Improvement Plan for
Unscheduled Care within the Belfast Trust
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1.0 Introduction
The purpose of this document is to clearly outline the journey the Belfast Trust is on in improving our Unscheduled Care Services.

It outlines the challenges the Trust faces. The action which has been taken to date and what we still need to do.

We acknowledge the considerable contribution our staff have made in improving our services for patients and clients.

We acknowledge that this is continuous journey of improvement and while much has been achieved, we recognise there is more to do.

1.1 What is Unscheduled Care?
Care which cannot reasonably be foreseen or planned in advance of contact with the relevant healthcare professional. It can occur at any time and crosses the traditional boundaries between general practitioner, community and hospital services.

In Belfast this accounts for 61% for all our activity/admissions. Levels of unscheduled activity are reasonably predictable and vary with the time of year being highest in winter.

1.2 Overview of Strategic Changes Trust Wide
Unscheduled Care is a key part of the Trust strategic direction, identified in New Directions (2007/8-12/13) which identified the focus of the 3 adult acute hospitals as:

- The Royal Victoria Hospital (RVH) as the centre for major trauma services, including a heart centre, with an increased focus on emergency services
- Belfast City Hospital as the centre for cancer, renal and a range of general acute hospital services, with an increased focus on elective services and chronic conditions management
- The Mater Hospital as the centre for ophthalmology services and general acute hospital services.

‘New Directions’ (2007/8) set the context for a series of publicly consulted strategic service reforms in 2010, designed to deliver services based around people’s clinical needs rather than institutions. The key principles defined for acute hospital services included the need:

By 2013, the majority of the service re-organisations had taken place, that is:

**ENT**: The inpatient & daycase service was focused at the Royal Hospitals, with Outpatient services across the Trust.

**Vascular Surgery**: The inpatient & daycase service has been based at the Royal Hospitals, linked to the trauma centre, with Outpatient services across the Trust.
**Gynaecology**: Belfast City Hospital provides all elective and emergency inpatient services. As an interim measure, until additional DPU capacity is available at BCH, day case services are undertaken at the Mater Hospital.

**Urology**: Belfast City Hospital provides for inpatients and day case elective and emergency services (sessions have been retained at the Mater Hospital).

**Centralised and Integrated Stroke Services**: The Stroke Strategy Implementation group which comprises key stakeholders, including users and carers and HSCB, have centralised acute stroke services on the RVH site and integrated the community rehabilitation and voluntary sector services as a single system and are working to achieve all targets related to stroke. This is demonstrating improved outcomes for patients and greater efficiencies.

**General Surgery**: An Emergency Surgical Unit (EmSU) has been established at RVH with elective services at Belfast City Hospital, Royal and Mater Hospital.
2.0 Delivering Timely Care including Discharge

2.1 The Challenges
Delivering a high quality service requires us to provide timely care to every patient who attends any of our services in an unplanned way, particularly those who attend our Emergency Department (ED). We have faced challenges in consistently achieving the target set for us, ie 95% of patients attending ED are either treated and discharged, or admitted within four hours of their arrival in the emergency department, and no patient waiting longer than 12 hours. We have seen a significant reduction in patients waiting beyond 12 hours for admission to a bed, from 3227 in 2010/11 to 515 in 2013/14. In 2013/14 65% of our patients are treated, admitted or discharged within four hours. This section of our plan sets out the actions we have taken so far to improve timely care and the further actions that we have planned.

When we temporarily closed the Emergency Department in the Belfast City Hospital, in November 2011, for medical staffing reasons, we also had to deal with the challenge of accessing services and resources on 3 acute sites, primarily through two adult Emergency Departments. Initially this required the transfer of patients who were acutely unwell between sites, causing delay in the delivery of the care patients required. This section also sets out the actions we have taken to reduce this problem.

2.2 Actions Taken to Date

2.2.1 A new model for Acute Medicine and General Surgery
Our immediate concern was to ensure that patients attending ED requiring admission were seen by a relevant specialist and where necessary admitted to a bed for prompt care without the need for a transfer.

The Trust established an expanded AMU (Assessment Medical Unit) from 28 to 60 beds on the RVH site in May 2012 (to include Acute Older People). Consultants in Acute Medicine, supported by other specialty consultants are involved in the assessment and care of patients who are likely to require admission. This substantially reduces the time patients spend waiting for the commencement of a comprehensive treatment plan. This approach also has the potential to reduce hospital admissions from ED, as patients will be able to access a specialist opinion at a much earlier stage in their journey.

