NHS
Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	8
Date of Meeting:	28 November 2018		

Title of Report:	Care Quality Commission Improvement Plan
Status:	For Noting
Board Sponsor:	Lisa Cheek, Director of Nursing and Midwifery
Author:	Rob Eliot, Quality Assurance and Clinical Audit Lead
Appendices	Appendix A: Improvement Plan from the CQC inspection of the RUH (June 2018)

1. Executive Summary of the Report

The CQC rated the Trust overall as ‘Good’ from its announced inspection to the RUH in June 2018 with medical care and critical care improving their overall rating from ‘Requires Improvement’ to ‘Good’ and maternity improving from ‘Good’ to ‘Outstanding’.

Urgent and emergency services remains rated as ‘Requires Improvement’ with all domains staying the same except ‘well-led’ which decreased from ‘Good’ to ‘Requires Improvement’. This was because the actions taken since the last inspection by the senior leadership team and department managers had not delivered improvements. The CQC noted that the department remained over-crowded, patients were waiting too long on trolleys and risks to patient flow were still concentrated on the emergency department rather than being shared through the system.

The CQC identified that four of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) were not met and have told the Trust what action must be taken to meet these. These compliance actions all relate to urgent and emergency services.

The Trust is required to submit an improvement plan to the CQC by 26 October 2018 detailing the actions that will be taken to address the compliance recommendations identified within the report. These actions are detailed in Appendix A.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors is asked to note the improvement plan that had been developed from the CQC inspection to the RUH in June 2018 and which was submitted to the CQC on 26th October 2018.

3. Legal / Regulatory Implications

It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

A failure to demonstrate systematic quality improvement in the delivery of patient care could risk the Trust’s registration with the Care Quality Commission.

5.	Resources Implications (Financial / staffing)
The costs of compliance with the CQC fundamental standards are embedded within operational delivery costs.	

6.	Equality and Diversity
Equality and Diversity legislation is an integral component to registration.	

7.	References to previous reports
None	

8.	Freedom of Information
Public	

Care Quality Commission (CQC) Inspection Report and Improvement Plan

1 Introduction

1.1 The Care Quality Commission (CQC) inspected four core services (urgent and emergency services, medical care, critical care, children and young people's services) between 5-7 June 2018 and the maternity core service between 26-28 June 2018.

1.2 The inspection focused on answering 5 key questions (domains) about services:

- Are services safe?
- Are services effective?
- Are services caring?
- Are services responsive to people's needs?
- Are services well-led?

1.3 The CQC also reviewed management and leadership of the Trust to answer the key question about whether the Trust is well led.

2 The CQC Judgement

2.1 The CQC published the final copy of the inspection report on 26 September 2018. The CQC make their judgement based on information readily available to them, such as through CQC Insight and the Provider Information Request (PIR) and information obtained during the on site inspection, including observations of the environment and patient care, interviews with staff and information given to the CQC from people who use the service, public and other organisations.

2.2 The CQC rated the Trust overall as 'Good', an improvement from the 'Requires Improvement' rating achieved during the last comprehensive inspection of the Trust in March 2016.

2.3 The Trust was rated as 'Good' overall for being well-led. This was because there was a clear vision and strategy to deliver high quality, sustainable care to people who use services. There were clear governance processes in place that ensured the quality and safety of patients were monitored, risks identified and action taken to address these. The CQC also noted that there was active engagement with patients, carers and staff.

2.4 The ratings for each of the core services and the CQC domains are shown on the following page. Where core services were not inspected during June 2018, the ratings shown are based on the ratings from the previous CQC inspection. This was applicable to surgery, end of life care and outpatients and diagnostics.

2.5 The CQC also published a report on the Trust's use of resources. The assessment was undertaken by NHS Improvement. The Trust was rated as 'Good' for using its resources productively.

