ANNEX 1

CQC action plan following CQC visit in March 2015

Regulation: Regulation 12(1), (2)(a), 2(b) & 2 (e) HSCA (RA) Regulations 2014 Safe care and treatment						
How the regulation was not being met		**Action plan**	**Lead Executive**	**Status and on-going compliance**	**Update as at July 2016**	**Assurance Committee**
1	The provider must take action to ensure that all patients in A & E have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011	The organisation took immediate action post inspection to ensure that all patients in A&E have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011. This action is complete	Medical Director/	**Partially completed This action is under constant review**	The organisation is working to an agreed monthly STF which has been achieved for April, May and June. Service improvements continue to be embedded and include the development of AMM on the Scarborough site, the introduction of the clinical navigator and pit	Finance and Performance Committee Quality and Safety Committee

					stop nursing roles in York ED. Funding for updated nursing establishments in both departments were agreed in June 2016. Pilot of ED Front Door Model at York has been approved buy the Board and was effective from 1st July 2016. Robust REAP escalation process internal to ED has now been agreed and is in place.	

	How the regulation was not being met	Action plan	Lead Executive	Status and on-going compliance	Update as at July 2016	Assurance Committee
2	The provider must address the breaches to the national targets for A & E, referral-to-treatment time targets, and achievement of cancer waiting time targets to protect patients from the risks of delayed treatment and care.	The organisation has an agreed programme with commissioners that aims to improve performance against national targets for, referral-to-treatment time targets, and achievement of cancer waiting time targets to protect patients from the risks of delayed treatment and care. It is also working with ECIST to improve A&E performance and most recently been identified as one of 28 communities receiving support through the Emergency Care Improvement Programme.	Chief Operating Officer	**RTT**: work on maximising elective surgery, transferring work to Bridlington, minimising elective cancellations and some outsourcing to the private sector have ensured that the Trust is complaint with the 18 week incomplete standard. **ECS:** work continues as reported in action 1. At	We have continued to deliver the 18wk incomplete and 6wk diagnostic target – so compliant every month this financial year to date. Our STF trajectories for these two indicators was full deliver of the national thresholds (92% and 99% respectively) for every	Finance and Performance Committee

				Scarborough we are involved in the development of the Acute services in the small rural DGH. Cancer Standards were delivered in Q1	month of 16/17	

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	How the regulation was not being met	Action plan	Lead Executive	Status and on-going compliance	Update as at July 2016	Assurance Committee
3	The provider must ensure that patient flow into and out of critical care is improved, specifically in relation to: delayed discharges, delayed admissions, running at high capacity and non-clinical transfers out of the unit.	The organisation has an Acute Strategy which details the multi faceted approach to improving patient flow throughout the organisation. Some facets of the plan have been delivered and others are still in progress. This is led by the Medical Director together with the Chief Operating Officer and Clinical Directors responsible for the acute care pathway.	Medical Director/ Chief Operating Officer	**Partially Completed**	SRCCG have approved the finding of an additional bed at Scarborough and we are currently recruiting to 6 vacancies to staff the bed. 2 out of 6 have been recruited. One staffing is in post this will significantly reduce any non clinical patient transfers.	Board of Directors and Finance and Performance Committee

					A Strategic Board has been established to take forward the longer term planning of the service and a business case for the first three main priorities has been prepared.	
4	The provider must ensure that there is adequate access for patients to pain management and dietetic services within critical care.	A review is to be undertaken of current resources within the dietetics team with a subsequent options appraisal being made to the Board. A	Medical Director	**28th February 2016 Action considered closed**	We can confirm that the dietetics service fully meets the standards of support for critical care.	Quality and Safety Committee

					An business case for the Acute Pain Service in Scarborough has been drafted and has been approved by panel and is awaiting ratification at Corporate Directors. In the meantime the York Team have provided some training for Scarborough ward based staff.	

