

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Emergency Care Update	Trust Board
1. PURPOSE:	REVIEWED BY (BOARD/COMMITTEE) and DATE:
<p>The purpose of this report is to update the Trust Board on the performance and actions being taken to reduce the waiting times for patients to be seen in the Emergency Department.</p> <p>This report provides an update on the Emergency Care Quality Improvement Programme (ECQIP) and the workstreams to be developed and implemented in conjunction with the Department of Health Emergency Care Intensive Support Team (ECIST).</p> <p>During the 2010/11 Christmas and New Year period, the Trust declared 'Major Incident' on two occasions. This report provides a summary of why that status was declared, key actions taken during that alert status and the subsequent debrief process being implemented to review the Trust's response to it.</p>	<input type="checkbox"/> PEQ <input type="checkbox"/> STRATEGY <input type="checkbox"/> FINANCE <input type="checkbox"/> AUDIT <input type="checkbox"/> CLINICAL GOVERNANCE <input type="checkbox"/> CHARITABLE FUNDS <input checked="" type="checkbox"/> TRUST BOARD <input type="checkbox"/> REMUNERATION <input type="checkbox"/> OTHER (please specify)
2. DECISION REQUIRED:	CATEGORY:
The Trust Board is asked to note the content of the report and support the actions to bring the performance back in line with target.	<input checked="" type="checkbox"/> NATIONAL TARGET <input type="checkbox"/> CNST <input type="checkbox"/> CQC REGISTRATION <input type="checkbox"/> HEALTH & SAFETY <input type="checkbox"/> ASSURANCE FRAMEWORK <input type="checkbox"/> CQUIN/TARGET FROM COMMISSIONERS <input checked="" type="checkbox"/> CORPORATE OBJECTIVE <input type="checkbox"/> OTHER (please specify)
AUTHOR: Neill Moloney, Director of Delivery PRESENTER: Neill Moloney, Director of Delivery DATE: 25 th January 2011	
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
Not applicable.	
4. DELIVERABLES	
95% of patients to be discharged from the Emergency Department within 4 hours of arrival.	
5. KEY PERFORMANCE INDICATORS	
Type 1 A&E performance	
All type A&E performance	
AGREED AT _____ MEETING	DATE: _____
OR	
REFERRED TO: _____	DATE: _____
REVIEW DATE (if applicable) _____	

BHRUT Emergency Care Update

Programme Progress Report to the Trust Board

Introduction

The purpose of this report is to update the Trust Board on the performance and actions being taken to reduce the waiting times for patients to be seen in the Emergency Department.

This report provides an update on the Emergency Care Quality Improvement Programme (ECQIP) and the workstreams to be developed and implemented in conjunction with the Emergency Care Intensive Support Team (ECIST).

The month of December proved to be one of the most challenging for the Trust in many years. Performance for all-type attendances was 90.59% and 80.24% for Type 1 attendances against a target of 95%.

