NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD - PUBLIC
14 SEPTEMBER 2017

Title	Waltham Forest and East London (WEL) Emergency Care Improvement Plan
Author	Jonathan Warren, Chief Nurse and Deputy Chief Executive Officer
Accountable Executive Director	Jonathan Warren, Chief Nurse and Deputy Chief Executive Officer

Purpose of the Report:

The purpose of this paper is to approve the current WEL Emergency Care Improvement Plan which commits ELFT to reduce the number of A&E attendances to both the Royal London Hospital and Newham General Hospital in line with CQUIN requirements.

Summary of Key Issues:

An agreement on a new performance management approach has been developed for A&E performance, as a result all 'systems' across England have placed into national groupings based on recent performance and levels of risk within the system

The WEL system is placed in Group 2 which is described as a system with low levels of performance and high volume of breeches that require national intervention and support. This paper presents the WEL System Emergency Recovery Plan. It was presented to the Barts Health Trust Board in June and to the CCG Governing Body in July.

All partners were asked to take the plan to their Trust Boards. Oversight of the delivery of the plan is via the A&E delivery board which is attended by the Deputy CEO.

Strategic priorities this paper supports (Please check box including brief statement)

Improving service user satisfaction	☐	
Improving staff satisfaction	☐	
Maintaining financial viability	☐	

Committees/Meetings where this item has been considered:

Date	Committee/Meeting
	State whether the report has been considered/approved by other committees or meeting groups including recommendations/points of exception

Implications:

Equality Analysis	Improvement in the performance of A&E will benefit the whole population
Risk and Assurance	A summary statement on the level of assurance that can be provided from the report, and the key actions taken to address any implications for risks/controls identified in the Trust's Board Assurance Framework; Trust's Compliance with its Terms of Authorisation; or legal or health and safety implications
Service User/Carer/Staff	The local emergency care pathways in both Newham and TH are currently being reviewed based on a series of patient and public

	consultations
Financial	The reduction in A&E attendances for MH patients is subject to a CQUIN for the Trust. 30% of Bart's Health STF funding is badged to the emergency care pathway
Quality	QI methodology is being used to support the reduction in A&E attendances by our patients.

Glossary

Abbreviation	In full
WEL	Waltham Forest and East London

WEL Emergency Care Improvement Plan

16 June 2017

Final

NHS
Tower Hamlets Clinical Commissioning Group

NHS
Newham
Clinical Commissioning Group

NHS
Waltham Forest
Clinical Commissioning Group

Contents

1.1 Actions since the April meeting with NHSE and NHSI

Since the previous meeting in April, we have:

- Agreed a new approach to understanding and improving emergency care performance across the WEL system, centred on establishing a range of key 'optimum conditions' for delivery across each part of the patient pathway.

- Worked with each of the three systems with WEL (Royal London / Tower Hamlets; Newham / NUH, and Waltham Forest / Whipps Cross) to:
  (i) refresh the diagnosis of current performance challenges;
  (ii) agree the level of performance required against each of the optimum conditions to support the level of improvement required against the 4-hour standard; and
  (iii) develop clear plans for delivery over the course of 2017-18.

- Agreed changes and improvements to local and system governance to support delivery of the plans, along with system-wide measures to address workforce challenges and win 'hearts and minds' to support delivery.

- Built a new trajectory to reflect the increasing challenge in recovering and sustaining performance on the Newham site. The trajectory has minimal impact on the overall Barts Health trajectory and it continues to meet the requirements outlined in the Stevens/Mackey letter of 9 March 17.

The remainder of the document sets out the detail:

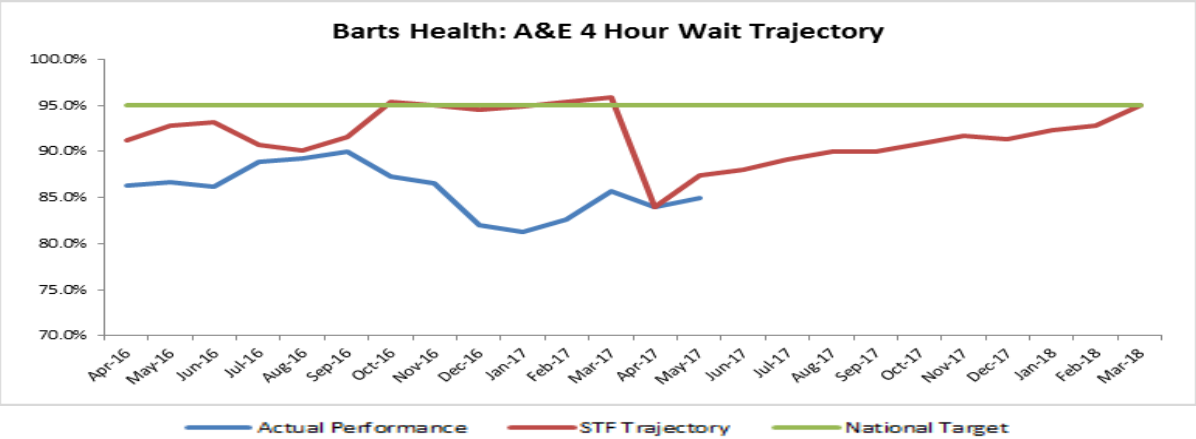
- Section 2 describes the 'optimum conditions' framework across WEL and within each system.
- Section 3 sets out a diagnosis of performance by system and the delivery plans to respond to the key drivers of performance.
- Section 4 describes the enablers and system-wide measures including actions to strengthen governance and resources to oversee delivery.

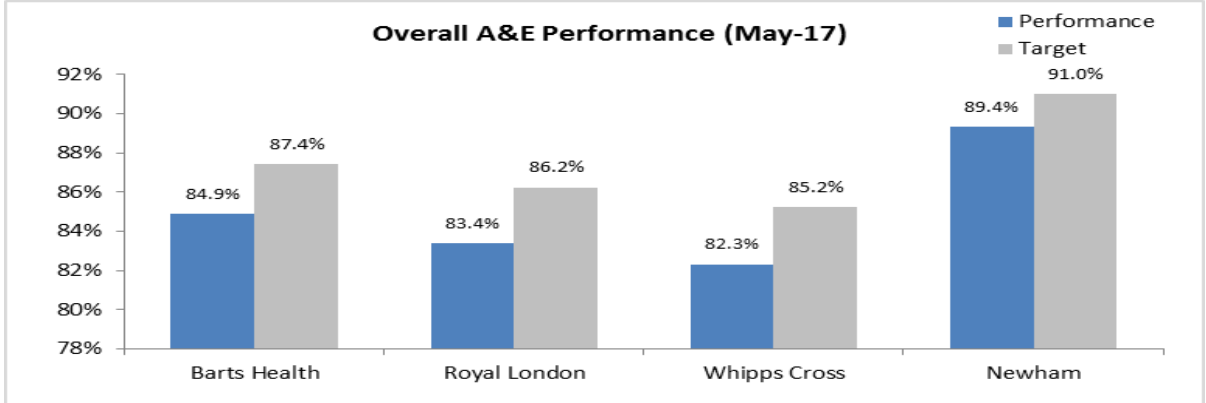
1.2 Trajectory for delivery against the four hour emergency care standard for 2017/18 – Barts Health NHS Trust

The Trust has re-based its 2017/18 A&E recovery trajectory during May 17 and therefore commenced the sequence with actual performance for April 17.

Month	Barts Health	Royal London	Whipps Cross	Newham
April 2017	84.00% actual	81.67% actual	81.41% actual	89.28% actual
May 2017	87.44% (84.92% actual)	86.25% (83.38% actual)	85.24% (82.33% actual)	90.98% (89.36% actual)
June 2017	87.97%	85.69%	86.89%	91.67%
July 2017	89.11%	87.07%	87.65%	92.94%
August 2017	90.04%	88.28%	88.64%	93.62%
September 2017	90.00%	88.51%	87.23%	94.80%
October 2017	90.82%	90.36%	88.90%	93.37%
November 2017	91.67%	91.72%	90.30%	93.13%
December 2017	91.29%	92.51%	87.82%	93.66%
January 2018	92.32%	93.81%	89.50%	93.60%
February 2018	92.84%	93.79%	90.79%	93.90%
March 2018	95.00%	95.28%	93.19%	96.48%

1.2 Barts Health: ED Trajectory Performance





Commentary

Barts Health: The Trust re-based its 2017/18 A&E recovery trajectory during May 17 and therefore commenced the sequence with actual performance for April 17, during this month Barts Health recorded a performance of 84.0%. In May 84.9% of patients were treated within four hours against a trajectory of 87.4%.

- Performance in February and March had started to improve on all 3 sites following a challenging December and January.
- April performance was however significantly impacted by IR35 issues with sites experiencing extreme difficulty in sourcing locum doctors in particular. Whipps Cross saw 50% of Consultant shifts unfilled in April. The impact was felt at the RLH with c30% GP and ENP shifts unfilled in the UCC. At Newham almost 50% of shifts were unfilled in April as compared to 10% of shifts unfilled in March with the major issue in middle grade shifts.
- In the last week of April the sites experienced disruption to both the Pathology and Radiology systems. Electronic reporting was not possible as data could not be written to shared areas. As a result staff were deployed to deliver requests on paper and clinicians were required to go to imaging machines where the diagnostic took place, to read the results, which extended waiting times in the department and reduced resource. This was the case for plain X-ray, MRI and CT scans. Once systems were back operational there was a backlog in reporting that reduced resource for new reports over the May bank holiday.
- The Cyberattack hit on 12 May and impacted on the effective running of all 3 Emergency Departments. Whilst attendances dropped immediately following the attack, demand returned to normal levels during the week of 15 May. Despite this the sites maintained performance above 80% on all sites.
- Performance week ending 11 June showed a recovering position with 95.35% At NUH, 90.71% at RLH and 86.81% at Whipps Cross giving an overall Barts Health performance of 90.79% against a June trajectory of 87.97%

1.2 Trajectory for breach reduction for 2017/18 – Barts Health NHS Trust

The table below presents forecast attendances and breaches, the volumes are derived by applying a mathematical formula to the 2015/16 and 2016/17 data in order to continue the direction of travel observed in the last two years to the 2017/18 data. The improvement trajectory is then presented with breach reductions required to deliver the trajectory presented on a monthly and daily basis in order to quantify the scale of improvement required.
The Optimum Conditions have been designed to mitigate forecast performance and deliver the improvement trajectory, in summary achieving the Optimum Conditions will result in a reduction in breaches and a reversal of the currently observed decline in performance.

Month	F/cast Attendances	F/cast Breaches	Breach trajectory	Breach reduction (monthly)	Breach reduction (daily)
April 2017	39,549 (actual)	6,328 (actual)	6,328 (actual)		
May 2017	41,702	6,185	5,238	-947	-31
June 2017	40,609	5,899	4,885	-1,015	-34
July 2017	41,652	5,625	4,535	-1,090	-37
August 2017	40,309	4,878	4,016	-861	-28
September 2017	40,980	5,599	4,098	-1,501	-50
October 2017	41,652	7,040	3,825	-3,214	-104
November 2017	40,359	7,256	3,361	-3,895	-130
December 2017	41,652	8,478	3,629	-4,850	-156
January 2018	41,652	8,476	3,198	-5,279	-170
February 2018	37,624	7,644	2,693	-4,951	-177
March 2018	41,652	7,226	2,082	-5,144	-166

1.3 Royal London system plan: summary

The table below describes the highest impact changes from the Tower Hamlets and Royal London system plan and the overall improvement that they and the other actions will have on performance against the 4 hour standard.