5	The provider must ensure all equipment is tested in a timely manner and in line with the trust's policy, especially checks on fridges and resuscitation equipment.	The organisation has a well-established programme of planned preventative maintenance checks for EME, and the same is replicated for non-clinical equipment. Domestic staff are responsible for the monitoring of food fridges, and nursing staff are responsible for the monitoring of drugs fridges.	Chief Nurse and Chief Pharmacist	**Action Completed** Improvement will be measured on these issues through regular audit and review with outcomes being reported into the Board of Directors No additional resource implications	This action is completed	Environment and Estates Committee

6	The provider must ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels: • nursing staff on medical and surgical wards; • consultant cover within the A & E; • registered children's nurses on children's wards, and other appropriate clinical areas and • radiologists • community inpatient services.	The organisation has successfully recruited an additional 73 RCNs who take up post in October 2015 to work in its acute sites. It has an open and centralised rolling recruitment campaign for RNs which will be reviewed on a monthly basis. We also have an active recruitment campaign targeting nurses from the EU.	Chief Nurse	**Actions Considered completed recruitment will always have a focus** Partly actioned , the organisation has recruited 73 additional nurses with a further 60 planned , progress will be reported to the Board of Directors on a monthly basis	Focus on recruitment continues, end of June vacancy position for adult inpatient areas was 130.5 fte RNs and 56.82 HCAs. Of which 101.55 RNs and 49.48 HCAs had been recruited too. Remaining vacancy position is 37 wte and 18.14 HCAs A campaign to recruit final year student nurses is underway	Workforce Strategy Committee and Quality and Safety Committee

7		The Trust is engaged in a continual recruitment programme for ED Consultants and most recently has introduced a recruitment and retention premia to enhance this. The Trust is also working with ECIST, ECIP and its Acute Board to explore the potential for alternative models of care that reduce the reliance on the ED consultant Workforce	Medical Director	Aim to recruit additional ED Consultants– **June 2016** Process of continuous recruitment and looking at alternative roles	The action is linked to the amendment in the MD risk register. Further workforce models are being considered and continuous recruitment in place , although not currently successful. Use of ACPs in ED to aid senior decision making	Workforce Strategy Committee

8		There is an open rolling recruitment for Paediatric Nurses	Chief Nurse	**Action Complete**	Additional Paediatric nurses have been recruited o B5 and B6 posts,	
9		The organisation is staffed to establishment on radiologists	Medical Director	**Action Complete**		Workforce Strategy Committee Quality and Safety Committee
10		The organisation has taken steps to increase staffing in community inpatient services	Director of Community Services	**Action complete**		

ANNEX 1

Regulation: Regulation 17 (1), (2)(b) & (2) (e) HSCA (Regulated Activities) Regulations 2014 Good governance.						
	How the regulation was not being met	**Action plan**	**Lead Executive**	**Status and on-going compliance**	**Update as at July 2016**	**Assurance Committee**
11	The provider must take action to ensure that the governance and risk management arrangements are strengthened to ensure risks are identified and acted upon in a timely manner.	The organisation is currently undertaking the Monitor 'Well Led' review and will act on any subsequent recommendations	Chief Executive	**Action Completed**	The Well Led Review has been received and considered by the Board. An action plan will be developed. Risk Management Processes continue to be improved and have received significant assurance by Internal Audit BAF has been revised Serious Incident	Board of Directors

					framework is being launched in September 2016	
12	The provider must ensure that there is a clear clinical strategy for both critical care and outpatients and diagnostics and that staff are engaged in agreeing the future direction and involved in the decision-making processes about the future of the service. The Provider must ensure that pathways,	The organisation has taken steps to develop a local clinical strategy for critical care by co-commissioning an external review of Critical Care Services	Medical Director	**Partially Completed** Local strategy completed. External review taking place in November 2015 to report January 2016 Resources already in place	Links to 3 above. SRCCG have approved the finding of an additional bed at Scarborough and we are currently recruiting to 6 vacancies to staff the bed. 2 out of 6 have been recruited. One staffing is in post this will significantly reduce any non clinical	Executive Board

					patient transfers. A Strategic Board has been established to take forward the longer term planning of the service and a business case for the first three main priorities has been prepared A local strategy has in the meantime been developed	

