York Teaching Hospital
NHS Foundation Trust

Board of Directors – 29 January 2020
CQC Summary Improvement Plan Progress Update

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☒	For approval	☐
For discussion	☒	A regulatory requirement	☒
For assurance	☐		

Purpose of the Report

Members of the Board will be aware that the CQC Programme Group has been established to ensure that progress against actions is monitored on a fortnightly basis. The report provides details on the current status of all actions, and escalates those actions that are either overdue, or where there has been a justifiable change in the target date.

Executive Summary – Key Points

This paper identifies those actions that have delivered status and therefore will be removed from the Summary Improvement Plan. The paper also escalates to the Board those actions which have not been delivered by their due date and those where there has been a significant change to the delivery date.

For note: RAG rating indicates

Blue: Action fully delivered
Green: Action on target for delivery
Amber: Action behind delivery, but with moderate change to delivery date
Red: Action: Actions overdue. Significant change to delivery date

The report also notes the CQC's decision, under the Health and Social Care Act 2008, the Urgent notice to impose conditions on York Teaching Hospital's registration as a service provider in respect of a regulated activity (Section 31) and the Section 29A warning notice

Recommendation

Members of the Board are asked to note the actions identified for removal from the Improvement Plan, and those identified for escalation.

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Director Sponsor: Heather McNair, Chief Nurse

Date: January 2020

1. Introduction and Background

The June and July 2019 site visits by the Care Quality Commission (CQC) concluded with an approved report on 16 October 2019.

The Trust accepted the content of the report and the recommendations within. Whilst the Trust retained an overall Requires Improvement rating; Safety on the Scarborough site went from Requires Improvement to Inadequate.

The Trust was subsequently visited on 13 and 14 July when the CQC undertook spot inspection of ED and the Medical Wards in Scarborough, and ED in York. On the 17th January, the Trust received correspondence from the CQC which indicated an intention to pursue Section 31 Enforcement Action for both ED's. This was followed by correspondence on 21 January indicating that the CQC had issued Regulation 29a Warning Notices covering a number of issues that are to urgently be addressed.

2. Detail of Report and Assurance

This report identifies those actions for removal from the Improvement Plan. Each of these actions can be evidenced. The report also escalates those actions where there has been some slippage and therefore has a revised delivery date. Pease note that only when all areas of an action are completed will the entire standard be considered as delivered.

2.1 Items for Removal from the Action Plan: Delivered Status

All actions from the immediate action plan from July have been removed a completed with the exception of 1A which has a focus on the Hospital Out of Hours Project. The project plan needs to be updated to reflect the delay in the digital solution for bleep filtering being implemented which is now due to be trialled in February 2020.

SD5.1: The action around the delivery of the Board Development Programme has been completed with the Plan being agreed at the December 2019 meeting of the Board of Directors.

2.2 Items for Escalation

The following actions are escalated for information.

Red Status

MD4: There are a number of components of MD4 that are escalated as moving to red status.

MD4.3 The Best Analysis Tool. This is being re-run in February 2020 with some support from the Service Improvement Team.

MD4.6: Immediate action to undertake a training needs gap analysis for the current Substantive medical and nursing workforce aligned to the RCEM recommendations and examining the possibilities of upskilling current staff to meet the needs of children. The TNA is in the process of being completed and it was reported that Paediatric Life Support is to be completed by May 2020. This is to be expedited with a number options being considered. There is also a requirement for an APELS trained clinician in ED 24/7.

SD6.1: The anti-ligature room in Scarborough ED is now identified; the original target date was 31/12/2019. The anticipated completion date is now mid- February subject to building regulation and infection prevention control approval as building work is required.

SD34.3: Entonox Gas**:** Business Case going to panel on 28 January 2020. This is likely to involve significant cost this will be subject to CPEG approval for the preliminary design work to be undertaken. The Health and Safety lead is confirming any mitigation and seek independent advice.

SD43.3: IT development to embed mental health capacity assessments and related documents electronically**.** This work has not yet commenced. A request to expedite this has been made to Systems and Network Services.

Amber Status

MD1: There is a minor delay in timeframe for the completion of the action from 31/12/2019) to allow for consultation of the Learning Policy. This will be completed by 31/1/2020 with an aim for approval at Quality Committee in February.

MD5.4: The Chief Pharmacist commissioned an internal audit on safe and secure handling of medicines. This has been completed but the Internal Audit Report is yet to be received.

MD6.3: Spot checks on records and security of records**.** Whilst spot are checks taking place there is a need for a standardised audit tool. Work is being undertaken to source/develop a suitable tool.

MD7:1: Work is ongoing in Care Group 2 to undertake a gap analysis against previous RCEM audit standards**.** This work is currently in progress and due to go to Care Group 2 Quality Committee in February**.**

MD9.2: This action is around engaging the support of ECIST to further develop approaches to improving the Trust's performance. The action requires a paper to the Board of Directors by 31/1/2020, however this will now be presented to the Executive Board in February 2020**.**

MD10.1 & 10.2. : Care Groups 2 and 3 are to document their Governance Management Structure. CG2 will meet on 27/1/2020 to document the arrangements that have been put into place. CG3 are in the process finalising their Governance

Structures.

MD12.2: This action around medical record keeping is specific to Care Groups 2 and 3. Care Group 3 are still to commence their record keeping spot checks**.**

MD16.2: Review of nurse staffing establishments for specified wards**.** A business case and accompanying paper is to go to Executive Board in February 2020.

SD2.1: The timeframe for the identification of the lead for the development of the Clinical Strategy has moved from 31/1/2020 to 29/2/2020. Once the individual is in post the delivery date for the production of the strategy will be agreed.

SD7.1: This action is to make improvements to the Paediatric area in Scarborough ED and was due for delivery by 31/12/2019. This is now being taken forward.
SD9.1: Clinical Supervision Strategy for Nursing. Not currently on track. To be picked up by the Head of Nursing for Care Group 6.This is to be completed by 17/2/2020.

SD11.1: Both Emergency Departments have been requested to review any out of date leaflets and ensure that the content was still appropriate, and that they were available in alternative formats and in the languages that meet the needs of our ethnic communities. A list of out of all leaflets are to be distributed to specialities for review of the content by 31/1/2020. Alongside this is a need to ensure that staff have received training in the Accessible Information Standard and how to update patient communication needs on the Core Patient Database. Training is available but the take up has been slow. Alternative ways of raising awareness are to be considered. Care Groups 1 and 2 are currently progressing this piece of work with a view to completion by 31/3/20.

SD47.1: Admissions criteria for Johnson Ward at Bridlington. This has been drafted and will be signed off by 15 February 2020.

3. Next Steps

The CQC Programme Group will continue to meet on a fortnightly basis to review progress against the Summary Improvement Plan and report and any removals/escalations on a monthly basis to the Board of Directors. The Section 31 and 29a will be mapped to the action plan and monitored through weekly meetings beginning W/C 27th January chaired by the Chief Nurse.

4. Detailed Recommendation

Members of the Board are asked to note those actions that have been delivered, and those escalated as a result of revised delivery dates.

York Teaching Hospital NHS
NHS Foundation Trust

Care Quality Commission Summary Improvement Plan

Board Assurance that CQC action is on track Key:
Delivered
On track to deliver
Some concerns – narrative disclosure
Not on track to deliver

Version Control

Version 5.3

23 January 2020

York Teaching Hospital NHS Foundation Trust – our improvement plan and our progress

What are we doing?

The Trust was rated as Requires Improvement following the last CQC inspection. The inspection focussed on the Trusts' east coast services and whilst most ratings stayed the same (9) or improved by one rating (2) it is noted that 'Safe' at Scarborough Hospital went down one rating to 'Inadequate'.

The CQC issued 3 requirement notices to the Trust. The 'MUST DOS' highlighted to the Trust for immediate attention are captured at the start of the Improvement Plan.

The CQC report made 77 recommendations in total, 26 of which the Trust must undertake and 51 of which the Trust should undertake. All 77 recommendations are included in our CQC Improvement Plan.

The plan is iterative and will be managed through new governance and meeting structures lead by the Chief Nurse.

The Trust Board has approved the CQC Improvement Plan which has been designed to deliver the immediate actions required as well as the longer term improvements needed. Support and engagement of our staff and our stakeholders will be fundamental to making the sustainable changes that are required for the benefit of everyone who uses our services.

A robust system of governance has been established to track and deliver the progress against the plan. The plans have been developed to match the new Care Group operational structure and thus delivery and governance will be largely owned at Care Group level. Care Group Leads have been identified to implement the plans. Care Group Leads will be supported, where identified, by Corporate Leads to ensure actions are implemented quickly and effectively and to unblock any obstacles that might prevent completion of the actions. There is Executive and Non-Executive oversight against all Care Group plans and further independent review will be provided through a clinically-led Peer Review and Audit process. Performance will be monitored through our CQC Programme Group and reported to the Quality Committee and to the Trust Board monthly. Further oversight will be provided to our stakeholders.