A key advantage of this model is that patients move to the acute medical unit for initial management and care planning. They can be discharged from here or moved on promptly to a specialty bed either in RVH or BCH. This substantially reduces the need to transfer patients directly from ED to another hospital site thus improving care and safety.

Patients in the Acute Medical Unit (AMU) are reviewed by a Consultant by 12midday and senior review later in the day to follow-up on any outstanding
actions. This facilitates and supports the patient journey encouraging earlier discharge.

An Emergency Surgical Unit (June 2013) has been established in RVH and all patients requiring emergency surgical care are now assessed in this unit under the care of the consultant surgeon of the week. This substantially reduces the need to transfer patients directly from ED to BCH site thus improving care and safety.

2.2.2 Specialty Take-In
To support the acute medicine service, medical and surgical specialties have found new ways of working that facilitate improved patient flow and ensure that patients are cared for by the most suitable team. We have therefore taken the following actions within specialties:

- Ward 6A RVH has been designated as additional beds for respiratory patients during winter months, allowing us to cohort these patients together under the care of respiratory specialists.
- We have introduced rapid access neurology clinics that reduce the need to admit patients for specialist assessment and investigation.
- Gastroenterology has fully implemented a specialty take with Gastroenterologist of the Week. This has led to earlier investigation and discharge of patients. It has also allowed us to introduce a 24/7 GI Bleeding Rota.
- In respiratory medicine we have implemented a specialty take. This has also allowed us ensure skilled staff are available 24/7 to manage the insertion of chest drains.
- In the surgical specialties we have introduced Consultant of the Week in Gynaecology and Trauma Services, with the benefit that patients get rapid access to a senior decision maker.

2.2.3 Direct Medical Admission on BCH Site
Recognising and pre-empting the increased workload being placed on the RVH and MIH, as well as the need to maximise the use of the BCH bed base, we developed a Direct Medical Admissions Unit (DMAU) The Trust had pro-actively engaged with GPs in establishing the Unit. The Unit built up to approximately 4000 attendances per year.

This service was subsequently extended for the RVH site, with some movement of resources this was done to reduce the number of transfers of acutely ill patients presenting to the RVH ED to the BCH site and to consolidate the presence of senior doctors in Acute Medicine on the RVH site to allow earlier involvement in the care of patients likely to be admitted

A direct access resource was retained in Ward 6N on BCH site under the supervision of general medicine and gastroenterology.
2.2.4 Older Persons Hospital based services

There have been a number of improvement initiatives across Older Person Services. These include:

- **Opening of OPTIMAL 7, BCH**
  Following the closure of BCH ED, frail elderly patients were admitted to the RVH via the expanded AMU, under the care of geriatricians. However, given that older people’s wards are located on the BCH site, there was a consensus that direct admission to BCH would be a preferable pathway for frail older people requiring admission. To this end the OPTIMAL 7 service (Older People’s Timely Intervention, Management and Admission service on Level 7 South BCH) was commenced on 3 March 2014. This service, which is operational during working hours, can be accessed by GPs via a dedicated mobile phone held by a consultant geriatrician. This provides an alternative pathway for admission for frail older people who do not require the services of ED, with direct access to the right specialist, in the right place at the right time.

- **Community In-reach team to RVH ED and AMU**
  Older People’s services has been piloting a small team of practitioners consisting of highly experienced in-reach nurses, physiotherapist, occupational therapy and social worker who provide a service which supports early discharge. These pathways include patients being discharged home with a range of conditions such as urinary tract infections, chest infections or cellulitis with nursing input for a variety of therapies and care.

2.2.5 Improving Emergency Department Services (ED)

The ED in the RVH and Mater engaged in an improvement programme which included:

- Pilot of a new triage system.
- Healthcare support workers (HCSW) allocated to triage nurses to enable investigations to be completed on a timely basis in conjunction with standardised clinical guidance.
- Named consultant in ED allocated to support triage nurse in early discharge and fast track to acute medical admissions/specialty/ambulatory pathway.
- Patients triaged directly to Physio or OT in ambulatory stream of ED.

