<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword from Chief Executive</td>
<td>3</td>
</tr>
<tr>
<td><strong>Section 1:</strong> Hospital Inspection Ratings</td>
<td>4</td>
</tr>
<tr>
<td><strong>Section 2:</strong> Areas for improvement</td>
<td>5</td>
</tr>
<tr>
<td><strong>Section 3:</strong> Actions the Trust “MUST” take to improve</td>
<td>6</td>
</tr>
<tr>
<td><strong>Section 4:</strong> Actions the Trust “SHOULD” take to improve</td>
<td>16</td>
</tr>
<tr>
<td><strong>Section 5:</strong> Evidence of Performance and Quality Assurance</td>
<td>20</td>
</tr>
<tr>
<td><strong>Section 5a:</strong> “MUST” actions for improvement</td>
<td>21</td>
</tr>
<tr>
<td><strong>Section 5b:</strong> “SHOULD” actions for improvement</td>
<td>26</td>
</tr>
</tbody>
</table>
Foreword from Chief Executive

Thank you for taking the time to read our CQC Improvement Plan. This plan details how we will successfully address the ‘must do’ and ‘should do’ actions identified by the CQC following their recent inspection of our hospitals.

We have already begun to establish an overarching Quality Improvement Plan which has been designed to deliver the longer term quality improvements needed over the next three years, the CQC Improvement Plan will form part of it in year one - this is really important, as I don’t want this action plan to be seen a tick box exercise. I want to ensure that together with the support of our partners, our doctors, nurses and managers are able to make changes that can be sustained well beyond a year and deliver real and meaningful improvements for the benefit of everyone who uses our hospitals.

To support the CQC Improvement Plan, we have created an Improvement Board, who over the next year will have the responsibility of overseeing and contributing to progress and will report directly to our Trust Board. This has been designed to be a very inclusive process and we have asked many of our partners such as the Clinical Commissioning Groups, NHS England, the patients champion Healthwatch and local authorities to be part of the Improvement Board.

The CQC Improvement Plan is time limited, it has to be, as we need to deliver the improvements at a greater pace and before our next Inspection. To ensure the improvements can be sustained and to tackle some of the some long standing issues such as culture, we will also be establishing an Improvement Academy within our Trust. The Improvement Academy will provide support and assistance to our staff, helping them to fully understand what ‘good’ and ‘outstanding’ looks like and providing them with the tools to achieve it. The Academy approach will assist with using tried and tested techniques for delivering consistent change.

I believe it is essential that we continue to communicate and keep everyone updated on our progress. Each month we will publish on our website a copy of the action plan and a summary of the improvements, we will also ensure we write to all of our staff, governors, volunteers and other stakeholders to make them aware.

Thank you for the continued support of our Trust.

Jackie Daniel
Chief Executive
As part of the Hospital Inspection, the Care Quality Commission looks at the quality and safety of the care provided based on the things that matter to people. They look at whether the service is:

- safe
- effective
- caring
- responsive to people’s needs
- well-led

Following the inspection of our three main hospitals, the Care Quality Commission published a report and ratings for each hospital inspected, as well as an overall Trust level rating:

### Section 1: Hospital Inspection Ratings

<table>
<thead>
<tr>
<th>Care Quality Commission Overall ratings for the Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall rating for UHMBT</td>
</tr>
<tr>
<td>Are acute services at this trust safe?</td>
</tr>
<tr>
<td>Are acute services at this trust effective?</td>
</tr>
<tr>
<td>Are acute services at this trust caring?</td>
</tr>
<tr>
<td>Are acute services at this trust responsive?</td>
</tr>
<tr>
<td>Are acute services at this trust well-led?</td>
</tr>
</tbody>
</table>

### Care Quality Commission Overall ratings for the three hospitals

<table>
<thead>
<tr>
<th>Royal Lancaster Infirmary Hospital</th>
<th>Requires improvement</th>
<th>●</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westmorland General Hospital</td>
<td>Good</td>
<td>●</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>Requires improvement</td>
<td>●</td>
</tr>
</tbody>
</table>
Section 2: Areas for improvement

As part of the findings from the inspection of our hospitals, the Care Quality Commission produced a list of recommendations. These recommendations are grouped into actions that the Trust must take to improve, and those that it should take to improve.

Action the hospital MUST take to improve

- The hospital must ensure staffing levels and skill mix in all clinical areas are appropriate for the level of care provided.
- The hospital must continue to actively recruit medical and specialist staff in areas where there are identified shortfalls.
- The hospital must improve the nurse record keeping on the medical wards.
- The Trust must improve its incident reporting. All staff must be aware of their responsibilities to both report incidents and implement remedial action and learning as a result.
- The hospital must ensure that appropriate action is taken in response to audits where poor practice is identified.
- The hospital must ensure that accurate and timely performance information is used to monitor and improve performance in all clinical areas.
- The hospital must ensure the timely availability of case notes and test results in outpatients department across the Trust.
- The hospital must ensure that its performance information is consistently and systematically collected and collated in order to support service improvement.

Action the hospital SHOULD take to improve

- The hospital should review the numbers of elective caesarean sections carried out in the maternity services.
- The hospital should review its staffing investment to ensure that the allied health professional workforce is developed at the same pace as the nursing and medical workforce to meet the growing demand for services.
- The hospital should consider its investment into diagnostic and imaging services to respond to increased demand.
- The hospital should improve communication with staff on the wards.
- The hospital should review its facilities and equipment in A&E so that patients who are subject to delayed transfer do not receive sub-optimal care.
- The hospital should review the opportunities to engage the workforce in the ‘better care together’ initiative so staff are aware of the future of the services they work in.
- The hospital should review the services provided by the chaplaincy at RLI so that patient’s spiritual needs are better met.
Section 3: Actions the Trust **MUST** take to improve

Section 3 contains a list of the key actions to address the actions the Trust MUST take to improve. It also shows the priority for each action, how each action is being monitored, summary of progress, completion date and status.

The progress status of each action is indicated by a coloured code, as shown in the key below:

<table>
<thead>
<tr>
<th>Milestone rating Key:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Completion Status</strong></td>
</tr>
<tr>
<td>Delivered</td>
</tr>
<tr>
<td>On track to deliver</td>
</tr>
<tr>
<td>Some issues – narrative disclosure</td>
</tr>
<tr>
<td>Not on track to deliver</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action Plan Key:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desired Outcome/Success Criteria:</td>
</tr>
<tr>
<td>Key Actions:</td>
</tr>
</tbody>
</table>

**Assurance Committees**

The Sub-Board Assurance Committees of the Trust consist of the Finance Committee, Quality Committee and Workforce Committee. These assurance committees will be the key vehicle for scrutiny and challenge and will seek assurance that the relevant actions with the CQC Improvement Plan have been implemented before approving submission to the Improvement Board.
### Actions the Trust MUST take to improve – Mission Critical Key Actions

#### Staffing Levels and Skill Mix

<table>
<thead>
<tr>
<th>No</th>
<th>Key Actions to address Areas for Improvement</th>
<th>Risk H/M/L</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating Progress</th>
</tr>
</thead>
</table>
| **1** | Introduction of the concept of red rules for nurse staffing (numbers/skill mix). | L         | 31.12.2013          | Executive Chief Nurse | Workforce Committee | • Red rules were introduced for workforce planning in December 2013 for general inpatient wards. A review will take place for these to be implemented  
• Board paper being prepared around investment priorities and risk mitigation.  
• Baseline staffing review undertaken and presented to the Board on the 29 January 2014 | 31.12.2013 | Delivered |
| **2** | Undertake baseline nursing staffing review. | L         | 31.01.2014          | Executive Chief Nurse | Workforce Committee | • A&E staffing review at FGH using the Best acuity tool completed.  
• A&E staffing review at RLI using the Best acuity tool to be completed by 31st October 2014 | 31.10.2014 | Delivered |
| **3** | Undertake A&E staffing review using the best acuity tool. | L         | 31.01.2014          | Executive Chief Nurse | Workforce Committee | • Paediatric acuity review using the HURST tool undertaken in June 2013. Informed business case developed and presented to Executive Management Team in January 2014.  
• Paediatric business case approved at the Executive Directors Group meeting held on 18 February 2014  
• Recruitment event held in May 2014.  
• Initial EWTD audit completed and reported to HR Team meeting in March 2014  
• Schedule of 6-monthly monitoring, to report to Workforce Assurance Committee | 30.06.2014 | Delivered |
| **4** | Undertake Children and young people acuity review using the Hurst Patient Dependency and Bed Occupancy tool. | L         | 18.02.2014          | Executive Chief Nurse | Workforce Committee | • Maternity staffing review using birth rate daily acuity tool is undertaken on a daily basis. The birth-rate plus tool is based on the different categories of women in the unit and on the delivery suites at the time of assessments  
• Recruitment approved for community midwives by the Executive Directors Group meeting held on 20 May 2014.  
• Recruitment event held in June 2014 successfully recruited and awaiting for staff to commence | 30.06.2014 | Delivered |

**Desired Outcome/Success Criteria:**

- **Month on month improvement to achieve Trust compliance with planned staffing establishment and skill mix utilising agency where necessary.**
- **Nurse Staffing Recruitment**
- Month on month improvement to achieve compliance with planned staffing establishment utilising agency where necessary. Compliance should not fall below 90% (10% variance) of planned staffing.
- The key actions to achieve this outcome will be to:

#### Story behind the Recommendation

Ensure staffing levels and skill mix in all clinical areas are appropriate for the level of care provided.