The improvement plan will be monitored by the CQC Programme Group on a weekly basis, with each service line being reviewed on a fortnightly basis. This document shows our plan for making these improvements and will demonstrate our progression against the plan.

The CQC Improvement Plan was signed off by the Board on 7 November 2019 and sent to the CQC on 13 November 2019.. The 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, Simon Morritt, is ultimately responsible for ensuring actions in this document are implemented. Executive directors are responsible for ensuring the plan is implemented as they provide the executive leadership for quality, patient safety and workforce.

Our success in implementing the recommendations of the CQC Improvement Plan will be assessed by the Chief Inspector of Hospitals, via the regional CQC Team who we will liaise with closely.

If you have any questions about the work we are doing you may contact our Deputy Director of Healthcare Governance, Fiona Jamieson, Fiona.c.Jamieson@.york.nhs.uk

The format of this plan.

This improvement plan is set out in the same format and sequence as the CQC report with the ‘MUST DOs’ and ‘SHOULD DOs’ in the same order.

For ease of reading where a similar concern was found across 2 or more areas the plan is cross referenced to this section.

We recognise that sustainable improvement requires cultural and or behavioural changes which will take longer than our immediate action plans. We need to build a culture that empowers colleagues, that instils ownership and accountability for quality and which ensures that we deliver our promises

Target dates going up to April 2020 reflects the ambition to deliver against all our MUST DOs and SHOULD DOs; this does not mean that our work will stop in April. There will be more work to do on some actions and where we have made changes we will continue to check that the improvements have been embedded and sustained.

We have rated the actions as “green” when in the planning stage planning. This is because we believe that the plan is realistic and is on track. We recognise that as time goes on, some actions may not go to plan and if this happens they will then change to ‘amber’ which means that there are reasons to be concerned that the action will not deliver the outcome or timescale or ‘red’ if we now believe that the action is not on track to deliver. There are some actions where important aspects are not under our control and so we have used ‘amber’ to show that we have less certainty.

A MUST DO (MD) and SHOULD DO (SD) key is provided at the end of the Implementation Plan for reference

How will we communicate our progress to you?

We will provide a progress report every month, which will be monitored by the CQC Programme Group and reviewed by the Trust Board.

The progress report will be published on the Trust website in the Trust Board papers, 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 stakeholders know our progress.

We will inform all Trust staff via Staff Briefs and Staff Matters letting them know more about the inspection outcome and describing the improvement plan, 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 updates to our stakeholders through the oversight and assurance meetings which will be held on a monthly basis.

CQC IMMEDIATE ACTIONS IMPLEMENTATION PLAN FROM THE VISIT

Issue No	Action	Lead responsibility	Key Actions	Target date	Measure or evidence of completion	Audit or ongoing assurance
IA 1	Assurance required to ensure sufficient numbers of suitably qualified, competent, skilled and experienced medical staff are deployed at night for medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients **NB: This action links to MD2; MD3; MD4; MD11; MD 19 and MD22**	Medical Director CG2 Clinical Director	Delivery of the Hospital At Night project	31 01 2020 (was 31/12/2019)	Hospital at Night Project Plan and Implementation Plan Medical staffing reported to CQC on weekly return Digital solution for bleep filtering and task allocation in place Junior doctor induction schedule and content to include bleep filtering and SBAR (AIRA course and links with Outreach Nurses)	The project plan requires updating to reflect the change in timeline for the Bleep filtering App Continues Currently over due to the delay in the App for bleep filtering being delayed Completed.

CQC MUST DO AND SHOULD DO IMPLEMENTATION PLAN FROM REPORT

MD1 Trust wide	Executive Lead: Jim Taylor	The trust must ensure is has a robust process for identifying learning from deaths and serious incidents and ensure this is systematically shared across the organisation	Delivery on track RAG Rating

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 1.1	Undertake promotion exercise to ensure ALL staff understand the current processes for identifying learning from deaths and SIs	Deputy Director of Healthcare Governance		31 12 19 (to be 31/1/2020 Completed	Article in Staff Matters Presentation at each Care Groups Quality Assurance Committee Presentation at Executive Board Develop presentation for medical staff induction	In Jan 2020 Staff Matters Policy to Feb Quality Committee June 2020 Presentation of Policy to Eb Feb 2020 undertaken Survey Monkey Audit to test that staff understand the current processes for identifying

						learning from deaths and SIs
MD 1.2	Develop a strategy for the identification of learning from deaths and serious incidents	Deputy Director of Healthcare Governance	Listening exercise with Care Groups. Aim to receive multi-professional feedback on current process	31 12 19 (Now 31/1/2020 to allow for comments on draft Policy)	Learning from Deaths and Serous Incidents Strategy document Sign off at Trust Quality Committee and Trust Board Evidence that the new strategy has been presented through the Care Groups Quality Assurance Committees – Feb 2020 Ongoing evidence that this is presented at appropriate groups, such as, at junior Doctor induction	See Actions for 1.1
MD 1.3	Undertake a multi-professional engagement exercise and in response review and revise the processes for the dissemination of learning from deaths and serious incidents	Deputy Director of Healthcare Governance	Engagement events	Linked to the actions 1.1 and 1.2	Report on what our staff think could be better about learning from deaths and serious incidents from the engagement events Revisions to current processes (to be determined)	Review document Revised processes and publications

MD2 – CG2 MD3 – CG2 MD11 – CG3 MD19 – CG5 MD22 – CG3	Executive Lead: Polly McMeekin	CG2 The service must ensure all medical staff in its urgent and emergency care service at Scarborough hospital are compliant with all aspects of mandatory training CG2 The service must ensure all medical and nursing staff in urgent and emergency care services at Scarborough hospital complete the required specialist paediatric life support training to enable them to safely care for children in the department CG3 The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with Trust policy (MD11 Scar and MD22 Brid) CG5 The service must ensure that all medical staffing complete mandatory training and safeguarding training modules in accordance with trust policy	Delivery on track RAG Rating
Scarborough site CG2 CG3			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance

MD 2.1	Implement the 'Training Passport' for staff employed from other NHS organisations – National Streamlining Programme	Director of Workforce and Organisational Development	Agreement of 'common standards' across STP for the 'Training Passport'	April 2021 (two year programme commenced April 2019)	Training Passport in place and aligned to Trusts 'Learning Hub'	Improved compliance with all aspects of mandatory training
MD 2.2	For immediate improvement: • Ensure that there is adequate and accessible mandatory training sessions for staff to access	Director of Workforce and Organisational Development / Chief Nurse / Medical Director	Review of mandatory training provision to ensure the delivery meets the needs of staff (TNA) (professional input sought from CN and MD)	Completed	Currently no waiting lists except for manual handling. Revised TNA applied and compliance assurance provided to Board	Learning Hub compliance discussed and monitored through CG2 Quality Assurance Committee monthly
	• Medical staff in urgent and emergency care will be issued with their individual compliance data and set a target date for full compliance	CG2 Clinical Director	Correspondence with each member of the medical staff Monthly monitoring of the progress through CG2	30 04 2020	Compliance matches Trusts target for each element of mandatory training on 'Learning Hub'	Mandatory Training compliance presented to Trust Board by Director of Workforce and Organisational Development monthly

			Quality Assurance Committee			
MD 3.1	For immediate improvement: For immediate improvement: • Ensure that there is adequate and accessible multi-professional paediatric life support training sessions for staff to access • Medical and nursing staff in emergency and acute care at Scarborough Hospital should undertake paediatric life support and 80% compliance should be maintained at all times	Sandra Tucker Quinn CG2 Clinical Director and Head of Nursing	Review of paediatric life support provision to ensure the delivery meets the needs of staff Training plan for paediatric life support for current staff Rolling programme of paediatric life support to ensure improvement is sustained and embedded	Completed Completed 31 03 2020	Compliance matches Trusts target (?80% of all medical staff) for paediatric life support training in acute and emergency medicine on Scarborough site :Training slots are available	Learning Hub compliance discussed and monitored through CG2 Quality Assurance Committee monthly Mandatory Training compliance presented to Trust Board by Director of Workforce and Organisational Development monthly

MD 11.1 MD 19.1 MD 22.1	For immediate improvement medical staff in surgery will be issued with their individual compliance data and set a target date for full compliance, specifically safeguarding training modules	CG3 Clinical Director	Correspondence with each member of the medical staff Monthly monitoring of the progress through CG3 Quality Assurance Committee	30 04 2020	Compliance matches Trusts target for each element of mandatory training on 'Learning Hub'	Learning Hub compliance discussed and monitored through CG2 Quality Assurance Committee monthly Mandatory Training compliance presented to Trust Board by Director of Workforce and Organisational Development monthly

MD4 Scarborough site CG2	Executive Lead: Polly McMeekin	The service must ensure it has enough, suitably qualified, competent and experienced medical and nursing staff in its urgent and emergency care service at Scarborough hospital, to meet the RCEM recommendations, including enough staff who are able to treat children in an emergency care setting	Delivery on track RAG Rating

