Summary of the CQC Improvement Plan

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<td>Delivered</td>
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<td>On Track to deliver</td>
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<tr>
<td>Some issues – narrative disclosure</td>
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<tr>
<td>Not on track to deliver</td>
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Version: Version 18.0
Date: 30.09.2015
What are we doing?

• The Trust was placed in Special Measures following a Risk Summit in June 2014 which discussed the findings of an inspection by the Chief Inspector of Hospitals in February 2014.

• The Chief Inspector made 15 recommendations in total, 8 of which the Trust “must” undertake and 7 which the Trust “should” undertake. All 15 recommendations are included in our CQC Improvement Plan. The key themes of these recommendations are summarised below:
  • Improving our staffing levels;
  • Engaging and communicating more effectively with frontline staff;
  • Improving performance information to drive improvement and good decision making;
  • Improving our nurse record keeping;
  • Continuing to improve incident reporting and the learning we gain from incidents;
  • Improving the availability of case notes and test results in our outpatients departments.

• At our July meeting the Trust Board approved an overarching Quality Improvement Plan, which has been designed to deliver the longer term quality improvements needed over the next three years and the CQC Improvement Plan is a key part of this in year one. Together with the support of our partners, our doctors, nurses and managers, we will be 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, The NHS has a formal system already in place called ‘Quality Surveillance Groups’ (QSGs) to bring together parts of the local health and care economies to routinely share information and intelligence. Working with our Local Area Teams we intend to make best use of this existing facility for discussing progress against our Improvement Plan and any connected matters. The Trust Board is satisfied that this provides sufficient governance arrangements to deliver the level of assurance required to track and question the progress being made. Board. Assurance is also provided through the appropriate Board Sub-Committees.

• The CQC Improvement Plan is time limited; however, to ensure the improvements can be sustained and to tackle some of the some long standing issues such as culture, we establishing an improvement hub within our Trust. The improvement hub provides support and assistance to our staff, helping them to understand what ‘good’ and ‘outstanding’ look like and providing them with the tools to achieve those high standards. This approach will support staff to use tried and tested techniques for delivering consistent change. The action plan will ensure our services are of the highest quality in relation to staffing numbers and skill mix, record keeping, access to health records, incident reporting, accurate and timely performance information, facilities and communication.

• This document shows our plan for making these improvements and demonstrates our progression against the plan. The Trust will remain in Special Measures while we take forward our plans to address the 15 recommendations from the Chief Inspector of Hospitals.

• The CQC Improvement Plan was refreshed and signed off by the Board on 1st December 2014. The refreshed plan ensures that the format and content align to the CQC reporting domains and that there is further clarity of the intended outcomes and key performance indicators across the programme of improvement. This will assist in the process to ensure that improvement actions align with the improvement recommendations.


### Who is responsible?

- Our actions to address the recommendations have been agreed by the Trust Board.
- Our Chief Executive, Jackie Daniel, is ultimately responsible for implementing actions in this document. Other key staff are Sue Smith, Executive Chief Nurse; David Walker, Medical Director; and Mary Aubrey, Director of Governance, as they provide the executive leadership for quality, patient safety and patient experience.
- This Improvement Plan is almost completed with residual risks around capital investment and staff recruitment. Ultimately, our success in implementing the recommendations of the CQC Improvement Plan will be assessed by the Chief Inspector of Hospitals.
- The CQC has now inspected the hospital in July 2015; there has been one unannounced visit which took place on the 26 August 2015. The outcome of the July 2015 inspection should be known in autumn 2015 and may lead to a new action plan being developed.
- Fiona Wise is the Improvement Director to support our progress by challenging our approach to ensure we deliver the most effective service to our patients. The Improvement Director acts on behalf of Monitor and works together with the relevant Regional Team of Monitor to ensure delivery of the improvements and oversee the implementation of the action plan overleaf. Should you require any further information on this role please contact specialmeasures@monitor.gov.uk
- If you have any questions about the work we are doing contact our Director of Governance, Mary Aubrey, mary.aubrey@mbht.nhs.uk, 01539 716688. Or, if you want to contact Monitor, you can reach them by email at enquiries@monitor.gov.uk.

### How we will communicate our progress to you?

- We will provide a progress report every month whilst we are in Special Measures, which was initially reviewed by an Improvement Board and received by the Trust Board. With the agreement of the Trust’s Board of Directors the Improvement Board stood down from 12th December 2014 and oversight of how the trust action plan is improving our services in line with CQC recommendations is now the responsibility of the Quality Surveillance Group (QSG).
- The progress report will be published on the NHS Choices and Trust websites, and subsequent longer term actions may be included as part of a continuous process of improvement.
- Each month we will let all staff, governors and partners know where the update can be found.
- We will update FT members letting them know more about the inspection outcome and describing the special measures, where members can access the action plan and how and when we will update it.
- We will present updates on progress at our scheduled Council of Governor meetings which are held in public.
- We will provide staff with an update on progress at our regular staff briefings.

