Summary of the CQC and SRFT Diagnostic Improvement Plan

BLUE	Milestone successfully achieved
GREEN	Successful delivery of the project is on track and seems highly likely to remain so, and there are no major outstanding issues that appear to threaten delivery significantly.
AMBER/GREEN	Successful delivery appears probable however constant attention will be needed to ensure risks do not materialise into issues threatening delivery.
AMBER	Successful delivery appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and if addressed promptly, should not cause the project to overrun.
AMBER/RED	Successful delivery is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed, and to determine whether resolution is feasible.
RED	Successful delivery appears to be unachievable. There are major issues on project definition, with project delivery and its associated benefits appearing highly unlikely, which at this stage do not appear to be resolvable.

Version	**Version 7.8**
Date	**31/8/17**

What and why we need to improve

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

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

The diagnostic focus was to identify areas for improvement that impacted on patient safety. It was not a full investigation into all aspects of operations of the trust. Nor was it a full due diligence of the trust. The diagnostic was informed by the immediate concerns raised by the CQC.

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

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

The CQC report has now been published (August 2016). The CQC identified 77 'Must Dos' and 144 'Should Dos' to ensure sustainable improvement to care delivered across the Pennine Trust services. The full report corroborates the findings of SRFT's diagnostic.

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

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

This improvement plan sets out the immediate (first 9 months) improvement actions – this is to ensure we are getting the basics right, stabilising services and creating the right conditions upon which we can continue to improve and ultimately transform care delivery across Pennine.

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

Who is responsible?

NHS Improvement (NHSi), in conjunction with GM Health & Social Care Partnership (coordinating the response of Bury, Oldham, HMR and North Manchester CCGs), invited Salford Royal NHS Foundation Trust (SRFT), to provide interim leadership support to PAHT from 1st April 2016 the Chair, Mr. Jim Potter and the CEO, Sir David Dalton, were appointed to interim positions of Chair and CEO of PAHT.

The Trust Chief Executive Sir David Dalton is ultimately responsible for implementing the actions in this document, the Trust executive team will provide the leadership to ensure we identify the right improvement actions that will tackle some of the long standing issues the Trust has faced and create the right conditions to deliver the changes required.

Our site leadership teams, divisional triumvirates and clinical leaders across the Trust will be key to delivering the actions that will ensure service sustainability and transformation. The high level deliverables articulated in this plan are underpinned by weekly improvement actions that clinical and management teams have developed and own. These weekly actions and evidence of delivery will be managed via an integration management office; teams will be supported to deliver changes at scale and pace with access to the SRFT standard operating model.

The GM Improvement Board will bring together parts of the local health and care economies to ensure there is a shared understanding and collective commitment to the delivery of the improvement plan, including resources that need to be made available to enable the changes to happen.

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

How will we measure our improvement?

Measurement of our improvements will be fundamental to ensuring sustainability and the reliability of our care.
We will develop a high level assurance dashboard against our key themes that measures our progress. We need to ensure that our improvement actions and activities are translating to improvement in outcomes for patients using a small number of key performance indicators.

We will assure our improvement plan through our Trust board and Executive assurance committees

How will we communicate progress?

Internal Communication to staff within the Trust will utilise the full range of existing communication channels and our new leadership arrangements to listen, update and engage staff in the delivery of the improvement plan.

We will utilise a weekly message circulated to all staff, site notice boards; monthly face to face Team Talk sessions led by an Executive Director; regular briefings with the staff side representatives and direct engagement sessions between the Executive team and senior managers with a particular focus on meeting with the Clinical Directors.

Briefing of key issues through the line management structure; use of dedicated pages on the Trust intranet and articles on our improvement journey will feature in the monthly Pennine News magazine. Any matters which require immediate communication will be sent through an all user email.

There are multiple routes for staff to feed-back comments including the dedicated staff.views@pat.nhs.uk email address; raising issues at face to face sessions with their line managers or at Team Talk sessions; contributing through the staff engagement programme; if necessary using the Speak in Confidence system to raise matters anonymously directly with senior managers.

