Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	9
Date of Meeting:	30 January 2019		

Title of Report:	Care Quality Commission Improvement Plan
Status:	For approval
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 purpose of this report is to update the Board of Directors on progress towards implementing the improvement plan following the Care Quality Commission (CQC) announced inspection to the RUH in June 2018.

Appendix A details progress in implementing the agreed actions on the improvement plan. These actions all relate to urgent and emergency services.

Overall, 13 of the 22 actions identified in the improvement plan have been completed. There are 7 actions graded as 'green' indicating that they are progressing in line with the timescales identified in the improvement plan. There are 2 actions graded as 'amber' indicating that they are not progressing according to the timescales identified in the improvement plan but there is evidence of progress to get back on track. These actions are described in the report.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors is requested to note progress in implementing the improvement plan from the Care Quality Commission (CQC) announced inspection to the RUH in June 2018 and the steps being taken to provide assurance that the implemented actions have been effective in addressing the recommendations identified by the CQC.

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 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.

1.3 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

1.4 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'.

1.5 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.

1.6 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.

2 Improvement Plan

2.1 An improvement plan was developed and returned to the CQC in October 2018 detailing the actions that will be taken to address the four compliance recommendations from the report.

2.2 The core service leads were requested by the Quality Assurance and Clinical Audit Lead to provide an update against the outstanding actions on the improvement plan. Appendix A shows progress towards implementing these actions.

2.3 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.

2.4 Overall, 13 of the 22 actions identified in the improvement plan have been completed. These are graded as 'blue' and indicated as completed in Appendix A.

2.5 There are 7 actions graded as 'green' indicating that they are progressing in line with the timescales identified in the improvement plan.

2.6 There are 2 actions graded as 'amber' indicating that they are not progressing according to the timescales identified in the improvement plan but there is evidence of progress to get back on track. The following recommendations are affected:

- The action related to the recording of treatment delays leading to adverse patient outcomes is graded as 'amber' as these are not currently routinely being recorded. The Interim Matron for the Emergency Department is due to discuss this with the governance lead for the Emergency Department.

- The action related to the monitoring of competencies for Paediatric assessments through the Urgent Treatment Centre Clinical Governance meetings is graded as 'amber' as the first report has been delayed until January 2019.

3 Next steps

3.1 On completion of all actions under each compliance recommendation, the identified action leads are 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.

3.2 Quality Board is responsible for monitoring the effectiveness of the actions taken to address the CQC recommendations. The Emergency Department is providing quarterly updates to Quality Board which include details of the actions taken and evidence, including performance data, demonstrating how these actions have improved services. The first update was presented at Quality Board in January 2019.

4 Recommendations

4.1 The Board of Directors is requested to note progress towards implementing the improvement plan from the CQC inspection to the RUH in June 2018.

4.2 The Board of Directors is also requested to note the steps being taken to provide assurance that the implemented actions have been effective in addressing the concerns identified by the CQC within the Quality Report.

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	Emma Morgan, Interim 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	Emma Morgan, Interim 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	Emma Morgan, Interim 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 Emma Morgan and

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)*
					Mike Menzies
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)	Emma Morgan, Interim Matron Mike Menzies, Named Nurse, Safeguarding Children	Blue	Results to be presented at the Children and Young People's Safeguarding Committee on 24 January 2019 and all subsequent committees (standing item – covered through risk register update). Completion is reviewed daily by ED admin and results sent to the ED reviewing nurse to assist in follow up processes.
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 Emma Morgan, Interim Matron	Blue	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. Initial scoping undertaken. Follow up meeting held in November with the Named Nurse ED, lead consultant (Liz Gilby) and ED Systems support. Discussed that ENPs will struggle with capacity to complete this. Agreed that ED admin will support completion by identifying those patients that have not had the Paediatric screening tool completed and sending on to the reviewing nurses to action these. This is now in place.
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 Emma Morgan, Interim 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. Completion of screening tool as mandatory process is on the must do list and high priority. Waiting for IT to action.
7	Think Family principles – Urgent Treatment Centre (UTC): Implement Safeguarding referral process to children's social care: • Children	Review by 31/12/2018	Yvonne Staples, Lead Nurse, Urgent Treatment Centre Tim Owen, Emergency Care Practitioner, UTC	Blue	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

