Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC – SEPTEMBER 2016 **Agenda Item Number: 117/16**
Enclosure Number: (3)

Subject:	**CQC Enforcement Notice and Urgent Care Quality Improvement Plan (CQC)** **July 2016 position status**
Prepared by: **Sponsored by:** **Presented by:**	Tracey Stenning, Head of Governance and Quality Fiona McNeight, Associate Director of Quality and Governance Maria Purse, Urgent Care Improvement Programme Manager Cathy Stone, Director of Nursing Cathy Stone, Director of Nursing
Purpose of paper	Inform the Trust Board on progress against the Urgent Care Quality Improvement Plan (CQC)
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	This report replaces the previous reports provided to the private part of the Trust Board with respect to compliance with the CQC Improvement Plan, CQC Enforcement Notice and the Urgent Care Quality Improvement Plan. The paper is divided into two parts: • Part a: relates to the CQC Enforcement Notice. • Part b: relates to the Urgent Care Improvement Plan (CQC and CCG Contract Performance Notice). **Part a:** • The Board are asked to note compliance with the Enforcement Notice Conditions 1, 3 and 4. • The Board are asked to note current compliance with the Enforcement Notice Condition 2. **Part b:** • The Board are asked to note compliance relating to the Urgent Care Quality Improvement Plan. • The plan is reviewed fortnightly by the Trust Urgent Care Improvement Board. • The plan has weekly scrutiny by the Chief Executive Officer at the Urgent Care Improvement Meeting. • This report describes actions with a required completion date up to July 2016. • The full plan is presented quarterly to the Trust Board and Governance and Quality Committee.
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	Any changes to format of report.

Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	Reporting to Governance and Quality Committee.
Consideration of legal issues (including Equality Impact Assessment)?	Legal requirement to meet the Health and Social Care Act regulations.
Consideration of Public and Patient Involvement and Communications Implications?	Nil.

Links to Portsmouth Hospitals NHS Trust Board Strategic Aims, Assurance Framework/Corporate Risk Register	
Strategic Aim	1: Deliver safe, high quality patient centered care 3: Become the hospital of choice for general, specialist and selected tertiary services 5: Develop sufficient financial strengths to adapt to change and invest in the future.
BAF/Corporate Risk Register Reference (if applicable)	1-1516
Risk Description	Inability to maintain on-going compliance with all CQC standards.
CQC Reference	All domains

Committees/Meetings at which paper has been approved:	**Date**

PART A: CQC Enforcement Notice – July 2016 position

Part a: CQC Enforcement notice	
Improvement Action(s)	**Progress to date**
Condition 1: The Registered Provider must ensure there is effective leadership of the emergency care pathway	
Delivering an Urgent Care Improvement Plan (UCIP) and the eight associated workstreams to deadlines	• UCIP agreed and approved by Trust Board. • Amended Governance structures in place; reviewed by the Chief Executive Officer and Executive Director Emergency Care weekly and Trust Board monthly moving forward.
Chief of Service and Head of Nursing with sole responsibility for the Emergency Department	• Implementation from March 2016 onwards.
CSCs and Executive team to deliver change by facilitating engagement from all staff levels with executive support	• UCIP performance assessed and discussed at all CSC Executive performance reviews. CSC specific KPIs reviewed monthly. • Refreshed communications plan; currently being reviewed
Establishment of workstreams within ED for Triage, Minors/UCC, PITSTOP and Paediatrics	• Workstreams established. • Pilot schemes (e.g. PITSTOP) have highlighted improvement opportunities. These are being implemented within the agreed timescales of the UCIP
Staff engagement with improvement processes through workshops and feedback sessions	• Communications plan in development (as noted above). • Two ECIP facilitated Operational Board improvement events have taken place; more planned and will be quarterly on going.
Condition 2: 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	
Establishment of escalation boards within ED.	• Installation will be completed following scheduled review of Escalation Policy (see below).
ED to continuously monitor: • effectiveness of ambulance arrival triage processes • enhanced triage at times of high demand and when patients are held in ambulances	• Significant and sustained improvement in 15 minute ambulance handovers. • Alignment of streaming and PITSTOP processes; implementation 5th September 2016.
Provide an appropriate and modern Trust Escalation Policy which safely and consistently delivers: • appropriate SOP for immediate clinical review, management and escalation of patients being held in ambulances • immediate ambulance handover • the Trust Full Capacity Operational Process	• Refreshed Escalation and Full Capacity Policies now in place and currently being reviewed.
Weekly submission of daily monitoring metrics as defined by the CQC	• In place.