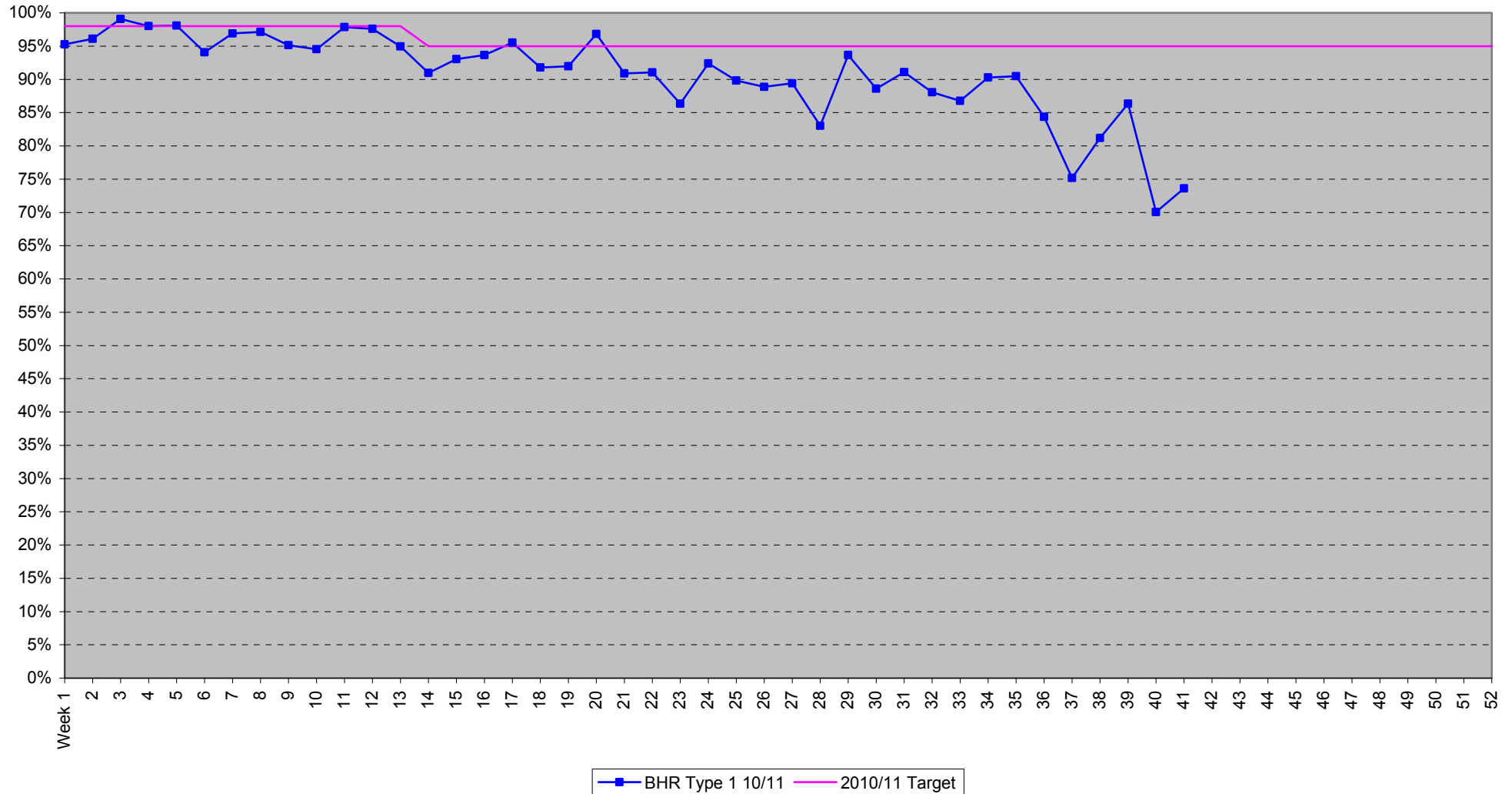
During the 2010/11 Christmas and New Year period, the Trust declared 'Major Incident' on two occasions. This report provides a summary of why that status was declared, key actions taken during that alert status and the subsequent debrief process being implemented to review the Trust's response to it.

Performance Summary:

