UHMBFT Annual Operational Plan 2017/19 Appendices

Within the appendices is an overview by section on the key actions that will be taken to support the delivery of the UHMBFT 2017/9 Operational Plan.

Appendix	Section	Updates 2018/19
1	Strategic Risks	New Appendix added
2	UHMBFT Quality Goals	Updated
3	Mortality review Process	New Appendix added
4	South Cumbria Adult Community Services transferred	New Appendix added
5	Approach to Workforce Planning	Removed one CQUIN indicator for H&W as this does not apply. Final Workforce KPI's to be signed off at Workforce Assurance Committee on the 21st May 2018.
6	LIA Schemes for 2016/17 overview	2017/18 LIA scheme evaluation to be completed in Q1 of 2018/19.
7	Procurement Opportunities & adherence to Agency Rules	Removed Appendix 4 as this is included in Annual Plan, 4.1 moved to Appendix 4 and updated.
8	Carter recommendations and implementation plan	Updated
9	Business Case Register 2017/18 Review of 2016/17 Business Cases approved	Updated with Business Case Register for 2017/18 and proposed business cases for 2018/19
10	Divisional and Corporate team business plans 2017/19	Updated with refreshed Business Cases for 2018/19

Appendix 1: Strategic and Corporate Risks 2018/19

University Hospitals of Morecambe Bay NHS Foundation Trust

Strategic and Corporate Risks 2018/19

The Trust Board approve the following as the top 4 Strategic and Corporate Risks for 2018/19 on April 25th 2018.

TOP STRATEGIC AND CORPORATE RISKS FOR 2018/19

Strategic Risks

1. **People Risk:** Ensure the Trust has a motivated and engaged workforce, in sufficient numbers and appropriately trained, to deliver the Trust's vision, values and objectives to be a "great place to be cared for, great place to work".

   Risks being mitigated through:

   - Workforce Plan (sustainable workforce across BHCP footprint)
   - Recruitment & Retention Strategy
   - Educational Governance Framework
   - Role-Specific and Core Skills Learning & Development
   - Towards Inclusion Strategy
   - Listening into Action
   - Embedding Behaviour Standards Framework
   - Employee Health & Wellbeing Plan (Flourish)

2. **Finance Risk:** Deliver the 2018/19 financial plan and continued development of the Sustainability and Transformation Plans to 2020/21.

   Risks being mitigated through:

   - Sustainability Programme and Cost Improvement Plans are in place. Plans to address the financial challenges and risks form part of the Two Year Operational Plan and Divisional Business Plans
   - Additional restrictions on authorised expenditure limits introduced including Agency Staff
   - Contract and commissioning work is ongoing
   - Submission of a Sustainability and Transformation Plan (STP) on a Lancashire and South Cumbria footprint
   - Ongoing negotiations to agree a deliverable Cost Control Total

3. **Urgent Care Performance Risk:** Ensuring the Trust achieves its trajectories on the NHS Constitution Access Standards for Urgent and Emergency Care, Elective Care and Cancer Care.

Risks being mitigated through:

- Improved analysis of cause and effect of patient flow through the whole system with corresponding ED Improvement Plan focussing on Front Door (triage, coordination and mental health)
- In Hospital (SAFER Care Bundle, Ambulatory Care and workforce) and Out of Hospital (DTOC programme) as well as broader admission prevention and avoidance projects.
- A&E taskforce established
- A&E delivery board established enabling system wide involvement and oversight
- Implementation of BCT work programmes, e.g. A&G, PIFU
- Implementation of theatre productivity programme
- Focus on timed pathways for cancer patients, e.g. reducing diagnostic turnaround times

4. **Change and Transition Risk:** Ensure the Trust leads the system change and retains delivery of safe services.

Risks being mitigated through:

- System wide PMO including –
- Project and programme management
- Change Management and Transformation Function,
- Specialist Support e.g. business intelligence, strategic planning
- BHACP Senior Leadership Team Development
- BHACP Assurance and Governance Framework
- UHMB Board and Executive Team Development
- UHMB and Primary Care Interface Programme

Corporate Risks

1. **Robust Sustainable Safe Staffing Levels:** Inability to meet agreed safe staffing levels may lead to poor standards of care, increased complaints, demotivated and fatigued staff and loss of organisational reputation as well as the inability to deliver the Trust's visions, values and objectives to be a "great place to be cared for, great place to work".

Risks being mitigated through:

- Safe staffing levels agreed
- Escalation process in place and clearly understood
- Staffing levels and skill mix monitored 4x a day through safety/flow meetings and staff moved to meet patient need
- National and international recruitment continues in line with recruitment plan
- Return to practice promoted widely with effect
- Modern apprenticeship scheme in place to deliver longer term workforce needs
- New roles and new ways of working considered when redesigning workforce and flow
- Discussions with Health Education England (HEE) regarding training needs and development of future practitioners to work flexibly across community and hospital
- Employment of staff to support skills acquisition e.g. mental health nurse in elderly care.
- Senior support on site at weekends and bank holidays

- Key Performance Indicators in place to support monitoring of quality of patient care/experience and of staff experience
- The Trust has produced a recruitment and retention strategy for the senior medical workforce with an individualised approach for each vacancy. The processes for recruitment are being reviewed to decrease the duration of the process and ensure optimal clinical and executive involvement;
- Overseas recruitment has been successful in a number of specialties and in several professional groups including nursing and consultant roles. Further opportunities are being explored including senior medical recruitment into radiology and paediatrics;
- Different models of care have been implemented in several specialties including radiology and gastroenterology to deliver services with a diversified workforce, for example through the use of nurse endoscopists and advanced nurse practitioners to reduce the impact of national shortages in particular staff groups.

2. **Patient Flow:** Inability to maintain flow through the hospital may result in poor patient experience through delays in the emergency departments and delays in discharge and transfer of care, increased complaints, fatigued staff and poor compliance against the agreed trajectories for the NHS Constitution access standards, particularly in urgent and emergency care and elective care.

   Risks being mitigated through:

   - System resilience delivery plan
   - Implementation of integrated care models through the Better Care Together strategy
   - Deployment of the 90-day improvement programme to reduce discharges and transfers of care
   - Implementation of best practice processes and pathways

3. **Bullying and Harassment:** Inability to provide workplaces free of bullying, harassment and discrimination will lead to a deterioration in employee experience and a subsequent increase in patient quality and safety harms.

   Risks being mitigated through:

   - OD Strategy
   - Policies and procedures
   - Freedom to Speak up Guardian
   - Respect Champions
   - Behavioural Standards Framework
   - Training and development
   - Inclusion and Diversity workstreams

4. **Quality of the environment and fabric of our estate and its implications for patient safety and experience:**

Risks being mitigated through:

- Estate Strategy
- Capital Planning Group
- Assessment and prioritisation s of programmes/projects
- Risk assessments of backlog maintenance
- Capital Expenditure Monitoring Group

The Board Assurance Framework for 2018/19 and the Corporate Risk Register for 2018/19 will be revised to take into account the above.

Appendix 2 Table 1: Quality Goals for 2018/19

Table 1: Priorities for Quality Improvement for 2018-19 detailed in Quality Improvement Strategy and Plan 2016- 2019		
Quality Goal	**Key Priority**	**Measurable Outcome**
Improvement Outcome 1 – Care that is safe		
Reducing Harm	Achieve at least 98% of patients receiving Harm Free Care, consistent across every ward as measured by the Department of Health 'Safety Thermometer Tool' within 5 years.	***Achieve at least 98% Harm Free Care 2017/18 to 2018/19***
	Reduction in variation of observations leading to better outcomes	Embed the National Early Warning Score (NEWS) and monitor through audit tools to achieve 95% standard
Improving Documentation	Delivery of E-Nursing Documentation across all In-Patient Wards	***2017/18 to 2018/19 98% improving documentation. Improvement in e-nursing documentation quality outcomes***
Reducing Avoidable Mortality	Reducing the Summary Hospital-level Mortality Indicator for HSMR & Summary Hospital-level Mortality Indicator (SHMI)	2017-18 to 2018-19 Mortality ratio to be 5-10% better than the national average
		2017/18 to 2018/19 Stroke mortality reduced to 75 or fewer deaths per annum as a result of admissions for stroke as a primary diagnosis
Improvement Outcome 2 – Care that is clinically effective		
Deliver Effective and Reliable Care	Reduce E-coli infection rates in hospital wards.	***25% reduction in hospital E-coli infections against baseline data from 2016/17 by the end of 2018/19*** 2019/20 Target - 50% reduction om hospital *E-coli infections by 2020/21 from the 2016/17 baseline*
	Ward Accreditation scheme	***50% of Inpatient Wards at Exemplar Standard by 2017/18 to 2018/19***
		15% of Outpatients areas to achieve exemplar status by 2017/18 to 2018/19
	Sharing Lessons Learned from Patient Safety Incidents	2017/18 to 2018/19 12 Standard Bulletins and 6 Themed Bulletins per annum

Table 1: Priorities for Quality Improvement for 2018-19 detailed in Quality Improvement Strategy and Plan 2016- 2019		
Quality Goal	**Key Priority**	**Measurable Outcome**
	Safety Incidents	Audit of lessons learned at 6-12 months following publication of themed bulletins to measure lessons being learned
	Commissioning for Quality and Innovation (CQUIN)	Develop and maintain 95% delivery as a minimum for 2018/19
Improvement Outcome 3 – Care that provides a positive experience for patients		
Improvement in Patient Flow and Experience	Reduce Formal Complaints and continue to Improve complaints response timescales and commitment in handling complaints in a sensitive and professional manner from which learning is made and implemented across the divisions	Maintain complaint levels below a ratio of 1 Complaints per 1,000 patient attendances
		100% of complaints acknowledged within 3 days
		95% of complaints to be responded to within 35 days
	Increase the scope and depth of public engagement	6 public engagement events per annum
	Reduce avoidable referrals into hospital through increased uptake in advice and guidance to GPs	***10% reduction in avoidable referrals. This relates to absolute number of admissions avoided through advice and guidance in 2018/19 compared to 2017/18***
	Work with local GP's and community nursing staff to reduce the number of patients who die in hospital against their wishes:	***Quarter 1 and Quarter 2: Develop a dataset to support delivery of an admission reduction of people who have a wish to die in their care home and avoid admission to hospital through targeted support in homes.***
	Work with local nursing homes to reduce the number of patients who die in hospital against their wishes:	***Quarter 3 and Quarter 4: A decrease in the proportion of patients on the End of Life pathway who die in hospital when they expressed a wish to die at home***
	Integration of physical and mental health pathways	7-day CAMHS support for Cumbria and Lancashire North
	Healthcare Communications (was IWGC) embedded in to Consultant experience feedback	***Healthcare Communications embedded in to Consultant experience feedback in 5 specialities***
Improve Staff Experience	Increased voice for staff in how their organisation can be	***Achievement of 60% on key result areas in the better than average/best 20% 2017/18 to 2018/19***

Table 1: Priorities for Quality Improvement for 2018-19 detailed in Quality Improvement Strategy and Plan 2016- 2019		
Quality Goal	**Key Priority**	**Measurable Outcome**
	improved, monitored by the overall staff engagement figure identified in the Staff Survey	

Appendix 3 – Mortality Review Process

UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST

Report on Mortality Review Process across the Trust

Overview

This is a summary of the mortality data for both sites including a review of the data, inferences and action plan. A review of HSMR & SHMI, a narrative on avoidable deaths and plans for improvement of quality of care.