Sector	Demand Management	Emergency Department	Bed Occupancy	Out of Hospital support to discharge
Interventions	1. Redesign RLH A&E front door model to a 24/7 Urgent Treatment Centre with access to same day diagnostics. 2. Direct booking into GP Access Hubs, 6.30 – 8pm 7 days per week 3. Sutton Care Homes Vanguard inc Red bag scheme, enhanced support to care homes etc. -	1. Increase the number of patients seen by Ambulatory Emergency Care Service – extension of working hours to 10pm increasing numbers in ambulatory care 2. Embed a 24/7 operating model for ED flow including the pilot of flow co-ordinator, escalation protocols and to drive breach prevention.	1. Roll out of SAFER bundle from current 11 wards to 22 wards by July 17. Red day / green day criteria established. Project roll out support agreed by division (ECIST sponsored) 2. Capacity management - Careful management of capacity involves a review of all patients in the hospital to identify reasons for delay & progress next steps. 3. ECIST escalation model to be implemented which frees space in the hospital to flow admitted patients out of the Emergency Department	1. Enforcement of the patient choice and discharge policy 2. Senior Operational Hub with escalation to NHSE for speciality rehab and to other boroughs where DTOCs exceed triggers. 3. Implement Tower Hamlet DTOC Strategy to achieve 3% to 2.5%
Optimum conditions	1. Maximum of 90 ambulances per day 2. Attendances per day below a maximum of 400 type 1 3. Urgent care centre cases per day above 150	1. Ambulatory care numbers per day 20 or over 2. Fewer than 90 patients in A&E at any one time 3. 95th percentile wait for patients at 3.5 hours	1. 30 free G&A beds each day at 8pm 2. 48 discharges (29%) before 12 noon 3. Reduction in MO occupied bed days to under 21	1. Minimise Delayed Transfers Of Care to 16 2. Minimise Medical Optimised patients to 21
Breach impact p/d	30	30	10	5
% of impact	40%	40%	13%	7%
4-hr Goal impact	6.5%	6.5%	2.2%	1.1%

Total improvement opportunity of 16.3% 75 breaches p/d

1.3 Whipps Cross system plan: summary

The table below describes the highest impact changes from the Waltham Forest and Whipps Cross system plan and the overall improvement that they and the other actions will have on performance against the 4 hour standard.

Sector	Demand Management	Emergency Department	Bed Occupancy	Out of Hospital support to discharge
Interventions	1. Reduction in paediatric ED attendances by the implementation of GPWSI in paeds 2. Implementation of DVT pathway and MH pathway and streamlined diagnostic access within the UCC 3. Improved integration of LAS with Rapid Response pathway and the expansion of RR to manage community IV antibiotics 4. Collaborative redesign of the urgent care front door system	1. Recruitment to 4 substantive consultants, 10 middle grades and 100 nursing staff. 2. Strengthen Clinical Leadership in the department with appointment of ED Clinical Director and Matron 3. Ensure consistency of performance between teams 4. Enhanced clinical pathways including Ambulatory Care and SAU. 5. Implement Surgical Assessment Unit	1.Bed management policy adhered to • Red-Green-Day implementation • SAFER bundle implementation • Reducing LoS for AAU • Provide discharge topic training for staff DToC and MO 2. Expand Frail Elderly Unit 3. Re-organisation of discharge and flow co-ordinator teams, enforcement of internal professional standards.	1. Optimise D2A pathway capacity and expand with winter funding 2. Streamline social care decision-making, reduce block to funding decisions, implement parallel processes for CHC, improve brokerage response times 3. Develop the Integrated Discharge Team to include trusted assessor model 4. Improve flow through Ainslie rehab service 5. Accountable care approach to out of hospital pathways and system beds
Optimum conditions	Maximum of 73 ambulance arrivals per day Maximum of 250 type 1 attendances per day Minimum of 150 type 3 attendances per day	Maximum 70 patients in department 95th percentile wait at 3.5 hours	Minimum daily G&A discharges of 91 Maximum daily DTOCs of 10 and MO of 17 Minimum of 16 of discharges before midday.	Reduction of DTOC to 2.5% (10) Reduction of MO to 17
Breach impact p/d	10	22	16	16
% of impact	16%	34%	25%	25%
4-hr Goal impact	2.3%	4.9%	3.7%	3.7%

Total improvement opportunity of 14.6% (64 breaches p/d)

1.3 Newham system plan: summary

The table below describes the highest impact changes from the Newham and NUH system plan and the overall improvement that they and the other actions will have on performance against the 4 hour standard.

Sector	Demand Management	Emergency Department	Bed Occupancy	Out of Hospital support to discharge
Interventions	1. Improve streaming at front door by: • increasing numbers streamed to UCC pharmacy, primary care and minor ailments (increase from 38% streamed to 48% streamed away). 2. 26,000 additional appointments commissioned in extended GP Access 8am-8pm. Ensure UCC and ED can easily directly book into 3000 allocated appointments.	1. Implementation of recruitment objectives and resolution of issues raised by IR35. 2. Ambulatory sensitive pathways are currently admitted to CDU. The establishment of a dedicated AEC unit will enable better use of CDU. Standardise ED nursing Leadership 3. Increased use of discharge lounge	1. SAFER Bundle Implementation - Daily MDT board rounds in place - All patients have EDDs which are tracked - Up to date white boards in use on all wards 2. Total discharges will be increased as they will have been identified and actioned before midday.	1. Formal D2A pathways implemented between health and social care with 'trusted assessor' arrangements. 2. Improvement of CHC processes including training of ward staff on CHC assessments.
Optimum conditions	Maximum of 225 type 1 attendances Urgent Care Centre – minimum of 182 attendances	Maximum of 45 patients in the department 95th percentile wait time for patients at 3.5 hours	Minimum 20 empty G&A beds at 8am Minimum of 77 discharges per day	4 daily DTOC patients 1 daily MO patient
Breach impact p/d	9	13	9	3
% of impact	26.5%	38.2%	26.5%	8.8%
4-hr Goal impact	1.4%	2.6%	1.6%	1.2%

Total improvement opportunity of 7% (34 breaches p/d)

1.4 Governance, Resources & Delivery - Strengthening our governance (1)

The following steps will be taken to strengthen governance at WEL level and within each local system:

1. Build on the strengths of the current local system partnerships through cross learning of the outputs of the 3 Urgent Care Working Groups, ensuring accountability for delivery of the Out of Hospital initiatives within the site level A&E Recovery Plans

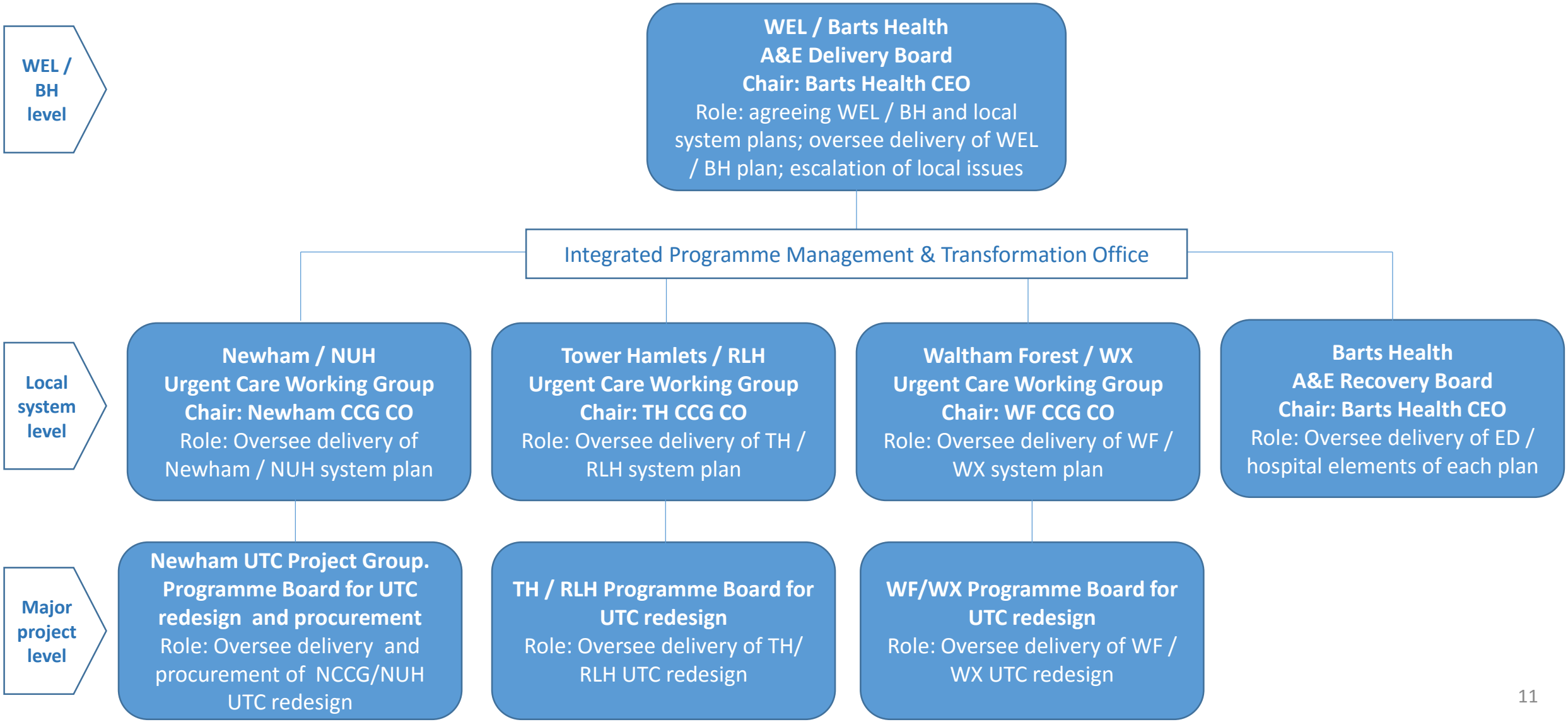
2. Each Urgent Care Working Group to be chaired by CCG Chief Officer (or nominated representative), working closely with the Managing Director for each local site. This is to ensure senior oversight and focus on all elements of the system plan. Site level meetings feed into the Bart Health Recovery Board chaired by the CEO, to drive progress on delivery of in-hospital changes and ensure learning between sites and sharing of best practice from elsewhere (e.g. Repatriation model from Kings College Hospital). CCG partners are also represented on this group. An Emergency Care Clinical Board has been established and will meet for the first time on 28 June 17. This group will explore cross site workforce opportunities and areas that would benefit from clinical collaboration.

3. Programme Boards have been created to support local UCWG and Recovery Boards on key projects, for example urgent care redesign in Tower Hamlets.

4. A single, integrated Programme Management and Transformation Office is being created to support the five key groups, to connect between local and WEL-wide level; to facilitate and follow up on actions; to identify required resource and ensure consistent and comprehensive oversight of the WEL-wide plan. This team will be 'hands on' supporting hospital sites, community and social care providers and CCGs to resolve issues and facilitate working across the system.

5. A consistent measurement framework based on the 'optimum conditions' will be put in place to ensure a clear line of sight on all elements of the plan at all levels, overseen by the PMO.
These strengthened arrangements are shown diagrammatically on slide 11.

1.4 Governance & Delivery - Strengthening our governance (2)



2.1 Optimum conditions framework - overview

- The Trust and local partners have reviewed the framework for quantifying improvement against the 4 hour standard performance. In order to ensure mutual system wide accountability for delivery of the plan against the 95% standard, a methodology has been devised to use key Optimum Conditions that system partners can directly influence and improve upon. Whilst these conditions contribute to breach reduction to meet the 95% standard, system partners will be held accountable for a condition that they can more easily relate to, for example:
    - A charge nurse on an acute ward will relate more to the Stranded Patient Metric;
    - The ambulance services will understand the requirement for reduction in conveyance of ambulances; and
    - A social worker will relate more easily to a Delayed Transfer of Care metric
- The Optimum Conditions framework describes the conditions that must be met that will allow the system to deliver 95%. The Optimum Conditions baseline values, thresholds and goals presented in the Improvement plan have been derived by interrogating the historic data and comparing more recent performance against periods when ED performed at a higher level. In addition operational local knowledge and business intelligence has also been applied to the data to ensure triangulation with operational experience.
- It is important to note that the Optimum Conditions have a complex causal relationship with the 4 hour performance. Achieving performance will be reliant on delivering multiple Optimum Conditions and some conditions will be larger drivers of delivery than others depending on the challenges in the system. This is demonstrated by the weightings in Slides 7, 8 and 9.

