03.07 | David Wilkinson | Mel Woolfall, Diane Smith | 2019/20: Achieve 95% Compliance with staff appraisal - Band 1-7 & Band 8A (no Staff) E-Appraisal | Need confirmation of March 2020 postion | TMS | Achieve 95% compliance | 31/03/2020 | 95% | | D | NA | Medium |
| MED03.08 | David Wilkinson | Mel Woolfall, Diane Smith | 2019/20: Achieve 95% Compliance with staff appraisal - Band 8 (With Staff) E-Appraisal | Need confirmation of March 2020 postion | TMS | Achieve 95% compliance | 31/03/2020 | 95% | | D | NA | Medium |
| MED03.09 | David Wilkinson | Andrew Higham | 2020/21: Achieve 95% Compliance with staff appraisal - Medical Appraisal | Focus for 2020/21 is to improve the level of compliance and the quality of Appraisals<br>Need to confirm progress with Care Group | TMS | Achieve 95% compliance | 31/03/2021 | 95% | | D | NA | Medium |
| MED03.09 | David Wilkinson | Mel Woolfall, Diane Smith | 2020/21: Achieve 95% Compliance with staff appraisal - Band 1-7 & Band 8A (no Staff) E-Appraisal | Focus for 2020/21 is to improve the level of compliance and the quality of Appraisals<br>Need to confirm progress with Care Group | TMS | Achieve 95% compliance | 31/03/2021 | 95% | | D | NA | Medium |
| MED03.10 | David Wilkinson | Mel Woolfall, Diane Smith | 2020/21: Achieve 95% Compliance with staff appraisal - Band 8 (With Staff) E-Appraisal | Focus for 2020/21 is to improve the level of compliance and the quality of Appraisals<br>Need to confirm progress with Care Group | TMS | Achieve 95% compliance | 31/03/2021 | 95% | | D | NA | Medium |
| MED03.11 | David Wilkinson | Mel Woolfall, Diane Smith | Review with Care Group to detrmine if this recommendation is encapsulated within Trust Wide Action TRUST02 and whether this recommendation can be closed and progress monitored through processes detailed in TRUST02. This will avoid duplication of reporting. | Discussed with Care Group at CQC review meeting on 26 November.<br>Confirmation that this recommenation can now be closed. | CQC Improvement Plan | Recommendation Action Plan closed | 30/11/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **MED04** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **WELL LED** |
| **CQC Service Name:** | **Medical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **Sue Smith** |
| **UHMBT Care Group:** | **Medicine Care Group** |
| **UHMBT Site(s):** | **RLI** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Progress** |
| **UHMB Theme:** | **Clinical Governance** |
| **CQC Recommendation:** | The trust should continue to assess and measure the effectiveness of the WESEE governance framework and adapt practice accordingly. |
| **Story behind the Recommendation:** | We reviewed the divisional WESEE meeting notes but this did not include monitoring of any service level agreements with third parties. Attendance at the divisional meeting was recorded in the WESEE notes and while this was good in September 2018, with representatives including the associate director of nursing, clinical leads, matrons and service managers, in previous months attendance had been very low, with less than half of those invited attending the four meetings prior. Points of actions were noted and it was clear where issues should be escalated<br>The divisional WESEE monthly report monitored workforce issues such as mandatory training, incidents, lone working, efficiency, medication errors, document control, medicine audit exceptions, NICE alerts, claims and patient experience. This document did not clearly state what the targets were in all areas and there was no direction of travel visibly displayed.<br>On examination, wards were not regularly completing WESEE reports monthly. Of the nine wards we looked at, seven had not completed their last three reports and one had not shown evidence of any WESEE reports or minutes this year. This was noted at divisional level in the division-wide. WESEE report but no solution or action plan was in place to address this. The divisional team were not assured that the flow of information from ward to board was in place. Attendance was not recorded in six of the 27 local reports we examined, and therefore we could not tell if meetings were always quorate. Divisional leaders on ward walkabouts noted that staff did not know what the WESEE acronym was for and some staff were not aware of the incidents in their area.<br>Minutes of ward WESEE reports varied in quality. Some were excellent, covering lessons learnt, compliments and complaints, local staffing and environment issues, mental health updates and Trust wide and national updates and alerts. Others were very poor, featuring little or no ward specific information and no dissemination of learning from incidents. We were not assured that the 'ward to board' governance arrangements were therefore robust.<br>We were told by staff that the WESEE reports covered risk but having reviewed 27 sets of notes from a variety of wards, we could not see any specific mention of ward level risk. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.<br>Staff are clear about their roles and accountabilities.<br>There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | TBC |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MED04.01 | Sue Smith | Mel Woolfall | Ensure that Governance Meetings are in place in all Departments and Wards and take place on a regular basis. | Need to consider if a standard minimum frequency of meetings is appropriate for all Departments and Wards. | | Regular Governance Meetings | 30/09/2019 | | | D | NA | Medium |
| MED04.02 | Sue Smith | Ward Managers | Attendance at and involvement in departmental Governance meetings by Band 5 RN's to be encouraged and monitored through the Appraisal process | Once established will need to monitor via appraisal as an ongoing process | TMS | Regular attendance by Band 5 Nurses | | | | D | NA | Low |
| MED04.03 | Sue Smith | Ward Managers | Attendance at and involvement in departmental Governance meetings by Band 6 RN's to be encouraged and monitored through the Appraisal process | Once established will need to monitor via appraisal as an ongoing process | TMS | Regular attendance by Band 6 Nurses | | | | D | NA | Low |
| MED04.04 | Sue Smith | Ward Managers | Ensure the Department/Ward learning boards are regularly updated with lessons Learned from a Governance process; Incidents, complaints, clinical Audit etc. | | | Regular (monthly?) updates | 30/09/2019 | | | D | NA | Low |
| MED04.05 | Sue Smith | Mel Woolfall | Consider introducing a standardised "checklist" for debrief sessions to include any relevant Governance information | | Standardised Checklist | Checklist established | 31/08/2019 | N/A | N/A | D | NA | Low |
| MED04.06 | Sue Smith | Leanne Cooper, Mel Woolfall, Andrew Higham, Emily Henry | Full review of Care Group Risk Register to be undertaken by Care Group Triumvirate and Governance Business Partner in order to, where practical, consolidate existing risks around key themes (e.g. Recruitment, Training, Estates, Operational Performance) to enable better oversight, managment and resolution of common risks at Care Group Level.<br>Where practical, this will encompass all Local Departmental/Service Risks within teh wider Care Group Risk. | Risk Register Review completed in August 2019.<br>Medicine Care Group Risk Register has a total of 11 Risk on the Risk Register, 9 of these Care Group Wide consolidated risks, 2 are Department specific risks.<br>The 9 Care Group Wide consolidated risks are;<br>1) The Management of Patient Access and Flow within the Care Group<br>2) Staff Recruitment, Deployment and Training within the Care Group<br>3) The Care Group's Financial Position<br>4) The Physical Environment and Equipment used by the Care Group<br>5) The Information Technology Systems used by the Care Group<br>6) The provision of Stroke Services by the Care Group<br>7) The continuing provison of Fragile Clinical Services by the Care Group<br>8) The Service Provision from Mental Health Trusts to Emergency Medicine<br>9) Acheiving the Care Quality standards expected by the CQC | Ulysses | Risk Register Review completed | 30/08/2019 | N/A | N/A | D | NA | Low |
| MED04.07 | Sue Smith | Leanne Cooper, Mel Woolfall, Andrew Higham, Emily Henry | Establish process for regular distribution of a Summary of Care Group Risk Register to senior Care Group staff (Clinical Leads, Service Managers and Matrons) via Audit Meetings, Governance Meetings, Matrons Meetings etc. | Completed | Risk Register distribution process | Process established and operational | 31/10/2019 | N/A | N/A | D | NA | Low |
| MED04.08 | Sue Smith | Emily Henry | Establish process for six monthly distribution of a Summary of Care Group Risk Register to Departments/Wards as part of exisiting Governance Update/Communication processes within the Care Group | Completed | Risk Register distribution process | Process established and operational | 31/10/2019 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **MED05** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **SAFE** |
| **CQC Service Name:** | **Medical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **Sue Smith** |
| **UHMBT Care Group:** | **Medicine Care Group** |
| **UHMBT Site(s):** | **RLI** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Patients** |
| **UHMB Theme:** | **Quality & Safety Assurance Checks** |
| **CQC Recommendation:** | The trust should ensure that bath and shower water temperatures are being accurately recorded and actioned in line with local policy. |
| **Story behind the Recommendation:** | In medical wards there was a wipe clean log for recording bath and shower temperatures. These had not been completed monthly. In the Huggett Suite, the check was last recorded two months prior to the inspection. On Ward 20 the check sheet was displayed on the wall but had not been used. Audits showed that several of the medical wards had not taken part in the care group's safe bathing audit, and the care group were 54% compliant. We were not assured that regular checks were being conducted. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | There are clearly defined and embedded systems, processes and standard operating procedures to keep people safe.<br>Standard operating or safety procedures are completed to the appropriate standard and frequency. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Bathing water checks live on MY Assurance and subject to review and escalation if required. |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MED05.01 | Sue Smith | Anna Smith | The Monitoring and Recording of Bath and Shower Temperature checks will be discussed at the Trust Wide Health and Safety Representatives meeting on 22/05/2019, with the aim of identifying any possible improvements to correct processes and procedures. | Outcome from meeting; there needs to be a more robust recording mechanism (e.g. My Assure), with performance monitored by Matrons, with escalation to Health and Safety Team if required. | Trust Wide Health and Safety Representatives meeting minutes | Update from Trust Wide Health and Safety Representatives meeting | 22/05/2019 | N/A | N/A | D | NA | Low |
| MED05.02 | Sue Smith | Anna Smith | Add monthly bath and shower temperature range check to the 'Ward Manager Frequent Check List' in My Assure.<br>Performance results to reported to Ward Manager, Matrons and Health and Safety Team.<br>Matrons to address initial non-compliance issues, with persistent non-compliance to be escalated to Health and Safety team. | The Additionof the Safe Bathing Compliance check on to the My Assure system has been discussed and agred wit the Quality Assurance Matron.<br>Awaiting implementation in My Assure.<br>June 2020: This is a H&S template for this which is currently inactive; however, the question set sits on the matron's checks. Confirmed as active question on Matron Checklist | My Assure | Updated Ward Manager Frequent Check List in My Assure. | | N/A | N/A | D | NA | Medium |
| MED05.03 | Sue Smith | Anna Smith | Raise at Learning to Improve Group to request Trust Wide communication of change of process and reasons for this;<br>- Scalding a Patient is a Never Event<br>- UHMBT has reported patient safety incident caused by out of range bath/shower temperatures<br>- HSE have issued major fines for Scalding a Patient | Ongoing Process, no target date.<br><br>Learning to Improve has issued reminder - July 19 Issue 52 | LTI Bulletin | LTI Bulletin | 31/07/2019 | N/A | N/A | D | NA | Low |
| MED05.04 | Sue Smith | Matrons | Review compliance with safe bathing audit | Review completed | N/A | Audit Completed | 28/06/2019 | N/A | N/A | D | NA | Medium |
| MED05.05 | Sue Smith | Matrons | Identify areas of low / no compliance with bathing water checks | Ongoing Process, no target date | N/A | Low Compliance area identified | 05/07/2019 | N/A | N/A | D | NA | Low |
| MED05.06 | Sue Smith | Mel Woolfall | Establish proces for Non compliance with monthly bath and shower temperature range check to be raised by Matrons to the Quality Matron to work with these areas to improve compliance | Process established | proces for Non compliance with monthly bath and shower temperature range check | Compliance Improved | 19/07/2019 | N/A | N/A | D | NA | Low |
| MED05.07 | Sue Smith | Matrons | Monthly review of compliance to be undertaken | Now checked as part of the regular matron assurance audit of Wards.<br>30/9 plan on page to be sent out & laminated form. Areas to establish method for recording info on an ongoing basis. | Matron assurance audit of Wards. | Process for regular review established and implemented | 04/10/2019 | N/A | N/A | D | NA | Low |
| MED05.08 | Sue Smith | Simon Glover | Request to the Quality Matron for addition to daily harm free care checks | 08/08 Request made to Quality Matron | N/A | Request Completed | 09/08/2019 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **MED07** |
| **CQC Report:** | **2019 Inspection Report, 2017 Inspection Report** |
| **CQC Domain:** | **SAFE** |
| **CQC Service Name:** | **Medical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **David Wilksinson** |
| **UHMBT Care Group:** | **Medicine Care Group** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMB Theme:** | **Staff Recruitment/Deployment** |
| **CQC Recommendation:** | Review medical staffing cover at night and consider additional support to keep patients safe. |
| **Story behind the Recommendation:** | Medical cover at night between the hours of 9pm to 10am was provided by one registrar and one intermediate (F2/CMT) on site with a consultant on call at home. There was an additional junior doctor on a twilight shift until midnight. This team were responsible for responding to patients requiring urgent medical care on the acute medical unit (AMU), the Complex and Coronary Care Unit (CCCU) and all medical wards as well as the potential to be pulled into the Emergency Department. There was no hospital at night team or critical care outreach team on this site to support the medical team.<br>The trust informed us that in extreme circumstances such as when there was no night registrar available the consultant stepped in as a team approach.<br>At the previous inspection medical cover at night was one consultant on call with one registrar, one middle grade doctor and an FY1/FY2 on site so this had been reduced since then. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | Staffing levels and skill mix are planned, implemented and reviewed to keep people safe at all times.<br>Any staff shortages are responded to quickly and adequately.<br>Where relevant, there are effective handovers and shift changes to ensure that staff can manage risks to people who use services.<br>Staff recognise and respond appropriately to changes in the risks to people who use services.<br>Risks to safety from changes or developments to services are assessed, planned for and managed effectively. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Maintain Medical Consultant and Junior Grade staffing levels at a level that ensures an appropriate level of patient safety and treatment. |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MED07.01 | Shahedal Bari | Andrew Higham, Leanne Cooper, Mel Woolfall | The Medicine Care Group Triumvirate, is collating a summary of the additional improvements and projects that will been undertaken to address this recommendation in 2019/20 | Completed | Medicine Care Group PMO Workbook | Summary Completed | 31/03/2020 | N/A | N/A | D | NA | Low |
| MED07.02 | Shahedal Bari | Andrew Higham, Leanne Cooper, Mel Woolfall | The Medicine Care Group Triumvirate, is collating a summary of the additional improvements and projects that will been undertaken to address this recommendation in 2020/21 | Completed | Medicine Care Group PMO Workbook | Summary Completed | 31/07/2020 | N/A | N/A | D | NA | Low |
| MED07.03 | David Wilkinson | Andrew Higham, Leanne Cooper, Mel Woolfall | Medicine Care Group to undertake risk assesment to review current mitigations and to establish the level of potential risk to Patients | Completed | Risk Assessment completed | Risk Assessment | 30/09/2020 | N/A | N/A | D | NA | Low |
| MED07.04 | David Wilkinson | Mel Woolfall, Diane Smith | Review with Care Group to detrmine if this recommendation is encapsulated within Trust Wide Action TRUST03 and whether this recommendation can be closed and progress monitored through processes detailed in TRUST03. This will avoid duplication of reporting. | Discussed with Care Group at CQC review meeting on 26 November.<br>Confirmation that this recommenation can now be closed. | CQC Improvement Plan | Recommendation Action Plan closed | 30/11/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **MED08** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **WELL LED** |
| **CQC Service Name:** | **Medical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **Sue Smith** |
| **UHMBT Care Group:** | **Medicine Care Group** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Performance** |
| **UHMB Theme:** | **Clinical Governance** |
| **CQC Recommendation:** | Ensure that staff on individual wards and clinical areas are clear of their local risks and have a plan to effectively minimise and manage their risks. |
| **Story behind the Recommendation:** | Staff we spoke with on the wards were unclear how local risks were recorded and who was responsible for managing them. They did not have sight of the care group risk register. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | The organisation has the processes to manage current and future performance.<br>There is an effective and comprehensive process to identify, understand, monitor and address current and future risks. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | TBC |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MED08.01 | Sue Smith | Mel Woolfall | Ensure that Governance Meetings are in place in all Departments and Wards and take place on a regular basis. | Need to consider if a standard minimum frequency of meetings is appropriate for all Departments and Wards. | | Regular Governance Meetings scheduled | 30/09/2019 | | | D | NA | Medium |
| MED08.02 | Sue Smith | Ward Managers | Attendance at and involvement in departmental Governance meetings by Band 5 RN's to be encouraged and monitored through the Appraisal process | Once established will need to monitor via appraisal as an ongoing process | TMS | Regular attendance at Governance meetings by Band 5's | | N/A | N/A | D | NA | Low |
| MED08.03 | Sue Smith | Ward Managers | Attendance at and involvement in departmental Governance meetings by Band 6 RN's to be encouraged and monitored through the Appraisal process | Once established will need to monitor via appraisal as an ongoing process | TMS | Regular attendance at Governance meetings by Band 6's | | N/A | N/A | D | NA | Low |
| MED08.04 | Sue Smith | Ward Managers | Ensure the Department/Ward learning boards are regularly updated with lessons Learned from a Governance process; Incidents, complaints, clinical Audit etc. | | | Learning Boards regularly updated | 30/09/2019 | | | D | NA | Low |
| MED08.05 | Sue Smith | Mel Woolfall | Consider introducing a standardised "checklist" for debrief sessions to include any relevant Governance information | | Standardised Checklist | Agreed Checklist | 31/08/2019 | N/A | N/A | D | NA | Low |
| MED08.06 | Sue Smith | Matrons | Identify local risks for each area | Risks identified & discussed at ward level. Predominantly around staffing levels | Ulysses | Risks identified | 28/06/2019 | N/A | N/A | D | NA | Medium |
| MED08.07 | Sue Smith | Ward Managers | Ensure local and care group risks are shared at departmental governance meetings | | Governance Meeting Minutes | Improved attendance | 26/07/2019 | | | D | NA | Low |
| MED08.08 | Sue Smith | Emily Henry | monitor attendance at meetings | Need to identify who attends & how the information from each meeting is disseminated to all in the dept.<br>30/9 - to be discussed at next ward managers meeting for each site | Governance Meeting Minutes | Improved attendance | 15/11/2019 | | | D | NA | Low |
| MED08.09 | Sue Smith | Matrons | Spot check audit of all staff's understanding of risks | | N/A | Better awareness of Risks | 29/11/2019 | N/A | N/A | D | NA | Medium |
| MED08.10 | Sue Smith | Leanne Cooper, Mel Woolfall, Andrew Higham, Emily Henry | Full review of Care Group Risk Register to be undertaken by Care Group Triumvirate and Governance Business Partner in order to, where practical, consolidate existing risks around key themes (e.g. Recruitment, Training, Estates, Operational Performance) to enable better oversight, managment and resolution of common risks at Care Group Level.<br>Where practical, this will encompass all Local Departmental/Service Risks within teh wider Care Group Risk. | Risk Register Review completed in August 2019.<br>Medicine Care Group Risk Register has a total of 11 Risk on the Risk Register, 9 of these Care Group Wide consolidated risks, 2 are Department specific risks.<br>The 9 Care Group Wide consolidated risks are;<br>1) The Management of Patient Access and Flow within the Care Group<br>2) Staff Recruitment, Deployment and Training within the Care Group<br>3) The Care Group's Financial Position<br>4) The Physical Environment and Equipment used by the Care Group<br>5) The Information Technology Systems used by the Care Group<br>6) The provision of Stroke Services by the Care Group<br>7) The continuing provison of Fragile Clinical Services by the Care Group<br>8) The Service Provision from Mental Health Trusts to Emergency Medicine<br>9) Acheiving the Care Quality standards expected by the CQC | Ulysses | Risk Register Review completed | 30/08/2019 | N/A | N/A | D | NA | Low |
| MED08.11 | Sue Smith | Leanne Cooper, Mel Woolfall, Andrew Higham, Emily Henry | Establish process for regular distribution of a Summary of Care Group Risk Register to senior Care Group staff (Clinical Leads, Service Managers and Matrons) via Audit Meetings, Governance Meetings, Matrons Meetings etc. | Completed | Risk Register distribution process | Process established and operational | 31/10/2019 | N/A | N/A | D | NA | Low |
| MED08.12 | Sue Smith | Emily Henry | Establish process for six monthly distribution of a Summary of Care Group Risk Register to Departments/Wards as part of exisiting Governance Update/Communication processes within the Care Group | Completed | Risk Register distribution process | Process established and operational | 31/10/2019 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **MED10** |
| **CQC Report:** | **2017 Inspection Report** |
| **CQC Domain:** | **SAFE** |
| **CQC Service Name:** | **Medical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Medicine Care Group** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **Patients** |
| **UHMB Theme:** | **Staff Development & Training** |
| **CQC Recommendation:** | Ensure all nursing and medical clinical documentation is completed in full and in accordance with recognised professional standards. |
| **Story behind the Recommendation:** | Where a falls risk assessment identified a risk and directed the need for a multi-factorial falls risk assessment, staff were unclear whether this had to be completed on the EPR or should be actioned and recorded in the medical records.<br>Five sets of records (25% of those reviewed) were deficient to varying extents. Our review highlighted two particular themes: a lack of personalisation and individualisation of some nursing care plans; and a failure to escalate care in accordance with National Early Warning Score (NEWS) triggers. The division completed a monthly QAAS documentation audit against 12 key standard indicators such as legibility, demographics, care bundle and paper record (fluid charts, observation charts, food charts and risk assessments) completion. Between July to September 2016, auditors reported variability in compliance against criteria. Legibility overall was very good (96%), completion of care bundles were good (88%) however a number of entries failed to include NMC numbers showing poor compliance (40%). The main issue appeared to relate to the completion of the electronic patient record (EPR) which had recently been implemented in the division. There had been reported improvement, which ward managers and matrons considered to be due to staff getting more familiar with the transition to the electronic platform. |
| **What the CQC expect 'Good' to look like:<br>(Taken from relevant KLOE definition)** | Risks to people who use services are assessed, monitored and managed on a day-to-day basis.<br>These include signs of deteriorating health, medical emergencies or behaviour that challenges.<br>People are involved in managing risks and risk assessments are person-centred, proportionate and reviewed regularly.<br>Staff can access the information they need to assess, plan and deliver care, treatment and support to people in a timely way, particularly when people are referred or when they transition between services.<br>When there are different systems to store or manage care records, these are coordinated. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | TBC |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MED010.01 | Sue Smith | Mel Woolfall | Request for this recommendation to be integrated into recommendation Trust08, to ensure common Trust Wide approach and response | Request made to Quality Committee<br>Approved at September 2020 Meeting | CQC Improvement Plan | Recommendation to be integrated into recommendation Trust08 | 30/09/2020 | N/A | N/A | D | N/A | Low |