Other improvement initiatives have included:

- An audit of time to drug administration, particularly antibiotics to provide assurance that the antibiotic protocol for sepsis is being applied.
- The development and roll out of customer care training for front line staff in the ED and AMAU with regard to communication with patients, relatives and the public.
- The piloting of a co-located GP Out of Hours service with the RVH ED over the winter months.
2.2.6 Programme Treatment Unit (PTU)
The Programme Treatment Unit (PTU) was established as a new service in the Royal Victoria Hospital in 2010. It facilitates ambulatory investigations, interventions and treatments where patients would previously have been admitted to a hospital bed. The unit has developed a pathway with primary care colleagues to facilitate ambulatory blood transfusions rather than GPs sending patients to our Emergency departments or medical admissions units. Along with enhanced patient safety and improved quality of services, cost effectiveness and efficiency have underpinned what we have sought to achieve with PTU.

2.2.7 Diagnostics
Access to CT scanning on RVH site has been increased for unscheduled care by redirecting outpatient activity to other sites. Additional ultrasound access has been provided across seven days and plans are progressing to offer additional CT scanning across seven days also.

2.2.8 Clinical Pathways
Alternative care pathways for the management of some clinical conditions, such as, headache, first seizures, chest pain, have been put in place.

2.2.9 Reablement
The Trust started to implement a reablement service in September 2012. This service is designed to provide a short-term intensive period of support to maximise independence and confidence. Central to this work was a partnership with the community and voluntary sector aimed at identifying and meeting social needs in relation to isolation, physical activity, support with managing the home. Community navigators have been appointed to support individuals to connect with local community networks and services.

By February 2014, the Trust was in a position to offer a reablement service to all clients eligible for domiciliary care both from community and hospital discharge. Reablement is now the main service for all new referrals for domiciliary care and hospital discharge offering a new approach to assessing for long-term needs. The Trust is seeking to integrate assistive technologies into reablement and domiciliary care.

2.2.10 NI Ambulance Service
The dedicated ambulance service resulting from the ED changes is in place however during periods of pressure the service may be reduced. We work closely with NIAS, however transport between sites remains a challenge. We have further developed our internal transport system to mitigate this challenge.

A model for ambulance co-ordination for the Trust has been agreed and implemented. A Hospital Ambulance Liaison Officer (HALO) has been appointed to co-ordinate ambulance activity within the Trust.
2.2.11 Patient Discharge
We have designed and implemented new Discharge Planning Pathway to be completed as part of the admission documentation. A discharge lounge has been in place from December 13 as part of the winter pressures plan.

We have implemented an Urgent Improvement in the Complex Discharge Process addressing delayed discharge to ensure patients have the appropriate care packages in place.

We have spot purchased nursing home step down bed provision to facilitate further assessment and decisions regarding long term placement outside the Acute setting.

2.3 Immediate Action Taken Following RQIA Inspection
We have allocated additional bleeps to appropriate junior staff to facilitate communication in AMU.

We have provided two additional SHOs to improve support for the medical take-in during winter.

We have developed an enhanced internal transport service with nurse escort to improve timely transport between sites.

Piloting the deployment of pharmacy staff to improve the completion of discharge scripts in AMU and EMSU.

Piloting the completion of discharge letters in real time as part of the ward round through the use of digital dictation.

2.4 Further Actions to be Taken
The actions that we have taken to-date, as described above have improved the timeliness of care and the safety and quality of the service patients receive. We have reduced the need to transfer acutely unwell patients in our system directly from the Emergency Department. However the Royal Victoria Hospital has become busier at a time when we have seen a 9% increase in admissions in the last year across the Belfast Trust. This has contributed to on-going difficulties in delivering timely care and also resulted in an increased number of patients outlying in beds outside their specialty ward. This has also made it more challenging to track patients in our system. The following further actions are therefore being taken:

2.4.1 Increasing Capacity
A General Medical ward on BCH, with appropriate staffing, is scheduled to open on 14th April. This will reduce the number of patients outlying from a general medical ward, on the RVH site.
In addition, the Trust is undertaking a pilot of a Medical Assessment Area out with the ED where the physicians can assess patients and commence treatment. Patients will be cared for in a Bed / Chair until they are admitted or discharged home. This will reduce the numbers of patients waiting in ED for admission, thus reducing crowding at busy times and improving the environment for staff and patients.

2.4.2 Tracking In-Patients through the Hospital System
The Trust has an electronic patient journey system and is currently upgrading the system to enable live tracking of patients. However, in the meantime to ensure patients are appropriately recorded and tracked on the Patient Administration System (PAS), additional clerical staff are undertaking a manual tracking role, visiting all wards, ensuring accurate recording of patients on the system.

2.4.3 Improving Patient Flow and Reducing Length of Stay
We are developing a system whereby emergency medicine consultants triage patients in ED reducing the time to be seen by a doctor and referral to the appropriate specialist.