### Chair / Chief Executive Approval (on behalf of the Board):

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<tr>
<th>Chair Name: Pearse Butler</th>
<th>Signature:</th>
<th>Date: 30&lt;sup&gt;th&lt;/sup&gt; September 2015</th>
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<td>(Commenced in post on 4&lt;sup&gt;th&lt;/sup&gt; November 2014.</td>
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<tr>
<th>Chief Executive Name: Jackie Daniel</th>
<th>Signature:</th>
<th>Date: 30&lt;sup&gt;th&lt;/sup&gt; September 2015</th>
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"University Hospitals Morecambe Bay NHS Foundation Trust - Our improvement plan and our progress"
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<th>Summary of Main Concerns</th>
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| **Domain 1 - Safe**      | Ensure staffing levels and skill mix in all clinical areas are appropriate for the level of care provided | • Undertake baseline nursing staffing review.  
• Introduce Red Rules. This is a staffing tool that is to be used for ward managers to flag any nurse staffing levels of concern and will ensure no less than two registered nurses on any shift. | Director of Nursing  
• 31.01.2014  
• 31.12.2013  
NHS England  
• 31.01.2014  
• 31.12.2013  
Staffing decision tool  
audit  
Workforce Committee  
• 30.06.2014  
• 30.06.2014  
Clinical Commissioning Groups (CCGs) | Delivered  
• Red rules for safer staffing are used throughout the Trust in line with NICE recommendations. Patient safety and unplanned staffing shortages are reviewed 4 times a day to ensure that risk is assessed and addressed in real time.  
• At the end of July 2015, there were 0.6 wte less nurses in post than were in post in June 2014.  
• At the end of August 2015, there were 172.9 wte more nurses in post than were in post in April 2014.  
Delivered  
• Ward boards are in place outside every inpatient ward. The boards describe staffing levels, key performance indicators and patient feedback. Department Boards continue to be introduced in Outpatient areas.  
Delivered  
• Bank & agency expenditure reported to the Workforce Assurance Committee on a monthly basis from October 2014 onwards  
• Plans for the KPIs to be further improved following implementation of the "Bank Staffing" module on e-rostering and the development of the Roster Perform reporting tool. This was implemented on 15th June 2015.  
• In August 2015 the actual nursing / midwifery staff (WTE) in post was 2164.3 wte. The variance was 150.6 wte. This was filled with bank staff equating to 130.68 and agency staff 75.86 (WTE) A total of 206.54 WTE  
• In August 2015 the actual medical (WTE) in post was 548.8 (including lead employer). The variance was 62.7 WTE. This was filled with agency medics equating to 82.93 and locum medics 10.47 (WTE).  
• The Trust continues to monitor workforce information monthly. The improvements in staffing continue to be delivered at the same time as improvements in patient outcomes and experience.  
Delivered  
There has been an overall decreased reliance on agency nursing staff and an increased reliance on Trust bank staff. Information regarding utilisation of temporary staffing is monitored through the workforce assurance committee (a sub-committee to the Board). |
|                           | • Introduce Ward Boards outside ward areas to display actual staffing levels publicly and publish staffing levels data on the national database and on the Trust website monthly.  
• Introduce rules to ensure nursing budgets are set with ward managers and signed off by the Exec. Chief Nurse. | 30.06.2014  
## Domain 1 - Safe

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

(Continued)

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<td>• Continue to actively recruit staff using local, national and international recruitment and implement our Recruitment and Retention Strategy to ensure patients’ needs are met.</td>
<td>• Introduce regular European Working Time Directive (EWTD) monitoring to ensure safe systems of work and to protect employee health and wellbeing and report 6 monthly to Workforce Committee. The EWTD is a directive from the Council of Europe (93/104/EC) to protect the health and safety of workers in the European Union.</td>
<td>• 31.03.2015</td>
<td>Director of Nursing NHS England Staffing decision tool audit Workforce Committee Clinical Commissioning Groups (CCGs)</td>
<td>Delivered • During 2014/15 the Trust has invested £3.3 million for extra ward nurses, £0.7 million for more paediatric nurses and £0.4 million for extra staff to release ward managers from direct clinical care. Total additional nurses and midwives in post when comparing April 2014 to August 2015 is 172.9 wte. During this period, mortality rates and harms have reduced and incident reporting is in the top quartile nationally. • The Trust Modern Apprentice Scheme commenced in February 2015 with 33 Healthcare Support Worker apprentices now in post and a second cohort of 36 people commenced in post in September 2015. • The apprentices have been appointed as HCAs with option to continue onto nurse training.</td>
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<td>• Introduce staffing decision tool in all inpatient areas. This is a tool which will assist ward managers and senior nurses to provide evidence based data to support their staffing decisions. • Roll out staffing decision tool across all general wards.</td>
<td>• 31.12.2014</td>
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<td>Delivered • EWTD Audits now completed on a 6-monthly basis and reported to the Workforce Assurance Committee. • The EWTD audit carried out in February 2015 was presented to the Workforce Assurance Committee on 15th June 2015. • The EWTD Audit demonstrates a reduced level of staff working over 48 hours and greater compliance with “opt-out” agreements. • The audit identified 154 staff working more than 48 hours. 147 staff members had opted out and there were 7 breaches with 1 of these having now left the Trust. • Percentage of staff working extra hours is BETTER THAN AVERAGE in 2014 NHS Staff Survey (February 2015).</td>
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<td>• Roll out e-rostering on all sites by January 2015. Electronic rostering systems enable managers to draw-up rosters quickly and achieve a better skill-mix of workers.</td>
<td>• 31.01.2015</td>