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 4.1	Review the RCEM standards for staffing and undertake a gap analysis. Present findings to Trust Board	Director of Workforce and Organisational Development	Currently ongoing	31 01 2020	Trust Board presentation	Set a six monthly schedule for repeat gap analysis and risk assessments so the Trust Board understand the continued level of risk
MD 4.2	Medical recruitment plan in place and performing well	Director of Workforce and Organisational Development with CG2 Clinical Director		Complete	Vacancy level for medical staff: 9.2% on 31 10 19 Vacancy levels reported to Trust Board	Medical staffing levels monitored Vacancy level Turnover

MD 4.3	Implement the BEST nursing workforce analysis tool and use this for the basis for workforce redesign	Deputy Chief Nurse with CG2 Head of Nursing	Procure hardware and software and engaged with IT to support programme Analyse data and set a 6 monthly rolling programme for data collection and analysis	31 01 2020 (changed from 30/11), CG 1& 2 has used the tool which only reflects establishment if excludes corridor care. Tool to be re- run excluding corridor care CG1 24.2.20	Data collection, analysis and report completed and presented to CG2 Quality Assurance Committee and included in Chief Nurse report for Trust Board Next steps for workforce redesign to be informed by data on other intelligence	Hardware has been procured and is being used in both Emergency Departments prior to wider roll out Six monthly audit schedule for nurse staffing workforce using approved tool
4.4	Develop a nursing recruitment plan which includes projections and risk analysis and mitigation plan acknowledging registered nurse recruitment at Scarborough is challenging	CG2 Head of Nursing		31 01 2020 currently ongoing	Recruitment plan with quarterly reviews and updated recruitment plans in place	Registered nurse staffing levels monitored Vacancy level Turnover
4.5	Utilising the east coast review work, undertaken by the external reviewers, the Trust will determine and approve the scope of the paediatric service at	Chief Executive with Executive Director colleagues CG2 Clinical Director		30 04 2020	System wide presentation and approval of scope of paediatric services at Scarborough Hospital	

	Scarborough hospital which may impact the staffing levels and paediatric training level requirements	CG5 Clinical Director			Fully aligned medical and nursing staffing and training plan to meet the needs of children who present as an emergency or urgent case	
4.6	Immediate action to undertake a training needs gap analysis for the current substantive medical and nursing workforce, aligned to the RCEM recommendations and examine the opportunities to upskill our current staff to better meet the needs of children who present as an emergency or urgent case	Director of Workforce and Organisational Development	Training needs gap analysis undertaken and presented Internal and external training opportunities explored to deliver most appropriate training	31 01 2020 (TNA currently underway) RCEM recommendations require a clinician with EPALS training on each shift – this needs to be taken into consideration and evidenced. Face the Future Document to be reviewed regarding MD 4.6 particularly Level 1&2 of the guidance.	Urgent and emergency care RCEM aligned training plan and dates booked for specific training as required Staff attendance / achievement of recommended training monitored on the Learning Hub	Ongoing / rolling programme of training for nursing and medical staff who are not paediatric trained; acknowledging recruiting paediatric trained medical and nursing staff is a challenge at Scarborough hospital

MD5 – CG2 SD16 - CG3 Scar SD32 – CG5 SD38 - CG3 Brid	Executive Lead: Heather McNair	CG2 The service must ensure medicines are managed safely in its urgent and emergency care service at Scarborough hospital CG3 The service should ensure that storage areas temperatures are monitored to demonstrate medicines are always stored in accordance with manufacturer's minimum and maximum temperature guidelines CG5 The service should ensure that daily checks on medicine fridges are carried out as per Trust policy	Delivery on track RAG Rating
Scarborough site CG2 CG3			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 5.1	Immediate action: Lead Nurse for Medicines Management attended Scarborough Emergency Department. Reviewed compliance with safe drug storage. Provided advice and guidance to all staff and assurances that processes for safe management are in place.	CG2 Clinical Director CG2 Head of Nursing Chief Pharmacist Lead Nursing Medicines		Completed	Immediate verbal assurance Controlled Drug Inspection Report Minutes from CG2 Quality Assurance Committee that audits are discussed and where needed improvement	Control drugs audits undertaken quarterly (minimum) which is reported through Pharmacy Governance – report produced

		Management			plans generated	
	In addition Lead Nurse for Medicines Management is running the preceptorship programme for all newly qualified nurses and international recruits and will deliver a section on the safe storage of medicines in all areas	Lead Nursing Medicines Management		Completed	Presentation from Medicines Management Day for new starters (nursing) Competency Assessment document for new starters (nursing)	
MD 5.2	The Trusts Medicines Management Policy describes the requirements for safe storage. This section of the policy to be reproduced with 7 key messages. A laminated copy will be displayed in the clean utility / drug storage areas.	Lead Nursing Medicines Management		Completed	Key messages sheet produced	Controlled Drug Inspection report
	The key messages sheet will be read out at each safety huddles for 1 week, Week commencing 11 November 2019, and signing sheet for department to be completed	CG2 Matron CG2 Head of Nursing		Completed	Signature sheet to say staff have attended a safety huddle where safe storage of medicines was discussed	

	The key messages sheet will be included in local induction packs for all new starters The key messages sheet will be included in local induction packs for all new starters				Local induction pack	
MD 5.3	Matrons to undertaken quality audits and spot checks which include the safe storage of medicines	CG 2 Head of Nursing		Completed (being done by Healthcare Governance and Matrons)	Audit and spot check tools Audit programme Reports and action plans	Rolling audit programme
MD 5.4	Chief Pharmacist has commissioned Internal Audit to undertake: Safe and Secure Handling of Medicines Audit	Chief Pharmacist Lead Nursing Medicines Management	Scope of audit approval Draft report Final report	31 12 2019 31 01 2020 the audit has been completed but not reported and therefore this standard has been moved from green to amber.	Scope of audit Schedule for audit Audit Report	Actions generated from audit will be management through the Medicines Management Group

SD 16.1 SD 38.1	Develop the current Fridge temperature monitoring Policy to include ambient temperature monitoring for all clinical areas	Chief Pharmacist		30 04 2020	Updated policy Evidence of compliance with monitoring ambient room temperatures	
SD 32.1	All wards and units in midwifery have a signing sheet for daily fridge temperature checks. The completion of this will be audited on a weekly basis by ward sister, in her absence Matron will be responsible and any lapses in compliance addressed	Head of midwifery		Completed	Weekly audit reports Copies of signing sheets Evidence that compliance is discuss at CG5 governance meetings – minutes of meetings	But need to continue review to ensure this is embedded

MD6 MD24	Executive Lead: Jim Taylor	The service must ensure that computer screens showing patient identifiable information, are not left unlocked when not in use, in its urgent and emergency care service in Scarborough hospital	Delivery on track RAG Rating
Scarborough site CG2 CG3			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 6.1	Information Governance Training contains information about securing patient detailed guidance on computer screens. Compliance with Information Governance mandatory training to be maintained at the nationally target of 95%	CG2 Clinical Director CG2 Head of Nursing		Completed	Learning Hub compliance with Information Governance Training Information Governance Training forms part of induction for all new starters Information Governance training compliance discussed at CG2 Quality Assurance meeting – meeting minutes	Provision of Training information Monitoring of New Starters at Induction Continuous review of training compliance
MD 6.2	Information Governance Team peer reviews which provide an opportunity for immediate rectification	Deputy Director of Healthcare Governance		Completed	Schedule for peer review. Reports, actions and feedback from peer	Review schedule in place, immediate

	and for staff feedback on all information governance concerns				reviews.	feedback provided with follow up. Reported to IGEG
MD 6.3	Matrons to undertaken quality audits and spot checks which include secure management of patient electronic and paper records	CG2 Head of Nursing CG3 Head of Nursing		Ongoing – requires evidencing Whilst there are some spot checks taking place a standardised audit tool is needed; work is underway with the HON CG1/2/3 and the DCN to look at sourcing/developing a tool. Therefore this has moved from green to amber rag rating.	Audit and spot check tools Matrons Audit programme Matrons Reports and action plans Matrons	Rolling audit programme undertaken by Healthcare Governance and Information Governance Team

MD7	Executive Lead: Jim Taylor	The service must ensure it takes action to improve its performance in the RCEM audit standards in its urgent and emergency care service at Scarborough Hospital	Delivery on track RAG Rating
Scarborough site CG2			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 7.1	Undertake a gap analysis against previous RCEM audit standards and as necessary develop and action plan that delivers improved performance against the standards	Medical Director CG2 Clinical Director	Progress to be reviewed at CG2 QC Feb 2020	31 01 2020	To be reviewed through Care Group 2 Quality Cttee and OPAMS	Work is currently ongoing in CG2 with a focus on Paediatrics, VTE , Obs, Frailty and Mental Health
MD 7.2	Based on the review report develop an auditable plan to improve performance against the RCEM audit standards	CG2 Clinical Director		31 03 2020	Auditable improvement plan Minutes of CG2 Quality Assurance Meetings Quarterly report to CEM audit standards at Care Group 2 Board Meeting	Achievement of RCEM audit standards are sustained and embedded in CG2 performance