#### Risk H/M/L

- H: High
- M: Medium
- L: Low

#### Date for completion

- 31.12.2013
- 31.01.2014
- 31.02.2014

### What good looks like

Safe staffing levels are appropriate for the level of care provided and demonstrated by compliance with planned staffing establishment. We will use established acuity tools where available, linked to professional judgement, clinical outcomes and patient experience to inform appropriate staffing levels and skill mix across the Trust. Exceptions will be reported to the appropriate assurance committee/ to the board along with mitigating actions to address shortfalls. The risk register will reflect the risks associated with staffing levels.

#### Desired Outcome/Success Criteria:

- Month on month improvement to achieve Trust compliance with planned staffing establishment and skill mix utilising agency where necessary.
- Nurse Staffing Recruitment
- Month on month improvement to achieve compliance with planned staffing establishment utilising agency where necessary. Compliance should not fall below 90% (10% variance) of planned staffing.
- The key actions to achieve this outcome will be to:

1. **Introduction of the concept of red rules for nurse staffing (numbers/skill mix).**
   - **Risk:** L
   - **Date:** 31.12.2013
   - **Person Responsible:** Executive Chief Nurse
   - **Monitoring Assurance Committee:** Workforce Committee
   - **Progress:** Red rules were introduced for workforce planning in December 2013 for general inpatient wards. A review will take place for these to be implemented. Board paper being prepared around investment priorities and risk mitigation. Baseline staffing review undertaken and presented to the Board on the 29 January 2014
   - **RAG Rating:** Delivered

2. **Undertake baseline nursing staffing review.**
   - **Risk:** L
   - **Date:** 31.01.2014
   - **Person Responsible:** Executive Chief Nurse
   - **Monitoring Assurance Committee:** Workforce Committee
   - **Progress:** A&E staffing review at FGH using the Best acuity tool completed. A&E staffing review at RLI using the Best acuity tool to be completed by 31st October 2014
   - **RAG Rating:** Delivered

3. **Undertake A&E staffing review using the best acuity tool.**
   - **Risk:** L
   - **Date:** 31.01.2014
   - **Person Responsible:** Executive Chief Nurse
   - **Monitoring Assurance Committee:** Workforce Committee
   - **Progress:** Paediatric acuity review using the HURST tool undertaken in June 2013. Informed business case developed and presented to Executive Management Team in January 2014. Paediatric business case approved at the Executive Directors Group meeting held on 18 February 2014. Recruitment event held in May 2014. Initial EWTD audit completed and reported to HR Team meeting in March 2014. Schedule of 6-monthly monitoring, to report to Workforce Assurance Committee
   - **RAG Rating:** Delivered

4. **Undertake Children and young people acuity review using the Hurst Patient Dependency and Bed Occupancy tool.**
   - **Risk:** L
   - **Date:** 18.02.2014
   - **Person Responsible:** Executive Chief Nurse
   - **Monitoring Assurance Committee:** Workforce Committee
   - **Progress:** Maternity staffing review using birth rate daily acuity tool is undertaken on a daily basis. The birth-rate plus tool is based on the different categories of women in the unit and on the delivery suites at the time of assessments. Recruitment approved for community midwives by the Executive Directors Group meeting held on 20 May 2014. Recruitment event held in June 2014 successfully recruited and awaiting for staff to commence
   - **RAG Rating:** Delivered

5. **Regular EWTD monitoring in place to ensure safe systems of work and to protect employee health and wellbeing and report 6 monthly to Workforce Committee.**
   - **Risk:** L
   - **Date:** 31.03.2014
   - **Person Responsible:** Director of Workforce & OD
   - **Monitoring Assurance Committee:** Workforce Committee
   - **Progress:** Initial EWTD audit completed and reported to HR Team meeting in March 2014. Schedule of 6-monthly monitoring, to report to Workforce Assurance Committee
   - **RAG Rating:** Delivered

6. **Undertake Maternity Staffing review using birth rate daily acuity tool.**
   - **Risk:** L
   - **Date:** 31.04.2014
   - **Person Responsible:** Executive Chief Nurse
   - **Monitoring Assurance Committee:** Workforce Committee
   - **Progress:** Maternity staffing review using birth rate daily acuity tool is undertaken on a daily basis. The birth-rate plus tool is based on the different categories of women in the unit and on the delivery suites at the time of assessments. Recruitment approved for community midwives by the Executive Directors Group meeting held on 20 May 2014. Recruitment event held in June 2014 successfully recruited and awaiting for staff to commence
   - **RAG Rating:** Delivered
<table>
<thead>
<tr>
<th>No</th>
<th>Key Actions to address Areas for Improvement</th>
<th>Risk H/M/L</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Monitor planned versus actual staffing and report nationally.</td>
<td>L</td>
<td>31.05.2014</td>
<td>Executive Chief Nurse</td>
<td>Workforce Committee</td>
<td>• Hard Truths data captured and reported to the Executive Directors meeting held on 10th June 2014. • To continue monthly reporting.</td>
<td>10.06.2014</td>
<td>Delivered</td>
</tr>
<tr>
<td>8</td>
<td>Actively recruit to vacancies. Aim for vacancy rate less than UK /Regional average.</td>
<td>L</td>
<td>30.06.2014</td>
<td>Executive Chief Nurse</td>
<td>Workforce Committee</td>
<td>• Recruitment commenced 2013 and current vacancy level in June 2014 was below national and regional average • Ward budgets for 2014/15 signed off with ward managers in June 2014.</td>
<td>30.06.2014</td>
<td>Delivered</td>
</tr>
<tr>
<td>9</td>
<td>All budgets to be set, agreed and signed off between ward managers/assistant chief nurses and finance.</td>
<td>L</td>
<td>30.06.2014</td>
<td>Executive Chief Nurse</td>
<td>Workforce Committee</td>
<td>• Recruitment commenced 2013 and current vacancy level in June 2014 was below national and regional average • Ward budgets for 2014/15 signed off with ward managers in June 2014.</td>
<td>30.06.2014</td>
<td>Delivered</td>
</tr>
<tr>
<td>10</td>
<td>Implement the findings and recommendations of the Nursing and skill mix review by 31.03.2014 utilising, if required, appropriate temporary staffing solutions to mitigate any risks identified whilst permanent solutions are implemented.</td>
<td>L</td>
<td>30.06.2014</td>
<td>Executive Chief Nurse / Director of Workforce and OD</td>
<td>Workforce Committee</td>
<td>• Monthly staffing exception reports to the Board of Directors. • Link to open and honest (commenced 28 May 2014) and Hard Truths (commenced June 2014) public reports.</td>
<td>30.6.2014</td>
<td>Delivered</td>
</tr>
<tr>
<td>11</td>
<td>Weekly monitoring of actual and planned nurse and health care assistant staffing levels. Openly publish planned versus actual staffing levels on our website monthly in line with the open and transparent ethos of the ‘Hard Truths’ requirements.</td>
<td>L</td>
<td>30.06.2014</td>
<td>Executive Chief Nurse / Director of Workforce and OD</td>
<td>Workforce Committee</td>
<td>• Hard Truths data demonstrates actual and planned nurse and health care support worker staffing levels and reported to the Executive Directors meeting held on 10th June 2014. • Hard Truths data to be published on the Trust’s website and nationally through NHS Choices from 24 June 2014</td>
<td>24.06.2014</td>
<td>Delivered</td>
</tr>
<tr>
<td>12</td>
<td>Review Trust approach to contingent (temporary) staffing and ensure that robust arrangements are in place for the supply, and monitoring, of temporary staff as agreed by the Boards.</td>
<td>M</td>
<td>30.09.2014</td>
<td>Director of Workforce &amp; OD</td>
<td>Workforce Committee</td>
<td>• HB Retinue retained for supply of medical locums with regular performance monitoring • Proposal being developed for use of NHS Professionals for supply of nursing and AHP staff</td>
<td>On track</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>KPIs to monitor the use of bank, agency and locum staff in place and monitored through the Workforce Assurance Committee.</td>
<td>M</td>
<td>31.10.2014</td>
<td>Director of Workforce and OD</td>
<td>Workforce Committee</td>
<td>• Workforce KPI Performance Report presented to the Workforce Assurance Committee in July 2014. Bank, agency and locum usage KPIs included on Business Intelligence Workforce Dashboard. • Latest review undertaken with ward managers and Assistant Chief Nurses in June 2014. • Next review due December 2014. • Paper to Board describing any gaps in meeting recommended staffing numbers and skill mix January 2015.</td>
<td>On track</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Full review of establishments to ensure funded establishment meet patient needs (link to red rules/acuity/outcomes).</td>
<td>M</td>
<td>31.12.2015</td>
<td>Executive Chief Nurse</td>
<td>Workforce Committee</td>
<td>• Latest review undertaken with ward managers and Assistant Chief Nurses in June 2014. • Next review due December 2014. • Paper to Board describing any gaps in meeting recommended staffing numbers and skill mix January 2015.</td>
<td>On track</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Set updated staffing levels through a comprehensive Nursing skill mix review using the Safer Nursing Care Acuity Tool on all adult inpatient wards (Milestones to achieve monitored through KPI’s).</td>
<td>M</td>
<td>31.03.2015</td>
<td>Executive Chief Nurse</td>
<td>Workforce Committee</td>
<td>• Safer Nursing Care Acuity Tool introduced in December 2013 and used in circa 20% coverage across general wards. • Plan for roll out in place. Completion expected 31.03.15. • IT solution to be explored which would support roll-out by December 2014</td>
<td>On track</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Key Actions to address Areas for Improvement</td>
<td>Risk</td>
<td>Date for completion</td>
<td>Person Responsible</td>
<td>Monitoring Assurance Committee</td>
<td>Progress (February 2014 – June 2014)</td>
<td>Date Completed</td>
<td>RAG Rating Progress</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------------------</td>
<td>------</td>
<td>---------------------</td>
<td>--------------------</td>
<td>--------------------------------</td>
<td>-------------------------------------</td>
<td>----------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>16</td>
<td>To continue to recruit to achieve planned staffing establishment by the implementation of our Recruitment and Retention Strategy to ensure that appropriate staff are available to deliver required standards of care, including the use of international recruitment as appropriate and apprenticeship programme. ((Milestones to achieve monitored through KPI’s).</td>
<td>M</td>
<td>31.03.2015</td>
<td>Director of Workforce and OD/ Executive Chief Nurse/ Medical Director/</td>
<td>Workforce Committee</td>
<td>• IT solution approved July 2014</td>
<td></td>
<td>On track</td>
</tr>
<tr>
<td>17</td>
<td>Number of staff recruited each month reported monthly to Workforce Committee. ((Milestones to achieve monitored through KPI’s).</td>
<td>M</td>
<td>31.07.2014</td>
<td>Director of Workforce &amp; OD</td>
<td>Workforce Committee</td>
<td>• Workforce KPI Performance Report presented to the Workforce Committee on 21 July 2014.</td>
<td></td>
<td>On track</td>
</tr>
</tbody>
</table>