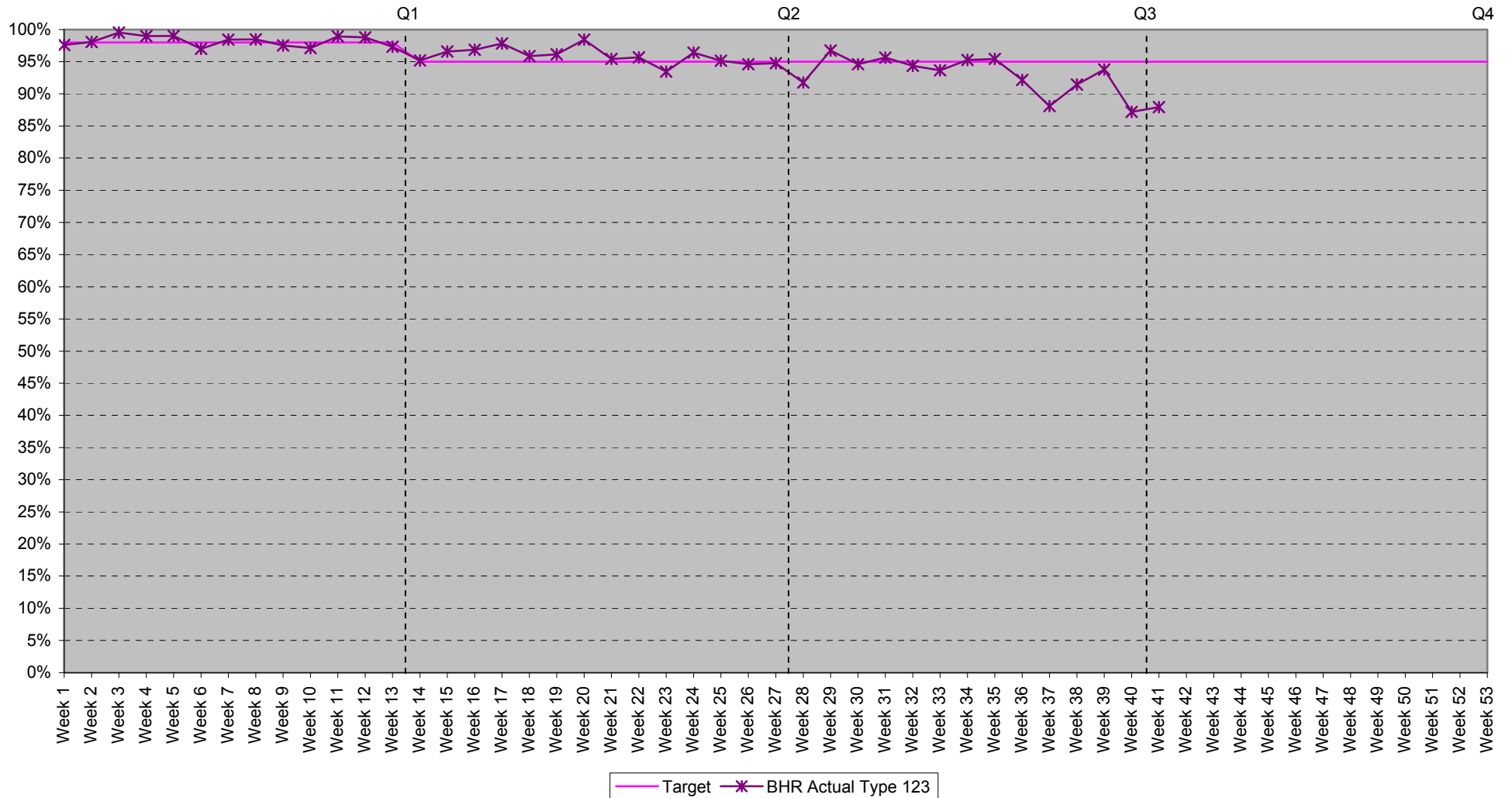
The following three pages summarise the Trust performance in relation to:

- A&E Performance – Type 1
- A&E Performance – All Types
- ECQIP - Whole Economy Summary

BHRUT Type 1 Only A&E Performance 2010/11



BHR A&E Performance 2010/11 Type 1/2/3



ECQIP - Whole Economy Performance Summary

Impact	Indicator	Target	Week Ending					
			19/12/2010	26/12/2010	02/01/2011	09/01/2011	16/01/2011	
1. Daily Flow Metrics								
Significant	Daily Flow Metrics	Declared beds between 08:00 and 12:00 (KGH)	65	25	28	*14	*17	* 25
		Declared beds between 08:00 and 12:00 (QH)	100	38	39	* 24	* 32	* 51
2. Weekly Variation in Demand								
Significant	No of DTAs on Monday Morning (@10am)	KGH	0	5	0	0	6	2
		QH	0	19	11	6	12	8
3. Length of Stay								
Significant	AEU to open at KGH with QH model to reduce LoS from 10 to 7 days for CoE patients	Average LOS on Sunrise A&B, Harvest B & Fern (Median)	7	7	7	8	6	6
		Foxglove (Median)	14	11	8	8	12	8
		Non-Elective LOS of patients over 80 on a monthly basis	7	11.33				
Significant	Reduce no of patients with LoS > 20 days within the hospital	Patients where LOS > 20 days (KGH)	75	90	93	94	82	94
		Patients where LOS > 20 days (QH)	100	160	154	156	142	134
4. A&E Staffing Resilience								
Significant	No of Breaches Resulting in Wait to First Assessment (type 1)	KGH	0	55	37	135	129	30
		QH	0	241	115	296	182	87
Significant	Number of Unfilled Shifts (Out of Hours) [Medical, Dental, Nursing & Midwifery]	KGH	0	5	5	7	5	7
		QH	0	3	12	14	12	14
5. Managing Demand								
Significant		Conversion Rate (KGH)	20%	17.13%	16.85%	16.76%	18.28%	21.39%
		Conversion Rate (QH)	20%	21.86%	23.55%	21.05%	22.96%	24.59%

* Due to a change in data recording practices, these figures have been adjusted according to the variation between PAS and declared bed data.