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| **Recommendation Ref. No.:** | **SCC01** |
| **CQC Report:** | **2019 Inspection Report, 2017 Inspection Reports** |
| **CQC Domain:** | **EFFECTIVE** |
| **CQC Service Name:** | **Surgical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **Kate Maynard** |
| **UHMBT Care Group:** | **Surgery & Critical Care Group** |
| **UHMBT Site(s):** | **FGH, RLI & WGH** |
| **UHMBT Board Assurance Committee** | **Finance Committee** |
| **UHMBT Strategic Objective:** | **Performance** |
| **UHMB Theme:** | **Operational Performance & Targets** |
| **CQC Recommendation:** | The trust should continue to monitor and improve referral to treatment targets for all specialities. |
| **Story behind the Recommendation:** | **FGH:** From August 2017 to July 2018, the trust's referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average. In the most recent month, July 2018, the number of admitted pathways at the trust that were completed within 18 weeks was 49.9%, which was worse than the England average of 67.0%. We discussed the RTT's with the senior management team. Improving RTT's had been set as a priority within the care group. From August 2017 to July 2018 the trusts performance for RTT in general surgery had declined compared to the last inspection figures in 2016 which showed an improvement against the England average of 75%.<br><br>**RLI:** The highest risks identified were meeting referral to treatment targets<br>We discussed the RTT's with the senior management team. Improving RTT's had been set as a priority within the care group. From August 2017 to July 2018 the trusts performance for RTT in general surgery had declined compared to the last inspection figures in 2016 which showed an improvement against the England average of 75%.<br>At the time of the inspection the trust gave assurance that they continued to review ongoing validation, new ways of working, pathway development and partnership working with stakeholders to improve RTT. Work was ongoing to improve waiting list size and RTT waits. Senior management explained that bed pressures, nurse and theatre staffing had impacted on RTT waiting times.<br><br>**WGH:** From August 2017 to July 2018, the trust's referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average. In the most recent month, July 2018, the number of admitted pathways at the trust that were completed within 18 weeks was 49.9%, which is worse than the England average of 67.0%.<br>We discussed the RTT's with the senior management team. Improving RTT's had been set as a priority within the care group. From August 2017 to July 2018 the trusts performance for RTT in general surgery had declined compared to the last inspection figures in 2016 which showed an improvement against the England average of 75%.<br>At the time of the inspection the trust gave assurance that they continued to review ongoing validation, new ways of working, pathway development and partnership working with stakeholders to improve RTT. Work was ongoing to improve waiting list size and RTT waits. Senior management explained that bed pressures, nurse and theatre staffing had impacted on RTT waiting times. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies.<br>This is monitored to ensure consistency of practice. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | TBC |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| SCC01.01 | Kate Maynard | Carol Park | RTT Action Plan developed and in place to achieve the Provider Sustainability Fund trajectory for Referral to Treatment (RTT) Incomplete % and have no more patients waiting at March 2020 than there were at March 2019. | Cross cutting work continues for Elective care plan this work links directly to RTT, OPD re-imaging and theatre cross cutting plan.<br>Significant impact on RTT Performance due to COVID and NHS England decision to step down Elective Surgical activity.<br>RTT recovery Plan developed to be reported to Trust Board in July 2020 | OPD dashboard<br>theatre dashboard<br>waiting list size report SQL | Achievement of local agreed trajectories | 31/03/2020 | 92% with local agreed trajectories | see performance report | D | NA | Low |
| SCC01.02 | Kate Maynard | Carol Park | Improve the recording of RTT codes/data quality to prevent errors that cause waiting list delays | Update 9/4/19: Plans to be confirmed via the trusts Data Quality Group with input from Andrew Browne<br>Update 28/05/19: Data Quality strategy has been ratified by Data Quality Group and is going to Procedural Documents Group in May. Cross Care Group Improvement group will then be launched to:<br>• Resurrect the Patient Safety Net (Compliance Framework) metrics<br>• Learn lessons from audits<br>Link to CQC feedback on data quality assurance at Board level<br><br>Initial discussion between Deputy ADOP, waiting list office manager, pre-operative assessment manager and Patient Coordination manager to look at collaborative working with Pre-operative assessment team to improve quality of validation and service and improved process.<br>Follow up discussion with finance team planned 15/04/19. If viable work to commence in May 19 with workforce input<br>28/05/19: paper prepared to go for consultation<br><br>Progress update (10.7.19)<br>Update on progress Information from Pete Nowells report to link WLO and Pre-Op assessment. Trying to merge woo together. Clair to check with Sue and WLO to see how far it has got. Claire to come back on this action for Claire to update.<br>Progress update 14.8.19-LINKS to SC6.6. Work underway in line with Elective care plan, a larger piece of corporate work for the compliance framework is required and until them this action will remain.<br>Progress update 11.09.19- Links to 6.6<br>Progress Update 09.10.2019 - Cross cutting work continues for | Clinical Coding | Reduction in Coding errors | 31/03/2020 | N/A | N/A | D | NA | Low |

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| SCC01.03 | Kate Maynard | Carol Park | Review process for Manual paper referral patients when accessing first appointments, compared to electronic ERS patients to reduce the number of Manual referrals without a first appointment. | 2743 patients without first appointment as at 18/11/18 from all referral sources.<br>Dec 18: new milestone of 18 weeks for all Specialties by 31/03/19 except 21 weeks for Pain, ENT, Oral and Ophthalmology.<br>Apr 19: These services have either already met or will have met by May 19.<br><br>Progress update (10.7.19)<br>The narrative reflects previous RTT which has now been updated. All specialties working to 18 weeks. An action to ask Harry to link in with Rhianna regarding the fortnightly performance operational meetings for data to be shared from that source. Verbal confirmation that the care group has moved from manual to electronic referrals for all areas apart from 2 WW rules. Claire to send the latest RTT. This will be marked as on track<br>Progress update 14.8.19 - All referrals electronic, 2/52 and Breast-checked by CPCC<br><br>Update 09.10.2019 - Cross cutting work continues for Elective care plan this work links directly to RTT. Includes OPD reimaging and theatre cross cutting plan.<br><br>Update 12.11.19<br>Identified management support for the elective care plan - not yet met with S&CC<br>Ongoing validation in all services - positive impact on RTT<br>Reduction in OPD follow-ups as part of the OPD cross cutting scheme<br>safe today report shared woth all clinical leads 12.11.19<br>Dedicated resource now identified to work with the Care Group | | | 31/03/2020 | | | D | NA | Low |
| SCC01.04 | Kate Maynard | Carol Park | Confirm how much activity is required to meet all of the different national standards for services (ED, Cancer, RTT, Diagnostics, Surveillance, Screening) | Draft Demand and Capacity models to be completed for all outpatient and inpatient elective services, Imaging diagnostics and Endoscopy.<br><br>Theatre timetable to be rewritten incorporating Capacity and Demand modelling to meet C&D across all services with the exception of Ophthalmology and General Surgery.<br><br>Theatre Efficiency project has identified even if all theatre efficiency plans are delivered RTT cannot be delivered currently.<br><br>Update 12.11.19<br>All service completed NHSI C&D planning<br>as part of a refresh for 20/21, T&O and Urology are completing a zero based C&D plan in alignment with Allocate. Zero based plans to include all non-elective, on call, ward rounds etc. Total activity plan from teh bottom up may identify any issues ir problems and enable feed back to the CCG<br>The Draft Theatre timetable has been circulated for discussions within the CBU's and<br>The initial timescale was to commence it on the 1st April, but that will depend on a Modular / Vanguard / WSC upgrade depending on which option is decided for the Kendal site and no major objections from clinicians.<br>All comments should have been returned by next month's SMB<br>The CBU's will then have to re-write all job plans and make the clinic templates changes etc.<br>Ward 1 will have an upgraded laminar theatre and will support activity by March 2020<br><br>Update 11.12.19 | | | 31/03/2020 | | | D | NA | Low |

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| SCC01.05 | Kate Maynard | Carol Park | Review pre-admission and waiting list office processes to facilitate chronological booking of patients in date order | New Management Structure in place.<br>Review of WLO SOPs completed.<br>More accurate forward planning of capacity in place.<br>Re-visit MIAA audit recommendations.<br><br>Progress update (10.7.19)<br>They have completed the SOP and MIAA have undertaken a review to ensure this processes is embedded. The future plan is to bring this through to Audit Committee and a date is yet to be confirmed. The MIAA final report will be used as evidence. This will be marked as on track and will be closed once we have received the evidence of the MIAA report.<br><br>Action is that we need a copy of the MIAA report and given that the Assurance Committees do not meet in August we need assurance that it will be brought to Sept meeting.<br>Progress update 14.8.19-Elective care plan in development, will replace RTT. MIAA report to be followed up regarding delivery at audit committee. Progress update 11.09.19- Elective care plan development continues. MIAA report to be brought to Octobers meeting.<br><br>12.11.19<br>All patients are now booked in order<br>Work is being implemented and going well however due tochange in personelle MIAA not revisited - was PN - replacement of HB<br><br>Update 11.12.19<br>MIAA report on Waiting lists and follow up appointments is at draft stage and was issued to the Trust on 7 November a meeting is planned to discuss the report in January. | | | 31/03/2020 | | | D | NA | Low |
| SCC01.06 | Foluke Ajayi | Claire Alexander | Deployment of the Vanguard theatre unit at WGH to replace activity lost due to Theatre 2 Upgrade | 24 week plan/rota for >90% re-utilisation, to deliver 50% more activity on same period last year.<br>Theatre 2 refurbishment expected to be completed by 30/06/2019.<br>Vanguard Unit expected to remain in use until 31/07/2019 to facilitate smooth transition back to Theatre 2.<br><br>Progress update (10.7.19)<br>Considerable delay in theatre 2. building wise 6-7 weeks behind. Off track but will be completed by the end of July. On the 11/7 is goes live as long as air handling is signed off. Been delayed due to major structure work. Air testing been done twice and failed on both occasions. Testing should be done today. To mark as on track and to close this ahead of next time if everything is on track<br>Progress update 14.8.19- Vanguard theatre removed action complete | | | 31/07/2019 | | | D | NA | Low |
| SCC01.07 | Kate Maynard | Carol Park | Develop an new Theatre Timetable to ensure theatre capacity allocated to services/clinician's with the greatest need | Re-utilisation SOP live from 05/11/18.<br>29/01/19: 4-eyes workshops through March, April and May 19 (See Theatre Efficiencies workbook)<br>Scoping of FGH moving to 4 hour sessions (same as other sites), linked to work-streams to increase bed capacity on EOU to allow 4 joints per day. 26/03/19: FA to run training session in May. 4 hour days at FGH: need update. Senior Manger "Fresh Eyes" shadowing in theatres 01/04/19 (4 theatres X-bay) for efficiencies.<br><br>Update 28/05/19: ideas generated from "Fresh Eyes" and 4 Eyes include 5 hour T&O theatre sessions and moving procedures of limited clinical value out of theatres (e.g. CTD, injections). Held a theatre timetabling workshop on 08/05/19 with FA; aim for November implementation of new timetable.<br><br>Surgery drawing up "blue sky thinking" plans for what it would take to centralise all elective operating at WGH, to be ready by 30/06/19.<br><br>Update 12.11.19<br>Theatre timetable planned to roll out January 2020<br>Transfer of day case surgery to WGH -complete and day case theatre closed<br>theatre estate plans being worked up with estates/capital teams.<br>NEL prioritisation process agreed at Proc docs and going to SGAG in Dec<br><br>Update 11.12.19<br>new theatre timetable was shared at S&CC board 10.12.19 - first draft for discussion. Consultation period of 1 month.<br>Vascular surgery, external service from LTH amenable to | | | 30/04/2020 | | | D | NA | Medium |