MD8 – CG2 MD13 - Scar MD23 – Brid SD29 – CG5	Executive Lead: Polly McMeekin Heather McNair	CG2 The service must ensure all nursing staff have an up to date appraisal each year in its urgent and emergency care service at Scarborough hospital	Delivery on track RAG Rating
Scarborough site CG2 CG3		CG3 The service must ensure all medical and nursing staff receive annual performance appraisals, in accordance with professional standards and trust policy (MD13.1 and MD23.1 Scar and MD 23.1 and MD23.2 Brid) CG5 The service should ensure that all staff have their annual appraisals	

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 8.1	Review current appraisal rate for nurses in urgent and emergency care and set a trajectory for appraisals to be undertaken to achieve 85%	CG2 Head of Nursing		29 02 2020	Learning Hub compliance with appraisal rates for nurses	Schedule of appraisals Appraisal rates monitored through CG2 Quality Assurance Meeting and CG2 Senior Nurses Meeting– meeting minutes
MD 13.1	Review current appraisal rate for nurses in surgery and set a trajectory for	CG3 Head of Nursing		29 02 2020	Learning Hub compliance with appraisal rates for nurses	Schedule of appraisals

MD 23.1	appraisals to be undertaken to achieve 85%					Appraisal rates monitored through CG3 Quality Assurance Committee – meeting minutes
MD 13.2 MD 23.2	Review current appraisal rate for medical staff in surgery and set a trajectory for appraisals to be undertaken to achieve 85%	CG3 Clinical Director		29 02 2020	Learning Hub compliance with appraisal rates for nurses	Schedule of appraisals Appraisal rates monitored through CG3 Quality Assurance Committee – meeting minutes
SD 29.1	Review current appraisal rate for midwives and medical staff in CG5 and set a trajectory for appraisals to be undertaken to achieve 85%	CG5 Head of Midwifery CG5 Clinical Director		29 02 2020	Learning Hub compliance with appraisal rates for nurses	Schedule of appraisals Appraisal rates monitored through CG5 Quality Assurance Committee – meeting minutes

MD9 Scarborough site CG2	Executive Lead: Wendy Scott	The service must ensure they continue to work to improve the following performance standards for its urgent and emergency care service at Scarborough hospital: • The median time from arrival to treatment • The percentage of patients admitted, transferred or discharged within four hours • The monthly percentage of patients that left before being seen	Delivery on track RAG Rating

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 9.1	Develop, review and deliver against the actions in the Recovery Plan	Deputy Chief Operating Officer (Acute Care) CG2 Care Group Manager	Plan developed and signed off at Trust Board Improvement trajectory achieved	Completed 31 03 2020	ECS Recovery Plan and schedule for review and reporting Monthly Performance Reports presented to and discussed at Trust Board Trust Board meeting minutes	Trust Performance Reports in place and will be reviewed at Care Group and Trust Board level every month Minutes of Trust Board
MD 9.2	Engage with the offer of support from ECIST to further develop approaches to improve the Trusts' performance as identified during the CQC	Deputy Chief Operating Officer (Acute Care) CG2 Care	Engagement offer from ECIST to be determined and key individuals to	Completed	Terms of engagement and timescales presented by Chief Operating Officer to Trust Board	Update 15Jan20 ECIST are supporting the Trust with Delivery of Same Day Emergency

	visit	Group Manager	be identified to link with ECIST on a programme of work Programme of work to be determined and key objectives and actions, with leads and timescales to be presented to Trust Board	31 01 2020 To be presented to EB Feb 2020	Present the programme of work to Trust Board	Care. The SDEC programme covers: Streaming in ED; process and workforce review and redesign to optimise use of SDEC areas in York and Scarborough hospitals. There is an agreed programme plan for SDEC with clear milestones, timescales, leads and risk management in place. Progress against plans is overseen at Care Group level by Care Group Boards. At a corporate level assurance for progress against plans is provided to Executive Board via SDEC programme

						inclusion in the monthly corporate Performance Report, and by a quarterly highlight report from Acute Pathways Programme Board for SDEC setting out achievements and risks to delivery against plan. During Jan20 a further programme of work with ECIST is being developed, to strengthen site management at York, and improve flow and performance in Emergency Departments in York and Scarborough Progress against the programme of

						work, including successes, challenges and obstacles to be presented to the Trust Board (quarterly), Internal Acute Board and monitored at OPAMs (both monthly.

MD10 CG2 SD17 CG3 Scar SD39 CG3 Brid SD48 CG2 Brid	Executive Lead: Heather McNair	CG2 The service must ensure the process for the management if risks, issues and performance, and the governance and oversight of these processes are fully embedded within its urgent and emergency care service at Scarborough hospital CG3 The service should continue to implement and embed the new governance structure and processes CG2 (Brid) The service should develop robust governance processes including performance dashboards, that local risks are identified, regularly reviewed and actions developed	Delivery on track RAG Rating
CG2 Scar CG2 Brid CG3			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 10.1 SD 17.2 SD 48.1	CG2 Management Team to review, revise and deliver a Governance Management structure that meets the needs of the new Care Group	CG2 Clinical Director CG2 Care Group Manager CG2 Head of Nursing		31/1/2020 (was 31/12/2019 on target	CG2 to produce a paper detailing their governance management and escalation structure (meeting taking place 27/1/2020) Minutes of CG2 governance management meetings Risk Register	Quality Committee, Governance and Resource

					Evidence of escalation to Trust Board Performance Reports	Committee Minutes
SD 17.2 CG3 SGH SD39 CG3 BH	CG3 The service should continue to implement and embed the new governance structure and processes	CG3 Clinical Director CG3 Care Group Manager CG3 Head of Nursing	CG3 still being formalised	31/1/2020 (was 31/12/2019 CG3 not on target currently.	CG3 to produce a paper detailing their governance management and escalation structure Minutes of CG3 governance management meetings Risk Register Evidence of escalation to Trust Board Performance Reports	Quality Committee, Governance and Resource Committee Minutes
MD 10.2 SD 17.2 SD 48.2	Executive oversight of CG2 and CG3 management of risks, issues and performance and governance will be managed through the CG2 and CG3 Care Group Boards	CG2 Clinical Director CG2 Head of Nursing CG3 Clinical Director CG3 Head of Nursing		31.12.19 Now ongoing: CG2 has an established process, CG3 not yet established.	Schedule of Care Group 2 Care Group Board meeting with executives Minutes of meetings CG2 Risk Register and evidence of escalation of risks to Corporate Risk Register Performance reports	

		Deputy Director of Healthcare Governance		Completed	Development of Governance Dashboards	

MD12 – CG3 MD14– CG3 Scar MD17 – CG2 MD26 – CG3 Brid SD27 – CG5 SD28 – CG5 SD42 – CG2 Brid	Executive Lead: Jim Taylor	CG3 The service must ensure that the quality of medical record keeping improves and that medical staff maintain accurate and contemporaneous records for all patients, in accordance with professional standards and trust policy CG3 The service must ensure that all records are secure when unattended (MD14 Scar and MD26 Brid) CG2 The service must ensure that all staff on medicine wards at the Scarborough Hospital site are maintaining securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided CG5 The service should ensure that all entries to women's records are legible CG5 The service should ensure that patients records trolleys are locked CG2 The service should make certain that staff adhere to record keeping policies and follow record keeping guidance in line with their registered professional standards	Delivery on track RAG Rating
Scarborough site Bridlington site CG3 CG2 CG5			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 12.1	In order to alert staff to this finding during the visit: • The Medical Director will write to ALL medical colleagues detailing their responsibility to comply with the Record Keeping Standards Medical Staff – Records Management Policy • The screensaver will be refreshed during September 2019 • Staff Matters article October 2019	Medical Director Deputy Director of Patient Safety Deputy Director of Patient Safety		Completed Completed Completed	Letter to ALL medical staff Screenshot of screensaver Staff Matters article	
MD 12.2 MD 18.1	Immediate action: Medical records audit to be designed and undertaken on a monthly basis with reports to CG3 and CG2 Quality	CG3 Clinical Director CG2 Clinical Director	Audit tool developed and a schedule of who and when the	Overdue (31/12/2019) Now established and	Evidence of monthly audits requested Audit results presented to the CG3 and CG2 Quality assurance Committees	Toolkit developed. Evidence required

