PORTSMOUTH HOSPITALS NHS TRUST
URGENT CARE QUALITY IMPROVEMENT PLAN

(June 2016)

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Foreword from the Chief Executive

The 7,500 people that make up the team at Portsmouth Hospitals NHS Trust (PHT) have a very simple purpose – to provide safe, high quality care to all, based on the specific needs of each patient.

We have a clear picture of how we want our urgent care services to run for the 675,000 population that we serve in Portsmouth and South East Hampshire – all achieved through the dedication, commitment and expertise of our clinical teams.

We want to provide outstanding care as standard at Queen Alexandra Hospital and the community sites we operate our services from. Our aim in the next five years is to deliver outstanding maternity; children's; medical; surgical; specialist; diagnostic and outpatient services. This is the standard that every patient should expect of us, which is no less than we would expect for any member of our own family.

There are many services that we deliver which are already rated good or outstanding. The CQC awarded our staff the highest accolade possible by rating their care for patients as outstanding. Despite the on going pressures from the unscheduled care agenda, we still continue to hold the position in relation to the remaining NHS Constitutional Standards. Our recent staff survey reaffirms the commitment and engagement of our staff.

We have an increasing reputation for Research and Innovation and are amongst the top NHS employers. While these are significant achievements, we cannot rest on them for our reputation and sense of pride. This must come from continuous improvement in the following key areas and we all have a role to play in their achievement:

- safe care
- high professional, clinical and constitutional standards by 'living our values'
- good experience for patients and staff through a culture of engagement, innovation and improvement
- good financial health so that we can invest in our future with confidence

Key to successful delivery in these key areas will be the sustainable improvement of urgent care services. We have already taken action but this has not yet achieved the outstanding services we want to see for patients and staff involved in the urgent care pathway or delivery of the 4 hour ED standard - both marker of a high quality hospital and health system.

The lack of sustainable flow though the hospital and out into community health and social care services results in an often overcrowded ED department and hospital. Too often patients continue to queue in ambulances, and are admitting patients into escalation beds that are not in the right location or with the right clinical teams for their care. This means our staff often work at their limits to maintain patient safety.

These are the symptoms we face daily – symptoms which hold us back from becoming the outstanding hospital we know we can be, and impacts upon our financial health. Symptoms we can and must do something about together.

While many of the urgent care issues are complex and long standing, there are evidence based models of care that when implemented sustainably, will lead to the improvements in urgent care we all want to see. We must now come together and work together the Portsmouth way – to implement the models of care set out in this improvement plan.

Our approach is very clear. We want to get the culture right – the way we do things at PHT, continue to focus on patient safety and concurrently improve upon our performance in a way that is sustainable financially. We have focused on eight key projects and a phased improvement approach. We are

committed to delivering this urgent care improvement plan and will stick with it, especially when the road ahead appears hard.

This is because improving urgent care services is key to being able to progress some of the larger strategic changes needed across the local health system that have been delayed by our current performance. Performance which is also holding back improvements in patient and staff experience, our reputation for clinical excellence in everything we do, our collective sense of pride and our financial health, with an estimated £10m plus spent on unnecessary patient waits and delays across the urgent care pathway at the hospital.

The Urgent Care Improvement Programme set out in this narrative is supported by project delivery plans, identifies what must be done now, how, by whom and by when – to address this issue once and for all. We look forward to working together on this critical phase of our urgent care improvement journey for the benefit of patients, staff and the communities we serve and to create a sustainable future for emergency care.

Tim Powell
Interim Chief Executive

Board Governance and Assurance

The Trust Board hold the Chief Executive Officer (CEO) to account.

The CEO will chair a weekly Urgent Care Improvement meeting which will report formally, twice a month to the Urgent Care Improvement Board, chaired by the Chairman.

The Urgent Care Improvement Board, a sub-committee of the Trust Board, will determine the extent to which implementation of the Urgent Care Improvement Programme (UCIP) is delivering quality and performance improvements against a range of key performance indicators. Consideration will be given to the extent to which the Trust has ensured compliance against the enforcement actions, requirement notices, and the Contract Performance Notice issued by the CCG.

The sub-committee should be provided with assurance against four key areas; UCIP on track in terms of actions, actions delivering expected impact in terms of quality and performance, delivery is within the appropriate culture, that the organisation is compliant with its statutory responsibilities and that they are considering the wider impact of the implementation of the plan e.g. financial impact and other unintended consequences/benefits.

The sub-committee will report to the Trust Board to provide assurance on Urgent Care Improvements triangulated with other quality intelligence, such as the Board Assurance Framework, Non-Executive Walkabouts.

The Trust Board holds the CEO and the Executive Management Team to account for delivery of the Urgent Care Improvement Plan to time, budget and forecast performance improvement. The System Resilience Group, and NHS Improvement hold the Trust Board to account for delivery of the urgent care improvement programme to time, budget and forecast performance improvement.

The governance that will support the delivery is key to successful delivery. There are a number of resources which support the operational teams in delivery and these are outlined below:

- Urgent Care Transformation Support Office
  The Urgent Care Transformation Support Office (TSO) is formed of the Programme Manager for Urgent Care, 2 project support managers and a project support officer who works directly with the project leads and teams that are responsible for delivery.

  The TSO is responsible for ensuring that the plans are robust, and deliverable. They independently track the projects and, will identify slippage in delivery and risks to delivery.

- KPMG
  KPMG have given practical advice and guidance on the completion of delivery plans, implementation of delivery processes and monitoring of compliance against plans as part of their transformational consultancy engagement with the Trust.

- Emergency Care Improvement Programme (ECIP)
  ECIP have been able to offer advice and guidance on best practice, access clinicians to support the change process and offers access to learning and development opportunities to staff that are involved in the delivery of urgent care services.

Governance Structure and Reporting
Each project has a named executive, clinical and project lead, and a named project team with project support assigned. They will be responsible and accountable for the delivery of the projects with support from the wider organisation. They will report, through an exception report, fortnightly to the Urgent Care

Delivery Group outlining the progress to date, any areas of concern that are impinging on the delivery of the actions within the agreed timescales and identified project delivery risks.

The Urgent Care Delivery Group will be chaired by the Executive Director Emergency Care. The clinical leads will be expected to attend the fortnightly Urgent Care Delivery Group or send a deputy to report on progress, areas of concern, slippage in delivery and project delivery risks. This will in turn report to the Trust Operational Board chaired by the Chief Operating Officer.

In addition the Urgent Care Improvement Board will report to the System Resilience Group Operations Board (SRGOB) with updates in the form of exception reports to ensure the SRGOB gain oversight to the overall system wide improvements.

Assurance Framework
The above structure and reporting ensures that there are clear lines of responsibility and accountability for the delivery of the urgent care improvement projects. Where there is a requirement by the project teams to "unblock" or secure external changes in order to deliver the desired outcomes the relevant Boards will act as enablers and ensure that the teams are able to implement changes.

Key Performance Indicators
The programme measures will map to the key areas of assurance that the sub-committee will be considering; UCIP milestones, UCIP impact, compliance with statutory duties and governance, culture and leadership.