**Desired Outcome/Success Criteria:** Safe staffing levels displayed on the ward board for the public and staff to view. Information demonstrates full staffing establishment achieved.

The key action to achieve this outcome will be:

- Develop and introduce ward quality boards outside every ward. L 30.06.2014 Executive Chief Nurse Quality Committee • All ward boards were in place by 13 June 2014.
  • Nursing vacancy level in June 2014 was below national and regional average.

- Publically display, on Ward Quality Boards, daily planned versus actual staffing levels alongside other key quality information including patient feedback, cleanliness and patient harms. L 30.08.2014 Executive Chief Nurse Quality Committee • Nurse sensitive outcomes monitored against staffing levels, and patient experience feedback. Information publicly displayed on most Ward Boards from June 2014.

**Desired Outcome/Success Criteria:** E-rostering implemented in 100% of all nursing clinical areas by January 2015 to ensure the correct level of skill mix and care provided. The key action to achieve this outcome will be:

- Milestone 1 - Roll out ‘Healthroster’ e-rostering at RLI to all planned wards by May 2014. L 30.05.2014 Director of Workforce and OD Workforce Committee • Achieved the roll out of e-rostering and training to all planned wards at RLI as of May 2014 which covered Acute Medicine, Surgery and Women’s and Children’s

- Milestone 2 - Roll out of e-rostering to all planned wards at WGH and be completed by September, 2014. L 30.09.2014 Director of Workforce and OD Workforce Committee • Roll out of e-rostering at WGH units commenced in May 2014 and will be completed by September 2014 at which time the Team will move to FGH to complete the rollout.

- Milestone 3 - Roll out of e-rostering to all planned wards at FGH units and be completed by January 2015. L 31.01.2015 Director of Workforce and OD Workforce Committee • Roll out on track
<table>
<thead>
<tr>
<th>No</th>
<th>Key Actions to address Areas for Improvement</th>
<th>Risk H/M/L</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Implement the Payroll link for those wards where e-rostering has been implemented and has enabled automatic timesheet and absence reporting.</td>
<td>L</td>
<td>31.01.2015</td>
<td>Director of Workforce and OD</td>
<td>Workforce Committee</td>
<td>The Payroll link commenced in May 2014 for those wards where e-rostering has been implemented and has enabled automatic timesheet and absence reporting (doing away with paper system entirely except for manual overrides). Trust managers and senior nurses are being trained in the use of the reporting tool ‘Rosterperform’</td>
<td></td>
<td>On track</td>
</tr>
</tbody>
</table>

**Actively Recruit Medical and Specialist Staff**

**Recommendation** T2, R2, F2  
Continue to actively recruit medical and specialist staff in areas where there are identified shortfalls.

**Story behind the Recommendation** Medical and Specialist staffing shortfalls in Radiology, Anaesthetists to provide appropriate care

**What good looks like** Safe staffing levels for Medical and Specialist staff are appropriate for the level of care provided and demonstrated by compliance with planned staffing establishment

**Desired Outcome/Success Criteria:** Safe staffing levels, Month on month improvement to achieve compliance with medical and specialist actual and planned staffing establishment utilising locums and agency where necessary. The key actions to achieve this outcome will be to:

| 24 | Commencing with immediate action, proactively monitor actual and planned staffing levels in relation to specific and ‘hard to recruit; staff groups within Medical staff and Allied Health Professions and report recruitment success/challenges to the Workforce Committee and the Board on a monthly basis. (Milestones to achieve monitored through KPI’s). | M | 31.07.2014 | Director of Workforce and OD/ Medical Director/ Chief Operating Officer | Workforce Committee | Board paper updates presented monthly (18 December 2013; 29 January 2014; 26 February 2014; 26 March 2014; 30 April 2014). Link to open and honest (commenced 28 May 2014) and Hard Truths (commenced June 2014) public reports  
Medical staffing level review report presented to the Workforce Committee on the 16 June 2014 and 21 July 2014.  
Workforce KPI Performance Report presented to Workforce Committee on 21 July with vacancy information. |  | On track |

| 25 | Develop workforce KPIs to monitor vacancy levels and recruitment to medical and AHP positions and monitor at the Workforce Assurance Committee. | M | 31.10.2014 | Director of Workforce and OD | Workforce Committee | Workforce KPIs developed and presented to the Workforce Assurance Committee on 21 July 2014 |  | On track |

| 26 | Develop and implement a five year Workforce Plan for Better Care Together that fully addresses strategic intention and changing model of health care delivery (e.g. 7 day working) and includes identified issues (including hard-to-recruit posts, skill mix review, investment in Allied Health Professionals). | M | 31.10.2014 | Director of Workforce and OD | Workforce Committee | High-level workforce planning figures incorporated in the Better Care Together Clinical Strategy.  
Further development and refinement to be undertaken as part of implementation planning. |  | On track |

**Record Keeping**

**Recommendation** T3, R3, F3  
Improve the nurse record keeping on the medical wards

**Story behind the Recommendation**  
Omissions were found in patient risk assessments and care planning documentation. Patient records are not always accurately maintained and consequently posed a potential risk to patients.

**What good looks like** Patient records are accurately maintained to include up to date care planning documentation and fully completed risk assessments.
<table>
<thead>
<tr>
<th>No</th>
<th>Key Actions to address Areas for Improvement</th>
<th>Risk H/M/L</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating Progress</th>
</tr>
</thead>
</table>
| 27 | Letter to be sent to all registered nurses regarding accountability and record keeping relating to:         | L          | 04.04.2014          | Executive Chief Nurse | Quality Committee                | • On the 13 March 2014 a letter was sent to all registered nurses and midwives reminding them nurses regarding accountability and record keeping relating to pressure ulcers  
• On the 4 April 2014, a further letter was sent to all registered nurses, midwives, Deputy Chief Nurses, Assistant Chief Nurses and clinical Directors reminding them of accountability and record keeping relating to observations | 4.04.2014 | Delivered |
| 28 | Raise awareness and reiterate the importance of accurate record keeping with all nursing staff utilising nurse staffing away days. | M          | 31.10.2014          | Executive Chief Nurse | Quality Committee                | • Good record keeping promoted at all away-days as an ongoing theme. Anonymised case studies are used to demonstrate the impact of poor record keeping.  
• Clinical Leaders Day – 4th April 2014, 27th June 2014, 5th September 2014  
• Registered Nurse Day – 12th March 2014, 10th September 2014  
• Specialist Nurse Day – 30th May 2014  
• Clinical Support Workers Day – 23rd April 2014, 1st August 2014, 28th October 2014 | | On track |
| 29 | Monthly reviews of documentation and efficiency of care through RAID peer reviews.                          | L          | 30.11.2014          | Executive Chief Nurse | Quality Committee                | • Peer evaluation reviews are in the process of being developed | | On track |

**Desired Outcome/Success Criteria:** Improvement of compliance with professional NMC record keeping standards/Trust’s record keeping policy. The key actions to achieve this outcome will be:

**Desired Outcome/Success Criteria:** Achievement of 90% compliance for identified staff groups accessing mandatory record keeping training at induction. The key actions to achieve this outcome will be:

30 Health Record Keeping Standards provided to all identified staff groups at local induction within 3 months of commencement of employment. (Milestones to achieve monitored through KPI’s).  