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| SCC01.08 | Foluke Ajayi | Claire Alexander | Investigate the scope for the Pooling of non-Specialist patients in services that do not currently pool patients and implement where practical | General Surgery:<br>Proposal taken to General Surgery steering group on 26/03/19: Team have concerns and have agreed not to pool any patients. On hold.<br>10/07/2019: pooling income areas in general surgery and sub specialties<br>14/08/2019: Gen Surgery still requires some work,<br>14/09/2019: Some areas of T & O and General Surgery require some work<br>09/10/2019: Increased communication on pooling available both verbally and visably at Surgery Board meeting<br>19/03/2020: Pooling protocol for general Surgery needs to dveloped and agreed, Implementation and monitoring of Pooling will become part of ongoing Elective RTT Plan<br><br>See action SC6.13, SC6.14 & SC6.15 for other Specialties | N/A | Pooling System in Place | 31/03/2020 | N/A | N/A | D | NA | High |
| SCC01.09 | Kate Maynard | Carol Park | Undertake a review Non-optimal outpatient utilisation/productivity | 29/01/19: T&O at FGH to compare the actual start/finish times against the electronic SQL link, whilst observing flow/process.<br>26/03/19: still not got access to link. T&O facture clinic pilot<br>01/04/19. Links to 4-Eyes Outpatient Efficiency workshops<br>28/05/19: Outpatient 4 Eyes efficiency programme to start June 19, in conjunction with “Fresh Eyes” approach in outpatients (mirror the theatre initiative).<br><br>Progress update (10.7.19)<br>This recommendation needs to be a Trust recommendation and will ask Carl to move this and reassign to Kate Maynard and Julian Greaves. Need to make sure there is a mechanism for them to feedback through to us. 09.10.2019 - Need to chase up with Julian to take ownership links to OPD | | | 31/03/2020 | | | D | NA | Low |
| SCC01.10 | Foluke Ajayi | Claire Alexander | Increase practioners skill base to increase the scope for ERCP procedures. | New business plan for Gen Surgery, but needs external training from other Trusts.<br><br>29/11/18: This is in General Surgery business plan for 2019/2020. Mr Khan is keen to undertake this and two endoscopy slots have been identified at RLI. Mr Khan has completed observations but not had any training yet.<br><br>26/03/19: no mentor yet in place<br><br>progress update (10.7.19)<br>Claire to confirm that it was not feasible<br><br>Progress update 14.8.19-Feasability study completed, shown to be not feasible-action complete | | | 01/08/2019 | | | D | NA | Medium |
| SCC01.11 | Kate Maynard | Carol Park | Redesign follow up pathway to implement 'Patient Initiated Follow Up' in Services. | 29/11/18: Pain Management patients are being added to PIFU from November<br>30/11/2018: Urology urinary tract symptom pathway to be implemented, 3 x PIFU Urology pathway criteria agreed<br>29/01/2019: Pain Management Services - 69 patients on PIFU<br>26/03/19: Breast Surgery Risk stratified approach on target but access plan issue<br>10/04/19: Review of PIFU impact | | | 31/03/2020 | | | D | NA | Medium |
| SCC01.12 | Foluke Ajayi | Claire Alexander | Undertake feasibility study to convert FGH TH03 (old Gynae/Maternity theatre) into a minor ops theatre | Progress update (10.7.19)<br>There has been a theatre reconfiguration as part of the development of the South Lakes facility. A formal feasibility study was not undertaken, however an opportunity to maximise theatres has been undertaken. There remains a small box theatre which is currently not equipped and limited use in terms of facilities. Therefore this action is being closed and any future capacity will revisited and a check of use of this facility | | | 01/04/2019 | | | D | NA | Medium |
| SCC01.13 | Foluke Ajayi | Claire Alexander | Investigate the scope for the Pooling of non-Specialist patients in services that do not currently pool patients and implement where practical | ENT<br>Have agreed to pool FGH Mr Main procedures with the RLI team.<br>Will revisit pooling cross-bay once a decision has been made following Capacity & Demand and a new Clinical Lead appointment in the new year (April 19). 26/03/19: Mr Main patients all pooled (complex at RLI).<br>10/07/2019: ENT Mr Mian left in December<br>14/08/2019: ENT all pooled<br>09/10/2019: ENT are pooling work and have the full elements embed. Increased communication on pooling available both verbally and visably at Surgery Board meeting<br>19/03/2020: Implementation and monitoring of Pooling will become part of ongoing Elective RTT Plan | N/A | Pooling System in Place | 31/03/2020 | N/A | N/A | D | NA | Medium |

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| SCC01.14 | Foluke Ajayi | Claire Alexander | Investigate the scope for the Pooling of non-Specialist patients in services that do not currently pool patients and implement where practical | T&O<br>10/07/2019 only working with some surgeons (2 our 22 for T&O)<br>14/08/2019: T & O carpal, minor ops and simple joints-forward look for hand & wrist Sept'19, foot & ankle in discussion,<br>14/09/2019: Some areas of T & O and General Surgery require some work,<br>09/10/2019: Increased communication on pooling available both verbally and visably at Surgery Board meeting<br>19/03/2020: Implementation and monitoring of Pooling will become part of ongoing Elective RTT Plan | N/A | Pooling System in Place | 31/12/2019 | N/A | N/A | D | NA | Medium |
| SCC01.15 | Foluke Ajayi | Claire Alexander | Investigate the scope for the Pooling of non-Specialist patients in services that do not currently pool patients and implement where practical | Other Specialities<br>14/08/2019: Urology day case, Max fax not relevant for pooling.<br>09/10/2019: Increased communication on pooling available both verbally and visably at Surgery Board meeting<br>19/03/2020: Implementation and monitoring of Pooling will become part of ongoing Elective RTT Plan | N/A | Pooling System in Place | 31/12/2019 | N/A | N/A | D | NA | Medium |
| SCC01.16 | Kate Maynard | Carol Park | Recommendation Action Plan reviewed by New SCC ADOP Carol Park and Director of Governance Andrea Willimott. | Agreed that outstanding Actions on this Recommendation Action Plan can be marked as closed and completed due ti significant changes to RTT delivery caused by COVID<br>New Action plan to be developed. | Feedback from ADOP Carol Park and Director of Governance Andrea Willimott. | Review completed | 07/07/2020 | N/A | N/A | D | NA | Low |
| SCC01.17 | Andrea Willimott | Carl Foulkes | Create New Trust Wide Preemptive Action to address RTT performance across all Care Groups, as part of wide work programmee monitored by the Strategy | Pre-Emptive Action Trust 13 created | CQC Improvement Plan - Trust13 | Pre-Emptive Action created | 30/09/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **SCC02** |
| **CQC Report:** | **2019 Inspection Report, 2017 Inspection Reports** |
| **CQC Domain:** | **EFFECTIVE** |
| **CQC Service Name:** | **Surgical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **David Wilksinson** |
| **UHMBT Care Group:** | **Surgery & Critical Care Group** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMB Theme:** | **Staff Recruitment/Deployment** |
| **CQC Recommendation:** | The trust should continue with staff recruitment and retention for both nursing and medical staff to achieve planned fill rate establishment. |
| **Story behind the Recommendation:** | From November 2017 to October 2018, the trust reported a vacancy rate of 11% for qualified nursing staff working in surgery. The trust did not provide a target rate. This figure was a deterioration compared to the last report in 2016 where the vacancy rate figure was 4.1%.<br>Nurse staffing levels continued to be a concern across the trust; senior management assured us that this remained high on the risk agenda. Vacancy rates had increased since the last inspection from 4.1% to 11%; however, a number of actions had been identified to address staffing vacancies, e.g. recruitment plans for current vacancies, robust sickness monitoring, the use of bank nurses, overtime, daily board rounds prioritising care and monitoring of staff rotas.<br>Medical fill rates were below establishment at all three locations offering surgical services at the trust. Fill rates of 86.7%, 92.7%, and 74.0% were reported for Furness General Hospital, Royal Lancaster Infirmary and Westmorland General Hospital respectively<br>The senior management team confirmed that the risk register identified ongoing national and local problems in recruiting medical staff (consultant and junior grades). It was recognised the care group had a significant challenge in meeting target staffing levels for medical staff and providing sufficiently skilled rota cover, this had the potential for adverse impacts on patient outcomes and safety, service delivery and meeting staffing level standards. |
| **What the CQC expect 'Good' to look like:<br>(Taken from relevant KLOE definition)** | Staffing levels and skill mix are planned, implemented and reviewed to keep people safe at all times.<br>Any staff shortages are responded to quickly and adequately.<br>Where relevant, there are effective handovers and shift changes to ensure that staff can manage risks to people who use services.<br>Staff recognise and respond appropriately to changes in the risks to people who use services.<br>Risks to safety from changes or developments to services are assessed, planned for and managed effectively. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Maintain Medical and Nursing staffing levels at a level that ensures an appropriate level of patient safety and treatment.<br>Identify and support recruitment Hot Spots |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SCC02.01 | David Wilkinson | Carol Park, Deepak Herlekar, Jane Kenny | Implementation of ongoing Recruitment Strategy and Programmes for all Staff Groups with focus on 'hot spot' areas. | The Care Group recognises that positive recruitment and retention will have direct implications for CHPPD.<br>On-going review of workforce and efficiency takes account of this and the related area have utilised the potential to substitute registered nurses with and healthcare support staff.<br>To provide managerial and workforce support to areas identified as having staff leavers in higher than expected levels. To focus on prevention not only those areas in crisis. | ESR | Improved WTE Across the Care Group | 31/03/2021 | N/A | N/A | OT | NA | Low |
| SCC02.02 | David Wilkinson | Carol Park, Deepak Herlekar, Jane Kenny | To engage and support recruitment exercises such as international recruitment projects<br>To support ongoing development. | LD nurse to present at Board of directors public meeting and also at SMB on experience of being LD nurse. | | | 31/03/2020 | N/A | N/A | D | NA | Low |
| SCC02.03 | David Wilkinson | Jane Kenny, Claire Alexander | Recruitment of Registered Nurses to reduce vacancy rate below 5% | April2019: Nursing vacancy Rate 11%<br>April 2020: Nursing vacancy Rate 3% | | Increase RN WTE | 31/03/2020 | 573.74 WTE | 555.04 WTE | D | OT | Medium |
| SCC02.04 | David Wilkinson | Jane Kenny, Claire Alexander | Recruitment of Clinical Support Workers to maintain vacancy rate at or below 0% | April2019: CSW vacancy Rate -9%<br>April 2020: CSW vacancy Rate -6% | | Maintain CSW WTE | 31/03/2020 | 259.48 WTE | 275.03 WTE | D | D | Medium |
| SCC02.05 | David Wilkinson | Jane Kenny, Carol Park | Recruitment and development of Nurse apprentices | 14 Nurse apprentices across S&CC (year 1) | | | 31/03/2020 | | | D | NA | Medium |
| SCC02.06 | David Wilkinson | Jane Kenny, Carol Park | Recruitment and development of Advanced Nurse Practioneers (ANP) | 2 newly qualified ANP's in T&O and General Surgery | | | 31/03/2020 | | | D | NA | Medium |
| SCC02.07 | David Wilkinson | Jane Kenny, Carol Park | Recruitment and development of Nursing Associates | Trainee nurse associates in Theatres 3 FGH and 2 WGH | | | 31/03/2020 | | | D | NA | Medium |
| SCC02.08 | David Wilkinson | Jane Kenny, Carol Park | Recruitment and development of Learning Disability (LD) and Mental Health (MH) Nurses | LD and MH nurses recruited to all 3 sites.<br>Further development and retention? | | | 31/03/2020 | | | D | NA | Low |
| SCC02.09 | David Wilkinson | Jane Kenny, Carol Park | Recruitment and development of Operating Department Practioneers (ODP's) | ODP academic provider identified.<br>Funding for backfill to be secured before progressing further. | | | 31/03/2020 | | | D | NA | Medium |
| SCC02.10 | David Wilkinson | Kam Mom, Jane Kenny, Carol Park | Recruitment and development of Pharmacy Technicians | Pharmacy technicians now on 4 wards at RLI (Ward 33, 34, 35 & 36).<br>FGH to explore potential to develop. | | | 31/03/2020 | | | D | NA | Medium |
| SCC02.11 | David Wilkinson | Deepak Herlekar, Carol Park | Recruitment and development of Medical Training Imitative (MTI) Doctors | 1 MTI Recruited | | | 31/03/2020 | | | D | NA | Medium |
| SCC02.12 | David Wilkinson | Deepak Herlekar, Carol Park | Recruitment and development of Consultant Grade Doctors | April2019: Consultant vacancy Rate 5%<br>April 2020: Consultant vacancy Rate 5% | | Increase Consultant WTE | 31/03/2020 | 103.12 WTE | 97.55 WTE | D | NTMA | Medium |
| SCC02.13 | David Wilkinson | Deepak Herlekar, Claire Alexander | Recruitment and development of Career Grade Doctors | April2019: Career Grade vacancy Rate 23%<br>April 2020: Career Grade vacancy Rate 16% | | Increase Career Grade WTE | 31/03/2020 | 80.60 WTE | 68.04 WTE | D | NTMA | Medium |
| SCC02.14 | David Wilkinson | Deepak Herlekar, Claire Alexander | Recruitment and development of Junior Grade Doctors | April2019: Junior Grade vacancy Rate 13%<br>April 2020: Junior Grade vacancy Rate -6% | | Increase Junior Grade WTE | 31/03/2020 | 62.00 WTE | 65.60 WTE | D | D | Medium |
| SCC02.15 | David Wilkinson | Carol Park, Deepak Herlekar, Jane Kenny | To provide managerial and workforce support to areas identified as having staff leavers in higher than expected levels. To focus on prevention not only those areas in crisis. | Recruitment plan in place for ICU Consultants.<br>RLI Theatre significant vacancies positive position as of may 2019 due to number streams of work including HSE stress assessment rollout and leadership review.<br>Behavioural standards sessions for high risk areas.<br>Support structure in place for international recruits. | | Reduction in Agency and Bank spend against Care group budget target | 31/03/2020 | | | D | NA | Medium |
| SCC02.16 | David Wilkinson | Carol Park, Deepak Herlekar | Recruitment and development of Consultant Grade Doctors | Need to confirm current performance levels<br>Get up date from Carol Park or Workforce BP | ESR | Maintan or Increase WTE | 31/03/2021 | ?? WTE | ?? WTE | OT | NTMA | Medium |

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| SCC02.17 | David Wilkinson | Carol Park, Deepak Herlekar | Recruitment and development of Career Grade Doctors | Need to confirm current performance levels<br>Get up date from Carol Park or Workforce BP | ESR | Maintan or Increase WTE | 31/03/2021 | ?? WTE | ?? WTE | OT | NTMA | Medium |
| SCC02.18 | David Wilkinson | Carol Park, Deepak Herlekar | Recruitment and development of Junior Grade Doctors | Need to confirm current performance levels<br>Get up date from Carol Park or Workforce BP | ESR | Maintan or Increase WTE | 31/03/2021 | ?? WTE | ?? WTE | OT | OT | Low |
| SCC02.19 | David Wilkinson | Carol Park, Jane Kenny | Recruitment and development Registered Nurses | Need to confirm current performance levels<br>Carol Park - Currently no significant issues | ESR | Maintan or Increase WTE | 31/03/2021 | ?? WTE | ?? WTE | OT | OT | Low |
| SCC02.20 | David Wilkinson | Carol Park, Jane Kenny | Recruitment of Clinical Support Workers | Need to confirm current performance levels<br>Carol Park - Currently no significant issues | ESR | Maintan or Increase WTE | 31/03/2021 | ?? WTE | ?? WTE | OT | OT | Low |
| SCC02.21 | David Wilkinson | Carol Park, Deepak Herlekar, Jane Kenny | Implement and deliver a Focussed Recruitment Support process for Hot Spot Areas with the Care Group, utilising Enhanced Support Programme and Strategy & Transformation Group | Current Hot Spot Areas: Opthalmology, Urology and Anaesthetics at FGH<br>Ongoing situation ?similar to FGH ED Consultants, where Recruitment has been a challenge for a prolonged period<br>Report at/through Strategy & Transformation Group? | | Focussed Recruitment Support for Hot Spot Areas | 31/03/2021 | N/A | N/A | OT | | Medium |
| SCC02.22 | David Wilkinson | Carol Park, Deepak Herlekar, Jane Kenny | Identified Recruitment Hot spot<br>Maintain or Increase Opthalmology staffing levels | new ways of working being investigated<br>Get up date from Carol Park or Workforce BP | ESR | Maintan or Increase WTE | 31/03/2021 | ?? WTE | ?? WTE | | | Medium |
| SCC02.23 | David Wilkinson | Carol Park, Deepak Herlekar, Jane Kenny | Identified Recruitment Hot spot<br>Maintain or Increase Urology staffing levels | longer working process required<br>Get up date from Carol Park or Workforce BP | ESR | Maintan or Increase WTE | 31/03/2021 | ?? WTE | ?? WTE | | | Medium |
| SCC02.24 | David Wilkinson | Carol Park, Deepak Herlekar, Jane Kenny | Identified Recruitment Hot spot<br>Maintain or Increase Anaesthetics staffing levels at FGH | Get up date from Carol Park or Workforce BP | ESR | Maintan or Increase WTE | 01/04/2021 | ?? WTE | ?? WTE | | | Medium |
| SCC02.25 | David Wilkinson | Mel Woolfall, Diane Smith | Review with Care Group to detrmine if this recommendation is encapsulated within Trust Wide Action TRUST03 and whether this recommendation can be closed and progress monitored through processes detailed in TRUST03. This will avoid duplication of reporting. | Discussed with Care Group at CQC review meeting on 26 November.<br>Confirmation that this recommenation can now be closed. | CQC Improvement Plan | Recommendation Action Plan closed | 30/11/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **SCC03** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **EFFECTIVE** |
| **CQC Service Name:** | **Surgical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **Kate Maynard** |
| **UHMBT Care Group:** | **Surgery & Critical Care Group** |
| **UHMBT Site(s):** | **FGH & RLI** |
| **UHMBT Board Assurance Committee** | **Finance Committee** |
| **UHMBT Strategic Objective:** | **Performance** |
| **UHMB Theme:** | **Operational Performance & Targets** |
| **CQC Recommendation:** | The trust should prioritise hip fracture outcomes to meet national standards (National standard is treatment within 36 Hours). |
| **Story behind the Recommendation:** | The perioperative medical assessment rate was 85.7%, which failed to meet the national standard of 100%. This was within the bottom 25% of trusts. The 2016 figure was 75.7%.<br>The proportion of patients not developing pressure ulcers was 94.0%, which failed to meet the national standard of 100%. This was within the bottom 25% of trusts. The 2016 figure was 94.1%.<br>The length of stay was 26.8 days, which falls within the bottom 25% of trusts. The 2016 figure was 28.2 days.<br><br>**NB**: CQC Report only had Recommendation for FGH, Care Group have added RLI to Recommendation to ensure Trust Wide consistency. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies.<br>This is monitored to ensure consistency of practice. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | TBC - Need to confirm how 2020/21 target has been impact by COVID - ref Theatre ICU Impact - 52 week waits (and woreking down time scale) by March 2021 |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| SCC03.01 | Shahedal Bari | Deepak Herlekar, Claire Alexander, Jane Kenny | Senior medical reviews undertaken in a timely manner | Update 30/06/2020 - Hip Fracture Performance to be addressed as part of Specialty Wide 2020/21 Action Plan for Trauma and Orthopaedics<br>Action Closed<br><br>Re-Audit KEOGH data for standard 2,3,6,and 8 with recommendations, gaps and risk in S&CC staffing<br><br>Progress update (10.7.19) - The audit is complete and showing on track and has identified 3 WTE vacancies. Work around the wider KEOGH requirements as part of an operation group, therefore we will not close the action but will link with the wider KEOGH reporting which is with Kate Maynard<br>Progress update 14.8.19 - #NOF dashboard will be validated upon receipt of the data back. Keogh group and efficient use of people are looking at zero job planning, and how Keogh will fit into job plans. Plan to pilot the Sunderland capacity demand tool with T & O<br>Update 09.10.19 - Q2 data outstanding<br>Update 11.12.19 - Q2 data | KEOGH meetings<br><br>Achievement of BPT | | 30/03/2020 | 100% compliance | Qtr. 4 218/19: FGH - 80.6% RLI - 59.7% | D | NA | Medium |
| SCC03.02 | Shahedal Bari | Deepak Herlekar, Claire Alexander, Jane Kenny | secure regular and sustainable cover for orthopaedics and general surgery wards in FGH and RLI - 7 day cover | Update 30/06/2020 - Hip Fracture Performance to be addressed as part of Specialty Wide 2020/21 Action Plan for Trauma and Orthopaedics<br>Action Closed<br><br>Orthogeriatrician cover in RLI site - not 7 day cover<br>Update 09.10.2019 - Continues to remain a struggle, Medicine appointed Ortho-Geriatrician 3 PA's but currently delivering base cover only<br>Update 12.11.2019 - Position remians the same. IC covering high proportion at RLI, work continues.<br>15/01/2020 - Work continues to secure regualr sustainable cover. Transformation plan to include service improvement and Keogh | KEOGH meetings<br><br>Achievement of BPT | | 31/03/2020 | 100% compliance | mapping required | D | NA | Medium |