2.2 Delivering the 2017/18 ED Trajectory Optimum Conditions Model (1)

					Royal London				Whipps Cross				Newham			
Performance drivers	Performance Driver ID	Optimum Conditions Baseline Data Definition for Full Year 2016/17 and March 17	Optimum Conditions Target Data Definition	Preferred Direction of Travel	Baseline Full Year 2016/17	Baseline March 17	Actual April 17	Goal	Baseline Full Year 2016/17	Baseline March 17	Actual April 17	Goal	Baseline Full Year 2016/17	Baseline March 17	Actual April 17	Goal
Demand Management	1	95th Percentile daily All Type ambulance attendances	Maximum daily All Type ambulance attendances do not exceed target levels	↓	112	119	103	90	95	101	95	73	91	92	87	71
	2	95th Percentile daily Type 1 attendances	Maximum daily Type 1 attendances do not exceed target levels	↓	476	489	470	400	326	329	316	250	279	280	255	225
	3	Mean daily Type 3 (Urgent Care Centre) attendances	Daily Type 3 (Urgent Care Centre) attendances achieve the minimum target level	↑	29	23	20	150	129	141	145	150	167	183	189	182
Emergency Department	4	Maximum volume of patients in Type 1 ED at any one time	Maximum count of patients in Type 1 ED at any one time	↓	175	175	149	90	137	137	130	70	130	109	108	45
	5	Total Type 1 ED journey time (arrival to dispersal) calculated at the 95th percentile	Total Type 1 ED journey time (arrival to dispersal) calculated at the 95th percentile is no greater than 3:30	↓	07:37	08:15	07:36	03:30	09:09	09:26	09:44	03:30	05:12	05:00	05:25	03:30
	6	Number of admissions per day to Ambulatory Emergency Care Units	Locally agreed targets for throughput to Ambulatory Emergency Care Units	↑	6 (daily)			20 (daily)	20 (daily)			50 (daily)	5 (daily)			11 (daily)
	7	Percentage of mental health attendances breaching 4-hours. Baseline data only available for April 17 the point in time new national performance definitions were applied	To consistently achieve 95% compliance against the 4-hour ED standard for mental health attendances, the target is therefore that breaches reduce and can be no greater that 5% of attendances	↓			14.60%	5.00%			4.59%	5.00%			4.00%	5.00%

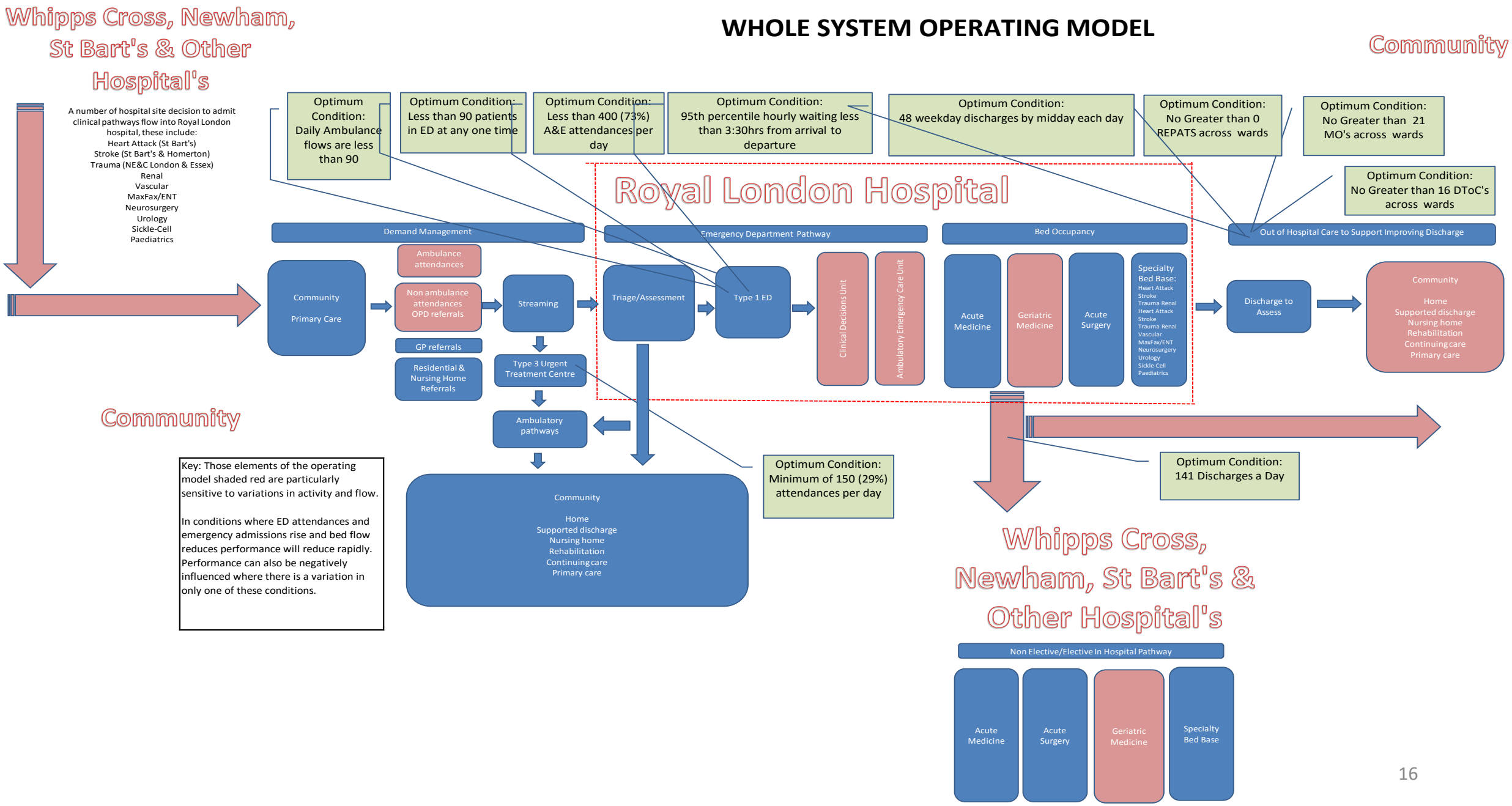
2.2 Delivering the 2017/18 ED Trajectory Optimum Conditions Model (2)

					Royal London				Whipps Cross				Newham			
Performance drivers	Performance Driver ID	Optimum Conditions Baseline Data Definition for Full Year 2016/17 and March 17	Optimum Conditions Target Data Definition	Preferred Direction of Travel	Baseline Full Year 2016/17	Baseline March 17	Actual April 17	Goal	Baseline Full Year 2016/17	Baseline March 17	Actual April 17	Goal	Baseline Full Year 2016/17	Baseline March 17	Actual April 17	Goal
Bed Occupancy	8	Minimum number of daily general and acute discharges	Minimum number of daily general and acute discharges required to maintain bed flow	↑	125	138	122	141	85	94	74	95	73	75	72	77
	9	Mean empty general and acute beds at 08:00 each morning	The minimum number of daily discharges required each day to maintain bed flow	↑	21	15	15	30	17	10	13	25	20	15	13	20
	10	Median general and acute bed occupancy	Daily general & acute bed occupancy not exceeding the range of 90%-95%	↓	96.85%	96.85%	97.22%	85.00%	96.97%	98.44%	98.55%	94.29%	91.97%	94.98%	94.54%	91.97%
	11	Average number of general and acute discharges by 12:00noon	The minimum number of discharges to be achieved by 12:00noon each day to maintain bed flow	↑	17	20	18	48	11	13	12	16	14	13	14	19
	12	Maximum number of beds occupied by Repatriations to: •External NHS Trusts •Barts Group hospital sites •Referrals (waiting for a Repatriation destination)	The maximum number of Repatriations that can be recorded per day to maintain bed flow	↓	17	22	17	0	NOT APPLICABLE FOR NEWHAM AND WHIPPS CROSS SITES				NOT APPLICABLE FOR NEWHAM AND WHIPPS CROSS SITES			
	13	The maximum number of general and acute beds consumed by patients with a LoS of =>7days ("stranded patients") •Excludes Delayed transfers of Care •Excludes Medically Optimised Pending •Excludes Repatriations	The maximum number of beds that can be consumed per day by patients with a LoS =>7 days to maintain bed flow	↓	275	314	318	200	304	282	301	220	89	92	100	45

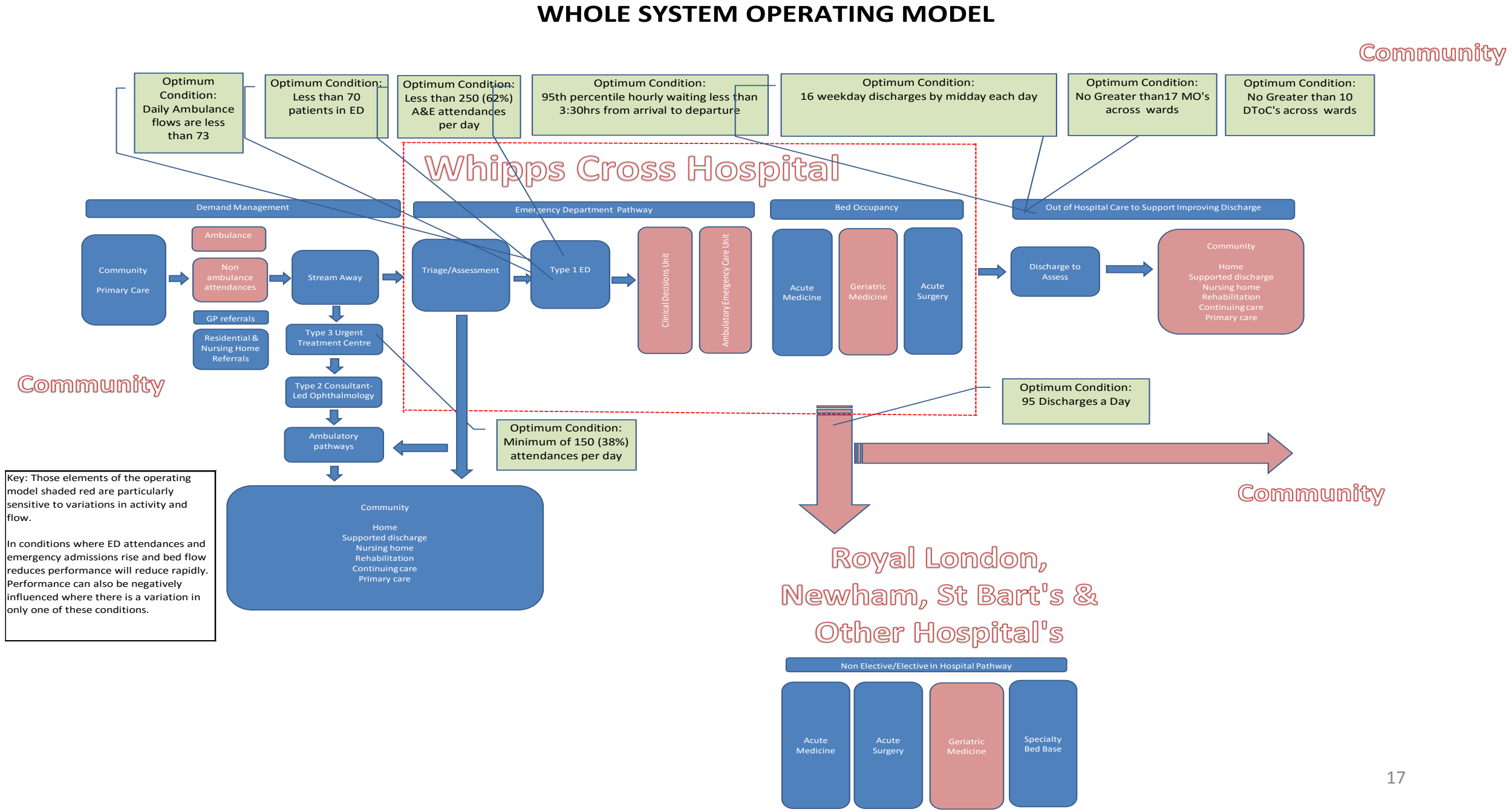
2.2 Delivering the 2017/18 ED Trajectory Optimum Conditions Model (2)