Major Incident Declarations

On Wednesday 22nd December 2010 and 5th January 2011, the Trust declared its alert status as 'Major Incident' (MI). The decision to declare a major incident was made following an assessment of the clinical safety of the Emergency Departments at both Queens and King George Hospitals and the significant shortfall in bed capacity to accommodate the patients requiring beds in the ED.

On each occasion, the actions included:

- Cancellation of non-essential activity (outpatient clinics/elective surgery)
- Conversion of SPAs into Direct Clinical Care
- Requesting staff to advise of their availability/calling in staff where possible
- Prioritisation/Increased pace of appropriate discharges (Increase in Consultant ward rounds)
- Diversion of ambulances to other receiving hospitals
- Re-distribution of staff across the Trust
- Opening of additional bed capacity
- LAS ambulance staff working full-time in the ED to care for patients unable to immediately offload into a cubicle space
- GPs drafted in to work in the ED alongside our regular clinicians
- Other specialities such as orthopaedics, neuro, medicine and surgery releasing medical staff to work shifts in the ED
- Out patient nursing staff have reported to the ED to assist with patient care
- Ward space has been made available in the ISTC to allow an orthopaedic ward to be converted to a medical ward
- Elective surgery reduced with only clinically imperative cases continuing.
- Day surgery unit has been used as short term capacity

The sector community partners have also responded by implementing the following actions:

- Harold Wood polyclinic has extended it's hours with later closing at 22:00 rather than 20:00
- Community matrons came into the Trust to support discharge
- PCT response co-ordinated through an appointed lead
- Additional community beds purchased and provided (20)
- Community admission criteria altered
- Daily and more senior sector presence and involvement in decision-making and planning
- UCC received additional staffing and GPs used to assist re-direction of less urgent walk-in patients to other facilities.
- Comms awareness heightened with leaflets and radio broadcasts to the public to use services wisely and appropriately
- GP calls were directed across the two QH and KGH sites in response to times of pressure at either

A 'Hot Debrief' was instigated by the Director of Delivery. Key staff across the Trust was asked for feedback regarding the MI in terms of the process followed to implement the MI plan, the actual implementation of the MI plan and any actions that may have been taken prior or during the MI that may have increased the effectiveness of the implementation of the MI plan. That feedback was subsequently analysed by the Executive and Divisional Management teams. The outcome of the Hot Debrief process will be formally presented to the Trust via a 'Major Incident - Debrief Report' that has been commissioned by the Director of Delivery (completion expected in February 2011).

Emergency Care Intensive Support Team

The Department of Health Emergency Care Intensive Support Team (ECIST) has been invited to work with the Trust in order to support the delivery of the emergency care standard target.

The Intensive Support Team has visited the Trust's Emergency Department, MAU, and Elderly care wards at Queens and also provided a presentation to senior clinical and managerial staff on the 13th January 2011. The Intensive Support Team has proposed three key area of work to link into the Emergency Care Quality Improvement Programme workstreams:

- 1. *The development of a rapid assessment and treatment model for the Emergency Department at Queens Hospital***
- 2. *The development of a Trust wide emergency ambulatory care strategy and implementation plan***
- 3. *The implementation of new internal professional standards that support patient flow across the acute trust***

The introduction of the ECIST will offer increased focus in these areas; therefore they will require a defined Executive/Senior Management Lead for oversight and accountability and a defined team that will be tasked with implementing those actions. As the ECIST is not a full-time and on-site team, there will also be a need for agreed internal reporting and support resources to ensure that there is momentum to their work is managed and maintained – the specifics of this is currently under discussion.

The ECIST is keen to work with the Trust's clinicians as soon as practicable, therefore supporting work/enabling events may be undertaken soon that would facilitate the development and implementation of the above work streams. The form and function of those supporting work/enabling events is yet to be agreed however it is envisaged that this will commence in earnest early February 2011.

Emergency Care Quality Improvement Programme

Strategic Goal

The Emergency Care Quality Improvement Programme unites seven autonomous workstreams with the aim to deliver an improvement of patient pathways and outcomes, deliver Emergency Care target performance, enhance capacity and patient flow on both sites and to ensure robust community services are provided for patients who are able to leave hospital.