PART A: CQC Enforcement Notice – July 2016 position

Part a: CQC Enforcement notice	
Improvement Action(s)	**Progress to date**
Condition 3: 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.	
Jumbulance' not to be used. If the vehicle is used, there should be appropriate action taken to ensure patients are kept safe at all times and ambulances waits do not exceed the recognised the national target	• Completed – 'Jumbulance' not being used • ED escalation process, supported by the Trust Escalation Policy in place, triggered by the ED triage nurse to escalate any patient safety concerns or ambulance holds at risk of exceeding national target. • The weekly metrics have demonstrated a significant sustained reduction in ambulance holding.
Condition 4: The Registered Provider must provide CQC with daily monitoring information that is to be provided on a weekly basis and based on the provided list of metrics	
Weekly (Thursday) submission of daily monitoring information to the CQC.	• In place. Completed weekly by multi professional teams with dedicated clinical input and signed off by Director of Nursing and Executive Director Emergency Care.
Improve incident reporting within the ED and AMU.	• Incidence reporting via professional standards log introduced 1st April 2016 onwards (used to escalate ED Governance concerns). • Root Cause Analysis undertaken on all 12-hour breaches.

PART B: Urgent Care Improvement Plan (CQC) – July 2016 position

Part b: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
March 2016			
Process to establish an enhanced triage system at times of high demand and when patients are held in ambulances.	• 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. • ED escalation plan agreed: SOP for assessing ambulance held patients submitted to the Director of Nursing and Director of Operations - unscheduled care for comment. Comments incorporated, however, an update of all Trust escalation plans is required to reflect new Majors layout is required.	• Ratified ED escalation policy.	Head of Nursing Emergency Medicine CSC
Weekly (Thursday) 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.	**Complete and on-going** • On-going improvements being noted in metrics.	• Weekly e-mails submitted to the CQC with all metrics and associated narrative demonstrating analysis of information, trends and learning.	Associate Director of Quality and Governance
Ownership of data, ensuring analysis and learning is disseminated across the Emergency Department.	• Analysis and learning from the weekly metrics are fed back to staff, including 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. • Incident reporting still being monitored although improved 15 minute assessments seem to be minimising the risk of events: on-going monitoring	• CSC newsletter. • Trust Board story.	Chief of Service Emergency Medicine CSC
Ownership of data, ensuring analysis and learning is disseminated across the organisation.	• Data used at the Operations meeting to manage flow. • Data reviewed at the Urgent Care Delivery Group. • SAFER flow bundle reported at CSC Performance reviews	• 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.	Director of Operations – Unscheduled Care

PART B: Urgent Care Improvement Plan (CQC) – July 2016 position

Part b: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
		• Unscheduled Care dashboard available on the intranet.	
Trust full capacity and escalation policies to be implemented fully and in a timely manner as the ED approaches full capacity.	**Complete and on-going** • Escalation implementation still not robust with variation across Trust with Trust on red while ambulances being held: ED review and production of escalation boards in ED may help mitigate this: Ops Centre need to be more robust in this.	• No 12 hour DTA breaches in June or July 2016; despite high level of attendances. • Weekly submission of metrics with associated narrative demonstrating improvement in ambulance holding compliance and sustained 15 minute assessment.	Director of Operations – Unscheduled Care
April 2016			
No actions.			
May 2016			
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.	• Commenced and on-going.	• Diarised performance reviews. • Performance review letters.	All line managers across the pathway
All new or reviewed processes and procedures will be developed with staff and communicated effectively with an opportunity for evaluating their effectiveness.	• Commenced and on-going.	• Listening into Action event for AMU staff.	Chief of Service for each CSC
Chief of Service and Head of Nursing with sole responsibility for the Emergency Department.	**Complete**	• Noted in the May 2016 Board CQC Enforcement Notice Exception Report	Chief Operating Officer
CSC senior management team (SMT) to deliver change by facilitating engagement from all staff levels with executive support.			Chief of Service for each CSC
Establishment of workstreams within ED for Triage, Minors/ UCC, Pitstop and Paediatrics.	• Pilots for Minors and PitStop completed in June and July. • New minors process commencing 5th September.		Chief of Service Emergency Medicine CSC