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<td>Delivered • The Trust is using the safer nursing care tool endorsed by NICE. • Staffing is monitored 4 times daily at the safety flow meetings where risks are discussed and actions documented. • An additional module (SafeCare) is in development and will be added on to the current e-rostering system which will show acuity and staffing in real time. • The project commenced on 7th July 2015 with roll out of first 4 wards expected by the end of September (and blocks of 4-6 wards rolled out regularly thereafter according to the project plan which is in development).</td>
<td>31.05.2015</td>
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<td><strong>Domain 1 - Safe</strong></td>
<td>Ensure staffing levels and skill mix in all clinical areas are appropriate for the level of care provided (Continued)</td>
<td>• Implement the Payroll link on those wards where e-rostering is live and enable automatic timesheet and absence reporting.</td>
<td>Director of Nursing NHS England</td>
<td>Delivered • The payroll link has been implemented on wards where e-rostering is live. This will enable automatic timesheets reporting. • The payroll link has also been rolled out in all inpatient areas and the majority of other nursing areas. This will also ensure increased adherence to working time regulations and deliver operational and financial efficiency.</td>
<td>30.06.2015</td>
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<td>• 31.01.2015</td>
<td>Staffing decision tool audit Workforce Committee Clinical Commissioning Groups (CCGs)</td>
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<td>• Number of staff recruited each month will be reported to the Workforce Committee and to frontline staff to inform them about progress against the plan.</td>
<td>31.08.2014</td>
<td>Delivered • Vacancy levels and staffing profile KPIs presented monthly to the Workforce Assurance Committee and Board of Directors from July 2014 onwards. Updates on progress to frontline nurses and midwives via monthly Executive Chief Nurse newsletter.</td>
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<td><strong>Domain 1 - Safe</strong></td>
<td>Continue to actively recruit medical and specialist staff in areas where there are identified shortfalls</td>
<td>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</td>
<td>31.10.2014</td>
<td>Delivered • Workforce KPIs developed and monitored through the Workforce Assurance Committee. A workforce exception report and dashboard is presented monthly – there is a standardised suite of Workforce Reports from Board to Division. • Current vacancy levels for August 2015 are 7.0% nursing &amp; midwifery against a key performance indicator (KPI) to be at or below 5%, 11.4% medical against a KPI of 7% and 3.1% AHP against a target of 2% – ongoing recruitment campaigns continue with vacancies covered by bank, agency and locum appointments • Recruitment plan for 2015/16 developed with measures aimed at domestic, national and international recruits. Recruitment strategy and plans were presented to WAC April • Revised KPIs agreed at Workforce Assurance Committee March 2015 and monitored monthly.</td>
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<td>• Develop workforce Key Performance Indicator to monitor vacancy levels and recruitment to medical and AHP positions and monitor at the Workforce Assurance Committee</td>
<td>31.03.2015</td>
<td>Delivered • Workforce KPIs are monitored through the Workforce Assurance Committee. A workforce exception report and dashboard is presented monthly – there is a standardised suite of Workforce Reports from Board to Division.</td>
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| **Domain 1 - Safe**      | Continue to actively recruit medical and specialist staff in areas where there are identified shortfalls | • Develop a five year Workforce Plan for Better Care Together to address strategic intention and changing model of health care delivery (e.g. 7 day working). | • 31.03.2015 | Buddy Trust (Salford) Workforce Committee CCGs | Delivered  
• The health care economy strategy Better Care Together included an initial five year workforce plan covering both out-of-hospital and in-hospital settings. As part of this strategy we have developed an understanding both ‘in’ and ‘out’ of hospital workforce needs. We will continue to work with Better Care Together key partners to further revise and refine the workforce plans in line with emerging needs.  
• From an out of hospital perspective we are dependent upon the development of the plan however we do not have total influence of this. |
|                          | 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. | • Inform staff of the Lessons Learned monthly newsletter, the importance of incident reporting and the automatic feedback process to the incident reporter on all categories of incidents reported including actions taken and lessons learned. | • 30.09.2014 | Buddy Trust (Salford) CCGs Quality Committee | Delivered  
• Information provided in the August Payslip to all staff.  
• Article published on 2nd September 2014 in the Weekly Newsletter.  
• Divisional and corporate news includes lessons learned.  
• The Trust has a lessons learned steering group which is led by a non-executive director and this team ensure that learning is communicated through a corporate newsletter.  
• Since January 2014 all reporters have received an automatic reply email thanking them for reporting the incident and giving them the incident number and details of how the incident will be managed. The text was amended in April 2015 to ask the reporter to contact the manager concerned if they have not received feedback within one month.  
• Since April 2014 the reporter is automatically sent a further email at the time of closure of the incident which includes incident details, recommendations and lessons learned. The text was amended in April 2015 to ask the reporter to give a simple reply to the Patient Safety Department if the feedback from the manager is incomplete or insufficient. These emails are then actioned through the Patient Safety Department to ensure the reporter’s concerns are followed up.  
• In April 2015 a process was implemented to ensure that the feedback to reporters is reviewed for all incidents and that the incidents have been closed. Any with no or poor feedback are referred to the department manager for completion of appropriate feedback. If this is not completed within a further 2 weeks the incident is escalated to the Deputy Director of Clinical Governance.  
• Staff are starting to complete the feedback forms to enable the patient safety team to assess the quality of the incident investigation.  
• A local governance staff survey was sent out to staff in July 2015 to obtain their views regarding their opinion on the incident investigation process and lessons learned. The results were reported to the Quality Committee on 17 August 2015. |
Domain 1 - Safe