Previously Identified Issues

- The Trust SHMI & HSMI has increased above 100 over the last quarter of 2016-17 and there was with an upward trend over a period of six months. This has improved and monitoring is ongoing.
- Given winter pressure and deployment of new software percentage of mortality reviews conducted at bothsites reamins poor.
- GP and CCG raised concerns about timely acting on results from Radiology and Lab sciences which may have caused increased motality/morbidity, new policy have been implemented.
- There is no clear pathway on how Trust learns from Coroner's report as the learning percolates through individual division.

Progress Achieved

- New software to capture mortality as per national guideline and RCP standard is now in place. Thanks to Governance team and I3.
- The Trust SHMI & HSMI is now improving comapred to last year. We note a small dip in winter months however it is better than national average. have investigated and the potential causes to gain an understanding of the reason for the change in this quality indicator.
- Sickness and busy work pressure on winter months and deployment of new software had an impact on the number of and percentage of mortality reviews conducted at both FGH & RLI in last 3 months compared to previous 3 months and ..
- A mortality lead at FGH still vacant. There has been a backlog developed in both sites because of winter pressure and sickness.
- Medical Director has written to all consultants encouraging them to comntribute to mortality meetings.
- A team including PSU, DMDs I3 and clinical codiung being formed to investigate the reasons the rise of HSMR and SHMI data and the actions taken seems to have an effect on both HSMR and SHMI.
- Dr Bari and PSU have now introduced a new policy to address the concerns raised by the GPs and other clinicians to ensure timely action on results.

- Results action policy has been implemented -http://uhmb/cs/tpdl/Documents/CORP-PROC-060.docx
- DMDs, ACN, CD and Legal team has met to discuss learning from coroners cases and a mapping process of lessons learnt which has been agreed. Dr SB to complete this by end of April 2018
- Linking in with CI system and mortality system by every individual patient achieved.

Summary of Data

Demographic Information

Number of Deaths and age distribution

	Jan 2018			Feb 2018			Mar 2018		
	FGH	**RLI**	**Total**	**FGH**	**RLI**	**Total**	**FGH**	**RLI**	**Total**
Number	50	67	117	34	64	98	35	80	115
Male	24	30	54	17	37	54	11	39	50
Female	26	37	63	17	27	44	24	41	65
Avg. Age	78	80	79	80	81	80	78	79	79
Oldest	97	107	107	98	96	98	100	96	100
Youngest	97	27	27	98	38	38	100	38	31

Speciality:

Speciality	Jan 2018			Feb 2018			Mar 2018		
	FGH	**RLI**	**Total**	**FGH**	**RLI**	**Total**	**FGH**	**RLI**	**Total**
Blank							0	1	1
Medicine	49	56	105	31	55	86	32	72	104
Surgery	1	11	12	3	9	12	3	7	10

ICU included in Surgery *Speciality is derived from the Consultant. Blank refers to cases where the consultant has not been filled in and so the speciality cannot be determined.

Length of Stay:

	Jan 2018		Feb 2018		Mar 2018	
	FGH	**RLI**	**FGH**	**RLI**	**FGH**	**RLI**
Avg. LOS	10	10	12	11	13	12
Max LOS	45	67	60	76	55	92
Min LOS	45	0	60	0	55	0

Mortality Reviews

Number	Jan 2018			Feb 2018			Mar 2018		
Reviewed	**FGH**	**RLI**	**Total**	**FGH**	**RLI**	**Total**	**FGH**	**RLI**	**Total**
Deaths	50	67	117	34	64	98	35	80	115
Reviews	31	17	48	3	35	38	2	59	61
Percentage	62.0%	25.4%	41.0%	8.8%	54.7%	38.8%	5.7%	73.8%	53.0%

NCEPOD Scores:

	Jan 2018		Feb 2018		Mar 2018	
NCEPOD	**FGH**	**RLI**	**FGH**	**RLI**	**FGH**	**RLI**
1	32	15	5	35	2	54
2	0	1	0	0	0	2
3	0	1	0	1	0	2
4	0	0	0	2	0	1
Blank	18	50	29	26	33	20

* Related to community services

** CHOCs related

NYD = not yet discussed which may relate to missing information or awaiting information.

HOGAN Grade:

	Jan 2018		Feb 2018		Mar 2018	
Hogan	FGH	RLI	FGH	RLI	FGH	RLI
1	32	16	5	34	2	54
2	0	1	0	3	0	3
3	0	0	0	1	0	2
Blank					0	1

**Only cases where a Mortality Review has started and the deceased has an admission date are included.*

Blank refers to cases where the Hogan has not yet been filled in.

Review of Changing HSMR and SHMI Trends.

Month	HSMR	SHMI
Oct-16	103.41	114.26
Nov-16	112.17	122.61
Dec-16	95.35	93.39
Jan-17	106.91	123.46
Feb-17	114.5	117.97
Mar-17	87.87	92.0
Apr-17	97.33	101.7
May-17	85.5	87.0
Jun-17	87.1	91.6

Jul-17	63.0	76.2
Aug-17	77.2	75.1
Sep-17	62.0	73.5
Oct-17	91.5	98.4
Nov-17	79.8	88.6
Dec-17	91.4	
Jan-18		
Feb-18		
Mar-18		

This data is independently calculated and not dependant on the Trust Mortality Reviews monthly reports.

Comments Relating to Data and Themes:

- There was a continuous improvement which has seen a dip in last 3 months especially at FGH site. This relates to the lack of a lead at FGH and consultant contribution.

- The data HSMR and SHMI indicates a progress towards the right direction after our intervention however in winter months it dipped, close monitoring continues.

- After introduction of the new software the standardisation of recording and quality has improved and readily available to extract.

- HOGAN and NCEPOD and site based mortality reports now includes lessons learnt and good practices.

- Avoidable deaths – For this quarter the number is 0.

  At our Trust we identify HOGAN 4 and above as aviodable however we capture all other cases and of score 2s and 3s where quality of care could be improved by person or system and feedback to the division. We also request reflections from clinicians or involved appropiate staff for reflection before closing the case or CI.

- We debrief monthly divisional meetings to ffedback and also lessons learnt bulletin as appropriate.

- Examples from last quarter where it was identified that quality of care could be improved and division was informed in senior clinicians meeting.

- Rolling out of Mortality software on both sites by Jan 2018- now achieved

- The Medical Division (in which over 80% of the deaths occur) has been tasked to replicate the post of mortality lead (0.5 session in job plan) that exists at RLI, on the FGH site.
- All permanent staff senior medical staff in the Medical Division have been asked to attend a minimum of two mortality reviews per a year. This participation will be reviewed as part of professional appraisal remains – remains to be achieved August 2018
- Better capture of number of reviews March at RLI, FGH remains low.
- Due to sickness no monthly mortality report published in last 2 months.

Action Plan

Mortality Reviews:

- Annual Report of death- Aim publish in June 2018 –SB
- Develop local coding policy (DMD & MD) to support the above, to cover in for external audit purposes etc. May 2018 - SB
- Mapping of Coroners case, CI and divisional learning SB April 2018
- Remind Medical Division about poor capture at FGH end PG Apr 2018

Appendix 4: South Cumbria Adult Community Services

Services Transferred

Total Staff numbers = 526

- **District Nursing Service**

  District nursing services deliver a wide range of nursing interventions and play a key role in supporting independence. Services are required for many reasons including those who are near the end of their life. Complex care once only delivered in acute settings is now being provided by district nursing teams in collaboration with key partners. Continuity and relational care is the strongest and most consistent theme for staff and patient experiences of District Nursing services.

- **Heart Failure Including Cardiac Rehab**

  Specialist nursing advice, support, and monitoring within bed base and clinic settings. Collaborating with primary and acute care partners to provide comprehensive assessment and care plans for optimising patients pharmacological therapies. To provide rehabilitation and non-pharmacological treatments inclusive of lifestyle advice, psychological support whilst working closely with respiratory and end of life care practitioners as appropriate.

- **Respiratory Including Pulmonary Rehab and Home Oxygen Services**

  Proactive highly specialised care for adults with Respiratory disease including specialist community Clinics, Oxygen at home Therapy support, Post discharge follow up and admission avoidance. Comprehensive pulmonary Rehabilitation Programmes take place twice weekly working very closely with Macmillan and Hospice at Home.

- **Integrated Rapid Response** (Includes Intermediate Care Team and discharge flow coordination)

  Preventing unnecessary acute hospital admission or long term residential care, facilitated hospital discharge and support for people to regain and retain as much independence as possible in order to remain at their home bed base.

- **Community Physiotherapy including Rehabilitation**

  Providing intervention and rehabilitation when injury or ill health occurs whilst promoting independence and supporting those who live with chronic conditions. Physiotherapists play a crucial role in supporting acute partners, occupational and adult social care in supporting people back to work and or independence in order to remain at their home bed base.