	Assurance Committees. Compliance to be monitored closely at Care Group level, with evidence of associated action plans or individual performance management where necessary		audits are going to be undertaken produced	ongoing on a monthly basis	Evidence of improvement plans or individual performance management as necessary Evidence of improvement against audit	
MD 14.1 MD 26.1	Matrons to undertaken quality audits and spot checks which include secure management of patient electronic and paper records	CG3 Head of Nursing		Ongoing	Audit and spot check tools Audit programme Reports and action plans	Rolling audit programme
SD 27.1	Medical and nursing staff documentation audit	Maternity Quality Assurance team		Completed	Audit schedule Audit report	Evidence requested
SD 27.2	Audit results and compliance will be monitored and any necessary associated remedial actions taken	Maternity Quality Governance Manager		Completed and ongoing	Audit reports and minutes of meetings where governance is discussed	Evidence requested
SD 28.1	The notes trolley in midwifery is being situated behind a lockable door	Head of Midwifery Head of Estates and Facilities		Completed	Commission for work Completion of remedial work	Evidence requested
MD 12 14 18 26	Medium / long term action: Chief Executive to examine recruiting to an executive director position which has a specific focus	Chief Executive		30 04 2020	Executive level appointment who has lead for digital Review commissioned of	This timeframe may be revised as recruitment has only just commenced

	on digital and who on appointments commissions a review of the Trusts' IT infrastructure and how this supports safe patient record keeping				Trusts' current IT infrastructure and how this supports safe patient record keeping	

MD15	Executive Lead: Jim Taylor Polly McMeekin	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced medical staff are deployed overnight for medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients	Delivery on track RAG Rating
Scarborough site CG2			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 15.1	Immediate action: Where the Trust has unfilled shifts bank, agency and locums are employed. Daily monitoring is in place to ensure the safety of the wards	CG2 Care Group Director		Complete	Weekly reporting to the CQC	Weekly reports
MD 15.2	Review, recruitment and retention strategic approach for Scarborough site	Medical Director Director of Workforce and Organisational Development	Workforce Strategy ratified by Board June 2019. East Coast Medical Recruitment Project made substantive – Corporate	Complete	Vacancy rate monitored monthly and report to Board of Directors. Reduced rate from 21% in July 2018 to 9.8% October 2019.	Reported to Board of Directors bi-monthly (public Board)

			Directors July 2019			

MD16 Scarborough site CG2	Executive Lead: Heather McNair Polly McMeekin	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced registered nursing staff are deployed across the medicine wards at Scarborough Hospital site to promote safe care and treatment of patients	Delivery on track RAG Rating

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 16.1	Immediate action: Where the Trust has unfilled shifts bank, agency and locums are employed. Daily monitoring is in place to ensure the safety of the wards	CG2 Head of Nursing		Complete	Weekly CQC return and letter	
MD 16.2	Immediate action: On identified wards the staffing plan was increased. The establishments will be reviewed and realigned as required to ensure safe patient care	CG2 Head of Nursing CG2 Head of Nursing		Completed 31 01 2020 revised date 29.2.20	Weekly CQC return and letter Business case and accompanying paper to go to exec board in Feb 2020	Evidence received and ongoing Require evidence
MD	Reporting internal and	CG2 Head of		Complete and	Nurse staffing levels are	SafeCare audit is

16.3	external to CQC	Nursing Deputy Director of Healthcare Governance		ongoing Complete and Ongoing	reported monthly on the Unify return as per national standards Nurse staffing levels and vacancy levels are reported to Trust Quality Committee A letter goes to the CQC on a weekly basis as part of weekly monitoring	scheduled to be undertaken 21 10 2019 for two weeks. The data will be analysed and feed into workforce planning There is a plan to alter some of the wards on the Scarborough site as part of plans to sustain and grow the SDEC model. Nurse staffing workforce plans will be reviewed as part of the bed modelling exercise
MD 16.4	Review, recruitment and retention strategic approach for Scarborough site	Director of Workforce and Organisational Development	Workforce and OD Strategy ratified by Board of Directors June 2019. East Coast Medical Recruitment Project	Completed 30 6 2020	NHS I Retention programme project plan submitted. International nurse recruitment programme to deliver a further 48 nurses to Scarborough	Vacancy data and stability index shared with Board of Directors bi-monthly.

			made substantive July 2019			

MD18	Executive Lead: Brian Golding	The service must ensure that substances hazardous to health are stored securely and used in a safe way to avoid potential or actual harm to patients	Delivery on track RAG Rating
Scarborough site CG2			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 18.1	A review of all substances hazardous to health to health to be undertaken to ensure only appropriate substances are stored correctly and that COSHH risk assessments are in place	Head of Safety and Security		Completed	Review report COSHH assessments in date across all areas	All Wards have files in place, but need to provide assurance
MD 18.2	Up to date list of COSHH leads for all areas to be provided and reported through CG2 Quality Assurance Meeting Appropriate training or training updates to be delivered to COSHH Leads	CG2 Head of Nursing Head of Safety and Security		Completed Completed	Up to date list of COSHH assessors COSHH training records	List held by CLAD 50-60 staff have been trained
18.3	COSHH Leads to provide local training and ensure staff in each department	CG2 COSHH Leads		31 03 2020	Learning Hub compliance with CG2 basic Health and Safety mandatory	

	understand their roles and responsibilities associated with the management of hazardous substances				training Evidence of local COSHH training initiatives	

MD20 – TW Scar MD25 – TW Brid SD15 – CG3 Scar SD20 – TW Scar SD21 – TW SD50 – TW SD51 - TW	Executive Lead: Wendy Scott	TW The service must ensure the backlogs and overdue appointments in the trust is addressed and improved CG3 The service should ensure that they continue their work to improve patient access and flow to reduce referral to treatment times and patient cancellations TW The service should ensure the services assess risk in patients waiting beyond the recommended appointment dates	Delivery on track RAG Rating
Scarborough site Bridlington site Trust wide Outpatients CG3		TW The service should consider ways to reduce the number of cancelled clinics in outpatients	

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 20.1 MD 25.1 SD	Delivery of the Outpatients Transformation Programme	CG6 Manager	Introduce: -Rapid expert opinion -Patient Initiated Follow Up in Rheumatology	1/04/2020 Completed	Programme Plan Highlight Reports Enhanced management of Follow up partial booking	Evidence of SOP development and integration

15.1 SD 21.1			-Video Consultation Diabetes & Cancer -2 way text reminders for all Outpatient appointment & follow up	29/2/2020 30 6 2020	Currently being rolled out in Diabetes and cancer, gastro to follow	
MD 20.2 MD 25.2 SD 15.2	An RTT Recovery Plan is being updated to clearly state the projections for service delivery and backlog reduction	Chief Operating Officer Care Group Managers All Care Groups	RTT backlog to be reduced to 28,880 (78% performance delivery)	31 03 2020 and ongoing	Updated RTT Recovery Plan Presentation / minutes of Trust Board meeting which reference monthly RTT performance	Weekly Performance Meetings with all Care Groups Weekly Performance Overview Documents at Care Group and Trust level
SD 15.3	Reducing patient cancellations	CG3 Manager	30% reduction in same day cancellations	Q1 20/21 Completed	**IP Cancellations** Develop Day Unit Recovery area on Scarborough hospital site General Surgery rota changes have moved cancer colorectal resections to York to alleviate bed pressures	Day Unit area operational

					and long Length of stay at Scarborough Hospital site	
SD 20.1	Risk assessment of patients waiting beyond recommended appointment dates	Clinical Directors All Care Groups	Reduce longest follow up partial booking waiters	Completed a Paper to Exec Board 15/1/2020 highlighting the risk and Care Group actions.	Risk assessment process tested and delivered reduced longest waiters. Risk assessment processes embedded in Ophthalmology and Gastro Further risk assessment processes being undertaken as required at Care Group level Reported in monthly Clinical Governance meetings as part of the standard template Very long waits added to Care Group risk registers and discussed through governance meetings	Governance meetings Risk Registers

MD21 - Scar MD26 - Brid	Executive Lead: Wendy Scott	The service must ensure improvements are made where the service is not meeting the 18-week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment	Delivery on track RAG Rating
Scarborough site Bridlington site Trust wide Outpatients			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
MD 21.1	Supporting Performance Delivery Paper presented to Trust Board which provided a detailed recovery plan for any specialty or cancer site that was not achieving RTT and cancer waiting times	Chief Operating Officer Care Group Managers		Complete Complete	Trust Board minutes	
MD 21.2	Progress against the Performance Delivery Paper is monitored at Trust Board .	Chief Operating Officer	On going	Completed Monthly and	Update report on progress to be presented at Executive Board in November 2019 Progress against	Performance

				ongoing	recovery provided by monthly Performance Reports Trust Board minutes	recovery assurance is monitored across a number of system meetings: Trust performance framework. Care Group Boards. System Performance Meeting. Weekly performance meetings are held with Care Groups to tackle issues arising from recovery plans in the moment.