Each project has defined within it a suite of measures that will ensure the project team is able to monitor delivery of performance and this will be reported through to the relevant board. The success of the programme will be determined by a set of programme measures. These provide oversight of the programme success.

Communications
Communication to staff is essential in the delivery of the urgent care improvement plan this is at a Trust, CSC and department level. Workshops with key front line clinical and operational staff were held as an integral part of the project planning process. On-going workshops are being held supporting the delivery phase utilising the Listening in Action methodology. A UCIP Workshop was held on 20th April and others scheduled for 6th July and 5th October. There is a fortnightly UCIP Newsletter and a monthly Team Brief update to all Trust employees.

There will be proactive public and media communications to keep local people informed, increase confidence and awareness of the improvements and engage with partners where there are wider system issues.

Improvement methodology
The Trust has an established quality improvement programme utilising methodologies previously used specifically LEAN and Six Sigma with both transformation and clinical members of staff trained and competent in process mapping the patient journey to identify quality improvement opportunities. A yearly programme of emergency care performance benchmarking is already in place and is being used to define the UCIP milestones. A dedicated member of the Information Services, experienced in measuring and analysing data related to urgent care is supporting the UCIP ensuring robust measures and control processes are in place against predefined parameters.

Best practice advice is obtained via ECIP, national recommendations and through membership of the Ambulatory Emergency Care and Acute Frailty Networks as well as site visits to hospitals within the ECIP cluster who have successfully implemented change to processes and practice. Each milestone is systematically evaluated for quality improvement as well as an improvement in performance with reviews undertaken at the weekly project group meetings. Any deviation within the individual projects

has a route cause analysis undertaken across stakeholder groups to ascertain and uncover the causes of events affecting achievement with remedial action agreed at the UCIP Delivery Group.

There is daily PDSA cycle review facilitated by the UCIP Programme and Project Manager support across clinical and operational teams as changes are implemented. A UCIP Group mailbox has been created as a first point of contact for queries, concerns and ideas. There are patient audits and analysis of balanced metrics and a 'You said, We Did' Programme of flyers communicating quick wins and successes. Patient involvement will be via the Trusts Friends and Family Feedback, patient surveys and direct interaction with patient groups facilitated by the hospitals patient experience lead.

Risk analysis

Each project team has identified project risks weekly and these are reported as part of the exception reporting process, these are discussed at the Urgent Care Improvement Board as required. These follow the Trust format of Patient Safety RAG rating risks for clinical effectiveness, patient experience, operational/ non clinical risks and overall project delivery. Quality Impact Assessments will be completed for each project.

Culture, Leadership and Staff Engagement

It is recognised and accepted that when our staff were asked by the CQC about what it felt like to work within the emergency care pathway, they reported a sense of learned helplessness, that they were not listened to and that changes were made to them and not with them. The leadership was not consistent or joined up across the pathway and teams were working in silos rather than in unity to deliver high quality patient centred care.

We want Portsmouth to be a great place to work and receive treatment and we are committed to improving the leadership, management and governance assurance to develop a culture which supports learning and innovation, promotes openness and fairness and builds on the resilience and compassion of our staff by encouraging inclusive contribution and engagement.

We intend to move forward and work on the principles of; no surprises, delivering on our promises and supporting each other. This means ensuring that there are appropriate mechanisms in place for our staff or patients to raise concerns or ideas that will be listened to and acted upon. It means we will work together across the emergency care pathway through one clear leadership and management framework to reduce variation, improve standards and avoid silo working to ensure a better patient experience. Staff will be involved in and empowered to make decisions and changes that affect them and be supported to report incidents or near misses so that we discuss, share and learn from each other to discourage any associated blame.

By winter 2016, all staff will have clarity on the strategic direction of the organisation and how their role contributes to it. Roles and responsibilities will be clear with underpinning objectives agreed and understood, outlining the specific individual and team goals to be delivered to improve our emergency care pathway. This will provide the structure, ambition and hope that has been lacking across the pathway. A clear performance management framework will be in place to ensure a disciplined approach to deliver against objectives with the appropriate support, training and development put into place for any individual or team requiring it. Processes and procedures will be developed with staff and communicated effectively with an opportunity for evaluating their effectiveness, and leadership will be visible and accessible for all.

We will deliver this positive change in culture, centred on our values and behaviours which promote quality of care, through working together with respect and dignity to ensure we deliver effective and efficient services for our communities and staff.

Specific actions to achieve the above are identified are outlined in the table below:

Culture, Leadership and Staff Engagement		
Action	**Responsible Lead**	**Deadline for completion**
1. Identify champions to promote and adopt the Listening into Action methodology for engaging staff to be involved in and empowered to make decisions and changes that affect them.	General Manager, Emergency Medicine, Medicine and MOPRs CSCs	22nd July 2016
2. Provide team leaders with the skills to lead change and deliver service improvements.	Head of Organisational Development	14th October 2016
3. All staff have access to and an understanding of the incident reporting system to promote reporting of incidents.	Acting Head of Risk Management	1st August 2016
4. Display in staff areas learning from incidents taking best practice from Critical Care's approach and share with wider organisation.	Governance Leads Emergency Medicine, Medicine and MOPRs CSCs	31st July 2016

Culture, Leadership and Staff Engagement

Culture, Leadership and Staff Engagement		
Action	**Responsible Lead**	**Deadline for completion**
5. All staff appraisals will be up to date and provide clarity of roles and responsibilities with underpinning objectives to enable the effective delivery of the emergency care pathway.	Chief of Service for each CSC	30th September 2016
6. Using the Trust's performance review policy, all staff will be monitored against the delivery of their objectives with an appropriate personal development plan identified where required.	All line managers across the pathway	Commenced – all staff minimum annually
7. Staff are clear on who to escalate to and how to access members of the senior leadership team.	Chief of Service for each CSC	31st July 2016
8. All new or reviewed processes and procedures will be developed with staff and communicated effectively with an opportunity for evaluating their effectiveness.	Chief of Service for each CSC	Immediately and as new / reviewed / developed
9. Priorities identified and appropriate actions taken from themes arising from the quarterly Staff Friends and Family Test.	Chief of Service for each CSC supported by Head of Organisational Development	31st August 2016
10. Clear intervention in place to reduce overall staff sickness rate and support staff health and well-being.	Chief of Service for each CSC supported by the Head of Organisational Development	31st August 2016

Measuring success

Through both national and local staff surveys, we will continue to measure how our staff feel about working here and whether they would recommend it as a place for care and treatment. At a local level, our engagement events and staff committees will continue to discuss and identify the priorities for improvements in development with our frontline teams. We will expect to see higher levels of reporting of incidents with evidence of learning embedded and shared as best practice across the organisation. In addition, an audit of the quality of appraisals will be undertaken following a series of associated training for team leaders. This will provide assurance that all staff are not only aware of their roles and responsibilities but have clear underlying objectives which contribute to the organisational priorities. Ultimately staff will report higher levels of overall engagement and improvements in the leadership and support they receive on a day to day basis enabling them to do their job more effectively.