- **MSK Physiotherapy**

  MSK Physiotherapy provides comprehensive diagnosis of spinal, upper limb and lower limb musculoskeletal conditions and supports patients to manage their conditions. The Physio service will offer treatment, advice and support for pain relief, improving mobility and the

ability to carry out day to day tasks. Exercises and postural advice are commonly recommended, and other treatments may be offered, such as hands-on mobilization for the joints or muscles.

- **Podiatry** including those under current Service Level Agreements to acute partners in South Cumbria and HMP Haverigg. Generic and specialist care from assessment, diagnosis and treatment, inclusive of surgery, for the prevention of biochemical/MSK conditions, improving mobility and healing whilst reducing amputations.

- **Tissue Viability Nurses**
  Provide expert advice to community nursing, CPFT in-patient units, residential care home staff, patients and carers. Effectively manage patients with highly complex wounds evaluating new products whilst supporting the implementation of evidence-based practice. To provide clinical scrutiny for integrated community equipment stores within pressure relieving equipment.

- **Continence Nursing Team**
  Provide Assessment, Complex catheter management, Containment, Ultrasound and other clinically required treatments. All patients have the right to continence with proper investigation and care: incontinence may be cured, improved but certainly made easier to live with. The primary aim of continence assessment is to promote continence and improve quality of life.

- **Speech and Language Therapists (SALT)**
  Providing evidence based services which anticipate and respond to the needs of individuals to effect optimum development, rehabilitation and or maintenance of skills for the functional needs of the individual.

- **Step Up/Step Down and Community Hospitals**
  Abbey View, Millom and the Langdale wards
  Community/Primary Care Step up-Step down Services and the Community Hospital aim to provide multi-disciplinary approach and intervention for all adults who require 24 hour nursing care and for therapeutic interventions for a short period envisaged as up to 14 days excluding all acutely medically ill patients. Users are regarded as low acuity /sub-acute but need inpatient treatment, nursing/rehabilitation which cannot be provided in their current bed base.

- **PCAS**
  Primary Care Assessment Service (PCAS) located at Westmorland General Hospital, is well-used and an integral part of the urgent care network, open 24 hours a day and seven days a week (11pm – 8am service provided by CHOC and commissioned by CCG) providing urgent care reducing unnecessary A&E visits

- **Better Care Together (BCT) investment posts**
  BCT investment currently offers innovative opportunity into community services developing roles and strategies for integrated patient care within the context of the Integrated Care Community (ICC)

Professional Service Lead

- Currently South Cumbria Community Services benefit from a County Wide Professional Service Lead for Podiatry, Dietetics, Physiotherapy, Occupational Therapy, Speech and Language though all the above are based in North Cumbria. It is an identified requirement in the February paper that this continued support remains as it is integral to ensure community knowledge and expertise is available to staff at a senior clinical level (and for SALT is not available within UHMB).

- **Palliative Care Services**
  The Provision of expert specialist medical and nursing advice to Community Nursing Teams and Community Beds. This service is fundamental in its expertise in the reduction of NELs and reduction of Length of Stay for patients on the End of Life Pathway.

- **Safeguarding team** resource for Adult community services

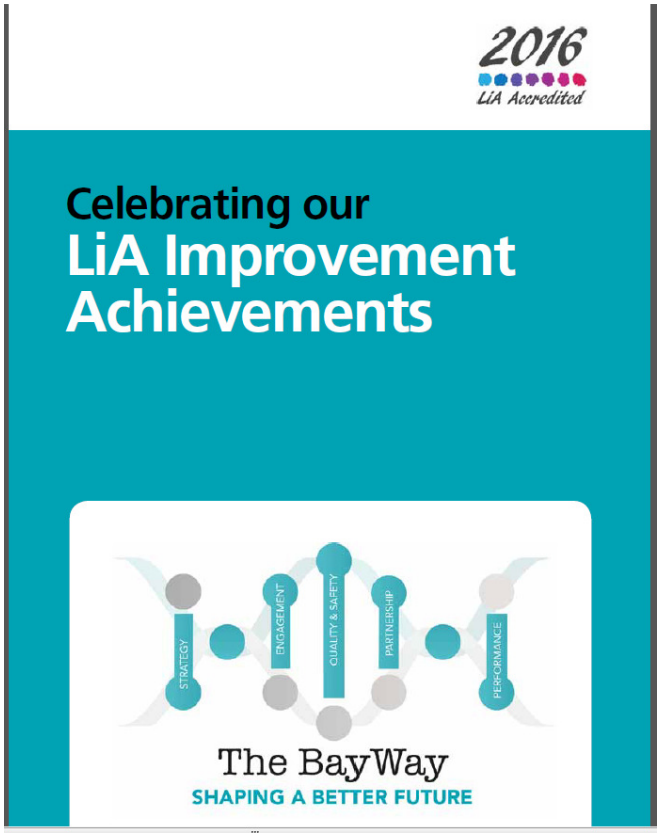
Appendix 5: Workforce and OD priorities for 2017/19

Workforce Efficiency & Performance Metrics

WORKFORCE KPIs 2017-2019				
RECRUIT & RETAIN				
Vacancy Rates	**Target**	**Green Range**	**Amber Range**	**Red Range**
Registered Nursing	3.25% - 5.0%	≤3.3%	>3.4% and <6.5%	>6.5%
Registered midwives	4% - 6%	≤6%	>6.1% and <8%	>8.1%
Consultant Medical Staff	5.0% - 7.5%	≤7.5%	>7.6% and <10.5%	>10.6%
Turnover	8.7%	≤8.7%	>8.8% and <9.5%	>9.6%
Agency Spend Cap	£20.9m	≥£20.9m		≤£20.9m
ENGAGE & INVOLVE				
Staff Survey	**Target**	**Green Range**	**Amber Range**	**Red Range**
Staff Survey	Normal distribution of Key Findings	≥50% above average	>40% and ≤50% above average	<39% above average

HEALTH & WELLBEING				
Attendance Rates	**Target**	**Green Range**	**Amber Range**	**Red Range**
Attendance	95.7 – 96.0%	≥95.7%	>95.6% and <95%	>94.9%
CQUIN Flu Vaccination	75%	≥75%	>74% and ≤64.9%	>64%
GROW & DEVELOP				
	Target	**Green Range**	**Amber Range**	**Red Range**
Appraisal Completion Rate	95%	≥95%	>80% and <94.9%	<79%
Core Skills Framework Compliance Rate	95%	≥95%	>80% and <94.9%	<79%

Appendix 6 - LIA Improvements



LIA Schemes - Waves 5 to 7 - 2016 / 2018

Schemes	Division	Site	Outcomes
Wave 5 Schemes - 2016			
NHS Care Certificate	**HR**	**X bay**	Implementation of Care Certificate at the Trust. Fully supported with robust E Learning package as well as highlighting the need for our CSW workforce to have a much needed Code of Conduct. All employees in bands 1-4 will be provided with a copy once completed, as well as new starters to the organisation.
Empowering Junior Doctors	**Surgery & CC**	**X bay**	Empowered junior doctors who will drive patient safety and timely care on orthopaedic wards at RLI.
Further Improvements to Phlebotomy	**CCS**	**RLI**	Phlebotomist trained and providing cannulation services at RLI
EPAU Pathway	**WACs**	**FGH**	All EPAU patients seen at FGH commenced on the EPR in whichever location they are seen, and any reviews of the patients care will be updated on the EPR.
Standardising ward handovers	**Corporate Nursing**	**X bay**	All wards will be using a standardised handover sheet
Nurse led Obstetric scanning	**WACs**	**RLI**	Review capacity and training needs to provide nurse led obstetric scanning – on going
Infant Feeding Strategy	**WACs**	**X bay**	A comprehensive infant feeding strategy for the antenatal period that reflects the BFI Standards

One stop clinic for Breast Surgery	**CCS**	**RLI**	To improve the quality of referrals and timeliness of patient care in one stop symptomatic service. We aim to see more than 90% of referred patients within 1 week of referral.
Wave 6 schemes – 2016/17			
Clinical Supervision for general nursing staff	**medicine**	**X bay**	Improve staff morale and engagement Improve patient care by action learning Continuous scheme
Resuscitation – Mind the gap	**medicine**	**X bay**	Better communication and understanding of needs of divisions and the service and alignment of training provision and requirements. Achievement of training compliance targets Staff who are trained and informed
Trainee in difficulty	**Surgery & CC**	**FGH**	Improved staff engagement with decreased stress of process Structured processes and support put in place Better communication Better support of the trainee in difficulty
Daily ward rounds checklist / electronic notes	**Surgery & CC**	**X Bay**	Develop a Trust wide clinical note on Lorenzo to build the patients ePR .
Treating nausea and vomiting in pregnancy as day treatment	**WACs**	**RLI**	Utilise day treatment services at RLI, to enhance the wellbeing of ladies experiencing pregnancy and sickness and reduce inpatient stays.
Recruitment	**HR Corporate**	**X bay**	Create a centre of excellence for recruitment which is employee centric which supports clinical leads and managers recruit a safe and sustainable workforce. System, skills, slick… Outcomes include -- 5.4 day reduction from conditional to unconditional offer. 6.4 day reduction from vacancy to conditional offer 3.7 day reduction in time to hire from vacancy authorisation to

			actual/booked start date. Reduce time to hire process TRAC training for managers recruitment focus in divisional teams
Improving patient engagement on the Childrens ward	**WACs**	**RLI**	Really positive engagement through the Big Conversation and links made with the wider health community and 3rd sector to support this work. Some barriers to moving things at pace due to staffing. Use of social media and engaging with families whilst on the unit to improve communications.
Flow across the emergency floor	**ALL**	**RLI**	Team development to support patient flow across the emergency floor at RLI – continuous improvement scheme
evaluate development of Emergency Surgery Ambulatory Care (ESAC) at RLI'	**Surgery & CC**	**RLI**	Matching capacity and demand for patients and staff Development of pathways and accurate recording and patient care Working in partnership with radiology to improve access to scans Involving patients in the co-design of services.
Improve IDS performance paeds	**WACs**	**FGH**	Since February 2017 the ward at FGH have achieved the target of 90% IDS. The paediatric ward at RLI are now achieving 90% most months and there is a definite shift across the wider division in achieving and sustaining this target - of which they have done since January 2018.