Ratings for Royal United Hospital, Bath

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Requires improvement →← Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement →← Sept 2018
Medical care (including older people's care)	Good →← Sept 2018	Good ↑ Sept 2018	Good →← Sept 2018	Good ↑ Sept 2018	Good →← Sept 2018	Good ↑ Sept 2018
Surgery	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016
Critical care	Good ↑ Sept 2018	Good ↑ Sept 2018	Good →← Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018
Maternity	Good ↑ Sept 2018	Good →← Sept 2018	Outstanding ↑ Sept 2018	Outstanding ↑ Sept 2018	Outstanding ↑ Sept 2018	Outstanding ↑ Sept 2018
Services for children and young people	Good →← Sept 2018	Good →← Sept 2018	Outstanding →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018
End of life care	Good Aug 2016	Good Aug 2016	Outstanding Aug 2016	Outstanding Aug 2016	Good Aug 2016	Outstanding Aug 2016
Outpatients and Diagnostics	Good Aug 2016	Not rated	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016
Overall*	Good ↑ Sept 2018	Good →← Aug 2018	Outstanding →← Sept 2018	Requires improvement →← Sept 2018	Good →← Sept 2018	Good ↑ Sept 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

2.6 Of the 40 indicators represented by the core services and CQC domains:

- 6 rated as 'outstanding'
- 28 rated as 'good'
- 5 rated as 'requires improvement'
- 1 indicator was not rated as the CQC did not have enough evidence to award a rating

2.7 10 of the ratings increased by one rating, 7 increased from 'Requires Improvement' to 'Good' and 3 increased from 'Good' to 'Outstanding'. Medical care and critical care improved their overall rating from 'Requires Improvement' to 'Good', whilst maternity improved from 'Good' to 'Outstanding'. The 'safe' domain also increased from 'Requires Improvement' to 'Good'.

2.8 Urgent and emergency services remains rated as 'Requires Improvement' with all domains staying the same except 'well-led' which decreased from 'Good' to 'Requires Improvement'. This was because the CQC did not feel that sufficient improvements had been made to key areas identified in the last inspection report that impacted on patient care. The CQC noted that the department remained over-crowded, patients were waiting too long on trolleys and risks to patient flow were still concentrated on the emergency department rather than being shared through the system.

2.9 The inspection report identifies many areas of good and outstanding practice including maternity care with the CQC noting that the person-centred culture was evident and the care and support that women and their partners received often exceeded expectations. The CQC also recognised, for example, that quality improvement was embedded within the Emergency Department (ED) and department leads were committed to the development of staff and the exceptional multidisciplinary working within children's and young people's services.

2.10 Within critical care the CQC noted that there were sufficient numbers of appropriately trained staff to meet patient needs. People were protected from abuse and neglect, there was good multidisciplinary working, staff adhered to infection control processes and there was a positive incident reporting culture on the unit, lessons were learned and action taken to improve practice.

2.11 Within medical care the CQC commented on how information from complaints, incidents and audit was used to improve services. Staff felt supported to speak up about any concerns they had and to develop initiatives to improve patient care.

2.12 For services for children and young people the CQC recognised that there were clearly defined and embedded systems, processes and practices to keep children safe and safeguarded from abuse. The CQC also noted the exceptional multidisciplinary working and care provided to babies, children, young people and their families. There were clear responsibilities, roles and processes to support effective governance with leaders demonstrating a clear vision and strategy for the service and having the skills, knowledge and experience to lead the service.

2.13 The overall rating for caring remained as 'outstanding' with the CQC recognising that the care provided to patients and their families was kind, compassionate and sensitive to patient needs. Services empowered patients and their families and there was a person-centred care approach.

2.14 The CQC identified that four of the fundamental standards were not met and have told the Trust what action must be taken to meet these. These compliance recommendations all relate to urgent and emergency services. The standards are:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

3 Improvement Plan

3.1 The Trust is required to send the CQC a written report of the action that will be taken to address the compliance recommendations from the report. This action plan must be submitted to the CQC by 26 October 2018. An improvement plan (Appendix A) has been developed which details the actions that have or will be taken to address the compliance recommendations.

3.2 Each action has been RAGB (red, amber, green, blue) rated to indicate whether the actions are progressing according to the timescales identified in the

improvement plan. The comments / action status column has been updated to reflect progress towards implementing the actions.

3.3 On completion of all actions under each compliance recommendation, the identified action leads will be responsible for providing examples or evidence of how the actions that have been implemented have led to improvements. Compliance recommendations will not be closed down unless there are demonstrable improvements.