					Royal London				Whipps Cross				Newham			
Performance drivers	Performance Driver ID	Optimum Conditions Baseline Data Definition for Full Year 2016/17 and March 17	Optimum Conditions Target Data Definition	Preferred Direction of Travel	Baseline Full Year 2016/17	Baseline March 17	Actual April 17	Goal	Baseline Full Year 2016/17	Baseline March 17	Actual April 17	Goal	Baseline Full Year 2016/17	Baseline March 17	Actual April 17	Goal
Out of Hospital Care to Support Improving Discharge	14	Maximum number of general and acute beds consumed by Medically Optimised Pending patients	Maximum number of Medically Optimised occupied beds to meet the London Standard	↓	69	36	39	21	71	35	45	17	6	6	5	1
	15	Maximum number of general and acute beds consumed by Delayed Transfers of Care	Maximum number of Delayed Transfers of Care occupied beds to meet the London Standard	↓	36	28	27	16	29	21	28	10	12	6	6	4
Enabler Consultant Workforce	16	Current Consultant WTE in post	Full establishment level maintained	↑	NOT APPLICABLE					7.6WTE	7.6WTE	13.4WTE		7.0WTE	7.0WTE	10.35WTE

2.3 Flow model – Royal London system



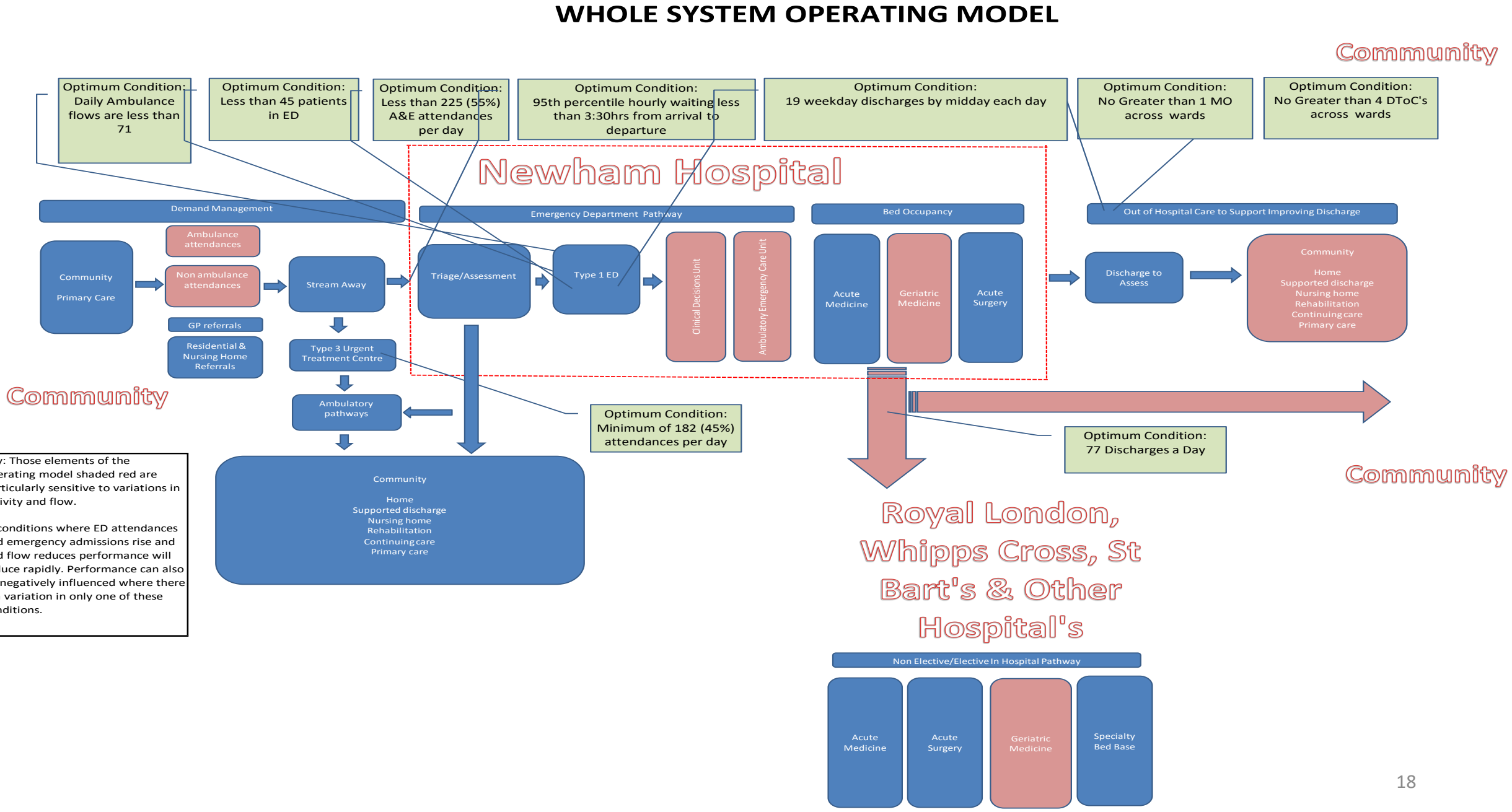
2.3 Flow model – Whipps Cross system



Key: Those elements of the operating model shaded red are particularly sensitive to variations in activity and flow.

In conditions where ED attendances and emergency admissions rise and bed flow reduces performance will reduce rapidly. Performance can also be negatively influenced where there is a variation in only one of these conditions.

2.3 Flow model – Newham system



3. Interventions and Improvements

This section sets out the following for the RLH, WX and Newham systems:

- Diagnostic of the problem
- Scale of Improvement Required
- Interventions and impacts covering:

✓ Demand management (CCG / system led)

✓ Emergency Department (Barts Health led)

✓ Bed Occupancy (Barts Health led)

✓ Out of hospitals services to support improving discharges (CCG/system led)

3.1 Royal London Hospital System

3.1 Diagnostic - Drivers of current performance on the Royal London Hospital site

Demand Management

We know that growing demand of patients attending ED puts additional pressure on the resources we have available to deliver against the 95% standard. The aim is to manage demand such that the ED sees only the appropriate patients who can not be seen in another setting, we would expect this to have the effect of reducing the number of Type 1 attendances based on a 95th percentile analysis of 476 to 400, a reduction of 76.

The Royal London saw a 7.4% growth in A&E attendances in 16/17 as compared to 15/16. The most significant increase was seen in Type 1 attendances with an increase of 3.8%. Where numbers of Type 1 attendances increase beyond the optimum level it will have a significant negative impact on RLH's ability to perform against the 95% standard.

ED Delivery and Flow

We know that when flow through the department is delayed, patient total journey time increases and this has a significant negative impact on RLH's ability to perform against the 95% standard.

The average time to initial assessment at the front door of ED is currently 26 minutes against the 15 minute standard. The 95centile journey time for Type 1 patients was 7.37hr (16/17). The aim is to reduce the journey time through the department in order to increase the number of patients seen within the appropriate timelines of good clinical care and thus increase the number of patients meeting the 95% standard.

We also know that as the volume of Type 1 patients in ED at any one time exceeds the optimum level of 90 that this has a significant negative impact on RLH's ability to perform against the 95% standard. The aim is to reduce the number of patients in the department at any one time based on a 95th percentile analysis of 175 to the optimum of 90, a reduction of 85.

Bed Occupancy

We know that where bed occupancy exceeds 85% this has a significant effect on the hospitals ability to admit patients in a timely manner and thus has a significant negative impact on RLH's ability to perform against the 95% standard.

The occupancy seen on the RLH site, based on a 95th percentile analysis of 96.85%, against the optimum level in line with national guidance expectations of 85%. A reduction of 11.25% in bed occupancy is therefore required to meet national guidance. The optimum number of discharges required on any day to achieve compliances is 141 and the optimum number of G&A beds available at 8am should be 30 to maintain flow.

Out of Hospital & Discharge

We know that high levels of medically optimised patients and delayed transfers of care decrease the bed flow in the hospital, this has an effect on the hospitals ability to admit patients in a timely manner and a consequent negative impact on RLH's ability to perform against the 95% standard.

Medically optimised patients occupied on average 12.8% (69 MO) of beds on the Royal London site against a London standard of 3% and an optimum level of 3.8% (21 MO). Delayed Transfers of Care occupied up to 6.7% (36 DTOCs) of the site bed base in 16/17, against an optimum level of 16. During Winter 16/17 delays due to Continuing Care more than halved and delays attributable to Tower Hamlets CCG and Local Authority remained at an average of 5 DTOCs per day (1% of bed base and a proportion of the total for all CCG areas). However the site saw increases of 46% for patients waiting for specialist rehab beds and assessment and a 65% increase in DTOCs for patient with immigration or no recourse to public fund issues. The aim is to reduce the MO to 21 and the DTOC to 16 to reach the optimum conditions.

Workforce

National recruitment problems related to supply of junior doctors and General Practitioners as well as the impact of IR35 have impacted on the difficulty of recruiting and retaining staff in the Emergency Department and UCC. In 2016/17 only 60% of shifts were covered in the UCC, compounded by a deterioration in the quality of the locums provided. In 17/18 the impact of IR35 has been partly mitigated through negotiations with existing GPs, however it will not have a significant impact on the existing shift shortfalls. Therefore, the aim is to move to new models of workforce to deliver care, including progressing development of advanced practitioner workforces.

3.1 Royal London Hospital System: Scale of Improvement Required - breach reductions

The table below presents forecast attendances and breaches, the volumes are derived by applying a mathematical formula to the 2015/16 and 2016/17 data in order to continue the direction of travel observed in the last two years to the 2017/18 data. The improvement trajectory is then presented with breach reductions required to deliver the trajectory presented on a monthly and daily basis in order to quantify the scale of improvement required.

The Optimum Conditions have been designed to mitigate forecast performance and deliver the improvement trajectory, in summary achieving the Optimum Conditions will result in a reduction in breaches and a reversal of the currently observed decline in performance.