					A Time out day for the development of clinical strategies took place in April 2016 and strategic plans covering the next 5 years are being developed	
13		Each individual division has a its own strategy for the management of outpatients, There is a strategy for Radiology	Medical Director	**Completed** Resources already in place		Executive Board
14	Policies and protocols are reviewed and harmonised across the Trust, to avoid confusion among staff, and address any gaps identified	The organisation already has a programme of harmonisation and review of policies. It is looking to appoint a Clinical Improvement Fellow (interviews W/C 2 Nov) and a Deanery Leadership Fellow for a year to lead on the project of harmonising and reviewing clinical guidelines.	Medical Director	**date 31st March 2017** Clinical guidelines in existence which conform to NICE Guidelines	1st new appointment is in place (Clinical Leadership Fellow) with the. The second appointment	Quality and Safety Committee

		Deanery Leadership Fellow to be advertised in November 2015. ll inform the new clinical strategy. The review is due to conclude on 12 November with a report being expected in January 2016		will continue to be used and will be relaunched as they are updated.	from March/April 2016 This work continues	
15	The provider must ensure that patient records are fully secured when stored, specifically within the school nursing records.	Action has been taken to undertake a new risk assessment of the building containing school nursing records. As a result some minor adjustments have been made to this facility that provide additional security	Director of Estates and Facilities	**Action Completed** The facility is secure and patrolled by the organisations Security Team Resources: the Quality Improvement Lead is part funded by the department. The Deanery Leadership Fellow post is	**This action is completed.** Additional security has been put in place for the building. The records have since been relocated to the ownership of City of York Council on 1 April 2016	Environment and Estates Committee

				part funded by Deanery funds and part by post grad work Reported to the Board as completed (December 2015)		

ANNEX 1

Regulation: Regulation 18(2)(a) HSCA (RA) Regulation 2014 Staffing						
	How the regulation was not being met	**Action Plan**	**Lead Executive**	**Status and on-going compliance**	**Update as at July 2016**	**Assurance Committee**
16	The provider must ensure there are suitable arrangements in place for staff to receive appropriate training and appraisals in line with Trust policy, including the completion of mandatory training, particularly the relevant level of children and adult safeguarding training and basic life support so that they are working to the up to date requirements and good practice.	The organisation has taken steps to ensure that all staff complete statutory and mandatory training with compliance being reported regularly to the Board. Compliance is currently at 81%. Current training levels for	Chief Executive	**Achieved annually** Improvements have been established, are measurable and are reported to the Board • Safeguarding Adults Awareness - 92% • Safeguarding Adults level 1 - 77% • Safeguarding Adults level 2 - 84% • Safeguarding Children level 1 - 91%	**This action is completed**. The system for an annual review is in place Overall compliance currently at 84 %	Workforce Strategy Committee
17		The organisation has implemented a new process that will ensure that all staff receive annual appraisals	Lead Executive		67.72% of staff appraised by end June 2016	

				• Safeguarding Children Level 2 - 83% • Safeguarding Children Level 3 -78% Basic Life Support - 83% Resources are in place.		
18	The provider must review arrangements to support staff working alone in the community to ensure their safety.	The organisation is currently engaged in re drafting its lone worker policy to more	Director of Community Services	**Action Completed on ratification of policy in August** Resource implications will be considered as part of the re-development of the policy.	The work on reviewing the policy has been completed, it has been redrafted and is currently going through the consultation/approval process and	

					due to be ratified in August.	

ANNEX 1

Regulation: Regulation 10(1) and 10(2)(a) HSCA (RA) Regulation 2014 Dignity and Respect						
	How the regulation was not being met	**Action plan**	**Lead Executive**	**Status and on-going compliance**	**Update as at July 2016**	**Assurance Committee**
19	The provider must ensure that patients' privacy and dignity is maintained when being cared for in the bays in the nursing enhanced unit based on ward 16 at York hospital.to the up to date requirements and good practice.	The organisation has taken steps to ensure that patients' privacy and dignity is maintained when being cared for in the bays in the nursing enhanced unit on Ward 16. Whilst it is at times unavoidable from a patient safety perspective for patients to experience being in a mixed sex environment patients are advised if this is the case, and given an option of being nursed on the NEU or elsewhere. Patients are also given information informing why they might find themselves on a mixed sex environment.	Chief Nurse	**Action Completed** This will be monitored via regular audit and reported to the Board. Resource requirements not applicable. Reported to Board that action completed (December 2015)	. The process put in place is the same as that used by the Vascular Imaging Unit	Quality and Safety Committee