We are establishing a cardiac assessment unit to facilitate senior cardiology review and have implemented rapid access cardiology clinics.

We are developing new pathways for the management of heart failure and atrial fibrillation.

We are working with our surgical and anaesthetic teams to increase the number of patients admitted on day of surgery.

We are extending consultant anaesthetic and pre-assessment and will establish a pre-admission clinic to facilitate admission on day of surgery.

2.4.4 Improving Patient Discharge
Design and implement an agreed repatriation protocol between Trusts to enable patients to return back to their Trust area, outside of the Belfast Trust, in a timely manner.

Consistently implement actions to ensure suitable patients are identified for Discharge Lounge and bed made available for new patients before 1pm.

Ensure widespread deployment of discharge letters being completed in real-time, as part of the Ward round through the use of digital dictation.

Implement access to care management, community and rehabilitation services 7 days a week/rehabilitation, increased care packages, rapid response teams at weekends.
3 Patient Experience

3.1 The Challenges
Patient experience underpins all aspects of service delivery and improvement in the Belfast Trust, with person centred and compassionate care a core value of the Trust. Consideration of the experience of patients and clients is a key factor in the decision making of all professionals with regard to the provision of care.

3.2 Actions Taken to Date
The Trust has fully participated in the monitoring of the patient and client experience standards and developed action plans as a consequence of this work. Actions have been developed in the areas of Respect, Attitude, Behaviour, Communication and Privacy & Dignity. The Trust has also fully engaged with the 10,000 Voices project, with the first section being Emergency Departments, Minor Injury Units and Out of Hours GPs. This is monitored through directorate governance processes, our patient and client working group and the Assurance structure to the Trust Board. The annual patient and client experience standards annual report for 12/13 was supplied to the Trust in December 2013 and presented to the Trust assurance group in January 2014. The Trust’s findings in relation to the patient experience in respect of the 10,000 Voices project and the standards were presented to the public Trust Board in March 2014.

3.3 Immediate Action Taken Following RQIA Inspection

3.3.1 Through the increase in nursing levels, staff have been supported to ensure appropriate care and privacy is given to patients and to ensure patients receive the appropriate assistance with their meals.

3.3.2 Work is underway through Support clinics with staff to identify and address any barriers to providing the appropriate level of care and privacy, respect and dignity to patients.

3.3.3 The Trust has re-emphasised that it is the responsibility of all staff to maintain patient privacy and dignity at all times. This is assessed on an ongoing basis and staff are supported to mitigate risk and ensure dignity and privacy is maintained at times of overcrowding.

3.3.4 Arrangements have been put in place to ensure that tea, coffee and water are available at all times for patient and relatives. The process for ordering meals has been changed and the catering department will now assess patient needs daily with the co-ordinator.

3.3.5 The Trust re-emphasised that it is the responsibility of the nursing staff to identify patients requirements at meals times and to ensure they are provided with adequate support.
3.4 **Further Actions to be Taken**

3.4.1 Review and update completed actions from the monitoring of the patient and client experience standards in respect of the Emergency Department and Acute Medical Unit.

3.4.2 To ensure the effective planning of care, risk assessments will be undertaken as part of the nursing admission. Relevant assessment templates will be included in this documentation. Nursing staff in AMU and ED will be reminded of the need to ensure all relevant risk assessments are undertaken and this will be monitored by Nurse in Charge. The Clinical Co-ordinator will be responsible for ensuring policy and standards are adhered to.

3.4.3 An outcome focused management plan and nursing care plan will be in place for all patients. Staff will be reminded to complete, update and amend as appropriate to reflect the changing care needs of patients as per trust policy and NMC and GMC Record Keeping Guidance. The Clinical Co-ordinator and the Clinical Lead will be responsible for ensuring policy and standards are adhered to.
4.0 Workforce

4.1 The Challenges
We do not have sufficient Consultant Staff in Emergency Medicine to deliver extended direct presence in the unit 7 days per week. There is a recognised national shortage of experienced and qualified medical staff in emergency medicine. This was also highlighted as an issue by the College of Emergency Medicine in its report of August 2013. The Trust has been unable to recruit and retain sufficient middle grade doctors who can provide senior decision making in addition to Consultants. The Trust is allocated 7 experienced Registrar Grade Doctors. While these doctors are attached to the Trust for training they provide a valuable resource as senior decision makers. However 7 doctors is the minimum required to maintain a rota and this rota is therefore vulnerable.