Month	F/cast Attendances	F/cast Breaches	Breach trajectory	Breach reduction (monthly)	Breach reduction (daily)
April 2017	13,743 (actual)	2,519 (actual)	2,519 (actual)		
May 2017	14,806	2,539	2,036	-503	-16
June 2017	14,462	2,375	2,069	-306	-10
July 2017	15,020	2,326	1,942	-384	-12
August 2017	14,688	1,866	1,721	-145	-5
September 2017	14,650	2,012	1,683	-329	-11
October 2017	14,824	2,743	1,429	-1,314	-42
November 2017	14,414	2,736	1,193	-1,543	-51
December 2017	14,505	3,011	1,087	-1,924	-62
January 2018	14,579	3,093	903	-2,190	-71
February 2018	13,037	3,039	809	-2,230	-80
March 2018	14,102	3,026	665	-2,361	-76

3.1 Royal London system: Actions to address demand management

Optimum Condition	Goal	Full year Baseline	Intervention	Owner	Start date	Expected Impact Sept 17	Expected Impact Mar 18
95th percentile daily all type ambulance attendances	90	112	**Demand Management (ACPs, See and Treat, Hear and Treat)** the 2017/18 contract plans an annual reduction of 2,139 conveyances for TH (mitigation of growth in activity)	LAS/CCG	September 17	Average reduction of 2 ambulances per day	Average reduction of 4 ambulances per day
			111 Green Ambulance disposition re-triage; clinically led enhanced assessment in place for ELC commissioners to support streaming in all care settings. Continued monitoring of 60% of all Green Ambulance dispositions each month, Of total calls triaged in 16/17, circa 40% (2,369 patients per year, 6.5 per day) were signposted to GP and other community services	CCG/111	In place		
			Implement **Sutton Care Homes Vanguard** initiatives: • Care Home posters signposting to alternate services (supplemented by *567 initiatives via 111) • 'Red Bag' scheme in two nursing homes • Dementia training • Falls training • Monthly MDT ward rounds including geriatrician and psycho-geriatrician targeting nursing homes. Minimum reduction in 2% of conveyances from Care Homes	Primary Care/ELFT	In place but in process of embedding.	Average reduction of 2 ambulances per day	Average reduction of 2 ambulances per day
			Reduction in conveyances of >85s through **extended operation hours of the LAS and Physician Response Unit** (12 hrs per day, 7 days per week) – the service has focussed on the top 250 most at risk patients.	LAS/Barts Health	August 2017	0	Potential to prevent 377 LAS conveyances to RLH, 435 ED attendances and 2334 inpatient days

3.2 Royal London system: Actions to address demand management - Total reduction of 30 breaches

Optimum Condition	Goal	Full year Baseline	Intervention	Owner	Start date	Expected Impact Sept 17	Expected Impact Mar 18
95th percentile daily Type 1 attendances	400	476	**Redesign RLH A&E front door model to a 24/7 Urgent Treatment Centre** with access to same day diagnostics. Will result in reduction in ED activity and respond to UCC staffing challenges.	CCG/Barts Health/GPCG/ELFT	September 17	Reduction in Type1 of 50 per day	Reduction in Type1 of 76 per day
			Implement initiatives to support streaming from ED: • **Direct booking into GP Access Hubs**, 6.30 – 8pm 7 days per week	GP Care Group/CCG	Commenced March 17	3 of the above seen in GP access hub per day	20 of the above seen in GP access hub per day
			Reduction in number of frequent attenders Shared system intelligence to support care in the community	RLH/ELFT/THSS	1st June 2017		
Mean daily type 3 (Urgent care centre) attendances	150	29	Streamed to Type 3 UTC and Primary Care - **increase from current 10% streamed away to 30%.**	CCG	September 17	Extra 60 of Type 1 seen in UTC per day	Extra 121Type 1 patients seen in UTC per day
% Mental Health Attendances breaching 4 hours. Baseline data available only for April17, for new national performance definitions .	5%	14.6% (April 17)	**Reduction in number of Mental Health frequent attenders** and breaches through implementation of the CQUIN and improvement of joint processes between the Trust and ELFT for patients seen by RAID	Barts Health/ELFT	April 17 onwards	Achievement of 95% standard	Maintenance of standard

3.1 RLH System: Actions being taken within ED to improve delivery and flow through the emergency care pathway– Total reduction of 30 breaches

Optimum Condition	Goal	Full year Baseline	Intervention	Owner	Start date	Expected Impact Sept 17	Expected Impact Mar 18
Number of admissions per day to ambulatory emergency care units, that avoided a breach	20 per day to be seen by AEC	6 per day seen by AEC	**Ambulatory Care (AEC)** Increase the number of patients seen by Ambulatory Emergency Care Service – extension of working hours to 10pm increasing numbers in ambulatory care to 15 per day by Sept 17 and 20 per day by Mar 18. Resulting in a reduction of 15 breaches per day in Sept 17 and 20 breaches in March 18	Site MD / CCG / All Divisions	Commenced 31 May 2017	Extra 30 patients in AEC	Extra 30 patients in AEC
Maximum volume of patients in Type 1 ED at any one time.	90	175	**Full capacity model** – Approved by ECIST, this protocol is used when there is significant congestion in ED due to patients waiting for beds. Stable patients are identified from AAU are transferred to wards as additional to core ward beds whilst patients on the ward are prepared for discharge. This frees up AAU for patients in ED awaiting beds.	Site MD / All Divisions	September 2017	Maximum of 130 patients in the department	Maximum of 90 patients in the department.
Total type 1 ED journey time (arrival to dispersal) calculated at 95th percentile of total journey time	3.30hr	7.37hr	**Embed a 24/7 operating model for ED flow** including the pilot of flow co-ordinator, escalation protocols and to drive breach prevention. **Increase ENP recruitment and retention** to increase workforce capacity to see non admitted patients. More non admitted patients seen in 4 hours and thus a reduction in non admitted breeches (5 breaches reduced per day)	Site MD / EC&T Division	Already commenced 31 July 17	Reduce journey time by 3.37hrs to 4.00 hours	Reduce journey time to 3.30hrs

3.1 RLH System: Actions being take to address Bed Occupancy - Total reduction of 10 breaches

Optimum Condition	Goal	Baseline	Intervention	Owner	Start date	Expected Impact Sept 17	Expected Impact Mar 18
Morning Discharges (by 12pm)	48	17	**Implementation of SAFER** in order to reduce LOS and increase number of discharges in the morning which will reduce breaches by 3 per day by Sept 17 and 5 by March 18.	Site MD	May 2017 – September 2017	Morning discharges increased to 20	Morning discharges increased to 48
Minimum number of daily G&A discharges (excl Maternity and Daycases)	141	125				Increase in daily discharges to >=137	Increase in daily discharges to >=137
Mean empty daily empty G&A beds at 8am	30	21	**Capacity management** Careful management of capacity involves a review of all patients in the hospital to identify reasons for delay & progress next steps.			Net bed balance of 15,	Net bed balance of 30,
Median G&A bed occupancy	85%	96.85%	**Develop and embed the discharge policy**, including embedding national standards of discharge planning.			Bed occupancy of 90%,	Bed occupancy of 85%,
Daily maximum number of beds occupied by Stranded Patients i.e. LoS =>7days (excl MO, DTOC and Repats)	200	275	**SAFER - Red day / green day** criteria established Project roll out support agreed by division (ECIST sponsored) Roll out from current 6 wards to all wards by September 2017.			Reduction in stranded patients to 238,	Reduction in stranded patients to 200
Daily maximum number of beds consumed by Medically Optimised pending patients	21	69	**Get me home meetings**, working with the whole system to support increase in speed of complex discharge.			Reduction in medically optimised patients to 40	Reduction in medically optimised patients to 21
Beds occupied by Repatriations to: •External NHS Trust •Barts Group site •Referral	0	17	Pilot Repat post to be created focussing on daily repatriations and more assertive approach to be taken led by the Medical Director Adoption of the SE/SW London policy on managing and escalating Repatriations	DM / Divisions / THSS / ELFT/ Medical Director	May 2017 July 2017	Decrease to 8 Repats per day	Decrease to 0 Repats per day

3.1 RLH system: Actions being taken out of hospital to support and improve discharge - Total reduction of 5 breaches

Optimum Condition	Goal	Baseline	Intervention	Owner	Start date	Expected Impact Sept 17	Expected Impact Mar 18
Maximum number of beds occupied by Medically Optimised patients	21	69	5 DTOCs per day are attributable to complex issues such as IMCA, Immigration, patient/relative choice. **Develop and embed the discharge policy** supported by the whole system Get me home meetings twice weekly to reduce these DTOCs. **Senior operational hub** Senior Operational Hub with escalation to NHSE for speciality rehab and to other boroughs where DTOCs exceed triggers. Currently an average of 5 DTOCs per day are attributed to Specialist Rehab issues. **Implement Tower Hamlet DTOC Strategy** to achieve 3% to 2.5% • CHT Social Worker • Hospital Social Worker OOH • Out of borough Social Worker • Discharge to Assess • Take Home & Settle	DM / Divisions / THSS / ELFT CCGs/NHSE ELFT/LA/Age UK (Voluntary Sector)	June 2017 Ongoing	Reduction to an average of 25 DTOCs per day	Reduction to an average of 16 DTOCs per day
Maximum number of beds occupied by Delayed Transfers of Care	16	36					

3.2 Whipps Cross System

3.2 Whipps Cross Hospital System Diagnostic – Drivers of current performance on the Whipps Cross site.

Demand Management

The Whipps Cross site saw a 2.6% growth in all types A&E attendances in 16/17 as compared to 15/16. Growth in Type 1 attendances was lower with growth of 1.5%. Higher levels of growth were recorded for children and over 80yrs. The new provider of the UCC has increased the proportion of people being seen in the UCC from 27% in July when they took over to 31% in March 2017. Based on the 95th percentile analysis, daily Type 1 attendances in 16/17 was 326 per day against an optimum level of maximum 250 per day. Admissions fell by 3% on in 2016/17 and have fallen by 25% in total from 2013/14.

ED Delivery and Flow

The average time to initial assessment at the front door of ED is currently 37 minutes against the 15 minute standard. The 95th percentile journey time for Type 1 patients was 9.09hr (16/17) and the maximum volume of Type 1 patients in ED at any one time during 16/17 was 137 against an optimum level of 70. There are on average 40 non-admitted breaches per day.

Bed Occupancy

There has been a year on year increase in Length of Stay from an average of 4.4 in 2013/14, 5.5 in 2014/15, 5.8 in 2015/16 to 6.5 in 2016/17. Daily median occupancy in 16/17 stood at 96.97%, against an optimum level of 94.29%. Minimum number of daily G&A discharges were 85 per day against an optimum level of 95 and the mean empty G&A beds available at 8am was 17 with an optimum level of 25. Morning discharges rates are low with an average of 11 discharges before midday in 16/17.

Out of Hospital & Discharge

Medically optimised patients occupied on maximum G&A beds 16.2% of beds (71 MO) on the Whipps Cross site against a London standard of 3% and an optimum level of 4% (17 MO) . Delayed Transfers of Care occupied a daily maximum of 6.62% (29 DTOCS) of the site core bed base in 16/17. The site has seen recent increases in DTOCs. Part of this increase has been attributed to processes at LBWF.

Workforce

A small reduction in the number of available locums due to IR35 has made it more difficult to mitigate against the substantive recruitment issues in ED. Significant gaps exist in substantive staffing numbers including Consultant (5.8wte), Junior Doctors (8.5wte) Paediatrics (2 SHOs) and Nursing number (83wte) across the Emergency and AAU departments.

Whipps Cross Hospital system: Scale of Improvement Required - breach reductions

The table below presents forecast attendances and breaches, the volumes are derived by applying a mathematical formula to the 2015/16 and 2016/17 data in order to continue the direction of travel observed in the last two years to the 2017/18 data. The improvement trajectory is then presented with breach reductions required to deliver the trajectory presented on a monthly and daily basis in order to quantify the scale of improvement required.
The Optimum Conditions have been designed to mitigate forecast performance and deliver the improvement trajectory, in summary achieving the Optimum Conditions will result in a reduction in breaches and a reversal of the currently observed decline in performance.