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.

(continued)

• Implement training programmes in 2014/15:
  - to improve the reporting of safety incidents;
  - to ensure that managers roles and responsibilities are understood; and
  - that appropriate investigations are undertaken for staff participating in completing the RCA template on the Safeguard system.

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<td>CCGs Quality Committee Workforce Committee</td>
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<td>• Continue to develop the Knowledge Management Website to include corporate and divisional lessons learned newsletters for staff.</td>
<td>31.12.2014</td>
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|                         | • Implement training programmes in 2014/15:  
  - to improve the reporting of safety incidents;  
  - to ensure that managers roles and responsibilities are understood; and  
  - that appropriate investigations are undertaken for staff participating in completing the RCA template on the Safeguard system. | 31.03.2015 |  |  | |
|                         | • Learning to Improve Bulletin (formally Lessons learned newsletters) is produced monthly and is circulated to all staff via email, Weekly News, the Friday message and delivered in hard copy to ward areas for display. A link is also available on the front page of the intranet and discussion is taking place about it being added to team brief.  
  • The whole process for capturing lessons has been revised with the Learning to Improve group, chaired by a Non-Executive Director and attended by a cross divisional, multi-professional team and leads from clinical governance and patient experience. The group collates and identifies themes arising from across the organisation and agrees the content for the bulletin, which is reviewed by a number of senior staff prior to publication.  
  • The learning to Improve web page is completed and available to all staff via the Governance Divisions intranet pages. Divisional and corporate bulletins are available from this page.  
  • Staff feedback has been received on the web site regarding recommendations to improve the learning to improve newsletter which is a welcomed initiative. The Friday message promotes the learning to improve bulletins. |  |  |  | |
|                         | • An incident reporting and management training programme was implemented in January 2014 in order to improve the reporting of safety incidents, promote a learning culture and reduction of harms. This has run each month to date. In addition Maternity has delivered their own training and have incorporated the training materials.  
  • From December 2014 the electronic RCA module within Ulysses Safeguard has been used and staff using the module for the first time are receiving individual training and support from members of the patient Safety Department Team.  
  • The number of incident reports submitted by the Trust to the NRLS is in the top quartile for Non-Specialist Acute Trusts. Rate of reporting published by the NRLS for the period April to September 2014 is 43.49 per 1000 bed days against a national Non-Specialist Acute Trust average of 35.89. The Trust remains in the top quartile.  
  • An updated RCA training programme (augmented by the NPSA RCA e-Learning package) has been piloted and this has now moved to a formal programme in June 2015.  
  • In December 2014 an electronic RCA Module on Ulysses safeguard system was implemented for SIRI, this replaced the previously used NPSA RCA Template.  
  • This introduction has been supported by staff from Patient Safety and all staff undertaking RCA investigations for incidents reported through SEIS are receiving training on the module as they are required to undertake the investigation |  |  | |
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<td>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. (continued)</td>
<td>• Implement training programmes in 2014/15:  - to improve the reporting of safety incidents;  - to ensure that managers roles and responsibilities are understood; and  - that appropriate investigations are undertaken for staff participating in completing the RCA template on the Safeguard system.</td>
<td>31.03.2015</td>
<td>CCGs  Quality Committee  Workforce Committee</td>
<td>Continued  • A RCA audit was undertaken to identify the level of compliance against the elements contained in the NPSA concise template. Between April and December 2014, all RCA’s were found to contain the information required in the NPSA concise template. The Policy for the Reporting and Management of Incidents has been amended in April 2015 to reflect the revised NHS England Serious Incident Framework and Never Event Policy and Framework. Work is ongoing with commissioners to amend the SIRI Panel Terms of Reference to reflect the revised role of the group, which is likely to become: receiving initial notifications of serious incidents, monitoring the completion of action plans and ensuring systematic learning throughout the organisation. The opportunity is also being taken to review the composition of RCA investigation teams and quality assurance processes in order to optimise clinical involvement, improve the independence of the investigation team and improve the quality of investigation. Incident reporting, management and RCA training is being revised to reflect the new frameworks and processes.  • The annual review of the Terms of Reference (TOR) for the SIRI Panel was undertaken in May 2015 and this incorporated changes to reflect the newly revised NHS England Serious Incident Framework and Never Event Policy and Framework. The TOR were approved at the Quality Committee meeting held on 15 June 2015  • Reduction in harm trends are being sustained in relation to HSMR, SHMI, perinatal mortality, hospital acquired pressure ulcers, falls resulting in harm and deterioration  • The content and learning from incidents is reviewed weekly by the patient safety summit and appropriate actions taken to ensure learning; actions are documented.  • In May 2015 reporting training was incorporated into Paediatric and Neonatal update training (PANDA) delivered by patient safety staff.  • In June 2015 e-Learning training packages for How to Report Incidents and How to Manage Incidents were finalised and made available to staff through the Training Management System (TMS). From that date all newly appointed staff have the reporting training incorporated into mandatory local induction on TMS. Similarly all newly appointed managers have the management training incorporated into mandatory local induction on TMS.  • As part of the Kirkup Plan all existing staff are to undertake the e-Learning reporting training. Similarly a check is being made that all staff who may manage incidents have attended face-to-face training or completed the e-Learning package.  • Staff are now completing the mandatory e-learning for incident reporting and RCA Investigation.</td>
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| 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. (continued) | • To monitor staff perceptions of incident reporting and feedback through the quarterly Pulse surveys. | • 31.03.2015 | Buddy Trust (Salford) CCGs Quality Committee Workforce Committee | Delivered
**Local Pulse Survey**
- From June 2014 a quarterly local pulse survey was undertaken and reported through the Workforce Dashboard and Workforce Committee. The survey asks the question: “If you have raised an incident or concern in the last 6 months have you received feedback from your line manager advising you of the outcome(s) - the results of the survey demonstrate continuing improvement, from an increase from 52% agreeing in September 2014 to 64% in February 2015, to 65% in April 2015.
- A further local Pulse Survey question, “I believe there is a culture that encourages the raising of incidents & concerns” has also shown improvement from 71% agreeing in September 2014 to 76% in February 2015 to 79% in April 2015.
- The next Pulse Survey will be undertaken in September 2015.

**National NHS Staff Survey**
- The 2014 NHS National Staff Survey (published February 2015) reports that 89% of staff agree/strongly agree that my organisation encourages staff to report errors, near misses or incidents - better than the national comparator. |

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| Ensure that appropriate action is taken in response to audits where poor practice is identified | • Annual clinical audit plan for 2014/15 to be developed using Healthcare Quality Improvement Partnership (HQIP) guidance to prioritise audits. HQIP was established in April 2008 to promote quality in UK health services, by increasing the impact that clinical audit has on healthcare quality. | • 21.07.2014 | Buddy Trust (Salford) Quality Committee | Delivered
**Annual clinical audit plan 2014/15 developed using Healthcare Quality Improvement Partnership (HQIP) Guidance and presented to the Quality Committee on 21 July 2014.**
- Annual clinical audit plan for 2015/16 developed using Healthcare Quality Improvement Partnership (HQIP) Guidance and was presented to the Quality Committee on 15 July 2015.
- An action plan template has been devised and implemented in line with HQIP to capture the actions required, required date and person responsible. For every audit that has been completed an action plan is developed using the template. An action plan module for clinical audit has been developed in ULYSSES so that every action plan received can be entered onto the system. We have improved our standard by escalating any outstanding action plans monthly to the Clinical Audit and Effectiveness Steering Group where by a letter is sent to the healthcare professional.
- Clinical audit progress report submitted to the Quality Committee meeting held on 20th April 2015 and 17 August 2015. |
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<td>• From the 2014/15 annual audit plan, all priority 1 and 2 audits will have an action plan developed in line with Healthcare Quality Improvement Partnership (HQIP) Guidance. Priority 1 and 2 audits are identified external and internal ‘must do’ audits.</td>
<td>• 31.03.2015</td>
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<td>• Develop a clinical audit module on the Ulysses safeguard system to follow up and monitor the timely implementation of clinical audit action plans.</td>
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<tr>
<td>Domain 2 - Effective</td>
<td>Ensure that appropriate action is taken in response to audits where poor practice is identified</td>
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<td>Summary of Main Concerns</td>
<td>Summary of Urgent Actions Required</td>
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<td>Domain 2 - Effective</td>
<td>To establish a Clinical Audit and Effectiveness Committee to monitor the effectiveness and impact of clinical audit.</td>
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<td>Review and update clinical audit procedure</td>
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<td>Domain 2 - Effective</td>
<td>Raise awareness and reiterate the importance of accurate record keeping with all nursing staff utilising nurse staffing away days in order to ensure that patient assessments are undertaken in line with professional regulations.</td>
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**Domain 2 - Effective**

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

**Continued)**

- Clinical Audit and Effectiveness Committee established.
- Terms of Reference for Clinical Audit and Effectiveness Committee agreed at the first meeting held on 12/09/2014.
- Clinical Audit procedure approved at the Clinical Audit and Effectiveness Steering Group on 15/10/2014 and ratified at the Procedural Documents Group on 22/10/2014.
- A planned audit on the implementation of the Clinical Audit Procedure was undertaken in May 2015. This is included in the clinical audit annual report which was presented at Quality Committee on 15th June 2015.