Scope and Definition

1. Capacity & patient flow – Simple Discharges

This work stream includes actions to improve patient flow through the Trust. Those tasks are aimed at reducing “waiting for bed” breaches across both sites, specifically by encouraging earlier discharges. To achieve this, a main task within this workstream will be to review and amend consultant job plans within the Medical and Surgical division, to enable senior decision makers be available to the ward staff before 9am to identify early discharges. Improvements in patient pathways, criteria led discharge and the electronic e-handover system will also contribute to the successful implementation of new consultant rotas. Wards will be configured by specialty to ensure patients are treated by specialist physicians. Improvements are to be made to patient care pathways to improve patient outcomes and achieve a reduction in LOS.

2. Capacity and Patient Flow – Complex Discharges

PCT's and the ACU had identified that the Trust's DToC's should be reduced to 1% (against performance target of 3.5%). This figure has been continuously monitored and since 1st August 2010 averaged at 4.57%. The aim of this workstream is to increase bed capacity and improve patient flow, by working closely with community providers. In place are actions to create more capacity for community beds and improve the patient's experience. DToC team is continuously monitoring Trust related delays against delays caused by the community or social services.

3. A&E flow and resilience

The intention of this workstream is to ensure that the Emergency Care division is able to achieve the emergency care standard using a full compliment of medical and nursing staff within A&E, with the aim of providing an improved service for patients. Consultant job plans are to be reviewed to enable effective clinical leadership and focus for medical teams. Nursing leadership is also to be reviewed to encourage staff retention and development for experienced A&E teams. If the workstream is successful, there will also be cost savings through reduced locum and agency staff usage. A more robust workforce within the A&E will assist to achieve the 95% target for type 1 activity for BHRUT, promoting a reduction in waiting time to first assessment and reduction in breaches.

4. Admission Avoidance

Several schemes are being discussed in this workstream to avoid unnecessary attendance to A&E and/or admission to an inpatient bed. These schemes are aimed at improving the quality of patient care by developing the service provided by virtual ward, Ambulatory Care Centre (ACC) and Post Acute Care Evaluation (PACE) which will also increase the number of bed days saved. This workstream will link with the PCT's to assist with education to patients regarding admission avoidance and the provision of community services for patients in the “virtual hospital”.

5. Ambulance Turnaround

This workstream is currently under review. The original workstream was detailing actions for Installation of Ambutime with the aim of reducing the ambulance handover times and improve clear up times. This workstream is evolving to include the introduction of the Capacity Management System (CMS) throughout the Trust to reflect the winter capacity escalation process.

6. Demand Management

To work with the PCT's to ensure that the UCC and other community admission avoidance schemes are utilised to their full potential. Workstream objectives and scope are in review.

7. CompStat Approach

The word CompStat stands for Comparative Statistics. Identifying key data sets that can be used to identify success, the collection of this data, presentation of the data, and distribution of data during a timeframe period allows Operational decision making to occur in confidence and in a timely manner ensuring the right strategies are identified and implemented. This approach will be used to define and implement patient pathways and strategies to deliver effective and efficient quality of care

Key Milestones

Work stream 1 - Capacity & Flow – Simple Discharges	Due Date	Expected Date	CRAG	Update / Actions to Resolve
Determine Surge capacity ward	29/09/2010	Complete	C	Sky A is now a Care of the Elderly facility – this action to be removed.
Provide weekly updates on Surge capacity ward	Ongoing	Ongoing	C	Sky A is now a Care of the Elderly facility – this action to be removed.
Ensure consultant availability on wards for Senior Decision Making	15/10/2010	30/11/2010	C	See below
Review Consultants job plans (Medical and Surgical divisions)	15/10/2010	01/04/2011	A	All Consultant job plans in across the Trust are currently under review and are subsequently being analysed using the Trust's e-Rostering system 'MAPS' so that the Divisional Management Teams are confident that they are best utilising their Consultant resources. The new job plans and rotas for the Emergency Department, Medicine and Surgery are due to be implemented by 01/04/2011. Remains Amber as there is outstanding Job Plans requiring validation in MAPS across CSS, Surgery and the ED.
Expansion of the ACC/Virtual Ward	30/11/2010	31/01/2011	R	ENT, Bone Infection, Pyleonephritis patients are being accepted by the ACC; however the 'final pathway' is yet to be formally agreed and signed off – envisaged to be completed by end of January 2011. The Executive Director of Delivery has instructed the Divisional Nurse Directors to recruit substantive staff to the ACC team as it will become a permanent team within the Trust and to recruit to any posts left vacant elsewhere within the Trust as a direct result of the ACC substantive recruitment. Remains Red as formal sign-off of the additional pathways is outstanding after original implantation date reached. NB – The ECIST has indicated this is a workstream they will be reviewing.
Therapies support agreed and implemented	--	Complete	C	NB: Since the Major Incident declarations, extended therapies support has been implemented at QH & KGH (extended and weekend hours). Whilst this is a recognised cost pressure, a cost v benefit analysis will be undertaken in relation to this additional support being maintained until the end of Feb '11.
Communicate requirement for TTAs to be written 24 hours in advance	15/10/2010	In progress	A	Ward and Consultant League tables are now produced weekly and issued to appropriate staff. Performance across the trust is 22% written 24 hours in advance. Requirement is communicated but performance still requires improvement.