Wave 7 schemes –January 2017			
patient not politics	**S&CC**	**X Bay**	Linked to the wave 8 scheme for governance - this scheme has now started to show benefits as it has held its first X Bay governance meeting, presented their work and findings at Critical Care conference, have a X Bay lead for Critical care. The joint meetings will focus on policies, mortality reviews and incidents to ensure promote together. The teams have been really positive about working together moving forward and have effective discussions sharing good practice and lessons learned.
#NOF care **Junior doctor teams in orthopaedics and role of ortho-geriatrician**	**S&CC**	**RLI**	#NoF Pain protocol written Trauma Co-ordinators more involved - up to 48 hours post-op Physio and TC improved working relationships / better communication Fortnightly Trauma meeting reviewing cases and capacity Ortho-geriatrician recruited. Reduced number of CIRs SOP created with instructions for Ward Rounds Junior Doctors feeling more supported
CHC assessment process	**X divisional**	**FGH**	This scheme started initial work and then merged into the wider DTOC and discharge improvement work
meds to beds	**CCS**	**X Bay**	The scheme was rolled out fully in December 2017 and is demonstrating improvements despite significantly reduced staffing and increased demands on the service. Headline Points 69% reduction in overall time taken per order. 62% reduction in CD turn-around time. 66% reduction in In-Pt turnaround time. 58% reduction in TTO turnaround time.

remembrance in safety improvement	**corporate**	**X bay**	Held a very well attended Big Conversation where lots of ideas were shared about how the health community would use remembrance in future safety work. The outputs have been themed and reproduced on a colourful map, which is being used on the sites for discussions with staff and service users.
colour coded beakers / SALT ward 23			The Speech and Language Team (SaLT) have produced clearer guidelines to put behind the patients' beds so that staff can clearly see what stage of diet and fluids the patient is on
Wave 8 schemes – March 2017			
End of Life Communications Diary	**Medicine**	**X bay**	Diary successfully trialled and rolled out onto wards xBay
Standardised Trust Meeting Formats	**X division**	**X bay**	Created two standardised agenda templates fit for all organisational meetings reducing inconsistency and confusion Single point of access for storage of all templates
Exploring diverse recruitment opportunities - people with long term conditions / disabilities	**corporate**	**X bay**	Job descriptions on a page trials. Working with careers and engagement team re work trials. Improving links with 3rd sector organisations. Information sheets - managers / recruitment team
Uniform Governance within ICU cross-bay	**S&CC**	**X Bay**	see wave 7 ICU scheme for update as a continuation of the scheme
Reduction in ED attendances and prolonged admissions for Kendal population identified as severely frail	**BCT**	**X Bay**	Pop-up alert on Lorenzo to highlight GSF patients DNACPR implementation onto whiteboards Education being provided to ED staff on documentation around advance care planning. ED looking at fast tracking patients

			through ED who are on GSF register. Working alongside the frailty team for early identification and rapid discharge.
Ophthalmic outreach nurse to visit inpatients	**S&CC**	**RLI**	Posters created and sent to wards to promote outreach service Teaching packing put together for general nursing staff around eye conditions
Facilities Helpdesk Web Portal	**E&F**	**X bay**	Clinically driven, requests are quick and accurate for service users. Ability to track/investigate clinical incidents and complaints. Porters tasks are allocated appropriately and distributed evenly. Clinical prioritisation of movements of patients. Saving in investment of additional staff. Porter activity is logged and analysed. Link work into training and qualifications. All developed in partnership.
Improving quality of appraisals	**corporate**	**X Bay**	Continued support for all Appraisers Everyone to take responsibility to keep Appraisal live Develop creative training solutions Recognise contributions and give ongoing feedback Regular reviews throughout the year
Safe storage and use of pharmaceutical fridges	**CCS**	**X Bay**	Development of a procedural document to provide more detailed information for ward and department staff to effectively manage their pharmaceutical fridges
Administration of Moviprep for OPD colonoscopy/endoscopy	**Medicine**	**RLI**	Patient pathway redesigned to allow timely collection of Moviprep if referred from OPD or GPs -clear instructions provided alongside appointment details.

Implementation of the Salaso App within the stroke team	**Medicine /CCS**	**RLI**	iPad App for exercises for stroke patients to use throughout their stay in hospital. Currently using on Stroke and rehab word working closely with the designers.
Wound Dressings Furness Area	**BCT**	**Furness area**	All patients who have had dressings done initially in hospital in and out of area would go to dressings clinic for first dressing then triaged to appropriate area for continued care
Improving patient journey with intermittent catheterisation	**S&CC**	**RLI**	A more structured post-TWOC plan from clinicians in IDS, clinic letters and TWOC referrals. Need to further develop the TWOC checklist. Create competency assessment for teaching CISC.
Maternity triage	**WACs**	**X Bay**	Set up a single phone line for patients to be triaged centrally wherever they are across the bay.
Identify opportunity in care planning into ICC's	**BCT**	**X Bay**	Development of a Multiagency working group to include: Community service providers from both counties Representation from Mental Health espcially Dementia Representation from LCC and CCC Adult Social Care UHMB I3
Bank Recruitment modernisation	**Corporate**	**X Bay**	Implemented weekly pay for bank workers. Consistent recruitment approach for Medical and Nursing Students joining the bank. Revised wording of conditional offer of employment letter on TRAC. Set up Bank cohort interviews in line with Trust values & BSF Reviewed Bank Team's presentation after induction and changed welcome pack handout. Created guidance notes for Bank Ward Clerks. Reviewed Bank recruitment adverts

Rainbow clinics	**WACs**	**RLI**	Writing a business case for costing implications for maternity service. Use of the rainbow logo on Lorenzo to highlight previous pregnancy loss in grey colour and then coloured when current pregnancy confirmed.
Paediatric MDT Safety Huddles	**WACS**	**X Bay**	Held daily on the paediatric wards with MDT - currently run on each ward with an update from the other site. The focus of the huddles are - acuity of wards, staffing, patient safety. As a result of this scheme which is part of the National Situational Awareness for Everyone (SAFE) work alongside other improvements, the units have seen a decrease in the number of transfers to tertiary services, reduction in level 2 safety incidents by 24% and level 3 by 69%.
Overseas Visitors	**corporate**	**X bay**	OSV Strategy Upfront charging policy Community Services Further refinement of documentation Maintaining awareness
Wave 9 schemes – July 2017			
Maximising potential in productivity for Ophthalmology - Out Patient and Theatre	**S&CC**	**WGH**	Improved staff engagement enabling increase in patient experience, efficiency and productivity For OPD - improve patient flow and reduce waiting times for patients in clinics on the day due to the review of on the day investigations and patients requiring pupil dilation identified beforehand For Theatre - increase in productivity, at least 6 patients on every list without an anaesthetist and 7 patients for those with

			an anaesthetist or topical anaesthetic Better flow will not only improve the patient experience it will also make it less frustrating for staff who will experience less pressure and have fewer unhappy patients to deal with.
Ophthalmology Journey Booklet	**S&CC**	**X Bay**	To improve a specialised service and try and make Opthalmology not as scary to people with a little bit of information and reassurance. To help improve patients overall experience from referral to meeting the team that will be looking after them and their eyes
Improving Knowledge, Awareness and Clinical Interventions for Time Critical Emergency Procedures	**S&CC**	**FGH**	Redesign of the emergency box for Varices - with clear signing, refresh of content and signage location. Check list complete and awaiting the board for hold the clipboards. Work continues to understand the effect for staff in these changes. Continue through the emergency procedures boards - through using PDSA cycles to check the process and improvement work.
Letters, information and preparation for patients' admissions			Large piece of work scoping the current information sent to patients about their admission and procedures. Started work on standardising information for basic admissions.
Wave 10 schemes –October 2017			
The role of the ANP in UHMB	**Medicine /S&CC**	**X bay**	This scheme has now extended its timeline to align to some wider organisational work looking at roles, responsibility and training for our ANPs, CNS and Aps. Links starting to forge with FY training sessions.
Improving recognition of patients on biologic drugs / biologic related sepsis	**Medicine /CCS**	**X Bay**	Pharm: Drug list compiled, final checks in process to then release onto Intranet. Teaching & Training: Juniors making PPTs to present at May Audit meeting Monday lunch time meeting Early

			May. GP training & adding Biologics to SCR: Will be actioned once drug list compiled and ready to go onto Intranet.
Wave 11 schemes – January 2018			Aims of schemes as still on-going
Ensuring all patients with dysphagia on Ward 23 at the RLI receive the correct consistency diet and fluids to reduce the risk of aspiration, dehydration and malnutrition	**Medicine /community**	**RLI**	Reduction in clinical incidents Improved communication between SLT and nursing staff Improved dysphagia knowledge of nursing staff Improvement in the systems of dysphagia management to reduce the risk of the incorrect consistencies being given Reduce the risk of aspiration pneumonia This scheme is on-going from earlier waves – due to staff sickness
Nutrition in Pregnancy	**WACs**	**X Bay**	The purpose of this project is to develop a pathway for midwives to follow in order to: Provide all women with evidence based information on the benefits of a healthy diet Provide practical advise on how to eat healthily throughout pregnancy Offer appropriate referral when further support is required
Grow your own Band 5 Radiographers	**CCS**	**X Bay**	Successfully develop a business plan for local recruitment specifically trying to retain the 3rd year students we have trained Create links with local university and explore current undergraduate apprenticeships taking place in the Trust such as nursing.
Improve patient experience when visiting the cardiac Catheter Lab	**Medicine**	**WGH**	Improved patient knowledge and satisfaction Using co-designed videos on intranet

Providing care in the best place for Urology One Stop Clinic at RLI	**S&CC**	**RLI**	Improved patient journey Improved staff morale Improved safety for patients More efficient clinic, possible reduction in nursing staff
Virtual CPAP Clinics	**Medicine**	**X bay**	Improve patient experience, able to trouble shoot problems and earlier intervention. Less patient visits. Most of the patients are of working age and find it difficult to get time off work. Also the area UHMBNHST covers means patients can travel up to 2 hours for an appointment. Making it easier for patient to succeed on CPAP. allow CIU to see more patients. With help from Coding and the commissioning group this would allow us to generate the correct tariff and generate income.
Performance assessment and review processes aligned to BSF	**corporate**	**X bay**	An ongoing cultural improvement journey - and building on the good work to date involving the BSF.
Improving Junior Doctors Morale at UHMB	**corporate**	**X bay**	Improve morale amongst Junior Doctors. Make UHMB a great place to train, improve our reputation within the Region and hopefully have less training vacancies.
LiA and Improvement Support			
Supporting improvements for Mental Health services			