3.4 Delivery of the improvement plan will be monitored by Management Board on a quarterly basis. Quality Board will also monitor the effectiveness of the actions taken to address the CQC recommendations. The Emergency Department will provide a quarterly update to Quality Board which will include details of the actions taken and evidence, including performance data, demonstrating how these actions have improved services.

3.5 In addition, as all of the actions relate to the Emergency Department and Urgent Treatment Centre, progress in implementing the improvement plan will also be discussed and monitored through the quarterly ED specialty reviews within the division, attended by the Head of Division, Divisional Manager and Head of Nursing.

3.6 The CQC have also made further recommendations where the Trust could improve, identified as ‘should do’ actions. Key learning themes identified from these will be linked to the Trust goals represented under the Improving Together programme and improvement actions incorporated, where applicable, into the work plans of existing Trust committees or groups.

3.7 Progress in addressing additional recommendations made for each of the core services in the inspection report will also be monitored through the specialty performance review meetings.

4 Recommendations

4.1 The Board of Directors is asked to note the improvement plan that had been developed from the CQC inspection to the RUH in June 2018 and which was submitted to the CQC on 26th October 2018.

Appendix A: Improvement Plan from the CQC inspection of the RUH (June 2018): Compliance Actions

Ref No	1
Compliance / Must Do Recommendation	Ensure the systems designed to protect children from harm and abuse are working effectively and processes are fully documented, especially during times of pressure. The trust must improve staff awareness of 'Think Family' principles in the Urgent Treatment Centre.
CQC Core Service	Urgent & Emergency Services
CQC Domain	Safe
Comments	We were not assured that the systems and processes around child safeguarding were operating effectively to protect children from harm and abuse. Staff were not always completing the assessment screening tool to ensure that children at risk were correctly identified. The urgent and emergency services must ensure the systems designed to protect children from harm and abuse are working effectively, especially during times of pressure in the emergency department. This includes the completion of the screening tool and the completion of record reviews. Also, to improve awareness of 'Think Family' principles in the Urgent Treatment Centre.

Action no	Actions required *(specify "None", if none required)*	Action by date	Person responsible *(Name and grade)*	Status	Comments/action status *(Provide examples of action in progress, changes in practices etc)*
1	Add an icon onto FirstNet to indicate where the Paediatric safeguarding screening is required (assessed for every child in A&E).	01/09/2018	Mandy Rumble, Matron Nickie Jakeman, Clinical Lead	Blue	Commenced June 2018.
2	Undertake weekly audits to check that every patient has the safeguarding screening tool completed.	01/09/2018	Mandy Rumble, Matron Nickie Jakeman, Clinical Lead	Blue	Weekly audits are being undertaken and fed back to the Clinical lead and matron for ED. Monthly BIU generated report for Quality Board. Target is 85% by end of January 2019 (for on the day completion).
3	Produce a weekly report that shows how up to date the Paediatric reviewing nurses are with Paediatric reviewing (the assessment of every child presenting to the Emergency Department).	08/06/2018	Mandy Rumble, Matron Mike Menzies, Named Nurse, Safeguarding Children	Blue	The Paediatric Reviewing Nurses assess every child presenting to the Emergency Department. As part of this process they check if the Paediatric screening tool has been completed and any consequent referrals or actions from it. Commenced during the week of the inspection. If there is a delay the nurses use the afternoon overlap to catch up and also are offered and take up additional hours. Weekly e-mail is sent to Mandy Rumble and Mike Menzies.