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)*
	• Adults presenting a risk to children		Mike Menzies, Named Nurse, Safeguarding Children		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 Next review: 31/05/2019	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. The Safeguarding Team, UTC lead and Paediatric Registrar are available for ad hoc supervision through the Trust safeguarding processes. The UTC lead nurse and safeguarding lead now have quarterly one to one safeguarding supervision with the Named Nurse for safeguarding. The Named Nurse has arranged to attend the twice yearly UTC away day for group safeguarding supervision. Safeguarding supervision booked for the next away day on 13 May 2019 and dates for ENP supervision and attendance at Friday afternoon Emergency Department safeguarding supervision sessions sent to the UTC lead nurse and UTC Emergency Care Practitioner for dissemination.
9	Think Family principles – Urgent Treatment Centre (UTC): UTC practitioners to work closely with the RUH safeguarding children and adult team to promote 'think Family Principles' in the department.	Review by 31/12/2018	Yvonne Staple, Lead Nurse, Urgent Treatment Centre. Tim Owen ECP, Children's safeguarding link nurse Lorraine Facey, Adults Safeguarding link nurse NP	Blue	Actions taken detailed above. The UTC Children's Safeguarding link nurse 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 to promote 'Think family

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)*
					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.	Blue	ED and Urgent Care Centre action plan created and monitored through the Safeguarding Children and Adults Committee.

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)

Compliance for completion of the safeguarding checklist is being monitored weekly and compliance was 92% for January 2019. Results from the weekly report for the Paediatric Reviewing Nurses shows that every child was reviewed between August and December 2018. The percentage reviewed within 48 hours has also increased from 30% in July 2018 to 81% in December 2018.

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	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	Emma Morgan, Interim Matron	Blue	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. Patient age has been 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	Blue	Added to the Trust Quality Scorecard for November 2018. The majority of breaches occur within Minors. This is also monitored at the Urgent Care Task and Finish Group.
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	Emma Morgan, Interim Matron Nickie Jakeman, Clinical Lead	Amber	Collaboration with Acute medicine governance lead to identify treatment delays. These will be reported to the ED Divisional Clinical Governance meetings. Emma Morgan to follow up with Phil Kaye (January 2019).
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 Emma Morgan, Interim	Blue	Daily BIU report produced and Datix submitted (since 6 December 2018) for the number of patients nursed 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)*
			Matron Shaun Lomax, BIU		(this does not currently include patient identifiable information). This is also included on the weekly Urgent Care scorecard.
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)

The number of patients cared for in the ED corridor is submitted to Datix and recorded on the RUH 4 Hour Performance Improvement Scorecard. Compliance for Time to Triage (within 15 minutes) has continued to increase since August 2018. Compliance was between 30 and 40% for August 2018 and has increased to nearly 70% by January 2019.

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	Blue	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 have booked on to training and most have completed. Training Needs Analysis developed which identifies which staff have received paediatric training. Paediatric master classes are being developed for ED and UTC staff (held 4 times a year) which includes key Paediatric competencies.
2	Monitor compliance with training competencies through the UTC Clinical Governance meetings	31/12/2018	Yvonne Staples, Lead Nurse, Urgent Treatment Centre	Amber	Results from the Training Needs Analysis to be discussed at the January UTC Clinical Governance Meeting.
3	Medical and Nursing staff rota review being supported by the Emergency Care Improvement Programme (ECIP) – to	30/03/2019	Nickie Jakeman, Clinical Lead	Green	Directorate workforce planning paper to be submitted to divisional team leaders.

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)*
	better understand medical staff requirement, to support business plan.		Claire Croxton, Specialty Manager Emma Morgan, Interim Matron		UTC: Meeting planned with deputy divisional manager / ED specialty manager to map workforce planning ED: Work undertaken with ECIP who have provided a medical staffing model
4	Nursing – undertake review by Head of Nursing and Matron (division wide review)	Ongoing	Nickie Jakeman, Clinical Lead Claire Croxton, Specialty Manager Emma Morgan, Interim Matron	Green	Review undertaken. Nursing staffing is monitored daily via RosterPro and escalated according to the nurse staffing escalation policy via live RosterPro system. 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)
100% UTC staff have completed Safeguarding Level 3 training. 100% UTC staff have completed an element of paediatric assessment within practitioner training. 40% UTC staff have completed the Paediatric Mimic course with a further 20% having completed alternative paediatric training courses (e.g. minor injury / minor health). 20% UTC staff have booked on to complete their Paediatric MIMIC or Paediatric PACR in 2019.

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	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	30/10/18	Emma Morgan Natalie Chedzoy, Senior Sister, ED Lance Jukes, Junior Charge Nurse, ED	Blue	SOP produced for use of the safety checklist. This is being rolled out.
3	Monitor weekly the completion of the safety checklist and obs chart	Ongoing	Emma Morgan 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)
Increased direct admits to Medicine and Surgery through ring-fencing areas on MAU and SAU. ED full capacity protocol established in September 2018 limiting the number of patients in the corridor. Fit to sit chairs introduced on the ED Obs Unit. Initial results for a four week period over December show an increase in discharges and shorter length of stay. Compliance for completion of NEWS ranges between 80 and 100%. NEWS2 was launched in November 2018. Further improvement is required for completion of the safety checklist. Compliance was approximately 60% in December 2018.

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