PART B: Urgent Care Improvement Plan (CQC) – July 2016 position

Part b: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
Staff engagement with improvement processes through workshops and feedback sessions.	**Complete** • 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
June 2016			
Emergency Department continues to monitor the effectiveness of ambulance arrival triage processes, utilising competent ED nurses.	**Complete** • 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 demonstrating a marked and sustained improvement in compliance with 15 minute assessment and ambulance holding.	• Sustained performance demonstrated through CQC weekly metrics.	Chief of Service Emergency Medicine CSC
Implementation of the Trust Full Capacity Policy and Capacity Escalation Policy Earlier robust activation and management by Operations Centre when triggers are reached.	• Commenced measuring unplaced speciality patients in ED at 0800 as a KPI.	• No 12 hour DTA breaches in June or July 2016; despite high level of attendances.	Director of Operations – Unscheduled Care
Audit the effectiveness of the 12 hour DTA breach SOP to ensure timely escalation and reporting of breaches.	**Complete and on-going**	• No 12 hour DTA breaches reported in June or July 2016; this will be audited should any patients be at risk of spending 12 hours from DTA.	Director of Operations – Unscheduled Care
University of Southampton to be invited into the Trust to meet mentors and discuss how they 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.	**Complete**	• Final report from the University of Southampton received. The Faculty were entirely satisfied that the learning environment within the Trust is of high quality, fit for purpose and meets the Nursing and Midwifery Council requirements.	Head of Nursing and Midwifery Education

PART B: Urgent Care Improvement Plan (CQC) – July 2016 position

Part b: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
Duty Matron daily review of compliance with single sex requirements in escalation areas.	**Complete and on-going**	• Daily staffing reports demonstrating compliance. •	Head of Nursing CHAT
Re-enforce professional accountability for senior nurses relating to safe storage of medicines; with engagement from pharmacy.	**Complete**	• Minutes of meeting held on 29th June 2016 confirming discussions.	Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke CSC
AMU audit of current processes and environment - outcome of audit.	**Complete** • 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.	• E-mails to Director of Nursing demonstrating audit compliance.	Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke CSC
Re-enforce professional accountability relating to infection control practices.	**Complete** • 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.	• Minutes of meeting held on 29th June 2016 confirming discussions.	Head of Nursing and Chief of Service Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke
July 2016			
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.	**Complete** Across the pathway: • 7 members of staff across the pathway are formally engagement/innovation champions. • 11 staff in addition have attended a training module for 'engaging for success'. • Further training sessions have been made available to actively promote staff led change. • Emergency CSC has a comprehensive National		General Manager, Emergency Medicine, Medicine and MOPRs CSCs

Part b: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
	NHS Staff survey action plan in place. • Success stories are shared via Staff-Led Change media channels, AMU and Emergency Team brief Slide, internal newsletter and will be incorporated into the PHT Change Day celebration on 19th October 2016.		
Display in staff areas learning from incidents taking best practice from Critical Care's approach and share with wider organisation.	• Various methods of shared learning currently exist across the pathway including written displays in staff areas and shared learning at department meetings. Head of Organisational Development has attended 2 of the 3 CSC board meetings (Emergency Medicine and Medicine, MOPRS due w/c 8 August) to date to discuss interventions to support delivery against all actions and for learning from incidents, it has been suggested that they make contact with Consultant Critical Care who leads on this to see an example of best practice. Consultant from Emergency Medicine is taking this forward		Governance Leads Emergency Medicine, Medicine and MOPRs CSCs
Staff are clear on who to escalate to and how to access members of the senior leadership team.	• Emergency Medicine have introduced a professional standards mailbox which allows staff to report/escalate issues to senior members of the team. A discussion/feedback follows and any themes identified are discussed within the department and escalated to the executive team where appropriate. • Understanding the extent to which staff are clear on escalation processes will be tested as part of the executive team walkabouts. • Medicine have 'Safety First' posters on all wards stating that safety is everyone's concern and providing contact details for relevant ward manager, Matron and Head of Nursing. There are patient escalation posters in all bays and side rooms telling them how to raise concerns	• Evidence of on-going development and compliance. Monitored by the Trust Urgent Care Improvement Board and the weekly Urgent Care Improvement Meeting	Chief of Service for each CSC