Provision of Early Morning Discharge team within Medical Division	11/11/2010	Complete	C	<p>Towards the end of November it was agreed that the Early Morning Discharge team would be replaced by weekday Consultant led morning board rounds on each ward. Both the Surgical and Medical Divisions report that these have been implemented and take place at 8.30am.</p> <p>*See below for additional initiatives implemented aimed at increasing early discharges</p>
Realign action cards for escalation to SIE to match CMS	21/10/2010	28/02/2010	R	<p>At the Emergency Care Taskforce, the CEO asked that senior divisional Managers meet to discuss the actions that are taken dependent on the Trust's alert status. At that meeting, the possibility of aligning the Trust's alert status to that of the Capacity Management System (CMS) was discussed; however it has since transpired that the calculations used by CMS would not truly reflect the actual Trust status as is i.e. the Trust would be shown on a lower alert than it actually is. The Interim Divisional Manager for the ED has therefore developed and sent out for comment a draft set of redesigned alert status criteria that would provide the Trust with a more robust set of actions to take subject to the alert status it is on. It is envisaged that the new criteria may be in effect by the end of February 2011. Delays have been encountered due to the recent extreme pressures faced by the Trust (including two Major Incidents and subsequent debrief process and stabilisation of the Trust).</p>

*To support an increase in the number of discharges before midday, the following actions have been implemented:

- Enhancement of criteria led discharge process on surgical wards.
- Opening hours of discharge lounge extended
- Monday clinical action meetings arranged at 8.15am chaired by Medical Director or nominated deputy to coordinate consultant teams and on any morning when at SIE.
- All Stroke & Trauma patients reviewed by 8.30am weekdays
- Neurology teams sweep MAU to check for appropriate patients
- Ortho-geriatricians assessing patients for earlier transfer to Erica
- Agreed lead clinician for SAU (Senior Decision making)
- Daily Floating Surgical Registrar relieved of clinical duties 8am to 8pm to review A&E and SAU patients
- Head of Operations role implemented on 13/12/2010 to ensure that any actions relating to patient flow are implemented throughout the week with the General Manager on call undertaking that responsibility at weekends.

Work stream 2 - Capacity & Flow – Complex Discharges	Due Date	Expected Date	CRAG	Update / Actions to Resolve
Agree community funded DtoC beds for BHRUT at KGH	31/10/2010	30/11/2010	C	
Agree community funded DtoC beds for BHRUT in Havering	TBD	TBD	A	Whilst Havering PCT have responded in recent weeks by ensuring that sufficient capacity has been made available in the community the process for authorising this additional capacity is cumbersome. Further consideration should be given to providing a dedicated facility on the St Georges site. A new Programme Director for the sector has been appointed to review community capacity.
Identify winter capacity requirements	24/09/2010	30/11/2010	C	
Identify detailed criteria and protocols to support Trust Direct Admission to Community beds (NB: now referred to as 'Rapid Access')	18/11/2010	TBD (End Jan 11?)	A	Process agreed and in place since 17/12/2010 for B&D patients and recently adopted by Havering PCT. Currently monitoring success of the scheme. Feedback from the meeting with Redbridge to consider implementation of this initiative is pending. Remains Amber due to the uncertainty of Havering's participation in this initiative.
Creation of Complex Discharge Board to review patients with an LOS of >20 days	01/10/10	Complete	C	As the majority of actions in this workstream have been completed, a new workstream is under development that will consider internal DTOCs and Community related issues in more depth (Workstream 8 – Discharge Process Improvement). During the Xmas and New Year period, the Trust implemented a successful rolling 'Golden 30' list that actively targeted the discharge of the 30 patients deemed as 'Complex' discharges – it is reported that the success of this initiative was due to the joint work of the discharge Partnership Board.
Creation of a DTOC database to enable accurate data recording within the Trust	30/11/2010	01/02/2011	R	Database still under development – first version should be tested by the end of January 2011. Initial implementation and trial will be in effect during February 2011. Initial date delayed due to the database becoming available to PCTs and Social Services and not just within the Trust. The database is being developed with a view to it becoming a multi-agency, real-time source of data that will better enable appropriate organisations to action DTOCs sooner and with greater accuracy.