Urgent Care Improvement Programme

The delivery of the UCIP is intended to deliver the required improvements in quality and operational performance and therefore result in addressing the Enforcement Notice, Requirement Notices and Must Do actions identified by CQC and the requirements within the Contract Performance Notice.

Urgent Care Improvement Programme
The organisation has an Urgent Care Improvement Programme that identifies the areas that will be the focus of improvement with changes within A&E, increasing capacity in the Frailty and Interface Team, additional referrals to Ambulatory Emergency Care and the implementation of the Short Stay Unit and Pathway resulting in immediate benefits, whilst other improvements lead to longer term benefits ultimately demonstrating an improvement in the 4 hour emergency wait standard.

The Urgent Care Improvement Programme has been formulated with full clinical and operational team engagement. This was established via individual conversations and facilitated workshops with those front line staff directly involved in the provision of Urgent Care. The workstreams relevant to partnership working across health and social care mirrored this process ensuring full engagement and commitment to delivery of the workstreams.

The Urgent Care Improvement Plan is intrinsically linked to the wider transformation agenda. The delivery of this wider transformation agenda is supported by an enhanced Urgent Care Transformation Support Office (TSO). A steering group, chaired by the CEO, will oversee the delivery of the transformation plan.

To support clinical teams and to make the changes set out in this improvement plan, the Trust has recruited a full time Executive Director Emergency Care.

The Urgent Care Improvement Programme for the Trust has been approved by the Trust Board and System Resilience Group. Overall accountability for programme delivery sits with the Director of Operations for Unscheduled Care supported by the Programme Manager. Each Clinical Lead has responsibility for the delivery of their individual project(s), supported through a process of escalation by their Executive Lead and through implementation of agreed actions by the Project Lead and project team. The necessity to rapidly agree projects led to an initial degree of central creation. Ownership of the project plans and delivery now sits firmly with the Clinical Leads and Clinical Service Centres supported by the Urgent Care Transformation Support Office (TSO). It is anticipated that the delivery of the programme and its contents will evolve within the agreed framework of the projects as actions are completed, reviewed and embedded within the urgent care pathway.

Urgent Care Improvement Programme workstreams
Objectives for each of the Urgent Care Improvement Programme workstreams are detailed in the table below. KPIs for the key Workstreams, which are to be discussed at the fortnightly Urgent Care Improvement meeting, chaired by the Chief Executive can be found in Appendix 1. The KPIs for the remaining worksteams will be discussed at the Urgent Care Delivery Group.

Accident and Emergency workstream	**Project lead: Chief of Service, Emergency Medicine CSC**
1. Removal of ED exit blockage. 2. Reduce the number of handovers/handoffs within ED. 3. Reduce the number of patient moves within the department of ED. 4. Decompress ED by the development of admissions pathway where all expected patients access the Trust via admission units or wards. 5. Work jointly with South Central Ambulance Service (SCAS) to ensure a safe level of risk in the community by reducing to a minimum, ambulance handover delays each day.	

Urgent Care Improvement Plan

Medical Take	Project lead: Chief of Service, MOPRS CSC
1. To implement an unselected general medical take which ensures today's patients are seen today. Unselected take is an initial assessment by a Physician before referral to a specialty as appropriate. 2. Ensure consultant review (post take ward round) completed for all admitted patients within 8h for patients admitted during the day and 14h for those admitted overnight as per RCP guidance including estimated date of discharge (EDD) targets for day and night take within. 3. The acute physician will manage the medical take supported by a generalist rota.	
Short Stay Unit and Short Stay Pathway	**Project lead: Chief of Service, Medicine CSC**
1. To increase from 50% to 65% of patients undertaking a short stay pathway. 2. Increased focus on effective and timely turnaround of short stay patients to facilitate discharge within 24 hours in AMU and 72 hours on the Short Stay Unit. 3. All short stay patients to be cohorted in a single clinical area with the exception of those who would require a specialty pathway bed such as stroke/cardiac/respiratory/gastro. 4. Implementation of a short stay pathway (SSP) for patients post assessment that ensures appropriate management of patients requiring specialist care who are expected to be discharged within 72 hours.	
Acute Medical Unit (AMU)	**Project lead: Chief of Service, MOPRS CSC**
1. To implement an unselected general medical take which ensures today's patients are seen today. Unselected take is an initial assessment by a Physician before referral to a specialty as appropriate. 2. Ensure consultant review (post take ward round) completed for all admitted patients within 8h for patients admitted during the day and 14h for those admitted overnight as per RCP guidance including estimated date of discharge (EDD) targets for day and night take within. 3. The acute physician will manage the medical take supported by a generalist rota.	
Ambulatory Emergency Care	**Project lead: Consultant, Acute Physician, AMU**
1. To increase assessment, diagnosis and treatment of medical conditions under the umbrella of ambulatory sensitive condition processes in an outpatient environment preventing the need for an inpatient admission.	
Ward discharges including SAFER	**Project lead: Director of Operations – Unscheduled Care**
1. Discharge more patients than are admitted on a daily basis. 2. Safer faster hospital: adherence to the internal professional standards.	
Acute Frailty Pathway	**Project lead: Chief of Service, MOPRS CSC**
1. Frailty Interface Team (FIT) to provide early initial comprehensive interdisciplinary assessment and signposting for frail older people over 75yrs within the Emergency Corridor. Reduce the numbers of avoidable admissions where clinically safe to do so, thus enabling people to be managed within their usual residences with the support of community services as required. Where admission is unavoidable there will be early initiation of comprehensive assessment and planning by the MDT to enable early supported discharge or pre-emptive discharge planning. 2. Acute Frailty Unit (AFU). Multi-disciplinary AFU with up to 18 beds co-located in emergency corridor for up to 72hr stay. 3. Specialty Based Frailty Care to provide in-reach liaison service to surgical and medical specialty patients over the age of 75yrs including peri-operative support for elective surgical patients to enhance recovery. 4. Acute Take for Geriatric Medicine being locality based providing specialist advice and guidance and intervention across the patient journey. 5. Safer faster hospital: adherence to the internal professional standards.	
Site Operations	**Project lead: Director of Operations – Unscheduled Care**
1. To have total overview of every adult bed in the hospital. 2. Central ownership of hospital beds, the Director of Operations/ deputy will be the final referee on all bed issues. 3. Create a fit for purpose Operation Team Structure including centralisation of flow teams to enable centralised management of patient flow. 4. Create an On Call Team compliant with operational, tactical and strategic command levels over a 24	

hours period.
5. Review function, membership and form of Operations Meetings with a view to them being action and safety focused, lasting no longer than 15 minutes.
6. CSCs take responsibility and accountability for achievement of discharge and flow targets.
7. Real-time management of beds using Bedview.
8. Safer faster hospital: adherence to the internal professional standards.

Quality Improvement Plan

Delivery of the Urgent Care Improvement Programme will improve the overall safety, quality of care and experience for patients throughout the whole organisation. The following actions detail the improvements required to comply with the CQC requirements and the CCG Contract Performance Notice.

All assurances against delivery of the action plan will be provided through the fortnightly Urgent Care Improvement Committee, chaired by the Chief Executive Officer.