Working in partnership with the multi-agency communications group we will:

- Ensure the clear, consistent and integrated delivery of all internal and external communications including staff, patients, families and carers, commissioners, GPs;
- Ensure the public/patients are informed and reassured that services are safe;
- Ensure that all key partners and stakeholders are kept up to date and informed about developments, decisions and any service changes that are required and their impact;
- Ensure all related media enquiries are co-ordinated and managed effectively, to ensure clear and consistent messages and to ensure media coverage is accurate;
- Work together to manage and protect the reputation of the NHS and social care in Greater Manchester and the services provided across the local healthcare economy;
- Ensure any subsequent operational or service changes are communicated effectively across PAT and the local healthcare system to staff, GPs, the public and externally.

PENNINE ACUTE HOSPITALS TRUST – SAVING LIVES, IMPROVING LIVES
OUR IMPROVEMENT PLAN AND OUR PROGRESS

Improvement Theme	Summary of actions required	Agreed timescale	Assurance and external support	RAG Status	Executive and Operational Leadership	Revised deadline if required	BAF
Improving fragile services	***Urgent Care*** Establish clear leadership for the urgent care services and EDs in line with site based leadership model	1.12.16	External – GM Improvement Board CCGs GM providers	All appointments made and commence in post June – Sept **GREEN**	Chris Brookes Chief Medical Officer	June for Division	
	Ensure adequate stabilisation of consultant and middle grade cover in ED at NMGH to meet the agreed service model requirements.	12.9.16	Internal – Care Board and Quality Assurance Committee	Stability of consultant cover. Middle grade to be kept under review until permanent appointments made **AMBER**		1.3.17 for review Revised 30.9.17	
	Assess the options for the Urgent Care service model for North Manchester	1.4 17		Options assessed and recommendation made to GMHSCP. **COMPLETE**		31.7.17	

	Have in place a nursing, ENP, ANP workforce to meet the demand of patients across EDs	31.3.17		**ROH vacancies =** no vacancies from Sept **NMGH vacancies =** 14 current, none from Sept **AMBER GREEN**	Chief Nurse	ongoing	
	Have in place a nursing, ANP, AHP workforce to meet the demand of patients across AMU's	1.9.17		**ROH=** 14 RN vacancies from Sept post new recruits **NMGH =**3 RNs current but 28RNs post expansion, 11 in pipeline **AMBER**	Chief Medical Officer	Ongoing 1.9.17	
	Develop and deliver primary care offer within ED at NMGH (including streaming)	30.9.16		Goes live October. Capital bid approved by NHSi **AMBER GREEN**	Chief Delivery Officer	31.7.17 1.10.17	
	Develop integrated ambulatory pathways and frailty model at NMG	31.3.17		Model agreed, see above re: capital bid against Frailty offer will be included within phase 2 of the AMU expansion. Workforce recruitment remains risk to expansion **AMBER**	Chief Medical Officer	31.7.17	

	Ensure best practice patient pathways within the ED and time to assessment, treatment and transfers are well understood and delivered in order to manage risks to patient safety and improve care	31.3.17		Improvement actions underway at all CO with weekly tests of change. Workforce & bed capacity remains key risk. Indicators stabilised or improving. ROH delivery risk increased. **AMBER**	Chief Delivery Officer	ongoing	
	Ensure the pathways/escalation response for medical, surgical and paediatrics and the speciality services capacity to respond to urgent and emergency care is developed in place.	31.3.17		Speciality solution not yet reliable but improving. DTAs at NMGH significantly improved. ROH delivery risk increased **AMBER**		30.6.17	
	Have in place an extended crisis response service for North Manchester, 8am – 10pm, 7 days	31.12.16		**COMPLETED**		Go live Feb 17	