31 Health record keeping standards included as part of essential job related mandatory training in place and operational.  

32 Poor compliance of induction and mandatory record keeping training monitored at the Monthly Workforce Committee and poor compliance addressed. (Milestones to achieve...
<table>
<thead>
<tr>
<th>No</th>
<th>Key Actions to address Areas for Improvement</th>
<th>Risk H/M/L</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>monitored through KPI’s.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Implement a training programme in 2014/15 to improve the reporting of safety incidents. Training recorded on TMS. (Milestones to achieve monitored through KPI’s).</td>
<td>L</td>
<td>31.03.2015</td>
<td>Director of Governance</td>
<td>Quality Committee</td>
<td>• Training sessions for improving incident reporting, improving incident management and improving RCAs have run monthly on each hospital site since 1st April 2014, with good attendance.</td>
<td>On track</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Implement a training programme in 2014/15 for managers to ensure that roles and responsibilities are understood and that appropriate investigations are undertaken. Training recorded on TMS. (Milestones to achieve monitored through KPI’s).</td>
<td>L</td>
<td>31.03.2015</td>
<td>Director of Governance</td>
<td>Quality Committee</td>
<td>• Individual department managers sessions have also been run for radiology, pathology, surgery and acute medicine</td>
<td>On track</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>Implement a training programme in 2014/15 for staff participating in completing the RCA template on the Safeguard system. Training recorded on TMS. (Milestones to achieve monitored through KPI’s).</td>
<td>L</td>
<td>31.03.2015</td>
<td>Director of Governance</td>
<td>Quality Committee</td>
<td>• NPSA RCA template module integrated into the Safeguard system from January 2014.</td>
<td>On track</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• The further development of a half day workshop for RCA has been piloted (10/6/14) with acute medicine; this was judged by participants as successful and has been added into the training programme from 1st July 2014.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• All training is recorded in TMS and can be monitored by managers.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>Inform staff via the Staff Payslip of the Lessons Learned monthly newsletter and of the importance of incident reporting and the automatic feedback process to the incident reporter on all categories of incidents reported which includes actions taken and lessons learned.</td>
<td>L</td>
<td>30.09.2014</td>
<td>Director of Governance/ Director of Workforce and OD</td>
<td>Quality Committee</td>
<td>• An automatic process is in place by which the incident reporter is provided with feedback regarding any incident they submitted.</td>
<td>On track</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• From 11/12/2013 staff have received an immediate response which is sent automatically to acknowledge the incident.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• From 08/01/2014, the process ensures that staff receives feedback automatically on the completion of the full investigation including actions taken and lessons learned of the incident when closed by the investigating manager. This feedback is aligned to an audit trail.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Key Actions to address Areas for Improvement</td>
<td>Risk H/M/L</td>
<td>Date for completion</td>
<td>Person Responsible</td>
<td>Monitoring Assurance Committee</td>
<td>Progress (February 2014 – June 2014)</td>
<td>Date Completed</td>
<td>RAG Rating Progress</td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------------------</td>
<td>------------</td>
<td>---------------------</td>
<td>--------------------</td>
<td>-------------------------------</td>
<td>--------------------------------------</td>
<td>----------------</td>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Staff to be sent an automated email triggered by reporting, at the time of reporting (all incidents). To amend the current text to provide a better explanation to staff of what happens to the incident following the grading and what happens to non-UHMBT incidents.</td>
<td>L</td>
<td>30.09.2014</td>
<td>Director of Governance</td>
<td>Quality Committee</td>
<td>• An automatic system is in place but further improvements will be made to the content of the information automatically sent back to the reporter</td>
<td>30.09.2014</td>
<td>On track</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>On completion of an investigation, triggered by closure of the incident, staff will get an automated email and attached pdf with outcome, actions and lessons derived from the Safeguard record for 100% of UHMBT incidents.</td>
<td>L</td>
<td>30.10.2014</td>
<td>Director of Governance</td>
<td>Quality Committee</td>
<td>• An automatic system is in place but further improvements will be made to the content of the final information automatically sent back to the reporter</td>
<td>30.10.2014</td>
<td>On track</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>To further develop the Knowledge Management Website to include corporate and divisional lessons learned newsletters for staff to access monitored by the number of ‘hits’ of staff accessing the Lessons Learned newsletter via the Knowledge Management Webpage. Publicise the Knowledge Management webpage via communications.</td>
<td>M</td>
<td>31.12.2014</td>
<td>Director of Governance</td>
<td>Quality Committee</td>
<td>• Lessons learned newsletters produced quarterly in April 2014 and June 2014 and circulated via communications.</td>
<td></td>
<td>On track</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>To monitor staff perceptions of incident reporting and feedback through the quarterly Pulse surveys.</td>
<td>M</td>
<td>31.03.2015</td>
<td>Director of Workforce and OD</td>
<td>Workforce Committee</td>
<td>• The first pulse survey was sent out on Monday 16th June for a period of 2 weeks, alongside the staff Friends and Family Test. The first set of results will be available in early July 2014 • Quarterly pulse survey to be undertaken and reported through Business Intelligence Workforce Dashboard and Workforce Committee</td>
<td></td>
<td>On track</td>
<td></td>
</tr>
</tbody>
</table>

**Clinical Audit**

**Recommendation T5, R5, F5**

Ensure that appropriate action is taken in response to audits where poor practice is identified.

**Story behind the Recommendation**

The use of information from local audits was not consistently applied to secure improvement and manage risks. Examples were found of local audit identifying performance and practice shortfalls that were not adequately addressed by action planning and appropriate escalation.

**What good looks like**

All audits identifying performance and practice shortfalls have an action plan developed to ensure improvements and manage and escalate risks.

**Desired Outcome/Success Criteria:** From the 2014/15 annual audit plan, 100% of priority 1 and 2 clinical audits have an action plan developed in line with Healthcare Quality Improvement Partnership (HQIP) Guidance.

<table>
<thead>
<tr>
<th>No</th>
<th>Action</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>Annual clinical audit plan for 2014/15 to be developed using Healthcare Quality Improvement Partnership (HQIP) Guidance to prioritise audits and approved by the Quality Committee.</td>
<td>L</td>
<td>21.07.2014</td>
<td>Director of Governance/ Medical Director</td>
<td>Quality Committee</td>
<td>• Annual clinical audit plan for 2014/15 developed using Healthcare Quality Improvement Partnership (HQIP) Guidance. Annual clinical audit plan presented and approved by the Quality Committee on 21 July 2014.</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>From the 2014/15 annual audit plan, all audits will have an action plan developed in line with Healthcare Quality Improvement Partnership (HQIP) Guidance. The focus will be on Priority 1 and 2 audits.</td>
<td>M</td>
<td>31.03.2015</td>
<td>Director of Governance/ Medical Director</td>
<td>Quality Committee</td>
<td>• A summary sheet report and action plan template has been implemented to capture the audit results and actions needed to improvement practice. • Annual clinical audit report 2013/14 presented to the Quality Committee in June 2014.</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Key Actions to address Areas for Improvement</td>
<td>Risk H/M/L</td>
<td>Date for completion</td>
<td>Person Responsible</td>
<td>Monitoring Assurance Committee</td>
<td>Progress (February 2014 – June 2014)</td>
<td>Date Completed</td>
</tr>
<tr>
<td>----</td>
<td>-----------------------------------------------</td>
<td>-----------</td>
<td>---------------------</td>
<td>-------------------</td>
<td>-------------------------------</td>
<td>---------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>43</td>
<td>Review and update the clinical audit procedure and present to the policy group for ratification.</td>
<td>L</td>
<td>30.09.2014</td>
<td>Director of Governance/ Medical Director</td>
<td>Quality Committee</td>
<td>• The clinical audit procedure is in the process of being updated</td>
<td>On track</td>
</tr>
<tr>
<td>44</td>
<td>Implement and utilise a clinical audit module on the Ulysses safeguard system to follow up and monitor the timely implementation of clinical audit action plans.</td>
<td>L</td>
<td>31.12.2014</td>
<td>Director of Governance/ Medical Director</td>
<td>Quality Committee</td>
<td>• Work is underway to develop a clinical audit module on the Ulysses safeguard system</td>
<td>On track</td>
</tr>
</tbody>
</table>
| 45 | To establish a clinical audit and effective committee and devise the Terms of Reference to monitor the process of clinical audit implementation of clinical audit. | L         | 30.09.2014          | Director of Governance/ Medical Director | Quality Committee | • Clinical audit and effective committee Terms of Reference are in the process of being developed.  
• Schedule of meeting dates are in the process of being developed | On track       | On track            |
| 46 | From the 2014/15 annual audit plan, 80% of audits will have an action plan implemented within the allocated timescales and the focus will be on Priority 1 and 2 audits. (Milestones to achieve monitored through KPI’s). | M         | 30.03.2015          | Director of Governance/ Medical Director | Quality Committee | • Work is underway to improve follow up of actions arising from clinical audit and will be implemented during this year using the Ulysses system to develop a clinical audit module. | On track       | On track            |

**Accurate and Timely Performance Information**

**Recommendation T6, R6, F6**

**Story behind the Recommendation**

Ensure that accurate and timely performance information is used to monitor and improve performance in all clinical areas.