Action no	**Actions required** *(specify "None", if none required)*	Action by date	**Person responsible** *(Name and grade)*	Status	**Comments/action status** *(Provide examples of action in progress, changes in practices etc)*
4	Results of the weekly screening tool audits and Paediatric reviewing status to be presented at the quarterly Children and Young People's Safeguarding Committee and ED Directorate meetings with the Senior Management Team.	30/10/2018 (ongoing)	Mandy Rumble, Matron Mike Menzies, Named Nurse, Safeguarding Children	Green	Results to be presented at the next Children and Young People's Safeguarding Committee on 25 October 2018 and all subsequent committee (standing item – covered through risk register update).
5	Scope the possibility of the early or 10-6 Nurse Practitioners reviewing every presenting child's history to check if there are any safeguarding concerns for those cases where the Paediatric Screening tool has not been completed the previous day.	30/11/2018	Zoe Lockton & Samantha Swift, Paediatric Lead Nurses for ED Mandy Rumble, Matron	Green	To scope by the end of October 2018, with the process to be established by 30 November 2018. The target is to ensure that all patients identified as not having the Paediatric screening tool completed on the day, will have been reviewed by the following day.
6	To continue working with the Emergency Department IT leads to consider making the Paediatric Screening Tool a mandatory process on FirstNet.	Review by 30/06/2019	Mike Price, ED Consultant Liz Gilby, ED Consultant Mandy Rumble, Matron Mike Menzies, Named Nurse, Safeguarding Children	Green	This is on the risk register and reported through the Safeguarding Children's Committee Quarterly. A project plan is being developed to support this.
7	Think Family principles – Urgent Treatment Centre (UTC): Implement Safeguarding referral process to children's social care: • Children • Adults presenting a risk to children	Review by 31/12/2018	Yvonne Staples, Lead Nurse, Urgent Treatment Centre Tim Owen, Emergency Care Practitioner, UTC Mike Menzies, Named Nurse, Safeguarding Children	Green	The process is now in place for referring children at risk and adults who present a risk to children (step by step guidance is available to staff in the UTC). This process will be monitored and reviewed monthly at the UTC governance meeting. This will assess whether the guidance is being followed for referral, review and check whether the safeguarding leads have been informed.
8	Think Family principles – Urgent Treatment Centre (UTC): Invite all practitioners in the UTC to the monthly group safeguarding children supervision, utilising 'Think Family Principles'. Ensure that UTC practitioners attend safeguarding supervision twice a year (this reflects current process for ENPs in the ED).	Review by 31/12/2018	Yvonne Staples, Lead Nurse, Urgent Treatment Centre Mike Menzies, Named Nurse, Safeguarding Children	Green	All UTC staff are invited to supervision sessions currently run monthly with ED ENPs facilitated by Safeguarding Children's team. Invites sent by email and posters in the UTC. The Safeguarding Team will be providing an initial safeguarding supervision session at the UTC team away day on 20 November 2018.
9	Think Family principles – Urgent Treatment Centre (UTC):	Review by	Yvonne Staple, Lead	Green	The UTC Children's Safeguarding link nurse

Action no	**Actions required** *(specify "None", if none required)*	Action by date	**Person responsible** *(Name and grade)*	Status	**Comments/action status** *(Provide examples of action in progress, changes in practices etc)*
	UTC practitioners to work closely with the RUH safeguarding children and adult team to promote 'think Family Principles' in the department.	31/12/2018	Nurse, Urgent Treatment Centre. Tim Owen ECP, Children's safeguarding link nurse Lorraine Facey, Adults Safeguarding link nurse NP		is well established with the RUH Safeguarding team. Newly appointed Safeguarding adult link nurse will work closely with the RUH safeguarding team to define her role and responsibility. Both will work towards the action plan created promote 'Think family Principles'.
10	Think Family principles – Urgent Treatment Centre (UTC): Progress in implementing the action plan for the UTC to be reported through the UTC governance meetings on a monthly basis. Progress to also be reported through the quarterly Safeguarding Children and Adults Committee	31/01/2019	Yvonne Staple, Lead Nurse, Urgent Treatment Centre Mike Menzies, Named Nurse, Safeguarding Children Debra Harrison, Adult Safeguarding lead.	Green	

On completion of all actions above, please provide examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Do the actions taken and the evidence provided give sufficient assurance that the compliance recommendation has been addressed and can be closed down?

☐ Yes
☐ No

If No, please state why this recommendation cannot be closed down and what further actions are required to ensure the recommendations are met:

Author: Rob Eliot, Quality Assurance and Clinical Audit Lead
Version 8
Date: 26 October 2018

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Ref No	2
Compliance / Must Do Recommendation	The trust must resolve issues preventing the collection of reliable data regarding time to initial assessment for ambulance and self-presenting patients. Ensure staff report treatment delays on the adverse incident reporting system.
CQC Core Service	Urgent & Emergency Services
CQC Domain	Safe Well led
Comments	Accurate data was not being collected to record the time to initial assessment of self-presenting or ambulance patients despite being requested to do so following our last inspection. We were not assured that the incident reporting system was working effectively so that the risks and harm experienced by patients was properly understood. Incidents involving patients were not always reported. We were not assured that the risks and harm experienced by patients was properly understood. Occasions where time-critical treatment was not provided in a timely way due to capacity or staffing pressures were sometimes not individually recorded and the level of harm sustained was not established, however the rate of serious incidents was used as a measure of risk and quality in the department.