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| SCC03.03 | Shahedal Bari | Deepak Herlekar, Claire Alexander, Jane Kenny | Increased trauma capacity at RLI | Update 30/06/2020 - Hip Fracture Performance to be addressed as part of Specialty Wide 2020/21 Action Plan for Trauma and Orthopaedics<br>Action Closed<br><br>Whilst trauma capacity was increased at the RLI in 2017 to review if this is still sufficient or requires a further increase. To scope trauma capacity at FGH as part of the theatre timetable re-write. To consider seasonal models for trauma capacity to reflect historical trends in demand i.e. unprecedented demand in Spring 2018, to be discussed in theatres on May Audit to propose a 4hrs session/7 day service<br>Prior 16.1.17 RLI - RLI we had 7.5 theatre sessions during the week (Monday to Friday) plus 2 morning sessions Sat & Sun so a total of 9.5 a week at RLI. We increased capacity on 16.1.17 to 11.5 a week by putting in all day Saturday and Sundays in as part of the baseline consultant job plans. So total increase from 8.5 – 11.5 a week at RLI<br>Progress update (10.7.19) - 7 days service implemented in RLI increasing trauma capacity but insufficient to meet increased capacity and demand. Will continue to monitor operational performance meetings Janette Wearing to provide the data. Also looking at developing a trauma board to increase visibility about issues and delays. To split that action for FGH as they have a 5 day trauma provision but at weekends are implementing a clinical prioritisation tool Task and finish group to be established, led by the clinical director and to report back at the end of September regarding progress<br>Progress update 14.8.19- All trauma at home patients are now on access plans, Policy for T & O patients at home complete. Task and finish group led by the clinical director to be confirmed at next meeting | SGAG<br>monthly performance | | 31/03/2020 | Achievement of BPT<br><br>Sufficient capacity for the demand | capacity and demand Service Manager to confirm | D | NA | Medium |
| SCC03.04 | Shahedal Bari | Deepak Herlekar, Claire Alexander, Jane Kenny | Increased trauma capacity at FGH | Update 30/06/2020 - Hip Fracture Performance to be addressed as part of Specialty Wide 2020/21 Action Plan for Trauma and Orthopaedics<br>Action Closed<br><br>Whilst trauma capacity was increased at the RLI in 2017 to review if this is still sufficient or requires a further increase. To scope trauma capacity at FGH as part of the theatre timetable re-write. To consider seasonal models for trauma capacity to reflect historical trends in demand i.e. unprecedented demand in Spring 2018, to be discussed in theatres on May Audit to propose a 4hrs session/7 day service<br>FGH<br>FGH capacity has stayed the same 5 AM sessions during the week (Monday to Friday). At the weekend there is no dedicated named trauma theatre sessions its classed as emergency theatre so it's mainly used between T&O and gen surgery at the weekend. There is however an on-going discussion around having a dedicated trauma list at the weekends at FGH as this is national guidelines for a Level-2 trauma centre (which FGH is) state that there should be a dedicated trauma list seven days a week.<br>Progress update (10.7.19) 7 days service implemented in RLI increasing trauma capacity but insufficient to meet increased capacity and demand. Will continue to monitor operational performance meetings Janette Wearing to provide the data. Also looking at developing a trauma board to increase visibility about issues and delays. To split that action for FGH as they have a 5 day trauma provision but at weekends are implementing a clinical prioritisation tool Task and finish group to be established, led by the clinical director and to report back at the end of September regarding progress | SGAG<br>monthly performance | | 31/03/2020 | Achievement of BPT<br><br>Sufficient capacity for the demand | capacity and demand Service Manager to confirm | D | NA | Medium |
| SCC03.05 | Shahedal Bari | Deepak Herlekar, Claire Alexander, Jane Kenny | Care Group to trial a dedicated assessment area for all Fractured Neck of Femur's presenting at the RLI ED.<br>The Trial will investigate optimising patients prior to Surgery to improve pain relief, reduce Length of Stay and achieve Best Practice Tariff. | Update 30/06/2020 - Hip Fracture Performance to be addressed as part of Specialty Wide 2020/21 Action Plan for Trauma and Orthopaedics<br>Action Closed<br><br>Side room on Ward 36 has been identified as potential assessment area.<br>Meeting on Monday 10/06/2019, to update the current optimisation tool and to develop guidelines, process and timescales for the trial. | | | 31/03/2020 | | | D | NA | Medium |
| SCC03.06 | Shahedal Bari | Deepak Herlekar, Claire Alexander, Jane Kenny | Introduce the use of the NHFD live dashboard at the fortnightly NOF meetings on each site | Update 30/06/2020 - Hip Fracture Performance to be addressed as part of Specialty Wide 2020/21 Action Plan for Trauma and Orthopaedics<br>Action Closed | NHFD live dashboard | NHFD live dashboard | 31/05/2020 | N/A | N/A | D | NA | Low |
| SCC03.07 | Shahedal Bari | Deepak Herlekar, Claire Alexander, Jane Kenny | Monitor 2019/20 performance at FGH against the National standard for treatment within 36 Hours - as per data submission to National Hip Fracture Database.<br>Data has not been validated by National Hip Fracture Database and may be subject to change. | 2-3 month lag on performance data due to data collection and collation process.<br>2018/19 Quarter 4 - 80.6%<br>2019/20 Quarter 1 - 76.5%<br>2019/20 Quarter 2 - 77.4%<br>2019/20 Quarter 3 - 68.8%<br>2019/20 Quarter 4 - 70% | National Hip Fracture Database | 100% of Patients in 36 Hours | 31/03/2020 | 100% compliance | 70.00% | D | NTMA | Medium |

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| SCC03.08 | Shahedal Bari | Deepak Herlekar, Claire Alexander, Jane Kenny | Monitor 2019/20 performance at RLI against the National standard for treatment within 36 Hours - as per data submission to National Hip Fracture Database.<br>Data has not been validated by National Hip Fracture Database and may be subject to change. | 2-3 month lag on performance data due to data collection and collation process.<br>2018/19 Quarter 4 - 59.7%<br>2019/20 Quarter 1 - 68.9%<br>2019/20 Quarter 2 - 52.1%<br>2019/20 Quarter 3 - 59%<br>2019/20 Quarter 4 - 56.5% | National Hip Fracture Database | 100% of Patients in 36 Hours | 31/03/2020 | 100% compliance | 56.50% | D | NTMA | Medium |
| SCC03.09 | Kate Maynard | Claire Alexander | Hip Fracture Performance to be addressed as part of Specialty Wide 2020/21 Enhanced Support Programme for Trauma and Orthopaedics | Specialty Wide 2020/21 ESP Action Plan for Trauma and Orthopaedics reported to Quality Committee on Monthly Basis.<br>Safe Today reporting process established.<br>Task and Finish Group Established.<br>Weekly Sessions established with Clinical Team to manage Action Planning.<br>6 Days a week, full day T&O list established (Impacted by COVID)<br>Agreed that Monitoring will continue through 2020/21 Enhanced Support Programme for Trauma and Orthopaedics only, to be closed on CQC Improvement Plan to prevent duplicate reporting.<br>Performance against NHFD will be reported at SCC Audit Meeting and Trust Clinical Audit Meeting. | T&O Enhanced Support Programme | T&O Enhanced Support Programme, ToR & Reports | 31/03/2021 | N/A | N/A | D | NA | Medium |
| SCC03.10 | Shahedal Bari | Deepak Herlekar, Carol Park, Jane Kenny | Monitor 2020/21 performance at FGH against the National standard for treatment within 36 Hours - as per data submission to National Hip Fracture Database.<br>Data has not been validated by National Hip Fracture Database and may be subject to change. | 2-3 month lag on performance data due to data collection and collation process.<br>2019/20 Quarter 4 - 70%<br>2020/21 Quarter 1 - 61.3%<br>2020/21 Quarter 2 - 57.9%<br>2020/21 Quarter 3 - %<br>2020/21 Quarter 4 - % | National Hip Fracture Database | 100% of Patients in 36 Hours | 31/03/2021 | 100% compliance | TBC | D | NA | Medium |
| SCC03.11 | Shahedal Bari | Deepak Herlekar, Carol Park, Jane Kenny | Monitor 2020/21 performance at RLI against the National standard for treatment within 36 Hours - as per data submission to National Hip Fracture Database.<br>Data has not been validated by National Hip Fracture Database and may be subject to change. | 2-3 month lag on performance data due to data collection and collation process.<br>2019/20 Quarter 4 - 56.5%<br>2020/21 Quarter 1 - 48.6%<br>2020/21 Quarter 2 - 48.9%<br>2020/21 Quarter 3 - %<br>2020/21 Quarter 4 - % | National Hip Fracture Database | 100% of Patients in 36 Hours | 31/03/2021 | 100% compliance | TBC | D | NA | Medium |

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| **Recommendation Ref. No.:** | **SCC04** |
| **CQC Report:** | **2019 Inspection Report** |
| **CQC Domain:** | **RESPONSIVE** |
| **CQC Service Name:** | **Surgical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **Kate Maynard** |
| **UHMBT Care Group:** | **Surgery & Critical Care Group** |
| **UHMBT Site(s):** | **FGH & RLI** |
| **UHMBT Board Assurance Committee** | **Finance Committee** |
| **UHMBT Strategic Objective:** | **Performance** |
| **UHMB Theme:** | **Operational Performance & Targets** |
| **CQC Recommendation:** | The trust should continue to monitor the average length of stay for elective and non-elective patients to improve performance standards measured against the England national average. |
| **Story behind the Recommendation:** | From June 2017 to May 2018, The average length of stay for All non-elective patients at the trust was 5.6 days, which was higher compared to the England average of 4.9 days.<br>The average length of stay for trauma and orthopaedics elective patients at the trust was 4.4 days, which was higher compared to the England average of 3.8 days.<br>The average length of stay for trauma and orthopaedics non-elective patients at the trust was 10.0 days, which was higher compared to the England average of 8.7 days.<br>The average length of stay for all non-elective patients at Furness General Hospital was 5.8 days, which was higher compared to the England average of 4.9 days.<br>The average length of stay for trauma and orthopaedics elective patients at Furness General Hospital was 4.6 days, which was higher compared to the England average of 3.8 days.<br><br>**NB**: CQC Report only had Recommendation for FGH, Care Group have added RLI to Recommendation to ensure Trust Wide consistency. |
| **What the CQC expect 'Good' to look like:**<br>**(Taken from relevant KLOE definition)** | People can access the right care at the right time.<br>Access to care is managed to take account of people's needs, including those with urgent needs.<br>Waiting times, delays and cancellations are minimal and managed appropriately. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | TBC - Need to confirm how 2020/21 target has been impact by COVID |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SCC04.01 | Foluke Ajayi | Kate Maynard | Bay Health & Care Partners Change Programme includes actions to help reduce the Length of Stay for Patients with Fractured Neck of Femur. | Part of the Frailty BHCP Programme.<br>In 2018/19 the following activities were initiated:<br>- Ortho-Geriatrician employed within Surgery<br>- Weight-bearing protocol disseminated to all T&O staff<br>- BPT transferred to 'business as usual' with fortnightly continuous improvement meetings held at RLI & FGH.<br>- Implementation of Golden Patient<br>- Trauma escalation procedure revised<br>Initiation of Quality, Service Improvement & Redesign (QSIR) projects to improve (these projects will continue into 2019/20):<br>- #NOF to theatre time<br>- Flow from ED to theatre and into rehab<br>- Nutrition and hydration (Enhanced Recovery)<br>- Pre-op optimisation – analgesics & anaesthetics<br>Projects to address LoS for Fractured Neck of Femur are also connected to system wide falls prevention work with view to improving end to end patient pathway and reduce the number of falls/ Fractured Neck of Femur. This work also includes the introduction of fracture liaison that is focussing on secondary prevention for individuals presenting to outpatient fracture clinic.<br><br>Update 09.10.19 - Improved system in place that includes 20+ metrics with give assurance and a sense of safety. 1 x metric that is included is LOS- monthly data available for all metrics and services | Data source – Lorenzo Electronic Patient Record. Average LoS monitored on a monthly basis through Bay Health & Care Partners Frailty Steering Group | Sustained reduction in average length of stay corresponding to KPIs | 31/03/2020 | Reduce average length of stay for fracture neck of femur patients from:<br>- 27 days down to 22 days at RLI by August 2019.<br>- 24.5 days down to 17 days at FGH by August 2019. | May 2019 –<br>average LoS<br>- RLI 16.4 days<br>- FGH 17.4 days | D | NTMI | Medium |
| SCC04.02 | Foluke Ajayi | Kate Maynard | UHMBT Bed Reconfiguration Project includes actions to help reduce the Length of Stay for all Patients. | Series of proposals for each site developed and to be consulted on over next month with respective implementation plan to follow.<br>2019/20 Bed Re-confirguration project halted due to major re-configuration due to COVID<br>Action closed | Bed Reconfiguration Project | Bed Reconfiguration Project | 31/03/2020 | N/A | N/A | D | NA | Medium |

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| SCC04.03 | Sue Smith | Claire Alexander, Deepak Herlekar, Jane Kenny | Clear clinical pathways to be created to support nurse led discharge | SAFER rolled out across all three sites. Principles to be discussed at SGAG 11th June 2019. PDSA planned for General Surgery. PDSA planned for Trauma and Orthopaedics.<br>Progress update 10.07.19: On track and for Claire to provide some narrative below:<br>Progress update 14.08.19: Part of SAFER PMO workbook. Highlighted areas-TTO/Pharmacy/Outliers<br>Progress Update 11.09.19: Formal process to take place for adaoption of SOP<br>Progress Update 12.11.19: 33 patients over 10 day LOS (not medically fit/not therapy fit/ fit with plans in place), longest stay VAC therapy (85 days), monthly SAFER meetings with medicine, independant surgical SAFER meeting with all matrons - reviewing. 1. Golden Patient, 2. fit to sit, 3. identifying patient the day before/ home safety/TTo's, 4. Discharge co-ordinators - review of workload and efficiencies, Additional work around Therapy Fit being undertaken by Km as part of D2A work new matron in post driving review with staff on SAFER in Surgery<br>Progress Update 11.12.19: Numbers over 10 days - move me Tuesday/Wednesday, Fit to sit - patient trasferred to SEAC (discharged from ward) - live November 19, Golden patient for discharge before 10, Silver patient by 12 - identifying day before, All discharge co-ordinators (4) working to the same work plan/same way - need to audit peformance through monthly meetings with peer challenge. and sharing bets practice. RTT cross cutting efficeiency scheme showing good processes, full slide deck available, effective use of people, reviewing clinical prioritisation and time back to service delivery<br>Progress Update 15.01.20: Work continues on the productive ward as a larger project | matrons monthly meetings<br><br>SAFER catch up meetings | SAFER principles embedded in all areas | 31/12/2019 | 33% discharges happening before 12 midday | Measurement under development | D | NA | Low |
| SCC04.04 | Sue Smith | Claire Alexander, Deepak Herlekar, Jane Kenny | Daily reviews of Estimated Date of Discharge (EDD) by ward managers / matrons and to challenge within ward areas. | Requested at ECN on Monday 29th April.<br>ADoN has met with all discharge co-ordinators at RLI and agreed:<br>• Discharge coordinator and Ward coordinator of the day to review data within whiteboard daily<br>• To review all patients have EDD populated and this is updated to reflect plan but once decided remains unchanged<br>• Drop down box of the reasons for delay past EDD to be reviewed and used so we can pull themes about why<br>• Utilise' home / tick ' button so the whiteboards can be viewed remotely about who is going or potentially going home<br>• Provide a list of patients at the end of each day who require TTO's to be done<br>• Escalate to Matron which patients have not been able to be discharged due to delays in pharmacy dispensing TTO's<br>• Cross cover each other for updating whiteboards when A/L or sickness occurs<br><br>Progress update 10.07.19: On track and further work around accurately capturing date of discharge and reason for any variance<br>Progress update 14.08.19: Reference to the PMO workbook. Audits to understand compliance or not, and if on track<br>Progress Update 11.09.19: Care Group 'SAFER' meetings have been set up with support from PMO-Lee Brady. This has identified areas of inaccurate data. Working wiht i3 to produce reports to be shared with ward managers. | matrons monthly meetings<br><br>SAFER catch up meetings | SAFER principles embedded in all areas | 31/03/2020 | 33% discharges happening before 12 midday | Measurement under development | D | NA | Medium |
| SCC04.05 | Sue Smith | Claire Alexander, Deepak Herlekar, Jane Kenny | Roll out of SAFER across more wards following completion of the test for change on ward 33 RLI | SAFER rolled out across all sites.<br>To be managed through PMO workbook:<br>- all areas to have e-outcome sheets linked to the whiteboard - 31.05.19<br>- roll out red to green days and provide education sessions<br><br>Progress update 10.07.19: To update as on track as significant work has been undertaken. This needs to be monitored for effectiveness and links in the wider trust safer work<br>Progress update 14.08.19: Ongoing. PMO workbook set up by Lee Brady. Linked to productive ward, forward look to Johnson and Johnson report on length of stay | matrons monthly meetings<br><br>SAFER catch up meetings<br><br>monthly performance | SAFER principles embedded in all areas | 31/03/2020 | To outperform nationally recognised LOS targets | Measurement under development | D | NA | Low |