Workstream 3 – A&E Resillience	Due Date	Expected Date	CRAG	Update / Actions to Resolve
Interview for three Consultant posts on 18/10/10	18/10/2010	TBD	C	x2 Consultants appointed. A rolling advert is in place to source the third.
Review consultant job plans	30/09/2010	01/04/2011	A	As referenced above, all Consultant job plans in across the Trust are currently under review and are subsequently being analysed using the Trust's e-Rostering system 'MAPS' so that the Divisional Management Teams are confident that they are best utilising their Consultant resources. The new job plans and rotas for the Emergency Department are due to be implemented by 01/04/2011.
Workforce review	30/11/2010	Complete	C	This has been completed however requires Trust approval to move forward.
MAU and A&E Improved Communications	30/11/2010	Complete	C	The ECIST may review this further as a part of their proposed Professional Standards Workstream.
Submit Business Case for A&E POCT	04/11/2010	Complete	C	This has been submitted however the costs were deemed prohibitive as it stood. A review of these costs is underway. POCT is referenced in the current Pathology competitive dialogue exercise currently in process.

Workstream 4 – Admission Avoidance	Due Date	Expected Date	CRAG	Update / Actions to Resolve
Implementation of PCT Discharge team at KGH	01/11/2010	Complete	C	
Revision of the operational model for the UCC	31/10/2010	1/4/2011	A	Havering PCT has indicated that a two phased approach to the continuing operations may be the way forward for the Urgent Care Centre (UCC). The Commissioning Director at Havering PCT is to head up a project that will consider UCC options and how this may be progressed. Initial indications are that reporting lines of Havering PCT staff will be directed to BHRUT Management for 1 st April 2011 until a formal tendering process for the provision of UCC services is undertaken (envisaged to be August 2011).
Develop a plan for the Trust to take responsibility for UCC operations	31/11/2010	1/4/2011	G	Subject to the above, the Trust has made it clear that it will maintain the current systems that clearly record activity going through the UCC in relation to the ED, however any undertakings by the Trust in terms of managing the UCC will need to be clinically and financially sound. Any changes to the operational policies and procedures are still within the gift of the Trust and may still be affected prior to the project referred to above commencing to ensure the most suitable practices are being implemented during the winter period.

Workstream 5 – Ambulance Turnaround	Due Date	Expected Date	CRAG	Update / Actions to Resolve
Implementation of Ambutime	31/10/2010	31/12/2010	G	Ambutime has now been implemented within the A&E in both QH and KGH. W&C Paeds and Maternity now have Ambutime installed, but training is yet to be arranged. Whilst the system is being embedded on both sites, accurate reporting as to the performance and therefore the impact of the systems will be provided from January 2011. Discussions with UCC are underway to install Ambutime. Time and resource may be an issue.
Implementation and embedding of RATting system in A&E	31/10/2010	Ongoing	A	RATing is currently being conducted within the A&E but due to staffing and training can be sporadic. The intention is to re-energise efforts to implement this agreed action with support from the Intensive Support Team.