Action no	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices etc)*
1	Investigate issues in recording and reporting of accurate time to initial assessment times with the Business Intelligence Unit (BIU).	31/10/2018	Mandy Rumble, Matron	Green	Reviewed the accuracy of the data on time to initial assessment with BIU. Daily report generated by BIU on daily validation pack which is reviewed daily by the triumvirate. Requested patient age to be added to the list so Paediatric patients can be easily identified.
2	Monitor time to initial assessment (self-presenting and ambulance) through the Trust Quality Scorecard and daily reports generated by the BIU.	30/11/2018	Peter O'Driscoll, Head of Business Intelligence Jo Miller, Head of Nursing, Medicine	Green	To be added to the Trust Quality Scorecard from November 2018 (in discussion). The majority of breaches occur within Minors.
3	Significant treatment delays leading to adverse patient outcomes will be recorded on Datix with patient identifiable information so that learning can be maximised and actions put in place.	31/12/2018	Mandy Rumble, Matron Nickie Jakeman, Clinical Lead	Green	Collaboration with Acute medicine governance lead to identify treatment delays. These will be reported to the ED Divisional Clinical Governance meetings.
4	Implement a BIU daily report about the number of patients who are cared for in the ED corridor and report to the monthly Urgent Care and Flow Dashboard.	31/10/2018	Claire Croxton, Specialty Manager Mandy Rumble, Matron Shaun Lomax, BIU	Green	Triumvirate will review patient level data. Daily Datix entries will be submitted for the number of patients in the corridor.

Action no	**Actions required** *(specify "None", if none required)*	Action by date	**Person responsible** *(Name and grade)*	Status	**Comments/action status** *(Provide examples of action in progress, changes in practices etc)*
5	IT to build an electronic escalation log (in line with the escalation policy) to raise to site where there are concerns about patient flow and the status in ED, e.g. where patients will need to be cared for in corridors	30/03/2019	Nickie Jakeman, Clinical Lead	Green	Once the log has been developed this will be reviewed by the Triumvirate.

On completion of all actions above, please provide examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Do the actions taken and the evidence provided give sufficient assurance that the compliance recommendation has been addressed and can be closed down?

☐ Yes
☐ No

If No, please state why this recommendation cannot be closed down and what further actions are required to ensure the recommendations are met:

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Ref No	3
Compliance / Must Do Recommendation	Provide staff who are involved in the assessment of children in the urgent care centre appropriate training in paediatric assessment in line with the recommendations of the Royal College of Paediatrics and Child Health. Ensure suitable numbers of medical and nurse staff are provided. This must ensure safe nurse to patient ratios can be maintained at predictably busy times and there are sufficient medical staff to maintain safe staffing levels and treat patients in line with best practice guidance.
CQC Core Service	Urgent & Emergency Services
CQC Domain	Effective Safe
Comments	Not all staff in the urgent care centre had completed specific training in paediatric assessment to support them in assessment of children. Medical and nurse staffing levels did not ensure safe care at all times, especially when the department was crowded. The department did not always achieve safe nurse to patient ratios when the department was crowded. The trust were told they must take steps to ensure they achieved planned staffing levels after the last inspection but nurse staffing had not improved.