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| SCC04.06 | Sue Smith | Claire Alexander, Deepak Herlekar, Jane Kenny | Audit readmission rate for T&O non-elective patients cross bay as identified the report | Update 30/06/2020 - T&O LoS Performance to be addressed as part of Specialty Wide 2020/21 Action Plan for Trauma and Orthopaedics<br>Action Closed<br><br>Development of trauma at home SOP.<br>development of Trauma at home dashboard (Live at RLI).<br>Trauma co-ordinators in place cross bay.<br>Review of trauma capacity cross bay.<br>To be registered on forward audit plan (need to explore with I3 re dashboard).<br>Update 12.11.19 on the audit plan Audit lead M.Kumar will work with the audit team to register the audit on the system.<br>Safe todat report will be used to identify readmission rates<br><br>Update 11.12.19<br>Not on the audit plan - to be added onto<br>All data now available on the safe today link<br>From March 20 #NOF patients will be transferred to Fragility unit at RLI as part of the bed reconfiguration changes - this will reduce LOS for trauma patients.<br><br>15/01/2020 - Audit (no 1685) is progressing and due to complete the full audit cycle 31/03/20<br><br>T & O from March NOF patients will transfer to Frailty unit when medically fit and improve LOS for NOF | HES Data<br>Audit meetings T&O<br>GIRFT reviews | readmissions will be lower that the England Average | 31/03/2020 | value below 100 | TBC | D | NA | Low |
| SCC04.07 | Sue Smith | Claire Alexander, Deepak Herlekar, Jane Kenny | The majority of the work has been achieved fro this reccomendation trhough the SAFER work. The ongoing monitoring to sustain the current levels will be managed through this action for:<br>SC9.3<br>SC9.4<br>SC9.5 | New Action created 20/01/2020<br>Action closed | matrons monthly meetings<br>SAFER catch up meetings<br>monthly performance | SAFER principles embedded in all areas | 31/03/2020 | N/A | N/A | D | NA | Low |
| SCC04.08 | Kate Maynard | Andrea Willimott | Director of Governance to confirm Trust Wide and Care Group level reporting, monitioring and assurance process for Length of Stay | Discusssions held with Non-Exec Director for Finance and Performance | Feedback from Director of Governance | reporting, monitioring and assurance process for Length of Stay confirmed | 31/08/2020 | N/A | N/A | D | NA | Low |
| SCC04.09 | Kate Maynard | Claire Alexander | Hip Fracture Performance to be addressed as part of Specialty Wide 2020/21 Enhanced Support Programme for Trauma and Orthopaedics | Specialty Wide 2020/21 ESP Action Plan for Trauma and Orthopaedics reported to Quality Committee on Monthly Basis.<br>Safe Today reporting process established.<br>Task and Finish Group Established.<br>Weekly Sessions established with Clinical Team to manage Action Planning.<br>Reporting to SGAG - Ecscalation via ESP and to QC, Board etc.<br>SCC Transformation Lead appointed.<br>Agreed monitoring to continure through Enhanced Support Programme for Trauma and Orthopaedics only to reduce dupliocate reporting of progress. | T&O Enhanced Support Programme | T&O Enhanced Support Programme, ToR & Reports | 31/03/2021 | N/A | N/A | D | NA | Medium |

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| **Recommendation Ref. No.:** | **SCC05** |
| **CQC Report:** | **2017 Inspection Report** |
| **CQC Domain:** | **EFFECTIVE** |
| **CQC Service Name:** | **Surgical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Surgery & Critical Care Group** |
| **UHMBT Site(s):** | **FGH, RLI & WGH** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **Performance** |
| **UHMB Theme:** | **Staff Recruitment/Deployment** |
| **CQC Recommendation:** | Increase Orthogeriatrician input on surgical wards. |
| **Story behind the Recommendation:** | The National Emergency Laparotomy Audit (NELA) report (2015) showed a rating over 70% for five measures and had a good rating for nine out of 10 elements of the audit. The element which was worse than required related to (No Suggestions) input for patients over 70 years old. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | Staffing levels and skill mix are planned, implemented and reviewed to keep people safe at all times.<br>Any staff shortages are responded to quickly and adequately.<br>Where relevant, there are effective handovers and shift changes to ensure that staff can manage risks to people who use services.<br>Staff recognise and respond appropriately to changes in the risks to people who use services.<br>Risks to safety from changes or developments to services are assessed, planned for and managed effectively. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | TBC - Need to confirm how 2020/21 target has been impact by COVID |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SCC05.01 | Shahedal Bari | Deepak Herlekar, Claire Alexander, Jane Kenny | Monitor 2019/20 performance at FGH against the National standard for Orthogeriatrician Review within 72 Hours - as per data submission to National Emeregncy Laparotomy Audit. Data has not been validated by National Emeregncy Laparotomy Audit and may be subject to change. | 2-3 month lag on performance data due to data collection and collation process.<br>2018/19 Quarter 4 - 94.4%<br>2019/20 Quarter 1 - 94.1%<br>2019/20 Quarter 2 - 100.0%<br>2019/20 Quarter 3 - 93.8%<br>2019/20 Quarter 4 - 95% | National Hip Fracture Database | 100% of Patients in 72 Hours | 31/03/2020 | 100% compliance | 87.50% | D | NTMA | Medium |
| SCC05.02 | Shahedal Bari | Deepak Herlekar, Claire Alexander, Jane Kenny | Monitor 2019/20 performance at RLI against the National standard for Orthogeriatrician Review within 72 Hours - as per data submission to National Emeregncy Laparotomy Audit. Data has not been validated by National Emeregncy Laparotomy Audit and may be subject to change. | 2-3 month lag on performance data due to data collection and collation process.<br>2018/19 Quarter 4 - 95.5%<br>2019/20 Quarter 1 - 64.9%<br>2019/20 Quarter 2 - 95.5%<br>2019/20 Quarter 3 - 95.6%<br>2019/20 Quarter 4- 90.6% | National Hip Fracture Database | 100% of Patients in 72 Hours | 31/03/2020 | 100% compliance | 94.90% | D | NTMI | Medium |
| SCC05.03 | Shahedal Bari | Deepak Herlekar, Carol Park, Jane Kenny | Explore and scope the options of shared cared with other care groups the options for an improvement to the fractured NOF pathway. | Pilot at FGH underway with 3 additional PAs of orthogeriatrician input.<br>MD written to CD wuith request to share with the team to alert to expectations of patient review | Scoping exercice | Scoping exercice completed | 30/06/2020 | N/A | N/A | D | NA | Medium |
| SCC05.04 | Shahedal Bari | Deepak Herlekar, Carol Park, Jane Kenny | Monitor 2020/21 performance at FGH against the National standard for Orthogeriatrician Review within 72 Hours - as per data submission to National Emeregncy Laparotomy Audit. Data has not been validated by National Emeregncy Laparotomy Audit and may be subject to change. | 2-3 month lag on performance data due to data collection and collation process.<br>2019/20 Quarter 4 - 95%<br>2020/21 Quarter 1 - %<br>2020/21 Quarter 2 - %<br>2020/21 Quarter 3 - %<br>2020/21 Quarter 4 - % | National Hip Fracture Database | 100% of Patients in 36 Hours | 31/03/2021 | 100% compliance | TBC | D | NA | Medium |
| SCC05.05 | Shahedal Bari | Deepak Herlekar, Carol Park, Jane Kenny | Monitor 2020/21 performance at RLI against the National standard for Orthogeriatrician Review within 72 Hours - as per data submission to National Emeregncy Laparotomy Audit. Data has not been validated by National Emeregncy Laparotomy Audit and may be subject to change. | 2-3 month lag on performance data due to data collection and collation process.<br>2019/20 Quarter 4 - 90.6%<br>2020/21 Quarter 1 - %<br>2020/21 Quarter 2 - %<br>2020/21 Quarter 3 - %<br>2020/21 Quarter 4 - % | National Hip Fracture Database | 100% of Patients in 36 Hours | 31/03/2021 | 100% compliance | TBC | D | NA | Medium |
| SCC05.06 | Shahedal Bari | Carol Park | Review of underlying Rcruitment/staffing levels for Orthogeriatrician by SCC ADOP | Confirmed, this is a Longstanding Recruitment issue, due to national shoartage of Orthogeriatrician<br>To be adddressed through SCC Transformation Inpatient Cell and Hive methodology<br>Investigate scope for recruitment of Middle Grade rather than consultant grade<br>Reporting via Transformation Inpatient Cell, Hive and Workforce Committee<br>Recruitment Action closed on CQC plan to prevent duplicate reporting<br>NELA performance reported at SCC Audit meetings and Trust Clinical Audit meetings. | Review | Review completed | 30/11/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **WACS01** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Safe** |
| **CQC Service Name:** | **Children and Young People** |
| **Must or Should Action / UoR Finding:** | **Must Do** |
| **UHMBT Exec Lead:** | **Shahedal Bari** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Patients** |
| **UHMBT Theme:** | **Patient Care & Dignity** |
| **CQC Recommendation:** | The trust must ensure that there is a clear pathway for 16 and 17 year old patients that all staff are aware of. |
| **Story behind the Recommendation:** | At the time of inspection, the service did not have a clear pathway for 16 and 17-year-old patients' delivery of care. Nursing staff we spoke with expressed concerns that they had experienced challenges in obtaining support from medical staff due to conflicts within the trust's policies as to who had responsibility for these patients. There had been patient safety incidents reported regarding this issue prior to our inspection. However, this issue had not been adequately addressed at the time of our inspection. We raised this concern during the inspection and the trust made immediate changes to policies and procedures so there was a clear patient pathway. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | *Risks to safety from changes or developments to services are assessed, planned for and managed effectively.*<br>*Risks to people who use services are assessed, monitored and managed on a day-to-day basis. These include signs of deteriorating health, medical emergencies or behaviour that challenges. People are involved in managing risks and risk assessments are person-centred, proportionate and reviewed regularly.*<br>*People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies. This is monitored to ensure consistency of practice.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | In 100% of patients the clinical management must follow the relevant guidelines. |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| WACS1.1 | Shahedal Bari | Nicola Askew | Associate Director of Nursing & Therapies for Children and Young People to undertake review of pathways for 16 and 17 year old patients used by Regional Paediatric Tertiary service providers, to identify best practice from Regional Paediatric Tertiary service providers | Review of guidance from Alder Hey & Royal Manchester Children's Hospital completed in Dec 2019. | Best Practice Review | Best Practice identified | 31/12/2019 | N/A | N/A | D | NA | Low |
| WACS1.2 | Shahedal Bari | Shahedal Bari | Trust Medical Director and Clinical Director of WACS to review and update the Trusts pathways for 16 and 17 year old patients | PAED/POL/003 - Transition of Young People with Diabetes from Paediatric to Adult Services<br>Review Completed on: 12/12/2019<br>Ratified by WACS Governance Assurance Group On 12/12/2019<br>CORP/PROC/033 Urgent and Emergency Care Pathways<br>Review Completed on: 12/12/2019<br>Ratified by Clinical Directors Group Meeting On 12/12/2019 | Trust Procedural Document Library | Revised Procedure in Place | 31/01/2020 | N/A | N/A | D | NA | Low |
| WACS1.3 | Shahedal Bari | Sanjay Sinha | Communicate revised pathways for 16-17 Year olds to transition from Paediatrics to Adult Services to all relevant Clinical Specialties and Departments as per agreed Communication plan approved at Trust Procedural Document Group | Communicated to all Paediatrics Staff<br>Also Included in the UHMB Friday Corporate Communications Roundup or Weekly News.<br>New document uploaded to the Trust Procedural Document Library | Communication Plan Records | Communication Plan completed | Completed | N/A | N/A | D | NA | Low |
| WACS1.4 | Shahedal Bari | Dr Ash Kale | Audit 1895:<br>Audit aim – To review admissions and outcomes, in line with NICE and updated trust policy of all the patients between 16 and 17 years age between Jan and March 2020.<br><br>Anticipated impact/Benefit – Were there any clinical incidents arising out of the care provided to this cohort of patients? Were any systemic issues (which did not lead to clinical incidents) identified on review of the care during this audit?<br><br>Standards – In 100% of patients did the clinical management follow the relevant guidelines? | Audit 1895 on Forward Audit Plan<br>Data collection completed<br>Audit Presented | Ulysses Audit Module<br>WACs Audit Meeting Agenda and Minutes | Compliance with Pathways | 31/05/2020 | 100% | Awaiting Formal Confirmation of Audit Results | D | D | Low |
| WACS1.5 | Shahedal Bari | Dr Owen Galt | Audit 1896:<br>Audit aim – To review admissions and outcomes, in line with NICE and updated trust policy of all the patients between 16 and 17 years age between Jan and March 2020.<br><br>Anticipated impact/Benefit – Were there any clinical incidents arising out of the care provided to this cohort of patients? Were any systemic issues (which did not lead to clinical incidents) identified on review of the care during this audit?<br><br>Standards – In 100% of patients did the clinical management follow the relevant guidelines? | Audit 1896 on Forward Audit Plan<br>Data collection underway<br>Audit Presented | Ulysses Audit Module<br>WACs Audit Meeting Agenda and Minutes | Compliance with Pathways | 31/07/2020 | 100% | Awaiting Formal Confirmation of Audit Results | D | D | Low |
| WACS1.6 | Shahedal Bari | Dr Ash Kale / Dr Owen Galt | Findings from Audits 1895 & 1896 to be presented to Trust Clinical Audit and Effectiveness Steering Group (CAESG), to provide assurance that Audits were successful and that clinical management followed appropriate guidelines. | Presentations currently scheduled for the September CAESG Meeting (to take place on 01/10/2020).<br>Maybe brought forward to July CESAG Meeting if possible - July CAESG Meeting Agenda under constant review du to COVID | Agenda, Papers and minutes of CAESG | Presentation to CAESG | 31/10/2020 | N/A | N/A | D | NA | Low |