Reference:	EA1 _ RN9 _ RN14 _ M1 _M12
Executive Lead:	Chief Executive Officer
Operational Lead:	Executive Director Emergency Care / Chief Operating Officer
Timescale:	31st March 2017
Committee oversight:	Urgent Care Improvement Committee

CQC requirements	
EA1	The Registered Provider must ensure there is effective leadership of the emergency care pathway. There should be a clinical transformation lead that is appointed based on external advice and agreement. The lead should have the authority to make decisions, and ensure there is swift and appropriate action in relation to identified problems. There should be effective leadership, resource and support of the trust improvement plan to ensure changes are appropriately supported and implemented at pace. The trust improvement plan should be adhered to and any deviation must be based on external advice and agreement. Medical and nursing leadership, that is specific to the emergency department, should be clearly identified and supported, so that staff are empowered to make and act on decisions in the interest of patient care and safety.
RN9	There needed to be appropriate leadership of the emergency care pathway.
RN14	Plans to change the urgent medical pathway were not being implemented in a timely manner.
M1	A clinical transformation lead is appointed based on external advice and agreement and ensure effective medical and nursing leadership in the emergency department.
M12	Plans to change the urgent medical pathway are implemented in a timely manner.

Actions taken following the CQC inspection

- Chief of Service and Head of Nursing solely accountable for the specific management and leadership of the Emergency Department.
- The Chief of Service and Head of Nursing for the Medicine for Older People Rehabilitation and Stroke Clinical Service Centre have taken accountability for delivery of the changes within the Acute Medical Unit and Ambulatory Emergency Care.
- Dr Rob Haigh was appointed in May and commenced working one day per week, pending his substantive post of Executive Director Emergency Care, which commences on Monday 18th July.
- There has been no deviation from the Urgent Care Improvement Programme.

Improvement action(s)	Evidence required	Deadline	Evidence of Completion	Lead	Exec. lead
Delivery of the Urgent Care Improvement Plan and the eight associated workstreams to deadlines.	• Delivery of the Urgent Care Improvement Programme milestones and KPIs for each of the workstreams.	31st March 2017		Executive Director Emergency Care	Chief Executive Officer
Chief of Service and Head of	• Trust notification of changes in	May 2016 and as	• Completed. Noted in the	Chief Operating	Chief Executive

Quality Improvement Plan

Improvement action(s)	Evidence required	Deadline	Evidence of Completion	Lead	Exec. lead
Nursing with sole responsibility for the Emergency Department.	leadership within the Emergency Department.	required for continued delivery	May 2016 Board CQC Enforcement Notice Exception Report.	Officer	Officer
CSC senior management team (SMT) to deliver change by facilitating engagement from all staff levels with executive support.	• Delivery of Urgent Care Improvement Programme workbooks. • ECIP feedback.	May 2016 and as required for continued delivery	• Staff newsletters and workshops. • Discussion at team meetings.	Chief of Service for each CSC	Chief Operating Officer
Establishment of workstreams within ED for Triage, Minors/ UCC, Pitstop and Paediatrics.	• Outcome of new workstreams and associated pilots.	May 2016 and as required for continued delivery	• Pilots for minors and PITSTOP completed on the 14th and 16th June. Re-pilot planned for the 19th July.	Chief of Service Emergency Medicine CSC	Chief Operating Officer
Staff engagement with improvement processes through workshops and feedback sessions.	• Evidence and outcome of staff engagement through workshops and staff survey. • Engagement with and feedback from ECIP.	May 2016 and as required for continued delivery	• Two workshops completed. Project groups have subsequently been established, involving all levels of staff to take forward the ED urgent care workstream.	Chief of Service Emergency Medicine CSC	Chief Operating Officer

How will we know improvements have been made and are sustainable

- Monthly reporting of progress against Urgent Care Improvement Programme to the Systems Resilience Group via the Operational Board.
- Weekly exception reports through the Transformation Office and fortnightly Urgent Care Improvement Board.
- Monthly Programme Managers report to Operational Board.
- Monthly CQC Enforcement Notice Exception Report to Trust Board.
- Support provided to the clinical teams by ECIP.
- Improved patient experience demonstrated through Friends and Family Test and complaints data.
- Increased staff satisfaction demonstrated through the quality Pulse Survey.
- Evidence from CSC SMT that there is delivery of workstream KPIs and a resultant improvement trajectory in performance across all metrics.

Quality Improvement Plan

Reference:	EA2 _ RN2 _ RN3 _ RN12 _ M2 _ M5 _ M6
Executive Lead:	Executive Director Emergency Care / Chief Operating Officer / Director of Nursing
Operational Lead:	Director of Operations – Unscheduled Care
Timescale:	31st July and on-going
Committee oversight:	Urgent Care Improvement Committee

CQC requirements	
EA2	The Registered Provider must operate an effective escalation system which will ensure that every patient attending the Emergency Department at Queen Alexandra Hospital is triaged, assessed and streamlined by appropriately qualified staff as set out in the guidance issued by the College of Emergency Medicine and others in their Triage Position Statement. April 2011. The trust should follow the escalation procedures identified to manage increases in demand and pressures on the emergency pathway. The escalation process should be defined based on external advice and agreement. The actions the trust should take should be responsive and should not be delayed.
RN2	Patients attending the Emergency Department at Queen Alexandra Hospital are not triaged, assessed and streamlined by appropriately trained staff and escalation procedures are not followed.
RN3	Patients waiting in the corridor, or in ambulance vehicles, were not adequately observed or monitored by appropriately trained staff.
RN12	The trust had not accepted clinical responsibility for patients waiting on the ambulance apron.
M2	Patients attending the Emergency Department at Queen Alexandra Hospital are triaged, assessed and streamlined by appropriately trained staff and escalation procedures are followed
M5	Patients waiting in the corridor, or in ambulance vehicles, must be adequately observed and monitored by appropriately trained staff.
M6	The hospital must accept full clinical responsibility for patients waiting on the ambulance apron.

Actions taken following the CQC inspection

- Ownership of patients on the ambulance apron re-iterated to ED staff.
- The nursing compliment has been increased to deliver enhanced triage.
- The Emergency Department Escalation Policy developed and ratified in conjunction with SCAS. Policy agreed by Chief Executive Officers of both the Trust and SCAS 14th June 2016.