Performance information was not effectively or consistently used to drive changes and improve practice.

**What good looks like**

Performance information is consistently and systematically collected and collated and used in order to support service improvement.

**Desired Outcome/Success Criteria: Monthly Accurate and timely performance information in clinical areas**

<table>
<thead>
<tr>
<th>No</th>
<th>Key Actions to address Areas for Improvement</th>
<th>Risk H/M/L</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating Progress</th>
</tr>
</thead>
</table>
| 47 | Review Board level and Assurance level Business Intelligence Dashboard by July 2014 and present to the Board. | M         | 30.07.2014          | Director of Finance & Deputy Chief Executive | Finance Committee | • Board level and Assurance level Dashboards approved in April and will be in use from July 2014.  
• In addition to the investment in improving core information systems a programme of education and training will be delivered to ensure divisional / operational and clinical ownership of the system inputs and the ability to interpret / analyse and take necessary actions resulting from such. This is a core component of our OD programme aligned to our focus on a strategy of continuous improvement. Alongside this will be the introduction of a Service Improvement team - ensuring tested methodologies for service improvement are consistently adhered to in the actions / improvements following from the triangulation and analysis of our information. | On track       | On track            |
<p>| 48 | Further develop divisional level dashboard to ensure an integrated suite of performance data is available for Finance, Clinical Standards, Quality, Human Resources and Governance for implementation in Quarter 2. | M         | 30.12.2014          | Director of Finance &amp; Deputy Chief Executive | Finance Committee | • Further development of Divisional level dashboards to be taken forward with the new Divisional analysts for implementation in Quarter 2. | On track       | On track            |</p>
<table>
<thead>
<tr>
<th>No</th>
<th>Key Actions to address Areas for Improvement</th>
<th>Risk H/M/L</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>49</td>
<td>To undertake a review of systems to identify areas for improvement to systematically collect and collate data e.g. Lorenzo, ‘Guru’, Safeguard Risk Management System, SharePoint etc. and present to the Audit Committee.</td>
<td>M</td>
<td>30.12.2014</td>
<td>Director of Finance &amp; Deputy Chief Executive</td>
<td>Audit Committee</td>
<td>• Internal Audit will review the effectiveness of systems in Q3 in line with the agreed annual audit programme</td>
<td></td>
<td>On track</td>
</tr>
</tbody>
</table>

### Availability of Case Notes and Test Results

**Recommendation T7, R7, F7**
Ensure the timely availability of case notes and test results in outpatients department across the Trust.

**Story behind the Recommendation**
Although performance had improved over the last year the trust is still experiencing some difficulties in outpatients in relation to the availability of patient records and test results.

**What good looks like**
At the time of the patient’s appointment, all test results will have been reviewed and case notes will be available in the outpatients department.

#### Desired Outcome/Success Criteria: To achieve 96% target per month of casenote availability. The key action to achieve this outcome will be:

<table>
<thead>
<tr>
<th>No</th>
<th>Key Actions to address Areas for Improvement</th>
<th>Risk H/M/L</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating Progress</th>
</tr>
</thead>
</table>
| 50 | To audit case note availability on a monthly basis and monitor progress against improvement trajectory. ((Milestones to achieve monitored through KPI’s). | M          | 31.03.2015        | Chief Operating Officer | Quality Committee | • Case note availability is audited on a monthly basis. Availability has remained at 91.6% clinics in 2013/14 against a target of 90%.  
• The results are reported at the monthly Divisional Performance Review meetings.  
• The Trust is currently rolling out paperlight project which is the first stages of electronic patient record within OPD consultations. | | On track |

#### Desired Outcome/Success Criteria: To achieve 100% target per month of test results being available on Indigo and Lorenzo within national standards. Clinically significant abnormal results are telephoned to the requester as per Royal College of Pathology Guidelines. The key actions to achieve this outcome will be:

<table>
<thead>
<tr>
<th>No</th>
<th>Key Actions to address Areas for Improvement</th>
<th>Risk H/M/L</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating Progress</th>
</tr>
</thead>
</table>
| 51 | To audit the timely availability of outpatient test results being available electronically within national standards. ((Milestones to achieve monitored through KPI’s). | L          | 30.09.2014        | Medical Director | Quality Committee | • All test results are available electronically on Indigo and Lorenzo for medical staff to access. When test results are read this can be captured through an audit trail for monitoring.  
• A live electronic programme identifies when the test was requested, when the result is loaded on the system and when viewed and by whom.  
• Implementation of E- requesting will enable alerts for when test results are available and acknowledge when results are reviewed by the requester. | | On track |
Section 4: Actions the Trust **SHOULD** take to improve

Section 4 contains a list of the key actions to address the actions the Trust **SHOULD** take to improve. It also shows the priority for each action, how each action is being monitored, summary of progress, completion date and status.

The progress status of each action is indicated by a coloured code, as shown in the key below:

<table>
<thead>
<tr>
<th><strong>Milestone RAG Rating Key:</strong></th>
<th><strong>Completion Status</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivered</td>
<td></td>
</tr>
<tr>
<td>On track to deliver</td>
<td></td>
</tr>
<tr>
<td>Some issues – narrative disclosure</td>
<td></td>
</tr>
<tr>
<td>Not on track to deliver</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Action Plan Key:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Desired Outcome/Success Criteria:</td>
</tr>
<tr>
<td>Key Actions:</td>
</tr>
</tbody>
</table>

**Assurance Committees**

The Sub-Board Assurance Committees of the Trust consist of the Finance Committee, Quality Committee and Workforce Committee. These assurance committees will be the key vehicle for scrutiny and challenge and will seek assurance that the relevant actions with the CQC Improvement Plan have been implemented before approving submission to the Improvement Board.
**Actions the Trust SHOULD take to improve**

### Elective Caesarean Section

**Recommendation T9, F8**  
Review the numbers of elective caesarean sections carried out in the maternity services

**Story behind the Recommendation**  
The high numbers of caesarean section births at the hospital should be reviewed.

**What good looks like**  
Elective caesarean section rates are at or below the national average.

**Improved process to monitor elective caesarean sections rates. The key actions to achieve this outcome will be:**

<table>
<thead>
<tr>
<th>No</th>
<th>Key Actions to address Areas for Improvement</th>
<th>Risk H/M/L</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>52</td>
<td>Strengthen existing approaches to reviewing and monitor elective caesarean section rates as part of the divisional clinical audit programme.</td>
<td>L</td>
<td>30.09.2014</td>
<td>Medical Director</td>
<td>Quality Committee</td>
<td>Monthly caesarean section audits undertaken. Analysis of increased rates at FGH being undertaken.</td>
<td></td>
<td>On track</td>
</tr>
</tbody>
</table>
| 53 | Independent review of randomly selected cases to ensure compliance with the Trust’s guideline. | L | 30.10.2014 | Medical Director | Quality Committee | In the process of consultation to agree a stability partner by July 2014  
Stability partner to undertake an independent review of caesarean section rates and cases by September 2014 | | On track |
| 54 | Findings of the independent review to be presented to the Quality Committee in November 2014. | L | 31.12.2014 | Medical Director | Quality Committee | Results to be reported to the Quality Committee in November 2014 | | On track |

### Staffing Investment in AHPs

**Recommendation T10, R8, F9**  
Review its staffing investment to ensure that the allied health professional workforce is developed at the same pace as the nursing and medical workforce to meet the growing demand for services.

**Story behind the Recommendation**  
Requirement to review staffing investment to ensure that the allied health professional workforce is developed at the same pace as the nursing and medical workforce to meet the growing demand for services.

**What good looks like**  
The Allied Health Professional workforce is appropriate for the level of care to be provided.

<table>
<thead>
<tr>
<th>No</th>
<th>Key Actions to address Areas for Improvement</th>
<th>Risk H/M/L</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating Progress</th>
</tr>
</thead>
</table>
| 55 | To develop implement and monitor a workforce plan for AHP staff to meet identified service needs | M | 30.09.2014 | Director of Workforce and OD | Workforce Committee | A workforce plan for AHP staff is in the process of being developed.  
Workforce KPI Performance Report presented to Workforce Committee on 21 July with vacancy information. | | On track |

### Diagnostic and Imaging Services

**Recommendation T11**  
Consider its investment into the diagnostic and imaging services to respond to increased demand.

**Story behind the Recommendation**  
Recognition of the increased demand on services.

**What good looks like**  
Diagnostic and imaging services are appropriately resourced and services are provided in a timely manner with agreed standards of reporting maintained.