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| WACS1.7 | Shahedal Bari | Nicola Askew | Implement Re-Audit of compliance with revised protocols | Re-Audit to be included On Audit Forward Plan.<br>Will reported at WACS Audit Meeting and Trust Audit Meeting, as per Audit 1895 & 1896 | Ulysses Audit Module<br>WACs Audit Meeting Agenda and Minutes | Audit on forward plan | 30/11/2020 | N/A | N/A | D | NA | Low |
| WACS1.8 | Shahedal Bari | Nicola Askew | Work underdvelopment with ICS to improve Paediatric Transition Pathways across the ICS | UHMBT Paediatrics will participate in ICS Review | TBC | TBC | Target Date TBC | N/A | N/A | D | NA | Medium |
| WACS1.9 | Shahedal Bari | Nicola Askew, Sanjay Sinha, Linda Womack, Carol Carlile | WACS Senior Management Team to review the Emergency Care Admisssions SOP (ED/SOP/06) to ensure that the sections relevnt to Transition Patients are compliant with the Transition Protocols (PAED/POL/003) | 18/11: Emergency Care Admisssions SOP shared with WACs senior management team<br>03/12: confirmation from Associate Director of Nursing &Therapy Services for Children and Young People<br>04/12: confirmation from Clinical Director of WACS<br>04/12: Action Closed | Trust Procedural Document Library | Emergency Care Admisssions SOP is compliant | 30/11/2020 | N/A | N/A | D | NA | Low |
| WACS1.10 | Shahedal Bari | Dr Owen Galt | NCEPOD commencing national review of care in relation to 'care delivered when young people transition from child to adult health services'<br>Request for input into the aims and objectives of the study protocol by 13/11/2020 | Study Protocol reviewed by Dr Galt.<br>Study Protocol, comprehensive and extensive.<br>No items to be requested to be added to study protocol. | NCEPOD national review of care | Response to NCEPOD | 13/11/2020 | N/A | N/A | D | NA | Low |
| WACS1.11 | Shahedal Bari | Dr Owen Galt, Sanjay Sinha | NCEPOD Final Study protocol for national review of care of Transition Patients to be published in February 2021 | Dr Galt to review Study protocol when Published<br>UHMBT Paediatrics will participate in National Review of Care | NCEPOD national review of care | Response to NCEPOD | 28/02/2021 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **WACS02** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Well Led** |
| **CQC Service Name:** | **Children and Young People / Maternity** |
| **Must or Should Action / UoR Finding:** | **Must Do** |
| **UHMBT Exec Lead:** | **Sue Smith** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **FGH & RLI** |
| **UHMBT Board Assurance Committee** | **Quality Committee / Finance & Performance Committee / Workforce Committee** |
| **UHMBT Strategic Objective:** | **Performance** |
| **UHMBT Theme:** | **Clinical Governance** |
| **CQC Recommendation:** | The trust must ensure all risks are assessed, monitored and actions taken to mitigate them are effective and timely. |
| **Story behind the Recommendation:** | The service had systems in place to identify learning from incidents, complaints and safeguarding alerts to make improvements. The divisional team reviewed the systems in meetings with the local leaders. We reviewed these systems during our inspection and requested further information following the inspection. This information identified some risks had been on the risk register since 2014. Risk management systems were in place to identify issues and manage risks but were not effective. The service had a risk register. We reviewed the risk register performance data as of November 2019. We saw 23.2% of mitigating actions were beyond their target completion date, 11.1% of risks required action and input from a commissioner for effective mitigation and 91.7% of risks had a mitigating action plan in place. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | *The organisation has the processes to manage current and future performance. There is an effective and comprehensive process to identify, understand, monitor and address current and future risks. Performance issues are escalated to the appropriate committees and the board through clear structures and processes.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Complete Review of Care Group Risk Register, improved monitoring at Care Group Governance meting to ensure performance is maintained. |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| WACS2.1 | Sue Smith | Anna Smith | Review of Care Group Risk Register to be undertaken by Care Group Governance Business Partner and Head of Health and Safety. | Review of Care Group Risks completed by Anna Smith and Roz McMeeking | Ulysses - Care Group Risk Register | Review Completed | 28/02/2020 | N/A | N/A | D | NA | Low |
| WACS2.2 | Sue Smith | Roz McMeeking | Revised Risk Register circulated to WACS Senior Management Team for review/Comment | 4 Risks agreed for closure at February CGGAG meeting Other Risk reviewed and updated with accurate Action Plans, current and target risk scores and additional controls | Ulysses - Care Group Risk Register | Revised Risk Register | 28/02/2020 | N/A | N/A | D | NA | Low |
| WACS2.3 | Sue Smith | Roz McMeeking | Improve Care Group Management team oversight of Risk Register | Review of Care Group Risk Register a standing item in Care Group Governance meeting to ensure greater oversight and scrutiny. | WACs CGGAG Meeting Agenda, papers and minutes | Review of Care Group Risk Register | 31/12/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **WACS03** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Well Led** |
| **CQC Service Name:** | **Children and Young People & Maternity** |
| **Must or Should Action / UoR Finding:** | **Must Do** |
| **UHMBT Exec Lead:** | **Kate Maynard** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **FGH & RLI** |
| **UHMBT Board Assurance Committee** | **Finance & Performance Committee** |
| **UHMBT Strategic Objective:** | **Performance** |
| **UHMBT Theme:** | **Data Quality & Systems** |
| **CQC Recommendation:** | The trust must ensure that systems to collect and analyse data are effective. Such as the maternity dashboard accurately reflects current data or performance . That validated data is easily accessible to staff to allow them to understand performance, make decisions and improvements. |
| **Story behind the Recommendation:** | Performance measures for the service were reported using key performance indicators and other metrics. This was reported as the women's and children service dashboard each month. The report included financial information, staff training, staff appraisals, risk register performance and Services for children & young people 25 Furness General Hospital Quality Report This is auto-populated when the report is published a quarterly review of outstanding actions. However, this did not break down the performance level to each area, so the divisional leads only had oversight of the division as a whole and not at service level where issues and concerns could be identified. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | *Integrated reporting supports effective decision making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people with quality, operational and financial information. Quality and sustainability both receive sufficient coverage in relevant meetings at all levels. Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary. Performance information is used to hold management and staff to account. The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Delivery of enhanced Maternity Dashboard by 31/12/2020 |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| WACS3.1 | Kate Maynard | Carol Carlile | Review of existing Dashboards to confirm capability to drill down to site/service level within WACS Care Group | Review completed, capability confirmed.<br>Existing Qliksense Dashboard can be drilled into by Site and by Service/Speciality.<br>Already available for review at Site and Service/Speciality meetings. | Qliksense Dashboard | Review Completed | 31/01/2020 | N/A | N/A | D | NA | Low |
| WACS3.2 | Kate Maynard | Philip Davies | I3 Data analysis team to undertake review of Maternity Dashboard to identify potential improvements. | Review completed, potential improvements reported to Director of Midwifery for review. | I3 Review | Review Completed | 30/04/2020 | N/A | N/A | D | NA | Low |
| WACS3.3 | Kate Maynard | Carol Carlile | Head of Midwifery to confirm what additional enhancements will be required to meet the CQC recommendations | Dash board will demonstrate the Data required for the North west maternity dashboard and NHS Resolution (CNST) requirements.<br>Completed | Qliksense Maternity Dashboard | Final dashboard | 31/05/2020 | N/A | N/A | D | NA | Low |
| WACS3.4 | Kate Maynard | Carol Carlile | Fortnightly review meeting scheduled between Head of Midwifery and I3 to review progress of Dashboard development and implementation | Meetings Scheduled | Schedule of review Meetings | Review Meetings | 30/04/2020 | N/A | N/A | D | NA | Low |
| WACS3.5 | Kate Maynard | Philip Davies | I3 to implement and deliver additional enhancements to Maternity Dashboard, including:<br>- break down of data by site<br>- accessible to appropriate staff by a link on their desktops.<br><br>To enable these enhancements a new validation process needs to also be implemented, that will enable validated data to be analysed in multiple ways and provide greater insight | First draft of Dashboard complete, under review.<br>HoM and BI to meet to check everything is included.<br>Revised Dashboard due for testing W/C 21/09<br>Dashboard Active - Action closed | Qliksense Maternity Dashboard | Final dashboard | 30/09/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **WACS04** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Safe** |
| **CQC Service Name:** | **Children and Young People** |
| **Must or Should Action / UoR Finding:** | **Must Do** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMBT Theme:** | **Staff Recruitment/Deployment** |
| **CQC Recommendation:** | The trust must ensure that there are sufficient numbers of suitably qualified medical staff on the rota |
| **Story behind the Recommendation:** | At the time of our inspection medical cover was provided by consultants, middle grades and junior grades. The consultant whole time equivalent establishment was ten. At the time of inspection there were six whole time equivalent consultants. Five consultants were permanent staff and one locum consultant. To fill the consultant vacancies, consultants were working additional shifts and had been required to cancel outpatient appointments based on risk to ensure cover was provided on the paediatric ward. At the time of inspection there was a shortfall of 4.9 whole time equivalent paediatric consultants. Medical staff told us there was a shortage of paediatric consultants and recruitment had not been successful to fill the vacant roles. In response to this an options appraisal had been performed. This had resulted in additional middle grade doctor posts which had been recruited. A new three tier rota system was due to start January 2020. At the time of our inspection senior leaders and staff told us different dates for the implementation of the new rota systems. They also described delays in the implementation of this rota. We escalated this at the time of our inspection and were assured that the rota would be implemented on 13 January 2020. Senior leaders recognised the requirement for the service to be compliant with national standards and guidelines for medical staffing. However, at the time of the inspection the service was not compliant with the requirements of the Facing the Future Standards. Staff told us there had been concerns with medical handovers and shift changes not starting on time. The concerns about the medical handovers included disrespectful behaviour, staff talking over each other and the time the handovers were taking. At inspection we discussed this with a senior manager who told us they were aware of this and action had been taken to begin to improve the handovers. Staff told us there had been improvement in medical handovers over the last few weeks. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | *Staffing levels and skill mix are planned, implemented and reviewed to keep people safe at all times. Any staff shortages are responded to quickly and adequately.*<br>*Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Continue rolling recruitment process until all posts are appointed to. |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| WACS4.1 | Shahedal Bari | Sanjay Sinha | Review Medical Rota at FGH to deliver two tier Medical Cover | Two Tier on call rota Implemented to enhance support<br>Completed on 13-01-2020 | E-Job Plan | two tier on call rota | 31/01/2020 | N/A | N/A | D | NA | Low |
| WACS4.2 | Shahedal Bari | Sanjay Sinha | Review Medical Rota at FGH to deliver three tier Medical Cover | Two Tier on call rota changed to three tier on call rota to enhance support<br>Completed on 13-03-2020 | E-Job Plan | three tier on call rota | 31/03/2020 | N/A | N/A | D | NA | Low |
| WACS4.3 | Shahedal Bari | Sanjay Sinha | Implement 'Hot Consultant' on each site to ensure appropriate cover/ward round | Hot week Consultant has been in place for a number of years on both sites | E-Job Plan | Hot Consultant Rota | 31/03/2020 | N/A | N/A | D | NA | Low |
| WACS4.4 | Shahedal Bari | Sanjay Sinha | Implement Recruitment Plan for Paediatric Medical Staff | Recruitment Plan Implemented and onitored through QACS Care Group Management meetings, with escalation to Trust Workforce Committee if required.<br>Dr Chinwendu Lilian - Offered initial 3 year Speciality Doctor post at middle grade level. Going through checks and clearances and hoping to start mid-July.<br>Dr Youseff - Offered initial 12 month Speciality Doctor post at intermediate grade level. Currently on hold due to travel and GMC restrictions due to Covid-19.<br>Dr Darshanika Gamage - Offered initial 12 month Speciality Doctor post at intermediate grade level. Currently on hold due to travel and GMC restrictions due to Covid-19.<br>Need to confirm any offers, interviews, appointments etc. since Dec 2019<br>Consultant appointed Jan 2020 withdrew and Consultant post out to advert closes 24th May 2020<br>September 2020 update: One Middle Grade vacancy and one Consultant vacancy, ongoing monitoring at Care Group. | E-Job Plan | Fully staffed rota | 31/03/2021 | Confirm Target WTE | Confirm Actual WTE | D | NA | Low |

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| **Recommendation Ref. No.:** | **WACS05** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Effective** |
| **CQC Service Name:** | **Maternity** |
| **Must or Should Action / UoR Finding:** | **Must Do** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **FGH & RLI** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMBT Theme:** | **Staff Development & Training** |
| **CQC Recommendation:** | The trust must ensure that it has appropriate arrangements in place to assure itself around staff competencies regarding equipment. |
| **Story behind the Recommendation:** | We were not assured that the overarching trust governance processes were robust as there were discrepancies in information that was held locally with centrally held trust data (see information section for more detail). This included the system regarding staff competencies relating to equipment, which highlighted a 35% compliance rate with competencies that was inaccurate. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | *All staff are qualified and have the skills they need to carry out their roles effectively and in line with best practice. The learning needs of staff are identified and training is provided to meet these needs. Staff are supported to maintain and further develop their professional skills and experience.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | To confirm which Committee/Sub-Committee/Group will have overall responsibility for providing Assurance Medical Device Training and Medical Device Training Records<br>To improve training for Practice Educator Facilities and to clarify their role in Medical Device TMS and TNA |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WACS5.1 | Sue Smith | Anna Smith | Trust Wide Medical Device training compliance and issues reported to Health and Safety Committee by the Chair of the Medical Devices Management Group (Sub Group of the Health and Safety Committee). | Training Compliance reported to Committee on regular ongoing basis. | Papers and Minutes of Health and Safety Committee | Regular Monitoring Report to Committee/Group | Completed | N/A | N/A | D | N/A | Low |
| WACS5.2 | David Wilkinson | Kate Casey | Care Group level Medical Device training compliance and issues reported to Education Governance Group (Sub Group of Workforce Assurance Committee) by Care Groups. | Training Compliance reported to Group on regular ongoing basis. | Papers and Minutes of Education Governance Group | Regular Monitoring Report to Committee/Group | Completed | N/A | N/A | D | N/A | Low |
| WACS5.3 | Sue Smith | Tony Crick | Following discussion at Care Group Performance reviews, Task and Finish group established, chaired by Tony Crick to review and address issues regarding medical Device Training records | Task and Finish group to improve training for Practice Educator Facilities and to clarify their role in Medical Device TMS and TNA | Task and Finish group | Task and Finish group Review | Completed | N/A | N/A | D | N/A | Low |
| WACS5.4 | Sue Smith | Tony Crick | Task and Finish Group to arrange additional training Medical Device TMS and TNA for Practice Educator Facilitors | Completed | Task and Finish group | Additional Training | Completed | N/A | N/A | D | N/A | Low |
| WACS5.5 | Sue Smith | Tony Crick | Task and Finish Group to provide clarity regarding the role of Practice Educator Facilities in updating the Medical Device TMS and TNA | Completed | Task and Finish group | Revised Role | Completed | N/A | N/A | D | N/A | Low |
| WACS5.6 | Mike Thomas | Paul Jones | Confirm if the reporting and escalation of Medical Device training compliance and issues to ensure appropriate oversight at Trust Board Assurance Committee/Sub-Committee, was included/identified as an issue in Corporate Governance review. | Not identified as an issue within the Corporate Governance Review | Governance Review | Confirmation if identified as issue | 31/05/2020 | N/A | N/A | D | N/A | Low |
| WACS5.7 | David Wilkinson | Kate Casey | Review of remit and processes of the Educational Governance Group (EGG) reports to Workforce Assurance Committee, is currently in Progress.<br>Review will involve integration of Medical Education and Clinical Skills.<br>Medical Device Training will be included within the Clinical Skills element of this review.<br>This will deliver ensure appropriate oversight, with Assurance and Escalation to the Workforce Assurance Committee. | Review in Progress, but currently delayed by COVID.<br>Confirmed that the Remit of EEG will not include Medical Device training<br>This will require a Trust wide decision on which Committee/Sub-Committee/Group will have responsibility for Resolving the issues related to Medical Device Training and Medical Device Training records | Procedural Document Library | Review Completed. Revised TOR and Procedural Documents completed | 31/12/2021 | N/A | N/A | D | N/A | Low |
| WACS5.8 | David Wilkinson | Linda Womack | Matron Fran Campion to undertake review of Medical Device Training with WACs care Group to provide the Care Group Triumvirate with Assurance that staff within WACS have been appropriately trained in the use of the relevant Medical Devices and that there is no immediate risk to Patient Safety | Review completed by WACs Matron.<br>No significant concerns identfied regarding staff competence with Medical Devices.<br>Review confirmed that Records to evidence staff competence are of varaiable quality and quantity. | Report to WACs Triumvirate | Report to WACs Triumvirate | TBC | N/A | N/A | D | N/A | Low |