- All staff complete mandatory training at induction which includes record keeping. New employees cannot commence employment unless induction is undertaken.
- The importance of accurate record keeping has been a key focus in development programmes and induction of clinical staff.
- A single, contemporaneous healthcare record has been developed by front line staff, piloted and a roll-out programme commenced in April 2015. This will be the only healthcare record in use across inpatient areas. It aims to reduce duplication and time spent writing, whilst improving communication and quality of patient care.
- The introduction of GMC and NMC stamps has supported further improvement in documentation standards.
- The new documentation has been audited in June 2015 and the audit findings presented to the Quality Committee meeting on 15 June 2015. The audit has demonstrated improvements. Further targeted work is required to ensure sustained improvements. The record keeping documentation has been reviewed to improve the documentation to record the plan of care.
- Spot check audits into the main areas of concern have been completed during June 2015.
- The plan is now to move to an electronic care plan supported by external funding from successful bids to the nursing Tech fund with a completion date of July 2016.
### Domain 2 - Effective

#### Improve the nurse record keeping on the medical wards

(Continued)

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<tr>
<th>Summary of Main Concerns</th>
<th>Summary of Urgent Actions Required</th>
<th>Agreed timescale for implementation</th>
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<th>Revised deadline (if required)</th>
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</table>
| **Domain 2 - Effective** | Improve the nurse record keeping on the medical wards (Continued) | • Health Record Keeping Standards provided to relevant staff groups at local induction to ensure staff understand professional responsibilities and they will be held to account for this. | • 31.03.2015 | Quality Committee CCGs | Delivered  
• Health Record Keeping Standards is included and delivered through local workplace induction with new employees with compliance monitored on a monthly basis at Board and Divisional level through the Workforce Information reports.  
• The data is captured through TMS - compliance figures have historically reported on compliance at one month point only. This is reported at Board and Divisional level through the Workforce Information reports.  
• Work has been undertaken to implement a revised recording and reporting approach on TMS which will more accurately demonstrate compliance against this KPI from May 2015 onwards. A process has been put in place whereby Learning and Development notify the Assistant HR Business Partners of those members of staff who do not complete their local induction within the timeframe and this is escalated to the Divisional Management Team and/or Performance meeting for follow up. This activity is maintained until all (i.e. 100%) of the new starters have completed their local induction. This robust follow up process commenced in March 2015 and therefore explains why only 57% of the February new starters have completed local induction within the expected timeframe. The expectation is that when the March 2015 new starters are followed up at the 3 month point, at the end of June 2015, compliance level will be nearer 100%.  
• Questions regarding completion of induction requirements have been added to the 90 day follow up calls  
• Local Workplace Induction (LWI) – 3 monthly follow up for the April 2015 new starters. A total of 95 new starters attended Corporate Induction in April 2015. The LWI compliance level as at the end of May (i.e. when the LWI should have been completed) was 32%. The 3 monthly follow up, as at the end of July 2015, indicates the compliance rate has increased to 60%. |
| | | | | 30.06.2015 | |
## Summary of Main Concerns

### Domain 3 - Caring
Review the services provided by the chaplaincy at RLI so that patient's spiritual needs are better met.

- To recruit additional members to the chaplaincy team to provide spiritual and pastoral support to patients and their families.

  - **Agreed timescale for implementation:** 23.06.2014
  - **External Support/Accreditation:** QSG
  - **Progress against original timescale:** Delivered
    - The Trust has recruited two chaplaincy members to support the service to patients. One commenced in post on 19/05/14, the second on 23/06/2014.
    - The chaplaincy team have recruited volunteers to support them. There are a total of 40 volunteers.

### Domain 4 - Responsive
Ensure that accurate and timely performance information is used to monitor and improve performance.

- Dashboards provide at-a-glance views of performance information. The Board level and Assurance level Business Intelligence Dashboards will be reviewed to ensure an integrated suite of performance data is available to the Board.

- Finalise divisional level dashboards to ensure an integrated suite of performance data is available to support robust performance management for Finance, Clinical Standards, Quality, Human Resources and Governance for implementation in Quarter 2.

- 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.

  - **Agreed timescale for implementation:** 31.12.2014
  - **External Support/Accreditation:** Finance Committee/Audit Committee/Internal Audit
  - **Progress against original timescale:** Delivered
    - The action relates to the recommendation made by the CQC in relation to the Trust use of information. The CQC reported that although the Trust appeared to have a number of systems in place, the process to ensure good data quality and that the data was used to produce meaningful information to inform decision making was lacking.
    - Since receiving the report from the CQC in June 2014 the following actions have been delivered:
      - The introduction of a suite of performance dashboards – using data to produce information to inform risk assessments / decision making at all levels of the organisation. These dashboards have been produced in conjunction with end users for use at Trust Board, Board Assurance Committees, Divisional Performance reviews and Ward based dashboards.
      - In addition, specific dashboards have been developed to take forward our quality improvement agenda – for example the Nursing Quality Dashboards and Dashboards to inform the Mock Inspection process.
      - There has been a strengthening of the Data Quality infrastructure, systems and processes to ensure that the information used is accurate, timely and fit for purpose.
      - We have used our Internal Audit function to review the changes made. Their reports have provided significant assurance that the changes are working effectively.
### Domain 4 – Responsive

**Ensure that accurate and timely performance information is used to monitor and improve performance**

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<th>Summary of Main Concerns</th>
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As a result of the above, we can demonstrate a number of decisions / actions taken as a result of having access to good quality information. In particular, more informed decision making with regards medical and nurse staffing – enabling live risk management and informing more focused recruitment strategies. We have also been able to improve our patient outcomes over the period in using the suite of information provided for Quality Committee and its sub committees – in particular harm reduction and using live patient feedback to inform rapid improvement.