**Desired Outcome/Success Criteria: Increased capacity of diagnostic and imaging services through 7 day working The key action to achieve this outcome will be:**

<table>
<thead>
<tr>
<th>No</th>
<th>Key Actions to address Areas for Improvement</th>
<th>Risk H/M/L</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>56</td>
<td>Continue to urgently recruit staff to achieve full establishment of staff in the Radiology Department and report progress to the Workforce Committee on a monthly basis.</td>
<td>H</td>
<td>31.03.2014</td>
<td>Chief Operating Officer</td>
<td>Workforce Committee</td>
<td>One Radiologist appointment and waiting to commence in post. Currently recruiting to the Radiology Department and advertisement in place.</td>
<td></td>
<td>On track</td>
</tr>
<tr>
<td>57</td>
<td>To review alternative models of service delivery and present recommendations to the Workforce Committee.</td>
<td>L</td>
<td>30.09.2014</td>
<td>Chief Operating Officer</td>
<td>Workforce Committee</td>
<td>Alternative models of delivery are in the process of being reviewed.</td>
<td></td>
<td>On track</td>
</tr>
</tbody>
</table>
**Communication**

<table>
<thead>
<tr>
<th>No</th>
<th>Key Actions to address Areas for Improvement</th>
<th>Risk H/M/L</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation T12, R9, F10</td>
<td>Improve communication with staff on the wards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Story behind the Recommendation</td>
<td>Staff reported that with the exception of the executive nurse, the executive team and board members were not visible and communication with front line staff was poor. This sense of disconnect was evident in the NHS 2013 staff survey.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What good looks like</td>
<td>Staff report that they are satisfied with the visibility of the executive team and senior leaders across the Trust and that staff report that they believe communication between senior management to be “good” or better.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Desired Outcome/Success Criteria:** Communication plan developed and implemented and success demonstrated by improved pulse survey results in communication. The key actions to achieve this outcome will be:

<table>
<thead>
<tr>
<th>No</th>
<th>Key Actions to address Areas for Improvement</th>
<th>Risk H/M/L</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating Progress</th>
</tr>
</thead>
</table>
| 58 | Communications team to review existing communication arrangements and recommend a plan to improve communication to all wards and departments across all sites and signed off by the Board. | M          | 30.09.2014          | Chief Executive/ Associate Director of Strategic Communications | Board of Directors | • Communication arrangements are in the process of being reviewed.  
• Links to item 63 – the creation of a communications operational/action plan |                                      | On track |                    |
| 59 | Continue the Non-Executive and Executive Director and Governors patient safety walkabouts including the 15 Steps Challenge and (RAID) Peer Reviews to ensure appropriate visibility across all sites. Information provided on SharePoint to inform staff of the outcome and follow up actions of the safety walkabouts. | L          | 30.09.2014          | Director of Governance | Board of Directors | • A patient safety walkabout website on SharePoint has been developed to include all aspects of patient safety walkabouts undertaken.  
• Follow-up of actions from walkabouts are followed through to ensure actions are implemented. |                                      | On track |                    |

**Facilities and Equipment in A&E**

<table>
<thead>
<tr>
<th>No</th>
<th>Key Actions to address Areas for Improvement</th>
<th>Risk H/M/L</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation T12, R9, F10</td>
<td>Review its facilities and equipment in A&amp;E so that patients who are subject to delayed transfer do not receive sub-optimal care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Story behind the Recommendation</td>
<td>Recognition that the A&amp;E dept. at FGH requires capital investment to maximise patient flow.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What good looks like</td>
<td>Expanded A&amp;E department and increase in short-stay acute beds.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Review its facilities and equipment in A&amp;E so that patients who are subject to delayed transfer do not receive sub-optimal care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Investment in A&E Facilities at FGH and optimal care provided demonstrated by improved FFT results. The key action to achieve this outcome will be:**

<table>
<thead>
<tr>
<th>No</th>
<th>Key Actions to address Areas for Improvement</th>
<th>Risk H/M/L</th>
<th>Date for completion</th>
<th>Person Responsible</th>
<th>Monitoring Assurance Committee</th>
<th>Progress (February 2014 – June 2014)</th>
<th>Date Completed</th>
<th>RAG Rating Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>Combining the Medical Admissions unit with Short stay in order to increase bed provision; Capital plans being developed, although expansion would be subject to available funding</td>
<td>M</td>
<td>31.12.2014</td>
<td>Chief Operating Officer</td>
<td>Quality Committee / Finance Committee</td>
<td></td>
<td></td>
<td>On track</td>
</tr>
<tr>
<td>No</td>
<td>Key Actions to address Areas for Improvement</td>
<td>Risk H/M/L</td>
<td>Date for completion</td>
<td>Person Responsible</td>
<td>Monitoring Assurance Committee</td>
<td>Progress (February 2014 – June 2014)</td>
<td>Date Completed</td>
<td>RAG Rating</td>
</tr>
<tr>
<td>----</td>
<td>-------------------------------------------</td>
<td>------------</td>
<td>-------------------</td>
<td>-------------------</td>
<td>-------------------------------</td>
<td>----------------------------------</td>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td></td>
<td><strong>Strategy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendation T14, R10, F12</td>
<td>Review the opportunities to engage its workforce in the ‘Better Care Together’ initiative so staff are aware of the future of the services they work in</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Story behind the Recommendation</td>
<td>Staff at the front line were not clear about what the trust’s priorities were and many knew little of the ‘Better Care Together’ strategy. Many were unclear and uncertain about what future provision would look like and what it meant for their service or for them as individuals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What good looks like</td>
<td>All staff to be aware of the Trust’s priorities, including the role of ‘better care together’. All staff to have opportunities to comment and feedback on Trust plans for the future and to be able to consistently access information and be kept updated, especially as to how it will impact on them, their services and ultimately the patient.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Desired Outcome/Success Criteria:</strong> Communication Strategy implemented and staff will be engaged and actively involved in shaping healthcare services in Morecambe Bay</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 61 | To develop a detailed staff engagement plan in relation to the implementation of ‘Better Care Together’ following the submission of the Strategic Outline Case and the Trust’s 2-5 year plan to ensure that all staff have the opportunity to influence decisions that affect them and the services they provide. | H | 30.09.2014 | Chief Executive/ Director of Workforce & OD/ Associate Director of Corporate Communications | Workforce Committee | • A draft detailed staff engagement plan in relation to the implementation of ‘Better Care Together’ was presented at the Executive Directors Group meeting held on 8.07.2014.  
• A workshop is being held with the Staff side organisations in September 2014 to develop engagement actions and activities. | | On track | |
| 62 | Continue to implement the Trust-wide Communications Strategy to ensure that all staff are able to easily access key corporate information e.g. management briefings, team brief, weekly message etc. and signed off by the Board. | M | 30.09.2014 | Chief Executive / Associate Director of Corporate Communications | Board of Directors | • All ward managers have been asked by the CEO to attend a monthly Team Briefing meeting. Guidelines (based on University of Manchester) have been developed, along with Team Brief training workshops. Dates of Team Briefings publicised for 12 months and aim is for onward cascade to local teams within 5 working days.  
• Operational/ communications action plan to be created to support 63 and 59. | | On track | |
| **Chaplaincy Service** | | | | | | | | | |
| Recommendation R11 | Review the services provided by the chaplaincy at RLI so that patient’s spiritual needs are better met. | | | | | | | | |
| Story behind the Recommendation | During a staff focus group, staff commented that the chaplain service was under resourced and that the spiritual needs of patients in the surgical wards was often not acknowledged. This is important as patients may well need some spiritual support to help them cope with their surgery, particularly if the surgery leads to life changes. | | | | | | | | |
| What good looks like | Adequate chaplaincy and multi faith services are provided to meet the spiritual needs of all patients. | | | | | | | | |
| **Desired Outcome/Success Criteria:** Recruitment to Chaplaincy and multi faith service to provide spiritual and pastoral support to patients and their families. The key actions to achieve this outcome will be: | | | | | | | | | |
| 63 | To recruit additional members to the chaplaincy team. | L | 23.06.2014 | Executive Chief Nurse | Workforce Committee | • The Trust has recently recruited two chaplaincy members to support the service to patients. One commenced in post in 19/05/14; one to commence in post 23/06/2014 | 23.06.2014 | Delivered | |
Section 5 contains a summary of how the performance and quality of each action will be assured. The tables are shown by MUST and SHOULD actions for improvements.
### Staffing Levels and Skill Mix

<table>
<thead>
<tr>
<th>Measure staffing levels</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>• % of compliance reports to be included in report to the corporate Divisional Performance Meeting and the Workforce Assurance Committee</td>
<td>• Target is that month on month improvement to achieve 100% compliance with planned staffing establishment and skill mix utilising agency where necessary will be achieved. Compliance should not fall below 90% (10% variance) of planned staffing.</td>
<td></td>
</tr>
<tr>
<td>• Bi-annual review of establishments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Weekly monitoring of actual versus planned staffing (reported to Board of Directors and also staff via hard truths/open and honest)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Communication to staff and public via quality display boards</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consistent methodology for assessing safe staffing levels</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Baseline staffing review to include (CYP, A+E and Maternity) (complete)</td>
<td>• Consistent and robust approach to setting safe staffing levels</td>
<td></td>
</tr>
<tr>
<td>• Implementation of Red Rules (complete)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Roll out of acuity tool to appropriate area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Completed acuity reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Staffing budgets to be set, agreed and signed off (complete)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Roll out of 'e' rostering at all sites</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implementation of payroll link</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recruitment</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Active recruitment programme</td>
<td>• To continue to recruit to achieve planned staffing establishment</td>
<td></td>
</tr>
<tr>
<td>• Monthly divisional recruitment report identifying professional groups, area of employment, start dates and remaining vacancies. To be included in report to the corporate Divisional Performance Meeting and the Workforce Assurance Committee</td>
<td>• To continue to utilise and monitor wide-ranging recruitment and development strategy</td>
<td></td>
</tr>
<tr>
<td>• Implementation of Recruitment and Retention Strategy monitoring report</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitoring of EWTD</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bi-Annual audit results reported to Workforce assurance Committee</td>
<td>• To ensure safe systems of work and compliance with EWTD to protect employee health and well-being</td>
<td></td>
</tr>
</tbody>
</table>