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
Emergency Department continues to monitor the effectiveness of ambulance arrival triage processes, utilising competent ED nurses.	• On-going review of escalation policies to reflect changes in models and pathways. • Improvement in compliance with the CQC daily metrics.	30th June 2016	• Emergency Department Escalation Policy agreed by Chief Executive Officers of both the Trust and SCAS 14th June 2016; to be reviewed through SRG in September 2016. • Weekly data submitted to the CQC	Chief of Service Emergency Medicine CSC	Executive Director Emergency Care

Quality Improvement Plan

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
			demonstrating improvement in compliance with 15 minute assessment and ambulance holding.		
Process to establish an enhanced triage system at times of high demand and when patients are held in ambulances.	• On-going review of escalation policies to reflect changes in models and pathways.	31st March 2016 and on-going	• ED Escalation policy agreed by Chief Executive Officers of both the Trust and SCAS 14th June 2016; to be reviewed through SRG in September 2016.	Head of Nursing Emergency Medicine CSC	Executive Director Emergency Care
Establishment of escalation boards within ED. These to be used in conjunction with new role and responsibility cards for consultant and nurse in charge.	• Escalation Boards in place and being followed.	Expected 20th July 2016 to be reported on 31st July 2016		Chief of Service Emergency Medicine CSC	Executive Director Emergency Care
Trust Escalation Policy to recognise patients being held within ambulances and to agree the appropriate level of escalation.	• Escalation policy reflects appropriate escalation levels.	31st July 2016		Director of Operations – Unscheduled Care	Executive Director Emergency Care Executive Director Emergency Care
Trust Escalation Policy to be reviewed post implementation in November 2016 in line with SRG agreement.	• Policy reviewed and ratified. • Minutes of SRG.	30th Nov. 2016		Director of Operations – Unscheduled Care	Executive Director Emergency Care Executive Director Emergency Care
Implementation of the Trust Full Capacity Policy and Capacity	• No 12 hour DTA breaches. • No speciality patients in ED	30th June 2016 and on-going	• No 12 hour DTA breaches in June 2016. • Commenced	Director of Operations – Unscheduled Care	Executive Director Emergency Care

Quality Improvement Plan

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
Escalation Policy Earlier robust activation and management by Operations Centre when triggers are reached.	overnight awaiting specialty beds, measured at 0800 each morning.		measuring unplaced speciality patients in ED at 0800 as a KPI.		
Implementation of the ED escalation Policy to allow immediate ambulance handover into a clinical care space.	• Sustained improvement in 15 minute assessment compliance. • Improvement in Dr first seen time. • Regular care observations noted on the electronic care record.	31st July 2016		Chief of Service Emergency Medicine CSC	Executive Director Emergency Care
Development of a Standard Operating Procedure to deliver a clinical review of patients held within ambulances when the Trust Escalation Policies have failed to provide capacity to allow immediate transfer of patients from ambulances.	• Standard Operating Procedure in place.	31st July 2016		Chief of Service Emergency Medicine CSC	Executive Director Emergency Care
Clear roles and responsibilities for ED staff as stated in the ED Escalation Plan.	• Clearly defined roles and responsibilities.	31st July 2016		Chief of Service and Head of Nursing Emergency Medicine CSC	Executive Director Emergency Care
The Urgent Care Improvement Workstreams will deliver earlier assessment. On completion,	• Business case submission and outcome.	31st August 2016		CSC Senior Management Team as required	Chief Operating Office

Quality Improvement Plan

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
business cases will be developed to support improved process and staffing establishment to reflect increased demand.					
Weekly submission of daily monitoring metrics as defined by the CQC including the triage, assessment and treatment of patients. Weekly analysis of metrics to identify trends and learning.	• Submission of weekly metrics with narrative highlighting data analysis and actions taken.	March 2016 and weekly with time frame changes as required by CQC	• Weekly submission of metrics with associated narrative demonstrating analysis of information, trends and learning.	Associate Director of Quality and Governance	Director of Nursing

How will we know improvements have been made and are sustainable

- Monthly reporting of progress against Urgent Care Improvement Programme to the Systems Resilience Group via the Operational Board.
- Monthly CQC Enforcement Notice Exception Report to Trust Board.
- Performance metric trajectory continues to improve then is maintained.
- Support provided by ECIP in the further development of the Emergency Department Escalation Policy.
- Ratified Emergency Department Escalation Policy. Policy signed by both SCAS and Trust Chief Executives and ratified at the Systems Resilience Group on 16th June.
- Reduction in the number of times the Trust is on 'Black' escalation status and reduced timescale to achieve de-escalation and recovery.
- Emergency Medicine Clinical Service Centre Newsletter.
- Team Brief.

Reference:	EA3 _ RN10 _ M3
Executive Lead:	Executive Director Emergency Care
Operational Lead:	Director of Operations – Unscheduled Care
Timescale:	30th September 2016 and on-going
Committee oversight:	Urgent Care Improvement Committee

CQC requirements	
EA3	The registered provider must ensure the large multi-occupancy ambulance known as the "Jumbulance" will not be permitted to be used on site at the Queen Alexandra Hospital. The exception to this will be if a major incident is declared. If the vehicle is then used, there should be appropriate action taken to ensure patients are kept safe at all times. The Registered Provider must ensure that ambulance waits do not exceed the recognised national target.

RN10	The "Jumbulance" should not be used in terms of patient safety and experience.
M3	The "Jumbulance" is not used on site at the Queen Alexandra Hospital, under any circumstances. The exception to this will be if a major incident is declared.

Actions taken following the CQC inspection

- Immediate withdrawal of the Jumbulance; which has not been utilised on the Queen Alexandra Hospital site since inspection.
- Ratified Emergency Department Escalation Policy. Policy signed by both SCAS and Trust Chief Executives and ratified at the Systems Resilience Group on 16th June.

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
Trust full capacity and escalation policies to be implemented fully and in a timely manner as the ED approaches full capacity.	• Ambulance holding data as part of the weekly CQC submission demonstrating no ambulances being held. • No 12 hour DTA breaches. • Sustained compliance with 15 minute assessments.	March 2016 and weekly with time frame changes as required by CQC	• Weekly submission of metrics with associated narrative demonstrating analysis of information, trends and learning.	Director of Operations – Unscheduled Care	Executive Director Emergency Care
Stop using HALO as additional capacity with patients queuing in the corridor.	• No patients queuing in the corridor; evidenced through the number of patients in the department detailed on the operations report.	30th Sept. 2016		Director of Operations – Unscheduled Care	Executive Director Emergency Care

How will we know improvements have been made and are sustainable

- No ambulances being held and ambulance waits not exceeding the recognised national target.
- Sustained achievement of Condition 4 metrics each week.
- SCAS able to provide timely response to calls.

Reference:	EA4 _ RN11 _ M4 _ M14 _ CPN6a _ CPN6b _ CPN6c _ CPN6d
Executive Lead:	Director of Nursing
Operational Lead:	Associate Director for Quality and Governance
Timescale:	31st August 2016 and on-going
Committee oversight:	Urgent Care Improvement Committee

CQC requirements	
EA4	The Registered Provider must provide CQC with daily monitoring information that is to be provided on a weekly basis.

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RN11	The trust required better and more accurate monitoring information to reflect patient safety and the quality of care.
M4	CQC receive daily monitoring information that is to be provided on a weekly basis.
M14	There is better and more accurate monitoring information to reflect patient safety and the quality of care.
CPN6a	Low number of datix incidents raised for unsafe care in ED and AMU.
CPN6b	Level of safeguarding adult concerns and alerts being reported and investigated when vulnerable adults are not provided with appropriate or timely care and treatment in the ED.
CPN6c	Non adherence to the AKI and sepsis pathways in ED which should be reported as clinical incidents and investigated appropriately.
CPN6d	Compliance in recording, escalating and investigating 12 hour DTA breaches.

Actions taken following the CQC inspection

- Weekly reporting of daily metrics to the CQC commenced 24th March 2016.
- Corporate Nursing Team provided daily additional support in ED in relation to facilitating timely assessment of patients arriving by ambulance; whilst new processes were being embedded.