Patient Flow from emergency to home – linked to NHS Improvement			
Introduction of Health Advocate Role			
QAAS – shaping the future			
Living our Behavioural Standards Framework			
Quality Improvement training for FY2 doctors		**RLI**	
Support for teams implementing SAFER care bundle			
Stroke pathway redesign			
Patient safety unit – targeted areas for improvement			
Assessment and management of Patient Harms process			
Design and implementation of the improvement approach across Bay Health & Care Partners			

Appendix 7: Agency Use diagnostic and Action Plan Procurement

Area for Review	Comment	Examples of what might need to be reviewed	Current position - key points	What are the safe staffing implications?	What are the cost implications?	Action Required	Lead	Timescale	Priority
Flexible workforce policies, procedures, guidelines	Clear frameworks should be in place to ensure that managers and staff understand how the Trust manages the use of the flexible workforce. What happens when managers do not follow the policies?	Relevant documentation might include: • A booking policy and documentation • Clarity on when it is acceptable to book flexible workers with specific reference to agency workers • A clear authorisation and control structure • Clarity on what happens if the policy and authorisation structures are not followed.	**Agency Staff**: All break glass bookings are approved by Exec Director. A Robust process is in place with thorough documentation to be completed **Nursing**: All nurse rosters are managed via E-Rostering system. Safe Care being rolled out to manage staff resources based on daily acuity reviews. All nursing agency is booked through Retinue with	Robust recruitment activity has improved staffing position, residual vacancy rates for RN 4.7% Midwives 4.6% Consultants 5.8%. Use of Roster Perform reports to understand staffing utilisation and planning. Full use of SafeCare reporting will support better utilisation activity forecasting to flex	software costs to expand e-rostering to AHP software costs for medical job planning and leave management	1. Clear SOP for Bank and Agency use 2. Review process documentation for temporary staff use to clarify when temporary staff can be used and define authorisation process 3. Policy to link to SFI to ensure clarity and accountability to manage temporary staffing 4. Full rollout of Roster perform 5. Develop business case for expansion of E-Rostering to AHP staffing for consideration 6. Develop business case for Medical Job Planning and	1. Procurement 2. Procurement & Workforce 3. Finance Committee 4. Deputy Chief Nurse & Workforce 5. Deputy Chief Nurse & AHP Lead 6. Medical Director & Workforce	1. Completed 2. Completed 3. Completed 4. On-going 5. In progress 6. Business case approved, implementation plan being developed Lead by Medical Director	5. Medium -low 6. Medium - high

			100% framework agency compliance. **AHP/HSS**: Advised of price caps and all break glass to be submitted for approval	staffing levels		Leave Management software for consideration			
Flexible workforce documentation	It should be possible to have a clear audit trail for every booking so they can be scrutinised if necessary. The documentation should include reference to what other options have been considered and the risk of not covering the requirement.	Documentation might include paper or electronic timesheets and/or an authorisation sheet.	100% medical locums & 99% nursing/midwifery agency booked through Retinue which provides a clear audit trail for bookings. Recent work has been completed to clarify booking reasons via Retinue system to give greater transparency. All bookings not managed	Staffing levels improving but where there are gaps there may be insufficient staff in place across 24/7 to provide safe and effective care. Robust reviews of acuity levels via SafeCare need to be BAU to enable flexible movement	Risk of using agency staffing on location where there may be resources available across the wider trust - based on acuity levels.	1. All nurse temporary staff to be managed via Bank Roster and E-Rostering 2. Roll out of Safe Care 3. Develop Business case to expand E-Rostering to AHP staff 4. Develop plan to support implementation electronic system for medical staff job planning, leave management and temporary staff utilisation 5. Review of current medical staff rostering across the Trust,	1. Deputy Chief Nurse & Deputy Director of Workforce 2. Deputy Chief Nurse 3. Deputy Chief Nurse & AHP Lead 4. Medical Director 5. Deputy COO	1. Completed 2. In progress 3. In progress 4. In progress 5. In progress with STP	1. Completed 2. Medium-high 3. Medium-low 4. Medium 5. Medium

			via Retinue are collated and reviewed on a weekly basis. These are AHP/HSS staff group which have not been transitioned onto Retinue	of staffing to manage safe patient care.		including potential for centralisation into a core medical staff Bank function and/or system (linked with Procurement & Workforce)			
Related policies	Effective management of rotas and leave reduce the demand for flexible workers. This is supported by policies usually grouped in patterns of working framework.	Relevant policies might include: • An annual leave policy that includes upper and lower levels of people on leave at any time. • A flexible working policy that balances the priority of safe staffing levels with the work life balance of the workforce.	Policies in place across Trust. Nursing staff - Roster Perform identifies inefficient staff utilisation to enable reviews Medical staff - electronic job planning & leave management system approved in principle to be deployed	insufficient staff in place across 24/7 to provide safe and effective care	additional temporary staff costs ineffective use of current resources	1. Review Rostering policy to ensure clarity and accountability and timescale for roster publication (6-weeks in advance) 2. Review implementation of Trust Annual Leave Policies (Medical and AfC) where inefficient staffing and/or high agency use identified 3. Review Trust Flexible working policy where inefficient staffing and/or high agency use identified 4. Define when temporary staff	1. Deputy Chief Nurse 2. Deputy Chief Nurse & Deputy COO 3. Deputy Chief Nurse, Deputy COO & Deputy Medical Director 4. Procurement & Workforce	1. On-going 2. On-going 3. On-going 4. Completed	1. Medium-High 2. Medium 3. Medium 4. Completed

						may be used and define accountability and escalation processes			
Pay costs	This information is often reported as part of the Finance dashboard and is likely to fluctuate over the year due to seasonal pressures. Understanding the financial breakdown of pay costs will help to identify where actions need to be targeted and also provide a benchmark to measure the effectiveness of any changes.	An annual breakdown on spend by month for: • Substantive staff • Overtime • Additional hours for part-time staff • Bank workers • Agency invoices • Contractor invoices.	Reports to both Workforce Assurance and Finance Committee showing pay spend, agency use and controls Weekly report to Cost Control Board (5 Execs) reviewing pay spend and agency use Executive dashboard developed showing spend, utilisation, compliance with capped rate Fortnightly review with Divisional teams focusing on areas of high spend and plan to	Allows clarify and line of sight on staffing and agency utilisation, helps to identify areas of concern for appropriate interventio n. Key focus on safety and staffing numbers	additional temporary staff costs ineffective use of current resources	1. Continue reporting into the WAC, FC & CCB ensuring congruence of information 2. Agency Use Programme Board to be established to review and undertake a detailed review of high spend areas 3. Link spend reports to establishment, recruitment and attendance rates	1. Workforce , Finance and Procurem ent leads 2. Deputy COO & DGMs/CD s 3. Workforce , Finance and Procurem ent leads	1. On-going 2. Established 3. On-going & developing	1. Medium 2. High 3. Medium - High

			manage mitigate						
Reasons for Booking	There should already be a method for recording the reasons for agency and bank worker bookings. If not one should be implemented. The bookings policy should include when it is appropriate to request additional cover. Consideration should be given to when it is appropriate to book additional workers, is it necessary to use an agency worker, how it is authorised and what processes are in place.	Reasons given may include: • Patient acuity • Transfer of patient • Increased observations • Interpreter. • Annual leave cover • Study leave cover • Increased administrative work • Sickness absence • Vacancy.	Classification for reasons for booking have been further developed and refined to improve clarity, this will allow for review via the Agency Use Programme Board and to cross reference against Workforce statistics.	Risk of using agency staffing where there may be resources available across the wider trust - based on acuity levels.	Additional temporary staff costs ineffective use of current resources. Increased risk of unnecessary demand for agency worker where capacity may be available internally.	1. Booking flow chart and SOP reviewed to clearly defining why shifts can be booked 2. Escalation process to Exec Director for approval for Break Glass rates, setting out reasons and impact of vacancy 3. Review Retinue system to clarify booking reasons detail to improve clarity of reporting 4. Report and review via Agency Use Programme Board reason for temporary staff use	1. Procurement & Workforce 2. Workforce, Finance and Procurement leads 3. Procurement & Workforce 4. Deputy COO	1. Completed 2. Completed 3. Completed 4. On-going	3. High 4. High
WTE Establishment against Flexible workforce WTE	The combined total of agency, bank, additional hours and overtime should not be greater than the combined WTE	WTE with reason given as covering vacancies against establishment vacancy factor. WTE with reason	Total hours established v worked across the established and flexible workforce is not currently	Additional temporary staff costs ineffective use of current resources. Increased	Increased risk of artificially raising demand for temporary workers (and	1. Refine Executive dashboard for reviewing total hours established v worked across the established	1. Procurement & Workforce 2. Agency Use Programme Board	1. Established & On-going 2. On-going	1. High 2. High

	for acceptable reasons for booking covered in the bookings policy. Consideration should also be given to the substantive/budgeted cost and the flexible workforce costs.	given as covering sickness absence against WTE on sickness absence.	consolidated and compared this way. Executive Dashboard developed to understand usage in context of recruitment, attendance and reasons for booking.	risk of unnecessary demand for agency worker where capacity may be available internally	consequentially rates) by not robustly utilising and re-deploying internal resources based on acuity levels	and flexible workforce. 2. Determine what actions would fall out of the review.			
Requested shifts **Filled Shifts** **Unfilled Shifts**	Consideration should be given to who is requesting the shifts and the reasons behind the requests Is it poor management or are there other issues. Ideally there will be a move away from shifts filled by agency workers to those filled by the internal Bank. Consideration should be given to the risk factor associated with unfilled shifts and/or if they are really necessary.	Shifts should be broken down by area and: • Staff group • Grade • Volume	Majority of shifts booked via Retinue system (100% medical and 99% RN/RM). All non-Retinue shifts collated and reviewed on a weekly basis. Roster Perform reports available to understand staff utilisation. Safe Care to further rolled out	Safe Care required to allow for better oversight of resources and activity forecasting to flex RN/RM staffing levels. E Job planning and Leave management for Medical staff to provide clarity and oversight of medical resources.	Additional temporary staff costs ineffective use of current resources. Increased risk of unnecessary demand for agency worker where capacity may be available internally.	1. Complete Safe Care implementation 2. Agency Use Programme Board set up to Check & Challenge utilisation 3. Report areas of high spend into CCB, Divisional Meetings and WAC/FC with specific focus on high spend via AUPB 4. Business case for AHP and Medical systems 5. Report on reasons for vacancy request to identify	1. Deputy Chief Nurse 2. Deputy COO 3. Procurement & Workforce 4. Deputy Chief Nurse & AHP Lead 5. AUPB 6. Procurement, Finance and Workforce Leads	1. Completed 2. Established 3. On-going 4. TBC 5. Established 6. Established	1. Medium - high 2. Medium 0-high 3. High 4. medium -low 5. High 6. High