### Domain 4 - Responsive

**Ensure the timely availability of case notes and test results in outpatients department across the Trust**

1. Audit case note availability on a monthly basis to monitor progress against improvement trajectory.
   - **30.08.2014**
   - **Quality Committee**
   - Delivered
   - Case note availability has improved and is audited on a monthly basis. All three sites consistently achieve the Trust target.
   - 95.66% achieved trust wide in January 2015, 96.16% in February 2015; and 97.09% in March 2015 against a target of 95%. The Trust achieved 97.37% in April 2015, 97.42% in May 2015 and 97.71% in June and 97.89% for July 2015 against a target of 96%
   - The results are reported at the monthly Divisional Performance Review meetings.
   - The Trust is currently rolling out Paperlite project
   - A task and finish group is in place to drive the implementation of Paperlite Outpatient Clinics which is the first stages of electronic patient record within OPD consultations. Informatics are supporting data collection) to show performance against improvement markers.
   - Case note availability continues to be audited on a monthly basis.

2. Audit the timely availability of outpatient test results being available electronically on a monthly basis to monitor progress against national standards.
   - **30.09.2014**
   - **Internal Audit**
   - Delivered
   - A total of 231,597 pathology tests were reported in August 2015 with 100% of tests produced from analyses in house being available on Lorenzo.
   - A total of 3393 tests were sent away for analysis in August 2015 with 99.98% being available on Lorenzo.

### Domain 4 - Responsive

**Review the numbers of elective caesarean sections carried out in the maternity services**

1. Strengthen existing approaches to reviewing and monitor elective caesarean section rates as part of the divisional clinical audit programme;
   - **30.09.2014**
   - **Quality Committee**
   - Delivered
   - Monthly caesarean section data collection undertaken.
   - January audit presented to the Quality Committee and demonstrates a C-section rate of 25.3 (national average 26.5) and 100% indication recorded in all records (43 at RLI and 22 at FGH)
   - Results have shown consistency month on month.
   - The caesarean section audit for June 2015 demonstrates a C-section rate of 31.06% and for July 2015 27.72% against a target of 26%.
   - The caesarean section audit for August 2015 demonstrates a C-section rate of 24.71% against a target of 26%.

2. **Independent Review**
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<th>Summary of Main Concerns</th>
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<th>Revised deadline (if required)</th>
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<tr>
<td><strong>Domain 4 - Responsive</strong></td>
<td>Review the numbers of elective caesarean sections carried out in the maternity services</td>
<td>• Independent review of randomly selected cases to ensure compliance with the Trust’s guideline;</td>
<td>• 30.10.2014</td>
<td>Quality Committee</td>
<td>Delivered</td>
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<td>Independent Review</td>
<td>• North Tees have undertaken an independent review and submitted the final report to the Trust. Action plan being monitored monthly by quality assurance committee</td>
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<td>• Monthly caesarean section audit is undertaken to monitor the implementation of caesarean section NICE guidelines. Overall compliance for the majority of standards audited is 100%.</td>
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<td>• Findings of the report of the independent review to be presented to the Quality Committee in January 2015.</td>
<td>• 30.12.2014</td>
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<td>Delivered</td>
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<td>• The findings of the report and action plan have been presented to the Quality Committee on the 19/01/2015 and the Executive Directors Group meeting on 20.01.15. The caesarean section audit action plan and progress is monitored on a monthly basis at the Quality Committee. The action plan was presented at the Quality Committee on 15/6/15 and presented again on 20/7/15.</td>
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<tr>
<td><strong>Domain 4 – Responsive</strong></td>
<td>Consider its investment into the diagnostic and imaging services to respond to increased demand.</td>
<td>• To take the necessary action to mitigate the impact of a reduced number of radiologists (a shortage occupation) to ensure continued delivery of high quality patient care.</td>
<td>• 31.03.2015</td>
<td>QSG Workforce Committee</td>
<td>On track to deliver</td>
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<td>• Develop new ways of working to facilitate increase in capacity including a skill mix review, new ways of working and recruitment</td>
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<td>• Radiology is a national shortage specialty. We also have a longstanding shortfall in consultant numbers which makes recruitment to the unit difficult. Over the last few months we have reshaped the department using innovative methods of delivery including outsourcing, development and appointment of a consultant radiographer, honorary contracts and advanced practitioners, to reduce our requirement for consultant staff.</td>
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<td>• This reconfiguration has improved service delivery so that our performance has improved progressively over the course of the last year. This is demonstrated by the fact that reporting times have reduced from June 2014 to present</td>
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<td>• In February 2015, the Royal College of Radiologists undertook a snapshot survey for England and UHMB FT contributed in this. The study identified that on 26 February 2015 there were no studies (plain film, CT and MRI) unreported on our PACS system which had been waiting more than 30 days for a report.</td>
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<td>• Since February 2015, 2 Consultant Radiologist posts have been filled with 1 consultant starting in May 2015 and the second in September 2015. Two Associate Specialists have also joined the team.</td>
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<td>• 10 radiographers have also been appointed since 2015 into a range of modalities, CT/MR and general radiography.</td>
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<td>• Recruited two Senior Associate Specialists on the 31st July 2015 and are awaiting recruitment clearances.</td>
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## Domain 4 – Responsive

Review its facilities and equipment in A&E so that patients who are subject to delayed transfer do not receive sub-optimal care.