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
Weekly (Thursday) submission of daily monitoring information to the CQC.	• Weekly submission of metrics to CQC and wider health system; to include additional narrative relating to actions being taken and operational position of the hospital. • Improvement in compliance with the CQC daily monitoring metrics.	March 2016 and weekly with time frame changes as required by CQC	• Weekly submission of metrics to CQC and partners, with associated narrative demonstrating analysis of information, trends and learning; contextualised with operational position of the hospital. • Improvements noted in 15 minute clinical assessment and ambulance holding. Further focus required on Dr first seen time and incident reporting, although improvements noted.	Associate Director for Quality and Governance	Director of Nursing
Ownership of data, ensuring analysis and learning is disseminated across the Emergency	• Evidence of learning through the metrics via the weekly narrative	March 2016 and weekly with time frame changes	• Analysis and learning from the weekly metrics are fed back to staff, including	Chief of Service Emergency Medicine CSC	Chief Operating Officer

Quality Improvement Plan

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
Department.	report. • Positive impact on compliance with the daily monitoring metrics.	as required by CQC	publication of the metrics on the staff noticeboard. In addition, key learning is included in the CSC Newsletter. • Following implementation of incident trigger list in ED w/c 27th June an increase in reported incidents is noted for that reporting period.		
Ownership of data, ensuring analysis and learning is disseminated across the organisation.	• Evidence of learning through the metrics via the weekly narrative report. • Positive impact on compliance with the daily monitoring metrics.	March 2016 and on-going	• Weekly submission of metrics to CQC and partners, with associated narrative demonstrating analysis of information, trends and learning; contextualised with operational position o f the hospital. • Data use at the Operations meeting to manage flow. • Data reviewed at the Urgent Care Delivery Group. • Unscheduled Care dashboard available on the intranet. • SAFER flow bundle available reported at CSC Performance reviews.	Director of Operations – Unscheduled Care	Chief Operating Officer

Quality Improvement Plan

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
Improve incident reporting within the ED and AMU.	• Reported incidents align to the Operational status. • Incidents reported in-line with the trigger list. • Increase in reported incidents.	31st August 2016 and on-going		ED and AMU CSC Management Teams	Director of Nursing
Ensure ED staff awareness of when and how to raise a Safeguarding Adult alert.	• Staff communications. • Increase in Safeguarding Adult alerts from ED when patients are not provided with appropriate or timely care and treatment.	31st July 2016		Head of Nursing Emergency Medicine CSC	Director of Nursing
Revise incident reporting trigger list to include non adherence to the AKI and sepsis pathways in ED, with staff re-education and publication of trigger list in all staff areas.	• Amended trigger list. • Increase in reported incidents. • Staff education, inclusion in CSC Newsletter.	31st July 2016		Chief of Service Emergency Medicine CSC	Medical Director
Audit the effectiveness of the 12 hour DTA breach SOP to ensure timely escalation and reporting of breaches.	• Outcome of the audit and any associated actions.	30th June 2016, and should any breaches occur	• No 12 hour DTA breaches reported in June.	Director of Operations – Unscheduled Care	Chief Operating Officer
University of Southampton to be invited into the Trust to meet mentors and discuss how they	• Outcome of joint Trust and University focus group to seek	30th June 2016	• Completed. Final report from the University is awaited. University	Head of Nursing and Midwifery Education	Director of Nursing

Quality Improvement Plan

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
are enabled to support students to ensure the learning environment provides the requisite experiences, mentorship and support to enable pre-registration students to progress to competent and capable registrants.	feedback first hand from students about their experiences.		confirmed assurance has been received as a result of the visit and will communicate this to the Nursing and Midwifery Council.		

How will we know improvements have been made and are sustainable

- Sustained compliance with all Condition 4 metrics and associated reporting; weekly and monthly.
- All patients will have timely assessment and treatment within the ED.
- Processes and procedures are in place to ensure no 12 hour DTA breaches occur.
- Continual improvement in incident reporting and learning from incidents; embedded in clinical and operational practice.
- Staff will be involved in and empowered to make decisions and changes that affect them and be supported to report incidents or near misses to share and learn from each other and to discourage any associated blame.

Reference:	RN1 _ M8
Executive Lead:	Director of Nursing
Operational Lead:	Head of Nursing CHAT
Timescale:	31st July 2016
Committee oversight:	Urgent Care Improvement Committee

CQC requirements	
RN1	People did not consistently have access to single sex accommodation in the escalation areas
M8	Patients are cared for in single sex facilities in the escalation areas

Actions taken following the CQC inspection

- Review and refresh of Single Sex Accommodation policy.
- Communication in Trust Team Brief June 2016.

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
Duty Matron daily review of compliance with single sex requirements in escalation areas.	• Daily staffing list to include compliance with single sex requirements.	30th June 2016	• Daily staffing reports demonstrating compliance.	Head of Nursing CHAT	Director of Nursing
Development of a Duty Matron checklist to	• Outcomes of Duty Matron observations	31st July 2016		Deputy Director of Nursing	Director of Nursing

Quality Improvement Plan

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
include escalation areas and single sex compliance.	against checklist				
Review escalation areas to include CCG and Governor validation.	• Outcome of the review of escalation areas and validation from CCG and Governor.	31st July 2016		Head of Nursing CHAT	Director of Nursing
Programme of education for senior ward leaders.	• Confirmation of education for senior ward leaders. • Incidents relating to single sex accommodation breaches.	31st July 2016		Deputy Director of Nursing	Director of Nursing

How will we know improvements have been made and are sustainable

- Processes and procedures are in place to ensure no single sex breaches occur.
- Monthly CQC exception report to the Trust Board and Governance and Quality Committee.
- Daily staffing report to include single sex compliance in escalation areas.
- Care Quality Review outcomes.
- Front line peer review outcomes.
- In-patient survey results.

Reference:	RN4 _ M7
Executive Lead:	Director of Nursing
Operational Lead:	Head of Nursing Acute Medical Unit and MOPRS
Timescale:	30th September 2016
Committee oversight:	Urgent Care Improvement Committee

CQC requirements	
RN4	Medicines were not consistently stored securely in the MAU
M7	The safe storage of medicines in the MAU.

Actions taken following the CQC inspection

- Due to annual leave, the Head of Nursing delegated that the Matrons met with Senior Staff, as part of a development meeting on the 29th June 2016, to re-enforce professional accountability and standards.

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
Re-enforce professional accountability for senior nurses relating to safe storage of	• Evidence of discussions.	30th June 2016	• Minutes of meeting held on 29th June 2016 confirming discussions.	Head of Nursing Acute Medical Unit and Medicine for Older People,	Director of Nursing

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Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
medicines; with engagement from pharmacy.				Rehabilitation and Stroke CSC	
Audit of current processes and environment.	• Outcome of audit.	30th June 2016	• Safe storage of medications audit undertaken by AMU Matron on 21st June 2016. • Pharmacy action plan regarding safe storage of medicines developed. • Alert signs developed and used in each ward.	Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke CSC	Director of Nursing
	• Action plan following audit outcomes.	15th July 2016		Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke CSC	Director of Nursing
Rolling audit programme to ensure safe storage of medicines.	• Audit programme outcomes and associated actions.	30th Sept. 2016		Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke CSC	Director of Nursing
How will we know improvements have been made and are sustainable					
• Safe storage of medicines; demonstrated through audit, Quality Care Reviews and Frontline Peer Reviews.					