Month	F/cast Attendances	F/cast Breaches	Breach trajectory	Breach reduction (monthly)	Breach reduction (daily)
April 2017	13,251 (actual)	2,463 (actual)	2,463 (actual)		
May 2017	13,513	2,362	1,995	-367	-12
June 2017	13,336	2,255	1,748	-507	-17
July 2017	13,482	2,435	1,665	-770	-25
August 2017	13,253	1,873	1,506	-367	-12
September 2017	13,821	2,434	1,765	-669	-22
October 2017	13,815	2,983	1,534	-1,449	-47
November 2017	13,654	3,129	1,324	-1,805	-60
December 2017	14,059	3,367	1,712	-1,655	-53
January 2018	13,692	3,004	1,438	-1,566	-51
February 2018	12,345	2,941	1,137	-1,804	-64
March 2018	13,578	2,664	925	-1,739	-56

3.2 Whipps Cross system: Actions to address demand management

Optimum Condition	Goal	Full year Baseline	Intervention	Owner	Start date	Expected Impact Sept 17	Expected Impact Mar 18
95th percentile daily all type ambulance attendances	73	95	**Ambulance Conveyance Demand Management (ACPs, See and Treat, Hear and Treat)** • Increase referrals to Rapid Response Pathway and alternative pathways to ED will support 10-20 fewer ambulance conveyances per month (LAS) • East of England ACP demand management programmes	LAS/NELFT EEAST	September 17 Improved ACP pathways for July 2017	Reduction of 1-2 ambulances per day	Reduction of 3-4 ambulance per day
			111 Green Ambulance disposition re-triage (minimum 60%); clinically led enhanced assessment in place for ELC commissioners to support streaming to alternative pathways.	PELC	April 17	Reduction of 1 ambulance per day	Reduction of 1 ambulance per day
95th percentile daily Type 1 Attendances per day Mean Type 3 UCC Attendances per day % Streamed to UTC/PC	326 150 37%	250 129 31%	**Urgent Care Front door and Urgent and Emergency Care Pathways Redesign.** Collaborative redesign and integration with wider urgent care services and implementation of the ECIP recommendations and new model for Urgent Care. • Planning group established • System specification being developed collaboratively across partners to be developed from September 2017 – March 2018.	CCG/Trust	Early implementation of key requirements System plan to be developed for implementation from Sep 2017 to March 2018.	20 fewer attendances per day 1 fewer admission per day 35% of attendances seen in the UCC	30 fewer attendances per day 2 fewer admissions per day 37% of attendances seen in the UCC
			UCC access to diagnostics • Increasing the volume of patients seen and treated in UCC, reducing the number of non-admitted breaches, and reducing referrals from the UCC to ED. • 5-7,000 reduction in ED attendances p.a. TBC)	EPUT/WX	1 Sept 2017		
			Paeds GP with Specialist Interest • Enhanced capacity and leadership in UCC 7/7 • 6000 reduction in ED attendances p.a. • Reduced referrals to ED	EPUT	1 June 2017		
			Implement UCC DVT Pathway • Improved pathway and UCC/ambulatory integration • 700-1000 reduction in ED attendances p.a. • Appropriate utilisation of Ambulatory	EPUT	1 June 2017		
			High Intensity Users • Winter OR project mainstreamed from April 2017 • Reduction in 600 ED attendances per annum for high intensity users of A&E	NELFT	1 April 2017		

3.2 Whipps Cross system: Actions to address demand management – contd. - Total Reduction of 10 breaches

Optimum Condition	Goal	Full year Baseline	Intervention	Owner	Start date	Expected Impact Sept 17	Expected Impact Mar 18
95% percentile daily Type 1 Attendances Mean Type 3 Attendances continued	250 150	326 129	**Extended Access to GPs**, extension to 8-8 weekends and weekdays. Improved access to GP, Reduced attendances to ED/UCC • Re-direction/ booking from streaming to GP hubs (5-10 per day)	GP FedNet	Started 1 April 2017	As previous page. 35% of attendances seen in the UCC	As previous page 37% of attendances seen in the UCC
			Enhanced model of care to support Care Homes. • Build on pilot implemented in 16/17 • 'Community Support GP' Goaled to care homes • Red bag scheme launch and review (Reduced 150 A&E Attendances p.a. Reduced 60 non elective p.a. 5% reduction in LAS care homes incidents)	CCG/GP FedNet	Started 1 April 2017	20 less attendances per day	30 less attendances per day
			Rapid Response Service to deliver IV anti-biotics • Community management of Cellulitis and UTIs (86 reduction in Non Elective Admissions per annum Reduction of 687 bed days)	NELFT	1 July 2017	1 less admissions per day	2 less admissions per day
			Rapid Response overnight expansion • Integrated working with NHS111/ GP OOHs to prevent overnight admissions and provide consistent and integrated 24/7 service	CCG/NELFT	1 October 2017	1 less admission per day	2-3 less admissions per day
			Social Care Admissions • Reduced social care referrals to ED	LBWF/ LBR	1 October 2017		
% Mental Health Attendances breaching 4 hours. Baseline data available only for April17, for new national performance definitions .	5%	4.59% (April 17)	**Implement UCC Mental Health Pathway** • Collaboration NELFT (MH) / EPUT (UCC) • 600-1000 fewer ED attendances p.a.	CCG/ EPUT/ WX	12 June 2017	95%	95%

3.3 Whipps Cross: Actions being taken within ED to improve delivery and flow through the emergency care pathway –Total Reduction of 22 breaches.

Optimum Condition	Goal	Baseline	Associated Interventions	Owner	Start date	Expected Impact Sept 17	Expected Impact Mar 18
95th percentile of total ED journey time	3 hours 30 minutes	9h09m	**Strengthen Clinical Leadership in the department.** Appointment of Clinical Director and 2nd ED Matron in place as of beginning of June. 2nd ED Matron will provide 8-8 site support to the department. Programme of OD development scoped and implemented. **Enhanced Pathways** diverting patients away from ED into other departments where appropriate. • Implementation of UCC DVT Pathway • Implementation of UCC Mental Health pathway • Full capacity protocol - commenced • Creation of surgical assessment unit – planning phase commenced • In reach – improved MDT working in each clinical area • Implement internal professional standards for imaging, echos, speciality referrals • Redefine leaderships roles on each shift in ED • ED summits • Expansion of ambulatory criteria (surgical) **Ambulatory Care** • Develop and agree Model of Care for Ambulatory Care in May 2017 • Achieve a high and consistent standard of ED Streaming • Refresh internal professional standards, develop internal ED escalation plan • Explore and implement Specialty In Reach to Ambulatory Care with a view to eventual Hot Clinic provision	Director of Commissioning Waltham Forest CCG Site Managing Director Site Managing Director	April 2017 to Sept 2017 April 2017 - Sept 2017	Reduction of 95th percentile of 2 hours and 5 minutes Reduction of 5 patients in the department 30 patients seen in the department	Further reduction of 95th percentile of 2 hours 30 minutes - 5h 50m end of year effect. Additional reduction of 9 in the department (Total 14 reduction) 50 patients seen in the department
Maximum volume of patients in Type 1 ED at any one time.	70	137					
Number of admissions per day to Ambulatory Emergency Care Units	50	20					
Consultant Workforce	13.4wte	7.6wte in post (5.8wte consultants vacancies) **Other Vacancies**: 8.5wte junior drs 2 Paediatric SHO 83 nursing vacancies across ED and AAU.	**Recruitment Strategy** **Consultant** Recruitment of 4 Additional ED Consultants with flexible job plans to make more attractive **Other Vacancies** • Re-advertisement of Advanced Care Practitioner role • Building in flexible use of middle grad in job plans • Recruitment drive overseas for medical vacancies • 100 Filipino nurses to be placed at WX. • Cross site rotations for Band 5 nurses • Conversion of agency nurses to substantive • Development of UCC staffing model and recruitment of pharmacist.	Site MD/Clinical Director/Ass. Director of Nursing	May to December 2017		**Consultant** Recruitment to 4 Additional Consultant staff underway. **Other Vacancies** Request to advertise for 10 Tier A vacancies in BMJ in May 2017. Interview paed. SHO to be held in early June 2017. Plan is to go back out to advert.

3.2 Whipps Cross system: Actions being taken to reduce bed occupancy –

Optimum Condition	Goal	Baseline	Intervention	Owner	Start date	Expected Impact Sept 17	Expected Impact Mar 18
Minimum G&A discharges (excl Maternity and Daycases)	95	85	• **Bed management** policy adhered to • Red-Green-Day implementation	Site managing Director	June 2017	Additional 2 discharges per day	Additional 8 discharges per day
Mean daily empty G&A beds at 8am	25	17	• Expand **Frail Elderly Unit –** a 7 bedded unit, open 24hrs per day	Site managing Director	Sept 2017	An average reduction of 2 demand for beds	An average reduction of 2 demand for beds
Median daily G&A bed occupancy	94.29%	96.97%	• Ensure effective bed management procedures are in place • Improve diagnostic turnaround times • Ensure suitable consultant level input throughout pathway • Reducing LoS for AAU • Implement Internal Professional Standards • Provide discharge topic training for staff DToC and MO • Weekend joined up approach with site team & social care • Waltham Forest patients with one point of contact for all current simple discharge • Senior Leadership Team Daily ward and department rounds • Neuro-navigator to support discharges	Site managing director WF CCG	July 2017	Average daily occupancy reduction of -1.3%	Additional reduction in bed occupancy of 0.65% Total reduction of 1.95% - over delivery by 0.1%
Average Number of discharges by midday	16	11				14 Discharged by midday	16 Discharge by midday
Maximum number of beds occupied by Stranded Patients ie LoS =>7days (excl MO, DTOC and Repats)	220	304				Stranded patients reduced to 228	Stranded patients reduced to 220

3.2 Whipps Cross system: Actions being taken to reduce bed occupancy cont – Total reduction of 16 breaches

Optimum Condition	Goal	Baseline	Intervention	Owner	Start date	Expected Impact Sept 17	Expected Impact Mar 18
Maximum number of G&A beds occupied by Medically Optimised pending patients	17	71	• **Improved integration with out of hospital pathways** and primary care • Community support GP • Work with Community provider to enhance Home support pathway (D2A) • Provide discharge topic training for staff DToC and MO • Weekend joined up approach with site team & social care • Expand Discharge to assess with IDT • Supported Home Discharge Team	Director of Commissioning Waltham Forest CCG Geriatric Clinical Lead	Sept 2017 July 2017	Reduction of MO to 25	Reduction of MO to an goal of 17
Mean daily empty G&A beds at 8am	25	17	• Guarantee high quality and consistent handovers between teams to ensure high quality of care and flow • Implementation of **SAFER** patient flow bundle to all ward areas • Daily review of stranded patients • Promoting and supporting early discharge from AAU • Refresh function of weekend discharge rounds to include consultant presence • Re-organise discharge and flow coordinator teams	Site Managing Director	May 2017 and embedding In place October 2017	Additional 6 beds available at 8am	Additional 2 beds available at 8am 8 total – in line with plan

3.2 Whipps Cross system: Actions being taken out of hospital to support and improve discharge – Total reduction of 16 breaches

Optimum Condition	Goal	Baseline	Intervention	Owner	Start date	Expected Impact Sept 17	Expected Impact Mar 18
Maximum number of beds occupied by Medically Optimised patients	17 Max	71	**Supported Home Discharge Team** established October 2016 • Joint assessment service with community rehab team • Integrated Discharge Team for complex patients • Daily system-wide telephone conferences • Optimise current D2A pathway (following mainstreaming) • Expand current model to integrate with existing rehab and re-ablement services with single point of contact for referrals • Expand D2A pathway capacity with winter funding (1000 fewer bed days p.a. DTOCs reduced by 50% 115 patients on Supported Home Discharge Oct- Feb)	NELFT	In place from October 2016 July 2017 October 2017 October 2017	Reduction of MO to 6% (25) Reduction of DTOC to 3% (12)	Reduction of MO to 17 Reduction of DTOC to 2.5% (10)
			Neuro-navigator employed to support discharges • Mainstream Winter pilot (800 XBD reduction p.a. for complex neurological patients) • Bank post holder in place, interviews w/c 12 June for substantive appointment.	NELFT	1 April 2017		
			Streamline social care decision-making • Reduce block to funding decisions • Implement parallel processes for CHC • Improve brokerage response times (LBWF attributed DTOC's less than 3 per day; Redbridge delays less than 2 per day)	LBWF/LBR	1 July 2017		
Maximum number of beds occupied by Delayed Transfers of Care	10	29	**Investments in Adult Social Care** (budget 2017 allocations) • LBWF attributed DTOCs less than 3 per day; Redbridge delays less than 2 per day)	LBWF/ LBR	1 July 2017		
			Improve flow through Ainslie • Address social care delays/ allocation of SW to Ainslie (Increased rehab capacity).	NELFT/LBWF	1 July 2017		
			Accountable Care approach to out of hospital pathways including system beds and services to support them including D2A and IDT with view to changes in provision of beds across the system • Reconfigure management of rehab beds at Whipps Cross to unify provision of rehab services	CCG/NELFT/WX	October 2017		
			Integrated Discharge Team • Develop robust professional discharge standards to support earlier discharge • DTOC and MO definitions and discharge training for staff • Implement family choice policy (standardise across BH); reducing section 2 and 5 paperwork to ensure seamless working • Re-configure existing team to make best use of resources and implement trusted assessor working model	IDT	1 June 2017 1 June 2017 1 June 2017 November 2018		

3.3 Newham University Hospital System

3.3 Newham Hospital System Diagnostic
Drivers of current performance on the Newham Hospital site

Demand Management
The Newham Hospital site experienced growth in Type 1 attendances of 6.7% in 15/16. The site saw a 5.5% growth in all types A&E attendances in 16/17. The numbers of patients streamed away from ED to the UCC fell below 35% in the first 5 months of 16/17, however returned to 41% in March 17. The site saw significant growth in 16/17 with circa 20% growth in attendances of children under 10. The site also saw unusual peaks in attendances from the over 85 age group with particular peaks in December and January and c10% increase across the year from this age band. There were 51 days when attendances exceeded the 450 mark as compared to 39 in 15/16 and the 95th percentile analysis daily Type 1 attendances in 16/17 was 279 per day against an optimum level of 225 per day.