Action no	**Actions required** *(specify "None", if none required)*	Action by date	**Person responsible** *(Name and grade)*	Status	**Comments/action status** *(Provide examples of action in progress, changes in practices etc)*
1	Obtain a list of staff and training competencies required for the Urgent Treatment Centre (in line with recommendations from the Royal College of Paediatrics and Child Health)	30/11/2018	Yvonne Staples, Lead Nurse, Urgent Treatment Centre Donna Redman, GP Lead, Urgent Treatment Centre Robin Fackrell, Head of Division	Green	Mike Menzies has discussed requirements for Level 3 Safeguarding Children training for nursing staff in the Urgent Treatment Centre with the Lead Nurse and Safeguarding Lead for the Urgent Treatment Centre. Staff requiring updates are booking onto training. ED and UTC Master classes are being established.
2	Monitor compliance with training competencies through the UTC Clinical Governance meetings	31/12/2018	Yvonne Staples, Lead Nurse, Urgent Treatment Centre	Green	
3	Medical and Nursing staff rota review being supported by the Emergency Care Improvement Programme (ECIP) – to better understand medical staff requirement, to support business plan.	30/03/2019	Nickie Jakeman, Clinical Lead Claire Croxton, Specialty Manager Mandy Rumble, Matron	Green	Directorate workforce planning paper to be submitted to divisional team leaders by November 2018.
4	Nursing – undertake review by Head of Nursing and Matron (division wide review)	Ongoing	Nickie Jakeman, Clinical Lead Claire Croxton, Specialty Manager	Green	Review undertaken. Nursing staffing is monitored daily via RosterPro and escalated according to the nurse staffing escalation policy.

Action no	**Actions required** *(specify "None", if none required)*	Action by date	**Person responsible** *(Name and grade)*	Status	**Comments/action status** *(Provide examples of action in progress, changes in practices etc)*
			Mandy Rumble, Matron	Green	Proactive recruitment takes place. Alternative workforces being trialled.

On completion of all actions above, please provide examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Do the actions taken and the evidence provided give sufficient assurance that the compliance recommendation has been addressed and can be closed down?
☐ Yes ☐ No **If No, please state why this recommendation cannot be closed down and what further actions are required to ensure the recommendations are met:**

Status	
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Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Ref No	4
Compliance / Must Do Recommendation	Improve the time taken to treat, discharge or admit patients to be compliant with the performance improvement plan agreed with NHS Improvement. Improve the flow of patients requiring admission to the medical wards to reduce the length of time patients wait on trolleys after admission has been agreed. Ensure patients are checked regularly whilst waiting in the department and that this is recorded on the observation chart and safety checklist escalation pro-forma.
CQC Core Service	Urgent & Emergency Services
CQC Domain	Responsive Safe
Comments	The trust had consistently failed to meet the four-hour performance target, to treat, admit or discharge a patient within 4 hours of their arrival. Patients were frequently waiting too long in the department to see a doctor with the authority to admit them in an inpatient ward for treatment. The department was unable to move patients from the department to an in-patient ward within the expected 4 hour timeframe. Documentation was not always completed to a good standard. Safety checklists used to ensure patients were safe and received the key elements of their care were often not completed so staff could not demonstrate the care given to patients whilst waiting in the department. Discharge summaries sent to GPs sometimes lacked relevant information from the medical review.

Action no	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices etc)*
1	Actions related to patient flow work to continue to be reported and monitored through the Urgent Care Collaborative and A&E Delivery Board	Ongoing. Review by 30/03/2019	Francesca Thompson, Chief Operating Officer	Green	A weekly urgent care meeting is held which reviews the actions relating to patient flow work and adds in any additional actions that are required prior to discussion at the Urgent Care Collaborative and A&E Delivery Board.
2	Develop a Standard Operating Procedure (SOP) for use of the safety checklist	31/10/2018	Mandy Rumble Natalie Chedzoy, Senior Sister, ED Lance Jukes, Junior Charge Nurse, ED	Green	
3	Monitor weekly the completion of the safety checklist and obs chart	Ongoing	Mandy Rumble Penny Rutter, Junior Sister, ED Natalie Chedzoy, Senior Sister, ED Lance Jukes, Junior Charge Nurse, ED	Green	Obs chart audited weekly (NEWS). Report on completion of safety checklist and obs chart presented monthly to ED Senior Nurses. The NEWS audit is included within the Divisional Scorecard which is reviewed monthly through the Executive Performance Review. The target is 90%. The checklist compliance is included within the ED Scorecard which is monitored quarterly through Quality Board. The target is 90%.

On completion of all actions above, please provide examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Do the actions taken and the evidence provided give sufficient assurance that the compliance recommendation has been addressed and can be closed down?
☐ Yes ☐ No **If No, please state why this recommendation cannot be closed down and what further actions are required to ensure the recommendations are met:**

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