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| • Combining the Medical Admissions Unit with Short stay in order to increase bed provision.  
  • Develop capital plans and submit funding request to facilitate expansion in the longer term. | | 31.12.2014 | QSG Quality Committee | Some Issues – Narrative Disclosure  
  • Mitigations delivered for period leading to realisation of estates strategy.  
  • The CDU has been relocated to an extensive and refurbished area alongside the HDU. This facility opened at the end of March 2015.  
  • The unit has seen the floor space for CDU double in size along with better facilities to improve patients’ environment and staff experience. The improvement works also include additional clinical assessment technology, improved storage space, and the creation of a fully en-suite isolation area.  
  • The Trust Estates Strategy includes development of a Combined Medical Assessment Unit (MAU) and Short Stay Clinical Decision Unit (CDU) to provide an improved pathway and capacity at FGH.  
  • Submissions to Monitor have been completed as a bid to accelerate the Estates Strategy.  
  • An in depth Clinical Service review of the A&E patient pathways has been undertaken to support the estates strategies vision for adjacencies, lean working and reduction of delayed transfer. | | 30.09.2015 - ongoing |
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<td><strong>Domain 5 – Well Led</strong></td>
<td>Improve communication with staff on the wards</td>
<td>• Communications team to review existing communication arrangements and recommend a plan to improve communication to all wards and departments across all sites which will then be signed off by the Board.</td>
<td>30.10.2014</td>
<td>Executive Directors Group Workforce Committee CCGs/ Healthwatch</td>
<td>Delivered&lt;br&gt;• The delivery of the Engagement Plan was submitted and presented to the Board on 28/01/2015&lt;br&gt;• The 2014 NHS National Staff Survey (published February 2015) reports statistically significant improvement in levels of staff reporting good communication between senior managers and staff&lt;br&gt;• Whilst levels slightly behind national average, communication satisfaction levels have never been higher over 11 years of NHS survey&lt;br&gt;• Listening into Action commenced 2014. Front line staff are leading a number of pioneering projects, supported by directors, across the Trust which are progressing well.&lt;br&gt;• An overview of progress regarding the improvement projects was presented to the Board on 25th March 2015.&lt;br&gt;• An Improvement Booklet has been developed and distributed to staff on 26th June 2015 during the CQC presentation to staff and is available on the Intranet for staff to access.&lt;br&gt;• A short achievements film has been made and published on the Intranet which is visible to patients and staff.</td>
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<td></td>
<td>Improve communication with staff on the wards (Continued)</td>
<td>• Various patient safety walkabouts will be undertaken including non-executive and executive director patient safety walkabouts, 15 Steps Challenge walkabouts, Quality Review Inspections of Department Standards and peer reviews. These will be undertaken to ensure appropriate visibility of senior management across all sites.</td>
<td>30.10.2014</td>
<td>Quality Committee CCGs/ Healthwatch</td>
<td>Delivered&lt;br&gt;• Schedule of patient safety walkabouts developed and available on SharePoint.&lt;br&gt;• Formal walkabouts at RLI and FGH have been replaced with a programme of mock CQC assessment visits.&lt;br&gt;• Mock CQC assessments have been carried out on a monthly basis at RLI and FGH. Letters have been sent out to all ward managers informing them of the outcome of the assessment.&lt;br&gt;• Three formal walkabouts have been undertaken at WGH in January 2015, one formal walkabout in April 2015 and three in June 2015 and three in July 2015.&lt;br&gt;• 2014 NHS Staff Survey (published in February 2015) reports positive improvement in levels of staff ‘knowing who the senior managers are’. Whilst levels are slightly behind national average, visibility of senior managers levels have never been higher over 11 years of NHS survey.&lt;br&gt;• In January and March 2015 staff listening events have been undertaken. A Pass It On Event was undertaken in June at the Castle Green Hotel to give staff the opportunity to deliver their improvement projects. Over 100 staff attended.&lt;br&gt;• A programme of Ward Visits took place throughout the month of June and senior managers within the Governance team have visited wards across the Trust to ensure staff are aware of the forthcoming CQC inspection and to answer any questions or concerns staff may have in relation to this.</td>
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## Domain 5 – Well Led

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

- 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.
- 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.

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<th>Agreed timescale for implementation</th>
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<td>30.10.2014</td>
<td>Board of Directors CCGs</td>
<td>Delivered</td>
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- Initial engagement plan for staff all delivered, including a series of clinician led briefings at all sites, including weekends. This has been further developed with a video briefing for staff by the Medical Director and the creation of a Q&A based on briefing feedback.
- The Trust Better Care Together Strategy was published in February 2015.
- An additional Staff Communications Officer has been recruited and commenced in post on 9 March 2015, with part of their role dedicated to communicating the Better Care Together Strategy to staff and supporting engagement.
- The annual communications work plan has been finalised and work is now taking place to implement the actions from it.
- Following the national announcement that Better Care Together had been selected as part of the ‘Vanguard’ for the NHS New Care Models scheme in April 2015, NHS England has announced that Better Care Together will receive the new investment of 9.9m from the national transformation fund for the year 2015-2016.
- ‘Vanguard’ communities have been selected by the NHS New Care Models Programme to help deliver the NHS Five Year Forward View. You will remember that Better Care Together applied to be a Vanguard site and was successful - one of just 29 successful applications across the country.

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<th>Revised deadline (if required)</th>
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<tr>
<td>31.01.2015</td>
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<td>Oversight and improvement action</td>
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<td>Monthly accountability meeting with Monitor to track delivery of action plan.</td>
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<td>Partnership working with a ‘Buddy Trust’ (Salford) to provide help and support to deliver improvements in quality of services.</td>
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<td>Partnership working with Wrightington, Wigan and Leigh (WWL) NHS Foundation Trust to provide help and support to deliver improvements in quality of services</td>
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<td>Appointment of an Improvement Director (by Monitor).</td>
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<td>Meetings of the Trust Improvement Board did review evidence about how the trust action plan is improving our services in line with CQC recommendations and reporting to NHS Choices on a monthly basis. This function has now been taken over by the single organisation Quality Surveillance Group.</td>
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<tr>
<td>Trust reporting to the public about how our trust is improving via monthly briefings/releases to local media.</td>
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<td>Re-inspection.</td>
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Appendix 1: Definitions of Terminology used within the Improvement Plan

This document provides a brief explanation of some of the terminology used within the CQC Improvement Plan.