An increase in admissions particularly in Care of the Elderly and medical specialties has placed specific challenges on the nursing teams caring for these patients. There is an increased level of acuity and dependence among the patients in ED and AMU.

Providing the appropriate nursing skill mix to ensure that patients in ED are properly observed and cared for 24 hours per day was a challenge.

4.2 Actions Taken to Date
In bringing the staff from Belfast City Hospital to the Royal and Mater Emergency Departments, we were able to ensure a senior doctor on duty in the RVH Emergency Department 24/7 with consultant presence in the unit until 12 midnight Mon-Friday.

We have had a recruitment drive both in UK and Europe with limited success.

Locum consultant staff have been appointed when available to cover maternity leave and other absences. In the last year we have been successful in recruiting four locum consultants.

Belfast Trust was the first Trust within N Ireland to commit to supporting the training of Advanced Nurse Practitioners (ANPs). Two nurses are currently enrolled and undertaking this training, which takes 4 years. They are working within ED in RVH and are being trained to the level of a middle grade doctor. They are clinically supervised by a consultant within ED.

The Trust is committed to maintaining and extending the existing Emergency Nurse Practitioners (ENP). These nurses provide an important resource for managing minor injuries.

The Emergency Department nursing levels were reviewed with the Clinical Team in October 2013. This resulted in a recommendation to increase nurse staffing levels. Recruitment was progressed. This mitigated the challenge regarding appropriate nursing skill mix.
The AMU nursing levels are regularly reviewed and benchmarked with peer Trusts within the UK. In October 2013 the recommended nurse to bed ratio was increased from 1:1.3 to 1:1.45. Recruitment was commenced at this time and is on-going.

The Specialty “Consultant of the Week” model has been implemented in certain specialties. The model ensures senior decision makers are involved as early as possible in the patient’s unscheduled care journey. Examples where it works are acute medicine, general surgery, trauma, gynaecology and gastroenterology.

The cadre of acute medicine specialists has been increased from 1 whole time equivalent (wte) in 2012 to approximately 6.5 wte in March 2014.

All newly qualified nursing staff undergo preceptorship for a period of six months which will be regularly reviewed and tailored to the needs of the individual nurse. They are also required to complete a portfolio of evidence of their learning within one year and this is overseen by their preceptor and the clinical educator/deputy ward sister.

An enhanced cleaning service to ED and AMU has been in place since October 2013, and this has been further developed.

Additional cleaning services have been put in place for ED and AMU. Additional arrangements have been put in place in respect of drinks and catering which is overseen by the co-ordinator of the Emergency Department and catering team.

There is a dedicated portering team based in the in Emergency Department 24/7

4.3 Immediate Actions Following RQIA Inspections

A Support Team involving Human Resources (HR), Nursing, Occupational Health, Psychology and trade union staff was brought into ED and AMU and made immediately available to staff for support. As a result this team reported to the Chief Executive and Senior Team on their findings and developed an action plan which is in the process of implementation. This plan is currently being communicated to staff in both areas.

The Emergency Department nursing levels have been further reviewed taking into account the specific recommendations of RQIA. This has resulted in a decision to further increase the staffing compliment by 18, to a total of 100 WTE staff. Recruitment is currently underway and there has been a good uptake for these posts. On completion of staff recruitment the skill mix will be 87% registered staff to 13% non-registered nursing support staff.

The AMU nursing level has also been further reviewed. As a consequence this was further increased to 100 wte staff. The preliminary RQIA report also made recommendations in relation to the role of the ward sister and handover
of patients. The increase enables the nurse in charge to be supervisory 24 hours per day, 7 days per week and will enable more effective patient handover.

Recruitment is currently underway and there has been a good uptake for these posts with 10 new nursing staff commencing their posts since early February 2014. An additional 15 nursing staff have been offered positions with potential dates to start over the next two months.

ED Nursing staff induction has been enhanced and now consists of a two week taught induction to support mandatory educational requirements facilitated by the clinical education centre. They then have a six week supernumerary period in the department which is facilitated by the practice educator.

AMU Nursing staff have a two week taught induction to support mandatory educational requirements, facilitated by the clinical education centre. The supernumerary period for AMU nurses has been further enhanced to a two week supernumerary period based on the ward which is facilitated by the deputy ward sister.

A dedicated Clinical Co-ordinator for AMU and ED, has been put in place for these areas to ensure dedicated leadership for these areas, has been put in place. These staff commenced their posts on 1st April 2014.