Part b: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
	including who they can contact Out of Hours, e.g. duty matron. Posters are present in all wards and clinical areas with the CMT team included with pictures and contact details (to be updated once General Manager is appointed). • Clinical Support - A change in Chief of service in May 2016 has allowed this to be put in place within the CSC with ease. Changes to senior leadership in the Trust and how the Trust manages business is only just being embedded. Staff within the CSC have regular updates (weekly (30 minutes) and monthly (2 hours)).		
Establishment of escalation boards within ED. These to be used in conjunction with new role and responsibility cards for consultant and nurse in charge.	• Delayed as completing business and ambulance hold SOP: requires updating of all escalation policies: planned review of ED part of escalation policies (w/c 1 August) for submission to Executive Director of Unscheduled Care and Director of Operations – Unscheduled Care.		Chief of Service Emergency Medicine CSC
Trust Escalation Policy to recognise patients being held within ambulances and to agree the appropriate level of escalation.	• Trust Escalation policy is currently being rewritten with a view to sign off in September 2016. This detail is currently in the ED escalation policy.		Director of Operations – Unscheduled Care
Implementation of the ED escalation Policy to allow immediate ambulance handover into a clinical care space.	**Complete** • 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.	• Marked reduction in ambulance holds: not at level where numbers allow correlation between CQC metrics and SCAS data on delayed handovers: assessment commenced w/c 1 August 2016.	Chief of Service Emergency Medicine CSC
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.	• Initial draft complete with limited feedback to date; out of hours ED consultant and SpR will need support from other teams to manage referred patients in ED. AMU/Medicine do not have capacity in the current model to deliver this.		Chief of Service Emergency Medicine CSC

PART B: Urgent Care Improvement Plan (CQC) – July 2016 position

Part b: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
Clear roles and responsibilities for ED staff as stated in the ED Escalation Plan.	• Roles and responsibilities detailed in escalation plan in last version: will be further reviewed as part of escalation plan review w/c 1 August 2016.	• To be reported in August report.	Chief of Service and Head of Nursing Emergency Medicine CSC
Ensure ED staff awareness of when and how to raise a Safeguarding Adult alert.	**Complete**	• Staff in the Emergency Department have received additional safeguarding training.	Head of Nursing Emergency Medicine CSC
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.	**Complete** • Trigger list complete. • Sepsis audit and meeting to support adherence to new CQUIN being arranged.		Chief of Service Emergency Medicine CSC
Development of a Duty Matron checklist to include escalation areas and single sex compliance.	**Complete** • Additional checks to the Duty Matron report added on 15th June 2016 as soon as the CQC report was received.	• Daily staffing reports demonstrating compliance.	Deputy Director of Nursing
Review escalation areas to include CCG and Governor validation.	**Internal actions complete** • All escalation areas reviewed internally by either Deputy Director of Nursing and/or Head of Nursing for CHAT. Staff in these areas given guidance about DSSA policy and use of Kwik screens to ensure compliance. Process for escalating concerns has been reinforced. Deputy Director of Nursing has met with Duty Managers to provide guidance on DSSA. Director of Nursing liaising with CCGs and Governors to validate areas. • Additional checks to the Duty Matron report added on 15th June 2016 as soon as the CQC report was received.	• Director of Nursing is part of the National Mixed Sex Accommodation Taskforce. • Awaiting external assurance.	Head of Nursing CHAT
Programme of education for senior ward leaders.	• Discussed the importance of single sex compliance with Heads of Nursing and Matrons. And an e-mail has also been sent detailing expectations on Duty Matron to ensure single	• To be discussed at the Nursing and Midwifery Advisory Committee 24th August 2016.	Deputy Director of Nursing