Quality Improvement Plan

Reference:	RN5 _ RN6 _ M10 _ CPN6e _ CPN6f
Executive Lead:	Director of Nursing
Operational Lead:	Head of Nursing Acute Medical Unit and MOPRS
Timescale:	31st July 2016
Committee oversight:	Urgent Care Improvement Committee

CQC requirements	
RN5	Assessments, planning and delivery of care was not always based on risk assessments and staff must follow plans and pathways.
RN6	Patients in MAU did not all have care based on plans developed to support identified risks.
M10	All patients in MAU have care based on plans developed to support identified risks.
CPN6e	Overall quality of nursing care in AMU.
CPN6f	Evidence of consistent recording of patient clinical observations in AMU and appropriate adherence to escalation protocols for physical deterioration.

Actions taken following the CQC inspection

- Due to annual leave, the Head of Nursing delegated that the Matrons met with Senior Staff, as part of a development meeting on the 29th June 2016, to re-enforce professional accountability and standards.
- A review of processes was undertaken utilising good practice from other areas.

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
Review current documentation audit tool to determine appropriateness for the Acute Medical Unit.	• Outcome of review of current audit documentation tool.	8th July 2016		Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke	Director of Nursing
Increase the use of VitalPac for the recording of risk assessments.	• Weekly documentation audits (following review of audit tool); associated outcomes and actions to demonstrate improvements.	Audits to commence 11th July 2016; review at 4 weeks, 15th August 2016		Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke	Director of Nursing
Improved completion and quality of nursing assessment documentation, to include Falls and Braden risk assessments, and appropriate individualised care planning,	• Weekly documentation audits (following review of audit tool); associated outcomes and actions to demonstrate improvements.	Audits to commence 11th July 2016; review at 4 weeks, 15th August 2016		Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke	Director of Nursing
Focussed education of staff	• Themes identified	15th August 2016		Head of Nursing Acute	Director of

Quality Improvement Plan

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
as part of audit programme.	informing feedback to staff.			Medical Unit and Medicine for Older People, Rehabilitation and Stroke	Nursing
How will we know improvements have been made and are sustainable					
• Sustained improvement demonstrated through audit. • Corporate Nurse Team providing oversight and support.					

Reference:	RN7 _ M11
Executive Lead:	Executive Director Emergency Care
Operational Lead:	Executive Director – Emergency Care
Timescale:	31st March 2017 (dependent on SAFER roll-out)
Committee oversight:	Urgent Care Improvement Committee

CQC requirements	
RN7	Patients did not always receive timely discharge from hospital.
M11	Patients receive timely discharge from hospital.

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
Delivery of the Urgent Care Improvement Plan workstream 'Ward discharges including Patient Flow Bundle – SAFER'.	• Delivery of the Unscheduled Care Quality Improvement Programme milestones and KPIs for each of the workstreams.	31st March 2017 (dependent on SAFER roll-out)		Medical Director	Executive Director Emergency Care
Implementation of an Integrated Discharge Services and Discharge to Assess (Pathways 1, 2 and 3) jointly with external health and social care partners.	• Reduction in patients Length of Stay once no longer need to be cared for in an acute bed	30th Sept. 2016		Director of Operations – Unscheduled Care	Medical Director / Director of Nursing
How will we know improvements have been made and are sustainable					
• SAFER dashboard to be included in the CSC Executive Performance Reviews.					

Quality Improvement Plan

Reference:	RN8 _ M13
Executive Lead:	Director of Nursing
Operational Lead:	Head of Nursing Acute Medical Unit and MOPRS
Timescale:	30th June 2016
Committee oversight:	Urgent Care Improvement Committee

CQC requirements	
RN8	Staff in the MAU did not always adhere to infection control policies and procedures.
M13	Staff in the MAU adhere to infection control policies and procedures.

Actions taken following the CQC inspection

- Due to annual leave, the Head of Nursing delegated that the Matrons met with Senior Staff, as part of a development meeting on the 29th June 2016, to re-enforce professional accountability and standards.
- Regular infection control audits by infection control team

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
Re-enforce professional accountability relating to infection control practices.	• Improved compliance with infection control practices and audit results.	30th June 2016	• Due to annual leave, the Head of Nursing delegated that the Matrons met with Senior Staff, as part of a development meeting on the 29th June 2016, to re-enforce professional accountability and standards.	Head of Nursing and Chief of Service Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke	Director of Nursing / Medical Director
Focussed education from Infection Prevention Control team concentrating on 'Back to Basics'- implemented 6/7`	• Improved knowledge and education of staff resulting in improved compliance with audits	18th July 2016		Head of Nursing and Chief of Service Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke	Director of Nursing / Medical Director
Weekly internal hand hygiene audits to commence 18th July 2016.	• Outcomes of internal weekly hand hygiene audits demonstrating sustained	18th July 20116		Head of Nursing and Chief of Service Acute Medical Unit and Medicine	Director of Nursing / Medical Director

Quality Improvement Plan

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
	compliance.			for Older People, Rehabilitation and Stroke	
Monthly peer review audits (hand hygiene, environmental and NPSA).	• Outcomes of monthly peer review audits demonstrating sustained compliance.	31st July 2016		Head of Nursing and Chief of Service Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke	Director of Nursing / Medical Director
How will we know improvements have been made and are sustainable					
• Continued compliance with infection control practices.					

Reference:	RN13 _ M9
Executive Lead:	Director of Nursing
Operational Lead:	General Manager and Head of Professions Clinical Support Services
Timescale:	31st July 2016
Committee oversight:	Urgent Care Improvement Committee

CQC requirements	
RN13	Notes should be kept secure at all times and only accessed by authorised people. Throughout the hospital notes were not consistently stored securely.
M9	Patient notes are stored securely across the hospital to prevent unauthorised access.
Actions taken following the CQC inspection	
• Due to annual leave, the Head of Nursing delegated that the Matrons met with Senior Staff, as part of a development meeting on the 29th June 2016, to re-enforce professional accountability and standards.	

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
Re-launch Health Records Management Policy.	• Communications to staff re-launching the Trust Records Management policy.	31st July 2016		General Manager and Head of Professions Clinical Support Services	Director of Nursing
Staff briefing in Team Brief.	• Team Brief.	31st July 2016		General Manager and Head of Professions Clinical Support Services	Director of Nursing

Quality Improvement Plan

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
Quality Care Review focussed on records management.	• Outcomes of Quality Care Review.	31st July 2016		General Manager and Head of Professions Clinical Support Services	Director of Nursing
Front line peer review focussed on records management.	• Outcomes of Front Line Peer review.	31st July 2016		General Manager and Head of Professions Clinical Support Services	Director of Nursing
Development of a Duty Matron checklist to include records management	• Outcomes of Duty Matron observations against checklist.	31st July 2016		General Manager and Head of Professions Clinical Support Services	Director of Nursing
How will we know improvements have been made and are sustainable					
• Monthly CQC exception report to the Trust Board and Governance and Quality Committee. • Outcomes of Quality Care Reviews. • Outcomes of Front Line Peer review.					