SD2	Executive Lead: Wendy Scott	The trust should develop a sustainable clinical strategy at pace building on the outcomes of the east coast acute services review and ensure it dovetails with the care group plans	Delivery on track RAG Rating
Trust wide Corporate			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 2.1	Determine nature and scope of Clinical Strategy Completion of Clinical Strategy document	Wendy Scott	Executive Board – Workshop to develop this. Identification of lead Drafting of Strategy Sign off by Executive Board and Board of Directors	29/2/2020 29/2/2020 Date to be confirmed	Target date changed from 31/1/2020 to 29/2/2020. COO in the process of identifying someone to lead this piece of work but has not been formalised as yet. the timescale for this revised to 29 Feb 2020.	Use of document as reference tool in future Board of Directors, Executive Board and Care Group Performance Review Meetings.

					Completed Document approved by Executive Board and Board of Directors	

SD4	Executive Lead: Wendy Scott Simon Morritt	The trust should continue its work to improve reporting of performance information to enable easier oversight and governance and continue its work to improve digital systems and processes	Delivery on track RAG Rating
Trust wide Corporate			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 4.1	Chief Executive to examine recruiting to an executive director position which has a specific focus on digital and performance reporting and who on appointment undertakes a review of reporting systems and develops a Digital Strategy which encompasses performance reporting infrastructure	Simon Morritt		30 04 2020	Successful appointment Digital review Digital Strategy	
4.2	Immediate action: New Care Group Dashboard have been developed on gone 'live'	Head of Information		Completed	Care Group Dashboards	

SD5	Executive Lead: Simon Morritt	The trust should continue to review the Board members skills and prioritise its planned board development activities	Delivery on track RAG Rating
Trust wide Corporate			Delivered

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 5.1	Introduction of a Board Development Programme 2020/2021	Lynda Provins	Draft Programme Dec 2019 Board Approved Programme Jan 2020	31 01 2020	Development Programme Schedule of Board Development days Attendance at and reflections from Board Development days	

SD6 CG2	Executive Lead: Brian Golding	The service should consider having a designated ligature free room in its urgent and emergency care service at Scarborough hospital for patients suffering from mental illnesses	Delivery on track RAG Rating

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 6.1	Immediate action: Whilst all rooms are observed at all times and the risk for injury from ligature is low an immediate action has been made to identify a room for high risk patients. This will be used as part of routine business and patients at high risk will be moved to this room as soon as it is available to further minimise any risk of injury from self harm	CG2 Head of Nursing Head of Estates and Facilities		31/1/2020 – Behind target-meeting w/c 13/1/ to identify the most suitable room Rooms on both sites identified, plans to be drawn and subject to IPC and building design approval as building work is required the revised date for completion is mid-February 2020 Moved from amber to	Consultation room 1 or 2 will adapted to care for high risk patients Completion of work and communication with staff about use of the room	Target revised to 31/1/2020

				red rag rating.		
SD 6.2	A designed ligature free room will be part of the planning for the new build Emergency Department at Scarborough Hospital	CG2 Head of Nursing Head of Capital Planning	See attached project programme (subject to regular review and update)  Acrobat Document	Ongoing See also attached project programme (previous column)	Specific sections of minutes when detailed planning commences	• Minutes of project Board and Project Team meetings • Project Programme • Approved SOC, OBC, FBC business cases • Approved designs and specifications (FBC-stage) • Construction procurement

SD7	Executive Lead: Brian Golding	The service should consider having a designated Paediatric area within the first assessment and majors areas of its urgent and emergency care service at Scarborough hospital	Delivery on track RAG Rating
CG2			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 7.1	Immediate action: Department review to examine whether improvements such as wall art or a screened area can be created. If feasible remedial work to be undertaken	CG2 Care Group Manager Head of Estates and Facilities	Report with departmental review and options	Not currently on target but working towards	Report New designated area for paediatrics	Revised date of 29/2/2020 from 31/12/2019
SD 7.2	A designed area for the management of paediatrics will be part of the planning for the new build Emergency Department at Scarborough Hospital	CG2 Care Group Manager Head of Capital Planning	See attached project programme (subject to regular review and update)	Ongoing See also attached programme (previous column)	Specific sections of minutes when detailed planning commences	• Minutes of project Board and Project Team meetings • Project Programme • Approved

			 Acrobat Document			SOC, OBC, FBC business cases • Approved designs and specifications (FBC-stage) Construction procurement

SD8 CG2 SD12 CG3 – Scar SD35 CG3 - Brid	Executive Lead: Brian Golding Heather McNair	CG2 The service should ensure all equipment is cleaned and labelled to indicate when it was last cleaned in its urgent and emergency care service at Scarborough hospital	Delivery on track RAG Rating
CG2		CG3 The service should ensure there is consistent use of labelling to show when equipment has been cleaned	

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 8.1 SD 12.1 SD 35.1	The Trust made a conscious decision to stop using labels to indicate that equipment was clean Staff at each local induction will be taught about what equipment is on each unit and how to clean it	Lead Nurse for IPC CG2 Head of Nursing CG3 Head of Nursing		Completed Immediate and ongoing at induction	When questioned staff can describe the equipment on their unit and when and how this should be cleaned Copy of IPC audits Minutes of CG2 Quality Assurance Meetings	The IPC Team undertake ‘Back to Basics’ spot audits where equipment cleaning is checked. Evidence requested

SD9 – CG2 SD14 – CG3 Scar SD37 – CG3 Brid	Executive Lead: Polly McMeekin	CG2 The service should ensure an embedded system of clinical supervision is in place in its urgent and emergency care service at Scarborough hospital CG3 The service should ensure that they can demonstrate nursing staff receive regular, formal clinical supervision, in accordance with professional guidelines and trust policy	Delivery on track RAG Rating
CG2			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 9.1	Medical; Midwifery and Allied Healthcare Professionals have Clinical Supervision in place. Policies in place Develop at Clinical Supervision Policy / Strategy for nursing	Medical Director/Head of AHP Deputy Chief Nurse		Complete 31 01 2020 not on track for this date 17.2.20 revised date for completion	Policies, Policy	Staff feedback / staff survey Staff feedback / staff survey

SD10	Executive Lead: Wendy Scott	The service should ensure it continues to look at new ways of working to improve patient flow from its urgent and emergency care service at Scarborough hospital	Delivery on track RAG Rating
CG2			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 10.1	Develop SDEC Model Create appropriate space to support delivery of SDEC Model Review and revise staffing model to effectively deliver SDEC, ensuring the correct level of medical and nursing leadership has oversight of how the SDEC Model is developed and governed	CG2 Clinical Director CG2 Head of Nursing		30 04 2020	Improved ECS	
10.2	Review and revise the delivery of SAFER	CG2 Head of Nursing CG2 Clinical		29 02 2020	'SAFER' model is well-understood and active on all wards across the site	

	• SAFER engagement event with staff • Consider small scale project creating and exemplar ward and then a programme to roll out SAFER more effectively	Director			Improvement in ECS	

SD11 SD44	Executive Lead: Heather McNair	CG2 The service should ensure it improves the availability of written information available in other languages and formats for patients using its urgent and emergency care services CG2 Brid The service should have a range of tools available to assess patients where their communication may be impaired	Delivery on track RAG Rating
CG2 – Scar CG2 – Brid (Johnson)			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
11.1	Identify most frequently issued leaflets to be translated into most frequently used languages	Lead for Patient Equality and Diversity / CG2 Head of Nursing	Most commonly requested leaflets in emergency and urgent care to be translated into the most frequently requested language translations.	31/3/2020 Leaflets identified , have been identified and are in the process of review Both Emergency Departments have been requested to review any out	Leaflets accessible in most commonly requested languages and available within the department Completion date changed to 31/3/2020 from 31/1/2020	Most commonly requested translations identified ED Patient Info leaflets currently working to ensure compliance with standards

				of date leaflets and ensure that the content was still appropriate, and that they were available in alternative formats and in the languages that meet the needs of our ethnic communities. Alongside this is a need to ensure that staff have received training in the Accessible Information Standard and how to update patient communication needs on the Core Patient Database. Training is available but the take up has been slow. Care Groups 1		

				and 2 are currently progressing this piece of work. The leaflets are to be distributed to specialities for review of content – medical Director to action this.		
11.2 44.1	Improve staff awareness and approach to Accessible Information compliance	Lead for Patient Equality and Diversity	Posters advertising communication needs to be displayed	Completed	Visible posters available throughout the emergency and urgent care department	Posters have been developed and approved
		CG2 Clinical Director/ CG2 Head of Nursing	Staff to undertake e-learning on Accessible Information standard	Date revised to 31/3/2020 from 31/12/2019 Behind plan training has been made available but slow take up due to current pressures	All staff have undertaken Accessible Information standard	
		CG2 Clinical Director/ CG2 Head of Nursing	Staff to undertake e-learning on updating	Date revised to 31/3/2020 from 31/12/2019 Behind plan	All staff know how to add or maintain patient communication needs on CPD	

			patient communication needs on CPD	training has been made available but slow take up due to current pressures		
		Lead for Patient Equality and Diversity / CG2 Head of Nursing	Develop arrangements for information to be available in easy read format	Timeframe revised to 31/3/2020 from 30/1/2020 Timeframe may slip as review of leaflets takes place	Library of easy read leaflets available to be printed when required.	
		Lead for Patient Equality and Diversity / CG2 Head of Nursing	Patient Leaflets to be available in MP3/audio format	Completed	Library of MP3/audio recordings of leaflets available to be played/emailed to patients by staff when required.	functionality for producing audio format leaflets now available… communication to be sent out during December on how this format can be accessed.
		Lead for Patient Equality and Diversity / CG2 Head of Nursing	Staff awareness of how to book interpreter and translation services	31 12 2019	Staff are confident in knowing how to make interpreter bookings and knowing how to request translation of documents.	Information currently on Staff Room is being re-written to make it more user friendly
		Lead for Patient Equality and	Staff to be made aware	31 12 2019	Staff are confident in knowing how to access	Information on Staffroom is being

		Diversity / CG2 Head of Nursing	how to access leaflets electronically and how to make into large print.		leaflets held electronically and produced in the patients chosen large print format	updated so that staff know how to request in these formats. Communication to be provided to all staff.