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| WACS5.9 | Andrea Willimott | Andrea Willimott | Escalation required to obtain a Trust wide decision on which Committee/Sub-Committee/Group will have responsibility for Resolving the issues related to Medical Device Training and Medical Device Training records | Learning and Orgnisational Development Team confirmed that Educational Governance Group (EGG) do not have remit to resolve these issues.<br>Medical Engineering are responsible for maintaining an up to date inventory of Medical Devices in use in the Trust, Learning and Organisational development are responsible for the TMS system , but are not responsible for the content of 'Non-Mandatory Training' Courses.<br>Clinical Skills Team have genera, responsibility for clinical training but this does not seem to encompass all medical device training, especially training on specialist devices.<br>Training on 'Specialist Devices' often can only be delivered by accredited trainers, these accredited trainers are often employed directly by the manufacturer of the devices, as such training is outside of the Trusts direct control to deliver and Assure.<br><br>Review of Educational Governance Group (EGG) Terms of Reference suggest the EGG are/should be responsible for teh oversight of 'Non-Mandatory Training' Courses - issue to be raised with Chair of EGG.<br>Educational Governance Group is a sub-committee of the Workforce Assurance Committee. | TBC | Clarity of responsibility for Medical Device Training Records | 31/12/2020 | N/A | N/A | D | N/A | Medium |
| WACS5.10 | Andrea Willimott | Andrea Willimott | Escalation of concerns regarding overall responsibility for Medical Device Training and Medical Device Training Records to Workforce Assurance Committee. | Concerns reporting in CQC Engagement/Improvement Report to Workforce Assurance Committee neeting on 16th November.<br>Advised that Tony Crick is still leading on this Issue. | Agenda and Papers of Workforce Committee | Escalation to Workforce Committee | 30/11/2020 | N/A | N/A | D | N/A | Low |
| WACS5.11 | Sue Smith | Tony Crick | Establish Task and Finish Group to review current TNA and TMS process and system related to Medical Devices to deliver a functional Medical Devices Module in TMS that provides accurate Medical Device Training Records. | Group established, Reps from I3, Medical Engineering and Governance - requires Rep from Practice Education.<br>Review meeting to held fortnighly from 19/11 onwards.<br>Tony Crick to take issues to ENACT meeting to raise awareness and engagement from Senior Nursing Team.<br>I3 to review current system and confirm scale and scope of change that is required. | TMS | Functional Medical Devices Module in TMS that provides accurate Medical Device Training Records | 31/03/2021 | N/A | N/A | D | N/A | Medium |
| WACS5.12 | Sue Smith | Andrea Willimott | Review of WACS Improvement Actions with Trust Wide Elements to determine if WACS ReCccomendation has been completed and whetehr Trust Wide elements can continue through other Reporting Mechanisms | Review of Reccommendation WACS5 (inc WACS5A)<br>Issues identified by CQC affect Trust Wide TNA and TMS Systems and require Trust Wide response.<br>All Trust Actions on this recommendation to be closed and transferred to new Trust Wide Recommendation TRUST14 | Review by Director of Governance | Decisions made | 31/12/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **WACS06** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Safe** |
| **CQC Service Name:** | **Children and Young People** |
| **Must or Should Action / UoR Finding:** | **Should Do** |
| **UHMBT Exec Lead:** | **Sue Smith** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **FGH & RLI** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Patients** |
| **UHMBT Theme:** | **Clinical Governance** |
| **CQC Recommendation:** | The service should ensure that incident records clearly evidence duty of candour has been completed. |
| **Story behind the Recommendation:** | Staff spoken with understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation when things went wrong. It was not always clear in the 27 incident records viewed, where an incident was graded as moderate or above, that the appropriate duty of candour letter in some cases had been sent within the recommended timescale. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | *Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistle-blowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Compliance with the target for issuing of Duty of Candour letter to Patient/Family. |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| WACS6.1 | Sue Smith | Andrea Willimott | Duty of Candour requirements detailed in Trust Incident Management Policy | CORP/PROC/022 'Reporting and Management of Incidents including Serious Incidents' already in place requires DoC to be competed, monitoring to be enhanced. | Procedural Document Library | DOC in policy | 31/12/2019 | N/A | N/A | D | NA | Low |
| WACS6.2 | Sue Smith | Andrea Willimott | Weekly meetings scheduled with Director of Governance and Deputy Director of Clinical Governance to ensure DOC has been actioned and any barriers are resolved. | Weekly meetings commenced in w/c 04/05/2020. | Agenda, Papers and minutes of meeting | Weekly Meetings | Completed | N/A | N/A | D | NA | Low |
| WACS6.3 | Sue Smith | Stuart Bates | Monthly reporting of DOC compliance at performance Reviews and to Quality Committee. | First Reported presented on 18/05/2020. No Outstanding DOC for WACS Care Group. | Agenda, Paper and minutes of meeting | Monthly Report | Completed | 100% | 100% | D | NA | Low |
| WACS6.4 | Sue Smith | Stuart Bates | Develop and deliver education sessions in respect of DOC and the regulatory/legal requirements to those staff who would be responsible for undertaking DOC processes to ensure full aware of requirements. | Developed however planned sessions on hold due to COVID-19. To be delivered post-COVID. | Education Sessions | Education Sessions | 30/09/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **WACS07A** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Well Led** |
| **CQC Service Name:** | **Children and Young People / Maternity** |
| **Must or Should Action / UoR Finding:** | **Should Do** |
| **UHMBT Exec Lead:** | **Shahedal Bari / Sue Smith** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMBT Theme:** | **Culture & Leadership** |
| **CQC Recommendation:** | The trust should ensure leads for mortality and **safeguarding** are in place within the service. |
| **Story behind the Recommendation:** | At inspection we established that within the trust thePaediatric Safeguarding Lead for FGH was no longer in post. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | *There are clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse, using local safeguarding procedures whenever necessary. Safeguarding adults, children and young people at risk is given sufficient priority. Staff take a proactive approach to safeguarding and focus on early identification.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Appointment of a Paediatric Safeguarding Lead for FGH |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| WACS07A.1 | Sue Smith | Linda Womack | Appointment of a Paediatric Safeguarding Lead | Doctor Alabi appointed as Paediatric Safeguarding Lead in Dec 2019 | Paediatric Safeguarding Lead for FGH in post according to Safeguarding Operational Performance Group | Paediatric Safeguarding Lead for FGH appointed | Completed | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **WACS08** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Safe** |
| **CQC Service Name:** | **Children and Young People / Maternity** |
| **Must or Should Action / UoR Finding:** | **Should Do** |
| **UHMBT Exec Lead:** | **Sue Smith** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Patients** |
| **UHMBT Theme:** | **Clinical Governance** |
| **CQC Recommendation:** | The trust should ensure that all appropriate incidents go to the serious incidents requiring investigation (SIRI) panel. |
| **Story behind the Recommendation:** | There is no reference to Recommendation this in the CQC Inspection Report for FGH.<br>Unclear as to the specific reason for this Recommendation. |
| **What the CQC expect 'Good' to look like:**<br>**(Taken from relevant KLOE definition)** | *When something goes wrong, there is an appropriate thorough review or investigation that involves all relevant staff, partner organisations and people who use services. The service participates in learning with other providers within the system.*<br>*Lessons are learned and communicated widely to support improvement in other areas where relevant, as well as services that are directly affected.*<br>*Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistle-blowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | All appropriate incidents are already reported to the Serious Incidents Requiring Investigation (SIRI) panel. |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| WACS08.1 | Sue Smith | Stuart Bates | The Trust has a policy and process in place to ensure that all Serious Incidents as presented either to Weekly Patient Safety Summit or if necessary SIRI Panel. Those presented at SIRI Panel are those incidents reported on StEIS. | CORP/PROC/ 022 in place:<br>All Incidents identified that met the StEIS/Serious Incident criteria that are/were reported to the Trust SIRI Panel.<br>Serious Incidents (e.g. Harm Level of Severe or Catastrophic) subject to multiple assessments to review/determine initial level of harm and ensure onward reporting to NHS England (StEIS) and to the Trusts SIRI Panel:<br>- All Incidents subject to initial data quality triage by Patient Safety Team<br>- All Incidents with actual harm of Severe or Catastrophic subject to 48 hour review to determine if it meets the StEIS/Serious Incident criteria, then reported if criteria is met<br>- All Incidents with actual harm or potential harm levels of Moderate, Severe or Catastrophic reported to Weekly Patient Safety Summit for awareness and ongoing review during investigation<br>- All incidents that meet the StEIS/Serious Incident criteria scheduled for review at Trust SIRI Panel | Agenda, Papers and Minutes of SIRI Panel | Review completed | Completed | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **WACS11** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Well Led** |
| **CQC Service Name:** | **Children and Young People / Maternity** |
| **Must or Should Action / UoR Finding:** | **Should Do** |
| **UHMBT Exec Lead:** | **David Wilksinson** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **FGH & RLI** |
| **UHMBT Board Assurance Committee** | **Quality Committee / Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMBT Theme:** | **Culture & Leadership** |
| **CQC Recommendation:** | The trust should consider increasing the visibility of senior leaders across maternity and the children and young people's service areas. |
| **Story behind the Recommendation:** | The children's and young people service leaders were led by a consultant paediatrician and matron. Staff told us they were visible and approachable. The service sat within the women's and children's care group which was led by a clinical director, associate director of operations and an associate director of nursing for children and young people. Staff told us they had not seen senior leaders at the hospital and were unaware if they had visited. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | *Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed.*<br>*Leaders at every level are visible and approachable. Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, deployment and support processes and succession planning.*<br>*The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and acts to address them.*<br>*Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. There are processes to support staff and promote their positive wellbeing. Leaders at every level live the vision and embody shared values, prioritise high-quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Understand what staff would like to be delivered in relation to increasing/improving the visibility of the Care Group senior management team by 31/12/2020. |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| WACS11.1 | David Wilkinson | Linda Womack | Review frequency of Senior Management representation at three main Hospital Sites and Community locations. | Care Group benefits from having 4 members of the senior management team (Clinical Director, Director of Operations, Head of Midwifery and Director of Nursing & Therapies for Children and Young People) as opposed to 3 members in other care groups (Clinical Director, Director of Operations and Director of Nursing). Number of days spent at each site by one, or more, senior management team member is proportionally high than other Care Groups.<br>The Review of findings from Corporate Quality reviews have also confirmed that the availability/visibility of senior management is a common concern raised by staff across all Care Groups.<br>The size of the geographical area covered by the Trust and the distance between the two main hospitals (FGH and RLI) present a very significant challenge in addressing this issue. | Review Documents | Review Completed | 31/01/2020 | N/A | N/A | D | NA | Low |
| WACS11.2 | David Wilkinson | Linda Womack | Review of National Staff Survey Results for WACS Care Group to identify any additional concerns raised regarding visibility of Senior Management Team, that could be relevant to CQC Recommendation. | Review of relevant questions on NSS shows that WACS Care Group performs around or above the Trust average in response to questions related to Senior Management.<br>No Clear conclusion to be drawn from the NSS results, no Care Group specific mitigating action undertaken.<br><br>NSS Q9a. I know who the senior managers are here.<br>WACS - 83.8% (Above Trust)<br>UHMBT - 80.1%<br><br>Q9b. Communication between senior management and staff is effective.<br>WACS - 38.1% (Slightly below Trust)<br>UHMBT - 38.5%<br><br>Q9c. Senior managers here try to involve staff in important decisions<br>WACS - 33.6% (Above Trust)<br>UHMBT - 32.1%<br><br>Q9d. Senior managers act on staff feedback.<br>WACS - 33.9% (Above Trust)<br>UHMBT - 31.7% | National Staff Survey Results | Review Completed | 31/01/2020 | N/A | N/A | D | NA | Low |
| WACS11.3 | David Wilkinson | Linda Womack | Care Group to undertake mini staff survey to investigate findings from CQC inspection and find out more about the concerns of Department/Ward staff and how staff would like the Senior Management Team to increase visibility | Staff to be asked how they would like leadership to be more visible. Questionnaire to be devised<br>Survey issued and completed | Survey Results | Survey Completed | 31/12/2020 | N/A | N/A | D | NA | Low |
| WACS11.4 | David Wilkinson | Linda Womack | Care Group Senior management team to review results from mini staff survey to identify any practical options to help increase senior management visibility. | Review of survey results competed.<br>Number of staff led suggestions to be carried forward;<br>Increaased visibility via regular team meetings<br>Detailed Action plan to be developed and communicated to WACS Staff | Review Documents | Review Completed | 31/12/2020 | N/A | N/A | D | NA | Low |
| WACS11.5 | David Wilkinson | Linda Womack | Develop and implement action plan | WACS Senior Management to:<br>Maintain physical presence at all three Hospitals on a rotaional basis.<br>Consider increaseing attendance at Speciality/Department Team meetings<br>Hold regular WACS 'Tea and Talk' Meetings to incrase scope for face to face interactionwith frontline staff | Action Plan | Action Plan Completed | 30/09/2020 | N/A | N/A | D | NA | Low |