	Maternity Care				Chief Nurse/ Chief Medical Officer		
	Put in place the senior management and clinical leadership to develop and drive forward the maternity improvement plan	30.9.16	External – GM Improvement Board CCGs CMFT/RBH	**COMPLETE**		1.12.16	
	Have in place robust workforce plans and available staff to deliver maternity services, including medical, nursing and support posts.	1.1.17	Internal – Care Board and Quality Assurance Committee	Midwife to births ratio improving. New recruits Sept. Interview dates for ROH consultant appointments made NMGH – 5 posts advertised after RCOG approval, interviews Sept 6th **GREEN**	Chief Nurse/Chief Medical Officer	Phase 2 30.6.17 appoints In post 30.9.17	
	Establish comprehensive risk and governance arrangements which includes learning from incidents, complaints, auditing practice and improving incident and risk management systems and processes. Embed learning culture	19.12.16		Systems and processes in place. **COMPLETED**		On-going On-going	

	Ensure all staff are trained and developed specific to their job roles Ensure the engagement of all staff in the improvement plan, developing a culture of continuous quality improvement	31.3.17 31.3.17		Indicators improving with CTG training at 93%. 200 midwives on advanced NHSi programme **GREEN** Continuous engagement on-going **GREEN**		On-going	
	Paediatric Care Ensure adequate numbers of trained paediatric nurses are in place to meet the demand and ensure safe care Develop and deliver on the new model to stabilise paediatric urgent care for FGH Ensure all staff are trained and	31.3.17 30.9.16	External – GM Improvement Board CCGs CMFT/RBH Internal – Care Board and Quality Assurance Committee	HDU beds reliably staffed (discussions with NHSE re funding). Beds flexed to daily staffing to maintain safe ratios and business case under review for expansion. Recruitment ongoing. Reduction in transfer out remains stable at reduced rate **AMBER** **COMPLETED**	Chief Nurse Chief Delivery Officer Chief Nurse	1.9.17	

	competent to manage the critically ill child and have in place a 24hr/7 day rota for APLS/PLS trained staff. Ensure the capacity to treat and care for children requiring elective treatment is in place sustainably Develop and deliver on the new models of care to receive, assess and treat paediatrics at all sites	1.12.16 1.3.17 30.6.17		**COMPLETED** Oral surgery wait list re-opened with agreement from NHSI. Daily elective lists in place with some weekend capacity **GREEN** 23Hr unit in place at NMGH. Gaps in workforce cap/demand at ROH and ANP role introduced **AMBER/GREEN**	Chief Delivery Officer Chief Delivery officer	1.9.17	
	Critical Care Ensure sufficient consultant and middle grade cover to the HDU at ROH	30.9.16	External – GM Improvement Board CCGs CMFT/RBH Internal – Care Board and Quality Assurance Committee	HDU cover maintained at agreed levels and middle grade recruitment progressed. Risks to sustainability due to emerging consultant gaps at FGH and ROH cover required. **AMBER**	Chris Brookes Chief Officer Chief Nurse	31.1.17 31.3.17 1.8.17 1.9.17	

	Ensure that the required nursing/AHP workforce across the critical care units is determined and in place Determine the requirements for critical care outreach and safe response at night and weekends	1.6.17 1.6.17		Nursing gap closing to enable delivery against agreed plan. AHP plan to be reviewed in line with benchmark and funding revision **AMBER** Review post QI- Deteriorating patient			
Improving Quality	***Develop and Ignite our QI Strategy*** Develop PAHT QI strategy Engagement and launch of Strategy with CO staff	1.9.16 31.4.17	External – GM Improvement Board CCGs	**COMPLETED** **COMPLETED**	Chief Nurse	14.11.16 12.12.16 31.01.17 ongoing	
	Improving Safety • QI Collaborative on deteriorating patients and managing sepsis Engagement of staff	30.9.16	Internal – Care Board and Quality Assurance Committee	**COMPLETED**	Chief nurse/Chief Medical Officer		