SD13 CG3 – Scar SD36 CG3 - Brid	Executive Lead: Heather McNair	The service should ensure quality dashboard information is displayed in public areas	Delivery on track RAG Rating
CG3 Trust wide			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
13.1	Perfect Ward providers visit to hospital to present their app	Deputy Chief Nurse		Completed	Presentation	
13.2	Business Case to be written and presented to panel to seek funding for Perfect Ward App and delivery of quality data that can be displayed on a dashboard	Deputy Chief Nurse		31 01 2020 on target	Business case panel Corporate Directors Action Log	

SD18 – CG2 SD19 – CG6 Scar OPD SD31 – CG5 SD49 – CG6 Brid OPD	Executive Lead: Heather McNair	CG2 The service should ensure that resuscitation trollies are checked in accordance with the trust's policy and action is taken and improvement monitored when this is found not to be so CG6 The service should ensure the resuscitation trolley is checked consistently and as required CG5 The service should ensure that daily checks on the resuscitation trolley are completed as per Trust Policy	Delivery on track RAG Rating
CG2 CG5 CG6			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
18.1	Matrons to undertaken quality audits and spot checks which include the resuscitation trollies	CG 2 Head of Nursing CG5 Head of Midwifery CG6 Head of Nursing		Completed	Audit and spot check tools Audit programme Reports and action plans	Rolling audit programme Healthcare Governance Completing monthly checks, outcomes escalated to Matrons. HoN and CN

SD22	Executive Lead: Heather McNair	The service should ensure clear cleaning guidance of the cuffs is in place when fabric blood pressure cuffs are used	Delivery on track RAG Rating
CG5			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
22.1	Standard Operating Procedure developed and distributed	Community Midwifery Manager		Completed	Standard Operating Procedure	Awaiting evidence
22.2	3 months post implementation of the Standard Operating Procedure audit of compliance. Audit report to be presented to CG5 Quality Assurance Committee	Community Midwifery Manager		31 01 2020	Audit report Minutes of CG5 Quality Assurance Meeting Feb 20	Awaiting evidence of Audit

SD24	Executive Lead: Heather McNair	The service should ensure that community equipment which requires calibration has this completed as per maintenance schedule	Delivery on track RAG Rating
CG5			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
24.1	Review medical engineering register of equipment to ensure this correlates with what the service holds	Community Midwifery Manager		Completed	Review document	
24.2	To ensure no outstanding equipment for calibration check with all individual community staff members From 2020 all staff to check this as part of annual appraisal	Community Team leaders Community Team leaders		31 12 2019 Slightly behind, checks currently being undertaken 31 01 2020	Minutes of meeting where individual community staff members asked to undertake check Annual appraisal records	
24.3	Annual audit against medical engineering register	Community Team Leaders		Completed	Audit report against medical engineering register	

SD30	Executive Lead: Heather McNair	The service should audit MEOWS so that they are assured the system is being used effectively	Delivery on track RAG Rating
CG5			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
30.1	Information Team have been requested to develop the IT system to enable the team to audit MEOWS	Head of Information		Complete	Mechanism to audit MEOWS electronically in place	
30.2	MEOWS audit	Head of Midwifery		28 02 2020	Audit schedule Audit results Minutes of governance meeting where audit results and associated actions are discussed	

SD34	Executive Lead: Brian Golding	The service should ensure that Entonox gas is removed from the atmosphere in Labour ward and monthly monitoring put in place to ensure that unsafe levels of Entonox gas are not in the atmosphere	Delivery on track RAG Rating
CG5			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
34.1	Testing undertaken and all levels are within normal limits	Head of Health and Safety		Complete	Testing results	
34.2	Re-testing of levels schedule in place to provide further assurance that the results are consistently within normal limits	Head of Health and Safety		Complete	2nd set of testing results indicate Entonox levels on both labour wards are out of normal limits. A Business Case is being established to address this to go to Business Case Panel in Jan 20.	Results of 2nd test and Subsequent Business Case. This leads to a third and new action
34.3	Development of Business Case to ensure that levels of Entonox gas are removed from the atmosphere in labour ward	Head of Health and Safety	Presentation of Business Case to Business Case Panel	31 01 2020 This will be subject to CPEG approval for the preliminary design work. Health & safety Lead to confirm	Drafted and approved business case…BC due to panel on 28 January 2020. This work will be at significant cost including design cost and therefore may not be approved. Moved from amber to red	

				any mitigation and seek independent advice.	as this will not be resolved to target date.	

SD40 SD46	Executive Lead: Heather McNair	CG3 The service should investigate and respond to complaints in accordance with trust policy CG2 The service should take action to improve complaints response times to bring them in line with their complaints policy	Delivery on track RAG Rating
CG3 Brid CG2 Brid TW			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
40.1 46.1 TW	Deliver complaints letter writing training to new managers and matrons	Lead for Patient Experience	Training undertaken September 2019	Reported as Completed but evidence reqested.	List of people who attended complaints letter writing training and course details Letter writing training course atten Writing-to-customers -course-V2.pdf	Monthly OPAM and EPAM reports highlight breaches and areas for improvement ~ escalated to care group managers
40.2 46.2 TW	Complaints Management Policy review and revision	Lead of Patient Experience	Survey of staff to understand their concerns	31 01 2020 (was31/12/2019) On target for Complaints Steering Group	Revised Complaints Management Policy	Monthly and quarterly Board reports highlight good practice and areas of concern.

			Listening exercise with care group management to inform review	Jan 2020		In-house complaints management training will be delivered in Q4 once policy has been ratified
40.3 46.3	Complaints management in accordance with Trust policy	CG3 Head of Nursing CG2 Head of Nursing		31 01 2020	Good compliance with timeliness Action log from CG3 OPAM CG3 Patient Experience dashboard	

SD41 CG2 Brid TW	Executive Lead: Heather McNair	The service should replace or repair broken equipment in a timely manner and [ensure] safety equipment is available to meet the needs of the patient	Delivery on track RAG Rating

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
41.1	Ensure each ward unit and department manager or team leader understands the process for reporting broken equipment and how to escalate if the correct equipment is not available for their patients	Estates (change from HON) Deputy Chief Nurse		Reported as Completed, evidence requested.	Communication with senior nurses at Bridlington Hospital Staff Matters article	

SD43	Executive Lead: Heather McNair	The service should complete mental capacity assessments on patients in a timely way where there is any doubt a patient is able to make an informed decision about their care and treatment. Assessment and outcomes should be documented in care records	Delivery on track RAG Rating
CG2 Brid (Johnson)			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
43.1	Quarterly audit, with analysis report and action planning	Nicola Cowley		Ongoing quarterly	Quarterly reporting and action plan completion.	Part of Safeguarding Adults Audit programme Exception reporting to individual care groups and the Safeguarding Adults Governance Group/
43.2	Targeted monthly training compliance review	Nicola Cowley		Ongoing monthly	Improved training compliance	Exception reporting to individual care groups and the Safeguarding Adults Governance Group
43.3	Ongoing work with IT	Lisa Haigh	The	31 January	Electronic evidence of	Audit of system to

	Development group to embed mental capacity assessment and related documents electronically		electronic system will act as a prompt to consider capacity throughout patient journey	2020 behind target this work has not yet commenced.	capacity consideration required under the Mental capacity Act.	be discussed. Progress will be monitored by the Safeguarding Adults Governance Group.