ED Delivery and Flow
The average time to initial assessment at the front door of ED currently sits at 18 minutes. The 95centile journey time for Type 1 patients was 5.12hr (16/17) and the maximum volume of Type 1 patients in ED at any one time during 16/17 was 130 against an optimum level of 45.

Bed Occupancy
Daily occupancy in 16/17 stood at 91.97% in line with their optimum level. Average discharges were 73 per day against an optimum level of 77 and the mean number of daily G&A beds available at 8am was 20 in line with the optimum level. Morning discharges rates are relatively good in comparison with the other sites.

Out of Hospital & Discharge
Medically optimised patients and Delayed Transfers of Care are not an issue on the NUH site and the system meets both the national standards with an 16/17 average of 2.2% (5 DTOCs) of beds occupied by DTOCs and 0.4% (1 MO) of beds occupied by Medically Optimised patients.

Workforce
The recent IR35 issues has impacted on the NUH site on what was a normally good fill rate, of shifts. Up to March 2017, NUH site team requested 230 shifts, 22 failed to be filled. In April 2017, 103 were shifts were requested, and 50 unfilled. There is concern about the quality of doctors attracted to fill shifts, particularly at Middle Grade, with significant challenges at night-time.

3.3 Newham University Hospital: Scale of Improvement Required – breach reductions

The table below presents forecast attendances and breaches, the volumes are derived by applying a mathematical formula to the 2015/16 and 2016/17 data in order to continue the direction of travel observed in the last two years to the 2017/18 data. The improvement trajectory is then presented with breach reductions required to deliver the trajectory presented on a monthly and daily basis in order to quantify the scale of improvement required.
The Optimum Conditions have been designed to mitigate forecast performance and deliver the improvement trajectory, in summary achieving the Optimum Conditions will result in a reduction in breaches and a reversal of the currently observed decline in performance.

Month	F/cast Attendances	F/cast Breaches	Breach trajectory	Breach reduction (monthly)	Breach reduction (daily)
April 2017	12,555 (actual)	1,346 (actual)	1,346 (actual)		
May 2017	13,383	1,284	1,207	-77	-2
June 2017	12,811	1,269	1,068	-201	-7
July 2017	13,150	864	928	64	0
August 2017	12,368	1,139	789	-350	-11
September 2017	12,509	1,153	650	-503	-17
October 2017	13,013	1,314	862	-452	-15
November 2017	12,291	1,391	844	-547	-18
December 2017	13,088	2,101	830	-1,271	-41
January 2018	13,381	2,379	857	-1,522	-49
February 2018	12,242	1,664	747	-917	-33
March 2018	13,972	1,536	492	-1,044	-34

3.3 Newham system: Actions to address demand management – Total breach reduction of 9 breaches

Optimum Condition	Goal	Baseline	Intervention	Owner	Start date	Expected Impact Sept 17	Expected Impact Mar 18
95th percentile attendances brought in by ambulance	71	91	**Demand Management (ACPs, See and Treat, Hear and Treat)** priorities in the 17/18 contract with the LAS to mitigate growth and divert to alternative pathways	LAS/CCGs	September 17	Average reduction of 2 ambulance attendances	Average reduction of 3 ambulance attendances (1 additional)
			111 Green Ambulance disposition re-triage (minimum 60%); clinically led enhanced assessment in place for ELC commissioners to support streaming to alternative pathways.	CCG/111	Commenced April 17	Average reduction of 2 ambulance attendances	Maintain average reduction of 2 ambulance attendances
			Clinical Support to Care Homes: Training focused on conditions most likely to be admitted. Awareness raising of alternative services such as Rapid Response, 111 and GPs GP led monthly MDT meetings being held in all 6 Newham Nursing Homes	CCG	Commenced April 17	A reduction of 6 conveyances	Further reduction of 6 conveyances (12 in totality for the year)
95th percentile Type 1 attendances per day Mean Type 3 (UCC) attendances per day % streamed away to PC/UTC	225 182 48% streamed away	279 167 38% Streamed away	**Improve streaming at front door** by: • increasing numbers streamed to UCC pharmacy, primary care and minor ailments. • increase in VB11Z, VB08Z, VB09Z treated in UCC. • Attendance avoidance through community services. • Rapid Response at the front door of ED • Protocol agreed with GP community that all GP 'Dear Doctor' letters to be triaged by urgent care, only direct referrals to specialties to appropriate pathways. • Clinical pathway is being revised to ensure that children are streamed to the most appropriate setting at the front door. • Clinical pathway for minor injuries are being revised to ensure that patients are streamed to the most appropriate setting at the front door.	CCG/Site MD	31 May 17	An average of 33 attendances extra patients streamed to UCC per day	Maintain 33 extra patients streamed to UCC per day
			26,000 additional appointments commissioned in **extended GP Access 8am-8pm**. Ensure UCC and ED can easily directly book into 3000 allocated appointments.	CCG	Commenced 30 April 17		
			Paediatric training for PC and UCC practitioners and a communications strategy and engagement plan on appropriate access of UC and Emergency services.				
% Mental Health Attendances breached 4hrs	5%	4% (April 17)	Reduction in number of **Mental Health frequent attenders** and breaches through implementation of the CQUIN.	ELFT/Acute MDT/CCG	Commenced 1 April 17	Maintain 95% standard	Maintain 95% standard

3.3 Newham system: Actions being taken within ED to improve delivery and flow through the emergency care pathway

Optimum Condition	Goal	Baseline	Intervention	Owner	Start date	Expected Impact Sept 17	Expected Impact Mar 18
Maximum volume of patients in Type 1 ED at any one time. 95th percentile of total ED journey time Number of patients seen in Ambulatory Care	45 3.30 hr 11	130 5.12hr 5	**Expansion of ED footprint to include ambulatory care** – Ambulatory sensitive pathways are currently admitted to CDU. The establishment of a dedicated AEC unit will enable better use of CDU, non admitted patients will be processed more efficiently as there will be enhanced space to assess more patients. This will reduce 2 breaches per day • Capital funding has been approved by DoH • Complete building work within agreed timeframe of October 2017	Site MD	31 October 17	3 fewer patients in the department, because of quicker throughput to meet goal of 45. Reduction in time from arrival to departure for 15 patients per day Reduction in the 95th percentile time journey time to 4.30hrs	3 fewer patients in the department, because of quicker throughput to meet 45 goal. Reduction in time from arrival to departure for 20 patients per day Reduction in the 95th percentile journey time to 3.30hrs
			Standardise ED nursing Leadership 1. Define and standardise the nurse- in charge and coordinator roles and responsibilities 2. Embed the above into BAU Will decrease the number of non-admitted and admitted 4 hour breaches	Site MD	30 June 17		
			Increased use of discharge lounge to move patients out of ED that require no on going medical treatment. Decrease number of non admit breaches by 3. 1. Increased awareness of criteria for use of discharge lounge 2. Discharge lounge checklist in use by all wards	Site MD	31 May 17	3 patients moved from wards to discharge lounge, freeing beds on wards	6 patients moved from wards to discharge lounge, freeing beds on wards
			Review of nurse roles in Observation unit to include discharge One nurse will be identified to focus specifically on discharge from the Obs Unit out of the hospital. Non admitted patients will be processed more efficiently as there will be enhanced space to assess more patients. This will reduce 2 breaches per day	Site MD	31 May 17	Senior nurse leadership in the Department – quicker decisions	Senior nurse leadership in the Department – quicker decisions

3.3 Newham system: Actions being taken within ED to improve delivery and flow through the emergency care pathway cont. Total reduction of 13 breaches

Optimum Condition	Goal	Baseline	Intervention	Owner	Start date	Expected Impact Sept 17	Expected Impact Mar 18
Maximum volume of patients in the ED at any one time (median)	45	130	**Actions to address Workforce issues** 1. Mitigation of IR35 impact 2. Recruit into vacant Consultant posts (3.35wte vacancies) 3. Recruit into Middle grade gaps (7.3wte SpR/clinical fellow vacancies) 4. Increase the number of ENPs with ED and UCCC 5. Reduce HCA vacancies and increase skill mix	Site MD	May 17 Aug to Dec 17 Aug to Dec 17 30 June 17 30 May 17	As above –	As above –
			Enhanced Streaming to achieve 15 minute triage time. The patients journey will begin earlier in their pathway 1. Fully functioning streaming in place 15 hours per day. 2. 95% of GP streaming slots filled 3. Expansion of Triage Space in ED Capital fund approved Complete building work within agreed timeframe	Site MD	31 May 17 31 October 17		
95th percentile of total ED journey time	3.30 hr	5.12hr	**Standardise the patient handover process** between different clinical areas- reduce the number of admitted breaches by 2. 1. Produce consistent handover process between: ED and Obs and Obs and the wards. 2. SOP documented 3. Process to be embedded into areas by senior nurses	Site MD	30 June 17		
			Produce ED Breach Escalation Plan to reduce the number of non admitted and admitted breaches by 4. 1. MDT working group formed 2. Working group tasked with writing breach escalation plan 3. Action plan to include escalation triggers	Site MD	30 June 17		

3.3 Newham system: Actions being taken to reduce bed occupancy –Total reduction of 9 breaches

Optimum Condition	Goal	Baseline	Intervention	Owner	Start date	Expected Impact Sept 17	Expected Impact Mar 18
Mean Daily Empty G&A beds at 8am	20	20	**SAFER Bundle Implementation** 1. Daily MDT board rounds in place 2. All patients have EDDs which are tracked 3. Up to date white boards in use on all wards Total discharges will be increased as they will have been identified and actioned before midday. Therefore increasing the potential for the discharges to occur on the same day. This will reduce admit breaches by 5% as beds will be allocated to ED in a timely manner	Site MD	31 August 17	20 Empty beds at 8am	20 Empty beds at 8am
Minimum Daily G&A Discharges a Day	77	73				1 More discharge per Day	3 More discharge per day
Median G&A bed occupancy	91.97%	91.97	**Bed meeting restructure** 1. Bed meeting policy and agenda in place 2. MDT attendance at bed meetings 3. Outputs and actions from bed meetings recorded	Site MD	3o June 17	Maintain 91.97% Bed Occupancy	Maintain 91.97% Bed Occupancy
Maximum number of beds occupied by Stranded Patients i.e. LoS =>7days (excl MO, DTOC and Repats)	45	89				Reduction of stranded patients to 98	Reduction of stranded patients to 95
Average % discharges by midday	19	14	**Improve CHC processes.** Decrease number of medically optimised patient Paperwork to be completed within the 28 day timeframe Total discharges will be increased as they will have been identified and actioned. This will reduce admitted breaches by 1 per day		30 June 17	17 discharged by midday	19 discharged by midday