						weaknesses either across Trust or specific areas 6. Series of Executive Dashboards (inc Financial and Workforce reports) to be further refined			
Bank workforce profile	The profile of the Bank should reflect the requested shifts plus any additional skills and competencies not currently requested because not available. The profile of agency demand should also be taken into consideration. A recruitment plan should be in place that links Bank recruitment to requested shifts with priority given to staff groups/grades that are currently filled with	The Bank profile should be based on demand and broken down by: • Staff group • Grade • Volume	Enhanced Bank service developed and in place, Bank recruitment processes reviewed and enhanced recruitment in place. Professional Nurse Lead for the Bank in post Bank rates have been reviewed to incentivise improved fill rates and training requirements	Improved Bank service enabling higher fill rates.	Reduced agency use	1. Define policy for when Bank and Agency staff can be used 2. Wider use of HBR to manage all agency staff Trust-wide 3. Review of Bank rates 4. Review Trust-wide position on Overtime, Agency and Bank use to drive activity via the Bank	1. Procurement & Workforce 2. Procurement & DGMs 3. Procurement, Finance & Workforce 4. Procurement, Finance & Workforce	1. Completed 2. Completed 3. Three reviews completed – on-going 4. In progress	3. Medium 4. High

	agency workers.								
Agencies	Ideally only a limited number of framework agencies should be used supported by local SLAs. Rates should be agreed and enforced. The quality and performance of agency workers should be recorded and monitored. Substantive staff should be restricted in working back in the Trust via an agency.	How many agencies does the Trust use? What skills do they supply? Are they framework agencies? What are their rates? How is agency workers performance managed? Where procurement involved in negotiating preferential rates?	**Medical Agency Staff:** A league of agencies through Retinue has been created with direct communication ongoing between Trust and agency. Not as mature as the nursing leagues. 100% bookings are made through Retinue with framework compliance. Any rates above £120 per hour are approved by Chief Exec via a robust procedure **Nursing:** 4 nursing leagues created with fixed rates against each agency.	The majority of the agency staff (100% medical 99% RN/RM) are contracted via Framework agencies which provides assurance in terms of meeting NHSI approval standards.	As the majority of the booking are via Retinue there is clarity of understand of spend, all AHP/HSS non-Retinue bookings are reviewed on a weekly basis. Clear reporting on all above cap rates for transparency and assessment.	1. Use of HBR as managed service provider to transfer risk 2. Full roll out and use of HBR to manage all agency use 3. Clear policy and process for all agency usage to be manage via HBR only 4. Review Retinue system to clarify booking reasons detail to improve clarity of reporting 5. Develop relationships with Medical agencies to look specifically at hard to fill specialties and alternative approaches/packages 6. Create a Medical locum ratecard to set a maximum rate by grade and specialty	1. Procurement 2. Procurement 3. Procurement & Workforce 4. Procurement & Workforce 5. Procurement, Workforce, CDs 6. Procurement & Workforce	1. Completed 2. Completed 3. Completed 4. Completed 5. On-going 6. Completed with half-yearly review points	4. High 5. Medium-high

			Regular challenge to bring rates down. All agencies framework compliant and have reduced rates during over the last two years **AHP/HSS:** only a handful of agency vacancies booked directly by division.						
Reporting & Monitoring	Pay spend should be broken down into its component elements and monitored in monthly board reports.	How often does the Board receive a monitoring report? Who else received the report?	Retinue allows detailed reporting to be issued around spend on staff types/grades. New reporting on agency spend includes: Monthly MI dashboard on Retinue spend, weekly tracking of	Greater transparency in pay spend allowing for better planning	Able to use the analysis to identify where using agencies for more expensive night/weekend shift mix, agencies used and rate comparisons Reviewing roster utilisation allows for timely	1. Information reported to AUPB for regular review with divisional leads to support Check & Challenge process 2. Regular reporting of spend and utilisation to CCB, FC, WAC	1. Procurement, Finance & Workforce 2. Procurement, Finance & Workforce	1. On-going 2. On Going	

			agency spend via CCB each week to monitor spend reduction against plan. Agency spend and progress against trajectory reported via AUPB, WAC, FC		interventions in high spend areas Meeting Roster publication requirements (6-weeks) allows for better staffing planning				
Benchmarking	Benchmarking against other similar Trusts will give an insight into the Trusts performance on reducing agency spend. Shared best practice will also help inform strategy.	What rates are other Trusts paying for agency workers? What rates are they paying Bank workers? What is their overall agency spend? What structures and processes do they have in place for booking agency workers?	Regional reviews set up across Cumbria & Lancashire via HR Deputy & Procurement networks	Greater transparency across regional footprint to allow for collaboration	Opportunities for greater sharing of information to better manage rates on a regional footprint	1. Share information with neighbouring Trust to identify spend, fill rate and agency utilisation information	1. Workforce & Procurement	1. Established & on-going	1. Medium

Strategy for reducing agency spend	The Trust should have a Board led strategy for reducing agency spend as part of a sustainable workforce approach. How the flexible workforce will be utilised should form part of an integrated business plan and part of a service line budget. There should be a task and finish group with responsibility for reducing agency spend linked to the strategy or it should be part of the remit of an established committee.	What structures are in place to reduce agency spend?	AUPB set up to review agency use across the Trust, looking at booking reasons, plans to manage reduction in agency use, recruitment plans and associated mitigation. Agency spend and high cost locums reviewed on an individual basis at CCB by Exec team	Opportunity for greater sharing of good practice across divisional teams. Opportunity to maintain consistency in approach to agency use Review of Roster Perform staffing reports to manage and improve roster publication and staffing utilisation	Improved use of internal and Bank resources to reduce agency spend	1. Recruitment strategy and recruitment plans for each hard-to-fill staff group developed 2. Set up AUPB to monitor and review agency use 3. Robust reporting structure to be developed for agency use 4. Report agency use and spend into relevant Cmttees (CCB, FC, WAC) 5. Develop strategies with partner supplier to proactively plan for known future pressures	1. Workforce 2. Procurement, Finance & Workforce 3. Procurement, Finance & Workforce 4. Procurement, Finance & Workforce 5. Procurement	1. Completed 2. Completed 3. Completed 4. On-going 5. Completed	4. Medium-high 5. High

Compliance checks	Framework agencies are audited to ensure compliance checks are in place but Trusts also need to carry out checks when an agency worker arrives on site. These should include proof of identity and professional registration details. A local induction should also take place before the worker starts.	What compliance checks are in place for Bank and agency workers? How are local inductions stored? Is a local checklist available and how is it monitored? If non framework agencies are used how is their compliance monitored?	The Trust has mandated the use of Retinue for Medical Agency locums and Nursing and Midwifery agency to ensure framework compliance. Retinue confirms all compliance checks are in place. HSS/AHP agency staff are sourced through framework compliant agencies.	All agency staff are sourced from framework agencies, ensuring all compliance checks are in place.	The use of Retinue incurs a Managed Service charge. For this fee, Retinue sources agency locums, manages the booking service, completes compliance checks and reports on shifts worked with detailed breakdown of costs to the Trust in a detail that would not be feasible using internal resources (both staffing and systems).	1. Internal processes to ensure compliance with audit of suppliers to be finalised.	1. Procurement & Audit (MiAA)	1. Completed	1. Completed

L&D and appraisal	To ensure quality of care both Bank and agency workers should have completed mandatory training and have regular appraisals. Levels should be monitored in the same way as for substantive staff.	Is there a structure in place for Bank worker appraisal? Are Bank workers allowed to do shifts if their mandatory training is not up to date? How is agency worker training monitored/evaluated?	Review of Bank rates included levy to ensure mandatory training and appraisal compliance. All Bank staff are required to re-validate which will be supported by the Bank Service Professional Lead. Agency worker training is managed by employing agencies and monitored via Retinue.	All staff must have completed mandatory training to ensure patient safety and sustainability	Improved support and training costs for Bank staff likely to be beneficial in reducing agency spend. Regular review points throughout 2016/17& 18 to ensure investment cost effective	1. Develop business case to support on-going Bank Service. 2. Business case for Bank service to include funding for Professional Standards lead. 3. Communicate the new rates and the new rigour introduced around mandatory training 4. Determine the recording methods, review process and sanctions for non compliance	1. Workforce 2. Workforce 3. Workforce, Bank Services Lead, 4. Bank Services lead	1. Completed 2. Completed 3. Completed 4. Completed	3. Medium-High 4. High

Performance management	To achieve a reduction in agency spend a performance management structure needs to be in place. KPI and targets should be identified and reported against. Exception reports should be produced to explain why KPI have not been achieved.	What KPI and targets are in place? What performance management structure is in place for particularly agency spend? What happens if targets are not achieved?	The following reports are produced currently: 1. Weekly Medical locum and Nursing agency spend against NHSI Trajectory plan reviewed via CCB weekly 2. Monthly MI produced by retinue for Medical locum agency and Nursing & Midwifery 3. High spend Medical Agency Locums for each division are reviewed at the AUPB bi-weekly with thorough review of action plans to remove cost 4. Monthly reviews between finance and	Greater transparency of agency use	Management of agency spend against NHSI trajectory	1. Develop process to oversee and manage Frame work compliance, price compliance, quality compliance 2. Review agency usage and rates via Check & Challenge to ensure divisional adherence to set price ranges and framework use via AUPB 3. Create a new dashboard to incorporate KPI's around % of rota lock down 6 weeks in advance; sickness rates; recruitment; agency use spend and reason; % framework compliant; % price cap compliant	1. Procurement 2. Deputy COO AUPB 3. Procurement, Finance & Workforce	1. Completed 2. On-going 3. Established and On-going	2. High 3. High

			budget holders will incorporate a review of agency spend. 5. Reporting of spend against NHSI trajectory to WAC, FC 6. Regular management meetings with Retinue to improve service offer and develop forward planning						
Forward planning Agency use			Developing forecasting models via AUPB for the remainder of the year to understand pressures and achievement of NHSI trajectory. Working with Retinue with develop process to anticipate likely demand during Winter	Improved planning to understand profile for the year to better manage demand	Forward planning likely to result in rates within cap	1. Divisional planning of recruitment, leavers, sickness to plan against each vacancy/absent member of staff to fill/mitigate/return to work to reduce costs.	1. Deputy COO, DGMs	1. on-going	1. High

			Pressures and strategies to meet demand.						