A review of consultant staffing for ED and AMU has been undertaken. Additional ED Consultants have been recruited towards improving the weekend out of hours consultant cover, however they will not all be able to take up post for several months.

4.4 Further Action to be Taken
We will complete the recruitment of ED and AMU nursing staff.

Following our review of ED Consultant numbers and our most recent recruitment drive we intend to undertake a further recruitment programme with the aim of reaching the consultant staffing levels recommended by the College of Emergency Medicine. This will allow us to move to 16 hours of consultant presence, 7 days per week.

We have submitted a business case to the Health and Social Care Board seeking the resources to progress towards 7 day working in areas including Imaging, Allied Health Professionals and Social Work.

The business case also covers care management, community and rehabilitation services 7 days a week.
5.0 Communication & Engagement

5.1 The Challenge
Throughout the Unscheduled Care Improvement Project, the Trusts Communication and Engagement Plan has emphasised the need for on-going communication with our patients, relatives and carers, our multidisciplinary teams across the Trust, Trade Unions and other groups. The Communication and Engagement Plan is being implemented via number of teams including the Unscheduled Care Reference Group and the Unscheduled Care Improvement Collaborative Team, all of which include clinical representatives from across the service.

5.2 Actions Taken to Date

5.2.1 Workshops & Reviews
The importance of inclusion and engagement of staff was pursued through a number of different routes including workshops. Clinical and managerial staff across the specialty and multidisciplinary teams were involved in a series of workshops which were facilitated by an external consultant of high standing. Two of these workshops were led by the Chief Executive.

5.2.2 Trade Unions
There have been a series of engagements with Trade Unions. The Trust will continue to engage in partnership with them to take forward the Unscheduled Care Improvement Plan.

5.2.3 Medical Reference Group
This group, chaired by the Medical Director, is where senior management and senior medical staff work collaboratively to review the service changes required to improve the delivery of care provided to patients who present as either an emergency or non-routine attendance.

5.3 Immediate Actions Following RQIA Inspections

5.3.1 Outcome of Staff Support Clinics
In response to issues raised by staff during Support Clinics, the following actions were agreed and communicated to staff, with immediate effect.

- Team brief to take place 2-3 times per day at set times to accommodate shift patterns. This brief will be led initially by manager/sister in charge.
- Monthly team meetings to take place. (Agenda items will include feedback to staff from SAI’s, IR1’s, complaints, patient compliments and staffing developments)
- Staff newsletter to be issued each month by the clinical co-ordinator.
- It is also proposed that Occupational Health and Health and Safety staff will undertake a stress survey in May 2014.
- Review of Zero Tolerance Policy, display of posters, enforcement of rules regarding patients and relatives (including liaison with Security staff and review of Security staff base).
5.4 **Further Actions to be Taken**

As per the Trusts Communication and Engagement Plan, the Trust will continue to work in partnership with all parties to deliver the Unscheduled Care Improvement Plan.
6.0 **Environment**

6.1 **The Challenge**
The Trust is focused on ensuring that the patient is treated in a clinical environment which meets expected environmental standards and is appropriately maintained and equipped.

6.2 **Actions Taken to Date**

6.2.1 **Environmental Review**
A review of the Unscheduled Care environment has previously been completed and no further building measures can be taken to improve the situation for the existing building. The focus, therefore, is on improving the environment through reducing the potential for crowding.

6.2.1 **Immediate Actions Following RQIA Inspections**

6.3.1 **Support Services Review**
A review in respect of support services has been undertaken in consultation with the clinical team by the PCSS senior team and is now complete:

- There are enhanced cleaning services in place with dedicated cleaning staff for the emergency department until 10 pm with further services then available from the night cleaning team until 7 am.

- Security is readily available 24hrs a day.

- Additional stocks of laundry are held by PCSS for times of increased requirement. The sister/charge nurse is responsible for this on an on-going basis.

- A review of essential patient equipment requirements has been undertaken and any appropriate procurement action taken.

6.4 **Further Actions to be Taken**

6.4.1 The Trust is about to commence a pilot of a Medical Assessment Area outside the ED where the physicians can assess patients and commence treatment. Patients will be cared for in a Bed / Chair until they are admitted or discharged home. This will reduce the numbers of patients waiting in ED for admission, thus reducing crowding at busy times and improving the environment for staff and patients.

6.4.2 A new purpose built Emergency Department will open in the Royal Victoria Hospital in early 2015. This will greatly assist in addressing the flow of patients and relatives within the department.