### Evidence of Quality Assurance

<table>
<thead>
<tr>
<th>Evidence of Quality Assurance</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>• Acuity tools</td>
<td>• Target is that month on month improvement to achieve compliance with planned staffing establishment and skill mix utilising agency where necessary will be achieved. Compliance should not fall below 90% (10% variance) of planned staffing.</td>
</tr>
<tr>
<td>• Bi-Annual review of establishments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Weekly monitoring of actual versus planned staffing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Baseline staffing reviews (complete)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Budget setting (complete)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Audit</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Compliance with European Working Time Directive (EWTD)</td>
<td>• To assure the Board of safe and sustainable systems in relation to EWTD</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Report</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Exception report identifying % of planned staffing establishment versus actual staffing levels presented to Workforce Assurance Committee and the Board.</td>
<td>• Reports to the Board, staff and the public demonstrate that the Trust is taking all steps possible to expedite the recruitment to staff vacancies to address shortfalls and that safe staffing and clinical skill mix is assessed and maintained in an appropriate and consistent manner</td>
<td></td>
</tr>
<tr>
<td>• Reports on quality boards for staff and public (actual v planned)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Recruitment report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Agency/locum/bank report (compliance against KPI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Monitoring of performance report from agencies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Actively Recruit Medical and Specialist Staff

<table>
<thead>
<tr>
<th>Evidence of Performance</th>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Report</td>
<td>• Month on month improvements in compliance with medical and specialist actual and planned staffing establishment as benchmarked against developed KPI’s</td>
<td>Successful recruitment of medical and specialist staff in areas where there are identified shortfalls.</td>
<td></td>
</tr>
<tr>
<td>Report</td>
<td>• Workforce plan for BCT</td>
<td>Strategic, long term workforce planning to address future staffing requirements</td>
<td></td>
</tr>
</tbody>
</table>

### Evidence of Quality Assurance

<table>
<thead>
<tr>
<th>Evidence of Quality Assurance</th>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>• Data in relation to compliance with medical and specialist actual and planned staffing establishment including the use of locums and agency where necessary</td>
<td>Safe staffing levels for Medical and Specialist staff which are appropriate for the level of care provided.</td>
<td></td>
</tr>
<tr>
<td>Report</td>
<td>• Comparative data of actual and planned staffing establishment</td>
<td>Safe staffing levels are demonstrated by compliance with planned staffing establishment.</td>
<td></td>
</tr>
</tbody>
</table>

### Record Keeping

<table>
<thead>
<tr>
<th>Evidence of Performance</th>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>• Compliance report to Monthly Workforce Committee to include % staff compliant with mandatory training in relation to record keeping.</td>
<td>90% compliance against record keeping mandatory training.</td>
<td></td>
</tr>
<tr>
<td>Review</td>
<td>• Compliance with record keeping as per RAID peer reviews</td>
<td>To identify areas to target to improve performance in relation to accurate records</td>
<td></td>
</tr>
<tr>
<td>Training and development</td>
<td>• Record keeping standards to be distributed at staff local induction and compliance monitored to Monthly Workforce Committee</td>
<td>Regular and consistent message to staff in relation to the importance of high standards of record keeping</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Letter to staff relating to pressure ulcers and observations and record keeping (complete)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Record keeping promoted at all ‘away-days’ (historic and future dates)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Evidence of Quality Assurance

<table>
<thead>
<tr>
<th>Evidence of Quality Assurance</th>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>• Compliance report to Monthly Workforce Committee</td>
<td>Robust and timely review of audit and compliance data to ensure continuing improvement and rapid response to areas of concern if identified</td>
<td></td>
</tr>
<tr>
<td>Review</td>
<td>• Intentional rounding review (peer review)</td>
<td>Patient records are accurately maintained to include up to date care planning documentation and fully completed risk assessments.</td>
<td></td>
</tr>
<tr>
<td>Training and development</td>
<td>• Compliance reports</td>
<td>To support an improved performance in relation to record keeping in the short term and a sustainable approach to high standards of record keeping in the future</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Staff communication (letters/training plans/agendas)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Incident Reporting

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training records on the Training Management System (TMS) and website monitoring</td>
<td>Compliant Staff training records in relation to - Incident reporting - Incident management - RCA Feedback process to those submitting incidents by - automatic feedback process - Development of the knowledge management website Feedback and learning lessons from incidents by - Developing the Knowledge Management Website - Lessons learnt newsletters</td>
<td>To develop a workforce who are confident to report, manage and investigate incidents</td>
</tr>
<tr>
<td>Survey</td>
<td>Results of enquiries of staff perceptions - Pulse surveys</td>
<td>As above</td>
</tr>
<tr>
<td>Report</td>
<td>To monitor incident reporting rates to ensure the Trust remain in top quartile nationally for incident reporting</td>
<td>To remain a high reporter of incidents</td>
</tr>
</tbody>
</table>

### Evidence of Quality Assurance

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Distribution of lessons learnt newsletters and knowledge management website monitoring - Reports to the Quality Committee - Training report (and TNA/plan) to the Workforce committee</td>
<td>To ensure a well-developed workforce that are able to identify and respond to incidents and receive feedback and learning from a clearly identified process</td>
</tr>
</tbody>
</table>

### Clinical Audit

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>% of clinical audits which have an action plan developed in line with HQUIP Guidance</td>
<td>100% of clinical audits have an action plan developed in line with HQUIP Guidance</td>
</tr>
<tr>
<td>Report</td>
<td>% of clinical audits that have an action plan implemented within the allocated timescales</td>
<td>80% of poor practice audits have an action plan implemented within the allocated timescales</td>
</tr>
<tr>
<td>Committee development</td>
<td>Terms of Reference and meeting schedules for Clinical Audit and Effectiveness Committee</td>
<td>Effective management of the clinical audit process</td>
</tr>
</tbody>
</table>

### Evidence of Performance

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of clinical audits which have an action plan developed in line with HQUIP Guidance</td>
<td>100% of clinical audits have an action plan developed in line with HQUIP Guidance</td>
<td></td>
</tr>
<tr>
<td>% of clinical audits that have an action plan implemented within the allocated timescales</td>
<td>80% of poor practice audits have an action plan implemented within the allocated timescales</td>
<td></td>
</tr>
<tr>
<td>Terms of Reference and meeting schedules for Clinical Audit and Effectiveness Committee</td>
<td>Effective management of the clinical audit process</td>
<td></td>
</tr>
</tbody>
</table>

### Evidence of Quality Assurance

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Standardised governance reporting mechanism (WESEE) from ward to board to include divisional audits) with clear lines of escalation</td>
<td>Consistent and robust approach to monitoring and responding to findings from audit</td>
</tr>
<tr>
<td>Report</td>
<td>Quarterly divisional report to Trust Audit Lead in relation to compliance against audit plan</td>
<td>To ensure progress against audit plan</td>
</tr>
<tr>
<td>Report</td>
<td>Annual Audit report to the Quality Committee to include performance in relation to actions in response to poor practice</td>
<td>To ensure Trust wide compliance with audit plan and monitoring of responses to audit findings</td>
</tr>
</tbody>
</table>
## Accurate and timely performance Information

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>Completion of Board Level Dashboard</td>
<td>Provision of high quality, timely performance and Governance data</td>
</tr>
<tr>
<td>Measure</td>
<td>Development of Divisional Level Dashboards</td>
<td>Monthly Accurate and timely performance information in clinical areas, coupled with divisional governance and appropriate training</td>
</tr>
<tr>
<td>Measure</td>
<td>Appointment of Divisional Business Intelligence Analysts</td>
<td>To support Divisional teams and Clinical areas with analysis of performance information</td>
</tr>
</tbody>
</table>

## Evidence of Quality Assurance

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>Accurate and timely performance information is used to monitor and improve performance in all clinical areas.</td>
<td>Performance information is consistently and systematically collected and collated in order to support service improvement.</td>
</tr>
<tr>
<td>Audit</td>
<td>Establishment of new I3 Function in response to PWC review. Internal Audit to review the effectiveness of systems in Q3 in line with the agreed annual audit programme</td>
<td>To provide a single point of contact and single source of the truth for all Informatics related work.</td>
</tr>
</tbody>
</table>

### Performance information is consistently and systematically collected and collated

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>Development of Divisional Level Dashboards</td>
<td>Monthly Accurate and timely performance information in clinical areas, coupled with divisional governance and appropriate training</td>
</tr>
</tbody>
</table>
| Measure       | • Appointment of Divisional Business Intelligence Analysts  
• Appointment of Senior Business Intelligence Unit Manager | To support Divisional teams and Clinical areas with analysis of performance information |