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| WACS11.6 | David Wilkinson | Linda Womack | Communication results of survey and proposed actions to WACs staff | Completed | Communication Documents | Communication Completed | 30/11/2020 | N/A | N/A | D | NA | Low |
| WACS11.7 | David Wilkinson | Linda Womack | Trust Wide process of reviewing findings from 2020 National Staff Survey to identify areas of improvement and for improvement to take place in February | 2020 NationalStaff Survey closed on 27/11/2020<br>2020 NationalStaff Survey Result available in Feb 2021<br>Management Visibilty to be considered as part of Review process | National Staff Survey Results | Process in place | 30/11/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **WACS13** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Safe** |
| **CQC Service Name:** | **Maternity** |
| **Must or Should Action / UoR Finding:** | **Should Do** |
| **UHMBT Exec Lead:** | **Sue Smith** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Patients** |
| **UHMBT Theme:** | **Quality & Safety Assurance Checks** |
| **CQC Recommendation:** | The trust should consider auditing in line with the WHO maternity safety checklist procedures carried out in birthing rooms. |
| **Story behind the Recommendation:** | Following the inspection, we requested and received copies of the "World Health Organisation five steps to safer surgery" audits. However, whilst we received data that highlighted that in the period May 2019 to December 2019 inclusive 100% compliance had been achieved consistently, there were no data of audits of procedures carried out in the birthing rooms. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | *Monitoring and reviewing activity enables staff to understand risks and gives a clear, accurate and current picture of safety.*<br>*Performance shows a good track record and steady improvements in safety.*<br>*There is participation (that includes all relevant staff) in relevant local and national clinical audits and other monitoring activities such as reviews of services, benchmarking and peer review and approved service accreditation schemes. Accurate and up-to-date information about effectiveness is shared internally and externally and is understood by staff. It is used to improve care and treatment and people's outcomes and this improvement is checked and monitored.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | To review the suitability of WHO maternity safety checklist and implement if appropriate |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| WACS13.1 | Sue Smith | Carol Carlile | Head of Midwifery to undertake Best practice review of the use of WHO checklist in delivery suites / birthing rooms | Review confirms that use of WHO Checklist is not common/best practice in delivery suites / birthing rooms - Checklist designed for developing countries, not established Health Care Systems | Review Documents | Review completed | 31/01/2020 | N/A | N/A | D | NA | Low |
| WACS13.2 | Sue Smith | Carol Carlile | Head of Midwifery to undertake Best practice review of the use of alternative checklist in delivery suites / birthing rooms wit Local Maternity System | Review confirms that there is no national standard Checklist is use in delivery suites / birthing rooms | Review Documents | Review completed | 28/02/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **WACS14** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Well Led** |
| **CQC Service Name:** | **Children and Young People** |
| **Must or Should Action / UoR Finding:** | **Should Do** |
| **UHMBT Exec Lead:** | **Shahedal Bari** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Quality Committee** |
| **UHMBT Strategic Objective:** | **Progress** |
| **UHMBT Theme:** | **Clinical Audit** |
| **CQC Recommendation:** | The service should continue to audit care plans to ensure they are not changed unless there is a clinical reason. |
| **Story behind the Recommendation:** | Staff we spoke with were concerned about working relationships between clinicians affecting patient care. We were told some patient care plans had been changed by consultants following another consultant review without a clinical indication. Nursing staff told us that they were expected to explain the change to the patient and their parents. The reason for change in care plans was unclear and nursing staff told us it was difficult to explain the change. Nursing staff had raised these concerns to senior staff. We discussed these concerns with board level staff during our inspection. Following the inspection, the trust told us that they had introduced an audit programme to identify whether children's care plans were changed without clinical need. The medical director was leading this piece of work. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | *Risks to people who use services are assessed, monitored and managed on a day-to-day basis. These include signs of deteriorating health, medical emergencies or behaviour that challenges. People are involved in managing risks and risk assessments are person-centred, proportionate and reviewed regularly.*<br>*People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies. This is monitored to ensure consistency of practice.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Any change of treatment plan must be appropriate, was taken according to the acuity of the patient and was documented in the Patients record. |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| WACS14.1 | Shahedal Bari | Sanjay Sinha / Ash Kale | Audit 1870:<br>To investigate variation in paediatric inpatient care at Furness General Hospital 2019-20<br>Principle Aim To ensure the quality of care provided is up to the standard of Royal College of Paediatric guidelines and investigate any variation in care<br>To ensure quality of care is provided at FGH without undue variation which may impact on quality/safety, with a target sample size of 30 cases between 15/01/2020 and 15/02/2020. | Audit 1870 completed:<br>- In 100% of cases where there was a change of treatment plan this was appropriate and was according to the acuity of the patient.<br>- In 97% of cases where there is a deviation from the guideline the reason should was fully documented in the patient record.<br><br>Results and Learning already disseminated to FGH Paediatric Clinical staff in March 2020.<br><br>Audit results scheduled to be presented at:<br>- WACS CGGAG meeting in April 2020 however impact of COVIFD-19 have delayed this presentation<br>- CAESG Meeting in July 2020, presentation on meeting Agenda | Ulysses | Compliance with treatment plans | 31/07/2020 | 100% | 97% | D | OT | Low |
| WACS14.2 | Shahedal Bari | Sanjay Sinha / Ash Kale | Request from Executive Chief Nurse that Audit 1870 is added to the Trust's Forward Plan as an annual re-audit at FGH. | Added to forward audit plan and scheduled for Re-audit in 2020/21 | Ulysses | Compliance with treatment plans | 30/04/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **WACS15** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Safe** |
| **CQC Service Name:** | **Maternity** |
| **Must or Should Action / UoR Finding:** | **Should Do** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMBT Theme:** | **Staff Development & Training** |
| **CQC Recommendation:** | The trust should consider ensuring data to monitor training compliance can be viewed at service level. |
| **Story behind the Recommendation:** | Following our inspection, we requested all mandatory training compliance for maternity staff at this location. However, the trust told us they were only able to provide overall compliance for the maternity and paediatric care group across the trust. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | *All staff, including volunteers, are qualified and have the skills they need to carry out their roles effectively and in line with best practice. The learning needs of staff are identified and training is provided to meet these needs. Staff are supported to maintain and further develop their professional skills and experience.*<br>*Staff are supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal. Where relevant, staff are supported through the process of revalidation. There is a clear and appropriate approach for supporting and managing staff when their performance is poor or variable.*<br>*The service has effective policies and processes for recruiting, training and supporting volunteers where necessary. These are implemented and volunteers feel supported and understand their roles and responsibilities.*<br>*Integrated reporting supports effective decision making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people with quality, operational and financial information. Quality and sustainability both receive sufficient coverage in relevant meetings at all levels.*<br>*Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary. Performance information is used to hold management and staff to account. The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Training compliance data to be available at Departmental level by 31/12/2019.<br>Review of Workforce performance data to include standardised reporting of Departmental/Ward Hotspots to be completed by 31/03/2021 |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WACS15.1 | David Wilkinson | Kate Casey | Review of TMS to confirm if training compliance data can be viewed at service level. | Training compliance data can be viewed at Care Group, Site, Service and Department Level.<br>Data at Care Group Level only was CQC, this was at request of the Deputy Director of POD | TMS | Confirmation of Data Granuality. | 30/06/2020 | N/A | N/A | D | NA | Low |
| WACS15.2 | David Wilkinson | Kate Casey | Develop and Implement a 'Managers Portal' on TMS (Training Management System) to enable managers to see an overview of all their staff providing information on training and appraisal goal compliance, to help early identification of potential non compliance. | Portal completed and made operational on 15/10/2019.<br>Additional functionality also includes a 'meeting log' tab for documenting details of one-to-one meetings held throughout the year around feedback, issues raised and actions identified. | TMS | Manager Portal Operational | 31/10/2019 | N/A | N/A | D | NA | Low |
| WACS15.3 | David Wilkinson | Kate Casey | I3 to develop an automated link from ESR to TMS to ensure staff records (starters, leavers, maternity etc.) in TMS are accurate and up to date to reduce the level of 'false negative' appraisal records in TMS | Draft Trust Leadership Competency Framework presented at Workforce Committee.<br>December 2019: This has gone to WAC. To go to further forums for sign off.<br>Target Implementation date of March 2020<br>March 2020: The feed from ESR is delayed due to I3 staffing issues but should be completed by the end of April for Band 8a+ with management responsibility.<br>May 2020: The I3 link is deferred currently due to COVID 19 - the I3 team are focussing their efforts on core business support. Manual work arounds are in place. | TMS | ESR-TMS Link | 30/06/2020 | N/A | N/A | D | NA | Low |
| WACS15.4 | David Wilkinson | Ray Olive | Consider review of Workforce performance data to include standardised reporting of Departmental/Ward Hotspots, in addition to overall Care Group Level reporting | This is in the POD work plan for 2020/21 and will be completed by 31st March 2021. | POD work plan | Revised hotspot reporting | 31/03/2021 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **WACS16** |
| **CQC Report:** | **2020 Inspection Report** |
| **CQC Domain:** | **Safe** |
| **CQC Service Name:** | **Maternity** |
| **Must or Should Action / UoR Finding:** | **Should Do** |
| **UHMBT Exec Lead:** | **Kate Maynard** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **RLI** |
| **UHMBT Board Assurance Committee** | **Finance & Performance Committee** |
| **UHMBT Strategic Objective:** | **Performance** |
| **UHMBT Theme:** | **Environment & Equipment** |
| **CQC Recommendation:** | The trust should ensure all equipment is appropriately located for the purpose for which they are being used. |
| **Story behind the Recommendation:** | A wall mounted resuscitaire was positioned on a wall in a corner next to the birthing pool. Staff told us due the location and proximity of the birthing pool and wall, this limited the area and space staff had to work when caring for a neonate, who required additional and emergency treatment. Staff shared examples of when this had happened and although they felt it did not have a direct effect on the care provided, it did make their job more difficult. The matron told us they had reported this issue and it was currently going through the process to have the resuscitaire moved to the other side of the room and in the meantime a portable resuscitaire was available in the corridor. However, there was no expected timeline for this to be completed. We raised this as a concern at the time of inspection. |
| **What the CQC expect 'Good' to look like:** | *Care premises, equipment and facilities are safe, maintained and fit for purpose.* |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Relocation of Resuscitaire |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| WACS16.1 | Kate Maynard | Tristram Reynolds | Resuscitaire decommissioned/unused, pending relocation work scheduled with Estates | Currently Decommissioned, Estates Work requested Delayed due to priority given to COVID related Estates work. Completed in June 2020 | Trackback | Resuscitaire relocated | 30/09/2020 | N/A | N/A | D | NA | Low |
| WACS16.2 | Sue Smith | Carol Carlile | Implement alternative mobile Resuscitaire, based in Annex to birthing pool | Completed | Trackback | Alternative Mobile Resuscitaire | 31/01/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **WACS17** |
| **CQC Report:** | **2017 BTHT Inspection Report** |
| **CQC Domain:** | **Responsive** |
| **CQC Service Name:** | **Community health services for children, young people and families** |
| **Must or Should Action / UoR Finding:** | **Should Do** |
| **UHMBT Exec Lead:** | **Kate Maynard** |
| **UHMBT Care Group:** | **Women & Childrens** |
| **UHMBT Site(s):** | **Community - North Lancashire** |
| **UHMBT Board Assurance Committee** | **Finance & Performance Committee** |
| **UHMBT Strategic Objective:** | **Performance** |
| **UHMBT Theme:** | **Operational Performance & Targets** |
| **CQC Recommendation:** | The trust should ensure waiting times in community therapy services are addressed as planned. |
| **Story behind the Recommendation:** | In Blackpool and Fylde and Wyre children were waiting over 18 weeks to have an appointment with a speech and language therapist and an occupational therapist. Actions were being taken to address the backlog of appointments. |
| **What the CQC expect 'Good' to look like:** | *People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies.* |
| **What the Trust believes is achievable in Financial Year** | Community Waiting List reports to be automated by 31/12/2020 |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Action Lead: Exec, Care Group or Specialist Function | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| WACS17.1 | Sue Smith | Linda Womack | The Community Paediatric Physiotherapy Teams in Blackpool Teaching Hospitals Trust were divided into Northern and Southern regions. It was the Northern region that transferred to UHMBT on 01/10/2018. | During integration it was identified that Waiting Times in Paediatric Speech and Language Therapy services were around or in excess of 18 weeks | Identification of waiting times on intergartion | Speech and Language times within 18weeks | 01/04/2019 | N/A | N/A | D | NA | Low |
| WACS17.2 | Sue Smith | Linda Womack | Ongoing monitoring and escalation of Community Physio waiting times at WACs Care Group Meetings (CGMT):<br>- Currently based on manual assessment of waiting time data in EMIS | Occupational/Physio Therapy waiting time is 8 weeks Monitored at CGMT | Monitored at CGMT | Community Physio waiting times will be monitored at WAC's care group meetings | 31/03/2020 | N/A | N/A | D | NA | Low |
| WACS17.3 | Sue Smith | Linda Womack | Ongoing monitoring and escalation of Community Speech and Language Therapy waiting times at WACs Care Group Meetings (CGMT):<br>- Currently based on manual assessment of waiting time data in EMIS | Speech and Language Therapy (SALT) waiting time is 18 weeks monitored at CGMT<br><br>SALT are continuing to improve waiting list performance through:<br>- more effective triage<br>- offering more drop in sessions<br>- offering more school clinics<br>Continue to find informtaion manually currently 6-8week wait for SLT | Monitored at CGMT | Community speech and language waiting times will be monitored at WAC's care group meetings | 31/03/2020 | N/A | N/A | D | NA | Low |
| WACS17.4 | Sue Smith | Tony Stewart | Create Process to develop automated Waiting List Reports from EMIS for Paediatric Physiotherapy and Paediatric Speech and Language Therapy services to enable monitoring of Waiting List times at WACs Care Group Meetings (CGMT) | Specification Developed.<br>Developmengt added to I3/BI development programme.<br>Project listed as low priority due to (relatively) small number of and (relatively) small volumeof clinical activity.<br>Progress to be monitored at WACS Senior management team meeting, records as Action.<br>No further action to be takne via CQC Improvement Plan | Development of automated waiting list report. | Waiting list report developed | 31/03/2021 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **CCS01** |
| **CQC Report:** | **2017 Inspection Report** |
| **CQC Domain:** | **Well Led** |
| **CQC Service Name:** | **Diagnostic Imaging** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **David Wilkinson** |
| **UHMBT Care Group:** | **Core Clinical Services** |
| **UHMBT Site(s):** | **RLI** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMB Theme:** | **Culture & Leadership** |
| **CQC Recommendation:** | Continue to build relationships and develop closer team working for medical staff in radiology and breast services across all locations to develop a one trust culture. |
| **Story behind the Recommendation:** | Some staff told us they felt the department had not been well-led in the past. Several clinicians had experienced difficulties when grievances, allegations and challenges had been made against individuals and staff felt little or no resolution was found. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | All staff, including volunteers, are qualified and have the skills they need to carry out their roles effectively and in line with best practice.<br>The learning needs of staff are identified and training is provided to meet these needs.<br>Staff are supported to maintain and further develop their professional skills and experience. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | Complete OD workstream and implment findings of Baxter Report |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
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| CCS01.01 | David Wilkinson | Debbie Crawford | Individuals with people management responsibility to go through key workforce policy training :<br>- Performance Capability<br>- Managing Difficult conversations<br>- Grievance Policy<br>- Dignity at Work Policy<br>- Disciplinary Policy | SAMI tools online (videos re these policies) so this would be the starting point and then a review of learning gaps/a session whereby these are reviewed as there isn't set training for them to sign up to.<br>Update Oct 2020 - Actions to address recommendation now complete, as per action CCS01.14 | | | 31/10/2019 | | | D | | Low |
| CCS01.02 | David Wilkinson | Debbie Crawford | Consider requesting team members to undertake Behavioural Standards Framework Pledges | January 2020: Initial briefing with team held. Engagement levels good, but planned approach has been used previously. Senior team meeting planned to revise approach, incliding re-utilisation of previously generated outputs.<br>March 2020: Behavioural Standards pledges approach not considered optimal for the team. A new approach has been developed. Please refer to acion CCS01.04 | | | 31/10/2019 | N/A | N/A | D | NA | Low |
| CCS01.03 | David Wilkinson | Faye Sagar | Undertake a Behavioural Standards Framework Session for all team members in conjunction with Workforce colleagues | Session held on 17/01/2019<br>A team charter and commitment developed using the Behavioural Standards Framework Toolkit | | | 17/01/2019 | N/A | N/A | D | NA | Low |
| CCS01.04 | David Wilkinson | Matt France | Meet with the team to review the process:<br>a) Play back a summary of the OD interventions and the agreed actions that have been reached, especially the outcomes of the previous BSF session<br>b) Emphasis on team responsibility and ownership of change<br>c) Get their views on progress against the previous work done<br>d) Set up the drop-in interviews as an opportunity to provide further information and opinion | Completed. Clear Plan developed for communicating next steps to those staff who were unable to attend meeting. | | | 12/03/2020 | N/A | | D | NA | Medium |
| CCS01.05 | David Wilkinson | Matt France | Drop-in OD diagnostic interviews in the unit to be held.<br><br>A) Georgia Argent and Leanne Coulson to encourage individuals to attend these sessions<br>b) Use as an opportunity to challenge whether individuals have taken action | March 2020: Proposed dates sent to Service Manager with a recommended completion date of drop in by 17 April 2020. Yet to be confirmed by department.<br>June 2020: This is now up and running and the diagnostic phase has started. This has started to show new themes that are not just related to the historical issues in the department.<br>Update Oct 2020 - Actions to address recommendation now complete, as per action CCS01.14 | | | | | | D | NA | Medium |
| CCS01.06 | David Wilkinson | Matt France | Senior team meeting to be held to regroup and assess data so far and amend the plan if necessary. Once this has been done there will be a team feedback session where:<br>a) play back findings<br>b) create challenge and appetite for change<br>c) possible 'line in the sand' for historical issues | March 2020: Feedback to Senior team to take place week commencing 27th April 2020.<br>Team feedback to be given week commencing 4th May 2020. These dates are tentative as awaiting confirmation for drop ins and availability of staff to attend sessions which directly impacts the ability to assess the data and any subsequent<br>Update Oct 2020 - Actions to address recommendation now complete, as per action CCS01.14 | | | 30/09/2020 | | | D | NA | Medium |
| CCS01.07 | David Wilkinson | Georgia Argent | Workforce advice and guidance to be developed for dealing with specific concerns and individuals. | New action. Chris Brisley to support.<br>Update Oct 2020 - Actions to address recommendation now complete, as per action CCS01.14 | | | 30/04/2020 | | | D | NA | Medium |

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| CCS01.08 | David Wilkinson | Georgia Argent | Engage the new Programme Director in shaping change and setting the tone. | New action.<br>Update Oct 2020 - Actions to address recommendation now complete, as per action CCS01.14 | | | 30/04/2020 | | | D | NA | Medium |
| CCS01.09 | David Wilkinson | Georgia Argent | All Team Members to undertake training on Inclusive Behaviours as part of ongoing Trust Wide three year training programme | Ensure all staff are scheduled to attend by end of Aug 2020<br>Update Oct 2020 - Actions to address recommendation now complete, as per action CCS01.14 | TMS | | 31/08/2020 | | | D | NA | Medium |
| CCS01.10 | David Wilkinson | Faye Sagar | Team Members to undertake Insights Session (Personality Type Assessment). | Session to build on from BSF session held on 17.10.19<br>Originally Scheduled for 18/06/2019, but now requires to be rescheduled - date TBC<br>Update Oct 2020 - Actions to address recommendation now complete, as per action CCS01.14 | | | 31/03/2020 | N/A | N/A | D | NA | Medium |
| CCS01.11 | David Wilkinson | Debbie Crawford, Russell Norman | Workforce Impact Assessment:<br>To undertake an analysis of the risks and issues which may present as a result of newly formed structure coming into place | NEED SOME NARRATIVE AROUND THIS IF COMPLETED<br>Update Oct 2020 - Actions to address recommendation now complete, as per action CCS01.14 | | | 31/10/2019 | N/A | N/A | D | NA | Low |
| CCS01.12 | David Wilkinson | Debbie Crawford, Georgia Argent | Review staff meetings:<br>To review the meetings and ensure staff are aware of the purpose & how reconfigure them to give opportunity for conversations other than technical. | NEED SOME NARRATIVE AROUND THIS IF COMPLETED<br>Update Oct 2020 - Actions to address recommendation now complete, as per action CCS01.14 | | | 31/10/2019 | N/A | N/A | D | NA | Low |
| CCS01.13 | David Wilkinson | Debbie Crawford, Georgia Argent | Implement recommendations from the Baxter Report | June 2020: The Trust had the Professor Baxter report which led to a Working Group chaired by Bruce Jassi. Some of the issues and recommendations from Baxter had not been fully resolved. This concerned one of the consultants who has been very ill .The Trust is planning to bring back a final sign-off board report into the Private Board in September about the Baxter Review and recommendations - this was deferred from March.<br>Update Oct 2020 - Actions to address recommendation now complete, as per action CCS01.14 | | | 30/09/2020 | N/A | N/A | D | NA | Low |
| CCS01.14 | David Wilkinson | David Wilkinson | Director of Workforce and OD to present Report on the outcome of Breast Screening Review at Private Board Meting on 28-10-2020<br>Reported at Provate Board due to personal and confidential data contained within the report. | Review Presented, Board informed that Actiosn now completed and ongoing monitoring should now take place with the Cor Clinical Services Care Group.<br>Director of Workforce and OD, has written to Core Clinical Services Care Group and has confirmed that there is no need to for fiurther tracking on this COC Improvement Plan | Agenda, Papers and minutes of Provate Board Meeting | Decision on the outcome of the Breast Screening Review | 31/10/2020 | N/A | N/A | D | NA | Low |

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| **Recommendation Ref. No.:** | **CCS02** |
| **CQC Report:** | **2019 Inspection Report, 2017 Inspection Report** |
| **CQC Domain:** | **SAFE** |
| **CQC Service Name:** | **Medical Care** |
| **Must or Should Action / UoR Finding:** | **SHOULD DO** |
| **UHMBT Exec Lead:** | **David Wilksinson** |
| **UHMBT Care Group:** | **Core Clinical Services Care Group** |
| **UHMBT Site(s):** | **FGH** |
| **UHMBT Board Assurance Committee** | **Workforce Committee** |
| **UHMBT Strategic Objective:** | **People** |
| **UHMB Theme:** | **Staff Recruitment/Deployment** |
| **CQC Recommendation:** | Continue to work on strategies to improve the recruitment and retention of therapy staff in medical care services. |
| **Story behind the Recommendation:** | Therapy staff provided services five days a week from Monday to Friday. The exception to this was the on call respiratory physiotherapy service, which was available out of hours. There were several vacancies in the therapy team and staff told us they found it difficult to recruit and retain staff due to the location of the hospital. Managers were aware of the shortage of therapy staff and they had formed an action plan to improve therapy input. The matron told us they were looking to develop generic workers who had therapy skills to work at weekends. |
| **What the CQC expect 'Good' to look like: (Taken from relevant KLOE definition)** | Staffing levels and skill mix are planned, implemented and reviewed to keep people safe at all times.<br>Any staff shortages are responded to quickly and adequately.<br>Where relevant, there are effective handovers and shift changes to ensure that staff can manage risks to people who use services.<br>Staff recognise and respond appropriately to changes in the risks to people who use services.<br>Risks to safety from changes or developments to services are assessed, planned for and managed effectively. |
| **What the Trust believes is achievable in Financial Year 2020/21:** | To achieve target AHP Establishment |

**The key actions to achieve this Recommendation will be:**

| Action Ref. No. | Lead: Exec or Care Group | Action Owner | Description of the Action to be taken | Progress on the Action | Measuring & Monitoring Methodology / Evidence Base / Data Source | Expected Outcome/ Result of Action | Target Completion Date of Action | Target KPI (Where Relevant) | Current KPI Performance (Where Relevant) | Action RAG Status | KPI RAG Status | Risk of Non Delivery |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CCS02.01 | David Wilksinson | Tony Crick | Associate Director of Clinical Professions and Workforce Team to commission a targeted Recruitment campaign for AHPs | Recruitment campaign with Just R.com, has been commissioned and implemented. | AHP Recruitment campaign | AHP Recruitment campaign | 30/11/2019 | N/A | N/A | D | NA | Low |
| CCS02.02 | David Wilksinson | Tony Crick | Deliver increase in AHP Establishment to target levels. | Update September 2020: AHP Establishment now at 403 FTE, Vacancy Rate at -0.8% | ESR | Increase in AHP Establishment | 31/03/2021 | 0% | -0.80% | D | NA | Medium |
| CCS02.03 | David Wilksinson | Tony Crick | Develop and implement new rotations Hospital Sites and Community Services to increase scope for profesional development and cross cover | New rotations have been implemented between CCS and ICCG and this has been identfied as a reason why a new recruit came to FGH to work. | E-Roster | New rotations Hospital Sites and Community Services | 30/11/2019 | N/A | N/A | D | NA | Low |
| CCS02.04 | David Wilksinson | Tony Crick | Development of Paper in relation to the over recruitment of newly qualified Therapy staff. | | | | | N/A | N/A | D | NA | Low |
| CCS02.05 | David Wilksinson | Tony Crick | Draft and present a Business case to Senior Ops Group in relation to addtional Therapy staff required | Paper to be submitted to Senior operational group in January 2020 | Business Case | Paper to be submitted to Senior operational group | 31/01/2020 | N/A | N/A | D | NA | Low |