	Development of QI faculty Commence collaborative Test of change being undertaken and QI learning being embedded Develop change package and scale up and spread	21.10.16 18.11.17 31.7.17 31.12.17		**COMPLETED** **COMPLETED** Underway **GREEN** To be develop following completion of collaborative		31.7.17	
	Improving Safety • 90 day improvement cycles for pressure ulcers, falls, CAUTI Have in place reliable data Develop ward improvement goals	(Mar-Jun17) 1.3.17 1.6.17	Internal – Care Board and Quality Assurance Committee	Pressure Ulcer data correct, falls data correct, CAUTI under review but using ST **GREEN** Falls continues to improve, and P Ulcer collaborative launched **GREEN**	Chief Nurse/Chief Medical Officer	ongoing 1.8.17	
	Improving Safety		Internal –				

	• 90 day improvement cycle reducing hospital acquired C.Diff Have in place reliable data Develop ward improvement goals and plans Review and improve the Trust antibiotic polices and antimicrobial stewardship Review and improve hand hygiene practices	(Oct-Dec) 1.10.16 1.1.17 30.9.17 30.9.17	Care Board and Quality Assurance Committee	**COMPLETED-**local action plans developed **COMPLETED** Policies reviewed by IP&C. Fundamentals of care programme led by CMO **GREEN** CO medical directors assuring compliance but system not yet reliable. **AMBER**	Chief Medical Officer	Dec-Feb Mar 17	
	Improving Safety • Implement NAAS System to ensure core nursing standards are met Mobilise team and engage senior nurse leaders in NAAS model	 9.9.16	Internal – Care Board and Quality Assurance Committee	**COMPLETED**	Chief Nurse		

	Undertake desktop assessment Identify data collections methods and priority areas (pilot wards) Baseline assessment of all priority wards and improvement plans developed Completion of all wards 50% of all wards to achieve Green status	30.9.16 14.10.16 31.3.17 30.6.17 1.3.18		**COMPLETED** **COMPLETED** **COMPLETED** On track – 7 wards outstanding will complete in next 3 weeks **GREEN** 33%, 19 amber = 44% and 10 green = 23%. Clear action plans agreed with ward managers and new corporate matrons for re-assessments **AMBER**		28.10.16 1.9.17	
	Improving Safety • Implement patient support system Deploy a support system to support vulnerable patients and families	Commence 1.10.16 Complete 31.12.16	Internal – Care Board and Quality Assurance Committee	**COMPLETED**	Chief Nurse	31.3.17	

	Evaluation of support system	1.9.17					
	Improving Effectiveness • Reducing mortality Outline methodology Undertake Trust wide mortality review Determine CO/Service level improvement actions using review data and Dr Foster intelligence Ensure reliable system for M&M reviews and learning from avoidable factors	 1.9.16 1.3.17 1.11.16 30.4.17	External – GM Improvement Board CCGs Internal – Care Board and Quality Assurance Committee	 **COMPLETED** COMP**LETED** **COMPLETED** Maturity of system seen at FGH. Roll out to other CO under MD leadership **AMBER GREEN**	Chief Medical Officer	 31.12.16 31.1.17 30.4.16 30.6.17 30.6.17 30.9.17	
	Improving patient experience • Improving End of Life Care		External – GM Improvement Board CCGs		Elaine Inglesby-Burke Site Nurse Directors and		

	Undertake a baseline assessment of bereavement care Work with wards and departments to agree the plan Roll out the Royals Alliance bereavement model	30.9.16 1.12.16 31.3.17	Internal – Care Board and Quality Assurance Committee	**COMPLETED** **COMPLETED** **COMPLETED**	Medical Directors		
	Improving patient experience • Implement 'what matters most to me' Undertake baseline assessment of Patient Experience and determine other key improvement actions Develop QI Collaborative on last 1000 days and PJ Paralysis	Commence 1.4.17 Complete 1.9.17 30.4.17 Commence June 17. Conclude 30.11.17		Project to form part of last 1000 days Ongoing improvement actions relating to FFT continue **GREEN** **COMPLETED**	Chief Nurse	ongoing	