3.3 Newham system: Actions being taken out of hospital to support and improve discharge – Total reduction of 3 breaches

Optimum Condition	Goal	Baseline	Intervention	Owner	Start date	Expected Impact Sept 17	Expected Impact Mar 18
Maximum number of beds occupied by Medically Optimised Occupied Bed Days (OBDs) Maximum number of beds occupied by DTOCs	1 4	6 12	**Improve CHC Processes** Training on CHC paperwork and more ownership by wards of completion, standards for completion of paperwork	Site MD	30 June 2017	Reduction of 1 DTOC	Maintain reduction of 1 DTOC
			Community in-reach team working with acute wards to identify patients who can be discharged to the community	CCG Deputy Chief Officer/ELFT	In place		
			Review current interfaces between providers and make improvement to systems, relationships and process where required	Site MD/CCG Deputy Chief Officer	September 2017		
			Home and Settle Service	CCG Deputy Chief Officer	In place		
			Development of formal D2A with Trusted Assessor.	Deputy Chief Officer, Newham CCG	January 18		
			Embedded training programme to nursing homes to enable patients to be accepted from hospital 7 days a week.	CCG Deputy Chief Officer/	In place		
			Social Worker available at weekends allowing all social workers to pre-authorise items to facilitate discharge eg equipment on behalf of other system partners.	CCG Deputy Chief Officer/ Local Authority	In place		
			Neuro-rehab issues account for majority of DTOCs. Newham CCG will continue to raise this issues as part of the London wide concern about numbers of neuro rehab beds.	CCG Deputy Chief Officer	In place		

4. System-wide enablers

A number of system-wide interventions will be needed to support delivery at a local level – these will be mapped as part of the overall plan along with clear expectations on timescales and ownership. Areas of focus include:

4.1 Workforce - Delivering the 5 Year Forward View and the Sustainability Delivery Plan

4.2 Workforce - Engagement for Staff Led Change

4.3 Site Level and System Level workforce plans

4.4 Escalation systems – refresh and review of current systems

4.1 Workforce – Delivering the 5 Year Forward View and the Sustainability Delivery Plan

Key drivers across North East London

- A 30% shortfall in nursing and a surge of ST3-8 doctors completing their training.
- Vacancy rates and turnover rates across secondary care are too high, leading to a strong reliance on temporary staff against a required reduction in agency spend.
- About 17.5% of registered roles in social care lie vacant, illustrating the difficulty of recruiting the right staff.
- 5 borough's (including Newham and Waltham Forest) with GP:Patient ratio's of 1:2300 or more (London average 1:2100, National 1:2000),
- Significant ageing GP and nursing workforce across 5 boroughs including Newham and Waltham Forest.
- Overall low GP training numbers – significant variation across NEL

Workstreams

Quality Improvement (QI) -Overseen by Primary Care Quality Improvement Board

Accelerate QI capability and capacity across NEL Primary Care – Business Intelligence, consistent approaches, share learning, measure impact.

Workforce - Overseen by Local Workforce Action Board

Build an understanding of workforce challenges through modelling.

Develop new roles including care navigators, physicians associates, medical assistants.

Develop multi-professional working including nurses, pharmacists and new roles, as well as GPs.

Implement enabling strategies – attracting, retaining, OD, Operational HR. Increase access - through hubs, networks and federations to offer long hours for all – delivered locally.

Provider development

Accelerate the development of providers working at scale through the newly formed Primary Care Provider Forum

4. Workforce - Engagement for Staff Led Change
co-designing the OD activities that will support delivery of system-wide emergency care improvement through staff-led change

In order to drive change in the Urgent and Emergency Care pathways and to deliver the priorities set out in the 5 Year Forward View, a system wide approach is required.

Primary drivers for staff engagement:

- Compelling narrative – set out what we are trying to achieve and why; ensure our leaders are able to tell this narrative well and support front line staff to see/understand their contribution; knowing who the leaders are within the system is an important start, as is really good communication and engagement plan
- Staff voice – opportunity for staff at all level across the system to come together and give their views of "what gets in the way of doing their best for patients" and "what will constitute an improvement" – and using that to kick start local improvement teams to take forward those ideas that have best chance of success, support by system wide approach to QI
- Engaging managers – building in time with middle managers so they understand what the emergency improvement plan is intending to do and give them the opportunity to clarify their role in its design and delivery. Having meaningful team & systems metrics that allow managers to track impact, celebrate success or course correct early when something isn't working. Identifying any gaps in middle manager capacity and capability and taking necessary action to support.
- Integrity – how will we commit to behave with each other across the system – agreed and role modelled at all levels – and crucially from senior system leaders. What are the values underpinning this work and how we work with each other to build the necessary continuous improvement culture

- To achieve this, system partners commit time to co-design the OD plan to support excellent staff engagement for staff led change across the system, that sets out the key activities and schedule, shaped to deliver what we know works
- At Barts Health, an Emergency Care Clinical Board with a Clinical Chair has been established, the first meeting is being held in June. The Board will be led by the Clinical Chair working as part of a triumvirate with a senior manager, senior nurse and clinical involvement across all 3 sites.
- The Clinical Board will have a standardised terms of reference and a common set of objectives including strategy development and implementation planning, review of standards and variation and identifying cross site workforce issues and priorities.

4.3 Royal London Hospital and Tower Hamlets System

Actions being taken to address Workforce issues –

Action	Owner	Implementation date	Progress update
Short term rota solutions in place to mitigate IR35 and cover as many shifts as possible. Shift gaps are in GP, junior doctors and practitioners.	Site MD	31 May 2017	Adjusted rota pattern being worked to, to provide medical cover in the most crucial slots. Nursing team leading work on creating a sustainable practitioner model including a training pipeline.
Implementation of Urgent Treatment Centre, moving to a new workforce model with GPs and practitioners.	Site MD	31 October 2017	Programme board set up with 6 workstreams monitored by board. Workflow workstream has met to agree how patients will move through the service.-
Work underway with GP Care Group (Current GP OOH provider) to share staff and rotas, increasing from 60% fill rates to >80%.	GP Care Group/Site MD	30 June 2017	This is on track.

4.3 Whipps Cross - Actions being taken to address Workforce issues

Action	Owner	Implementation date	Progress update
Medical IR35 recruitment issues 6 registrars and 2 Consultants have been sourced to fill gaps. Existing agency doctors are considering a revised pay and working hours arrangement with feedback due on 18th May Corporate and Network support for this	Managing Director Corporate Directors Network Director	April 2017 on going	Reached agreement with doctors for continued working and greater commitment to twilight and night working
Medical Recruitment Following sign off of Business Case for 4 Additional ED Consultants, the posts have been advertised with interviews on 20th June. Jobs have an attractive JD and feature flexible job plans to make more attractive	Clinical Director	Adverts to be placed April 2017, candidates anticipated start date, October 2017	Adverts closed 4th June 2017, posts sent to clinical lead for shortlisting. 2 applicants as at 2nd June 2017
Medical Recruitment Revision of Advanced Care Practitioner Job Description, and re advertisement week commencing 29th May 2017	Associate Director of Nursing Service Manager	Advert to be placed week commencing 29th May 2017	Advert placed on 7th June 2017
Medical Recruitment CESR Programme Re-advertisement	Clinical Director	Advert to be placed May 2017	Advert to close 11th June 207, one applicant to date.
Medical Recruitment MSc in conjunction with QMUL Emergency medicine Rotational Programme Flexibility use of existing middle grade establishment feature in job plans	Professor Tim Harris	August 2017	Post closed 4th June 2017, 10 applicants as at 2nd June 2017.
Medical Recruitment ED now approaching all overseas firms to help with attracting overseas staff	Clinical Director	Commenced	2 CV's received as at 5th June 2017.

4.3 Whipps Cross - Actions being taken to address Workforce issues cont.

Action	Owner	Implementation date	Progress update
Nursing Recruitment Cross Site Band 5 Rotations agreed for 12 staff	Associate Director of Nursing	31 July 2017	Start date now 1st September 2017.
Nursing Recruitment In terms of recruitment from the Philippines, corporate recruitment are currently reconciling the numbers of Filipino nurses appointed to the Trust, of which 100 will be placed at WX, 15 nurses starting every 4 weeks	Associate Director of Nursing	Commenced	Commenced
Nursing Recruitment Conversion of Agency Nurses to substantive	Associate Director of Nursing	30 June 2017	Commenced
Nursing Recruitment Dedicated HR Search Team established to nurture pipeline of candidates for all WX vacancies. Ad placed for HR Recruitment manager with interviews scheduled for next 2 weeks	Head of Human Resources	End May 2017	Recruitment business partner appointed 2nd June 2017, start date being arranged. Two open days running in June 2017 for HCSW;s and RN;s (10/6/2017 and 17/6/2017 respectively)
Overall Recruitment Exec Led task and finish group to rapidly progress recruitment initiatives to support site to deliver plans.	Director of Work Force Chief Medical Officer Managing Director	End May 2017	Task and Finish Group established. Action plan being developed.
UCC Staffing (CCG Action) Development of UCC staffing model to include GPs with Specialist Interest (Winter OR project being mainstreamed) to support workforce capacity. Recruitment of pharmacist to work across the UCC and ED to provide additional support for medicines and minor illness.	Director of Commissioning WFCCG	Commenced	GPWSI in paediatrics project to be implemented in June 2017 Pharmacist proposal to be developed for approval by UCWG with planned implementation from September 2017

4.3 Newham University Hospital - Actions being taken to address Workforce issues

Action	Owner	Implementation date	Progress update
Mitigation of IR35 impact: Normalised rates and a dialogue with the doctors Corporate HR to mitigate the risk going forward	Site MD Director of workforce	May 2017	Complete
Recruit into vacant Consultant posts. There are currently 3.36wte consultant vacancies. One post holder starts in August. Site and specialty recruitment campaign agreed to fill the remaining Medical and nursing workforce gaps, being driven by the Assistant Director of Workforce Development working with the site Medical Director, CDs, GMs and central recruitment team.	Emergency care clinical director Medical Director Assistant Director of Workforce	August – December 2017	On track
Recruit into Middle grade gap. 7.3 wte SpR/clinical fellow gaps. International recruitment to be maximised by working with central recruitment team. Plan to appoint a small number of agencies (on Framework) to do some active domestic and international recruitment supported by central recruitment.	Site MD CD ED Assistant Director of workforce	August –December 2017	On track
Increase the number of ENPs within ED and UCC. ENP / ANP development / ANP in emergency medicine about to go out to advert. A Trust wide programme is required to maximise the opportunities of recruitment into ENP training posts; discussions ongoing the funding, training and development of these posts.	Director of Nursing (NUH) Emergency care clinical director AD of workforce	June – Sept 2017	On track
Nurse leadership and ownership – Updating and roll out of standard operating procedures. Review of Nursing Establishment to be undertaken looking to identify transformation opportunities i.e. new roles to support substantive appointments at various levels. National expert from NHSI will assess the Observation unit following the recommendation from the Shelford tool that the establishment is increased. Developing a paediatric rotation model to address the issues with covering and recruiting to paediatric and paediatric ED posts. Developing an acute rotation which will include ED to maximise recruitment opportunities There is work needed to further explore the role of senior nurses in ED in the RAT model. Exploring overseas nursing both via pull from pool in UK already via HCL and also overseas recruitment.	Director of Nursing (NUH)	30 June 2017	On track
HCA profile and vacancies: Reduce the number of vacancies with ED to ensure skills are appropriate to role requirements (ability to take bloods). The site will review the band 2-3 roles though a community programme which enables us to recruit staff who have the potential to rapidly up-skill.	Director of Nursing (NUH)	31 May 2017	On track

4.4 Enablers - Escalation and On Call System

Action	Owner	Implementation date
Review of existing internal Trust on call arrangement to better respond to emerging issues.	Director of Operational Systems Barts Health	July 2017
Review of existing Surge Escalation Framework to ensure triggers are relevant and actions are commensurate and appropriate. The framework should enable trends to identified and prediction enabling escalation to take place earlier and with more robust actions cards for all parts of the system. Need to ensure that triggers for de-escalation are also appropriate.	CSU/A&E Delivery Board	July 2017
Seek best practice examples from inside and outside the STP to inform review of Escalation Framework	CSU	June 2017
Undertake a Table Top Major Incident Planning exercise across WEL using the reviewed plan	CSU Surge	July 2017
Review learning from the recent Cyberattack incidents to ensure that Communications pathways are robust and that contingency plans are in place for system wide IT breakdown.	A&E Delivery Board	June/July 2017
Review existing Repatriation policy in line with the South (SE and NELCSU SW) and apply best practice models for managing and escalating Repatriations (King's model). Use STP to lever change in hospitals with North East London.	A&E Delivery Board	June 2017