SD45	Executive Lead: Wendy Scott	The service should work towards reducing length of stay for non-elective patients	Delivery on track RAG Rating
CG2 Brid (Johnson)			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
SD 45.1	A comprehensive piece of transformation work as to how Johnson Ward functions as a rehab ward with some palliative care beds is due to commence November/December 2019. This project will focus on the workforce model (People), refresh the processes that underpin how Johnson Ward functions (SAFER) and how Johnson Ward fits with the various community and local authority offers that are in place.	CG2 Care Group Manager CG2 Head of Nursing	Project scope and Project plan in place. Confirmation of patient criteria for transfer onto Johnson Ward Revised workforce model	Commencing Dec 2019 31 01 2020 31 03 2020	LOS data for patients on Johnson Ward Draft admission guidance currently being reviewed. LOS data monitored at CG2 Quality Assurance Committees – minutes of meetings This will involve system stakeholders and the date of 31/3/2020 may be extended.	Trust Performance Reports in place and will be reviewed at Care Group and Trust Board level every month Minutes of Trust Board

SD47	Executive Lead: Heather McNair	The service should consider developing documented admission criteria for the ward	Delivery on track RAG Rating
CG2 Brid (Johnson)			

IMPLEMENTATION PLAN

Issue No	Action	Lead responsibility	Key Milestones	Target date	Measure or evidence of completion	Audit or ongoing assurance
47.1	Develop an admissions criteria for Johnson ward at Bridlington hospital site	CG2 Head of Nursing AHP Lead for Professional Standards		31 12 2019	Admission criteria document	

A Key to Must Do and Should Do Actions	
MD/SD	
MD1	The trust must ensure it has a robust process for identifying learning from deaths and serious incidents and ensure this is systematically shared across the organisation.
MD2	The service must ensure all medical staff in its urgent and emergency care service at Scarborough hospital are compliant with all aspects of mandatory training.
MD3	The service must ensure all medical and nursing staff in urgent and emergency care services at Scarborough hospital complete the required specialist paediatric life support training to enable them to safely care for children in the department.
MD4	The service must ensure it has enough, suitably qualified, competent and experienced medical and nursing staff in its urgent and emergency care service at Scarborough hospital, to meet the RCEM recommendations, including enough staff who are able to treat children in an emergency care setting.
MD5	The service must ensure medicines are managed safely in its urgent and emergency care service at Scarborough hospital.
MD6	The service must ensure that computer screens showing patient identifiable information are not left unlocked when not in use, in its urgent and emergency care service at Scarborough hospital.
MD7	The service must ensure it takes action to improve its performance in the RCEM standards in its urgent and emergency care service at Scarborough hospital.
MD8	The service must ensure all nursing staff have an up to date appraisal each year in its urgent and emergency care service at Scarborough hospital.
MD9	The service must ensure they continue to work to improve the following performance standards for its urgent and emergency care service at Scarborough hospital.
MD10	The service must ensure the processes for the management of risks, issues and performance, and the governance and oversight of these processes are fully embedded within its urgent and emergency care service at Scarborough hospital.
MD11	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy.
MD12	The service must ensure that the quality of medical record keeping improves and that medical staff maintain accurate and contemporaneous records for all patients, in accordance with professional standards and trust policy.
MD13	The service must ensure that all medical and nursing staff receive annual performance appraisals, in accordance with professional standards and trust policy.
MD14	The service must ensure that all records are secure when unattended.
MD15	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced medical staff are deployed

	overnight for medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients.
MD16	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced registered nursing staff are deployed across the medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients.
MD17	The service must ensure that all staff on medicine wards at the Scarborough Hospital site are maintaining securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
MD18	The service must ensure that substances hazardous to health are stored securely and used in a safe way to avoid potential or actual harm to patients.
MD19	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy.
MD20	The service must ensure the backlogs and overdue appointments in the trust is addressed and improved.
MD21	The service must ensure improvements are made where the service is not meeting the 18-week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment.
MD22	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy.
MD23	The service must ensure that all medical staff receive annual performance appraisals, in accordance with professional standards and trust policy.
MD24	The service must ensure that electronic records are secure (screens locked) when unattended.
MD25	The service must ensure the backlogs and overdue appointments in the trust is addressed and improved.
MD26	The service must ensure improvements are made where the service is not meeting the 18-week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment.
SD1	The service must ensure improvements are made where the service is not meeting the 18-week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment.
SD2	The trust should develop a sustainable clinical strategy at pace building on the outcomes of the east coast acute services review and ensure it dovetails with the care group plans.
SD3	The trust should ensure there is a clear accountability framework setting out the governance arrangements for the care group structure.
SD4	The trust should continue its work to improve its reporting of performance information to enable easier oversight and governance and continue its work to improve its digital systems and processes.
SD5	The trust should continue its review of the Board members skills and prioritise its planned board development activities.
SD6	The service should consider having a designated ligature free room in its urgent and emergency care service at Scarborough hospital for patients suffering from mental health illnesses.

SD7	The service should consider having a designated paediatric area within the first assessment and major's areas of its urgent and emergency care service at Scarborough hospital.
SD8	The service should ensure all equipment is cleaned and labelled to indicate when it was last cleaned in its urgent and emergency care service at Scarborough hospital.
SD9	The service should ensure an embedded system of clinical supervision is in place in its urgent and emergency care service at Scarborough hospital.
SD10	The service should ensure it continue to look at new ways of working to improve patient flow from its urgent and emergency care service at Scarborough hospital.
SD11	The service should ensure it improves the availability of written information available in other languages and formats for patients using its urgent and emergency care service at Scarborough hospital.
SD12	The service should ensure there is consistent use of labelling to show when equipment has been cleaned.
SD13	The service should ensure quality dashboard information is displayed in public areas.
SD14	The service should ensure that they can demonstrate nursing staff receive regular, formal clinical supervision, in accordance with professional guidelines and trust policy.
SD15	The service should ensure that they continue their work to improve patient access and flow to reduce referral to treatment times and patient cancellation rates.
SD16	The service should ensure that storage areas temperatures are monitored to demonstrate medicines are always stored in accordance with manufacturer's minimum and maximum temperature guidelines.
SD17	The service should continue to implement and embed the new governance structure and processes.
SD18	The service should ensure that resuscitation trollies are checked in accordance with the trust's policy and action is taken and improvement monitored when this is found not to be so.
SD19	The service should ensure the resuscitation trolley is checked consistently and as required.
SD20	The service should ensure the services assess risk in patients waiting beyond the recommended appointment dates.
SD21	The service should consider ways to reduce the number of cancelled clinics in outpatients.
SD22	The service should ensure clear cleaning guidance of the cuffs is in place when fabric blood pressure cuffs are used.
SD23	The service should obtain advice from the infection prevention team about the use and storage of non-packaged cotton wool balls.
SD24	The service should ensure that community equipment which requires calibration has this completed as per maintenance schedule.
SD25	The service should ensure that staff responsible for cleaning of the pool are shown the correct cleaning procedure/guidelines for this piece of equipment.
SD26	The service should ensure single use equipment is within its expiry date.
SD27	The service should ensure that all entries to women's records are legible.

SD28	The service should ensure that patient's records trolleys are locked.
SD29	The service should ensure that all staff have their annual appraisals.
SD30	The service should audit MEOWS so that they are assured the system is being using effectively.
SD31	The service should ensure that daily checks on the resuscitation trolley are completed as per Trust policy.
SD32	The service should ensure that daily checks on medicine fridges are carried out as per Trust policy.
SD33	The service should ensure that all patient group direction paperwork has authorisation signatures against those staff names who are able to administer patient group direction medicines.
SD34	The service should ensure that Entonox gas is removed from the atmosphere in Labour ward and monthly monitoring put in place to ensure that unsafe levels of Entonox gas are not in the atmosphere.
SD35	The service should ensure labelling is used to show when equipment has been cleaned.
SD36	The service should display quality dashboard information in public areas.
SD37	The service should ensure that they can demonstrate nursing staff receive regular, formal clinical supervision, in accordance with professional guidelines and trust policy.
SD38	The service should ensure that storage areas temperatures are monitored to demonstrate medicines are always stored safely in accordance with manufacturer's minimum and maximum temperature guidelines.
SD39	The service should continue to implement and embed the new governance structure and processes.
SD40	The service should investigate and respond to complaints in accordance with trust policy.
SD41	The service should replace or repair broken equipment in a timely manner and safety equipment is available to meet the needs of the patients.
SD42	The service should make certain that staff adhere to record keeping policies and follow record keeping guidance in line with their registered professional standards.
SD43	The service should complete mental capacity assessments on patients in a timely way where there is any doubt a patient is able to make an informed decision about their care and treatment. Assessments and outcomes should be documented in care records.
SD44	The service should have a range of tools available to assess patients where their communication may be impaired.
SD45	The service should work towards reducing length of stay for non-elective patients.
SD46	The service should take action to improve complaints response times to bring them in line with their complaints policy.
SD47	The service should consider developing documented admission criteria for the ward.
SD48	The service should develop robust governance processes including performance dashboards, that local risks are identified, regularly reviewed and actions developed.
SD49	The service should ensure the resuscitation trolley is checked consistently and as required.
SD50	The service should ensure the services assess risk in patients waiting beyond the recommended appointment dates.

SD51	The service should consider ways to reduce the number of cancelled clinics in outpatients.