	Undertake tests of change Develop change package and spread	July-Nov Nov-Dec		Commenced **GREEN**			
	Ensure safe medicines management Develop plans derived from core standards and audits Deliver on improvements to: - CD/RD checks - Fridge ambient temps - Crossing out/signatories Revise Medicines Safety Group	31.10.16 31.7.17 31.7.17		**COMPLETED** Improvements in Duthie audits. Clear action plans at ward level assured by DONs **AMBER** New TOR agreed and membership, Medical Director appointed to chair, schedule of dates agreed **AMBER-RED**	Chief Medical Officer	30.4.17	

	Complete MIAA audit actions	31.8.17		Plans in place to address actions **AMBER**			
Improving Risk and Governance	***Implement new risks and governance arrangement across the Trust*** Undertake comprehensive assessment of governance arrangements and develop work plan focussing initially on 4 priority areas: complaints, claims, serious incidents and coroners inquests Implement new risk and governance framework Put in place new Board Assurance Framework Ensure risk and governance arrangements during Transition to new CO and once new CO are	 31.11.16 1.8.17 31.12.16 31.10.16 1.9.17	External – GM Improvement Board CCGs Internal – Care Board Executive Risk Assurance Committee	Assessment and early improvement actions determined **COMPLETED**. Month on month improvements continue Complaints backlog trajectory agreed real time response to be in place by November 17 **GREEN** **COMPLETED** **COMPLETED** New Transition Board established. Clear project plan **AMBER- GREEN**	Chief Nurse	30.11.17	

	established remain robust Roll out risk training for all staff Phase 2 training to be delivered for new Divisional leaders once established Implement new Datix system	 31.3.17 Commence July 31.4.17		**COMPLETED** for phase 1. Additional training procured and underway **GREEN** Implementation underway – track mobilisation issues **AMBER GREEN**		1.6.17 1.7.17 1.8.17	
	Review all safeguarding Deliver on level 3 children's safeguarding training to agreed standard Undertake gap analysis for MCA DOLs and deliver on agreed action plan	 31.11.16 31.2.17	External – GM Improvement Board CCGs Local Authorities Internal – Executive Quality Assurance Committee	New Head of Safeguarding in post, training compliance maintained for high risk areas **GREEN** Gap analysis completed. Plans in place to develop staff knowledge and application	Chief Nurse	31.3.17 On-going On-going	

				AMBER/GREEN			
Improving Operations and Performance	***Ensure improvement to patient flow*** Implement SAFER model across all wards Improving reliability of SAFER Commence QI project on Reliable ward rounds Commence QI project on standard work for bed managers	16.12.16 31.7.17 Start 1.7.17 Start 1.7.17	External – GM Improvement Board CCGs Local Authorities Community providers Internal – Executive Operations and Performance Committee	**COMPLETED** See refresh below Tests on 2-3 wards per CO to identify bottlenecks PID approved 90 day improvement cycle underway. **AMBER** PID approved 90 day improvement plan underway **AMBER** AMU/ambulatory	Chief Delivery Officer	1.9.17	

	Ensure flow/bed requirements are driven by agreed clinical pathways of care, are modelled and delivered	1.4.17		pathways modelled. **GREEN** Workforce risks to AMU/Ambulatory expansion. Acute bed capacity limited and optimum occupancy reliant on OOH improvements **AMBER/RED**		Revised date 1.9.17	
	Have in place systems and processes for the management and escalation of patient flow across the acute sites to ensure patients are care for in the right place	1.4.17		Trust escalation systems revised to include OPEL. **COMPLETE**		1.9.17	
	Put in place and deliver against agreed standards which ensure medically optimised patients are transferred safely and appropriately	1.6.17		IDT teams in place. Needs agreed timeliness standards across NES & TA. Agreed DTOC levels not achieved **AMBER**			
	Ensure data quality systems and processes are robust to deliver on operational performance Reduce PAS open registrations by completing data cleanse exercise	28.10.16	External – GM Improvement Board CCGs	Open registration closure	Chief Delivery Officer	14.11.16 14.2.17	