Quality Improvement Plan
The Quality Improvement Plan has been developed following the Care Quality Commission (CQC) Inspection of our hospitals in February 2014. The Chief Inspector made 15 recommendations which are all included in our CQC Improvement Plan and can be summarised into the six key areas listed below. The plan identifies the improvements that need to be made, how the improvements will be delivered and timescales in which these improvements will be implemented.
- Improving our staffing levels;
- Engaging and communicating more effectively with frontline staff;
- Improving performance information to drive improvement and good decision making;
- Improving our nurse record keeping;
- Continuing to improve incident reporting and the learning we gain from incidents;
- Improving the availability of case notes and test results in our outpatients departments.

Improvement Board
To support the CQC Improvement Plan, an Improvement Board was created to oversee and contribute to progress on actions and would report directly to the Trust Board. This approach was replaced by a Quality Surveillance Group in line with national requirements.

Quality Surveillance Group
The NHS has a formal system already in place called ‘Quality Surveillance Groups' (QSGs) to bring together parts of the local health and care economies to routinely share information and intelligence. Working with our Local Area Teams ensures that the Trust makes best use of this existing facility for discussing progress against our Improvement Plan and any connected matters.

Improvement Academy
The Improvement Academy will provide support and assistance to our staff, helping them to understand what ‘good' and ‘outstanding' look like and providing them with the tools to achieve those high standards. The Academy approach will support staff to use tried and tested techniques for delivering consistent change.

Recruitment and Retention Strategy
The Recruitment and Retention Strategy is a document which sets out the direction in which the Trust will work towards recruiting and retaining the best skilled and dedicated workforce. It aims to improve existing recruitment and retention practices and identifies how we will ensure that we are an employer of choice.

Hard Truths staffing level data
NHS England and the CQC have issued joint guidance to Trusts on the delivery of the ‘Hard Truths’ commitments associated with publishing staffing data regarding nursing, midwifery and care staff levels. Staff numbers will need to be displayed on boards outside all inpatient ward areas. To see further details please refer to the link below:
http://www.england.nhs.uk/2014/04/01/hard-truths/

Workforce Key Performance Indicator (KPI) Report
Key Performance Indicators are a measure that provides managers with important information to enable them to understand the performance level of the Trust. The setting of KPI's in respect of workforce will enable the Trust to ensure that staffing levels are safe and that staff can provide appropriate levels of care. The KPI's will be used to monitor the use of bank, agency and locum staff and recruitment of staff. This data will be reported to the Workforce Assurance Committee in the form of a Workforce Key Performance Indicator Report.

European Working Time Directive (EWTD) monitoring
The EWTD is a directive from the Council of Europe (93/104/EC) to protect the health and safety of workers in the European Union. Monitoring will ensure safe systems of work and to protect employee health and wellbeing. This will be reported on a 6 monthly basis to the Workforce Committee

Electronic Rostering Systems
Electronic rostering systems enable managers to draw up rosters quickly and achieve a better mix of workers.

Workforce Plan for Better Care Together
The Trust has developed a 5 year workforce plan to address the changing model of healthcare delivery taking into account the proposals for future healthcare across Morecambe Bay as identified in the ‘Better Care Together Strategy’. For further information relating to Better Care Together please refer to the link below:
http://www.bettercaretotgether.co.uk/
Health Record Keeping Standards
Record keeping is an integral part of Nursing, Midwifery and Allied Health professional practice and is essential to the provision of safe and effective care. For further guidance on Record Keeping Standards please refer to the link below: http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Record-Keeping-Guidance.pdf

Lessons Learned monthly newsletter
The Lessons Learned monthly newsletter is published on the Trust Intranet and is a means of sharing lessons learned across the organisation following the investigation of an incident, complaint or claim. All members of staff have access to the Trust Intranet in order to view the Lessons Learned monthly newsletter.

Knowledge Management Website
The Knowledge Management Website is currently in development. This will be accessible on the Trust Intranet and will contain lessons learned and changes in practice following the investigation of an incident, complaint or claim. All staff will have access to this website to enable sharing of lessons learned and improvements identified.

Pulse surveys
A pulse survey is a survey given to employees of an organisation to get a sense of their satisfaction and productivity at a single point in time.

Healthcare Quality Improvement Partnership (HQIP)
HQIP was established in April 2008 to promote quality in UK health services, by increasing the impact that clinical audit has on healthcare quality. For further information on HQIP please refer to the link below: http://www.hqip.org.uk/

Ulysses Safeguard Risk Management System
The Ulysses Safeguard Risk Management System is an electronic database used by the Trust to report and manage patient safety incidents, staff / visitor incidents, customer services and alerts. The system will be further developed to include the management of clinical audit.

Clinical Audit and Effectiveness Committee
The Clinical Audit and Effectiveness Committee will be established to monitor the effectiveness and impact of clinical audit.

Lorenzo
Lorenzo is an electronic patient record management system used by the Trust.

Guru
Guru is an electronic clinical data sharing tool that enables Trust clinicians to remotely access GP patient records.

SharePoint
SharePoint is an electronic system that can be used to provide intranet portals, document and file management which can be accessed by a designated group of staff members.

Paperlite Project
The Paperlite project enables patient records to be electronically tracked and reduces the reliance on outpatient case notes by ensuring outpatient records are available electronically.

15 Steps Challenge
There are five toolkits that make up the 15 Steps Challenge; each toolkit provides a series of questions and prompts to guide patients, service users, carers and NHS staff through their first impressions of a care setting - See more at: http://www.institute.nhs.uk/productives/15stepschallenge/15stepschallenge.html#sthash.D29KpBwm.dpuf

Review and Inspection of Department Standards (RAIDS)
RAIDS are patient safety walkabouts conducted by a senior nursing team who will visit wards unannounced and follow a set process to assess First Impressions, Nursing Evidence and Patient Experience.

Better Care Together
Better Care Together is a project to reform health and social care in North Lancashire and South Cumbria. The programme is a partnership of local NHS organisations and councils. It is driven by a shared recognition that major changes are needed to ensure services can continue to meet the needs of local people.

Strategic Outline Case
The strategic outline case is a brief, high-level document that identifies how the Trust will deliver health care services in partnership with the local community.

Communications Strategy
The Communications Strategy provides a framework for the delivery of effective communications that are clear, honest, timely and relevant. It will reflect the Trust’s aims and values.

Monthly accountability meeting with Monitor
The Trust Executive team meet with Monitor on a monthly basis to discuss progress against the action plan.