Part b: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
	sex in place, particularly in escalation areas has been sent to Heads of Nursing, Matrons and Hospital at Night. • The Deputy Director of Nursing has met with lead for the Duty Hospital Managers to clarify expectations and will attend a team meeting in August to talk through scenarios with the team. • Single sex requirements will be discussed at the Duty Director training. • Further discussions to take place with ward managers and Matrons in August and ad-hoc if single sex breaches occur to ensure learning is implemented. • Reminder of single sex requirements included in the June 2016 Team Brief.		
AMU audit of current processes and environment - Action plan following audit.	**Complete** • No further action required. • To ensure that practice is maintained and evidenced through weekly Matron checks. • Decision made to purchase new POD lockers; funding currently being sourced.		Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke CSC
Review current documentation audit tool to determine appropriateness for the Acute Medical Unit.	• Current documentation tool does not give level of assurance required. • New documentation audit designed by Matron/ Practice Educator.		Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke
Increase the use of VitalPac for the recording of risk assessments in AMU (audit).	• Audits commenced on time; led by Band 6 nursing team.	• Weekly reporting of compliance to the Director of Nursing.	Head of Nursing Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke
Improved completion and quality of nursing assessment documentation, to include Falls	• Audits commenced on time; led by Band 6 nursing team.	• On-going audit programme.	Head of Nursing Acute Medical

Part b: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
and Braden risk assessments, and appropriate individualised care planning in AMU (audit).			Unit and Medicine for Older People, Rehabilitation and Stroke
Focussed education from Infection Prevention Control team concentrating on 'Back to Basics'.	• Initial education undertaken; further education required. • In-depth Infection Control plan for AMU.	• Week commencing 28th August over 75% of all nursing staff have had a refresh of infection control training.	Head of Nursing and Chief of Service Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke
Weekly internal hand hygiene audits to commence 18th July 2016.	• Weekly internal hand hygiene audits have commenced.	• Feedback to wards with increased evidence of compliance.	Head of Nursing and Chief of Service Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke
Monthly peer review audits (hand hygiene, environmental and NPSA).	• Monthly peer review audits continue.	• Monthly peer review.	Head of Nursing and Chief of Service Acute Medical Unit and Medicine for Older People, Rehabilitation and Stroke
Re-launch Health Records Management Policy.	• Partially complete – links to staff briefing at team brief about importance of record management and confidentiality.		General Manager and Head of Professions Clinical Support Services

PART B: Urgent Care Improvement Plan (CQC) – July 2016 position

Part b: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
Staff briefing in Team Brief.	**Complete** • Outcome of April Quality Care Review relating to the identification of poor care of patient records in the May and July 2016 Team Briefs. Team Brief also included a verbal discussion regarding patient records and the duty to maintain patient confidentiality.	• May and July 2016 Team Brief.	General Manager and Head of Professions Clinical Support Services
Quality Care Review focussed on records management.	**Complete**	• Records management now include in reviews. Evidenced through reports from the reviews.	General Manager and Head of Professions Clinical Support Services
Front line peer review focussed on records management.	**Complete** • Frontline peer review undertaken on Friday 10th June 2016. Results indicate a mixed picture of compliance with some areas demonstrating good compliance, whilst other areas medical notes found accessible whilst in use and not put back in trolleys. Feedback has been provided to clinical areas.	• This will be an on-going theme of front line peer and quality care reviews.	General Manager and Head of Professions Clinical Support Services
Development of a Duty Matron checklist to include records management.	• The Deputy Director of Nursing to discuss with the General Manager and Head of Professions Clinical Support Services the possibility of amending the Duty Matron SoP to include records management, single sex etc rather than a specific checklist to be completed each day; to include the requirement to escalate any concerns immediately. Information from the shift is already contained in a three times a day report.	• Mixed Sex Accommodation compliance reporting included. • Site Operations process under review.	General Manager and Head of Professions Clinical Support Services
Sub-committee of the Board to review progress against the implementation of the Urgent Care Improvement programme.	• Agreement made at Trust Board workshop 28th July 2016. The Director of corporate affairs is supporting development of the Terms of Reference and scheduling.	• Terms of Reference available for Chief Executive Officer weekly meeting. • Board Terms of Reference awaiting ratification.	Executive Director Emergency Care

PART B: Urgent Care Improvement Plan (CQC) – July 2016 position

Part b: Urgent Care Improvement Plan (CQC)			
Improvement Action	**Current status**	**Evidence**	**Responsible Lead**
Review Terms of Reference of the Urgent Care Improvement Board.	• Confirmed at Urgent Care Improvement Board on 28th July 2016. Terms of Reference and reporting structures currently being reviewed by the Executive Director Emergency Care. • New governance arrangement in place from w/c 25th July 2016 with a Board, an Urgent Care Improvement Committee and a Delivery group. New terms of reference to be drawn up following the review of each group.	• Underway; full report to be provided in September 2016.	Executive Director Emergency Care