	and put in place systems and process for access control			commenced **AMBERGREEN**		16.4.17 30.6.17 31.8.17	
	Create business intelligent patient tracking list and tools to support operational staff in managing stages of treatment for patients	1.1.17	Internal – Care Board and Executive Operations and Performance Committee	RTT and FU PTLs live in July/Aug **AMBER GREEN**		30.6.17 31.7.17	
	Ensure all identified staff groups have access to and are trained and assessed on referral to treatment rules and PAS functionality	1.1.17		Core systems trainers appointed. Training on-going **GREEN**		On-going	
	Ensure booking and scheduling functions and resources are in place to meet the standards required and are structured to support operational delivery and the best patient experience.	31.3.17		Engagement sessions delivered, plan developed **AMBER**		1.6.17 30.9.17	
	Put in place systems and processes to ensure clinical input into validation of ED breaches and non breaches	1.10.16		**COMPLETED**			

	Ensure ED symphony system is utilised and optimised in patient tracking and clinical pathway management. Ensure ED patient tracker roles are developed and supported across all EDs Undertake self-assessment against audit commission standards on DQ, develop action plans to address gaps.	1.12.16 31.12.16 1.6.17		Continued delays with technical solution **AMBER RED** **COMPLETED** DQ and assurance processes underway as BI functions aligned and CO's develop **AMBER**		31.3.17 31.5.17 27.6.17 31.8.17 (TBR) ongoing	
Workforce and safe staffing	***Undertake baseline safe staffing review of nursing*** Assess all wards and departments against Salford Nursing Standards commencing with high risks areas Agree and develop workforce plan to address shortfalls	30.9.16 31.10.16	External – GM Improvement Board CCGs Internal – Care Board and Executive Quality	**COMPLETED** Strategic work underway with HEIs and international recruitment partner procured.	Chief Nurse	14.11.16 30.11.16 1.5.17 Ongoing	

			Assurance Committee	**AMBER RED** Fill rates achieved with reliance on temporary staff due to recruitment challenges. NHSP gone live. New graduates start Sept **AMBER RED**		Ongoing	
	Have in place systems and processes to report and close workforce gaps to achieve safe reliable staffing (90% standard)	30.6.17					
	Undertake baseline safe staffing assessment for medical staff Understand vacancies against funded establishment Assess fragile services against national standards and clinical service need. Develop plans for resolution of gaps	31.8.16 31.12.16	External – GM Improvement Board CCGs, GMTU Internal – Care Board and Executive Workforce Assurance Committee	**COMPLETED** Assessment **COMPLETE** Agreed initial investment 12.5 WTE Consultants across the three CO's to support general internal medicine **COMPLETED**	Chief Medical Officer		

	Close all critical medical workforce gaps on sustainable base	31.6.17		Progress on stabilisation. Sustainable solution at risk – timescale and cost Overseas recruitment underway with circa 10-14 MGs in pipeline **RED**		1.12.17	
	Implement new model for recruitment						
	Identify hard to recruit groups	30.9.16		**COMPLETED**		31.11.16	
	Outline model and strategy for recruitment for fragile services	30.9.16		**COMPLETED –** plan revised following exec discussion			
	Evaluation of strategy	1.9.17		**COMPLETED** – revised action plan developed			
	Deliver on staff 'Happy Health Here' programme		External – GM Improvement Board CCGs				
	Promote and improve the health, wellbeing and engagement of the	31.3.17	Internal –	Sickness absence static Engagement strategy		On-going	