Appendix 8: Carter recommendations relevant to the Trust

	Work stream	Carter recommendations to be delivered by Trust
1	Nurse & care worker productivity	Monthly submission of care hour per patient day data to NHSI (beginning **April 2016),** so that CHPPD becomes the principle measure of nursing and healthcare support worker deployment; with similar approaches in place for medical staff and Allied Health Professionals (AHPs) by **April 2017**
		Note / implement NHSI good practice guidance
		Use e-rostering:
		i. To implement effective approval process by publishing rosters six weeks in advance and reviewing against trust key performance indicators
		ii. To set up a formal process to tackle areas that require improvement, and
		iii. To develop associated cultural change and communication plans.
		Implement guide on enhanced care ('specialling') by **October 2016,** and submit associated returns
		Chief nurse ensures that nurse and healthcare support staff are managed using the recommended e-rostering, 'Enhanced Care' and CHPPD recording and reporting arrangements
2	Clinical productivity	Improve analysis and application of consultant job plans
		Collaboration within and between specialist teams (working in adjacent hospitals} to improve productivity and 7 day working
		Develop medical staff banks to manage vacancies in shortage specialties across a geographical region (principally NW London or regional clinical networks}
		Medical director ensures that each consultant has an up to date accurate job plan
3	AHP productivity	Improve understanding of the configuration of the AHP workforce
4	GIRFT	Respond as required to Dec 2016 publication of NHSI metrics on imaging department productivity (equipment and workforce}

		Respond as appropriate to implement three-year GIRFT project, Right Care and similar NHSI & DH programs
		Respond to roll out of NHSI programmes across clinical specialties
		Submit data to existing national registries and those to be established
		Evidence routine use of comparative data in local dashboards to identify and drive the required changes (14f) Medical director to ensure that the recommendations of the GIRFT report for the hospital are implemented
		Medical director to ensure that the recommendations of the GIRFT report for the hospital are implemented
5	Hospital pharmacy & medicines	Develop local hospital pharmacy transformation plan for board sign off and contribute to NW London HPTP
		Ensure that more than SO% of trusts' pharmacist resource is utilised for direct medicines optimisation activities, medicines governance and safety remits; review options for consolidating local infrastructure services
		Trust Chief Clinical Information Officer (Medical Director) to implement Electronic Prescribing and Medicines Administration systems (EPMA)
		Finance Director, working with their Chief Pharmacist, to ensure accurate coding of medicines, particularly high cost drugs Respond to monthly publication of NHSI list of top 10 medicines with savings opportunities
		Respond as required to support initiatives led by the Commercial Medicines Unit (CMU) in the Department of Health
		Consolidate medicines stock-holding and modernise the supply chain to reduce stock-holding days from 20 to 15 to reduce deliveries to less than 5 per day, and To ensure 90% of orders and invoices are sent and processed electronically.
		Support NHSI initiatives aimed at rationalising and integrating hospital pharmacy procurement and production

		Medical director ensures that the chief pharmacist creates a hospital pharmacy transformation plan (to include medicines optimisation)
6	Pathology	Introduce the Pathology Quality Assurance Dashboard (PQAD) by **July 2016** and demonstrate use for assurance
		Ensure full compliance by April 2017 of Trust recording of NHS pathology tests in line with HSCIC definitions published in
		October 2016 Respond as required to the October 2016 NHSI guidance on collaborative joint ventures and specifying managed equipment service contracts
7	Procurement	Board approval of local procurement transformation plan and implementation (in collaboration where relevant)
		Submit data and demonstrate use of NHSI analysis and benchmarking solution **April 2017,** including the **immediate use of the** purchasing price index) and board reporting on local performance against the PPIB index from **October 2016;**
		Prioritise the role of procurement on ensuring effective system control and compliance, build supply chain capability and work in collaboration both to explore common systems adoption
		Demonstrate use of key procurement metrics for driving compliance to the following targets by September 2017: 80% addressable spend transaction volume on catalogue 90% addressable spend transaction volume with a purchase order, and 90% addressable spend by value under contract.
		Demonstrate collaboration with other trusts on aggregated sourcing to reduce variety, contribute to clinically driven product testing and evaluation and adopt the outcomes of these processes.
		Adopt and promote NHS Standards of Procurement with the support of the new Skills Development Networks (if Level 1, then achieve Level 2 by **October 2018; or** attain Level 1 by **October 2017).** Agree self-improvement plan by **March 2017.**
		Finance directors to ensure use of purchasing price index of 100 products to optimise value in procurement expenditure and work towards achieving the benchmarks of spend against catalogue, under contract and by purchase order by **2018.**
8	Estates & facilities	Put in place a strategic estates and facilities plan, including: short and long term cost reductions based on benchmarks (by April 2017) Investment and reconfiguration plans for the whole estate.
		Invest in energy saving schemes funded through a new Department of Health 'invest to save energy efficiency fund' (from April 2017), or other partners (e.g. Salix)

		Improve data accuracy by improving governance and assurance of the ERIC data; (with Finance Director) ensure financial ledger and ERIC reported costs are aligned by July 2016
		Ensure estates and facilities costs are embedded into patient costing and service line reporting
9	Administration & back office	Test existing services against shared service solutions and deliver any identified savings of 5%
		Submit plan (by **October 2016)** to reduce corporate/administration workforce costs below 7% of income benchmark functions and services using NHSI tools commit to national shared service models where relevant
10	Model hospital	Demonstrate use of NHSI model hospital portal intelligence to adjust practice and clinical pathways to reduce unwarranted variation
		Support the model hospital programme
		Demonstrate the use of NHSI benchmarks and best practice in the hospitals management
		Demonstrate the use of the adjusted treatment cost (ATC) and total cost per weighted average unit (WAU) and wider set of productivity metrics developed by NHSI
		Ensure Trust data is submitted routinely as part of the national mechanism to track total cost per WAU (quarterly) and demonstrate this data's use to achieve productivity gains and to recognise and act on areas of slow progress
		Assure board that Electronic Staff Record (ESR) is reconciled to the financial ledger on a weekly basis (target minimum reconciliation of 95% from **October 2016)**
		Identify preferred comparator organisations for each of the ten specialties and functions that represent the largest potential productivity and efficiency gains
		Ensure consistency in costing and budgeting approaches including a common Chart of Accounts and the use of a standard patient level costing system (PLICS) by **April 2017**
		Chief executives ensure that management information submitted for the Model Hospital and Integrated Performance Framework is robust and reliable

		Chairs and chief executives prepare Boards to use the Model Hospital portal
11	Integrated performance framework	Trust board to **review** the dashboards for three specialties each month (by October 2016), benchmark against established metrics and best practice and track progress Integrated Performance Framework.
		Align the ward-to Board reporting cycle with the NHSI integrated performance framework demonstrating use of the Model Hospital portal consideration of efficiency, productivity and care improvement, and Alignment with commissioner, CQC and regulatory requirements.
		Reduce internal reporting in line with the NHSI ambition to reduce the reporting burden, identify requirements that can be ended and when
		Improve, cleanse and validate data submissions, in particular those that will be used for national benchmarking
		Chief executives ensure that management information submitted for the Model Hospital and Integrated Performance Framework is robust and reliable
		Chairs and chief executives prepare Boards for the introduction of the
		Chief executives introduce lean daily management (LDM)
12	People management & engagement	Implement a clear set of leadership capabilities and demonstrate their use in selection and performance management of leaders
		Regular staff performance reviews engage staff in developing a continuous improvement culture
		Developing management practices to gain a better understanding of the reasons for high levels of staff attrition (1d) Improve sickness absence adopt common definition improve data collection manage as part of the operational scorecard and process
		Chief Executive to personally lead sustained campaign to reduce rates of bullying and harassment

		Creating an environment that is fair and transparent, review polices, practices and agreements to be reviewed to ensure that they are clear, simple and swift to operate
		Mandatory use of Trust and national level succession planning processes, demonstrate use NHS Executive Search to shortlist executive appointments before external recruitment consultancies
		HR director to introduce the 'nine management practices' that strengthen organisational resilience, effectiveness and productivity
		Chair, NEDs, CEO and executives to attend NHSI change implementation mobilisation events in **second quarter of 2016**
13	Delayed transfers of care	Demonstrate that have identified how to best cooperate tactically with local health and social care partners on a daily cycle of early and proactive transfer out of hospital
		Optimise IT system to capture patients' data across a variety of care settings - e.g. acute, community, and care homes
		Identify barriers that prevent patients from being transferred from hospital
		Developing model and guidance on when and how to provide new alternative capacity (such as sub-acute step-down facilities) outside of acute hospitals.
14	Digital & technology	Develop and implement plans for the innovative use of approved system-wide information and communications technologies to support clinical processes and empower patients
		Put in place a fully integrated and utilised systems for the following by October 2018: e-Rostering e-prescribing patient-level costing and accounting e-catalogue and inventory for procurement RFID systems where appropriate, and Electronic health records.
		Meet NHSI standards for 'meaningful use' of such systems
		Pro-actively prepare for outcomes of DH Spending Review of IT investment, e.g. requirements for investment