## Evidence of Quality Assurance

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>Accurate and timely performance information is used to monitor and improve performance in all clinical areas.</td>
<td>Performance information is consistently and systematically collected and collated in order to support service improvement.</td>
</tr>
<tr>
<td>Audit</td>
<td>Establishment of new I3 Function in response to PWC review. Internal Audit to review the effectiveness of systems in Q3 in line with the agreed annual audit programme</td>
<td>To provide a single point of contact and single source of the truth for all Informatics related work.</td>
</tr>
</tbody>
</table>
## Case note and test results availability

<table>
<thead>
<tr>
<th>Evidence of Performance</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure</strong></td>
<td>audit case note availability on a monthly basis and monitor progress against improvement trajectory</td>
</tr>
<tr>
<td><strong>Evidence</strong></td>
<td>At the time of the patient’s appointment, all case notes will be available in the outpatient department (minimum Target 90%)</td>
</tr>
<tr>
<td><strong>Measure</strong></td>
<td>% of outpatient test results being available on Indigo and Lorenzo within national standards</td>
</tr>
<tr>
<td><strong>Evidence</strong></td>
<td>The % of outpatient test results being available on Lorenzo is compliant with national standards. Monitor through CIR</td>
</tr>
<tr>
<td><strong>Measure</strong></td>
<td>% of outpatient test results being read on Indigo and Lorenzo</td>
</tr>
<tr>
<td><strong>Evidence</strong></td>
<td>The number of outpatient test results read within agreed time frame between test request and next consultation. The numbers are sufficient to demonstrate to the Quality Committee that clinicians are acting upon results.</td>
</tr>
</tbody>
</table>

### Evidence of Quality Assurance

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit</td>
<td>audit case note availability on a monthly basis and monitor progress against improvement trajectory</td>
</tr>
<tr>
<td><strong>Evidence</strong></td>
<td>At the time of the patient’s appointment, all case notes will be available in the outpatient department (minimum Target 90%)</td>
</tr>
<tr>
<td>Audit</td>
<td>% of outpatient test results which meet the national standards</td>
</tr>
<tr>
<td><strong>Evidence</strong></td>
<td>Results show 100% compliance for the outpatient tests results being available on Lorenzo in line with national standards.</td>
</tr>
<tr>
<td>Audit</td>
<td>% of outpatient test results being read on Lorenzo within agreed time frame by requesting clinicians</td>
</tr>
<tr>
<td><strong>Evidence</strong></td>
<td>Results show that a significant and sustained improvement for the outpatient tests results being read within agreed time frame.</td>
</tr>
</tbody>
</table>
## Section 5b: “SHOULD” actions for improvement

### Elective Caesarean Section

<table>
<thead>
<tr>
<th>Evidence of Performance</th>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Audit (In-house)</td>
<td>Elective Caesareans Audit results and any ensuing action plans</td>
<td>To ensure elective caesarean section rates are in-line with expected national levels and that decision making in relation to elective caesarean sections is in line with NICE recommendations</td>
</tr>
<tr>
<td></td>
<td>Monthly service Dashboard</td>
<td>Monthly dashboards and dashboard narratives and dissemination process</td>
<td>To monitor monthly activity as a service and on each obstetric site and to share data widely within the service</td>
</tr>
<tr>
<td></td>
<td>Service review</td>
<td>Position paper reviewing provision of care for vaginal birth after caesarean (VBAC)</td>
<td>To ensure adequate provision and support is available to woman irrespective of site to support the principle of VBAC</td>
</tr>
<tr>
<td></td>
<td>Independent review by stability partner</td>
<td>Audit, results (action plans) and report</td>
<td>To provide assurance that the monitoring of service outcomes in relation to elective caesarean is robust</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence of Quality Assurance</th>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Audit (In-house)</td>
<td>Results and action plans, evidence of lessons learnt and service review (dependant on findings)</td>
<td>To ensure robust review of patient choice and clinical decision making in relation to elective caesareans</td>
</tr>
<tr>
<td></td>
<td>Monthly service Dashboard</td>
<td>Monthly dashboards and dashboard narratives</td>
<td>Demonstrates a continual review of outcomes amongst clinicians and managers which is triangulated against audit findings to inform clinical care planning and service development</td>
</tr>
<tr>
<td></td>
<td>Service review</td>
<td>Position paper reviewing provision of care for vaginal birth after caesarean (VBAC)</td>
<td>To ensure equitable access to high quality service provision across the bay in relation to VBAC</td>
</tr>
<tr>
<td></td>
<td>Independent review by stability partner</td>
<td>Audit, results (action plans) and report</td>
<td>External assurance of quality of service provision</td>
</tr>
</tbody>
</table>

### Staffing Investment in AHPs

<table>
<thead>
<tr>
<th>Evidence of Performance</th>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Report</td>
<td>• Annual review of AHP staffing investment</td>
<td>To ensure regular robust review of AHP workforce growth in-line with other clinical professions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Workforce plan for AHP</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence of Quality Assurance</th>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Report</td>
<td>Report to workforce Committee for review of AHP requirement and investment</td>
<td>Investment to ensure that the allied health professional workforce is developed at the same pace as the nursing and medical workforce to meet the growing demand for services.</td>
</tr>
</tbody>
</table>
### Diagnostic and Imaging Services

#### Evidence of Performance

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment</td>
<td>% of compliance reports to be included in report to the corporate Divisional Performance Meeting and the Workforce Assurance Committee</td>
<td>Target is that month on month improvement to achieve compliance with planned staffing establishment and skill mix will be achieved.</td>
</tr>
<tr>
<td>Review</td>
<td>Paper to Workforce Committee</td>
<td>Service review to scope current and future service requirement</td>
</tr>
</tbody>
</table>

#### Evidence of Quality Assurance

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment</td>
<td>% of compliance reports to be included in report to the corporate Divisional Performance Meeting and the Workforce Assurance Committee (for current staffing levels and any recommendations from planned service review)</td>
<td>Full recruitment to agreed staffing requirement to maintain high quality service</td>
</tr>
</tbody>
</table>

### Communication

#### Evidence of Performance

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit</td>
<td>Improved Results of staff survey in relation to communication</td>
<td>To improve executive team members communication and visibility with ward staff</td>
</tr>
<tr>
<td>Audit</td>
<td>Findings from executive/non-executive safety walk around (as per standardised proforma)</td>
<td>To improve executive team/non-executive members communication and visibility with ward staff</td>
</tr>
</tbody>
</table>

#### Evidence of Quality Assurance

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit</td>
<td>Findings from staff survey and executive walk rounds</td>
<td>To ensure Executive team members are visible in all areas of the Trust and communication between senior management and staff is regarded to be of a high standard.</td>
</tr>
</tbody>
</table>

### Facilities and Equipment in A&E

#### Evidence of Performance

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit</td>
<td>Compliant audit in relation to standards of care for delayed patients</td>
<td>Identify any patients who do not receive high standards of care</td>
</tr>
<tr>
<td>Report</td>
<td>Themed report for emergency medicine identifying incidents in relation to failure to care for this cohort of patients</td>
<td>Identify trends in relation to this cohort of patients</td>
</tr>
<tr>
<td>Report</td>
<td>progress in relation to prioritisation of capital investment and programme of works to address shortcomings</td>
<td>The environment and equipment at FGH A+E facilitates high quality care</td>
</tr>
</tbody>
</table>

#### Evidence of Quality Assurance

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit</td>
<td>Compliant audit</td>
<td>All patients subject to delayed transfer receive high quality care during delay</td>
</tr>
<tr>
<td>Report</td>
<td>Progress report for Trust capital and Estates strategy</td>
<td>The environment and equipment at FGH A+E facilitates high quality care</td>
</tr>
<tr>
<td>Report</td>
<td>Incident report</td>
<td>Continual monitoring of quality of care</td>
</tr>
</tbody>
</table>
### Strategy

<table>
<thead>
<tr>
<th>Evidence of Performance</th>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey</td>
<td>Staff Survey results identifying increased understanding of the Better Care Together initiative following implementation of engagement plan</td>
<td>Staff are aware of the ‘Better Care Together’ initiative and how this will affect their service or them as individuals.</td>
<td></td>
</tr>
<tr>
<td>Report</td>
<td>communication strategy disseminated</td>
<td>To increase awareness of methods of communication</td>
<td></td>
</tr>
</tbody>
</table>

#### Evidence of Quality Assurance

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey</td>
<td>Staff Survey results identifying increased understanding of the Better Care Together initiative and communication strategy</td>
<td>Staff are aware of the ‘Better Care Together’ initiative and how this will affect their service or them as individuals.</td>
</tr>
</tbody>
</table>

### Chaplaincy Services

<table>
<thead>
<tr>
<th>Evidence of Performance</th>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Successful recruitment of chaplaincy to support the service to patients at RLI reported to Workforce committee</td>
<td>Adequate staffing levels for high quality provision of spiritual care</td>
<td></td>
</tr>
</tbody>
</table>

#### Evidence of Quality Assurance

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Evidence</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Performance report of chaplaincy services</td>
<td>All patients attending RLI will have their spiritual needs met.</td>
</tr>
</tbody>
</table>
If you require any further information, or assistance regarding this plan, please do not hesitate to contact:

Mary Aubrey  
**Director of Governance**  
Mary.Aubrey@mbht.nhs.uk  
Tel: 01539 716688