Reference:	CPN6g
Executive Lead:	Chief Executive Officer
Operational Lead:	Director of Operations – Unscheduled Care
Timescale:	30th September 2016
Committee oversight:	Urgent Care Improvement Committee

CQC requirements	
CPN6g	Sufficiency of current ward to board quality assurance processes.

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
Sub-committee of the Board to review progress against the implementation of the Urgent Care Improvement programme.	• Minutes of Urgent Care Improvement Committee sub-committee.	31st July 2016		Executive Director Emergency Care	Chief Executive Officer
Revision of the Board Assurance	• Board Assurance	30th Sept. 2016		Director of Corporate	Chief Executive

Quality Improvement Plan

Improvement action(s)	Evidence required	Deadline	Evidence of completion	Lead	Exec. lead
Framework.	Framework highlighting key risks to delivery of the Trust strategic aims.			Affairs	Officer
Review Terms of Reference of the Urgent Care Improvement Board.	• Revised function of the Urgent Care Improvement Board reflecting the creation of the Urgent Care Improvement Committee	Expected 18th July 2016 to be reported on 31st July 2016		Director of Operations – Unscheduled Care	Chief Executive Officer
How will we know improvements have been made and are sustainable					
• In agreement with the CCG a new set of metrics will not be required; compliance will be through the delivery of this improvement plan.					

Appendix 1 : Urgent Care Improvement Programme Key Performance Indicators

Project A&E													
KPI		2016/2017											
Achievement of 4 hour wait trajectory		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	75.5%	76.1%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	89.0%
75.10%	Actual	76.1%	80%										
	Variance	0.6%	4%										
KPI		2016/2017											
Time to initial assessment. 95% patients assessed in 15 mins		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	62%	62%	62%	62%	62%	62%	72%	80%	95%	95%	95%	95%
62%	Actual	67%	61%										
	Variance	5.4%	-1%										
KPI		2016/2017											
Time to treatment 95% of patients treated within 60 mins (all patients)		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	46.5%	46.5%	46.5%	46.5%	46.5%	46.4%	56.0%	80%	95%	95%	95%	95%
46.50%	Actual	52.9%	44%										
	Variance	6.4%	-3%										
KPI		2016/2017											
DTA made on 95% of patients within 2.5 hours		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	39.6%	39.6%	39.6%	39.6%	39.6%	39.6%	50.0%	75%	85%	90%	95%	95%
39.60%	Actual	48.9%	46%										
	Variance	9.3%	6%										
KPI		2016/2017											
% of ambulance patients treated within 60 minutes		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	41.5%	41.5%	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
41.49%	Actual	45.9%	49%										
	Variance	4.4%	8%										
KPI		2016/2017											
Median Numbers of speciality patients in ED waiting a bed at 0800		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	15.00	12.00	8.00	8.00	5.00	5.00	3.00	2.00	5.00	8.00	3.00	0.00
7	Actual	10.50	7.00										
	Variance	-4.5	-5										
KPI		2016/2017											
Number of times 4 or more ambulances are waiting over 30 minutes		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	80	60	20	0	0	0	0	0	0	0	0	0
121	Actual	81	38										
	Variance	1	-22										

Urgent Care Improvement Programme Key Performance Indicators

Project Site Operations

KPI		2016/2017											
Number of 12 hour trolley breaches based on decision to admit		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	0	0	0	0	0	0	0	0	0	0	0	0
3	Actual	22	34										
	Variance	22	34										
KPI		2016/2017											
Median number of non-clinical bed moves between midnight and 0600		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	10	8	3	3	3	6	8	6	3	10	8	3
5	Actual	7	6										
	Variance	-3	-2										
KPI		2016/2017											
Number of patient bed moves for non-clinical reasons. Patient moving >2 times		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	0	0	0	0	0	0	0	0	0	0	0	0
1	Actual	0	0										
	Variance	0	0										
KPI		2016/2017											
Median Number of escalation beds in use		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	25	25	19	12	8	4	4	5	5	15	15	5
25	Actual	25	21										
	Variance	0	4										
KPI		2016/2017											
Number of stranded patients LOS >=7 Days		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	547	547	547	538	534	530	528	526	524	520	518	515
547	Actual	559.5	572										
	Variance	12.5	25										

Project Short Stay Unit Pathway

KPI		2016/2017											
Medical discharge LoS <3 days		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	50%	50%	55%	60%	63%	65%	65%	65%	65%	65%	65%	65%
50%	Actual	62%	65%										
	Variance	11.8%	15%										
KPI		2016/2017											
Medicine Bed Occupancy		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	100%	100%	98%	95%	95%	95%	95%	95%	94%	100%	95%	95%
124.39%	Actual	127%	128%										
	Variance	27.3%	28%										

Project Acute Medical Unit													
KPI		2016/2017											
Number of patients on AMU with a LoS over 24 hours		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	40%	35%	30%	25%	18%	10%	10%	5	10	20	10	5
38.66%	Actual	41.08%	36.66%										
	Variance	1.1%	2%										
KPI		2016/2017											
33.3% of Medical Take (Medicine and Emergency Medicine CSCs only) being seen through AEC		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	25.6%	25.6%	25.6%	25.6%	25.6%	30.0%	33.3%	33.3%	33.3%	33.3%	33.3%	33.3%
25.60%	Actual	21.0%	21%										
	Variance	-4.6%	-5%										

Project Ward Discharges													
KPI		2016/2017											
95% of Patients with an EDD		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
86%	Actual	72.1%	79%										
	Variance	-22.9%	-16%										
KPI		2016/2017											
33% Daily discharges by midday		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%
8%	Actual	19.7%	22%										
	Variance	-13.3%	-11%										
KPI		2016/2017											
100% Weekday Discharge Target Delivered		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
97.70%	Actual	97.7%	100.80%										
	Variance	-2.3%	1%										
KPI		2016/2017											
100% Weekend Discharge Target Delivered		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
99.10%	Actual	106.2%	109.30%										
	Variance	6.2%	9.3%										

Urgent Care Improvement Programme Key Performance Indicators

Project Acute Fragility Pathway													
KPI		2016/2017											
% of Discharges < 72 LoS >= 75 yrs.		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	35%	35%	35%	37%	37%	40%	40%	40%	40%	40%	40%	40%
35%	Actual	39%	43%										
	Variance	4.0%	8%										
KPI		2016/2017											
Average LoS for MOP acute wards >= 75 yrs.		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	16	16	16	15	15	14	14	14	14	13	13	12
17 days	Actual	17	17										
	Variance	1	1										
KPI		2016/2017											
Number of MOP Outliers (Excluding E4/AMU)		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Baseline:	Plan	25	25	23	21	19	17	17	15	15	13	13	13
24	Actual	24	18										
	Variance	-1	-7										