	workforce		Care Board and Executive Workforce Assurance Committee	approved and underway with launch of 1000 voices **AMBER GREEN**	Chief of Strategy and Organisational Development		
	Improve availability of the workforce and reduce reliance on temporary staffing	31.3.17		Temporary staffing spend remains high. Staff appointments in pipeline for Sept starts. Group wide approach developed for management of temp staffing (nursing and medical) **AMBER/RED**		On-going	
	Develop new PDR offer and ensure staff have opportunity to engage in performance development discussions.	31.3.17		New offer developed. **COMPLETED**		On-going	
	Meet 90% PDR standard	31.3.17		PDRs at 71% DQ issues being addressed. **AMBER**		On-going	
	Ensure all staff have access to and complete mandatory training	31.3.17		Current performance marginally below target at 86% against 90% standard		On-going	

	Meet 90% standard			**AMBER-GREEN**			
Improving Leadership and strategic relations	***Development of Group*** Transition from interim executive Chair and CEO arrangement to permanent solution Finalise group structure and governance arrangements	 1.8.16 31.3.17	External – NHSi, NHSE, GM Improvement Board CCGs	 **COMPLETED** **COMPLETED**	Chief Executive	30.11.16 31.3.17	
	Implement Site Leadership model Agree model and for site leadership and management of services Recruit to site leadership teams Develop site improvement plans and accountability framework	 31.10.16 Commence 1.9.16 Conclude 1.4.17 1.12.16	External – GM Improvement Board CCGs Internal – Care Board and Executive Workforce Assurance Committee	 **COMPLETED** **COMPLETED** **COMPLETED**	Jon Lenney Executive Director of HR &OD	 1.4.17	

	Develop and deliver on clinical leadership programmes Design, commission and deliver joint clinical leadership programmes with Chief Nurse, PAHT MD and Salford Head of Leadership (post TFL programme)	Design 1.10.16 Delivery commence 1.12.16		QI and Leadership programmes developed and delivery underway. **GREEN**	Chief of Strategy and Organisational Development	1.4.17 31.6.17 Ongoing delivery	
	Develop and deliver a range of leadership workshops for non-clinical leaders with SRFT Head of Leadership and Executive Sponsor(s)	Develop 31.10.16 Delivery commence 1.11.17		Plans developed with CO and underway **GREEN**		1.4.17 31.6.17 On-going	

Requirements to support improvement action	Timescale for implementation	Owner	Progress against timescale	Revised deadline if required
Agreement of management contract with SRFT	31.10.16	Raj Jain	Complete	31.11.16 31.3.17
Financial settlement agreed to support improvement plans and delivery on LTFM in 16/17 and projections for 17/18	30.9.16	Damien Finn/CCGs	Complete	31.11.16
Agreed specification and plans from commissioners on model of care for 'primary care front end'	1.12.16	CCGs	Requires finalisation in all localities	30.4.17
Engagement with and support from CCGs and LA to deliver on site and locality clinical service strategies	31.3.17	CCG/LAs	Joint Transformation Board in place. LCO plans in various stages of development	Requires revised deadline
Engagement and contribution to system wide UC improvement & safety workshop led respectively by ECIP and Charles Vincent	31.1.17	CCG/LAs and PAHT	Commenced	
Review of clinical quality and performance arrangements with commissioners to ensure robust assurance and safety systems in place	1.12.16	CCGs and PAHT	Contributions to CQC inspections by Commissioners	
Establishment of IMO to manage integration and co-ordinate improvement activities/synergies with SRFT	31.9.16	Jude Adams	In place	
Support from GM transformation unit and GM providers to develop and contribute where appropriate to new models of care for frail services	30.9.16	GMTU	In place	

SALFORD STANDARD OPERATING MODEL

Components of Standard Model

Governance Model:	Leadership Model	Commissioning and local stakeholder management	Strategic Partnership Model
Operations Model: •Organisational Structure •Process •People •Data •Control Centre	Patient insight and activation	Clinical process reliability: •SOPs and IPOM	Reliable and cost effective administration processes (automation)
Quality Improvement:	Staff Engagement	Corporate Services Models	Shared Clinical Services