15	Engagement & influencing	Align with activities of national bodies charged with coordinated and proactive approaches to the supply of staff, including overseas recruitment
		Adhere to agency rules
		Complete STP as per 2016-17 planning guidance
		Support implementation of the New Care Models, Vanguard and Success Regime programmes, and adopt learning from these programmes as they develop.
		Chief executive to identify and prioritise productivity and efficiency opportunities that can be delivered by the Trust on its own and in collaboration and cooperation with others, and to plan their realisation over at least the next three years
		Continue to engage with the Model Hospital (which transfered to NHSI from **July 2016)**
		Engage with the NHSI Analytical Unit developing the Model Hospital as necessary
		Engage with the Professional Leads appointed by NHSI for each component of the Model Hospital and Integrated Performance Framework as necessary
		Engage with the NHSI regional/ national resources to reduce reliance on external consultancy where possible
		Trust Executives and non-executive directors to engage with NHSI to secure 'Analytical, Professional and Engagement' support as necessary
		Participate in NHSI's programme of activities linked to the introduce of the Model Hospital and the Integrated Performance Framework

Appendix 9: Business Case Register

Business Cases Register 2017/18

Ref N0.	Business Case Title	Care Group	Lead person	Stage of process
1	Mole scanning	Medicine	Leanne Cooper	Not being progressed
2	Dermatology private patient development - Part of CIP over 2 years & BCT	Medicine	Leanne Cooper	Not being progressed
3	Fracture Liaison Service	Medicine	Leanne Cooper	Not being progressed
4	7 day CIU	Medicine	Leanne Cooper	Not being progressed
5	Digital dictation	Corporate	Andy Wicks	Moved to next year
6	MS Licenses	Corporate	Andy Wicks	Moved to next year
7	LYNX procedure	Surgery&CriticalCare	Ali Warsi	Development
8	Upper GI Nurse	Surgery&CriticalCare	Ali Warsi	Development
9	Bariatric services	Surgery&CriticalCare	Ali Warsi	Development
10	Hydrotherapy	CoreClinicalServices	Vanessa Chew	Moved to next year
11	McMillan Cancer Information and Support Service	Corporate	Carol Park	Not being progressed
12	AKI/ Sepsis Nurses	Medicine	Mel Woolfall	Approved
13	CNS Head & Neck	Surgery&CriticalCare	Pauline Robinson	Development
14	CNS Breast Surgery	Surgery&CriticalCare	Pauline Robinson	Development
15	Orthopedic LLP	Surgery&CriticalCare	Belinda Pharoah/	Development
16	Radiology Managed Service	CoreClinicalServices	Debbie Crawford	Development
17	Vascular Access/ PICC lines	Surgery&CriticalCare	Kate Boothroyd	Development
18	Anasthetic staffing - RLI (Phase 2)	Surgery&CriticalCare		Approved
19	Stroke Early Supported Discharge service	CoreClinicalServices	Susanna Roberts	Development
20	ERCP to radiology	Medicine	Leanne Cooper	Being Revised
21	DEXA replacement (no capital funding marked as high priority)	Medicine	Leanne Cooper	Approval process
22	Oncology psychologist	Medicine	Richard Vallely	Development
23	Pathology collaborative	CoreClinicalServices	Nigel Nelson	Development
24	Whitegate Drive - Breast screening	CoreClinicalServices	Anne Boyle	Moved to next year

25	**Female Over Active Bladder (continence pathway)**	CoreClinicalServices	suzanne Willacy	**Development**
26	**Additional Quality Staffing ISO 15189**	CoreClinicalServices	Nigel Nelson	**Development**
27	**Contract for radiology IT system**	CoreClinicalServices	Debbie Crawford	**Development**
28	**Recruitment Strategy - radiographers**	CoreClinicalServices	Debbie Crawford	**Development**
29	**Medicines administration programme**	CoreClinicalServices	Vicky Rose	**Development**
30	**Security series - Provisional**	Corporate Health and Safety	Anna Smith	**Not being progressed**
31	**new prostate procedure**	Surgery&CriticalCare	Belinda Pharoah	**Moved to next year**
32	**POA – Capacity and Demand.**	Surgery&CriticalCare	Sue Howard	**Moved to next year**
33	**Breast Surgery Consultant**	Surgery&CriticalCare	Rishi Parmeshwar	**Development**
34	**Endoscopy - Activity Switch**	Medicine	Leanne Cooper	**Approved**
35	**Home Oxygen service**	Medicine	Suzanne Lofthouse	**Moved to next year**
36	**Ipads for electronic Medusa Guide**	CoreClinicalServices	Carrie Eddie	**Not being progressed**
37	**dietetic input to paed diabetes**	WACS	Tessa Shanahan	**Moved to next year**
38	**Rainbow Clinic**	WACS	Celia Sykes	**Development**
39	**Essex Sexual Health**	CoreClinicalServices	Tony Crick	**Approved**
40	**Frequent Flyer - Heat Team RLI**	Medicine	Leanne Cooper	**Not being progressed**
41	**Bedwatch**	Medicine	Leanne Cooper	**Being Revised**
42	**Pre-poured Media Plates**	CoreClinicalServices	Nigel Nelson	**Development**
43	**Pathology IT System - Technidata V12 upgrade**	CoreClinicalServices	Nigel Nelson	**Development**
44	**Liaison Analyser Upgrade - to include Fecal Calprotectin**	CoreClinicalServices	Nigel Nelson	**Development**
45	**Repatration of Microbiology Tests/Samples to UHMB**	CoreClinicalServices	Nigel Nelson	**Development**
46	**Biofire Extension 17/18**	CoreClinicalServices	Nigel Nelson	**Development**
47	**Fit and bowel cancer screening**	CoreClinicalServices	Nigel Nelson	**Development**
48	**Provision of Physiotherapy to ICU's to meet the National Standards**	CoreClinicalServices	Tony Crick	**Development**
49	**Expansion of Virology repertoire to include confirmatory testing**	CoreClinicalServices	Nigel Nelson	**Development**
50	**Expansion of Immunology Screening Reportoire**	CoreClinicalServices	Nigel Nelson (JE)	**Development**
51	**Biochemistry Specialist Service Review - including referred tests.**	CoreClinicalServices	Nigel Nelson	**Not being progressed**
52	**Anticoagulanty Therapy Assistant**	CoreClinicalServices	Nigel Nelson	**Development**
53	**Radiology Information System (RIS System)**	CoreClinicalServices	Debbie Crawford	**Development**

54	**Medicines Administration Programme (MAP)**	CoreClinicalServices	Jo Knight	**Development**
55	**Exogen Therapy**	Surgery&CriticalCare	David Knowles	**Moved to next year**
56	**Car Park**	Estates and facilities	Tristram Reynolds	**Development**
57	**Internal Bank Rates**	Corporate Governance	Gertie Nicphilibs	**Development**
58	**Paediatric Opthamology**	Surgery&CriticalCare	Sam Riding	**Moved to next year**
59	**Organisational Leadership of Community Services**	Corporate	Karen Kyle	**Approval process**
60	**CHC healthcare**	Corporate	Kate Maynard	**Approved**
61	**Additional Hours for Freedom to Speak up Officer**	Corporate	Heather	Approved
62	**Cynergin**	Estates and facilities	Tristram Reynolds	**Approved**

Proposed Business Cases 2018/19

Ref N0.	Business Case Title	Care Group	Lead person	Stage of process
1	**Molecular Diagnostics service**	CoreClinicalServices	Nigel Nelson	**Development**
2	**Frequent Flyer - Heat Team FGH**	Medicine	Leanne Cooper	**Development**
3	**CBCT Scanner**	Surgery&CriticalCare	Vicky Hadden	**Development**
4	**Surgical Care Practitioners**	Surgery&CriticalCare	Carol Hillman	**Development**
5	**Dietetic input to paed diabetes**	WACS	Tessa Shanahan	**Development**
6	**Whitegate Drive - Breast screening**	CoreClinicalServices		**Approval process**
7	**Hydrotherapy**	CoreClinicalServices	Vanessa Chew	**Development**
8	**Digital dictation**	Corporate	Andy Wicks/	**Development**
9	**MS Licenses**	Corporate	Andy Wicks	**Development**
10	**Digital Dentistry CAD CAM Technology.**	Surgery&CriticalCare	Paul Mallet	**Development**
11	**Paediatric Optomotery**	Surgery&CriticalCare	Paula Harman	**Development**
12	**Home Oxygen service**	Medicine	Suzanne	**Development**
13	**Exogen Therapy**	Surgery&CriticalCare	David Knowles	**Moved to next year**

Appendix 10: Care Group and Corporate Business Plans 2017/19

Refresh for 2018/19

Outlined below are all the Care Group and Corporate teams refreshed business plans in the order detailed below. Separate word versions of each of the Business Plans below are available on request.

Division/ Team	Business Plan
Medicine	Medicine Business Plan 2017-2019 FINA Medicine Care Group Income and Activity F
Surgery and Critical Care	Refresh Divisional Business Plan SCC 17 Surgery Care Group Income and Activity F
Women's and Children	WACS_BusinessPlan 20172019 refreshed. WACS Care Group Income and Actvivity
Core Clinical	2018-19 Business Plan CCS 2018 02 16 CCS Care Group Income and Activity F
Workforce and Organisational Development	Workforce and OD Business Plan 2018 -
Corporate Nursing	Corporate Nursing Business Plan 2017-1 The 2017/19 Business Plan is currently in the process of being updated.
Governance	Governance Business Plan 2017-19 REFRES
Operational Performance	Business Plan 2018-2020- Operatio
I3	FY1819 Revision to I3 BusinessPlan 2017
Strategy and Business Development Team	SBDT Business Plan 2017-19 Refresh.doc
Community Services	Community 20170703 2017-18 bu Community 20170703 2017-18 bu

	Community CHCG Strategic Plan Final D As part of the Integration of Community Services the final plan is to be developed in year, in line with the transition of Blackpool Community Services.
Procurement	Procurement BusinessPlan fy18-19 Procurement 2yr plan CIP (Feb 18).xls
Estates	EstatesFacilities Business Plan 2017-1 The 2017/19 Business Plan is currently in the process of being updated.
Finance	Business Plan to be finalised in year.
Communications	Corporate Communications Busir
Cancer Team	Plan to be produced in 2018/19
Research and Development	BusinessPlan201_19 _Research and Devel Draft Business Plan to be finalised in year.