Workstream 6 – Demand Management (PCT Led)	Due Date	Expected Date	CRAG	Update / Actions to Resolve
No key milestones identified at this stage	TBD	TBD	--	

Workstream 7 – The CompStat Approach	Due Date	Expected Date	CRAG	Update / Actions to Resolve
Determine pathways to be monitored via CompStat for each division	--	Complete	C	
Arrange CompStat meetings for each pathway	22/10/2010	Complete	C	
Agree criteria for each pathway:	07/10/2010	Complete	C	
(x3) #NOF, Stroke & Pneumonia	27/10/2010	Complete	C	
(x3) UTI, Delirium and Normal Delivery with Complications	29/10/2010	Complete	C	
(x1) Respiratory (paediatrics)	22/11/2010	10/12/2010	C	There was a rethink on the criteria within this pathway (revised criteria only agreed as at 15/12/10); however the pathway is now up and running.
Collect data daily to support pathway criteria	22/10/2010	Ongoing	G	The data collector from Burkeway has been retained until the end of Jan 2011 until a sustainable resource can be identified for current and future CompStat pathways
Arrange for an Executive to be in attendance at every meeting	Ongoing	TBD	G	Executive Board members have been allocated to Compstat meetings

NB: From Jan 2011, GMs are responsible for facilitating and progressing actions arising from the CompStat meetings.

Risks and Issues

NB: All risks and issues for the ECQIP are currently under review.

Action Ref	Risk	Mitigation	Risk Rating	Owner
1.3.8 and 1.14.1	Review and redesign of consultant job plans to ensure senior decision making is available on a daily basis to enhance the service provided to patients	All divisions are currently having job plans entered into MAPs for validation. Medicine is now completed. Some outstanding plans still remain within Surgery and EC. Once completed feedback will be given and further reviews to take place thereafter.	R	DDs Medicine, Surgery & ECD
1.12.1	Only a small improvement of TTA's currently being written 24 hours in advance	Improvements to the tracking system have been made and are now electronic. All information is collated by Ward and by Consultant and is being distributed to Divisional management teams, CD's, Consultants, Matrons and Ward Managers (in league table format) to encourage competition and compliance. All appropriate areas have been advised of the standing order that all TTAs should be written 24hrs in advance whenever possible. Although this system has now been in place for 4 week, no improvement has been seen.	R	DM CSS
2.1.8	Winter capacity for Havering patients has not been agreed by the PCT	The DToC Lead has passed the Trust requirements to ONEL Sector regarding capacity plans. The Dir of Delivery is in regular contact with ONEL Sector to progress this asap, although Havering PCT has been seeking to meet the demand for Rehab and other beds through a process of escalation and agreement on an individual basis.	R	ONEL Sector, Dir of Delivery, DToC Lead

Activity during the period

- Continued liaison with the PCT's regarding DToC and Rehab beds. NELFT confirmed within cost for staffing provision – waiting for accommodation cost for St Georges
- League table for TTA's by site, consultant and ward - audit sent to all Divisional Directors/Managers, CD's, Consultants, Matrons and Ward Managers for circulation and communications to their teams on a weekly basis
- Continued monitoring of Consultant presence on the ward by 8.30am, monitored by Matrons
- Collation of daily bed declarations before 12 noon throughout the Trust by DM ECD/Bed & Site
- Early identification of patients requiring rehabilitation or reablement services process has now been put into place for Havering patients with additional community therapists recruited to the Early Discharge Facilitation team
- Continued development of DTOC database, now improved to include input by PCT's and Social Services, testing of the database should be completed by the end of January 2011
- Monitoring success of "Nurse Tracker" within the ED to assist with times to first assessment for patients
- Continuation of working with complex discharges - "Golden List" - to review top 30 patients with LOS >20 days to facilitate discharge
- Sky A contingency ward reclassified as Care of the Elderly (step down ward)
- Area for discharge lounge identified at KGH during busy periods
- Amended Consultant rotas for ED introduced and workforce plan completed

Activity planned for next period

- Finalising agreement for DoH Intensive Support Team involvement in work streams
- Liaison with Redbridge PCT regarding the effectiveness of the Intensive Therapies Support Team
- Training for Ambutime to be rolled out to W&C (Maternity and Paediatrics)
- Plan to be put into place for rollout of Ambutime to the UCC
- Iron out the issues to ensure that RATING is consistent within the A&E department – review by the ECIST
- Substantive recruitment for the ACC to be actioned, and backfilled vacancies approved as appropriate
- Final development for the DTOC database to enable testing during January 2011 – anticipated go-live date of February 2011
- Continuation of "Golden List" to review top 30 patients with LOS >20 days to facilitate discharge
- Identification of "Data Collector" to enable continuation of the CompStat meetings for each division
- Ensure plans to enable reduction of bed base are available from Medicine & Surgery
- Review of business case for the POCT for the ED
- Monitor position in relation to the ED workforce plan and associated Trust approval